Converting the Physician Practice into a Revenue Cycle Champion

By J. R. Thomas

Hospital and health system leaders face challenges in employing physicians, but if they take the time to engage with each of their employed or affiliated physician practices, they can convert them into financial assets. There is no simple solution for physician alignment. Achieving successful hospital-physician alignment requires time, but the immediacy of alignment or aggregation due to payment and technological requirements shortens the time available to build the foundation of a truly functional hospital-physician relationship. Despite their differences, hospitals and physicians should be aligning on the topic of revenue cycle because it provides the firm financial foundation and cash flow to support important endeavors, such as purchasing technology, hiring and retaining specialists and support staff, and expanding services.

Five key metrics can be used to help achieve alignment while strengthening the revenue cycle.

**A Study in Physician Engagement**

Our firm worked with the largest health system in North Texas to grow its provider base from 90 to 750 physicians. That represents an increase of nearly 850 percent, and begs the question of how the health system managed to align an additional 660 providers in just 30 months. The key was strategic engagement.

The health system had developed a clear physician alignment model, from physician contracts compliance to technology and processes. It invested time and resources in both physician and non-hospital leadership to execute its well-defined physician alignment model. Leaders used five key metrics to ensure that they built a strong foundation of private practice operations, including appointment scheduling, charge posting, onsite self-pay collections, and customer service. These simple metrics provide the physician and manager with a clear and effective means to evaluate revenue cycle processes.

**Date of service to date of charge entry (DOS:DOCE)**

DOC:DOCE identifies the amount of time between the physician performing a service and the entry of the charge into the system. Delays in charge entry may lead to lost charges, increased past-filing-deadline denials, and potential lost revenue. The benchmark set by our firm for outpatient DOS:DOCE is two days or less, while the benchmark for inpatient DOS:DOCE is five days or less.

**Unreconciled visits (or unreconciled appointments)**

These are arrived appointments that have no related charges posted against them. In other words, services were rendered, but no associated charges have been entered into the system for billing. The benchmark for unreconciled visits is no more than 0.5 percent of total appointments.

**Pre-bill reject rates**

Claims are scrubbed at three different levels during the submission process: performing edits at the practice management system level, within the e-commerce clearinghouse, and at the payer
before adjudication. If an error or unidentifiable piece of information is discovered at any of the three checkpoints, the claim will be stopped and flagged for correction. Pre-bill reject rate percentages are calculated by dividing the total number of current procedural terminology (CPT) codes rejected by the total number of CPT codes posted during the month. The benchmark for pre-bill reject rate is 4 percent or less.

**First-pass denial rates**
The denial rate is calculated by comparing the total number of CPT codes denied in the current month to the total number of CPT codes posted during the current month. A denial is defined as any CPT code that results in adjudication by the payer in the amount of $0. The best-practice benchmark for denial rates is 10 percent. This rate is based on CPT codes, not visits. Many denial rates are publicized at a visit basis versus CPT code basis. Each CPT code is a unique financial transaction regardless of modifiers or units.

**Pass-through rates**
Pass-through is the percentage of monthly collections that is transferred from an insurance balance to a self-pay balance. The pass-through rate is measured in terms of both absolute dollars and a percentage. The pass-through percentage is calculated by dividing the pass-through amount by the total collections within the same period. When measured as a percentage of total collections, pass-through is intended to provide a snapshot of the magnitude of dollars that will be delayed as a result of having to enter the self-pay collection cycle, instead of being dealt with at the time of service. The benchmark for pass-through rate is 3 percent or less. There is a direct correlation among pass-through rates, eligibility denials, and over-the-counter collections.

Based on achievement of these metrics, the health system established an incentive plan for office staff that was easily self-funded from the significantly increased cash collections. Through 100 percent involvement in physician meetings, the health system presented and taught the metrics while also successfully incentivizing participation from staff. (See an overview of a health system business office incentive plan at the end of this article.)

Meetings with physicians and their managers were held each month on a predetermined schedule to begin the process of leading the physicians and their practice team through the five key metrics. Trust in a physician relationship means health system leaders will be consistent, transparent, and present at all times.

There is no substitute for time commitments and process rigor in the early phases of these critical relationships. See an example of a health system dashboard for tracking the key metrics below.

**Tools Needed**

If healthcare organizations expect physician practices to comply with their financial expectations, they should provide not just the guidance and counsel, but also the business tools required to meet goals, such as automated revenue cycle imaging software that can integrate with any practice management system.

Instead of setting practices up for failure and mission-damaging frustration, such tools help practices adopt new ways of driving revenue with familiar technologies.
If health systems are going to closely scrutinize remittances through the revenue cycle, then they should offer physicians a way to capture every explanation of benefits, patient statement, check, and bank correspondence, without taking more time or resources.

A Careful Balance

The results of a well-orchestrated management services organization (MSO) model behind a solid physician market strategy are significant not only in financial terms, but also in aligning private practices side by side with health systems. This alignment improves the quality and cost of care in communities served, while the trust relationship with a physician practice becomes rooted in the revenue cycle process. (See sidebar on MSOs below.)

Without this trust relationship, no physician alignment initiative will meet its overall objective, and the opportunity to turn physicians into financial assets through the time-consuming conversion process is lost.

The Role of a Management Services Organization

In recognizing that their bureaucracies do not mesh well with physician practices, health systems should create management services organizations (MSO) that can align with the specific business needs of smaller, nimble physician practices. A well-executed MSO will not only keep physicians happy by allowing them to focus on medicine instead of business, but it will also help optimize revenue for their practices.

A well-run MSO is the start of the trust relationship between hospitals and physicians. It will include all of the management services required to support the physicians, including the timing and costs of all of the pieces involved in the onboarding process, such as credentialing, marketing, IT, and office build-outs.

These MSOs can achieve extraordinary results if the physician model is well defined and the revenue cycle management processes are well executed with clear benchmarks over time. Once a trust relationship is established, and clear opportunities to improve practice performance are related, physicians no longer seek autonomy.

As a result, hospitals and physicians will find tremendous opportunities to convert revenue cycle data into highly effective patient information. For example, they can easily target and call all of a practice’s over-age-65 diabetic patients who have not been seen in the last 180 days as a financial and clinical solution.

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