Many medical group practices find that weak cash flow represents their top financial challenge. No matter how strong their productivity, payer mix or market position, claim processing and collections bog down.

Five “failure points” in the revenue cycle typically account for most of the financial drag. Fixing them takes focus, determination and teamwork.

**Five failure points**

A vigorous revenue cycle depends on taking advantage of every opportunity to keep information moving and learning from mistakes. Group practices struggling with cash flow usually experience some or all of the following weaknesses:

1. Slow charge entry;
2. Poor claims editing;
3. Unfocused denial processes to correct and resubmit rejected or denied claims;
4. Inadequate follow-up on unpaid claims; and
5. Ineffective payer analysis.

All of these failure points stem from lack of organized processes. A case study shows how well-designed claims and collections processes can form the backbone of a strong revenue cycle.

**Strong footing, poor results**

A large multispecialty group in the Northeast suffered from a seemingly contradictory financial situation. It enjoyed lucrative managed care contracts and high physician productivity, with gross charges at approximately the 80th percentile in comparison to Medical Group Management Association better-performing practices. Nevertheless, revenue performance was weak. The group had an 86 percent net collections ratio, accounts receivable (A/R) exceeded $500,000 per physician and A/R days were over 100.

What caused these poor financial results?

To find out, the group launched an enterprise-wide performance improvement project. A multidisciplinary team of practice leaders, business office managers, information technology (IT) representatives and physicians identified a variety of issues. Prominent among them were weaknesses in the five key areas of charge entry, claim edits, rejections/denials, follow-up and payer analysis. The team implemented seven improvement initiatives:

- **Reorganizing the business office by function.** Some functions were organized by payer, some by specialty and others by staff dedicated to particular physicians. There was no way to identify outcomes and track productivity.

- **Organizing claims staff by payer gave employees better understanding of individual payers, helping resolve claims problems quickly.**

In response, the project team reorganized business office staff by functional area — e.g., claims, denials, follow-up, posting — and defined processes for each function. This yielded a greater ability to manage the revenue cycle and implement best practices.

- **Creating a “performance-driven” framework.** The project team identified key indi-

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cators and targets for each functional area, from coding accuracy and data entry to self-pay collections and payment posting. These measures helped identify problems and opportunities for improvement.

In addition, the group established accountability for data integrity to ensure the accuracy of fee schedules, reimbursement tables, coding dictionaries and more. It developed procedures for periodic reviews of financial reports.

Organizing follow-up staff by payer. The group divided its insurance follow-up staff into payer teams. This allowed employees to develop payer expertise and forge relationships with key contacts. The result: greater efficiency in reviewing claims and aggressive working of “no-response” files.

Creating sequential billing processes. The project team discovered that sequential billing was a major source of claims confusion. It developed ways to identify primary, secondary and tertiary payers. Efforts yielded standardized, automated methods to address insurance eligibility, prioritize non-contracted payers, coordinate benefits under Medicare and identify patients’ financial responsibility.

Improving edit tracking. The project team used information services capabilities to track edits by type, physician, payer and other factors. It established processes to spot trends in recurring edits and follow them back to the source. For example, staff found that recurring coding errors stemmed from particular specialties and employees.

Developing aggressive rejection management process. To speed correction of rejected claims, IT staff configured the information system to link specific payer remark codes with rejection codes. The project team created rejection categories, allowing for quick reporting, review and correction. Again, organizing claims staff by payer gave employees a better understanding of individual payers, helping resolve claims problems quickly.

In addition, staff began using the infor-
mation system to generate reports on denial patterns. This helped identify weak spots, focus remediation efforts and highlight issues with certain payers. Solutions included enhancing payer-specific edits and revisiting claims procedures during contract renegotiations.

Boosting payer analysis. The project team discovered that reimbursements often fell short of contracted fee schedules. Group practices can address this problem by sampling reimbursements for contract compliance. The team loaded the fee schedules by plan into the information system and set a schedule for reports to evaluate payer remittance, helping capture significant dollars.

Stronger cash flow and more

The group launched its turnaround project in summer 2004. Within months, processes that had been failure points were now driving strong revenue cycle performance.

The most immediate impact was a one-time collections windfall of $5.25 million from efficient working of old A/R. The new processes helped the group increase its net collections rate from 86 percent to 94 percent within nine months. Underlying these figures was a reduction of A/R days from 88 to 58. Ongoing improvement processes have pushed A/R days even lower and increased net collections.

While fixing weaknesses in the revenue cycle can optimize cash flow, the benefits don’t end there. Through its improvement initiatives, the group billed insurance companies more accurately and resolved claims disputes quickly and definitively. Now, patients get bills only after payer processes are complete, resulting in clear balances due. Patients are less frustrated and physicians receive fewer billing complaints—gains in customer service just as valuable as increased cash flow.

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