The Revenue Engine that Could: “Think You Can” by Refining the Revenue Cycle with the Right People, Processes, and Tools

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Many physicians continue to wrestle with an economy-in-recovery and declining reimbursements. In this business climate, practices can’t afford reimbursement process mistakes and inefficiencies; they’re simply too expensive. Just a few denied surgical claims can cost a practice thousands of dollars. That’s the cost of the annual electronic health records license or the T1 line. Uncovering any and all opportunities to improve the speed and efficiency of getting paid can positively contribute to the bottom line. This article reiterates the basics and “best” practices for efficient revenue cycle operations. The goal is to have the right tasks performed by the right number of people at the right time and with the right tools to optimize revenue.

KEY WORDS: Revenue cycle; reimbursement; accounts receivable; collections; billing; EOB; claims submission; insurance; coding; operational process; electronic claims.

REVENUE CYCLE REDUX

One of my favorite stories is The Little Engine That Could. A little railroad engine was employed by a station yard to pull boxcars on and off switches. One morning as it waited for its next job assignment, the Little Engine heard a long train of freight cars ask a large engine if it would take the freight cars over a big hill. “I can’t,” the large engine said. “It’s too much for me to pull.” Other large engines agreed.

In desperation, the long train asked the Little Engine if it could do it. “I think I can,” puffed the Little Engine, as it put itself in front of the long train and started pulling the train over the hill, all the while saying, “I think I can, I think I can, I think I can.” And when the Little Engine made it to the summit, the Little Engine congratulated itself all the way down, saying: “I thought I could, I thought I could, I thought I could.”

The process of getting a claim paid, the revenue cycle, is like this long train. It can seem daunting with its many “boxcars” full of rules and steps and complexities. But if you have the right fuel and focus for the engine, and the right people to drive it, you can move the reimbursement train forward with minimal effort—even if your engine is not large. Think you can, and you will, and the train will pull into the station on time, with payment.

In our work with practices nationwide, we describe the revenue cycle as having two major components: front-end processes (the engine), and back-end processes (the caboose). See Table 1 for a list of processes in each component.

Front-end processes are those that happen prior to or on a date of service and that have the most patient interaction. Appointment scheduling, pre-registration, and check-in are examples. Like a train engine, the accuracy of patient information and timely completion of front-end processes drive the success of the back-end processes to ultimately achieve revenue optimization. Front-end processes are where most practices have the biggest opportunity to make improvements; they produce many of the root causes of revenue cycle problems.

Back-end processes are tasks that happen after a date of service occurs, whether that service was performed in the office or the operating room. They are nearly all performed by office staff. Claim/statement production, payment processing and analysis, claim denials management, and accounts receivable follow-up are examples. These processes take up the rear of the revenue cycle, like a caboose, and the level of effort required to complete them is almost entirely dependent on how well the front-end processes were completed.

You may be reading this right now and saying to yourself, “I already know this. It’s not rocket science.” Fair enough. But as we spend time on the front lines, in clinic, and auditing claims for hundreds of practices each year,
we find that even though revenue cycle is not rocket science, there are a series of common problems that result in missed reimbursement and revenue. Many of them are the same challenges that have plagued practices for years, and most of them are on the front-end. The good news is: all of them are solvable with some fine-tuning.

**ADD FUEL TO THE FRONT-END ENGINE**

1. **Take appointment scheduling seriously.** The new patient appointment call is typically a practice’s first encounter with the patient. It’s *one of the most critical steps in the revenue cycle and yet it gets the least amount of respect.* Staff members tasked with scheduling appointments sit in the hot-seat at the reception desk and are asked to juggle appointment scheduling phone calls with check-in tasks. They are rarely given customer service training, reimbursement process training, or written protocols to do their job well. Train your appointment scheduling staff well, and provide specific protocols and direction about how to collect data accurately. Future third-party billings and collections efforts depend on it.

2. **Pre-register new patients.** Business-savvy practices don’t wait for the patient to show up in the office to register. They obtain complete patient demographic and insurance information from the patient—not the referring physician’s office—before the first visit. Patient portals—interactive Web sites that may or may not integrate with your electronic health records (EHRs) system—are effective, online tools for enabling patient pre-registration as well as appointment scheduling, online bill payment, and more. If a patient portal isn’t an option, your practice Web site administrator can easily create an online form for patients to complete, so that registration information is transmitted to the office for data entry into the billing system before patient arrival. The HIPAA Privacy Policy statement and other forms typically provided at the check-in window can also be handled through the Web site.

3. **Verify insurance eligibility and benefits for patients prior to their arrival.** We continue to be amazed at how many practices skip this step. All too often, a practice finds that a patient, new or established, does not have the insurance coverage he or she claims to have, and the practice ultimately is not paid for rendered services. In pre-Internet days, this verification took a lot of staff time on the phone. Today, many billing systems and EHRs can be scheduled to perform these checks automatically, overnight, and produce a report indicating the result for each patient. If your system doesn’t have this feature, nearly all payers provide the information on their Web site. In addition to verification for new patients, smart practices re-verify insurance benefits on all established patients not in a postoperative global period.

4. **Obtain required managed care referrals for all patients.** Depending on the size of the practice, referrals management can be performed at the time of appointment scheduling, or it can be a separate process. If a patient arrives for a nonurgent issue without a referral, obtain it before he or she is seen or reschedule the appointment. If you don’t, your reimbursement for that visit is at risk.

5. **Be vigilant about verifying patient identity, demographics, and insurance at check-in.** The receptionist plays a pivotal role in the revenue cycle process by validating the patient’s identity and any previously obtained insurance information. This step is frequently overlooked due to the fact that the check-in staff members are often overwhelmed with phone calls, chart prep, appointment scheduling, and check-in tasks. Like appointment scheduling, take this task seriously. Set up your check-in team members for success by minimizing multitasking and allowing them to focus on verification tasks.

6. **Collect mandatory encounter copays at check-in.** Patients “can’t pay today” less frequently when copays are

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**Plan Ahead for Tests and Scans**

Third-party payers often require precertification for testing such as plain films, MRIs, and CT scans. Since many patients will require further diagnostic testing and/or diagnostic or therapeutic procedures after being seen by a physician or provider, successful practices incorporate obtaining precertification into the revenue cycle process, particularly if the practice has the capability of performing the imaging or laboratory service.
collected prior to seeing the physician. Accept all forms of credit and debit cards to give patients the greatest number of options to pay. Many Americans, especially those under 30, carry little cash these days, and checkbooks are fast becoming a thing of the past.

7. **Code correctly and completely.** Insist that all physicians, providers, and clinical staff who render an office service (e.g., E/M code, radiology code) or a procedural service (e.g., injection code, diagnostic test code) are trained in compliant and accurate coding. CPT and ICD-9 codes are the standard code sets used for medical billing. Coding and documenting for services performed is most efficiently and accurately done by the rendering provider. Attend your physicians’ specialty society coding course or have on-site training by a reputable coding consultant who is aligned with the physicians’ specialty society.

8. **Use claims estimators to boost point-of-service collections.** “Point-of-service” collecting is asking the patient to pay all estimated co-insurance, unmet deductibles, and any previously unpaid balance before he or she leaves the office. Collecting the patient’s portion of the charge before the patient leaves your office optimizes the speed with which the account is paid and reduces the cost of sending patient statements. It used to be nearly impossible to predict what these amounts would be until the Explanation of Benefits (EOB) came with the plan’s payment. Today, **claims estimators** are gaining speed as a real-time, “best” practice solution for calculating a patient’s portion of the charge while the patient is at the check-out window. Availity’s CareCost Estimator (Figure 1) delivers data about a patient’s co-insurance, copay, and estimated financial responsibility for multiple plans. Such estimators are fast, easy-to-use online tools that are typically quite accurate. Check with payers to find out what’s available in your market.

**CALL FOR THE CABOOSE: ENSURE EFFECTIVE BACK-END PROCESSES**

1. **Code and submit claims daily and electronically as much as possible.** Payers process electronic claims faster than paper claims, which helps improve cash flow and keep accounts receivable low. The goal is to submit a “clean claim,” one without errors or omissions, only once, so it can be paid in a timely manner. Successful practices submit accurate, clean electronic claims on a daily basis to as many payers as possible. This includes federal and private payers, as well as workers’ compensation carriers—many of which now offer e-billing via a number of clearinghouses and practice management systems. Check to see if your clearinghouse or system is

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**Figure 1.** Availity’s CareCost Estimator. Claims estimators are gaining speed as a way to accurately collect from patients at the point of service.
EOBs: Revenue Cycle Diagnostics

Explanations of benefits (EOBs) are the best diagnostic test for evaluating whether revenue cycle processes are working. Appropriate analysis of each EOB is critical to ensure the practice was paid according to contract terms and to drive the next steps in the revenue cycle, such as billing a secondary payer or sending a statement to the patient for payment of the balance.

Another important aspect of EOB analysis is to determine any primary third-party claim follow-up, such as appealing services denied for inappropriate bundling, medical necessity, low-pay appeals, incorrect coding, and inappropriate reporting of services during the global period. Involve physicians and other providers in denial appeals for medical necessity and coding denials.

Smart managers actually look through a random stack of EOBs quarterly or several times a year and analyze for denial trends that identify front-end, process-related problems such as:

- Demographic errors;
- Eligibility-related denials;
- Wrong primary/secondary insurance company;
- No referral authorization; and
- No coverage at time of service.

It’s important to ask if a payer provides payments on the ERA by “line item” (in other words, by each CPT code billed), or if it “lumps” all services together on the same date of service. If the latter is the case, require that staff contact the payer for each payment received, to determine the allocation of each payment, for each CPT code. Without this additional investigative work, there is no way to determine that payment is correct.

5. **Follow up on current balances quickly.** Some third-party payers reimburse providers in a very timely manner. For example, Medicare pays clean electronic claims within 14 days. Other payers may take weeks to months to reimburse. Focus on unpaid claims in the “30 day” bucket of the accounts receivable report first. If staff members stay ahead of the curve and get the current claims paid quickly, in a short period of time the number of “very old” outstanding balances will be minimized.

6. **Create policies and procedures for addressing outstanding unpaid balances.** If point-of-service collections are lackluster or your practice is just putting such processes in place, most likely you’ll have outstanding patient balances that are 60 or more days old. Generally, these are the more difficult to collect. In addition to focusing on the use of claims estimators and improving front-end collection processes, make sure there is an organized process for monitoring and following up on unpaid balances. Create written policies for the practice and have them reviewed and approved by the physicians. Include specific protocols for handling issues such as payment plans, charity care, and the uninsured and underinsured patients who ask about cash discounts.

7. **Use collection agencies wisely.** High-performing practices rarely need to engage an outside collection agency. But uncollectible balances happen to every practice at some point. If you plan to send a patient to a collection agency or take legal action for payment, it’s imperative that the provider who rendered the service—not the billing staff or the office manager—approve the decision to pursue the external collections process.

**CONCLUSION**

Every employee and provider in the practice, from the person who answers phones to the physician and clinical staff, has an important role to play in the revenue cycle. Use this article as a process audit checklist for your practice. Sit with staffers and ask questions. Observe them scheduling appointments and collecting money at check-out. Ask the billing staff about the biggest denial challenges, and analyze EOBs for rejection patterns.

Every little improvement to efficiency counts when it comes to improving the revenue cycle engine. And if you think you can, you will.