JULY 2023 EDITION

RCM Life By OP

A monthly newsletter exclusively for OP RCM Practices

CONTACT US

Email our inbox at **rcmlife@officepracticum.com** for urgent issues or non-claim-specific questions. Tickets will automatically be created and routed to your RCM Client Services Specialist.

Saving Keystrokes

What is Coordination of Benefits (COB)?

COB is an insurance payer attempting to determine if the patient you are treating has any other insurance coverage. The insurance sends a notification to the subscriber of the plan, and asks them to confirm whether or not there is any other insurance for the patient that you are treating.

How is a COB updated?
The subscriber MUST contact the insurance payer to provide this update either by calling the insurance or updating their Coordination Of Benefits information on the payer's website.

The parent/subscriber is supplied a reference number or tracking number, which they should supply to your office. Please note this reference number or tracking number in the patient's account.

Why am I getting so many COB denials?
Insurance payers are beginning to require quarterly versus the yearly updates that they use to request.

Can RCM update Coordination of Benefits for me?
No, we wish we could because then we could actually control the timelines. The subscriber will need to coordinate with the insurance company to update this information.

RCM can resend the claims once this has been updated in the insurance payer's system.

What if the subscriber states there is no other insurance, do they still have to follow up?
Yes, the subscriber must update this information regardless if there is only one plan active for the patient.

What happens if the subscriber does not update the COB?
Insurance payers may withhold the payment for all claims not just the one visit, until the COB has been updated in the payer's website. Once the COB is updated, the claims will need to be reprocessed.

RCM should be informed when the COB has been completed and if there are any changes to the insurances listed in the OP system.

Net Collection Rate (NCR) and Gross Collection Rate (GCR)

The formula to calculate GCR and NCR is as following:

- Gross Collection Rate = Total Payments / Charges *100% (for a specific time period)
- Net Collection Rate = (Payments / (Charges – Contractual Adjustments)) * 100%

Gross Collection vs. Net Collection

When it comes to Medical Billing Metrics or Key Performance Indicators (KPIs) in Medical Billing, the net collection is considered as the best indicator of a practice's true income. It is because unlike gross collection, the net collection gives a better insight to identify the actual status of a provider's revenue cycle. A healthy revenue cycle can be maintained by ensuring 90% or above net collection rate. However, if your practice's net collection rate is lower than 90% (after deducting write-offs) then it is advisable to audit your billing practice.

Since the gross collection rate does not deduct write-offs, it is considered to be a less effective KPI as compared to the net collection rate. It is because without eliminating write-offs, refunds, contractual/non-contractual amounts from the calculation you cannot get an insight into your practice's actual income.

The net collection helps to reveal the amount/payment that your practice is collecting from the payer. But the gross collection rate only shows what your practice is allowed to collect. For example, you may have charged $200 but you only collected $175 from your insurance payer due to the agreement/contract that you might have signed. Here, the $175 is below the gross rate.

Net Collection rate plays a huge role in medical billing as it is the only way to calculate net income from various sources/payers.

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Industry News
GCR and NCR

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What Should Your Gross and Net Collection Rates Be?

A 96% net collection rate is considered ideal across the industry. Anything lower than a 95% clean claims ratio means your medical practice is losing revenue, which also indicates your medical practice is wasting further money and time reworking rejected claims. In reality, most medical practices have a rate that varies between 75% and 85%, which means that somewhere around 15–25% of claims submitted each month have to be worked on twice, at minimum.

Working with RCM
Hospital Visits

Do your providers see patients in the hospital? If so, the quick reference guide for entering hospital charges is very helpful. Following these steps helps RCM identify and convert these claims. When you see newborns in the hospital, it may take additional time for the insurance carrier to add the baby to the parent's policy. Entering newborn pending insurance information may be necessary.

If you have questions, please reach out to your CSS or email rcmlife@officepracticum.com for more information.

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