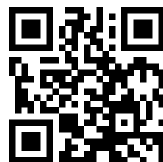
Top **5** Ways to **Improve Collections**

a guide to help you strategize in the age of increasing denials, rising costs, compounding inefficiencies, strict compliance regulations, and other operational impediments



TOP 5 WAYS TO IMPROVE COLLECTIONS SNAPSHOT

1 KEY STRATEGIES TO REDUCE DENIALS

Insurance claim denials are a significant financial liability for most health systems. CMS denies nearly 26 percent of all claims, and 40 percent of those are never resubmitted even though two-thirds are recoverable and 90 percent are preventable. By using a multi-pronged approach, and engaging clinical, operational, and financial employees can help reduce claim denials.

Multi-Pronged Approach to Reduce Denials

- Select a Champion to Communicate the Vision, "Reduce Denials": The champion should articulate the vision and issues in a way that providers, and operational staff understand that avoiding claims denials and getting billing right the first time would have a positive impact.
- Resuscitate Focus on Quality Improvement in the Revenue Cycle: One-time tasks should be buried and a culture of continuous improvement by conducting ongoing assessment, research, and continuous cycles of Plan, Do, Check, Act (PDCA) should be developed.
- Dedicated Claims Denial Management Team: The team would be responsible for reporting, quantifying opportunities over time, identifying trends, assessing improvement opportunities, and communication with operational staff.
- Use RCM Robots or AI to Make Data Visible and Actionable: Using small scale automation tools and a suite of robotic process automation (RPA) bots can give new insights into the data.
- Let Effective Analytics Drive Improvement and Engagement: Revenue cycle analytics tools expose denials data in meaningful ways, allowing the team to drill into and explore specific issues with ease.

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2 UTILIZE SOFTWARE TO CREATE EFFICIENCIES

In the healthcare space, RCM bots integrate with client systems, including EHR, billing systems, patient payment portals, payer portals, clearing houses, credit card processing applications, and the like. This automation is usually ideal for supervised learning, rule-based, repeatable processes that leverage the organization's key systems, including claims follow-up, payment posting, AR calling, converting paper EOB to ERA, and more. Bots benefit RCM operations by decreasing costs, improving efficiency, reducing errors, increasing scalability, and increasing collections and revenues.

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IMPORTANCE OF MONITORING REVENUE HEALTH OF YOUR PRACTICE OR FACILITY

Once, you have chosen the right EMR for your practice or facility, you need to closely monitor the revenue health to improve processes and gain more efficiencies. RCM experts suggest the following critical indicators to help you with.

- Days in Accounts Receivable (DAR)
- Net Collections
- Average Collections per Encounter (Visit, Surgery, or Procedure)
- Clean Claim and Denial Rate
- Unbilled Charges and Discharged, Not Final Billed (DNFB)

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MAXIMIZE CODING

- Overarching Criterion: CMS has implemented the overarching criterion for E/M services which makes it clear that medical necessity is the driving force of the level of service assignment. It relies solely on physician's judgment to document what level of exam or history is required for any condition.
- Documentation Guidelines: The Documentation Guidelines and the audit tools provide a more objective tool in auditing an E/M note. Using these tools, the level of service is based upon the key components of history, exam and medical decision-making.
- CPT Guidelines for E/M: For established patients, subsequent hospital care, subsequent nursing facility care, and a few other categories, you choose the E/M code based on two out of three components.
- Update – CMS Proposes Revamping E/M Documentation Guidelines: CMS announced its intention to undertake a multi-year effort to revise the current E/M documentation guidelines. This revision will likely include removal of the history and exam documentation requirements.

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STREAMLINE PAYER CREDENTIALING

Medicare Advantage provider directories are still packed with errors. As reported by *Modern Healthcare*, the audit revealed that almost half of provider directory locations included at least one mistake. This report also described CMS actions comprising 18 noncompliance notices; 15 warning letters; 7 warning letters with a request for a business plan. Errors included, wrong location, wrong phone number and that the provider was accepting new patients when they were not.

Based on the CMS investigation, there is a general lack of internal audit and directory testing in many Medicare Advantage organizations. CMS expects managed care plans to review their provider directories and correct inaccurate and missing information.

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As there are so many moving parts throughout the billing and collections processes, the smallest inefficiency can lead to costly rework efforts, denials and lost reimbursements.

Read further to discover deeper the top five keys to increase collections. Learn how to streamline payer credentialing, reduce denials, utilize smart RCM solutions, monitor principal RCM metrics, and maximize coding to receive appropriate or outstanding payments in a timely manner.

Key Strategies to Reduce Denials

For most health systems, insurance claim denials are a significant financial liability. CMS denies nearly 26 percent of all claims, and 40 percent of those are never resubmitted even though two-thirds are recoverable and 90 percent are preventable. Usually health systems lose tens of millions of dollars struggling to reduce denials and the inability to identify and correct the root causes.

Any large healthcare organization's revenue cycle has a lot of variation and complexity. Policies and procedures differ from payer to payer, technology and communication systems vary from patient to patient, and the complexities of separate hospital and professional revenue cycles in the same system can lead to defects and waste. Research reveals that efforts by organizations are usually too broad and require excessive effort from stakeholders. Following are some of the key areas which negatively impact denial management:

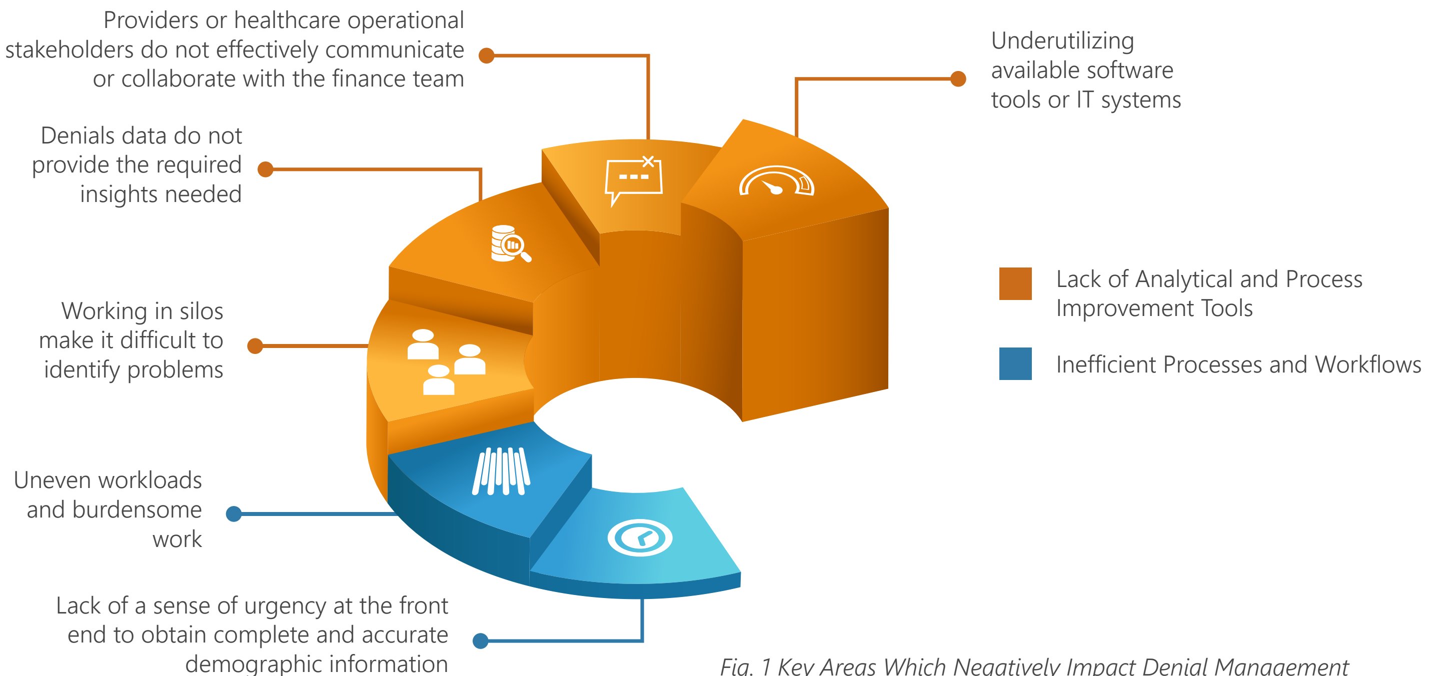
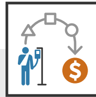


Fig. 1 Key Areas Which Negatively Impact Denial Management

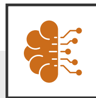
Essentially, a healthcare organization needs to get upstream of its challenges with claims denial management, and needs a comprehensive improvement plan. Supported by substantial data, the improvement plan needs to use a multi-pronged approach, and engage clinical, operational, and financial employees in tackling the problem.

Multi-Pronged Approach to Reduce Denials



Resuscitate Focus on Quality Improvement in the Revenue Cycle

To drive sustainable change, the revenue cycle improvement plan is built with an eye on sustainability, and flexibility. The focus should be on specific problem areas rather than the ocean. The progress of the set of implemented series of initiatives should be closely monitored. One-time tasks should be buried and a culture of continuous improvement by conducting ongoing assessment, research, and continuous cycles of Plan, Do, Check, Act (PDCA) should be developed. In addition, aligning lean improvement principles to address specific areas of denials should be implemented. This robust approach will help identify root causes and develop effective interventions to address inefficient processes, workflows, and manual work.



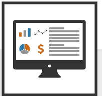
Use RCM Robots or AI to Make Data Visible and Actionable

To supplement a dedicated denials team, a healthcare organization needs meaningful data to move ahead and upward. Effective business offices use small scale automation tools to replace inadequate stock reports from the EHR, creating visualizations and dashboards which give new insights into the data. Utilizing a suite of robotic process automation (RPA) bots can achieve the following wonders:

- Analyzes State of the Claim
- Comes up with the Set of Actionable Insights
- Performs certain Follow Up Tasks
- Improves the Quality of Work by Achieving Consistent Accuracy
- Drives up the Clean Claim Rate
- Reduces Denials
- Significantly Improves Resolution Time

Select a Champion to Communicate the Vision, "Reduce Denials"

To set the stage for organization commitment to make the Vision, "Reduce Denials" a success, a champion should endorse and promote the denials reduction initiative. The leadership should designate an executive champion to convey the vision and the "why" for the work. The champion should articulate the vision and issues in a way that resonates with providers, and operational staff. This should illustrate how revenue cycle impacts organizational performance. Operational staff should understand that avoiding claims denials and getting billing right the first time would have a positive impact.



Let Effective Analytics Drive Improvement and Engagement

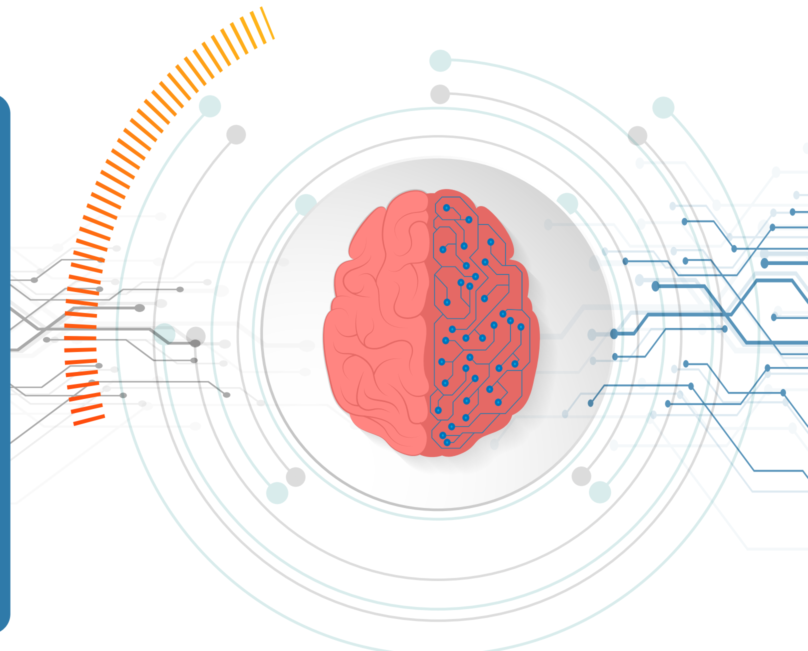
Revenue cycle analytics tools expose denials data in meaningful ways, allowing the team to drill into and explore specific issues with ease. Blending AI capabilities with this powerful analytics application, can slice and dice data and obtain detailed information for denial trends over time. With this actionable data in hand, your organization can standardize a core set of metrics that will drive engagement and lead to the successful adoption of improvement initiatives.

Dedicated Claims Denial Management Team

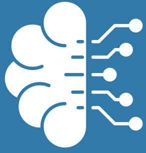
Healthcare providers and organizations should realize that to maintain momentum and to sustainably reduce denials and write-offs, a dedicated denials analysis team is needed. The team would be responsible for reporting, quantifying opportunities over time, identifying trends, assessing improvement opportunities, and communication with operational staff. In addition to its revenue cycle expertise, the team can also provide consulting solutions to facilitate and develop partnerships with stakeholders.

Utilize Software to Create Efficiencies

A smart RCM software solution utilizes robotic process automation (RPA) to optimize RCM operations. Usually subject matter experts (SME) deploy RPA to drive efficiencies in resource utilization. By leveraging SME expertise and RPA, you can blend the right mix of human and machine capability to capture more revenue for your clients at the lowest total cost of collections. According to McKinsey & Company, more than one third of tasks in the healthcare industry could be automated, increasing efficiency. These smart RCM robots would be able to close that efficiency gap in your revenue cycle operations.



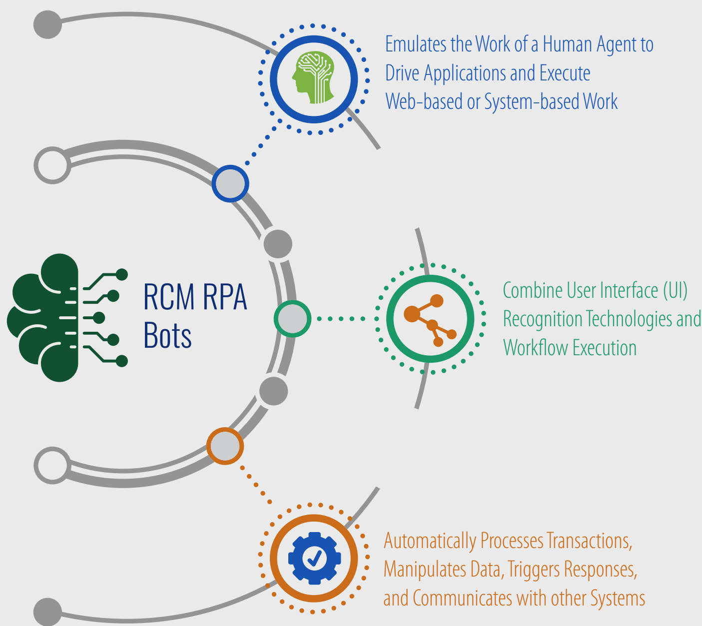
How does **Robotic Process Automation** (**RPA**) **Bots** Work?



Robotic Process Automation (**RPA**) is an emerging form of business process automation technology based on the concept of using software robots (a.k.a. bots). Powered by cognitive technologies like speech recognition, natural language processing (NLP), and machine learning (ML), these bots offer actionable insights, improved business efficiency, data security and effectiveness by imitating human actions, automating repetitive tasks across multiple business applications without altering existing infrastructure and systems.

In the healthcare space, our proprietary RCM bots integrate with client systems, including electronic health records, billing systems, patient payment portals, payer portals, clearing houses, credit card processing applications and the like. This automation is usually ideal for supervised learning, rule-based, repeatable processes that leverage the organization's key systems, including claims follow-up, payment posting, AR calling, converting paper EOBs to ERA, and more.

How does a Bot Benefit RCM Operations?



DECREASED COSTS

Reduces the cost of performing equivalent work by up to two-thirds.

IMPROVED EFFICIENCY

Can work 24×7.

REDUCED ERRORS

Eliminates human delay and error.

INCREASED SCALABILITY

Can dial up or down the number of bots deployed according to the volumes.

INCREASED COLLECTIONS AND REVENUES

Better accuracy improves collections. Efficient and faster billing enable quicker payments for providers and facilities.

PROCESS IMPROVEMENT

Identifies bottlenecks and helps in optimizing and improving the core processes.

Importance of Monitoring Revenue Health of Your Practice or Facility

Annual physical examinations are vital for a patient, enabling a physician to monitor and understand the patient's current health condition. The physicals offer proactive steps to ward off potential health issues and prevent emergency scenarios. Do you scrutinize the financial health of your company to include a comprehensive analysis of different metrics on a regular basis?

Several studies reveal that for most small to mid-size healthcare companies, the answers are negative. Most are too busy trying to keep up with daily operations, and they fall behind monitoring critical revenue factors. In some cases, providers struggle to stay up-to-date with ongoing payment reforms, new regulations and the dramatic shifts in the healthcare industry.

Once, you have chosen the right EMR for your practice or facility, you need to closely monitor the revenue health to improve processes and gain more efficiencies. RCM experts at **EqualizeRCM Services** (**ERCM**) suggest some critical indicators to help you with. Using these vital pointers would not only help you in providing some actionable insights but also propel your RCM performance to the next level.

Auditing Financial Health of Your Practice or Facility

Providers should conduct financial health audits at least monthly, if not daily or weekly. According to **ERCM** experts, some of the critical indicators you should monitor are as follows:

Days in Accounts Receivable (DAR)

This metric is the one of the best in showcasing the overall health of your accounts receivable (AR). Days in AR (DAR) reflects the number of days for which the AR is outstanding, based on the provider's average daily charge volume.

Here's How to Calculate Days in Accounts Receivable (DAR)

- Calculate the average daily charges of the practice or facility:
  - Add all of the charges posted for a given period (e.g., 3 months, 6 months, 9 months, 12 months)
  - Subtract all credits received from the total number of charges
  - Divide the total charges, less credits received, by the total number of days in the selected period (e.g., 30 days, 90 days, 120 days, etc.)
- Calculate the Days in AR by dividing the total receivables by the average daily charges

Net Collections

The adjusted (or net) collection rate is a measure of a practice or facility's effectiveness in collecting billed charges. This is calculated by dividing payments by adjusted charges for the period being analyzed.

Average Collections per Encounter (Visit, Surgery, or Procedure)

This ratio exhibits the amount of money generated for each patient encounter. By dividing revenue into the number of encounters, you can calculate this ratio.

Clean Claim and Denial Rate

Clean claim rate outlines the percentage of claims which are fully resolved by the insurance on the first submission itself. Claims which are not "clean" require rework. This results in delayed and potentially reduced payment. Most unclean claims (denials and rejections) can be prevented and can typically be fixed with a change in processes, policies or behaviors related to benefits/eligibility, coding, delayed claims follow-up or changing medical policies. To alleviate these issues, you should categorize total denials by the associated Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC), as well as make needed adjustments in processes. The next section, "Key Strategies to Reduce Denials" focuses on strategies to drive up your practices' or facilities' clean claim rate.

Some Other Key Performance Indicators (KPIs) for Hospitals and Frequency of Reporting

Charges and Volumes

- Volumes: You are likely already looking at the admissions and discharges daily and monthly
- Charges – Daily / Weekly / Monthly
  - Daily – Totals
  - Weekly – Totals / By Department
  - Monthly – Totals / By Department / Service Type / Payer
- Unbilled Charges and Discharged, Not Final Billed (DNFB)?
  - What's in DNFB?
  - Lag Days, Not Coded, System Edits, Other Holds
  - Benchmark – 4 days (3 lag + 1 extra). Could vary based on the service type
  - $ Unbilled Charges / $ Average Daily Charges

Collections

- Daily – Totals
- Weekly by Payer (including self-pay)
- Monthly by Payer / Service type / Non-AR
- Time to Pay
- Collection Rates
- Payment Projections (bonus info)
  - Medicare, Other Payers through Clearing House Reports
  - Daily Received Projected for the Month
  - More Complex Projections
- Paid according to Contract (bonus info)

Adjustments

- Daily – Totals
- Weekly – Split by Patient / BD / Insurance
- Monthly – Totals / Split by Payer

Accounts Receivable

- Daily – Totals
- Report Daily on Patient / Insurance / 90+ / MCR 60+
- Monthly – Slice and Dice it
- Goals:
    - Insurance 90+ at lower than 15%
    - MCR 60+ at lower than 10%
    - Insurance DAR at 40-45 days
    - Total DAR – variable depending on Self Pay policies
- Credit Balances

Maximize Coding

Overarching Criterion

CMS has implemented the overarching criterion for E/M services which makes it clear that medical necessity is the driving force of the level of service assignment. Specifically, CMS states in their statement of overarching criterion, "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed." *(Medicare Claims Processing Manual 30.6.1)*

The overarching criteria is subjective, brief and to the point but provides no mechanism to operationalize the guidance. It relies solely on physician's judgment to document what level of exam or history is required for any condition. The overarching criterion is interpreted as below by many practices – documentation of the key components determined by the nature of presenting problem and medical necessity.

Documentation Guidelines

The Documentation Guidelines themselves and the audit tools provide a more objective tool in auditing an E/M note. Using these tools, the level of service is based upon the key components of history, exam and medical decision-making. Some services require all of the three components and audit to the level of the lowest component. Some services require only two of the three key components.

Providers do need to use their electronic health records in a way that more clearly documents what happened at the visit and be prudent in copying / clicking. Medical necessity should guide the provider in terms of the documentation of the key components.

CPT Guidelines for E/M

The Documentation Guidelines themselves and the audit tools provide a more objective tool in auditing an E/M note. Using these tools, the level of service is based upon the key components of history, exam and medical decision-making. Some services require all of the three components and audit to the level of the lowest component. Some services require only two of the three key components.

Since the CMS overarching criterion is subjective, we advise providers to perform and document only medically necessary services and to choose the E/M level based on CPT Guidelines.

Update: CMS Proposes Revamping E/M Documentation Guidelines

CMS has proposed for the revamping of the E/M guidelines. It sought comments from stakeholders (physicians and non-physicians billing E/M) and Stakeholders have long maintained that both the 1995 and 1997 guidelines are administratively burdensome and outdated with respect to the practice of medicine, stating that they are too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels. In general, stakeholders agree that there may be unnecessary burden with these guidelines and that they are potentially outdated, and believe this is especially true for the requirements for the history and the physical exam.

In response, CMS announced its intention to undertake a multi-year effort—with the input of providers and other stakeholders — to revise the current E/M documentation guidelines. This revision will likely include removal of the history and exam documentation requirements.

Streamline Payer Credentialing

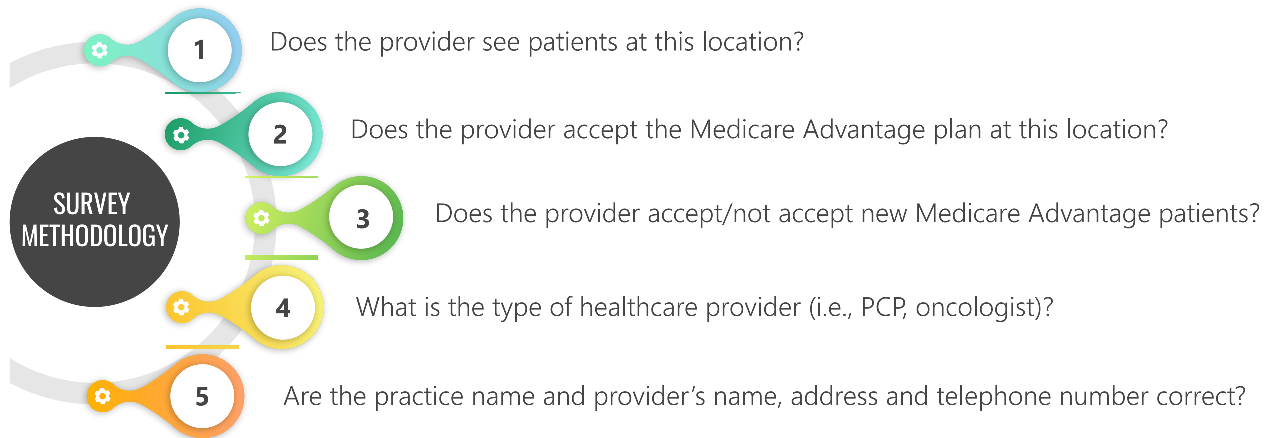
Medicare Advantage provider directories are still packed with errors. That is the finding released recently based on federal audits of those directories. This audit began under the Obama administration and encompasses about one-third of Medicare Advantage plans every year. As reported by *ModernHealthcare.com*, the audit revealed that almost half of provider directory locations included at least one mistake.

- The wrong location
- The wrong phone number
- That the provider was accepting new patients when they were not

For the third straight year, significant errors were found that may result in fines or other penalties for those insurers. The Centers for Medicare & Medicaid Services (CMS) may begin imposing monetary penalties. The Modern Healthcare report described CMS actions comprising 18 non-compliance notices; 15 warning letters; 7 warning letters with a request for a business plan. There have been no fines assessed as yet and the plans have 30 days to correct the identified compliance issues.

Based on the CMS investigation, there is a general lack of internal audit and directory testing in many Medicare Advantage organizations. CMS expects managed care plans to review their provider directories and correct inaccurate and missing information.

Survey Methodology

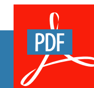


How Provider Directory Errors Can Affect Consumer Choices

As an example of one type of error, a person may choose a Medicare Advantage plan because a long-time doctor is listed as being in the plan network. However, that information is incorrect and the individual must now choose a new doctor that may be in an inconvenient location.

Other errors include some providers who did not work at any of the directory locations, or who did not accept the health plan there. CMS auditors even found that, because the directory information had been out of date for a long time, some listed providers had retired or even died.

You can read the full **CMS Online Provider Directory Review Report** here.



EqualizeRCM Services (**ERCM**) provides best-in-class healthcare advisory as well as revenue cycle management (RCM) solutions that help providers increase their profitability through improved reimbursements and collections at a lower total cost of operations. With experienced RCM experts, proprietary RCM automation platform, *Optimus Suite*, and SOC 1 – Type II certified operations, **EqualizeRCM** has delivered proven success to more than 2,000 physicians and above 100 facilities across the nation.

EqualizeRCM provides service support for every aspect of the RCM process from credentialing to medical coding to denial management. Utilizing platform-agnostic RCM solutions, **ERCM** serves a variety of different provider groups including hospitals, surgery centers, behavioral health centers, physician groups, FQHCs, RHCs, urgent care centers, DME companies and labs, among others.

For more information, please visit us at https://EqualizeRCM.com.