

Revenue Cycle Management: The Foundation of Physician Leadership

Key Terms

Allowable – The total amount a provider can be reimbursed for a procedure, including co-pays, co-insurance, and payments by payers. It can either be a contracted rate (private insurance) or a rate set by the government (Medicare, Medicaid, or worker's compensation).

AR Days – Measures the average length of time between the date of service and the date the claim is paid. MGMA calculation: $((\text{Total A/R} / \text{Previous 2 Months' Average Charges}) \times 30)$. This formula does include credit balances.

Current Procedural Terminology (CPT) Code – A list of descriptive and identifying codes used for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, patients, and third parties.

Denial – Charges that the insurance company refuses to pay. This could be because the patient is no longer covered by that insurance company, the patient hasn't met their deductible, the services provided were not covered on the patient's plan, or there is some missing or incorrect information. Making sure that a patient's insurance information is current and accurate is very critical to bringing down the number of denials a practice will receive.

Date of Service / Date of Charge Entry (DOS: DOCE) - identifies the amount of time between the service and entry of the charge into the system. Delays in charge entry may create lost charges, increased past filing deadline denials and potential lost revenue.

HCFA – Standard form on which all claims are printed (former name of CMS)

HIPAA – Health Insurance Portability and Accountability Act, passed by Congress in 1996. The regulations include standards for transactions and code sets, privacy and security. The deadline for compliance with the privacy standards was April 14, 2003. The deadline for compliance with the transaction and code set standards is October 16, 2003 for those providers who filed for a one year extension last October. The deadline for compliance with the security standards is April 21, 2005.

Pass Through Rate - This is a measure of the amount of accounts receivable that is transferred from insurance responsible to patient responsibility during the month.

Pre-bill Edits and Rejects - This is a measure of the total number of CPT codes rejected by the payor/clearinghouse or edited for data compared to the total number of CPT codes posted during the month.

Relative Value Unit (RVU) – Originally developed to determine the Medicare physician fee schedule, relative value units (RVUs) are now recognized as a standard tool for analyzing and improving medical practice productivity and financial performance.

Revenue Cycle Management (RCM) – The submission, collection, and analysis of collections for group medical practices.

Unreconciled Appointments – unreconciled appointments reflect arrived appointments that have no related charge posted against the appointment. Unreconciled appointments September indicate charges that were performed and not entered into the system for billing.