HEALTH CAPITAL Topics
Volume 13
Issue 5
May 2020
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COVID-19: The Role of Revenue Cycle Management in Physician Practices

The COVID-19 global pandemic has brought a time of uncertainty for many healthcare providers. While the focus of healthcare providers is on the access and delivery of care to those impacted by the outbreak, there are many providers who will require substantial financial resources to persevere. Physician practices in particular are striving to stay open, and are adopting new technology such as telehealth, to continue to see their patients and generate much-needed revenue. The revenue cycle management (RCM) process is playing a more vital role now, and this process may need to be modified in order to provide necessary cash flow. This *Health Capital Topics* article will discuss some of the ways in which the pandemic impacts the RCM process and the factors to consider in maintaining cash flow and patient satisfaction.

The *Healthcare Financial Management Association* (HFMA) defines RCM as "*all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue*."[1] It encompasses the process of financial data and information through a typical healthcare encounter from admission (registration) to final payment (or adjustment of accounts receivable).[2] The healthcare revenue cycle begins with the scheduling of a patient appointment and ends upon the collection of all claims and patient payments.[3]

In general, the RCM process involves the following steps:[4]

(1) Patient Registration/Eligibility Checking: Patient registration and eligibility checking of patients' demographic and insurance information by the front desk staff is necessary to ensure the patient's insurance is in effect for the date of service to submit a "*clean*" claim. A clean claim is defined by Medicare as one that can be directly paid, with no investigation or analysis required; if a claim is not clean, it cannot be processed, and must be corrected and resubmitted, prolonging the payment timeline.[5]

(2) Provider Treatment: The patient is then treated by the provider, who documents the services rendered via procedure and diagnosis codes in the *electronic medical record* (EMR). The use of correct, and the most clinically appropriate, codes will decrease the probability of denied claims.

(3) Claim Submission: Once the patient demographics, insurance, procedure, and diagnosis codes are reviewed internally, the claim is submitted to the third-party payor.

(4) Payment: The payor sends the provider an *electronic remittance advice* (ERA), which explains the claim payment (and the components thereof).[6] The payor pays their portion of the amount owed to the provider according to the payor's contracted fee schedule. The balance of the payment, if any, is then transferred to the patient (or secondary insurance payor), who is responsible for any amount that the first insurance payor did not pay, such as the patient deductible.[7]

Reimbursement from payors can be delayed due to a multitude of reasons, such as incorrect patient insurance or demographic information, or incorrect procedure or diagnosis codes entered by the provider. The billing staff may then need to spend additional time resolving the denial and resubmitting the claim, further delaying reimbursement.

The COVID-19 pandemic has adversely affected the cash flow of many physician practices,[8] requiring practices to re-focus on their RMC process in order to optimize cashflow. Not only are physicians seeing significantly fewer patients,[9] many of those patients that they are seeing may have lost insurance coverage due to layoffs or job loss, leaving patients responsible for payment of the healthcare services at a time when they may not have a regular income.

In order to survive financially during this tenuous time, the RCM areas that providers may consider modifying in order to maintain cash flow and patient satisfaction may include:

(1) Patient Registration: It is perhaps even more important now than ever to submit clean claims in order to accelerate cash flow, which requires obtaining and reporting correct patient demographic and insurance information. Physicians may be able to bolster digital engagement with patients by requesting them to pre-register on the practice website or via a patient portal to enhance the accuracy of patient information and reduce the staff time required to enter it into the billing system. If there is no portal

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or website for patients to enter their data, it is particularly important for the front staff to ensure that all of the demographic and insurance information is verified electronically to prevent delays in insurance payments. Providers may also consider inquiring as to whether the patient has a secondary insurance plan so that the balance after the primary plan pays is transferred to the secondary payor, expediting payment.

(2) Billing Policies and Procedures: If a patient loses health insurance due to being laid off, and becomes financially responsible for healthcare services, they may need financial assistance. This may mean re-evaluating existing payment plan policies and revising the practice's charity care policy in the short term. For example, providers may consider offering a discount program to patients who will quickly pay their balances to accelerate cash flow. Communicating such options will not only help the patients but also provide some immediate form of cash flow.

(3) Billing System: Providers may wish to utilize some of this down time (as a result of fewer patient visits) to review with staff procedure and diagnosis codes, as well as payor policies, to ensure that the proper codes are billed.[10] As noted above, submitting clean claims ensures quicker payment turnaround time from payors, which is crucial to maintaining cash flow.

(4) Outsourced Vendors: Providers will likely want to inform the outsourced billing vendor of any changes in the financial policies regarding patient balances. Ask the billing vendor to assist in working denials and rejections quicker to speed up cash flow. Engage the collection agency on the revised financial policies so they can align their strategies with patient friendly billing techniques while collecting during this time.

(5) Insurance Accounts Receivable: Providers may want to consider swiftly resolving denied claims that were submitted prior to the pandemic to increase cash flow.

(6) Patient Accounts Receivable: If a practice currently has a patient portal, they may want to this technology to send statements to patients, instead of mailing costly printed statements, and suggest that patients make electronic payments via the patient portal. Encourage new and established patients to sign up for the portal (if they have not done so already) so that they can access their statements and pay (quickly) online.

In an effort to continue seeing patients and maintain their revenue stream during the COVID-19 pandemic, some providers have implemented telehealth services.[11] According to a recent physician survey, 94% of surveyed physicians are afraid that their patients are foregoing care due to fear of contracting COVID-19 in their office.[12] Another survey found that 48% of physicians are currently treating patients via telemedicine, up from only 18% in 2018.[13] Approximately one-third of all physician services payments (191 physician procedure codes) are currently eligible for Medicare fee for service (FFS) reimbursement via telehealth.[14] Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology-based services wherever they are located.[15] The law also introduced a number of telehealth flexibilities for Medicare and Medicaid providers, including increasing the virtual services that can be furnished and the clinicians who can perform them.[16] Per the new guidelines, new, as well as established, patients may now stay at home and have a telehealth visit with their provider.[17]

Providers may want to incorporate CMS's specific guidelines established for telehealth with the practice's existing policies and procedures.[18] In addition, there are several new modifiers to add to the telehealth procedure code;[19] if the incorrect code or modifier is used, payment may be denied or delayed. Providers may also want to consider identifying the policies and reimbursement for telehealth from the top commercial payors, since not all payors follow Medicare regulations. Incorporating any updated commercial payor policies will enable clean claims to be submitted and paid in a timely manner.

The onset of the pandemic is putting more pressure on the financial aspects of physician practices and has a direct bearing on patients' insurance coverage and financial responsibility. Focusing on the optimization of the RCM process will not only help practices to survive financially, but also maintain patients through this difficult time.

For more information on revenue cycle management, including HCC's experience and services related to these services, please email us at solutions@healthcapital.com or call us at 800-FYI-VALU.

Please find below additional COVID-19 resources for providers:

- COVID-19 (2019 Novel Coronavirus) Resource Center for Physicians: https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
- Financial Assistance and Guidance for Practices – Coding/Billing and Reimbursement: https://www.mgma.com/landing-pages/covid-19-resource-center/financial-assistance-and-guidance-for-practices
- New and Expanded Flexibilities for Rural Health Clinics, (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE): https://www.cms.gov/files/document/se20016.pdf
- Hospitals: CMS Flexibilities to Fight COVID-19: https://www.cms.gov/files/document/covid-hospitals.pdf
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS Flexibilities to Fight COVID-19: https://www.cms.gov/files/document/covid-dme.pdf

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