Discover the Truth about RCM Services

An exposé revealing predatory business practices of some revenue cycle management vendors, and tips on what to look for in an RCM agreement before signing a contract.
Discover the Truth about RCM Services

Revenue cycle management (RCM) vendors are supposed to help physician practices ease the burden associated with the daunting - yet critical - task of billing and collections. These vendors should also streamline RCM processes to help practices improve cash flow and ultimately enable physicians to make more money faster. However, some RCM vendors seem to concentrate much more on helping themselves to the money that practices make, versus helping the practices make more money.

This white paper is a candid assessment bringing to light the ugly, but true, facts about predatory RCM business practices that often go unnoticed and unadvertised.

RCM vendors getting paid on revenue they never collect

How the term “collections” is defined in RCM service contracts can have a substantial negative impact on your practice’s revenue. Typically, collections are thought to include payer reimbursement or patient balances, and sometimes both sources of revenue. When defined broadly, however, collections can encompass nearly all practice revenue, including income never collected by an RCM vendor, which may consist of the following:

++ Bonus payments
++ Capitation payments
++ Compensation for drug or clinical trials
++ Consulting stipends
++ Co-pays
++ Revenue sharing
++ Surplus distributions
++ Speaking engagements
++ Incentive program payments
  - Meaningful Use Payments
  - PQRS Payments
++ Withhold returns
++ Other managed-care payments

There is a significant difference between paying an RCM vendor a percentage of revenue collected by the vendor versus paying a percentage on all sums of income generated by a practice. Broadly defining the term “collections” works in favor of discreditable RCM vendors, because the contract defines compensation as a percentage of the practice’s total revenue and income, compared to the revenue actually collected by the RCM vendor.

In these situations, RCM vendors are charging a fee on revenue they never process or collect. Therefore, practices engaging an RCM vendor should carefully study the contract to see how collections are defined, which will provide a more accurate assessment of the potential financial impact to the practice.

The true definition of collections should be payments received from payers and patients nothing more and nothing less.

Bait-and-switch advertising tactics

To attract new customers, some RCM vendors advertise low rates to take advantage of uneducated buyers and build market share. What you may not know is many times these low rate offers do not include a full suite of RCM services and/or have an elevator clause associated with the advertised low rate. ALWAYS read the fine print in any RCM services agreement, as they can conceal many “gotchas”. One of the most common elevator clause stipulations contains a minimum revenue requirement, which is set high, thereby making the low offer ineligible or unattainable.

87 percent of all physician practices agree that their billing and collections systems/processes need upgrading*

72 percent of physician practices anticipate declining to negative profitability in 2014 due to diminishing reimbursements and underutilized or inefficient billing and records technology*

71 percent of physician practices are considering a combination of new software and outsourcing services to improve their RCM systems*

Many physician practices looking to improve the cash flow of the business side of medicine, this white paper exposes seven predatory business practices that should be closely evaluated before signing a contract with a billing and collections or revenue cycle management vendor.
Some low-rate RCM models may only include a one-time submission per claim and other basic services, but do not include working denials or resubmitting claims, as doing so would cut into the RCM vendor’s profit margin. In these business models, the burden of working denied claims and collecting unpaid balances is shifted back to the physician’s staff to resolve or the claim simply is abandoned and remains unpaid, therefore leaving money on the table. This is the anti-RCM business model, meaning that the revenue cycle model becomes more of a one-time attempt versus a complete cycle of services.

Higher fees may be incurred for using an RCM vendor’s extended services to resolve denials, resubmit claims, collect patient balances, or numerous other issues that need resolution. Unsuspecting physicians may think they are signing up for a lower-cost RCM service, only to discover that the capabilities they need in order to completely and accurately collect payment for services rendered are not included as part of the advertised low rate. Other RCM vendors offer a flat-fee model to perform RCM services. Some of these models may also be limited in terms of the true RCM service offerings.

True pay-for-performance RCM vendors should not nickel and dime their clients or have expiration dates on their agreed upon service rates or elevator clauses in their contracts. RCM vendors that use a true pay-for-performance compensation model align their financial interests with the financial interests of the practice. The more the RCM vendor collects, the more the RCM vendor gets paid. In this truly win-win scenario, there is no need for up-front deposits or hidden fees.

The list below represents full-service RCM contract offerings, but are often left out of low-rate models:

- Charge coding, entry and review
- Electronic claims submission
- Electronic claims status
- Electronic claims management
  - Payment posting
  - Re-filing of denied claims
  - Appeals of claims
- Managing accounts receivable
- Workflow and metrics analysis
- Financial performance
- Operations efficiency
- Best practices comparison
- Provider credentialing and registration with payers
- Payer performance
  - Ranking
  - Negotiations
  - Compliance
- Customized patient statements
- Patient collections
- Performance reporting
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- Payer performance
  - Ranking
  - Negotiations
  - Compliance
- Customized patient statements
- Patient collections
- Performance reporting

Hidden fees and charges
You certainly won’t find any of these “details” advertised until you get to the contract stage. In addition to low rates being indicative of incomplete RCM services, they are also a sign of hidden fees and charges. Though you may never hear mention of these details until the contract signing, they are common strategy for keeping advertised rates low and vendor profits high. Believe it or not, it is a common practice for some RCM vendors to assess these additional fees as a method of keeping their business costs down and making more money from their clients.

Some examples include:
- Non-refundable, up-front deposits and start-up fees
- Deposits that are conditional upon an implementation timeframe, leaving the client responsible for the implementation
- Charges per order, for orders entered and received
  - Lab orders
  - e-prescriptions
  - Diagnostic imaging
- Additional fees for training, implementation, and travel
- Lockbox or bank agreements that have not been clearly disclosed
- EDI, software, and hardware costs

Ambiguous contract definitions
Contract language can be confusing – even for those who are well-versed in business management and legalese. Sometimes the ambiguity is unintentional, while other times confusion is carefully employed to obscure business shortcomings or protect the profit margins of the RCM vendor. The key is to fully understand the contract language when negotiating with an RCM vendor, and even ask for commonly used industry terms to be defined within the contract language.

A case in point is the term “first-pass claim acceptance rate,” which is a pivotal metric in RCM contracts that guarantee performance rates, and gives practices an idea of how soon they’ll typically receive payment following
claim submission. This term, however, can mean many different things, such as the claim:

+ Making it through the practice management or billing service claim scrubbing technology for technical edits (e.g., syntax, format, etc.). **Point of failure** – The claim may not be accepted by the payer for a myriad of reasons.

+ Acceptance by the payer as determined by the payer’s claim status category code. This type of first-pass rate is also called a “first-time claim acceptance rate.” **Point of failure** – The claim may not make it to adjudication because the payer flags it for review or denies it for clinical edits. This could potentially lead to both low first-pass rates and high denials.

RCM service vendors should be transparent in how they disclose their first-time claim acceptance rates, their collections rates, their denial rates, and other key performance indicators (KPI), and in how they define these terms. The Medical Group Management Association (MGMA) publishes such standards in their annual cost and revenue survey, which is an excellent resource to compare your practice’s and your RCM’s performance against.

It’s also important for RCM vendors to disclose their days in accounts receivable (DAR) performance, by specialty, as well as compare your practice’s performance versus industry benchmarks. Knowing how an RCM vendor’s DAR performance compares to industry standards, such as this example below versus MGMA benchmarks, is valuable and indicative of how an RCM vendor might perform for your practice. However, most RCM vendors don’t voluntarily publish this data or share it with their clients.

There are many other ambiguities found in some RCM agreements and you should take your time to review each and every clause of an agreement. Additionally, you should compare the contract against the last version of the proposal that you received.

**Get these questions answered when evaluating an RCM agreement:**

_How long is the term of the agreement?_ Choosing the right RCM vendor is a decision that bears heavily on the financial success of your practice. Be wary of RCM vendors who may want to lock you into long-term agreements without any history with your practice or accountability or performance metrics in place. Standard contract lengths are 24, 36, 48, and 60 months.

_HoW owNS the DATA?_ When the agreement is terminated, who owns the data? In some situations the data is held hostage by the RCM vendor to avoid or discourage termination.

_Are there any revenue thresholds that the practice must attain?_ Some contracts contain penalties that a practice must pay if certain revenue thresholds are not met.

_Does the agreement contain any monthly minimums that the practice must pay or guarantee to achieve each month?_ Some RCM contracts contain clauses in which the physician practice guarantees to achieve a certain level of revenue each month – or the RCM vendor may assess a monthly minimum fee to the practice. This type of arrangement is okay, as long as both parties mutually agree upon it and if the monthly revenue amount is achievable based on the past performance of the practice.

_Is the deposit (if applicable) used to pay any RCM vendor fees or returned at any point in time?_ Another area for careful consideration is deposit money. Some RCM vendors will require up-front deposits on the first few months of invoices, but will not refund or apply the deposits to future balances in any way. Be sure you understand how your deposit money will be managed.

_How are services paid?_ It is important to know how services will be paid for, as well as how often payments will be made. Some RCM vendors will send a monthly invoice giving the practice 30 days to pay, while others use a lockbox system with automatic, weekly payment withdrawals giving the vendors their share of the revenue before the practice receives its money.

<table>
<thead>
<tr>
<th>MEDICAL SPECIALTY</th>
<th>PULSE PERFORMANCE</th>
<th>MGMA BENCHMARK</th>
<th>PULSE ADVANTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic**</td>
<td>19</td>
<td>38</td>
<td>19 days</td>
</tr>
<tr>
<td>Dermatology***</td>
<td>18</td>
<td>36</td>
<td>18 days</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>23</td>
<td>38</td>
<td>15 days</td>
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<tr>
<td>General Surgery</td>
<td>25</td>
<td>47</td>
<td>22 days</td>
</tr>
<tr>
<td>Infectious Disease**</td>
<td>17</td>
<td>38</td>
<td>21 days</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>26</td>
<td>35</td>
<td>9 days</td>
</tr>
<tr>
<td>Neurology**</td>
<td>26</td>
<td>38</td>
<td>12 days</td>
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<tr>
<td>OBGYN</td>
<td>22</td>
<td>37</td>
<td>15 days</td>
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<tr>
<td>Orthopaedic</td>
<td>32</td>
<td>40</td>
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</tr>
<tr>
<td>Pulmonary***</td>
<td>33</td>
<td>38</td>
<td>5 days</td>
</tr>
</tbody>
</table>

* DAR benchmarks are all based on the median MGMA Cost Survey for Single Specialty & Multispecialty Practices, 2012 Report based on 2011 Data, Copyright 2012 MGMA-ACMPE

** Specialty not listed individually. Benchmarks are from the Single Specialty Non-Surgical category

*** Specialty not listed individually. Benchmarks are from the Single Specialty Surgical category
What are the cancellation clauses? You will want to know how cancellation works in your agreement. Ask the proposed RCM vendor if your practice can cancel at any time with or without cause (or both). Then ask the vendor the same questions about their rights under the agreement. Cancellation for convenience can jeopardize the financial stability and income of your practice if the RCM vendor chooses to eliminate service versus your practice exiting an agreement due to lack of vendor performance.

Are there any financial penalties to pay upon termination of the agreement, regardless of who terminates the agreement? You’ll also want to know if any financial penalties apply if/when the agreement is terminated, by either party. This is especially important for practices that are looking for short-term engagements to resolve workflow, personnel, or backlog issues.

Lack of transparency and real-time reporting
Daily visibilities into practice management systems and real-time billing, collections, and other financial performance metrics, are essential tools to assess the financial health of a practice, as well as the true performance of an RCM vendor. However, some RCM vendors are reluctant to voluntarily give physicians, administrators, and office managers real-time access to financial and performance reporting or provide them with performance data on a routine basis.

In a transparent RCM vendor relationship, practices should be able to access the practice management and billing systems on-demand and run their own reports, at will, rather than relying upon the vendor to run the reports for them. Practices should also leverage the expertise of the RCM vendor to view specialized reports that can improve performance, both short and long term, such as showing claim denial codes by reason and other reports. A true RCM partner will help identify repetitve and outlying issues, as well as develop a plan to remedy those issues to improve performance.

Obtaining a clear financial snapshot of the practice and the performance of the RCM vendor may occasionally require adjusting some of the variables within reports. Practices need to ensure that they can run reports in the following scenarios, or have their RCM vendor assist them with the process on an as needed basis:

Days in Accounts Receivable (DAR) - The MGMA is the industry standard in best practices for physician office management. The MGMA defines DAR as the summation of the amounts owed to the practice by patients, third-party payers, employer groups, and other fee-for-service (FFS) activities, with days counted from the time the invoice is submitted for payment (not date of service).

Percentage of A/R Greater than 120 Days - The percentage of your accounts receivable (A/R) greater than 120 days represents your ability to get paid timely and to monitor old debts that are not getting paid. This can also be a sign that your office has not established, or is not following, a disciplined credit collection procedure. A good collection policy will define the number of attempts to collect from the payers, then the process of collecting from the patient when responsibility has been turned over to the patient.

Net Collection Rate (a.k.a. adjusted collection rate) - This rate is a measure of the practice’s effectiveness in collecting all legitimate reimbursements. This takes into account those payers where the practice has contracted with, and agrees to write-off the difference between, their standard fees and the payer’s reimbursement fees. This rate shows how much revenue is lost to bad debt, untimely filing, and other non-contractual adjustments.

Denial Rate (a.k.a. first-pass claim rate) – This rate is the percentage of claims denied by payers. This is usually by the claim counts, but sometimes counts the number of line items on the claims for denial. The lower the rate, the better, because it indicates a clean claim is being received and no further claims editing is required. Many factors affect this clean claim rate, and real-time (or online claims editing) patient tools such as eligibility, Correct Coding Initiative (CCI), and Local Coverage Determination (LCD) compliance edits, allow quick and efficient edits to produce an error free, or “clean” claim.

Accounts in Collection – The potential revenue in these accounts may not be accounted for in the standard DAR calculation because they are written off of the current receivables. Calculating DAR should be performed with and without accounts that are in collections to get a more accurate assessment of finances.

Patient Payment Plans – Similar to accounts in collection, patient payment plans can increase DAR. Calculating DAR with and without payment plan balances will provide a more accurate snapshot of the organization’s finances, and will also show if payment plans are beneficial to the practice.
Non-disclosed outsourcing
This is purely a greedy, profit salvaging, and usually undisclosed business practice. Some RCM vendors outsource the medical coding and call center operations to outside, non-U.S. based vendors, enabling the RCM vendor to save on labor costs and put more money in their pockets.

While this arrangement may make sense from an RCM vendor’s perspective, it may not make sense from the perspective of the physicians they serve. More importantly, it impacts the physician’s patient base and third-party payers that these overseas employees and contractors interact with on a daily basis.

There are five potential pitfalls associated with outside, non-U.S. based vendors that can negatively impact the cash flow and reputation of a practice.

✚✚ Understanding of current and updated U.S. health care reimbursement system
✚✚ U.S. coding knowledge and coding edits required
✚✚ Credentials of staff performing coding
✚✚ Language differences and dialects with U.S. patient base
✚✚ Sacrificed service level

No performance guarantees
Most reputable RCM vendors offer some type of performance guarantee. However, some RCM vendors do not offer any type of performance guarantee or stand behind their services at all. Those are the types of RCM vendors that you'll want to avoid.

Knowing whether or not a potential RCM vendor offers a performance guarantee is something that you’ll want to know early in the selection process. Find out what performance guarantees are offered and the metrics within the contract that will allow your practice to terminate the agreement, should the RCM vendor not perform to contract standards. Understand what financial penalties, if any, may apply to the early termination if the performance guarantees are not met.

On the flip side, make sure you know whether or not the agreement contains a performance bonus payable to the RCM vendor, should their performance exceed expectations. While this is a great incentive to agree upon, some contracts automatically contain this language and it may not ever be known by the signing authority of your practice, until it’s time to make the payment – which is too late. Important contractual elements such as the performance guarantees and potential incentive payments based on performance should be discussed and mutually agreed upon before the contract stage.

Conclusion
Don't give up hope! There are some very good, and even great, RCM vendors in the industry. Choosing the right RCM partner is really just a matter of finding the right one for your practice based upon your own values, how you like to do business, and who you want working with you as a representative of your practice with your payers and your patients. You’ll want to make sure that you choose a partner that treats you and your staff with dignity and respect. And above all, choose one that knows that they work for YOU and that their number one job is to help you get paid accurately, timely, and ultimately help your practice make more money faster.

Tips on what to look for in an RCM agreement:
✚✚ Make sure that each term of the contract is clearly defined and acceptable to you, especially the definition of “collections”
✚✚ Know exactly what you are paying for as well as what services the agreement includes and excludes
✚✚ Don't fall victim to bait-and-switch advertising tactics – get answers up front during question and answer sessions with proposed vendors
✚✚ Search contracts for hidden fees
✚✚ Demand clarification, in writing, when you discover ambiguous contractual language
✚✚ Require on-demand transparency and routine reporting so you can see how your practice and your RCM vendor are performing on a day-to-day basis
✚✚ Find out who's doing your work, where are they geographically located, what language they speak, and what certifications and qualifications the employees have that will be working on your business
✚✚ Understand how performance will be measured and how guarantees work
✚✚ Recognize what happens financially upon voluntary or involuntary termination of the agreement

Pulse RCM Services
Pulse RCM supports the financial functions of physician practices with experienced, results-focused, certified professional coders, and billing and collections experts. Pulse’s RCM is the perfect solution for physician practices that want to focus on delivering healthcare to their patients, while Pulse focuses on the financial health of your practice. We’re so confident in our ability to deliver positive results for our clients, that we actually publish our RCM performance. Click here to see our RCM performance metrics.
Earn more and get paid faster
Because Pulse’s RCM uses comprehensive claims scrubbing rules, Pulse clients receive optimal billing rates and first-time claim acceptance rates that average over 98%. Pulse’s RCM clients benefit from higher collection rates, shorter payment cycles, and reduced operating expenses. Pulse’s RCM results are measured against and often exceed MGMA best-practice benchmarks.

An easier way to get started
There are no start-up costs, no software licensing fees, no hardware or server investments, and no ongoing maintenance or software upgrade fees. Pulse RCM’s cost-sharing model aligns with the success of the practice. Pulse RCM has been delivering results for more than two decades, continuously striving for improvement through an ongoing process of measuring results, streamlining processes, and developing advanced automation tools.

Pulse offers a complete suite of RCM services as seen below:

- Charge coding, entry and review
- Electronic claims submission
- Electronic claims status
- Electronic claims management - Payment posting - Re-filing of denied claims - Appeals of denied claims
- Managing accounts receivable
- Workflow and metrics analysis - Financial performance - Operations efficiency - Best practices comparison
- Provider credentialing and registration with payers
- Payer performance - Ranking - Negotiations - Compliance
- Customized patient statements
- Patient collections
- Performance reporting

About Pulse Systems
Pulse provides certified, integrated, electronic healthcare management solutions to thousands of physicians across more than 40 specialties nationwide. Pulse’s award-winning, interoperable technology platform includes easy-to-use, cost-efficient EHR, Practice Management, e-Prescribing, and Revenue Cycle Management Solutions. Pulse is committed to helping our physician partners gain greater work flow efficiencies, reduce costs, and achieve meaningful use incentives all backed by our best-in-class client support, training, and implementation services.

To learn more about Pulse RCM services, please visit us at http://www.pulseinc.com/services/revenue-cycle-management or call us at 1.800.444.0882 x3.

FREE RCM Assessment
Find out how much more money you could collect - and how much faster you could collect it - with our FREE, no obligation, assessment of your RCM performance. Call 800.444.0882 x3 or visit pulseinc.com/RCMTruth

Endnotes

Call us today at 1.800.444.0882 x3, email Info@pulseinc.com to schedule a free, personalized demonstration or visit our website, pulseinc.com to learn more.
To learn how Pulse’s Complete EHR, PulsePro Practice Management, Pulse Revenue Cycle Management and e-Prescribing solutions can benefit your practice, call 1.800.444.0882 x3 or email us at Info@pulseinc.com.

Pulse cares for your practice, as if it were our own.

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Pulse is consistently in the Top 1% of HIT developers nationwide! Here are some of our accomplishments:

- Pulse Complete EHR
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