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RCM Life By OP

A monthly newsletter exclusively for OP RCM Practices

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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.

Working with RCM

Understanding 3 Crucial RCM KPIs that Help Us and YOU Manage your Practice

You've partnered with OP RCM to help you manage your revenue cycle. In order to do so effectively, we monitor several key performance indicators (KPI) so that we can help protect and increase your cash flow. Although we have our eyes on these metrics, it's crucial that you understand what these KPIs are and how they impact your practice.

A/R Days [also known as Days in Revenue Outstanding (DRO)]
DRO is the average number of days it takes for a claim to be paid. Why is this important? The faster your claims are paid, the sooner you receive your payments for the services your practice has provided.

DRO Calculation: [Total A/R Outstanding - Credits] / [your Average Daily Gross Charges (note: average charges per day based on the last 90 days of charges)]

This number is affected when your daily charges drop dramatically, if you divide your total A/R by a lower number, it artificially increases your days in A/R. With the fluctuations due to COVID, this has caused fluctuations in this standard calculation that traditionally provides a stable way for us to evaluate your A/R. In order to understand if this is a true change in your days in A/R or just an artificial increase, we review your claims to ensure that they are getting billed and followed up on in a timely manner and check that your payments are getting posted in an acceptable time frame.

Imagine, for ease in calculation sake, that your total A/R outstanding is $110,000, your credits are $10,000 and your average daily charges are $4,000. 110,000-10,000 / 4,000 = 25 days in A/R. If your average daily charges drop to $3,000, your days in A/R increases to 33 days (110,000-100,000/3,000). Often organizations use a rolling 3 month average to avoid fluctuations in seasonality and volumes.

What is my target? Practices should aim for the industry benchmark of 30-35 days in A/R. It is important to keep in mind that Days in A/R is affected by your payer mix (the main payers that your families have) and the percentage of your families that have state programs like Medicaid.

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Some payers pay providers more swiftly than others. Since we manage many practices' receivables, we have a unique purview into how these insurance companies work and know what you should expect by payer and plan. This helps us to manage your receivables and manage your payments.

Net Collection Ratio (NCR)
NCR reflects how effective we are in collecting the reimbursements that you are allowed. We calculate NCR to see how much revenue is uncollected due to factors such as uncollectible debt or other non-contractual adjustments. Why is this important? NCR shows how effective we are at collecting payments from payers.

NCR Calculation: [Payments / (Charges - Contractual Adjustments)] X 100%

What is my target? The net collection ratio should be in the 95-98% range after factoring in write offs. Keep in mind, the net collection rate may vary depending on your practice's payer mix.

Clean Claim Rate (CCR)
ercentage of claims paid upon the first submission to the payer without any rejections or denials.
Why this is important: CCR provides your practice with insight on the quality of the information captured at the front desk. Although OP RCM will assist in addressing many of the rejections and denials, improving the CCR will not only result in reducing cost and improving the pace to collect, but also reducing your accounts receivable. To improve your CCR, it is important that your practice updates the patient demographic often, verify insurance eligibility, ensure correct coding and modifiers usage.

CCR Calculation: Clean claims / total claims submitted

What is my target? 95% or higher reflects a successful RCM strategy.

We track and measure these 3 critical Key Performance Indicators as well as several others. Should you have any questions about your metrics, your performance, or ways that we can work with you to increase your practice's performance, we'd love to hear from you.

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Industry News

New COVID Vaccines

New Monovalent COVID vaccines are here. As we know, Babies and young children get a different number of doses than older children and teens, link for reference.Here is a link where you can find step by step how to add these new Monovalent COVID vaccines in OP.

On another note, the CDC COVID vaccination program has ended. With these FDA and CDC actions, the CDC COVID-19 Vaccination Program ended as of September 12, 2023, as it applied to the administration of the bivalent Moderna and Pfizer-BioNTech mRNA COVID-19 vaccines previously provided by the US Government (USG). Now, with FDA's authorization on October 3, 2023, of the 2023–2024 Novavax COVID-19 Vaccine, Adjuvanted, the CDC COVID-19 Vaccination Program has fully ended as of October 3, 2023. All authorized/approved doses of COVID-19 vaccine in the United States are now the 2023–2024 formulas. Here is the complete article with helpful requirements and recommendations for the providers.

Eligibility Corner

Let's discuss Coordination of Benefits (COB) and the Payers Change to Quarterly Updates (and why it is holding up your money)

What is Coordination of Benefits (COB)?

Many of you, even if you have had a practice for years, have not had to deal with this in the past, at least to the degree that we have in the last few months. COB is an insurance payer attempting to determine if the patient you are treating has any other insurance coverage. They use to send these notices out annually, and now many of them have begun to send them out quarterly. 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. We never used to talk about this much as it was a very small time effort involved and it happened so rarely in the past. Well, this has drastically changed. The insurance companies for the parents are asking this question much more frequently and honestly, it is even bothering the parents themselves. Many of them are thinking, "hey, I just filled this out", and in truth, they could have only 3 months ago.

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How is a COB updated?

How do these forms get 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. Unfortunately with the payers asking this question more frequently, you parents are having to do this several times a year for some of the plans that they have.

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. Across our client base, this has become a truly time consuming and frustrating process in that it HOLDS UP your payments while they wait to receive this information from the patient's family. It is forcing subscribers to review and update policy files before they will issue your payment.

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.

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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.

How to determine which insurance should be entered as primary: What is the Birthday rule?

"The birthday rule is an informal procedure that the health insurance industry has widely adopted for the coordination of benefits when children are listed as dependents on two parents' group health plans.

Under the birthday rule, the health plan of the parent whose birthday comes first in the calendar year is designated as the primary plan, according to the National Association of Insurance Commissioners. It doesn't matter which parent is older. The year of birth isn't a factor. Thus, if your birthday is July 15, 1985, and your spouse's is Sept. 17, 1983, your health plan would be considered primary because your birthday comes first in the calendar year." (insure.com)

There are a few exceptions such as Divorce or separation and Court Order. Please understand, not all insurances follow the birthday rule and sometimes a parent post divorce is covering a child as primary.

What if the patient has Commercial and Medicaid insurance?

Commercial plans will always be primary to a medicaid or state plan, however, the parent, the subscriber, is still responsible for updating the COB.

Summary

As payers attempt to hold your money and alleviate their own cash flows, we aim to highlight these insurance hurdles and work with you to get this information as quickly as possible. Let us know if you have any questions or concerns. We are here to help.

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