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REVENUE CYCLE MANAGEMENT - WAYS TO IMPROVE YOUR BOTTOM LINE

The healthcare eco-system is changing, and billing solutions are undergoing a major overhaul. Gear up for these changes and stay afloat when the rules of the game change and the dust has settled.

While money isn't the end objective of a healthcare system in any country, it is unquestionably the blood that keeps it alive. For provider organizations to provision quality care to their patients, they need to be financially sustainable. This is why Revenue Cycle Management (RCM) assumes the centre stage in the US healthcare. Also, there are a few contextual realities that warrant an enhanced focus on RCM.

Increased risk exposure through PR

Traditionally, providers systems and RCM operations were primarily focussed on payers for reimbursements. With the recent changes, high deductible plans aren't uncommon as they were. As a result patient responsibility (PR) becomes an important component of providers' revenues. RCM processes and systems need to be equipped to handle this change and avoid revenue leakage.

Transition from FFS to Managed Care Plans

Managed Care being an efficient system to manage cost, utilization and quality, lets its members to flexibly enroll & did-enroll between different health plans throughout the year. The cause could be Patient's Primary Care Physician not being part of MCO network, Patient's needed services not being covered by MCO Plan etc., which may lead to patients changing their plans frequently. This may result in No coverage issues when claims are not submitted in right time. Tracking of patient's payer responsibility on the DOS & timely filing helps in improving receivables. Another important dimension that defines receivables while generating claims is identifying the right charges based on the combination of provider and patient. For example whether the provider is treating a patient under the contract model or FFS model, charges may vary.

Value based care

Fee for service (FFS) was a reimbursement model providers have gotten used to and find simple enough. However, the transition to value based care demands them to take responsibility for the overall well-being of the patient as opposed to delivery of services while they are in the provider facility. Existing billing systems were never equipped to handle this and will need a transformation to incorporate 'care' and 'health' into the process.

Patient's continuous change of plans

Many a times, patients changes their plans so often that providers aren't able to keep their systems current with this information. Especially in the behavioural health space this is a common scenario. By the time the providers submit the claims, the plan information changes. As a result, the billers pick the incorrect plan information assuming that the current plan was valid even at the time of service.

Claims submission is a batch process that happens after a week or more from the actual date of service, meanwhile if the eligibilities are not tracked properly, there is high possibility of submitting to a wrong payer, which ends up in either multiple resubmissions or timely filing issues.

Continuously changing Payer environments

Payer systems have been in a state of constant flux and it continues to be so. The changing codes, expectations from the providers and the way rules get applied constantly undergo a change. The billers need to learn this quickly and need to incorporate these to minimize denials.

Show me the money

Even though most of it seems like common sense, provider organizations don't always pay attention to the reasons for revenue leakage. Below are a few usual suspects we have seen in the past.

Failure to check eligibility

About one fourth of practices never verify patient eligibility and co-pay amounts. Another one fourth don't verify this information until the patient has left the office. While a basic step, this gets missed more often than one would expect. As a result, the payments never reach the providers.

Also as there are many plans under each payer umbrella, identifying the right plan code is a challenge. Eligibility checks help in identifying the right plan. Identifying Inactive eligibilities, other Insurance details before hand will improve receivables.

Pre-Authorization not sought

Providers depend on their front office staff for administrative task completions. However, they are not always able to perform these functions on account of many reasons including but not limited to human error.

Incomplete or incorrect claims

For timely reimbursements claims need to be created with correct information. On the payers' end too there is a 'system' verifying these claims, so a mistake could mean a negative binary response. Typical errors claims include those related to Provider/Patient/Plan Codes/Contract Plans/Revenue Codes / Rate Codes / Frequency of submissions / Reference of previous ICN numbers, ICD-9/10 code usage and missing/improper service codes among many others. Often due to contextual changes / contract changes, the claims might be sent to the wrong payer altogether, especially seen in case of scenarios such as MCO transitions.

Transparency with the consumers

VBP brings a change in RCM. Patients need to be educated about the financial repercussions of clinical decisions. Before the providers provision the necessary care, they need to ensure that they will get paid for it. Providers need to educate patients about the estimated patient responsibility through eligibility checks in order to be sure of payments.

> While payers are going to take cover under VBP, the patients may turn out to be bad debt.

Not staying current with payer requirements

The code sets keep changing from time to time and providers need to adapt to those. For instance, CPT codes are again going to change starting Jan 2017. Identifying the right REV code &

Rate codes for every CPT / HCPCS codes. Provider need to ensure that their billing folks are trained on these changes in time to avoid rejections.

'Forgetting' rejections

Often the billing departments of providers are so overwhelmed with submission and posting that AR isn't always addressed the way it should be. As a result, the AR cycle gets stretched and the probability of payments diminishes. For instance, a claim billed to a specific plan, can be denied with CO24, CO22, CO 109 where it needs to be billed to a different payer/plan which may end in timely filling issues, if not reconciled immediately. Were there a way to automate this process, providers could get more for doing less annually.

No visibility into the end to end RCM cycle

Claim fixing is an expensive process. Organizations that rely on manual billing for most part bleed in ways they may not even know. Automation can ensure that errors fixed once don't recur and minimize the cost of fixing progressively.

According to a study, health care providers typically spend 8 to 14 percent of overall revenue on clerical follow-up on rejected claims which can be improved with a more effective system in place.1

Not 'seeing' the revenue trends

When a biller handles claims manually, their vision of the RCM process is myopic. 80/20 rule applies pretty much everywhere, even in RCM. Unless the billers look at the trend, they will fail to fix the root cause and the impact of their efforts will always be narrow. Generalizing the payer specific reasons for denial codes through analytic tools built on top of the RCM data can prove to be an asset as they enlighten the users with information they don't even know exists. Learnings from this behaviour data can directly and indirectly impact the money the providers make. For instance, while submitting claims to MCO plans, corresponding REV codes / Rate codes should be tagged to avoid denials like CO16 / CO197 which can be identified based on analytics.

Inability to track patient responsibility

As high deductible plans become more common, the patients share of the healthcare payments gains more significance. Providers weren't traditionally used to this. They need to adapt to this change by taking necessary steps before and while the patient is in the facility and during the collection process. Payers, they had one point of contact to follow-up with for all outstanding claims/rejections, with patients the number balloons. Now, a B2B transaction suddenly changes to B2C and the providers need to adapt to this change by leveraging technology to enhance their reach without increasing collection costs.

Clueless about their own workflow flaws

One of the biggest flaws with the manual processes is that it's almost impossible to pin-point the inefficiencies in the workflows as the metrics

aren't present. For instance, claims can end up in multiple resubmissions for different denials reasons. Each denial will require a specific reference inclusion in the claim. Automation of the RCM process enables providers to look at their own processes and weed out the inefficiencies causing denied/delayed payments. As the noose tightens with VBP, this will be imperative to stay afloat.

A survey of providers revealed the following as the biggest challenges the practices know about.

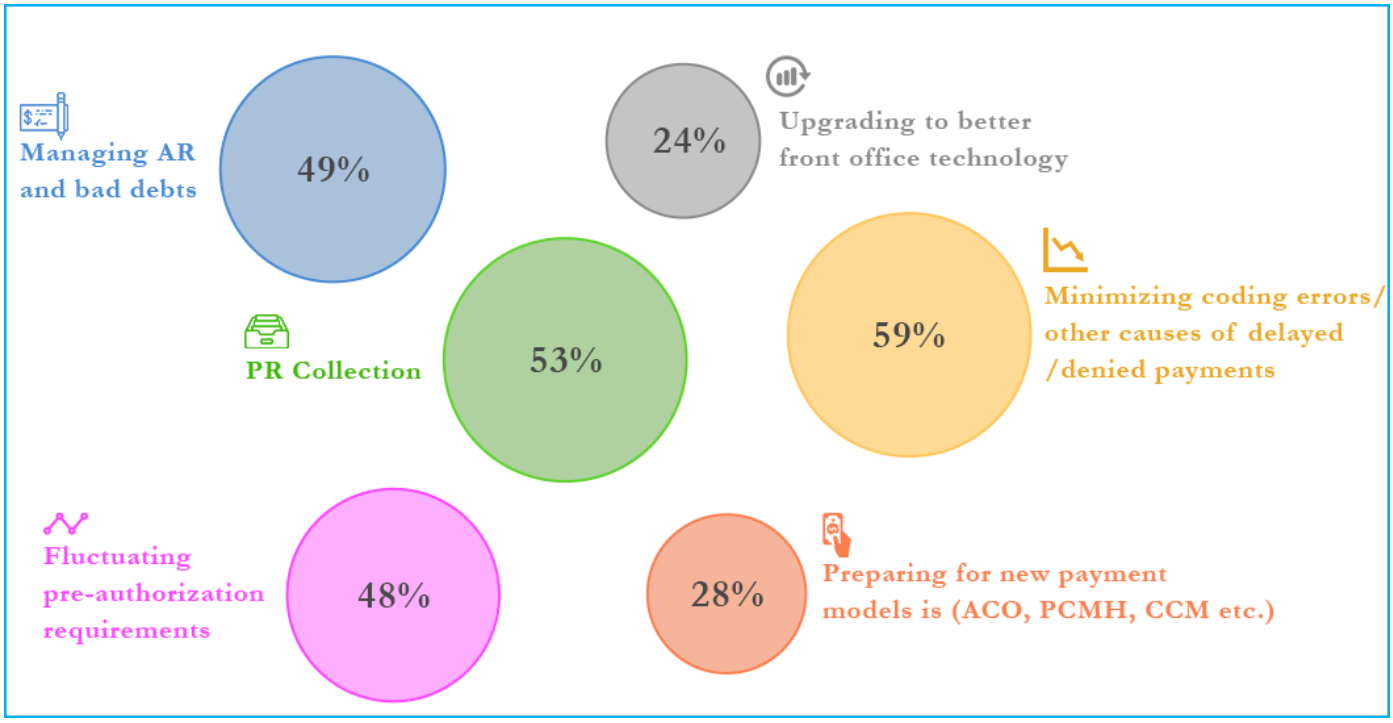

Figure 1: Survey results showing what providers believe are the biggest challenges for practices

Below are a few scenarios that you may relate to. These are intended to bring out the ways in which providers bleed and still continue to. Not all of these might be relevant to you but if you foresee an exponential growth in imminent future, you may need to gear up for some change so as to scale up and address these challenges in a smarter way.

Scenario 1: Worker's Comp sound tricky?

About a dozen states have what are called "**no fault**" car insurance laws. No fault insurance means that the automobile insurer will pay some or all of your medical bills and lost earnings if you get into a car accident, regardless of who was at fault for the accident. The complex claims and attachments handling workflow often result in delays if not denials on account of 'missing' documents. More often than not, these claims involve paper which makes it inherently slow and makes the tracking difficult.

A study by Accenture, titled Unlocking the Value in Claims , indicated that more than 40% of claim handling time is spent on non-core, routine administrative items that don't affect the outcome of claims. Claims costs could be reduced by 15% while maintaining quality standards high.[2]

How do we fix it?

We understand that filling paper forms like the C4, C4.2, C4.3, AMR, OTPT etc. is a challenge for two reasons – paper and workflow complexity. Most organizations without the supporting modern technology continue to handle these inefficiently. But through intelligent systems in place, this can not only become faster but also helps you to track the claims status, fix rejections (if any) and also process payments electronically.

There are over 50 different data elements that needs to be entered on the paper C4 form for example and then these selections need to be remembered for a follow-up visit and the provider is expected to fill the C4.2 form. An intelligent system can auto-populate the existing information from previous visits for the provider or the biller to refer while working on the progress report.

Risk Management Newsletter reported that the cost of **processing a workers compensation bill from $15 to $4 by using technology**. Online access to claims information reduced the number of calls requesting sta1tus information, reports etc.

A study by Visiongain, entitled E-Claims Market Outlook , found that 61% of the claim time was spent on unnecessary administration and paper-work. Examples of wasted time included time spent on querying status, waiting or looking for paper files and documents etc. The study also showed the usefulness of technology in improving accuracy (eliminating 98% of errors) and improving claims processing time (dip from 18 to 5 days).[3]

Benefits

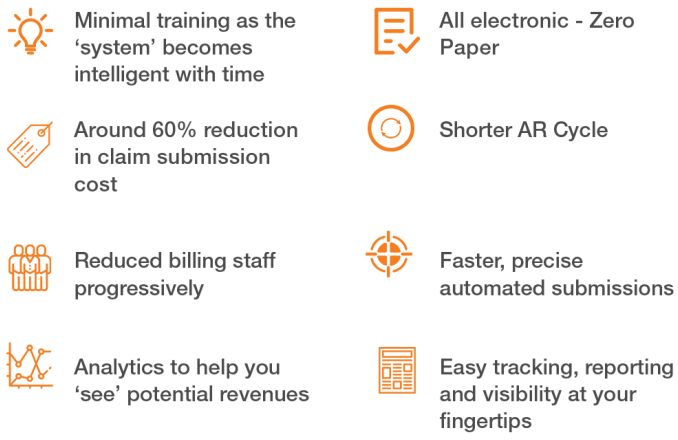

Figure 2: Benefits of intelligent technology

Scenario 2: Rejections hurting you?

The most common problem while creating a claim is the use of CPT, ICD, Modifiers and other claim level information to ensure that you follow the appropriate standards in coding and get reimbursements for it. Most billers use their experience to bill the right codes to the payers. However they may not always be right as the context is volatile on account of changes to the payer specifications and modification to the services delivered by provides.

Payers trust providers to provide necessary, cost-effective, and quality care. They control the documentation describing what services patients received and the documentation serves as the basis for claims sent to insurers. The CMS pays claims based solely on representations in the claims documents. If a submitted claim was false, then the attempt to collect payment constitutes a violation.

Examples of improper claims include services that were:

1. Not actually rendered
2. Not Bundled properly
3. Not medically necessary
4. Under-coded or Up-coded
5. Performed by an improperly supervised or unqualified employee or by an employee excluded from participation in Federal health care programs, so identifying the right provider NPIs
6. Of low quality that are virtually worthless
7. Already included in a global fee, like billing for an evaluation and management service the day after surgery [4]
8. Identifying whether to submit APG rate codes / Medicaid Fee schedules

According to "Medical Coding and Billing School" there are multiple reasons for the practice to never get paid in full. [5]

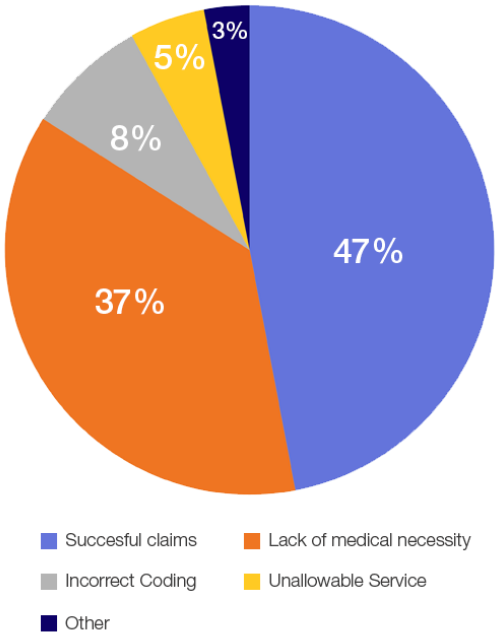

Figure 3: Reasons for denied/partial payments

Repercussions

While not getting paid in full hurts the providers, there are worse repercussions in case the claims filed to the CMS aren't proper. The Civil Monetary Penalties (CMP) Law authorizes the imposition of CMPs ranging from $10,000 to $50,000/ violation.

CMPs also may include an assessment of up to three times the amount claimed for each item or service or up to three times the amount of remuneration offered, paid, solicited, or received.

Scenario 3: COB Nightmares?

When a provider's office submits a claim to the primary payer they look forward to get partial payments and send the balance to the secondary payer. Posting these payments is a time consuming and tedious task as each of the payments/ adjustments need to be captured with the reason codes before submission to secondary payers. Also, manual handling stretches the AR cycle while being error prone too.

The same process can be streamlined through automation. An Electronic Remittance Advice (ERA) is sent by the payer in a standard EDI ANSI X12 835 format. This ERA can be shown to end users in a human readable format resembling the EOB that they ae used to. Payments in the ERA (EOB) can be posted with a single click reducing the posting time by 80%, following which the system will automatically identify the claims that need to be forwarded to secondary payers by adding the payment information from the ERA received.

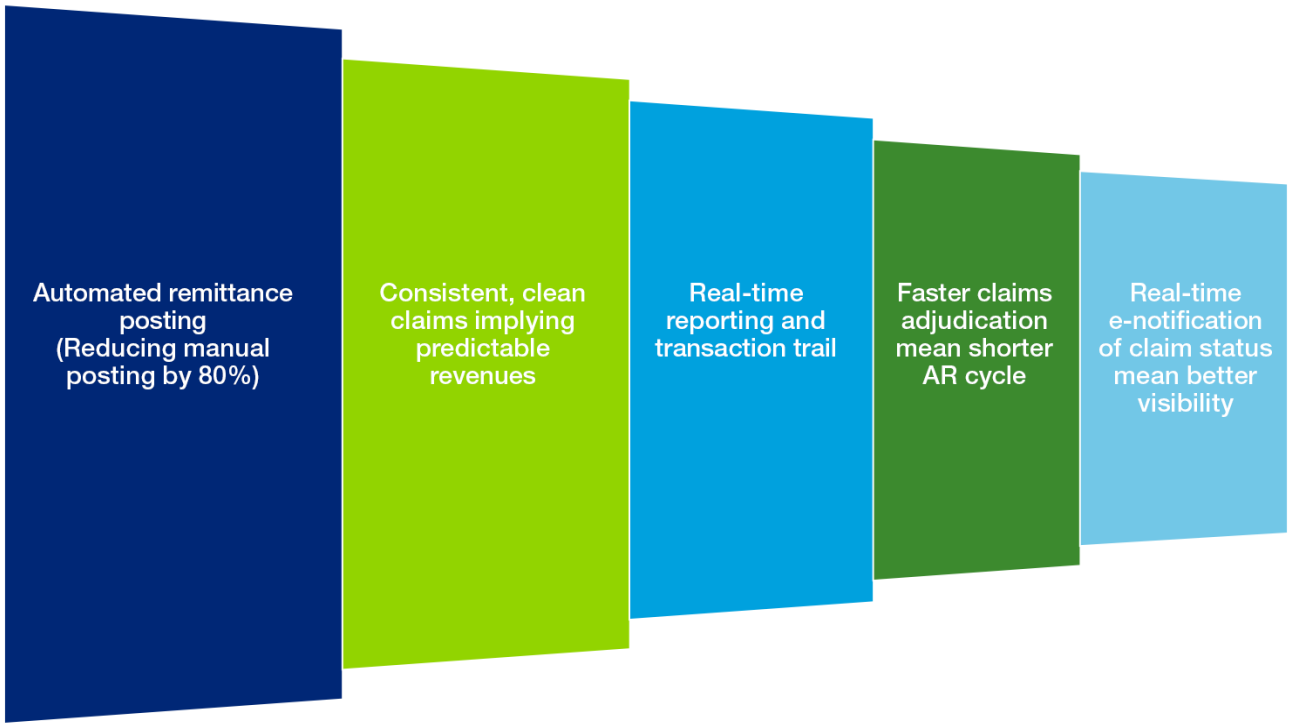

Figure 4: Benefits of automation for claim submissions

Plug the gap, get more dollars

Go digital

The first step to improvement is quite obvious – embrace technology. To start with, eliminate paperwork and associated manual work. The entire process of claim generation, resubmission, payment posting etc. can be automated to ensure that your data is rendered useful.

Optimize operations

Moving to electronic transactions is the first step to get your hands to data that you can act upon. RCM cycle data is valuable as it helps you understand your revenue stream behaviour, cost structure and operational handicaps.

> We recommend leveraging your data from RCM cycle.
>
> Here is why!

- **Focus on the right patients –** Your patient mix is the key to understand your risk exposure. The front desk needs to know the customer lifecycle value and cater to them accordingly.
- **Understand your schedule –** Knowing the behaviour of your appointments can help you utilize your time better. You could learn what are the most profitable conditions, time of the day when you may want to book multiple appointments to account for no shows, and other such insights will help you perform better.
- **Know your contracts –** It's important to compare your reimbursements against what you agreed for through your contracts. This would also help you realize how your revenues are impacted through what you agree on at the beginning of the year with payers.
- **Eliminate bottlenecks –** Its natural to miss the forest for the trees when the transaction volume is as high as it is in the billing departments. However, having a quantified outlook of the process can yield meaningful insights. This could help you identify steps that bring about the slack in the AR cycle, dip in the reimbursements, training needs for billers etc.
- **Minimize clicks –** Traditional systems were designed with limitations imposed by technologies. As a result the billing solutions often demand their user to key in a ton of data and perform millions of clicks every year. However, with modern tools and technology it's possible to automate these workflows and minimize the time the billers spend on these processes.

Accelerate payments

AR with payers can be accelerated by automating the entire claim management process. However, as patient responsibility portion of the payments increases, providers need to focus on the collection from them as well. Traditional AR management with providers were designed keeping payers as the primary if not only reimbursement channel. Providers can however leverage technology to recover money from patients without a linear raise in the workforce.

Below are a few ways to achieve that.

- **Give them an estimate –** It is advisable to let patients know what might be the financial repercussion of a clinical decision that the provider takes. They need to know what the payer is likely to pay and what they might be expected to pay. While it won't be accurate to the last decimal, this would give them a ballpark figure through a PR estimator.
- **Make payments painless –** The probability of collection from patients is highest during the first 30 days from the date of visit. A lot can be learnt from the way consumers maintain the payment discipline with utility bills. Providers need to take the payment channels to the last mile such as mobile phones to ensure timely payment. Through such channels, providers can push value-adding features such as appointment reminders, statements, educational content etc. to them.
- **Provide them options –** Inability to pay shouldn't be confused with lack of propensity to pay. In cases where patients can't make the payment in full, providers can extend options so that the patient can choose a payment plan based on their comfort. Typical options could include card on file, mobile wallets etc. that give more control to providers to charge the payments based on their agreement with the patients.

Learn from mistakes

Often providers focus on delivering the right care but aren't really keen on looking at the financials of the care equation. Most often the IT department is too busy to 'learn' from the data and ed-

> Uncover the truth that you never knew existed. Here is how you should leverage modern technologies

ucate the providers. This is why providers continue to fly blind.

- **Understand rejections / denials –** It's important to know what went wrong with the claims in order to fix those. Unless the AR data is analysed, providers and their billing departments will keep fixing the symptoms but not the root cause.
- **Learn 'when' AR becomes bad debt –** Efforts for AR recovery should focus on cases where the outcome is most promising. But how do providers/billers prioritize? In the absence of an intelligent system, they are clueless and choose aging or the amounts as guiding principles. Based on history, data can tell them where to focus so as to maximize outcome.
- **Smart templating –** While there are limitations on the effort that can be put into AR follow-ups, automation could bring about an exponential increase in reach. A smartly configured system can ensure timely communication is sent out to individuals in a manner that's customized to a certain scenario or individual.

About the author

Amit Manral

Amit is a healthcare enthusiast who is passionate about the application of creative ideas to improve the healthcare ecosystem. He has been involved with US healthcare for over a decade and loves to understand the challenges of various stakeholders, impact of regulations on them and figure out ways to leverage technology that will impact business positively.

About Nalashaa

Nalashaa believes in simple solutions to derive meaningful insights and in exceeding your expectations. Our clarity of thought has earned us many laurels in this fast paced world where healthcare technology advancements are rolling out continuously.

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Connect with Us

If you are plaguing from a billing process nightmare and would like to bring about a transformation in the way you conduct your business, we would like to help you in your journey. Nalashaa helps organizations create the value that they are looking for. Have a more in depth conversation about how some significant changes can affect your business positively.

Drop us a line at tech@nalashaa.com and we shall get back to you within a business day.

You can also reach us at:

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References

1. http://www.healthcareitnews.com/blog/top-5-provider-mistakes-revenue-cycle?page=0
2. https://www.accenture.com/t20160927T223550__w__/us-en/_acnmedia/Accenture/Conversion-Assets/DotCom/Documents/Global/PDF/Industries_7/Accenture-Claims-Transformation-Services.pdf
3. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf
4. http://business.illinoisstate.edu/downloads/katie/affect_of_technology_and_automation.pdf
5. http://www.medicalbillingandcodingonline.com/medical-billing-errors/