How RCM works?

Steps in Revenue Cycle Management in Healthcare


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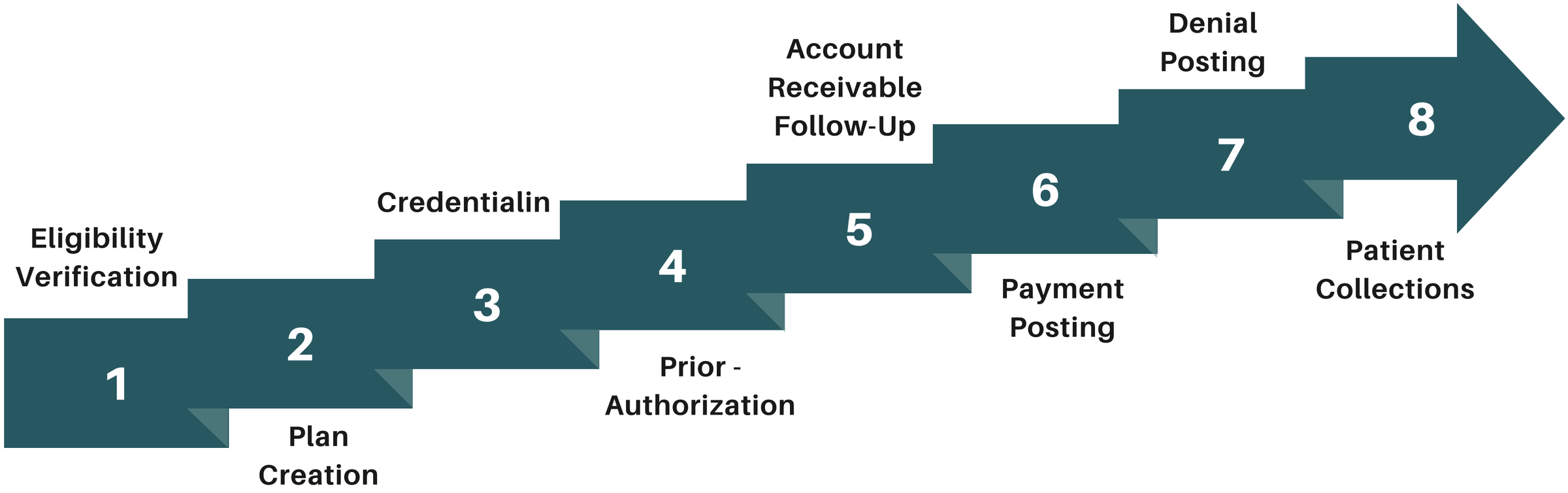
SERVICE WE OFFER



Timeline

01) Appointment Confirmation **(2 days prior to the appointments)**

02) Eligibility & Verification of the scheduled patients **(along with walk-ins) (1 day prior to the appointment)**

03) Authorization & Referral obtaining process **(7 days prior to appointment)**

04) Coding **(By Certified Coder, with in 24-48 hrs)**

05) Charge Entry process **(By Certified Coder/Biller, within 24-48 hrs)**

06) Working on Clearing House Rejection **(Within 24-48 hrs of receipt)**

07) Account Receivable follow up process **(By experienced and expert staff)**

08) Denial Management and Corrections **(Within 24-48 hrs of receipt)**

09) Payment Posting process - EOBS & ERAS **(Within 24-48 hrs of receipt)**

10) EDI/ERA/EFT Enrollment & Credentialing Process **(Within first month from onboarding)**

11) Monthly releasing of e-patient Statement **(Upon checking accuracy of patient balance)**

12) Attending Patient calls for statement queries

Step 1: Design your RCM Work Model

A repeatable work model for proven gains in RCM is the first crucial milestone of the 13 steps of revenue cycle management. Analyze the current teams that you have working towards the RCM in your organization. More than 50% of the healthcare leaders in recent years have shifted towards adopting RCM software for this job, or they have outsourced the end-to-end RCM to professional companies.

Leading companies in this industry can help you soar higher on the cash flow curve by ensuring they are always updated on the latest rules and regulations. They follow the best practices for maximizing the revenue of the healthcare providers. You can get in touch with them to know which system will work the best for you

Step 2: Align your RCM Staff

Now that you have decided on what kind of work model will be the most suitable for your organization, you need to focus on the alignment of staff. The staff members in the department are the true heroes of financial management since they are the ones handling every path of RCM on the ground level. If you have adopted revenue cycle software, go for staff training programs so that they are comfortable using it. For outsourced companies, know what they are offering and how you can assign in-house staff to be in correspondence with them.

Step 3: Patient Registration

Patient registration is the first important step towards getting a clean claim, making it one of the crucial 13 steps of revenue cycle management. Make sure to take down the proper ID to register or update the account. Revenue cycle experts point out that in many cases, inaccurate or incomplete patient details during the registration process lead to claim denial.

Step 4: Patient Eligibility Verification

You need to verify the insurance details on the account to know which services the insurance company covers for the patient. In case of any discrepancy in the verification process, you must reach out to the patient beforehand to maintain a transparent relationship. Ensure that the insurance coverage is up to date and has not expired. Otherwise, the patient will have to pay out of pocket, which is often difficult to collect.

Step 5: Prior Authorization

Different insurance companies have specific rules regarding the prior authorization process for particular medical services. You need medical necessity for these procedures with ample proof to support the claim before approaching for a pre-auth. Keep in mind that the rules for the pre-auth process might be different for the private and government entities.

Step 6: Co-payment and Deductibles

At the time of the medical service, the patient needs to pay the out-of-pocket expenditure that their insurance company does not cover. This process can be challenging to handle since most healthcare systems fail to collect the payments during this period. Convey the details of any financial assistance services that the office provides so that the patients know their options well and the cash flow of the organization remains stable.

Step 7: Coding of Services

Coding is one of the most critical steps to get a clean claim and proper reimbursement. Ensure that the coders are up to date with the latest changes in the coding guidelines from the federal authorities. Conduct regular staff training programs to make sure that you don't miss out on revenue due to outdated codes. Keep an eye on the Medicare and Medicaid updates from the CMS for better understanding.

Step 8: Claim Submission

Once all the codes are in the proper place, fill out the claim form and submit it to the insurance company. Points to note do not let the claims pile up so that the reimbursement comes on time. Before the submission of the claims, re-check the format and the assigned codes so that you do not leave out any information. Remember that a complete claim with all necessary data stands a better chance of getting accepted.

Step 9: Claim Reimbursement

Once the insurance company receives the claim, they cross-check it within their system to assign the proper reimbursement that they deem fit and in accordance with the patient's policy. Any denied service or lack of papers could lead to a decrease in the reimbursement amount. The insurance company will send the Explanation of Benefits to convey the reasons for the denial.

Step 10: Claim Denial Management

Even though the billing teams do their best in ensuring a clean claim for submission, most of the claims are partially or fully denied by the insurance company due to several other reasons. You need to have a proper denial management workflow in place to ensure that you re-submit the rectified claims on time or with supplemental documents that the insurance asked for.

Step 11: Review for Payment Variances

You might end up getting paid a different amount than what you applied for in your claim due to several reasons like lack of medical necessity or incorrect coding of major/minor surgeries. Review the amounts once the reimbursement comes in and appeal to the respective insurance company with the necessary documents.

Step 12: Patient Collections

Collecting the remaining due amount from the patients is one of the most challenging phases in the 13 steps of revenue cycle management. Following up with the patients regarding their dues with the proper explanation of the insurance coverage is crucial to ensure proper collections. RCM companies appoint dedicated task groups to follow up on the patients to make sure that the revenue cycle stays strong.

Step 13: Financial Evaluation

Evaluate the finances from the revenue cycle in the organization to make meaningful decisions for the future. Data analytics reports provided by RCM software or customized reports from RCM companies can prove to be highly beneficial in this case. Reports will highlight where you are doing good and which areas you need to focus on.

Our Medical Billing Claim Settlemnt Success Ratio is avereging between 87 to 92%

- **AR calling is the communication process between a healthcare provider and an insurance company that has outstanding balances or pending claims**
- **We partners with billing companies to bolster their operational capabilities, reduce cost and allow them to focus on client retention and increasing sales**
- **With We collaborative efforts, hospitals can overcome challenges of a healthy revenue cycle, gain control over the increasing A/R & improve the financial performance**

eCW Billing

We at We have helped above 500 physicians revise profit benchmarks and create better tomorrow for their practices. We receive provider's information, perform Eligibility check, Verify Demographic details, Assign Accurate codes, do Charge Entry, so from Demographic Entry to Payment Posting, everything is entered into the eCW EMR by We, so doctor has instant access to the information of his practice.

Clean claims that get paid the first time, every time!

The medical coding and charge entry feature offered by the eCW billing software helps streamline our billing process further

We perform real time code checks against insurer specifics and coding guidelines before submitting claims, which leads to creaky clean claims. The practices see a rapid reduction in rejected claims. And from a rejection rate of an alarming 40% physician's experience, it was now down to almost nil!

What our New Physician had to say:

When the Billing Team of We told us that his team was well equipped to work on eCW Platform, we were thrilled to bits. We and eCW Billing Software have helped over 100 Medical Practices run smoothly without any flaw. Practices feel relieved when we managed to work on the eCW Billing Software without any loss of data and revenue.

Not just that, when We, guided us with all the features of the software, we were amazed. It took us a week to touch base with all the features, but very soon we could see the results in the services and the revenue.