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SPRING 2021

REVENUE CYCLE UPDATE

Revenue cycle expertise, data analytics, workflow optimization and problem solving:
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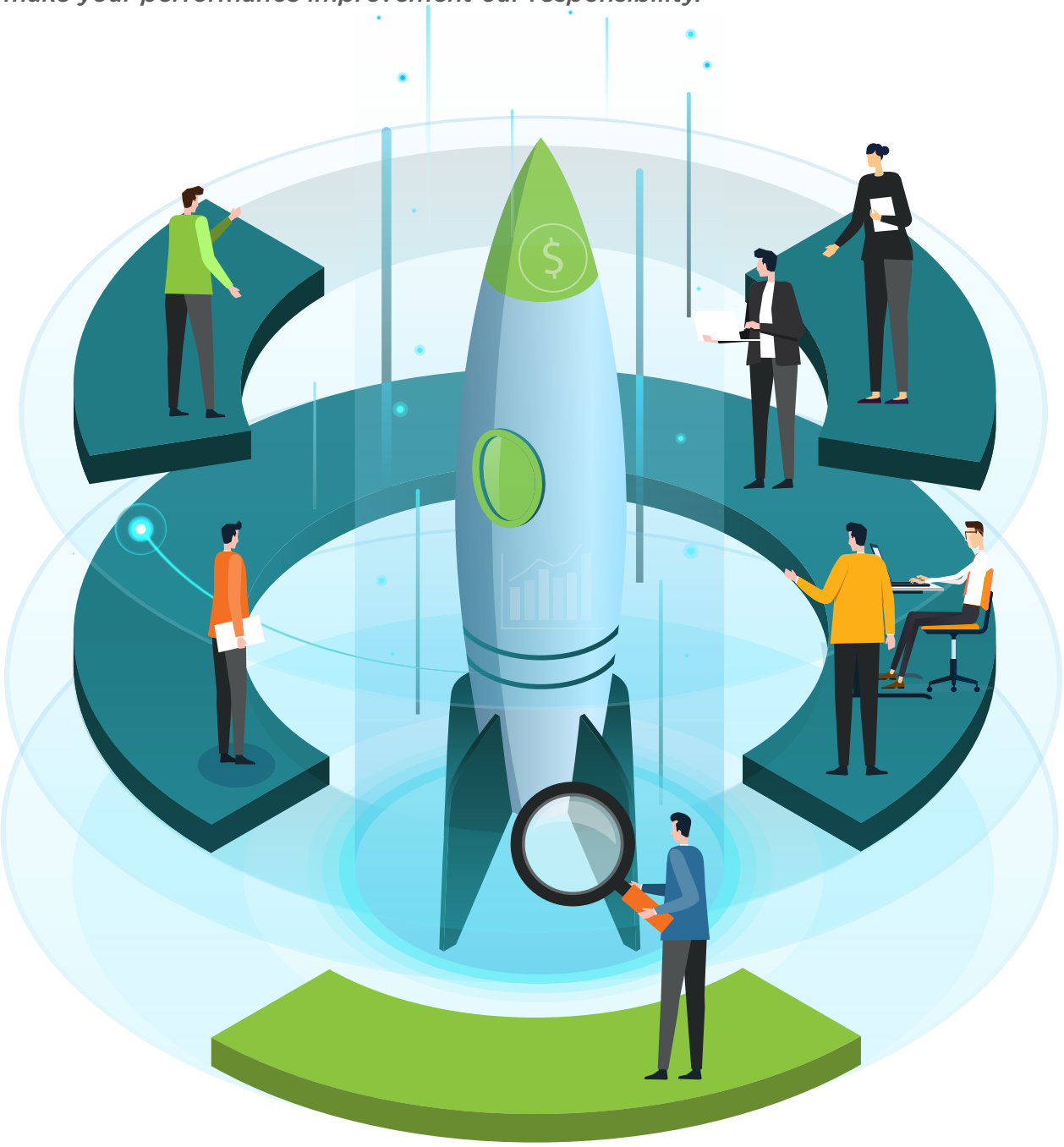
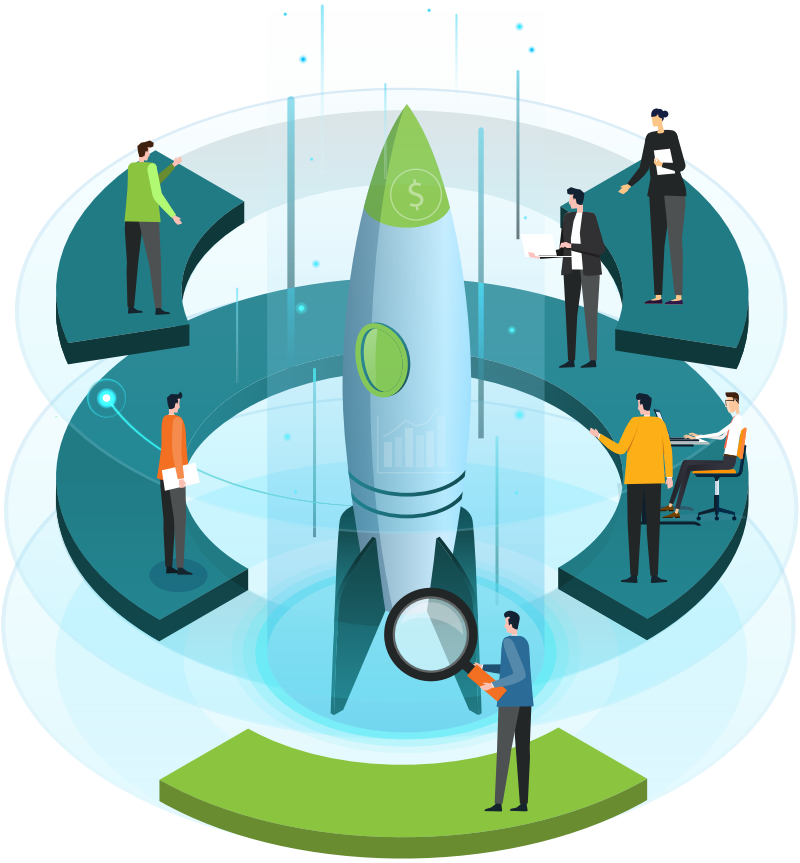


In this issue:

“Mars-landing” capabilities urgently needed in denial management

By Jesse Ford, CEO



Last month I watched in amazement as NASA’s Perseverance Rover touched down softly on Mars. After traveling six and a half months and over 100 million miles, Perseverance aimed for the Jezero Crater, a 5-by-4-mile area featuring dangerous pits, cliffs and boulders. As I watched, I marveled at the precision of each calculated step that led to touchdown, and I celebrated (not always knowing why) whenever the NASA team cheered. NASA prepared for years and applied innovative, automated technology that mapped and analyzed rough terrain to find a precise spot for a flawless landing.

Being a technology geek as well as someone who spends his time thinking about how to streamline revenue cycle workflow and processes, naturally I started to think about denial management. OK, it’s not the Mars landing, but it is a complex topic, made mission critical by the unprecedented strain on cash flow at healthcare entities across the nation.

The new technologies that allowed NASA to hit its target to perfection were not available for the early efforts at landing rovers or stationary devices, a few of which crash-landed. In healthcare revenue cycle today, our applications and processes are closer to NASA’s older technology. We need to advance denial management into “Mars-landing denial science.”

Hitting the wrong spot

Traditional denial management depends on data from remittance advice and other sources, and the denials are typically mapped to categories to identify trends. With this data, and in the spirit of “collaboration throughout the revenue cycle,” denials are assignedto the department that caused them, such as health information management, utilization review, clinical service areas and registration. These departments are responsible for investigating the root cause of the denial and implementing improvements to ensure future claims won’t meet the same fate.

What if Perseverance landed on Mars, but missed the Jezero Crater? NASA selected this spot following five years’ research because Jezero offered the most promise for uncovering whether Mars held life billions of years ago. Missing it by a small margin would have ruined the mission. The problem with traditional denial management is that it frequently lands in the wrong spot – in areas that did not cause the denial and/or in the wrong follow-up work queue. The fault lies in problematic data.

The data problem

Denial data is inconsistent and potentially misleading. Under HIPAA, the government established national standards for electronic transactions, including codes that explain denials. However, between codes changing periodically and payers interpreting them differently, we’ve found that the categorization is not simple and cannot be static. In a 90-day period for one of our clients, a reason for denial based on “non-covered service” included eligibility (50%), coding or coverage (45%) and insurance and other issues (5%).

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Based upon our client data, payer inconsistency could affect from 10% to 30% of denials that healthcare providers receive. NASA would not be satisfied with anything like that kind of failure rate. When data are faulty, denial management teams make inaccurate assignments and conclusions, including holding the wrong departments accountable.

Denial science

The industry is ready for denial scientists and next generation technology embedded in the business office.

Denial scientists apply scientific method to identify and correct data anomalies. Scientific method consists of making observations, formulating hypotheses, testing hypotheses, drawing conclusions and refining hypotheses. It implies that there is potential to continuously evolve as new hypotheses lead to new conclusions.

As a simple example, consider seeing a large volume of denials related to revenue codes. In health systems, there is typically a manager responsible for the charge description master (CDM) to map revenue codes to each service provided. In traditional denial management, the revenue code denials would be automatically routed to the CDM manager to fix issues. However, in this case the denial scientists identify that only one insurance is sending this denial. It is rare for revenue codes to be mapped differently for each payer, so the hypothesis is that this was not a CDM manager issue. Investigation reveals this was a false denial from the insurance company.

In a much broader context, an approach utilizing denial scientists to investigate denial abnormalities ensures accurate data and enables departments to review clearly defined problems, potentially saving their work on 10% to 30% of accounts. The time saved translates to more time to focus on improving processes or, more importantly, on patients.

Artificial intelligence will likely be the future of denial management. I have noted previously that right now AI is more of a dream than a reality in revenue cycle, however much the term is bandied about. In the meantime we need real-world solutions that:

- Enhance the accuracy of reporting denials and denial trends
- Accurately assign denials to responsible departments so they can identify and correct the root causes
- Simplify/optimize denial workflow and training

A focus on data integrity through denial science can ensure these goals are achieved and denial improvement objectives land precisely where they should, like Perseverance.

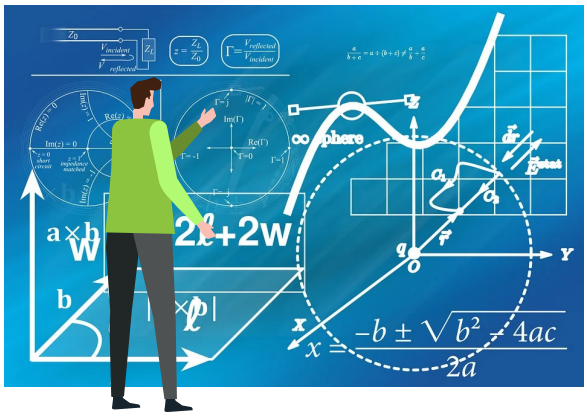
In today's healthcare revenue reality, such an outcome, however far from the headlines, would be something to cheer.

Jesse Ford is President and CEO of Salud Revenue Partners

CONNECT WITH US THIS SPRING!

- MARCH: Jennifer Swindle, Salud's VP of Quality and Service Excellence, will present at HealthCon2021, the AAPC's annual conference, in Dallas on March 29. Her topic is "Modifiers' Impact on the Revenue Cycle: Are Modifiers the Solution to Some Denials?" The hybrid event features both in-person and virtual attendees.
- APRIL AND MAY: We will be exhibiting at First Illinois HFMA's Accounting & Reimbursement Conference, a virtual event, April 22-23, and its Revenue Cycle Conference, also virtual, May 11-12.
- MAY: Will be at onsite at Florida HFMA's Spring conference from May 23-26 in Tampa.

The math behind turning bad debt into cash collections



By Richard R. DeSoto, CRCE

Editor's note: This article first appeared in the winter 2021 issue of AAHAM's Journal of Healthcare Administrative Management.

During this long pandemic, revenue cycle management has had the daunting task of improving cash flow with fewer internal resources, amid a shift to remote work. Many organizations, faced with demand for quick change, have outsourced some or all of their business offices, hoping for the best.

As 2021 dawns, some organizations seem to have righted the ship, but as the virus rages, most continue to struggle and are having difficulty seeing a path forward. Some have established processes in the form of requests for proposals that spell out their needs, while others are calling vendors they have worked with before, with a plea that can be summarized in a single word: Help!

I have two questions for anyone thinking of outsourcing:

- Is additional support needed immediately to improve cash flow and operational requirements?
- Do you have an established baseline of reporting data to determine your goals for improvement (ROI)?

My past experience working with hundreds of hospitals, providers and health systems tells me that all have some key performance indicator data that they can use as a baseline to establish performance goals and decide whether to seek outside help with revenue cycle operations.

Let's evaluate the numbers for a large, multi-hospital, safety-net health system that uses multiple vendors throughout the revenue cycle operation, from eligibility processing in registration to bad debt. At this system, the vendors seem to be performing well, according to recent year-end financial reports. Taking a harder look at the data, though, reveals some performance gaps and missed opportunities for improvement.

Annual gross patient revenue for the system was approximately $5.6 billion. After taking out the allowance for doubtful accounts, charity and contractual adjustments, net patient revenue was approximately $1.25 billion. That's certainly a bunch of money and an improvement on fiscal year 2019 results, but it still only represents 22.5% of gross (charged) revenue. When dealing with large organizations producing large numbers, even the slightest improvement or decline can also produce large numbers and variances. As an example, if we were to assume that net patient revenue equates to payments made to accounts receivable, a 1.5% improvement to the system's payment activity would be almost $19 million in additional cash, which could be freed to use on operations. Asking revenue cycle staff to improve cash by 1.5% seems reasonable.

Marginal change, better margins

Now let's dig a little deeper, taking a look at collections and bad debt. The system is showing approximately $650 million in bad debt. As accounts are generally written off net of contractual allowance, this seems to be a net number. Assuming the revenue cycle leaders can get their early out vendor and internal staff to improve collections by just 1.5%, bad debt goes down and the cash position rises by almost $13 million.

So how do you make this happen?

I recommend that you start off with some baseline information. What are the total self-pay collections for last fiscal year? Can you break down these collections by straight self-pay and self-pay after insurance? Can you report self-pay after insurance by payer classification? What are the revenues by payer classification? All this information can be very helpful in evaluating where to improve processes and reduce bad debt.

It appears the system is attempting to collect self-pay as early as possible. It has implemented point of service collections at all entry points and is tracking those payments. Results vary, but progress is being made. The system has a robust insurance verification tool and

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service estimator to provide the patient with self-pay expectation prior to service. The system has partnered with an early out vendor that receives accounts at 31 days after service for straight self-pay. For those with some coverage, the vendor sees the account 31 days after insurance payment is received and insurance balances are zero and/or moved to self-pay after insurance. Patients receive timely statements, some collection call attempts are made, and some large balance accounts are screened for Medicaid eligibility or charity-care status. It's the policy of the system to send an initial detail type bill for outpatient accounts and a summary uniform bill for inpatient accounts. After three statements the patient receives a final demand notice. It is at this point that the patient financial services system produces a pre-bad-debt List.

When business as usual blunts opportunity

Typically, most revenue cycle operations have some type of pre-bad-debt report that has a list of accounts that if not paid within a set period (usually one to four weeks), accounts will automatically move from active accounts receivable to placement with a bad debt agency. It is the responsibility of staff to review and make one last attempt to collect these unpaid accounts before writing them off their active accounts receivable and placing them with an agency. In practice, it is my experience that most organizations do not actually review this list. They simply acknowledge that the final statement requesting payment has been made, the account sits unpaid for the required time, and then it is transferred to the collection agency.

As noted above, establishing a baseline to determine effectiveness of the early out vendors and others involved in the collection of accounts receivable is critical. One method is to take the total self-pay payments and divide that amount by the self-pay placements. This is a very simple and effective KPI, but it has one caveat to keep in mind: Most collection efforts get rolling as long as a month after an account is placed, but large placements made within the last 15 days will lower your collection percentage.

As it is, our health system with $650 million in annual bad debt is writing off almost 12% of total revenue. As a safety net hospital serving a large metropolitan area this may not be too unusual. Of that total, how much is being collected by bad-debt agencies? I suspect very little, but for now this is just an unknown number that should be baselined.

Comparing payments to placements (less provider request for return with no action) brings us to another measurement: How much is being written-off to charity/financial assistance? In the case of this large system, approximately 4.3% of gross revenue. It appears from these numbers that bad debt is way too high and charity is way too low for this type of organization.

Two actions to consider

Take a more aggressive approach to identify potential charity. How much of the bad debt is made up of account balances greater than $5,000? Segment the balances to identify large balance accounts. Asking a patient to pay $100 is much easier to collect than asking for a payment of $100,000. The large balance should be worked more aggressively for Medicaid or charity. Although allocating more to charity does not increase cash, but it more accurately depicts how you are providing healthcare to the needy. By contrast, high bad debt represents a failure of your revenue cycle operation to collect receivables that could help deliver better care.

Another solution is to take on a vendor to work accounts and make a final collection effort for 15 to 30 days before assigning the account to bad debt. The vendor would need to be able to employ the latest technology. Using text, email and Interactive Voice Response (IVR) to reach 50% to 80% of this receivable will most certainly generate additional cash and reduce bad debt. The IVR should not be the standard "Press 1" for this or "Press 2" approach. Many patients do not respond well to automated systems like this. But what if this system could act like a real collector and have a conversation-like telephone call and response that would ask for payment and confirm the patient's intentions to pay or not to pay? What if it accepted the patient's response as is without making a tense situation worse?

This should be the goal of every revenue cycle operation – collecting self-pay receivables and improving customer service/satisfaction at the same time.

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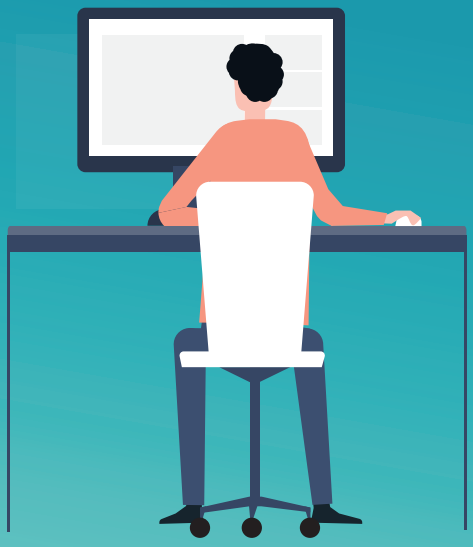
CODING CORNER

Documenting outpatient care requires even greater attention to quality

By Jennifer Swindle



Clinical documentation improvement (CDI) programs have become commonplace in inpatient care in the past decade due to continual flux in reimbursement rules and increased scrutiny of claims by third-party payers. With expanding volumes at outpatient facilities as a result of a shift away from higher-cost acute care, payers are using audits and other tools to ensure physicians in offices and clinics are accurately capturing services provided. Another factor driving the migration of CDI is that hospitals are acquiring physician practices, so they fall under acute-care CDI programs.

A major impetus for this new scrutiny is the Merit-based Incentive Payment System (MIPS), which rolled three quality and value reporting programs into one points-based program. MIPS isn't just about scores and reputation, however; it is a catalyst to transforming physician practices from pay-for-volume to value-based reimbursement.

In any care setting today, physician participation, buy-in and support for CDI are crucial. Some physicians view this as just one of the many hoops they must jump through to get paid. They shouldn't. Although there is an opportunity for a positive financial return, CDI is about quality. Accurate and complete clinical documentation will not only validate the care that was provided but also improve communication among all providers caring for a patient.

Any good CDI program incorporates factors such as severity of illness, risk of mortality, and length of stay. Lack of complete documentation may alter mortality and morbidity case mix index scores, which influence both physician and hospital profiles. However, outpatient CDI programs have distinct challenges from inpatient CDI. Outpatient visits are significantly shorter, making a concurrent review impossible. Also, the volume of outpatient visits is significantly higher. The program structure should allow for review as soon after the visit as possible, but prior to claim submission.

These factors result in much less medical information gathered from each episode to identify areas of opportunity. It also most likely will not be feasible to review all outpatient services, so the encounters most prone to risk should be identified.

Every organization will not have the same plan; each plan must be right for the types of outpatient care provided. Often when getting started a CDI program may focus on particular departments or service lines. Operational assessments may help determine where to focus efforts, paying special attention to claims denials at care sites with large medical necessity, such as the emergency department, observation services, ambulatory clinics, physician practices and ambulatory surgery centers.

Physicians are at the heart of all successful CDI programs, as it is their clinical documentation that is needed; however, clinical and coding language do not always translate directly. CDI programs help bridge that gap by helping to identify areas where things are not clearly stated so coding is done to a high degree of specificity.

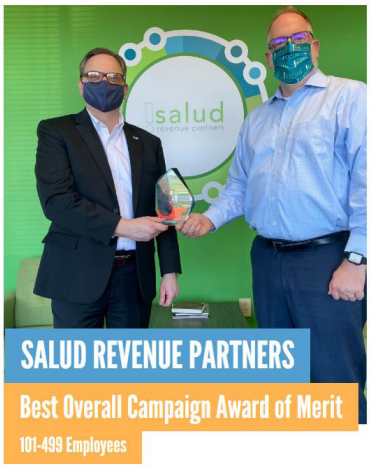
There is some prospective work that can be done in an outpatient CDI program, including chart reviews of medication lists and chronic conditions, to update records and help plan what should be addressed at the time of the encounter, but the bulk of outpatient CDI is done after the patient encounter.

Objectives of inpatient and outpatient CDI programs differ, but quality of documentation is the driving factor. An inpatient CDI program often focuses on case mix index and severity of illness metrics while an outpatient program more often focuses on reducing denials and resolving missing charges.

You must have a way to measure results, so performance metrics are required. There need to be tracking tools and consistency in the data to allow key performance indicators to be established and met. The program should be incorporated into the normal workflow so as not to become a burden on staff and physicians. How physicians use and documentation in an electronic health record can have a tremendous impact on CDI. Staffing determinations may be resource-driven, input-driven or ratio-driven, but there needs to be a way to measure the return on investment. Timely feedback should be available.

In the end, the best metrics on documentation are whether care is improving and appropriate reimbursement for services rendered is being achieved.

Jennifer Swindle, CPC, CIC, CPMA, CEMC, CFPC, AAPC Fellow, CICA, RHIT, CCS, CCS-P, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer, is Salud's Vice President of Quality and Service Excellence



Salud Revenue Partners recognized by United Way of Greater Lafayette

United Way of Greater Lafayette recognizes outstanding volunteers and corporate partners each January during the Annual Meeting and Awards Celebration.

Salud received a Best Overall Campaign Award of Merit for its United Way campaign efforts among similar size organizations (101-499 employees).

Visit the award page for more information about the award program and United Way.