

TRENDSETTERS

Effective Revenue Management Puts Back-Office Function on Front Burner

Questions Highlight 'Need to Know'

To better manage the revenue cycle in occupational health programs and clinical practices, Don Kilgore recommends that providers consider these key questions:

- What are the group's policies related to verifying claim compensability at patient registration?
- Is the workers' compensation business concentrated among a few employers or spread across hundreds?
- What is the mix of small versus large employers?
- What are the standards for getting bills generated and out the door?
- How aggressive are collection activities and to what degree will the provider extend credit?
- Are labor resources in the right places in the right amounts?
- Does the provider understand its direct and indirect per-claim processing costs?
- What state or federal program governs most of the clinic's claims?
- How many patient visits does the program or clinic average and what is the net revenue per treated work injury?
- Is the provider coding appropriately and charging enough to maximize revenue?

Failure to effectively manage the workers' compensation revenue cycle can drag a clinic under.



Don Kilgore

"You can do everything else right, but if you don't pay attention to processes and activities related to revenue and margin generation, then there will be stress on the organization's long-term survival," said Don Kilgore, a partner with Unified Health Services (UHS), a national company specializing in revenue cycle management for workers' compensation claims.

A member of the NAOHP Vendor Program, UHS manages more than \$45 million in workers' compensation receivables and nearly 300,000 patient visits annually for clients in 25 states.

As a rule of thumb, Mr. Kilgore says a clinic with a large and broad client base is "doing a good job" with revenue cycle management if 95 percent of its workers' compensation accounts receivable (AR) are consistently aged less than 90 days and its bad debt is less than 5 percent of total revenue.

A common oversight in judging AR occurs when workers' compensation claims on an outstanding account are denied and shifted to group health or patient-pay. These situations contribute to, and can mask, bad debt: Patient-pay collections are more challenging, and there may be filing time limits on group health claims.

"When a claim originates in the workers' compensation payer class and is

shifted to a non-comp payer class and then subsequently not paid, that bad debt can be traced back to a process flaw on the workers' comp side," he said. "When I see AR that doesn't look good, it's usually symptomatic of an underlying process problem."

In addition to understanding how bad debt occurs, proper allocation of manpower is a critical factor in revenue management. Mr. Kilgore finds that most clinics tend to have a disproportionate number of staff engaged in AR-related functions when they should be more focused on claim eligibility when services are scheduled or a patient presents for treatment.

Upfront claims management helps ensure that claims billed as workers' compensation truly are work-related cases. Additionally, it facilitates reimbursement by prompting employers to do the work they may need to do, such as notify their carrier. It also allows the clinic to verify its billing protocol.

Another important factor is attaching all the necessary documentation. State workers' compensation regulations include provisions that require providers to attach office notes, operative reports and records to the proper billing forms. No attachments means no payment; especially when reimbursement is by report.

"Many factors impact the revenue cycle and cash flow," Mr. Kilgore noted.

Eligibility is Key

Effective revenue cycle management starts with two critical steps: 1) verification by the employer that the patient's injury is eligible for reimbursement under the workers' compensation system and 2) determining where invoices should go. Without coverage verification the provider accepts risk, which

Ten Tips for Revenue Cycle Management

The following are tips for improving workers' compensation revenue cycle management:

- 1** Lower your "days-to-bill" rate. A reasonable goal is to distribute an invoice within three days of the patient visit. Optimally, charges should be entered and billed daily. Even with a solid process, it can take 55 days on average to be reimbursed. "The quicker you get the bills out the door, the quicker they can be paid," said Don Kilgore of Unified Health Services, a company specializing in workers' compensation billing and accounts-receivable functions.
- 2** Have a protocol in place to ensure that the bill is always sent to the right place. "Mis-billing creates rework, slows down payments and angers employers," Mr. Kilgore noted.
- 3** Make sure invoices are clean, correct and have all the required attachments: "It takes time and costs money to monkey around with re-billing." Put the claim number on the HCFA (now CMS)-1500 form if you have it.
- 4** Ensure coding is appropriate. "Get paid what you are entitled to get paid," Mr. Kilgore said. "If you are in doubt, consider hiring a consultant to conduct a medical chart and coding review."
- 5** Avoid price discounting and don't undercut workers' compensation fee schedules.
- 6** Keep your eye on the ball. Run periodic reports on client activity to identify employer injury volumes, payment history, etc. How long would it take your program to identify the loss of a key client? If workers' compensation receivables balloon for a client, how long will it be before action is taken?
- 7** Have a method to identify patients from new employers so you can quickly follow-up to thank them and cultivate a relationship.
- 8** Minimize aging of accounts by quickly identifying and acting on unpaid balances after 30 days. Sort and work unpaid balances in descending order but address all unpaid claims with an employer or payer in a single call. Remember there are employers whose business you may not want!
- 9** Scrutinize explanations of benefits (EOBs). (The EOB indicates services that were billed and amounts that were paid to the provider or denied by the insurer.) "EOBs contain valuable information," Mr. Kilgore noted. For instance, should an appeal be filed? Are providers being paid at appropriate rates? In fee schedule states, is the provider getting 100 percent of allowable reimbursement, and if not, is there a trend with a certain payer or bill reviewer? Is down-coding occurring? They also contain claim numbers.
- 10** Establish metrics and measure process performance.

can cause the clinic to send invoices to the wrong person's in-basket.

"If you are not familiar with the company, use the verification call to ensure reimbursement and collect basic contact information to pass along to your sales team. Also, speak with the employer's carrier or third party administrator (TPA) to validate coverage," Mr. Kilgore advises.

For example, smaller companies with infrequent claims may communicate they have required coverage when in fact they don't or that they are self insured when they can't be.

"If you are familiar with the employer, take a moment to confirm that the information you have in the company's profile is correct," he added.

While the process sounds simple enough, according to Mr. Kilgore, many clinics fall short in this area and routinely assume what they have on file is current or what an employer tells them is true.

"We find it takes an average of about nine minutes to conduct an eligibility call, including telephone tag," he observed. "These calls are often supposed to be made by busy receptionists who are extremely pressed for time. Consequently, the calls may not be made. Most often the perception is that the back office will handle it."

A critical first step is to speak with the person who can make the eligibility determination on the employer's behalf. If the answer is 'Yes, it's work-related,' then encourage the employer to move forward with getting the claim on file with its TPA or carrier.

"All those things help grease the payment skids," Mr. Kilgore noted.

If verification cannot be readily obtained, it is advisable for the clinic to get backup payer information from the patient—such as a photo copy of the patient's group health card—before treatment is rendered and to make sure there is complete and accurate patient contact information. Overall, about 6 percent of the workers' compensation claims managed by UHS are denied for various reasons.

Treatment Authorization

In many instances, treatment authorization is another essential aspect of the process. Permission may need to be obtained, for example, from a nurse case manager, the employer, an insurance carrier or TPA, or a managed care company to conduct diagnostic tests and many types of treatment.

"It's important to obtain that pre-authorization," Mr. Kilgore said. "It may be a compensable claim, but you may be an out-of-network or non-panel provider. You may consider a treatment medically necessary but the payer may not agree or may want an alternative treatment. Or the payer may authorize fewer treatment encounters than what is recommended in the care plan. The goal is to get authorization beforehand and eliminate reasons why the provider wouldn't get paid."

Unified Health Services protects its clients' interests by verifying workers' compensation claims and assuming responsibility for collections and reimbursement. On initial patient visits, UHS verifies claims and obtains accurate payer information. It subsequently distributes invoices and collects reimbursement for clinics.

With standardized processes, UHS is able to guarantee a client's reimbursements and assume payment risk on denied claims. Clients pay UHS a fee contingent on the amount of net cash managed. The company's clients include hospital-based occupational health programs, free-standing occupational medicine practices, urgent care clinics, multi-specialty groups and hospitals.

"Having a solid process is important, but having performance indicators is equally as essential," Mr. Kilgore said. "Providers should look across the board—from registration to cash application, identify key activities, establish productivity targets and then measure performance."