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A New Economic Reality and a New Way to Work

The Perfect Medical Bill, Paid Perfectly

3 Questions to Ask in Pursuit of Reduced Days Revenue Outstanding

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Introduction

3 Questions to Ask in Pursuit of Reduced Days Revenue Outstanding

It's no secret that in recent years, accounts receivable management has changed dramatically for healthcare providers. Payment used to be as simple as submitting a claim to an insurance company and following up to verify the remittance date. But a number of outside forces have made life, ahem, complicated for providers these days, including:

- Resource-intensive deployment for new electronic medical record (EMR) systems
- Upward trends in claim denials
- Looming reductions in Medicare reimbursement
- Increasing uninsured and underinsured populations
- Declining access to non-patient revenue

All of these complications amount to one simple truth: More than ever, time is money. The question, of course, is where to start. This paper sets a general framework for the discussion your organization needs to have to in order to identify weaknesses across your receivables operations, and choose a course of action to collect more cash, quickly. It all comes down to three easy questions…

#1

Are my days revenue outstanding meeting my goals?

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#1

Are my days revenue outstanding meeting my goals?

You have a portfolio of reimbursements you're owed, and you keep a close watch on gross days revenue outstanding. Is that number fueling your mission, or hindering it?

A few thoughts to consider:

- Top organizations aim for 35-40 average gross days revenue outstanding
- Initial denial rates can be as high as 20% of insurance claims
- Starting in 2014, Medicare reimbursements drop for providers not maintaining a quality-of-care standard

These points all boil down to the fact that, perhaps for the first time in history, accelerating accounts receivable is a matter of necessity. Healthcare providers who can't collect quickly won't have the cash to reach quality-of-care standards – Which means those providers won't have the cash they're owed, putting all-important Medicare reimbursements at great risk.

Take a look at your operation and ask yourself:

1. How much cash do I need each month to maintain my quality-of-care standard?
2. On average, how long does it take to collect that cash from my portfolio?
3. Given that timeframe, how long would it take for me to run out of cash if that standard was implemented tomorrow?
4. How much cash would I lose in Medicare reimbursement if I didn't recover what I was owed?

Chances are, it's more than you're willing to lose. So it's best to start formulating a plan today to reduce your days revenue outstanding so you can adequately support the services you provide and deliver the quality of care your patients deserve. That leads to the next question …

#2

What am I doing today to reduce my days revenue outstanding?

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#2

What am I doing today to reduce my days revenue outstanding?

Once you submit a claim, it's the follow-up process that determines when and if you get reimbursed. As we noted above, common understand of industry norms dictates 1 out of every 5 insurance claims are rejected on the first submission – So efficiently managing claims and denials, and providing best-of-breed patient financial services, can go a long way to quick payment.

Reducing days revenue outstanding can be as simple as:

- Segmenting technical and clinical denials by origin, dollar amount, and root cause
- Expediting denial responses to the most appropriate specialty staff or department
- Tracking the workflow so no claim falls off the automated conveyor belt
- Providing common reports on claim status and denials management to uncover trends and process improvements

It might seem like a lot of work, but it's what the best, most progressive providers are doing. By accessing payer web sites, claim status, eligibility, and adjudication data can be reviewed without a phone call. By fully leveraging EDI remittance advice (835), you can glean and respond to denial data in an automated manner, expediting the denial to the best party to review and respond.

So, before you feel too overwhelmed, ask yourself:

1. What are the most common reasons why your claims are denied?
2. Who in your company can provide the information you need to resolve each denial category?
3. How can you ensure those denials reach the correct party the fastest?
4. Is there a simpler way to collect that information and get it back to the insurance company?

Backing up that strategy with compassionate staff who can work with patients after partial reimbursement is collected becomes the final piece of the puzzle. Because at the end of the day, you don't want X% of a bill – You want 100% of it. Your final move, therefore, is to ask this last question…

#3

Do I have the processes, technology, and people in place to make a change?

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#3

Do I have the processes, technology, and people in place to make a change?

On a case-by-case basis, the process we've outlined above can be carried out manually by a highly-organized, truly dedicated staff. But for healthcare systems that manage thousands of claims, and millions of dollars every day, it's nearly impossible to manage without the right tools. Luckily, systems exist that can help you track a claim from cradle to grave, provide expedient financial service to patients, and ensure your perfect bill is paid perfectly, every time.

Leading accounts receivable operations have the capabilities to:

- Leverage EDI X12 transactions for remittance advice (835) and claim status (277)
- Get the right account to the right person at the right time, automatically
- Navigate payer websites quickly and efficiently
- Determine the root cause of line-item denials
- Ensure policies are adhered to in an escalated fashion

The trick here is to automate your workflow in a fashion that reflects the payer's behavior. Doing so makes it possible to identify trends that can indicate whether your operation needs fixing, or if you need to hold your payers accountable. The latter is often the difference between an operation that collects quickly, and one that gets left behind.

Some of the questions you might ask yourself when crafting that workflow might include:

1. How quickly after submission do you check with a payer for claim acknowledgment?
2. Are you proactively responding to denials and moving them into an appeals process?
3. Is there a process in place to resolve claim underpayments?
4. What is your threshold for writing off underpayments?

At the end of the day, you're relying on your people's expertise to shed light on these issues, look at your contracts, review how and why you got paid, and work with the patient to bring their balance to zero. No technology can take the place of a team working together to ensure your operation is run like a machine.

About Ontario Systems

5 of the 10 best healthcare organizations in the country*run their receivables operations on Artiva® Healthcare from Ontario Systems – a comprehensive solution delivering a fully-fused contact management system, professional services, and business expertise. Organizations using our products are 200% more profitable in their revenue recovery efforts on average, leveraging our technology to ensure compliance and sensitivity to patient needs at every step of the process.

Our 30+ years of experience enabling innovation, strategy, legal compliance, and efficiency have made Ontario Systems the receivables management technology provider of choice for more than 55,000 customer service representatives in more than 500 locations across the country. We uncover revenue opportunities to help our customers grow and prosper in complex industries.

An ideal platform for virtually any patient-focused company, Artiva Healthcare customers include:

- Hospitals
- CBOs
- IDNs, ACOs, and PHOs
- BPOs and EBOs

Whether you're trying to unite disparate business units under a common recovery strategy, boost efficiency, or navigate an always-complex regulatory and reimbursement process, we can help. Call us or email today to learn how.

**U.S. News & World Report – Best Hospitals 2012-2013*

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Steve Scibetta is a 20+-year healthcare technology veteran, having served roles in software development, product management, customer service, and business planning. Strategy, development, and competitive analysis are Steve's bread and butter at Ontario Systems, where he brings channel partnership and strategic product management disciplines together to help healthcare clients achieve their most ambitious growth plans.

Tom Yoder's career amounts to more than 14 years in healthcare technology, and 20+ in the life sciences industry as a whole. An integral player in the development of several market-leading healthcare receivables platforms, Tom has helped dozens of companies plan, organize, and coordinate their operations to meet both patient care and corporate growth objectives.