

RECONDO

Engaging Touch Free Practices

October 16, 2014

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Overview

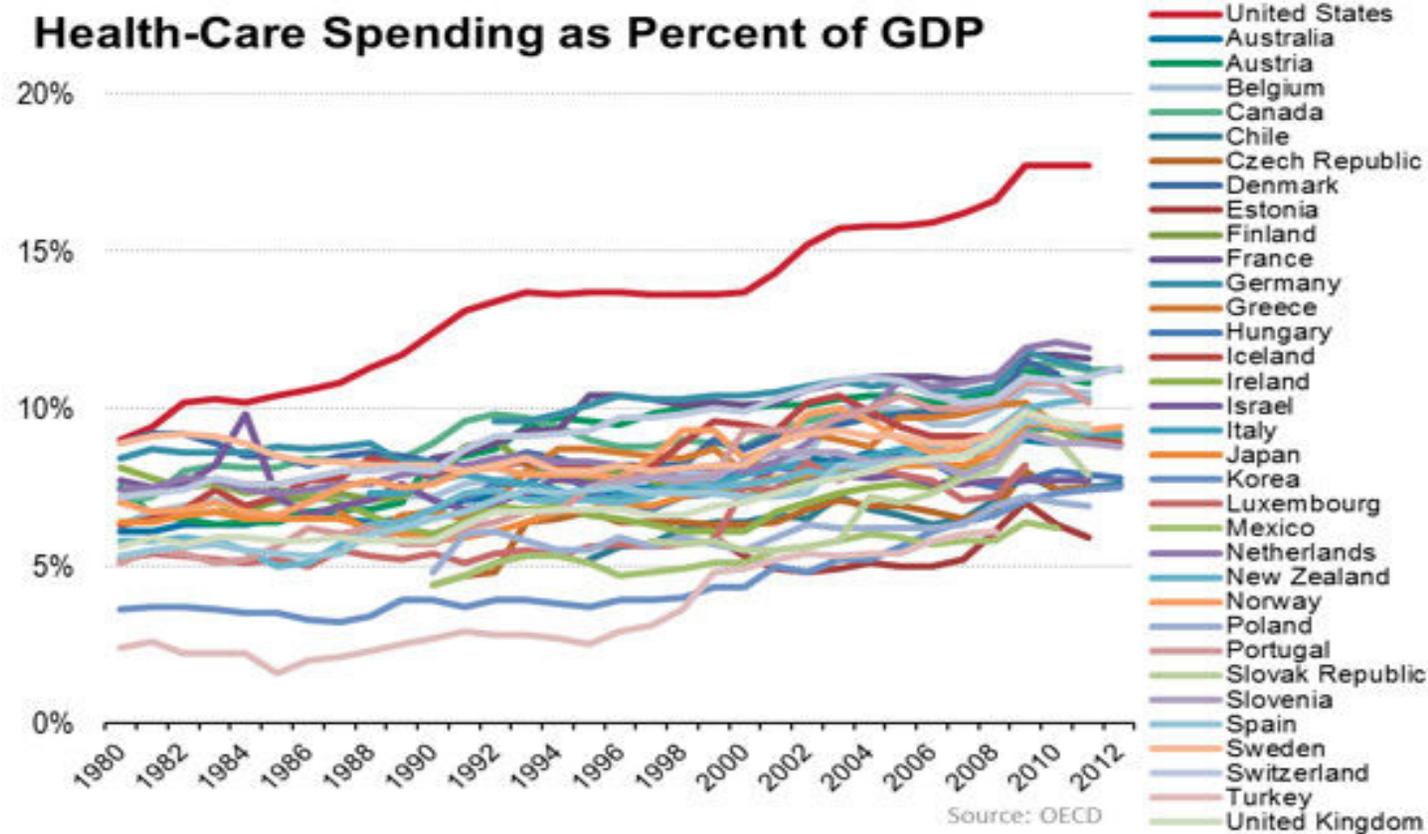
Transforming today's manual revenue cycle activities into an automated "no touch" process dramatically improves staff productivity and financials.

Attendees will learn/confirm:

- Current challenges across Patient Access and Business Office areas
- The importance of "getting it right upfront" to avoid delays / rework / unnecessary reimbursements
- Technology, data, and automation capabilities to improve operations
- Best practice considerations to increase patient satisfaction and improve financials

This transformation enables staff to spend less time on payer websites (and phone calls) and more time with patients which leads to increased patient satisfaction.

US Health Spending continues to increase at a higher rate than other Industrialized Nations



Healthcare Revenue Cycle is becoming more challenging

Increasing volume and complexity of healthcare transactions

Verifying Eligibility is a challenge today and is expected to be more challenging with the Affordable Care Act Health Exchanges

Confirming Authorizations are highly manual and often require staff to call the payer or verify on payer websites

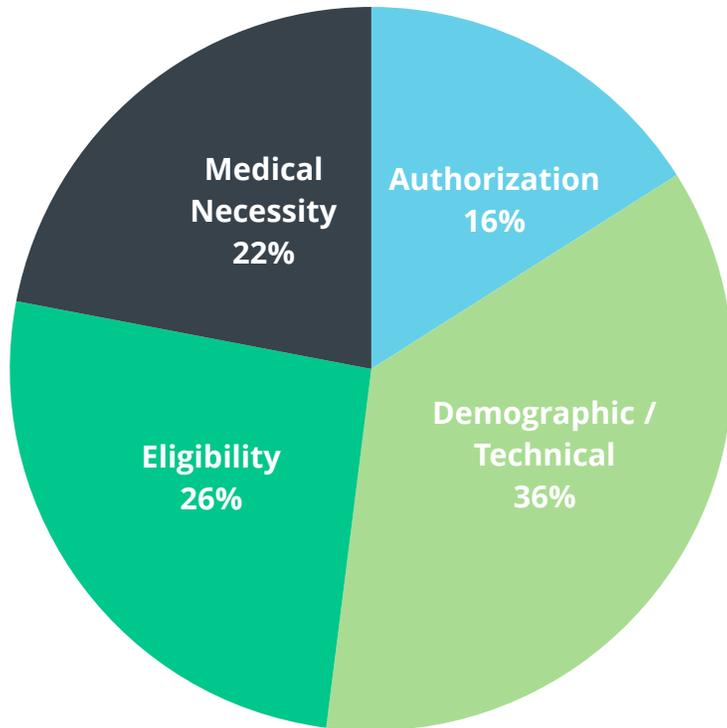
Industry administrative costs will grow by about 10 percent annually over the coming years—higher than the rate of growth of medical inflation.

- Source: McKinsey

***Circumstance: Attempt to complete in Patient Access--
--- otherwise hope that business office can resolve***

Source of initial denials result in rework in the business office

Source of Errors Leading to Initial Denials

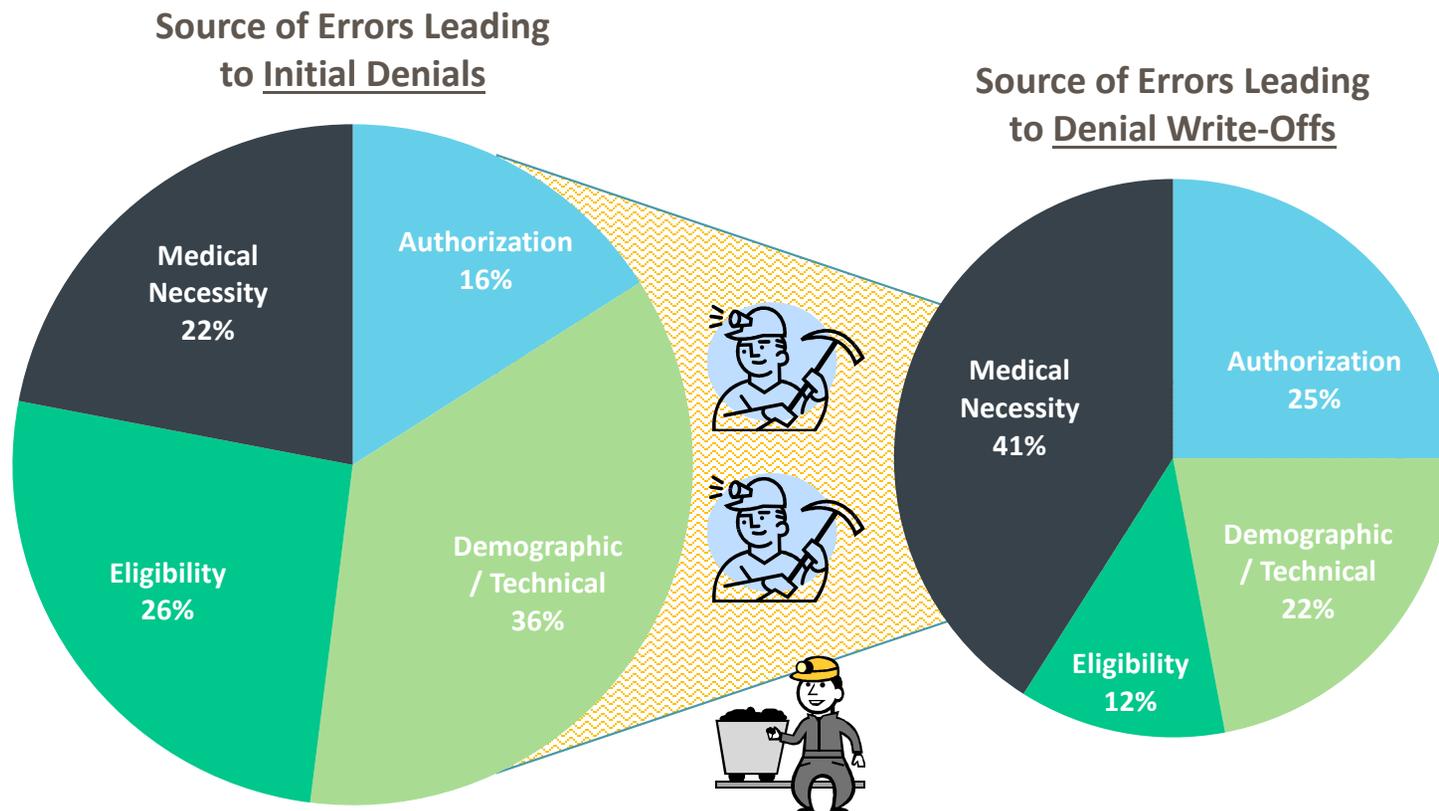


Denial Sources:

Demographics and Eligibility can often be resolved by staff reworking and rebilling

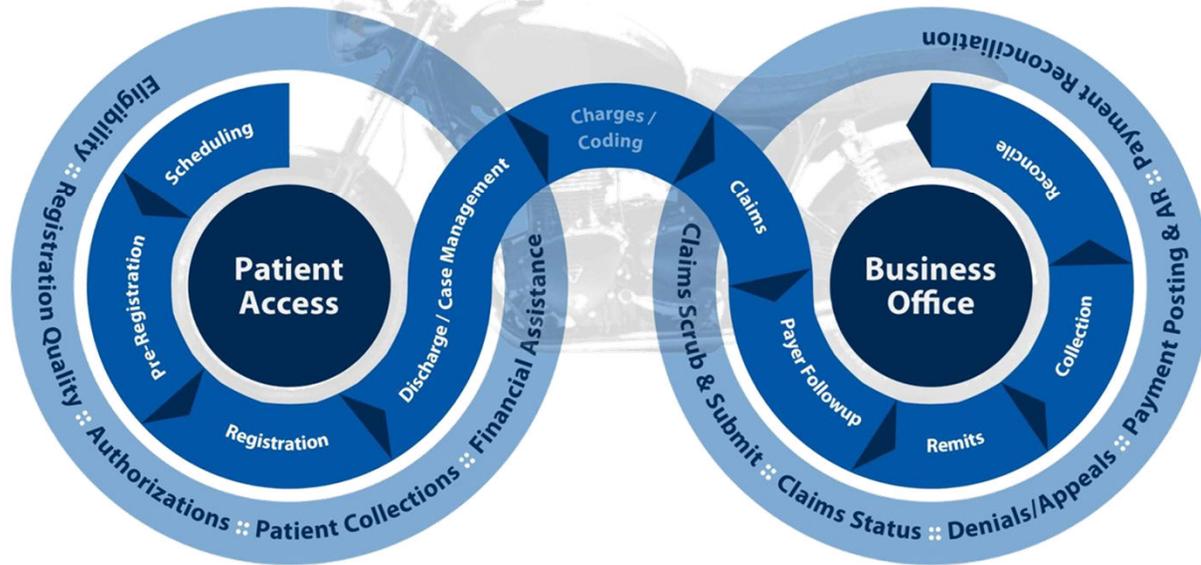
Authorizations and Medical Necessity often require more staff effort and appeals

After working denials, the remaining write-offs can still be significant



Source: Advisory Board, 2013

Robust capabilities reduce denials and automation increases productivity



Reducing denials and improving productivity helps patients and providers.

Transforming Patient Access allows refocusing on patient care

Transformation	Empowers
1. Eligibility Alerting	Identify data requiring review or update
2. Comprehensive Payer Data	Payer website data retrieval avoids users logging into multiple payer sites
3. Authorization Status	Returns Auth Status and Numbers from payer sites
4. Patient Financial Responsibility	Calculates the patient financial responsibility
5. Automated Transaction Processing	Application “pushes” transactions to completion
6. Exception Based Worklist	Focus on the 10% exceptions instead of 90% norm
7. Learning Loop	Learn from prior errors and apply rules to avoid again

Typical Eligibility Verification is not enough

Eligibility and registration quality can account for more than 50% of the denials encountered in Patient Access

- Patients do not always know their insurance(s) or have their cards
 - Medicare Managed Care can be recognized as eligible with Medicare yet be delegated to a Managed Medicare Payer (same for Medicaid); requires rebill
 - Secondary coverage can be unknown

Incomplete benefit data on many EDI (Electronic Data Interchange / Clearinghouse)

- Payer portals oftentimes contain more comprehensive benefit data
 - Verified eligibility does not guarantee claims acceptance
 - Certain data can reject claim (i.e., name, policy#, relationship codes, etc.)

Bottom line:

Eligibility is more than Yes or No; it requires acting on intelligent data to reduce denials.

Eligibility capabilities that reduce denials and enable efficiency

- **Comprehensive payer data from EDI 270/271 data and payer portal data using “bots” to retrieve key benefit data**
- **Alerts identify when eligibility needs further review:**
 - Managed Care on File: Medicare and Medicaid
 - Part A or Part B only
 - Other Payers on File
 - Self Pay Validation
- **Early Integration with Hospital Information System to retrieve eligibility and benefit data as early in revenue cycle as possible (i.e., scheduling)**
- **Exception-based worklist to empower staff review only the exceptions (i.e., eligibility not confirmed or active alerts). No Touch ~ 80% or higher**
- **Easy to view data highlighting benefits unique to visit, supporting cascading eligibility searches and formatting benefit response sequence**

Best Practice Considerations: Eligibility

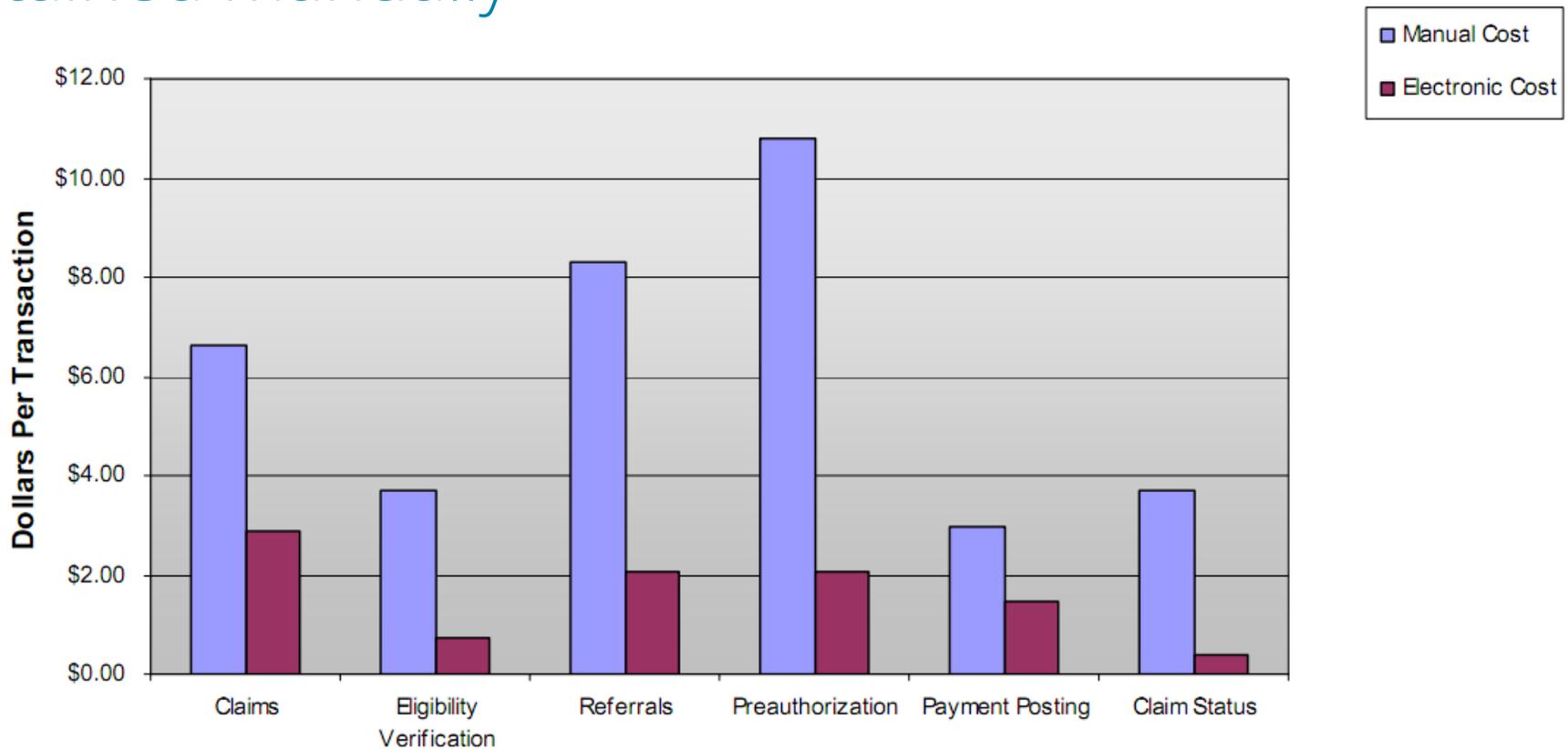
- Understand root cause of your Eligibility Rejects/Denials; take action to avoid repeating errors
- Outreach/collaboration with physician scheduling (demographics and insurance)
- Incorporate Registration Quality checks in the process
- Set team and individual goals and expectations: measure, publish and manage
- Engage Financial Counselors with Self Pays and high patient responsibility
- Manage verifications to completion seven days or more prior to date of service
- Recheck patient eligibility on first day of month as needed
- Leverage eligibility/benefit data across departments (i.e., discharge planning, business office)

Authorizations are a challenge and are becoming more frequent and complex

Lack of an authorization for required services can result in significant financial loss to a hospital. For medium sized hospitals, these denials can result in the tens or hundreds of thousands of dollars each month in lost net revenue.

- Traditionally minimizing the financial risk requires hospitals to employ teams to confirm that authorizations are obtained
- For team members, this requires:
 - Keeping current on payer/plan authorization requirements
 - Frequently calling the payer or logging into the payer websites to check status
- Medical Necessity rules must be applied for Medicare and ABNs (Advanced Beneficiary Notifications) must be signed for services not covered (prior to rendering)
- Inpatient Notification requires notifying payers when a patient has been admitted. Each payer has unique rules on timing and types of admissions. Other payers are in the starting phases of this process

Authorizations have one of the highest costs when obtained manually



Many Current Authorization tools have limited automation

There are an increasing number of solutions that support some of the authorization functions. Many of these support a single auth function or require significant staff effort to manage:

- EDI 278 is not broadly used by payers; many payers authorization capabilities' have been placed on individual payer portals
- Medical Necessity tools generally work well for Medicare checking but there are more commercial payers adopting their own medical necessity rules
- Some authorization tools support determination of whether an authorization is required by a payer or tracks when the user has manually obtained the authorization number and marked as complete.

Bottom line: Authorizations can require significant staff effort to comply with payer rules and avoid authorization denials.

Authorization capabilities reduce denials and significantly improve staff efficiency

- Integrated and automated processing at point of scheduling, pre-registration or registration
- Authorization required rules defined for payers, plans and groups
- Support the authorization requirements:
 - Authorization Submission
 - Notifications
 - Hospital initiated services (i.e., Direct/ER Admissions)
 - Authorization Status
 - Payers and authorization agents
 - Bots automate status inquiries
 - Alerts for exceptions
 - Substantiation (payer site images) for evidence on appeals
 - Medical Necessity
 - Latest NCD and LCD rules supported by ABN form
 - Supports Commercial Payers variations
- Integrate data back into Hospital Information System

Best Practice Considerations: Authorizations

- Clearly define and communicate authorizations policy
 - Certification timing (Auth required x days prior to service)
 - Staff roles and responsibilities
- Obtain input from internal departments
- Outreach to physicians to collaborate
 - Identification of payer authorization requirements
 - Process to notify when missing (Timing and method)
- Engage Denial Committee (learning from actual denials)
 - Review reports – Internal and External: Physician and Payers/Networks
 - What is the human effort dedicated hospital wide?
 - Timeframe constraints
- Collaborate with payers
 - Understand and publish authorization requirement rules
 - Ongoing communication to improve the process and obtain planned rule updates

Upfront Patient Responsibility Collection has become the norm

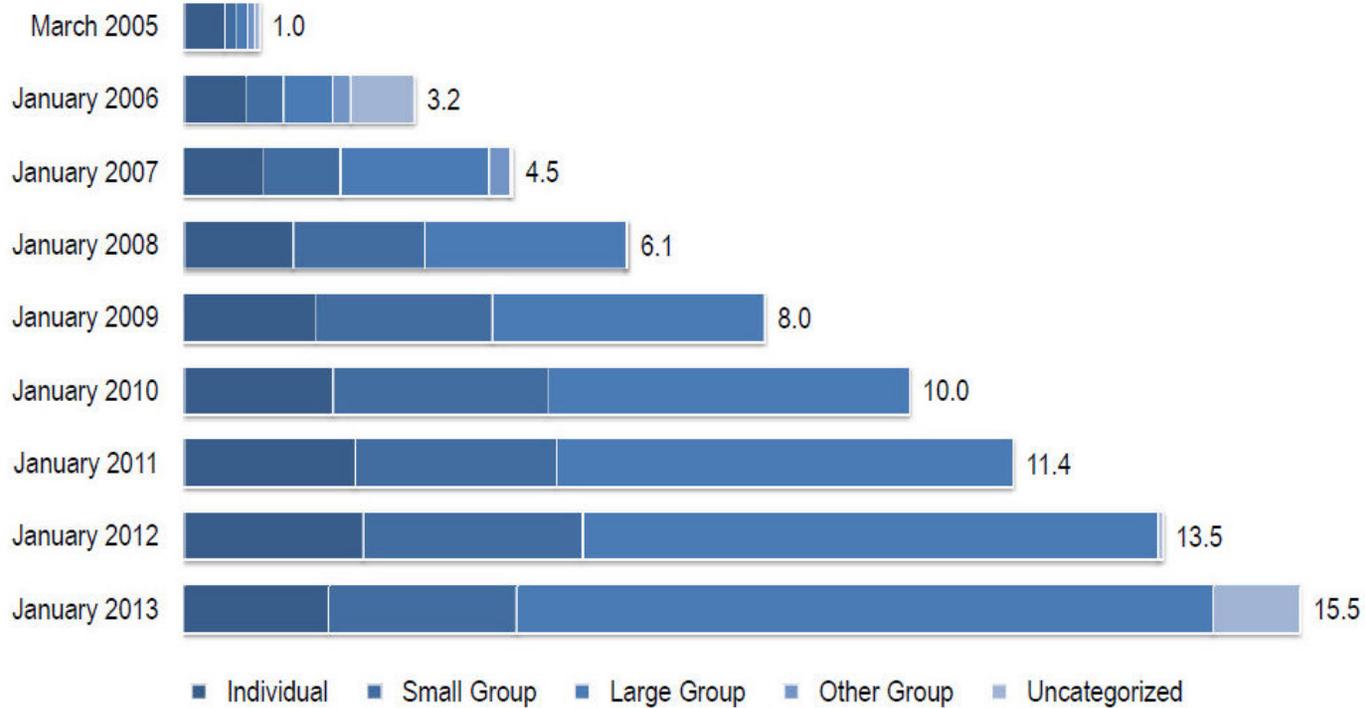
- The losses for many hospitals' investment income has caused their executives to look for additional ways to increase net revenue, reduce bad debt and lower cost.
- Point of service collections no longer an emerging trend – it's now mainstream for Patient Access best practices
- Maximizing point of service collections rank in top 10 CFO priorities

– Advisory Board Company

***Result: rising bad debt and less cash on hand;
especially with the continued growth of HSA & High Deductible Health Plans
(more financial responsibility put on the patient)***

Growth of HSA / HDHP Enrollment

**Growth of HSA-Qualified High-Deductible Health Plan Enrollment,
Covered Lives (Millions), March 2005 to January 2013**



Source: AHIP Center for Policy Research, Jan 2013

Increasing POS Collections: Why the Focus?

Significantly improve the bottom line of your organization through:

- Reduce cost to collect
- Reduce uncompensated care
- Reduce self-pay receivables
- Increase overall cash flow
- Improve patient satisfaction
- Reduce call volumes
- Reduce patient confusion about their bills



Not all patient estimation tools are created equally...

Automation – ability for application to determine patient responsibility without registrar intervention

- Load from HIS at point of scheduling, pre-registration and/or registration
- Automatically determine patient responsibility without user intervention => eligibility verification, procedure(s) selection, application of benefits and calculation of patient responsibility

Accuracy – ability to match estimate with payer remits

- Apply chargemasters and contract rates
- Completeness of benefit data (leveraging benefit data from payer portals)
- Comparing estimations to payer remits

Integration – ability to integrate seamlessly with related functions

- Payment processing
- Payment plans/arrangements
- Financial Assistance (propensity to pay, likelihood to qualify for charity)

Patient estimation tools should be highly automated, accurate and integrated with downstream functions

Best Practice Considerations: Upfront Collections

- **Obtain input and support from stakeholders**
- **Pilot collecting in areas with greatest opportunity: OP Rad/ER, then Surgery**
- **EMTALA Compliance (Emergency Medical Treatment and Active Labor Act) – screen/stabilize prior to insurance/collecting**
- **Communicate Internal Goals and Expectations**
 - Define Policy, Procedures and Responsibilities
 - Train staff on process, tools and scripting
 - Define and manage team and individual goals; publish results and recognize
- **Communicate externally: Community physician offices, local news**
- **Determine patient responsibility days ahead of visit when possible**
- **Inform patient of responsibility prior to visit and offer payment options as needed**
- **Coordinate patient room visits to collect patient financial responsibility and/or payment arrangements**

Financial Counseling has become increasingly important

The Financial Counselor is a growing need in many hospitals to help the patient and hospital understand how patient can receive care while managing the financial responsibility expectations:

- Helps patients receive care while ensuring payment method is understood
- Plays key role in protecting the hospital's cash flow and exposure to bad debt and collection expense
- Medical assistance screening
- Alternative state funding application process
- Credit scoring (propensity to pay)
- Charity care screening
- Establish financial arrangements

Automation - Exception based processing focuses staff

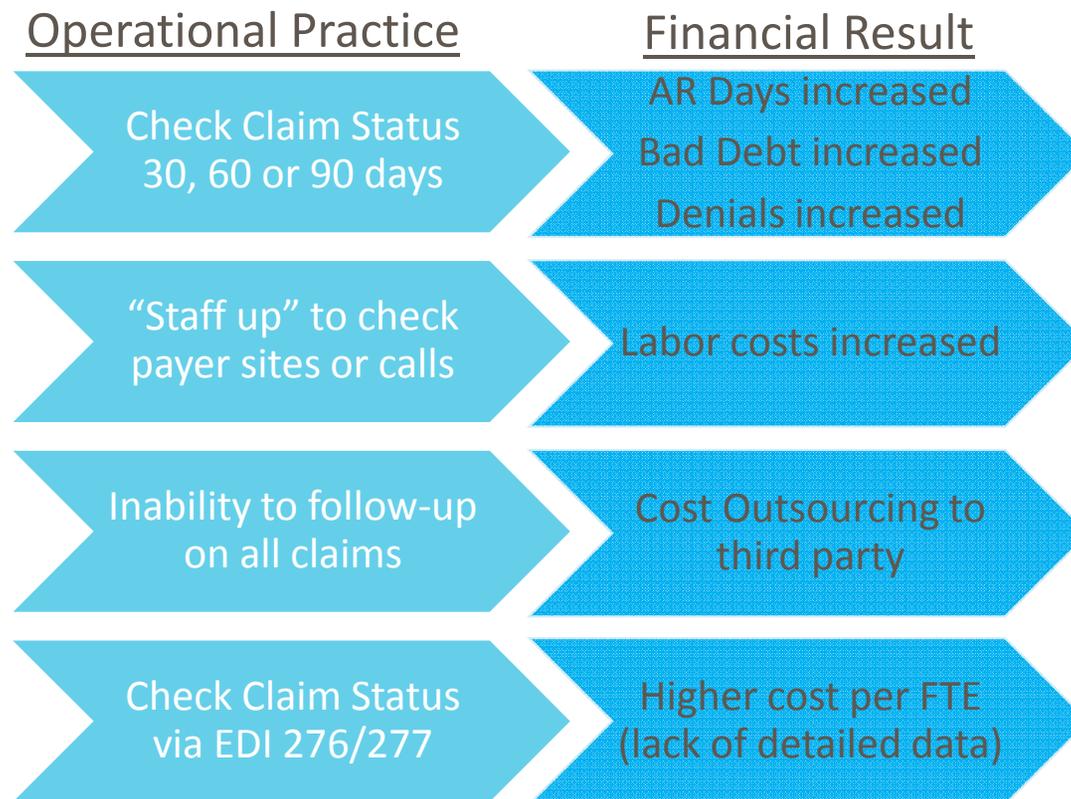
Automation allows your team to work exceptions only

Select	Elig Plus	Submit	Status	Calculation	Collection	Account #	Service Date	Last Name	Patient Type	Service	Payer 1	Payer 1 Elig
Select	✓	⊖	✗	✓	✗		10/01/2013		Outpatient	Surgery	BLUE CHOICE/BLUE CROSS	Yes
Select	✓	⊖	✗	✓	✓		10/01/2013		Outpatient	Surgery	UNITED HEALTHCARE	Yes
Select	✓	⊖	✗	✓	✗		10/01/2013		Outpatient	Surgery	UNITED HEALTHCARE	Yes
Select	✓	✗	✗	✓	✓		10/01/2013		Outpatient	Radiology	MEDICARE MGD CARE AETNA	Yes
Select	✓	✗	✗	✓	✗		10/01/2013		Outpatient	Surgery	UNITED HEALTHCARE	Yes
Select	✓	⊖	✓	✓	✗		10/01/2013		Outpatient	Radiology	BLUE CROSS FED EMPLOYEE PROG	Yes
Select	✓	✗	✗	✓	✓		10/01/2013		Outpatient	Surgery	GRT WST PPO HMO/ONE HLTH OTHER	Yes

And working “exceptions only” allows more time for patients

Business Office Claims Follow-up practices

Despite the best upstream efforts, there are inevitably claim rejections, delays and denials that require follow-up. Common practices typically follow one or more:



Payer Portals provide actionable status opposed to EDI 277

EDI Claims 277 only indicates "Denied"

Claim Status Information	
Tot Claim Charge Amt:	14499.04
Status Eff Date:	[REDACTED]
Health Care Claim Status	
Status Code:	0
Claim Status	Finalized/Denial-The claim/line has been denied. (F2)
Category Code:	

Payer website indicates detail an is available via a 'bot'

Claim Totals						
Charge Amount	Paid Amount	Primary Impact on Claim	Allowed Amount	Medicare Paid Amount	OI Paid Amount	Phys/Provider Not Covered
14,499.04						0.00

Remark Codes											
11- ITEMIZED BILL INCLUDING DATES OF SERVICE, DIAGNOSIS, SVC CODES, ETC											

Charge Amount	Paid Amount	Primary Impact on Claim	Allowed Amount	Medicare Paid Amount	OI Paid Amount	Phys/Provider Not Covered	Phys/Provider Adjust/Disc	Remark Code	Description of Service	Patient Not Covered	Copay/ Deductible	Co- Insurance	Patient Responsibility
14,499.04						0.00	0.00						

Transforming Claims Workflow achieves 90% no touch rate

Transformation	Empowers
1. Check Payer Claim Status when Payer Adjudicates	Significant AR Days reduction; speeds up patient statements
2. Automatically return actionable status	Staff productivity improved by avoiding payer websites and calls
3. Eliminate manual review of "Paid" or "To Be Paid" Claims	Staff productivity and satisfaction focusing on relevant activities
4. Automate exceptions (Auth#,s, Itemized Bills, Medical Records)	Staff productivity improved by automatically resolving common requests
5. Staff and Management Performance	Staff productivity and satisfaction knowing real-time goal attainment
6. Learning Loop	Avoidance of repeat/common denials
7. Payer Collaboration	Claim resolution and identification of activities to collaborate

Thank you.

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