How automation helps steer the revenue cycle process

While the goal of revenue cycle management remains essentially the same, healthcare reform will make it infinitely more complex.

Phil Colpas | June 2013

If there’s one aspect of healthcare that’s omnipresent – that is connected in some way to virtually every component of the medical trade – it’s the revenue cycle; and vendors’ solutions to manage it are as varied as the experts we queried on this topic.

The revenue cycle actually touches on nearly everything related to healthcare – from the time a patient books an appointment with a healthcare facility, until the patient and insurance company provide final payments for services rendered to the healthcare provider.

Over the past several decades, software programs and computers have replaced ledger books and calculators. And while the goal of revenue cycle management (RCM) remains essentially the same, healthcare reform will make this process infinitely more complex, due to reduced reimbursements and the onset of ICD-10 in October 2014. Additionally, reimbursement will be tied to quality, rather than quantity.

According to an Information Week article by Ken Terry, outsourcing of billing and collections continues to grow, “because hospitals and physician groups are not very good at these non-core tasks.” Think writers and math: I know a great many writers, including yours truly, who possess truly weak math skills. Granted, both skills involve opposite brain hemispheres – different parts of the brain. But what may be even more important is the fact that math is not generally an integral component of the main function of writing. A similar situation exists in healthcare facilities; just replace writing with providing care for people.

A 2012 Black Book Rankings survey states 96 percent of organizations are in the process of acquiring several crucial accountable care organization (ACO) data solutions, including clinical decision support, RCM, health information exchange (HIEs), electronic health records (EHRs), e-prescribing, data center security and storage solutions, business intelligence and care coordination management.
So it’s clear that RCM will continue to remain a top-of-mind issue as we see how healthcare reform plays out. Here’s what our select group of experts had to say about how automation helps to steer the revenue cycle process.

**Edward Wrzesinski, Jr., CMPE, director, RCM services, Allscripts**

**RCM should be closely connected to patient data**

Revenue cycle is more closely linked to care quality than ever before. As government and commercial accountable care organizations (ACOs) spread around the country, health insurers are continuing to look for more programs that peg physician and hospital payment to performance metrics.

That’s why RCM technology has to be just as closely linked to data in the patient chart. More importantly, organizations need the tools to analyze the data to find out where costs are growing, where revenue is improving and how costly patient populations are responding to interventions.

To prepare for the increased number of value-based payment models, here are some other factors to consider when assessing revenue cycle technology:

- **Flexibility:** Health plan and government requirements for physician performance will continue to change in a value-based payment market. An organization’s RCM system needs to adapt by allowing for simple back-end configuration as health plan contract terms change.

- **Data accessibility:** With the arrival of the ICD-10 deadline next year, payers will be armed with even more data to deny an organization’s claims or reduce payment. Be prepared for this dynamic by selecting RCM technology that allows staff to easily access and comprehend the clinical data they can use to appeal the denial or underpayment.

- **Point-of-service collections:** Although an organization’s rate of uninsured patients post-healthcare reform is likely to decrease, patient payment responsibility for deductibles will continue to grow as health insurers try to reduce their costs. Ensure the RCM system can offer real-time access to patient insurance eligibility prior to service, offer patient responsibility estimates ahead of time and collect payment via credit card or debit card once payer remittance advice is received.

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**Michael Najera, VP, professional services, Craneware**

**Building revenue integrity with charge-data management**

Today’s hospital and health systems face unprecedented challenges as they work to provide quality care and improve financial performance. Uncertainty about new payment models, coupled with declining
reimbursement and increased compliance risk, are putting healthcare organizations under mounting pressure to improve internal operations and find cost-cutting methods to ensure financial stability and achieve operational efficiency and compliance.

An essential cornerstone of RCM is maintaining an accurate chargemaster, as every transaction goes through the chargemaster before being posted to a patient’s account. Yet many organizations do not even realize they should be performing ongoing chargemaster maintenance. Currently, up to 64 percent of hospitals are still using error-prone manual processes for chargemaster updates, leading to lost revenue and compliance risk. Charge-data errors not only justify delayed or denied payment, but given today’s regulatory landscape, errors can also constitute fraud and abuse. As such, it is necessary that organizations shift away from tedious and often mismanaged manual processes for maintaining the chargemaster and move toward automated maintenance in order to deliver quality care without compromising revenue accuracy.

Some key questions every organization should consider to ensure a clean and accurate chargemaster include:

- Are all charges for services rendered accurately captured?
- How is accountability assigned, tracked and measured for the revenue cycle performance of each clinical department?
- Does staff have the required information to ensure charges are current, complete and compliant?
- Does your organization have effective, automated charge-capture tools in place to capture information efficiently and accurately across disparate systems?

Justin Steinman,
VP and GM, clinical business solutions, GE Healthcare

Revenue cycle and ICD-10: The big healthcare reform challenge

As meaningful use, shared savings and other initiatives rise to the top of the priority list for provider organizations across the U.S., many are focusing attention on the clinical side of the equation and overlooking the impact of RCM. Healthcare reform presents diverse challenges and needs; sound RCM is critical to not only survive the current healthcare evolution, but to ultimately thrive in the new environment.

One area that is affecting almost every aspect of revenue cycle – service delivery, billing, claims processing and reimbursement – is ICD-10. ICD-10 represents an enormous shift and requires significant investments in time, resources and costs. It is a challenge that healthcare organizations must undertake with complex planning and robust technology solutions. This is critical to ensure a successful ICD-10
transition. As the complexity of ICD-10 increases, providers need smart technology to help drive productivity and efficiency, including tools such as health claims denial, online repair, tasking and analytics. An advanced EMR/practice-management system or revenue cycle system will also be necessary to improve workflows related to the visit and provider coding, as well as to decrease costly errors resulting from inefficiencies.

Whether it is staff training, process analysis or IT implementation, providers must plan carefully during this transition to avoid reimbursement disruptions. We can learn from other countries and lessons from their ICD-10 experiences, which have shown that early preparation and effective technology implementation are absolute success factors.

Steve Francis,
president and GM, GMC North America

Speeding the revenue cycle starts with the EOB

Increasing the efficiency and speed of the revenue cycle is a top priority for healthcare organizations – and rightfully so. In today’s environment, explanations of benefits (EOBs) don’t just represent an outbound communication with your customer. It is important to consider the inbound aspect of that communication, particularly as it requires customer response to keep the revenue cycle moving along.

How you populate and deliver the contents of the EOB are equally critical factors in getting patients to pay their bills – and making that experience as personalized as possible will improve the chances even more. Additionally, adopting a multichannel approach to EOBs has become increasingly necessary. People interact with their EOBs through a variety of channels: print, email, mobile phone or tablet. Combining the printed EOB with electronic payment options – such as having a QR code on the EOB for online bill payment – speeds up the remittance process.

The format of the EOB can also make a big difference in the remittance process. When a patient disputes a line item on his or her bill, often all the other line items are left unpaid while the charge is disputed. This slows down the revenue cycle tremendously. Separating out costs on the EOB provides a clear path for patients to pay the charges they agree with, even while disputing some of them.

Statistics show that 95 percent of transactional documents are opened and read. Providing patients the opportunity to interact with the communications you deliver through their method of choice, assuming it meets compliance, will help achieve optimal RCM operations.
Let automation help steer the revenue cycle through ICD-10

The transition to ICD-10 could have major consequences for RCM if your practice is not prepared. As part of transition planning, anticipate that denials will increase and expected reimbursement for certain services may decrease. Until practices are comfortable with the new code system, it may take longer to submit claims, correct rejections or appeal denials – all of which are critical to maintaining a healthy RCM.

Facing this reality, practices must tighten their RCM strategies. Look at which processes are manual and which could be automated through partnerships with vendors such as clearinghouses or practice management (PM) systems. There is no better time than now – before ICD-10 adds extra complexity – to leverage technologies to automate processes, such as:

- **Denials:** Knowing which claims were denied is only the first step. Tools offering denial tracking and correction help prevent recurrences and keep the revenue cycle strong. Implementing these tools will allow practices to understand their denials pre-ICD-10, helping with a smoother transition.

- **Appeals:** Practices tackling appeals manually should consider tools with pre-developed letters that populate patient and denial information. This way appeals can be completed quickly, allowing practices to focus on other tasks that may be taking longer due to the ICD-10 transition.

- **Eligibility:** Eligibility is another example of a manual process that can be automated while preparing for ICD-10 changes. Ineligibility is one of the most common denial reasons. Verification technology reduces denials, supplying eligibility information before providing services and can tie directly into some PM systems.

Technology can help assist practices during the ICD-10 transition. Practices getting comfortable with RCM technology now are more likely to keep their revenue cycle strong once ICD-10 arrives.
As payment responsibility shifts more to patients, hospitals are implementing strategies to collect more up front. This paradigm shift makes sense because the likelihood of collecting improves if patients pay before leaving the hospital. Organizations are realizing that it’s now essential to involve patients early in the revenue cycle process, moving past the traditional practice of involving patients only at the back end of the revenue cycle.

When moving collections efforts up to pre-registration and registration, some executives worry about overloading staff. For many, the solution is self-service technology. Providing patients with opportunities to review financial information, complete forms and make payments before a visit offers the following benefits:

- **Higher rate of up-front collections**: Self-service tools – such as online portals, mobile applications and kiosks – enable patients to conveniently view and pay healthcare bills. Because patients are better informed about financial responsibility, they are more likely to pay when the payment screen appears. The result is faster transactions, which help speed the revenue cycle and lower bad debt incurred because of missed payments.

- **Improved patient satisfaction and loyalty**: Providing self-service software enables hospitals to simplify the registration process and decrease wait times, meaning staff can be better utilized to answer questions and solve problems. Creating a better patient experience results in a more satisfied, loyal patient who is more likely to visit the hospital again.

- **Additional revenue sources**: The time savings realized when hospitals use self-service software enables staff to handle more registrations and providers to see more patients each day. This increase in efficiency allows hospitals to schedule more patient visits and collect additional revenue.

Technology can never replace the knowledge and experience of staff, but self-service tools can augment staff efforts. By improving convenience for patients and optimizing staff time, hospitals can transform their revenue cycle processes to meet the financial challenges of today and the future.

**Brian Fugere, chief operating officer, RemitDATA**

**Leveraging analytics to boost revenue cycle performance**

Healthcare organizations are increasingly using analytic solutions to monitor their revenue cycles and to pinpoint areas where they should focus their efforts to maximize performance. Some organizations, however, are reluctant to evaluate analytic solutions due to budget limitations or concerns that they don’t possess the in-house expertise to effectively use the solutions. These are legitimate concerns, but analytic solutions come in many flavors, and recent innovations are improving their affordability and ease of use. For example:
• **Functionality:** It’s important to distinguish between business intelligence (BI) and comparative analytics. BI solutions are designed to collect, maintain and organize key performance indicators, such as accounts receivable days and internal performance metrics. In contrast, comparative analytics solutions leverage the concepts of BI, but provide further insights by contextually comparing data against peers and other benchmarks.

• **Deployment:** Both BI and comparative analytics solutions can be deployed via a cloud-based model, which enables organizations to benefit from data insights without incurring large up-front investments or system maintenance headaches.

• **Expertise:** Recent innovations have leveraged the subscription model of cloud-based solutions and applied it to analytic advisory services – essentially creating a “pay-as-you-go” model to tap into needed expertise.

Companies that are combining cloud-based comparative analytic solutions with subscription-based advisory services are making analytics affordable for even the smallest provider organizations. This new approach to analytics enables a greater number of organizations to identify opportunities to increase their margins, whether it’s by reducing claim error rates, implementing more efficient denial-management strategies or leveraging industry statistics to understand how their performance measures up against peers.

Ric Sinclair, head of product, Zirmed

**Use patient payment estimations to streamline RCM**

Thanks to higher deductible plans, a greater number of uninsured patients and larger co-pays, more of the money owed to providers is coming directly from patients’ pockets. Increasing patient responsibility is making it tougher for providers to collect what they’re owed, and in many cases, neither the provider nor the patient knows exactly how much the individual will owe at the time of service. While getting reimbursement from insurance companies can be difficult, collecting from patients has historically been one of the biggest challenges hospitals and practices face, and it has become too significant a portion of total revenue to overlook.

Communicating strategically with patients is essential for successful patient payment collection. To use patient estimates to boost revenue performance, follow these best practices:

1. **Make sure estimations are accurate.** Look at plan specifics, deductible balances and payer payment histories.

2. **Carefully train staff on how to talk to patients about what they owe.** This can be a delicate conversation but, handled properly, it can actually enhance the patient-practice relationship.
3. **Collect as soon as possible**, at or before the time of care.

4. **Notify patients early and often of their expected payment responsibility**, allowing patients to make informed decisions, have accurate expectations and prepare financially.

5. **Offer ways to help patients meet their financial responsibility**, such as setting up a payment plan that meets their budget. Patients that stay out of debt and avoid external collections agencies pay off their balances sooner, improving the provider’s cash flow and bottom line.