EHR Intelligence

Best Practices in Reimbursement Guide

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Foreword

Reimbursement is changing in healthcare. Even before elements of the Affordable Care Act began to go into effect, a growing focus on value versus volume has led many healthcare organizations and providers to consider accountable and patient-centered care models in which they assume a greater share of risk. In this changing climate, revenue must be managed differently to ensure that the value delivered to patients is paid for appropriately both in terms of accuracy and timeliness. This guide offers best practices in reimbursement, identifying the resources and processes necessary to manage claims in the right way.

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Understanding claims in the context of the revenue cycle

For hospitals and physician practices to ensure that their claims are paid, they must first understand how the different components of claims management affect reimbursement.

"Whether you call it revenue cycle or protecting your reimbursement, success will depend on making many improvements simultaneously," says Nalin Jain, Delivery Director of Advisory Services for CTG Health Solutions "It's not just one small thing that you fix, but making several improvements and making them simultaneously through the process from pre-care to zero balance."

The negative impact poor claims management can have on reimbursement is significantly more pronounced in clinical settings where resources dedicated solely to the revenue cycle are often lacking.

"We realized early on that physicians are running the business, but they are not businessmen," Jain explains. "They are caregivers, yet they have to manage their practice as a business and claims processing was the sand in the gears of practice management."

According to Jain, those healthcare organizations and providers succeeding at reimbursement take into account and address how each of the various components of the patient-provider interaction fit into the revenue cycle and could introduce gaps leading to loss or risk:

- Pre-service (e.g., pre-registration, pre-authorization)
- Process of care
- Process integrity practices (e.g., charge master, coding compliance, clinical documentation)
- Billing services (e.g., customer support, collections, follow-up)
- Administrative services (e.g., contract management, fee schedules, debt collections, managed care contracts, denial management)

"When you compartmentalize your practice or your hospital across these five areas," Jain continues, "you're able to address within each of these components what is working and not working, what are the industry standards, where are your peers compared to where you are, and what you need to do to get to the next stage and then beyond that."

In other words, improving reimbursements begins with assessing the current state of affairs. Jain recommends that physician practices and hospitals pay special attention to three broad functional areas: financial, technical, and operational.

The financial side looks at accounts receivable (A/R), its metrics around collection rates, denials, and denial management. The technical side considers the systems, applications, and processes throughout the entirety of the patient-provider interaction. The operational side takes into account the staffing, vendor relationships, and workflows.

Depending on the size of the healthcare organization and extent of processes surveyed, the assessment can last from a few months to several months. But once it is complete, hospitals and physician practices have the means to create a remediation roadmap as well as benchmarks to measure performance against.

For Jain, the ideal remediation roadmap is tiered and begins with simple activities before moving on to more complex tasks. "Doing it this way ensures that you're going to have buy-in within the organization because you can quickly come up with some low-hanging fruit and prove the proof of concept to the stakeholders, get their buy-in, and then move on to the larger target and the more difficult to achieve targets in stage 2 and stage 3," he claims.

Technology indeed has a role to play in improving claims management and reimbursement rates, but it is of course not a replacement for the processes responsible for introducing or increasing the errors that leave bills unpaid, overpaid, or underpaid.

Only when the various part of the revenue cycle are in tune will reimbursements flow predictably. "They all contribute toward making sure that your revenue cycle is managed effectively," says Jain.

Identifying key stakeholders, activities in claims processing

A successful claims processing operation comprises skilled personnel and well-monitored processes. The revenue cycle, of which claims processing is but one part, will vary according to the makeup of a health-care organization as well as the billing model being used by that health system, hospital, or physician practices.

Here is a breakdown of personnel and activities within a hybrid billing model that marries both a decentralized and centralized billing models:

Frontend staff

· Capture insurance data
· Verify Insurance and eligibility
· Conduct prior authorizations and obtain referrals
· Collect co-pays and deductibles at time of service

Backend staff

· Track and resolve billing edits
· Conduct timely submission of claims to payors
· Follow up on outstanding A/R balances
· Post denials and resolve
· Engage in accurate payment posting
· Provide education and feedback to front-end staff and providers

Providers

· Capture charges accurately
· Conduct timely completion of clinical documentation (affects charge lag)

Clinical staff

· Obtain patient consents and waivers

Management

· Ensure communication and feedback across all stakeholders
· Monitor staff performance
· Review revenue cycle metrics and analyze trends on a regular basis

In order that the revenue cycle functions smoothly and that opportunities for improvement in reimbursement are addressed in a timely fashion, leaders from the various departments in a healthcare organization must communicate in a scheduled way with certain meetings occurring more frequently than others.

For instance, whereas the business office manager and financial counselors and members eligibility/authorization team might on a biweekly basis to review trends in patient access, the group administrator, business office manager and business office staff might meet on a monthly basis to discuss underpayment trends, cash balancing, and claims-related problems or concerns.

No matter the size of an organized, key stakeholders and activities in claims processing from the front to the back should be organized in a standardized way.

This information comes from an *EHRIntelligence.com* presentation given by Benjamin C. Colton of ECG Management Consultants, Inc.

How are federal policies changing reimbursement strategies?

A shift from fee-for-service to pay-for-performance has healthcare organizations reconsidering how their clinical practices will impact their bottom lines moving forward as providers assume greater and greater accountability.

With most health systems, hospitals, and physician practices still relying on encounter-based, reimbursement challenges over next several years could become "exponential," says John Dugan, CPA, Partner at PricewaterhouseCoopers (PwC) who oversees its healthcare provider practice.

"Those that are getting it are making investments in several areas as well as trying to understand how well they are following evidence-based medicine across the organization," he explains. "Having those standardized levels of care that are supported by data analytics for them to understand what the outliers are in the cost to treat, that's where you're seeing savings driven out of the system."

The areas in question generally fall into two categories: regulation-based or patient-centered. The first has become more salient over the past few months with the Centers for Medicare & Medicare Services (CMS) imposing more and more rules around admissions, which has led to an increasing number of denials among the providers Dugan works with.

"Certainly from a clinical denial space, a lot of it surfaces around medical necessity for inpatient admissions," he observes. "Medicare came out recently with a further clarification on an existing regulation that was known as the two-midnight rule that has left many of our clients scampering around."

While the purpose of these and similar regulations was to shift hospital use away from inpatient and toward outpatient settings, the effect has been that healthcare organizations have "had to take a much deeper look at their short-stay admissions practices" and CFOs have had to calculate potential losses in revenue and ways of counteracting them, claims Dugan.

With the implementation of the Affordable Care Act well underway, the healthcare industry has also had to come to terms with the consumerization of the patient population — that is, the patient as consumer — and what that means to doing business in a new era of patient-centered care.

"What you're seeing providers doing right now to augment that is making more investments within the entire patient access function (e.g., call centers, relationship portals — around pricing transparency to compete in a high-deductible world," Dugan reveals. focus on the needs and wants of patients has emerged as a significant differentiator among healthcare providers.

"The winners in the game are going to be the ones who really focus on patient/consumer — those patients now become their own payer class," says Dugan. "And I don't mean self-pay in the old form of the case where somebody didn't have insurance. Every single customer ultimately has a form of self-pay now with high-deductible plans."

This emergent retail mentality in healthcare has hospitals, health systems, and physician practices thinking about quality not only in terms of providing evidence-based care but also understanding the patient experience from the receiving end.

"Those that are getting it are making investments in those areas as well as trying to understand how well they are following evidence-based medicine across the organization," Dugan maintain. "Having those standardized levels of care that are supported by data analytics for them to understand what the outliers are in the cost to treat, that's where you're seeing savings driven out of the system."

As the healthcare industry transitions from volume to value, where healthcare organizations are making their investments becomes as important as how much they are making available. With patients becoming more knowledgeable about the care they receive, providers must offer something worth paying for.

The value of editing abilities in the claims management process

How does an effective claims management process differ from an ineffective one? The most obvious way is in the former's willingness to invest in opportunities that will help streamline the claims management process and avoid repeated mistakes.

Rather than respond to denials, top-per-formers in claims management strive to prevent them, saving both time and money.

According to one subject-matter expert, a key component of this proactive strategy involves enabling

staff to edit problem areas of a claim well in advance of it being submitted to a payer. Steve Sewell is the

Senior Solutions Engineer at Optum whose professional experience includes having worked on the payer's side of reimbursement.

In this question and answer interview, Sewell explains why editing capabilities are essential to a successful claims management process and how providers can use editing tools to keep their reimbursements running smoothly.

How does editing allow providers to prevent against missed billing opportunities?

First activity is defining what unbilled revenue is and realizing what a significant impact it has to the overall bottom line of the organization's revenue cycle. By editing claim before submission, those missed items can be included without causing delay to the submission. All too often revenue is not pursued after a denial or a partially paid claim because the value of the reimbursement outweighs the resource cost and effort to rebill.

Think of it this way, organizations are probably not going to go after $3 to $15 in revenue that was omitted from the original submission because it would cost more to try and recover it. The painful statistic is that when this occurs a 1,500 to 3,000 times a year, there is enough revenue to fund an FTE.

How do creating rules (e.g., business, clinical) and having the right editing capabilities impact the claims process?

By getting paid the first time a payer adjudicates a claim. The money lost from payer adjudication is from either unbilled revenue or additional resources used to receive the correct payment (corrected claims, rebilling, appeals, etc.). Having the control in the billing office to create specific rules to prevent these things from happening should be viewed as a requirement. By allowing editing to happen broadly at an enterprise level or as granular as a single physician or payer level affords an organization need for constant denial remediation.

How does editing fit into denial prevention as part of best practices in denial management?

One of the first best practices is to realize the importance of a denial prevention process and it relates to denial management. Denial prevention has evolved to the point of being as important if not more important than denial management.

The denial management school of thought is to wait and see how claims will be denied by a payer, then take measures to resubmit corrected claims, and eventually set up a correction and resubmission process to handle future denials. Think of the phrase "garbage in, garbage out." Denial management often tends to manage the denial rather than prevent it.

Denial prevention can be achieved through technology by identifying those claims before submission to a payer that are certain to be denied. If you have mitigated the denial before submitting a claim to the payer, that larger denial management process that happens on the backend is significantly reduced and claims get paid faster and more accurately.

Another best practice is allowing denial management staff access to the denial prevention software for future edits to be addressed before submission rather than creating a resubmission process on denied claims.

What is the risk of relying on typical clearing-house edits when reviewing claims?

It is extremely important to have an editing solution beyond technical service offered by clearinghouses. A true adjudication editing solution ensures the resolution of claims that are certain to deny and also identify unbilled revenue.

Think of what the basic function is for a clearinghouse: Their job is to get claims through a payers HIPPA compliancy frontend editing platform and into the payer's adjudication system. Most clearinghouses are really good at it, touting a 97-percent to 99-percent first-pass rate. The problem is claims — from 5 percent on the low end to 25 percent to 40 percent on the higher side — are

denied in the payer's adjudication system and returned to be reworked.

Where should claims management system integrate with other systems make most of its editing capabilities?

The best-case scenario would be to integrate at the charge entry process since editing occurs at the least costly point, before the claim is even created. By editing at charge entry, the attention to the detail is greatly enhanced because the work is still fresh to the coder and the biller while the EMR is being reviewed to create the charges. If charge entry is not an option, then having integration into the electronic data interchange (EDI) stream is another option. This provides all levels of editing, technical and clinical, to happen within a single process while still allowing for edits to be addressed before submission to a payer. This method is extremely advantageous to organ-

izations that have groups on disparate EMRs and billing systems.

How do providers stay on top of changing regulatory guidelines through the use of claims management tools?

Finding a partner that can do the research of all changes in regulatory guidelines and provide software solutions that can keep up with the changes is critically valuable. In picking an editing solution that edits claim based on all of the published regulatory guidelines, one must be careful to choose the solution that provides regulatory source information and disclosure statements, which will ensure that your edits are in place because of the regulatory guideline and not the whim of the software solution developer. When this happens, the software can do the majority of the process and staff can focus on more critical tasks.

Tackling claims processing, payment management bottlenecks

Healthcare organizations of all sizes find themselves in a particularly challenging spot when it comes to reimbursement. Although reimbursement is beginning to shift away from volume to value, much of their revenue today still depends on the fee-for-service payment system. How then do healthcare organizations — from health systems to physician practices — ensure that best practices are in place to succeed in both reimbursement environments?

The answer to that question involves taking a step back and looking at several key considerations impacting the professional revenue cycle and ways to implement organizational models that support efficiencies in billing operations and claims management.

"If the professional revenue cycle is not managed effectively, billing costs will rise, collection rates will drop, and accounts receivable (A/R) will increase to the point that the value of the acquisition is lost," says Benjamin C. Colton, Senior Manager, ECG Management Consultants, Inc.

This understanding is especially important during a time of increasing provider consolidation wherein larger organizations such as health systems and hospitals are acquiring or affiliating with independent practices. In this current environment, organization becomes the key to eliminating loss or waste within the revenue cycle.

"The quality of the revenue cycle is dependent upon the linkage of people, processes, and infrastructure," Colton maintains. "When considering physician billing, members of leadership must identify the degree to which they want to "manage" professional revenue cycle operations."

According to Colton and based on his work with a host of healthcare organizations, several billing models exist, each with their own advantages and disadvantages:

In a *centralized billing model*, the majority of billing functions are completed in a central business office (CBO). Its advantages are economies of scale, consistency, dedicated expertise, standardized reporting and monitoring, and opportunities for enhanced IT systems/re-sources. Its disadvantages

come in the form of increased physician billing and response lag, higher billing cost, potential for "not my job" mindset among frontend staff.

In a *decentralized billing model*, the majority of billing functions are completed/managed at the site of service (i.e., each practice maintains a small business office). On the plus side, it allows organizations to have site-level control, close relationships with patients and physicians that create a sense of "ownership," and prompt resolution of physician-driven errors. On the negative side, it can lead to disparate standards and processes as well as staffing inefficiencies.

As part of an *outsourced model*, functional areas (typically backend functions) are managed by a third party, which enables the organization to focus on its core competencies (e.g., patient) but at the cost of these third parties not being apt to "care" as much as much for the patients and the billing services themselves.

Colton views the *hybrid billing model* as the best fit for most organizations with a moderate-sized physician group. This mixture of centralized and decentralized (e.g., coding, charge capture/entry, co-pay posting) gives organizations the best of both worlds although it does require additional training and the implementation of reporting/control tools.

Irrespective of the model chosen, healthcare organizations that are successful in managing their revenue cycle from pre-registration to zero balance are those that have access to the big picture and the ability to communicate to the staff whose performance may be negatively affecting reimbursement.

In the end, an effective and efficient revenue cycle has the following attributes:

- A scalable, coordinated, robust practice management system.
- Dedicated and well-trained staff to support professional fee billing.
- Shared accountability between the front- and back-end.
- Consistent, well-documented, and properly communicated policies, procedures, and performance expectations.
- Effective management reporting around relevant performance metrics.

It is within that last couple of points where real gains are made by healthcare organizations. "Actively reviewing the revenue cycle of your clinical practice will identify opportunities for cash improvement, cost reduction, and increased margins, regardless of whether billing functions are centrally maintained," says Colton.

Using technology innovations to maximize claims reimbursements

For hospitals and health systems, the revenue cycle and reimbursement fall most directly under the purview of the chief financial officer (CFO) and the business office manager and staff.

During a time of significant change to how health-care is paid for, these personnel have the challenging task of making sure the healthcare organization is receiving payment for services rendered.

Rick Lyman, the Vice President of the Revenue Cycle at Advocate Health Care, knows the challenge the industry is facing all too well. His health system recently decided to implement new financial IT

solutions to improve the financial performance of Advocate Health Care. In this question and answer, Lyman reveals how his organization is planning to improve its financial efficiency by centralizing many of its revenue cycle activities.

What is the current state of the health system's revenue cycle?

On the hospital side, it's been decentralized for years. Every hospital has been doing its own thing and managed by our VPs of finance, which is equivalent to a CFO. We had studied creating a shared revenue cycle service center for years and implementation started in April of 2012. We are now

five days away from go-live. We're going to roll the hospitals in here in five days. It's an exciting time.

What's the ultimate aim of a well-organized and –managed revenue cycle?

The purpose of the revenue cycle is to maximize cash flow and net revenue. For that reason we are always looking to improve performance. We will never be in maintenance mode. We will always look at some way to squeeze it a little bit more, get more efficient, reduce cycle time and waste.

We actually believe we are going to help our hospitals from a revenue perspective — that if we do a service and do all the things right to bill the account, we're going to get paid for it. That's how we help our hospitals.

What IT systems does the revenue cycle touch?

Most IT systems interact with the revenue cycle in some way. What you can say from an admit, discharge, transfer (ADT) perspective is that when we do registration we see that ADT transaction, all that HL7 demographic information gets blasted out to a number of systems. For example, when you get registered and go to the lab and they run a test, it knows to send that charge to that account. We receive charging data from all these ancillary systems throughout the day.

The health information services (HIS) system performs day-end and month-end processes for us, and we generate bills from it, too. Of course, you have HIM content embedded in there, so they're abstracting medical records when they're coding accounts and flowing that data to us for the bill. And then you have a series of bolt-on tools on the backend to scrub claims against payer-specific edits to transmit claims via electronic data interchange (EDI). On top of that, too, we have a workflow tool so that we can aggregate all the receivables into an exception-based workflow for account follow-up. That's the high level of what we're doing, and we've got to leverage technology in order to be successful.

How did you go about selecting a financial IT product? What were your selection criteria?

It's really a due diligence process in two broad areas. None of this is rocket science. Everyone has probably been doing this for years. There are the technical requirements in terms of servers and other hardware that's going to be needed to run the system, perform data recovery, and provide business continuity, how that all gets set up and what we need to run the software that we would choose.

The other side of that are the business requirements. What we like to do is be very, very granular and be very specific with what we want and then you scale it for our operation. Some things you have to have; some things are nice to have. You have to weight and score those.

What you're trying to do, to be honest, is take the bias out of the selection process. Everybody has a favorite. You want to take the bias out and then make a rational decision about what you need because you're never going to get everything you want.

Who was part of the selection committee or group to ensure that the right decision was made?

The key is to cast a pretty wide net. From the IT side, it's probably the typical people you can think of. It's the host HIS systems, so it's all the people who run the patient account, patient management piece of the registration system. So it's pretty much all those folks. You've got to include your security folks (because obviously PHI and all that other security issues need to be addressed) and the business continuity folks. The clinical folks are needed as well as the people who run these ancillary charging systems.

On the business side, it's really broad even for those who aren't directly touched by it. For example, HIM doesn't report to me but they are a core function to us. We need their point of view because I want to flow workflow to them — the same with our nurses

and case managers — I want to send them things to make their lives easier and to help us resolve issues. Sometimes, in the old days, people were doing this all on email, so you didn't have visibility into trending issues and how many dollars are hanging out there for answer. So it's including all of those people.

What's the plan for rolling out your IT solutions?

We haven't done it yet, but we're going to move next year to a centralized insurance verification pre-registration model for elected patients. We also have revenue integrity, which is composed of the group that manages all of our RAC audits, revenue capture, insurance audits — all those types of things. That's all in a central shared environment, so we built out one of our buildings that we owned — it's a 70,000 square-foot service center — and we're ready to go.

What benefits do you expect to see as a result of implementing new IT?

We expect that there will be one-time cash improvements. A good example of that would be accounts waiting to be coded in the HIM. We expect that we could reduce the accounts that are waiting and get those out. Another good example would be that we have some buckets of A/R, maybe it's the low-dollar stuff, we're able to use technology to status it and get it paid instead of having to wait for someone to manually follow it up.

What we're really focused on is net-revenue improvement. It's all about net-revenue, to be honest. It's improvement on denials, underpayments, and reducing bad debt. Also, we need to be efficient. We don't have the luxury with reimbursement being down and cuts to Medicare of overstaffing. We always need to cut cost and we've got to serve our hospitals. We really are focused on that.

How can IT, automation help improve healthcare revenue?

Since the passing of the Health Information Technology for Clinical and Economic Health (HITECH) Act, the healthcare industry has spent most of its time and resources on selecting, implementing, and optimizing EHR systems.

While EHR adoption certainly will play an important to clinical quality improvements, what about the IT systems and services necessary for ensuring that a healthcare organization's care is being properly billed and paid?

According to industry insider, that's a question being asked by members of the finance departments at healthcare organizations. "You're at an interesting time where meaningful use has created the government investment into wiring up electronic health information and at the same time running parallel are executives saying, 'Are we making the same investments on the revenue side of those applications?'" says John Dugan, CPA, Partner with PricewaterhouseCoopers (PwC).

And the current state of reimbursement-related technologies — a series of bolt-ons and ad-hoc solutions — bear witness to the lack of market forces increasing the demand for more mature and robust IT in this area.

"There is a tremendous amount of opportunity with automation," continues Dugan. "From a claims processing perspective, there are still a number of manual processes as you go through the entire revenue cycle, which in and of itself contributes to inaccuracies. That is why there is a huge need for claims scrubbers, follow-up work, etc."

One obvious way for health systems, hospitals, and physician practices to meet increasing demands on value over volume is by having accurate and timely data in the hands of decision-makers.

"We're making huge strides in technology each and every day to solve those problems," he explains. "The question is how quickly it will come. We've got a group of executives and middle managers that are struggling with basic business intelligence as they try

to position their organizations in a new health economy of reimbursement. The technology will certainly be a big enabler in providing a solution."

Dugan sees this technology taking the form of dashboards capable of clueing members of the C-suite into various areas of the revenue cycle, especially the status of claims in accounts receivable (A/R).

"Those that are investing in some capabilities are getting daily key performance indicator dashboards at the C-suite level which are customized for the user," he observes. "That CFO can get a daily feed on some of the key statistics — whether it's days in A/R, discharged not final billed, or case mix performance — in more real-time."

Although the interest in financial capabilities will continue to grow over the next several months and years, healthcare organizations need to be careful of buying too much into marketing speak and investing in a product that doesn't perform as advertised.

"Each day, business intelligence is getting stronger," Dugan maintains. "To me, part of the challenge is that many firms are saying 'big data' and 'analytics,' but that doesn't mean they are providing analysis. There's a lot of data out there but not with the insight."

Ultimately, all that drilling down serves the purpose of moving healthcare financial services closer to its primary aim — its proverbial Holy Grail of information — the true cost-per-case. "Can we dig down to a true cost-per-case based upon a service line? That's what they're trying to answer," says Dugan.