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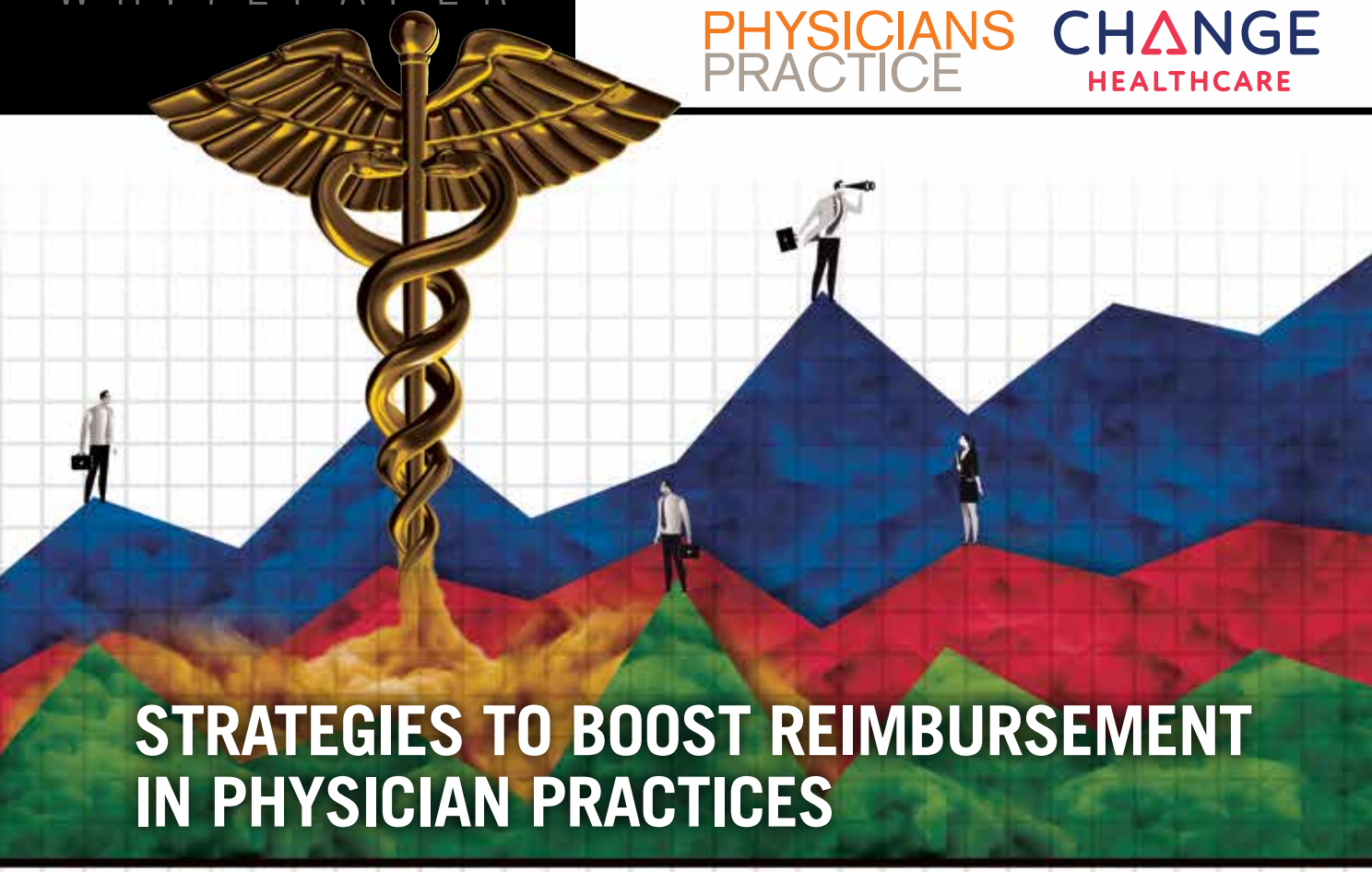

STRATEGIES TO BOOST REIMBURSEMENT IN PHYSICIAN PRACTICES

BY DAVE SCHAFER | PHYSICIANS PRACTICE CONTRIBUTING WRITER

The rise of high-deductible health plans has given patients more freedom in plan choices — and added to their burden for paying for healthcare costs. In fact, patients are now the third-largest payer of healthcare costs, according to a recent report.

And patients are struggling to pay those costs. The Commonwealth Fund states that 79 million Americans reported having problems with medical bills or debt. Another analysis found 68 percent of patients with bills of $500 or less didn't pay their balances in 2016.

Not surprisingly, 83 percent of practices with five or fewer physicians say slow payment from high-deductible patients has affected revenue. And Citi Retail Services predicts 30 percent of patient responsibilities — around $200 billion — will be written off in 2019.

With reimbursement decreasing, it's more important than ever for practices to capture as much outstanding revenue as possible.

"Healthcare has migrated from the good country doctor who you can pay $10 a month for now and forever, and you're in good stead with them," says Eric Krepfle, CRCR, senior director of product management for revenue cycle management (RCM) applications at Change Healthcare, which provides revenue and payment cycle management and clinical information exchange solutions. "Now it's, 'If you don't pay me within 90 days, I'm turning this account over to bad debt because I've got to get paid. If I don't, I can't continue to provide services for other people.' Physicians' offices cannot be charitable organizations. They're a business."

At the same time, commercial payers are scrutinizing claims more than ever, making collecting revenue even harder. So, practices are taking on an increased burden in collecting on claims.

In the face of this new reality, practices need to alter the patient journey to incorporate a positive financial experience and strategize how to proactively boost collections by allocating more resources and technologies toward the front end of the revenue cycle.

STREAMLINE THE PRIOR AUTHORIZATION PROCESS

Krepfle offers three key elements that must happen pre-service or at the point of service:

1. Practices must have advanced payer connections by going through a clearinghouse or an application, so they understand who is responsible for paying for what;
2. Pre-appointment authorizations; and
3. Documentation that explains to the payer what they're responsible for.

"Those three are not negotiable," he says.

Those pre-exam revenue elements can eat up staff time. In some practices, staff spend as much as 30 minutes completing a single manual prior authorization transaction, according to the 2018 CAQH Index.

But, Krepfle notes, getting that prior authorization is an important first step to getting paid because it helps take the burden off patients.

To smooth the payment path, practices should start the insurance eligibility process the moment the patient makes the appointment. Practices can a streamline many aspects of the prior auth process by using technologies that help determine eligibility, automate preauthorization and estimate out-of-pocket costs.

"Without an electronic or automated solution, it requires human intervention like logging into payer portals or calling payers manually," Krepfle says, adding some even still accept and/or require faxing. "These are expensive alternatives to an electronic, automated, systematic approach. Plus, the human error of managing the correct details and updating means there is more risk introduced."

Moore Martini Medical is a firm that provides consulting for dental practices. One of its clients deployed Change Healthcare's Eligibility and Estimation tools in 90 percent of its offices. After implementation, the practice saw a 50 percent increase in revenue over the previous year, says Kathy Moore, MBA, the firm's owner.

CREATE A POSITIVE FINANCIAL JOURNEY

Seventy-three percent of patients don't know how much of the cost of a service they'll be responsible for even after they leave the doctor's office, according to the Healthcare Business Management Association's "Trends in Healthcare Payment" report.

"Part of the care process is working with patients and helping relieve the anxiety they may have for collecting on a bill," says Owen Dahl, MBA, a medical practice management consultant with Owen Dahl Consulting. "A positive financial experience for patients makes it easier to collect, and the easier we can make that on them, the better off (practices) are."

It's critical that patients understand what they're responsible for when they're in the office, Moore says. "Many times, when the patients leave, you've lost your opportunity to engage with them and educate them on what their whole treatment plan is, what it's going to look like and what it's going to cost."

When patients don't understand whether they're in or out of network or don't understand their deductible, they're going to be more reluctant to pay their bill, she says. Therefore, practices should prepare phone scripts, brochures, presentations or other materials to explain to patients what their responsibility is, who to contact or where to find that information. That will remove the shock from surprise medical bills and help patients see physicians as care coordinators who deserve to be compensated for their services.

The best solutions help practices visually show patients what their responsibility is — and why. "If you're showing a patient an estimate of what their surgical treatment is going to cost, that's visual, and the patient is more likely to remember it," Moore says.

Dahl recommends every practice put together a financial policy to share with all patients, especially new patients who might need additional education. This policy should state that the practice will provide care and bill the insurance company, but the patient is responsible for paying the co-payments and deductible at the time of visit.

"You really need to talk with that new patient about what those expectations are, and you need to have someone who is well-versed in billing and insurance, who is friendly and who can really engage the patient," he says.

Dahl also recommends practices create a collection policy that lays out to employees the expectations for collecting the co-pay and deductible. The policy should define what constitutes a delinquent account, how aggressive they should be with phone calls and letters in trying to collect that delinquent account and how to assist with the collection process.

Moore agrees: "(Practices should) already have a strategic plan for collecting those monies upfront. Provide a payment plan that's going to lead to success for them to actually obtain the money from their patients."

Clearly communicating with patients, and giving them payment options, can create a palatable financial experience. That has another side effect beyond simple payment: If they have an unpleasant experience, or if they're surprised by the bill, patients are less likely to return to the practice. They might also review the practice poorly to friends, family and perhaps even online. That could cost the practice future patients and revenue.

Practices can create a positive financial experience even before the patient registers by designing a website that clearly states what services they provide, allows potential patients to enter insurance information, run eligibility checks in real time and gives an estimate of out-of-pocket costs, Krepfle says.

DRAW ON TOOLS TO IMPROVE CLAIMS APPROVALS

Improving the financial journey will improve collection from patients, but it creates another headache: 76 percent of healthcare leaders say claims denials are their greatest challenge, according to a HIMSS survey. But it doesn't have to be that way.

"About 90 percent of rejected claims are preventable, and more than 70 percent of denied claims can be overturned," writes Beverly Gibson, MBA, a senior industry advisor with MGMA. "A robust denials management system is vital to making that happen. The right system can help to identify where the most money is lost, determine the root causes and focus efforts on developing corrective actions and prevention plans."

Simply put, clean claims mean you get paid faster, Krepfle says. "The cleaner you can make a claim, the faster you will get paid. You don't want any errors. Every time you have to touch a claim, it eats into your profitability. You want to hit it right the first time."

Denials management systems help practice administrators create those cleaner claims. "The more you understand from your denial report the types of errors you're getting, the better you can educate your clinicians and staff to help them understand the appropriate coding process so they can get it done more quickly," Dahl says.

BRING IN ANALYTICS TO DISCOVER THE CAUSES OF REJECTIONS

Analytics can help practice administrators ferret out the root causes of rejections and address them to reduce denial rates and improve cash flow.

"All the data that's available around eligibility and authorizations and filing claims and getting paid — there's so much intelligence in that data that can help providers understand where they're failing," Krepfle says. "If you're getting lower reimbursement or not reimbursed at all, you need that level of information. You need reporting, you need alerts and you need warnings."

Revenue cycle analytics can provide real-time insight into claims monitoring activities, key performance indicators (KPIs), internal benchmarks and external comparisons.

"If you only measure yourself against yourself, how do you know if your numbers are really good?" Krepfle says. For example, a practice may notice that days in accounts receivable dropped from 32 last month to 31 this month, and so that practice may think it's doing well. But its peers may be at 22 days, meaning the practice isn't doing as well as it should.

While many national organizations can provide comparative metrics, those reports are sent out periodically, so practices often watch numbers over a period of weeks or months before acting to correct the issues.

"You need real-time updates so you can understand where you have problems and how you can correct them immediately," Krepfle says.

An RCM analytics platform with robust reporting capabilities and easy-to-use dashboards for sharing KPIs with physicians and staff allows practice administrators to take advantage of collected data.

Features of an effective denials management system that practices should look for, writes

BEVERLY GIBSON, MBA, A SENIOR INDUSTRY ADVISER FOR MGMA.

IDEAL FEATURES:

- Interfaces with practice management system
- Customizable (e.g., categorizing denial codes and assigning root cause of error)
- User-friendly
- Reports are easy to read with downloadable data that can be manipulated

PROVIDES:

- Patient name
- Medical records number (MRN)
- Subscriber number
- Employer plan number
- Date of service (DOS)
- Procedure code(s)
- Description of procedure codes(s)
- Fee(s)
- Diagnosis code(s)
- Description of diagnosis code(s)
- Modifier(s)
- Payer
- Date of denial / rejection
- Remittance identification number
- Denial / rejection code(s)
- Description of denial / rejection code(s)

ALLOWS THE ADDITION OF:

- Category of denial / rejection code
- Assignment of blame: payer or provider (staff member)

But reports and analytics are only useful if everyone is looking at the right numbers — and understands how to turn raw data into actionable insights.

There are hundreds of reports that you can run, but Dahl recommends practices look at:

- Collection percentage,
- Actual or average days bills have been outstanding and
- The aging report. (Less than 10 percent of outstanding accounts should be 120 days outstanding.)

"Then we would look at all of this by payer," he says. "I also want to know my charge payments and adjustments, and what the activity is per provider."

Once practice administrators have that information, they can drill down to get more depth and look at not only production by provider, but also who is denying claims and why and how successful appeals are, Dahl says. Practices can track by payer how many denials they had because of coding errors or demographic errors, so they can find trends and investigate how to fix the problems.

"Instead of wasting time fixing something in a claim that should not have happened in the first place, you're now being proactive in fixing and dealing with your revenue cycle," Dahl says. "Then, if you add artificial intelligence (AI) and predictive analytics to this whole equation, you should be able to get a much better perspective of what your projected Medicaid, Medicare and Blue Cross volume is going to be; what your collection percentages have been in the past; and what your volume is throughout the year."

TAKE ADVANTAGE OF EMERGING TECHNOLOGIES

Emerging and evolving tools and technologies are bringing all of this together to allow practices to get the intelligence out of the data.

"The software for doing billing continues to improve," Dahl says. "There are more tools, more reports that you get directly from your practice management software. All of those are getting much more sophisticated in giving us reports and giving us the kind of information that can prevent a number of errors from occurring."

They include AI, which is finding a home in healthcare, particularly on the clinical care side, Krepfle says. On the revenue side, AI can act like an app that provides driving directions, offering multiple paths to help clean up coding errors and decrease the likelihood of denials or delays. It compares clean, quickly paid claims against rejected claims to determine what is missing before the claim goes out.

"If you pay attention to the warnings, you're going to get to the ability to submit something and get paid as quickly and as efficiently as possible. That means (getting) the most money to physicians' offices," Krepfle says.

Predictive analytics, meanwhile, can give practices a clear picture of what cash flow is going to be or when practices are likely to have collections issues.

"You have very bright doctors out there who can do this analysis, but truly, if they're doing that, they're taking away from patient care," Krepfle says. "That's why this tool is important. It doesn't take the time. It allows them to focus on patient care. It's not subjective, it's objective."

These tools allow practices to change the revenue cycle story. No longer do they have to send in a claim and wait for it to be denied, then fix it and resend it. Now they can discover the problem before it goes to the payer, which costs less money, doesn't have to be reworked and generates faster payment.

"Pull the intelligence early into the process," Krepfle says. "Start putting those warnings, those flags, those recommendations in there so that you get to a clean claim and get paid faster."

PREPARE FOR THE REVENUE-RECOVERY PROCESS BEFORE THE PATIENT ENTERS YOUR OFFICE

Practices have a responsibility to educate and equip their staff to help improve reimbursement. Fortunately, there are ways to improve the patient journey at every step, and technology solutions that help staff educate patients, automate some of these responsibilities to reduce staff burden and provide insight to help decrease denied claims. That way, practices can continue to deliver the same — if not better — care while ensuring their long-term profitability.

"If practices call on all of these innovative tools that are available to them, they can do pre-call planning for patients, or pre-call treatment," Moore says. "They can practice and prepare the treatment plans with the financials before patients get there, and they can have visual explanations for patients, including being able to see how they're going to manage the payments. That's why we encourage them to use the tools."

"You need solutions, and honestly, I think it's a partnership," Krepfle says. "Seek a partnership (with a solutions vendor) so that you'll have the resources available to deal with whatever problem you're having."

To learn more, call 866-817-3813 or visit https://www.changehealthcare.com/solutions/revenue-performance-advisor