REVENUE CYCLE
EXECUTIVE GAME PLAN

PARAREV

PROVEN AUTOMATION STRATEGIES THAT DELIVER RESULTS

For hospitals and health systems, external forces are converging to make it increasingly difficult to consistently optimize revenue cycle management and sustain predictable cash flow.

On the front-end, transparency regulations and consumer-driven healthcare are imposing new realities on traditional hospital business models, making accurate, market-appropriate, and publicly available pricing essential.

Separately, the COVID-19 pandemic has transformed the labor landscape—perhaps permanently—by accelerating both the need and desire of employees to work from home. Employee burnout, vaccine mandates and an historic shift in employment priorities are further complicating the task of finding top-quality revenue cycle personnel.

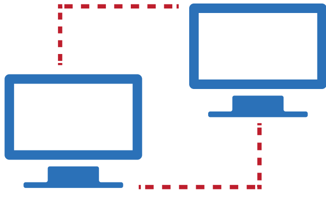
Kaufman Hall's 2021 Healthcare Performance Improvement Report found that 92% of responding healthcare organizations said they were struggling to recruit staff, and all reported they were facing issues with staff burnout, vacancies, wage inflation and high turnover.[1]

"75% OF RESPONDENTS SAID LABOR PROBLEMS HAVE IMPACTED REVENUE CYCLE"

The growing challenges of recruiting and retaining experienced claims analysts can have a major impact on claims and denial management, given the exponential growth in the complexity and volume of payer rules and policies. By some estimates, a claims analyst must access or address upward of 1,200 separate pieces of information daily.

Unfortunately, many analysts simply aren't equipped with either the skills or tools required to manage this data and complete their work effectively. It's no wonder that even though 90% of denials are preventable, 65% are never corrected and resubmitted for reimbursement.[2]

In the Kauffman Hall survey, 75% of respondents said labor problems have resulted in poor revenue cycle impacts, with the most common being "an increased percentage of Medicaid patients, followed closely by an increased rate of denials, a lower percentage of commercially insured patients, and an increase in bad debt and uncompensated care."[3]



HARNESSING THE POWER OF AUTOMATION

In today's environment, hospital and health system leaders can no longer expect traditional revenue cycle processes to produce the desired outcomes. To maximize cash flow, hospitals must instead harness automation and advanced analytics to augment their existing approaches at each step of the revenue cycle. That means developing an end-to-end action plan—from pricing through closed-claims audits—that can transform revenue cycle operations and help personnel quickly and consistently make the right decisions.

PRICE OPTIMIZATION AND TRANSPARENCY

That plan begins with pricing. In the face of rising consumer expectations surrounding healthcare price transparency, hospitals that make their prices easily available online will have a competitive edge over those that do not. Equally important, they'll mitigate the potentially severe financial consequences of non-compliance with Centers for Medicare and Medicaid Services' (CMS) transparency regulations.

Before prices can be posted, however, organizations must be certain that the numbers they're releasing make economic sense and are justifiable and competitive when compared to peer pricing. To accomplish this, hospitals should work with pricing experts equipped with advanced analytics to create consistent, rational pricing models assembled around cost, reimbursement, and peer pricing data.

This process begins with a joint review of existing pricing information across all hospital revenue streams, including room rates, emergency visits, diagnostic and therapeutic procedures, operating room, anesthesia, PACU, pharmacy and medical supplies. Detailed comparisons should then be made to peer prices using ubiquitous, publicly available data sources.

Price-setting should also take into account contractual reimbursement rates to ensure all new rates are consistent with payer policies. Finally, timelines should be established for the implementation of any price adjustments designed to align with market conditions.

Refined pricing models—carefully calculated by experts equipped with analytic applications and developed in close partnership with hospital finance personnel—can help organizations improve revenue capture and strengthen margins while remaining competitive in local markets and compliant with the CMS rules. Additional intelligent automation processes capable of providing programed revenue integrity audits can help mitigate revenue leakage to increase collections and improve margins.

AUTOMATED DENIAL MANAGEMENT AND PROCESS FLOW

Once pricing has been refined, the next step in optimizing the revenue cycle is strengthening denial management. Most hospital leaders understand the financial damage denied claims can produce. Yet organizations continue to fight a losing battle when it comes to eliminating new denials and resolving existing ones. The complexity of revenue cycle management, coupled with frequent changes in payer policies and rules, can make it extremely difficult for providers to consistently identify and mitigate denial root causes.

As a result, the problem of denials is becoming substantially worse, with the average denial rate jumping by 23% in 2020 compared to four years earlier.[4] A recent American Hospital Association report found that nearly 90% of hospitals and health systems had experienced an increase in denials over the past three years, and more than half said the increase was significant.[5] And even with the administrative costs of resolving denials estimated at nearly $9 billion a year, only about one-third of denials are actually reworked.[6] As a result, operating cash flow margins for not-for-profit hospitals fell to a median of 7% in 2020, down from 8.3% in the three prior years, according to Moody's.[7]

"AVERAGE DENIAL RATE JUMPED 23% IN 2020 VS FOUR YEARS EARLIER"

Effective denial management requires an entirely new approach that utilizes intelligent automation-driven decision trees to help staffers quickly make good decisions when working a denied claim. New guidance platforms accessible to analysts via the web provide a systematic and consistent approach for working claims, regardless of where the employee is located.

With these platforms, denial inventory can be organized by department, carrier, complexity, or dollar size. Once categorized, coded data indicating why a specific claim was denied is extracted from the payer electronic remittance advice (ERA) 835 files and assigned to the claim interface.

When the claims analyst opens the denial, they're presented with a click-through decision tree that includes brief descriptions of the steps required and presents progressive, "if-then-else" questions to isolate details about the issue. The decision tree can lead the analyst through the correct protocol to mitigate the problem and resubmit the claim, regardless of whether the core issue involves coding and billing, coverage, utilization, contractual issues, submission/re-billing, cash posting, or process delays.

This level of automated decision support is a game-changer when it comes to denial management, both in terms of reducing the burden on staff and in enforcing quality control. Instead of searching manually through multiple documents to find specific payer guidance—likely located in a three-ring binder or computer folder—the analyst is presented with all payer-specific information within the application and simply clicks through to the appropriate next step.

Importantly, these solutions also automatically generate detailed, clearly constructed notes that immediately populate an adjacent note field as the analyst works through the steps to resolve a claim. This concurrent documentation not only ensures an accurate record of the actions taken, it also saves an enormous amount of time. It's estimated that each denial management note can take from one-to-11 minutes to complete.

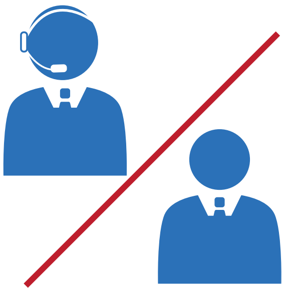
ROOT CAUSE ANALYSIS

As critical as it is to address denials quickly and accurately, it is arguably even more important to consistently identify where, when, and why they're occurring. Root causes ranging from flawed internal processes and technology errors to insurance and clearinghouse mistakes must be uncovered and resolved. Scrutiny therefore must be brought to bear in a wide array of areas, including front-end processes and payer issues. In addition, system edits and automation opportunities should be explored to ensure denial triggers are permanently eliminated.

From this process, hospital revenue management staff can develop a comprehensive knowledge base around the issues that trigger payment delays, either independently or in partnership with an AR follow-up vendor. Going forward, the hospital will then be positioned to systematically address the full spectrum of shortcomings that contribute to payment delays and write-offs.

For truly effective denial remediation and prevention, it is important for hospitals to align with a qualified AR follow-up management vendor; one that utilizes intelligent automation to automatically categorize and prioritize claims by root cause and identify relevant deadlines associated with each claim.

Combining this level of intelligent automation with staff specialization will help streamline and accelerate the resolution process. However, an effective process also requires ongoing collaboration and communication between the parties. That means essentially treating the vendor as an extension of the hospital's internal business office.



DIVISION OF LABOR

Best practice AR management strategies likewise should incorporate a division of labor between billing teams, with separate groups focused on different tasks before and after the claim has dropped.

Pre-submission team responsibilities can include:

- Analyzing the chargemaster to identify and correct chargemaster errors, compliance issues and missing charges. Conducted by Health Information Management (HIM) coding staff, this is essentially an audit designed to map as many claim data points as possible back to their originating source before claims submission.
- Analyzing current pricing methodology and comparing it locally and with similar-sized facilities to identify opportunities to be more competitive.
- Assessing the efficiency of current clearinghouse and coding edits in place prior to claims submission.

Post-submission teams should take responsibility for claims from the point of submission out to 30-60 days. At 60-180 days, another team can pick up the claim to free the initial billing staff to focus on younger claims.

At 180-210 days, it is useful for a secondary team to step in to target remaining aging claims. Finally, once any account is at zero, deploying another secondary team to handle zero-balance and bad debt forensic analysis is an effective strategy.

Creating dedicated teams for each phase of AR management helps establish a competitive yet cooperative environment, with each team striving to perform at the highest level when they're "up to bat." The approach also helps create checks and balances at various stages of the revenue cycle. That said, staffing challenges may compel organizations to incorporate external partners for assistance with some or all these AR-related tasks.

AR STRATEGIES FOR AGED ACCOUNTS: EXTERNAL PARTNERS

A growing number of hospitals are partnering with third parties to implement end-to-end AR management strategies that can help ensure facilities collect every dollar they're entitled to on every denial.

These hybrid approaches typically see hospital billing staff focusing exclusively on the newest claims, then turning over unpaid balances to specialists at specific aging intervals. Relying on external experts to pursue low-dollar, high-volume claims is often the most cost-effective way to optimize collections and minimize write-offs, since it frees up staff to concentrate on fresher, higher-dollar claims.

Pre-write-off insurance collection experts well-versed in health plan policies can provide an additional safeguard to help prevent legitimate claims, regardless of age or size, from going uncollected. A comprehensive approach will help organizations obtain hard collectable dollars from the full spectrum of aged accounts, including pre-write-off claims and even closed balance accounts.

ZERO-BALANCE REVIEWS OF CLOSED BALANCE ACCOUNTS

The final, critical element in a comprehensive AR management strategy is a zero-balance claims review. Zero-balance reviews are essentially forensic audits of written-off claims that also serve to validate claims integrity and maximize contractual revenue from all payers. They are designed to assess whether the factors that initially caused a payer's denial can be mitigated to secure retroactive reimbursement.

While some may assume that pursuing old write-offs isn't likely to be productive, experts skilled at identifying common mistakes that frequently result in denials can recover up to one percent of a hospital total net patient revenue. For large hospitals and health systems that may generate hundreds of millions of dollars annually, this can translate into a significant amount of found revenue.

Issues that can cause claims to be written off include underpaid commercial and government insurance dollars, complex reimbursement methodologies, ambiguous contract language causing underpayments, and lack of time to reprocess claims. Another area of vulnerability that can cost hospitals millions in revenue is when Medicare and Medicare Advantage patients' discharge status codes don't reflect the post-acute care received. While these services are outside the hospital's control, the use of customized intelligent automation can greatly improve the reconciliation of post-acute care discharge status codes.

OPTIMIZE REVENUE AND REDUCE LEAKAGE WITH PARAREV SERVICES AND SOFTWARE

Hospitals are projected to lose $54 billion in net income through 2021, according to recent analysis by the American Hospital Association.[8] The reduced income reflects the ongoing effects of the COVID-19 pandemic, including fewer outpatient visits, greater patient acuity, and higher costs for supplies, labor, and medications.

Hospitals and health systems consequently must evolve rapidly to ensure long-term financial health and sustainability. For many, that means adopting new approaches to administrative staffing, revenue cycle management, reimbursement, and pricing to control labor costs and replace lost revenue. Many understand that integrating intelligent automation into the revenue cycle can help optimize the process. However, taking these steps can be challenging due to lack of IT resources and funding.

ParaRev offers a full spectrum of healthcare revenue cycle management services, from front-end charge master analysis and contract management to end-of-cycle zero-balance denial recovery. The Para prefix, which means alongside or parallel, reflects the company's commitment to working seamlessly with hospital financial and billing staff to minimize denials and bad debt, improve collections and boost revenues.

ParaRev has three operational divisions focusing on the core pillars of the healthcare revenue cycle. RevCap, the revenue capture services division, supports primary and secondary AR recovery resolution, targeted denial resolution and zero-balance underpayment recovery. RevTeg, revenue integrity services division, provides contract analysis, coding and compliance services and market-based pricing analysis. RevTek, the revenue technology services group, offers ParaPath, our revolutionary denial decision software, and ParaRev Data Editor, a robust web-based single source solution for pricing, coding, reimbursement, and compliance, along with price transparency, contract management and payer scorecard tools.

ParaRev's comprehensive capabilities, when aligned with hospital internal teams, can help hospitals improve operating margins and collect additional revenue.

INTERESTED IN IMPROVING YOUR AR OPERATIONS AND INCREASING REVENUE?

At ParaRev we've taken intelligent automation to the next step. Our quick demonstration can illustrate the breakthrough benefits of automating over 12,000 payer/provider variables in a single solution, with processes to address and resolve every AR situation automatically. Simplify processes, increase quality restrictions, and provide employees with visual process reminders and automated notes through a comprehensive management solution that improves overall quality and optimizes insurance collections.

To schedule a demo, please click this link and provide a date and time that's convenient for you.

[1] 2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment, KaufmanHall, October 18, 2021

[2] Glen Reiner, "Success in Proactive Denials Management and Prevention," HFMA, May 18, 2021

[3] 2021 State of Healthcare Performance Improvement Report: COVID Creates a Challenging Environment, KaufmanHall, October 18, 2021

[4] Jacqueline LaPointe, Hospital Claim Denials Steadily Rising, Increasing 23% in 2020, RevCycle Intelligence. Feb. 4, 2021.

[5] Jacqueline LaPointe, Hospital Claim Denials Up for Most, Driven by Prior Authorizations, RevCycle Intelligence, Dec. 8, 2020

[6] Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA Resource Library, July 7, 2015

[7] Susan Moore, Moody's: Rising costs will slow hospitals rebuilding margins to pre-COVID-19 levels, Healthcare Finance, Oct. 26, 2021

[8] Report projects U.S. hospitals will lose at least $54B in net income this year, American Hospital Association, Sept. 21, 2021

ParaRev transforms accounts receivable follow-up by harnessing intelligent automation to help hospitals and health systems accelerate cash flow and improve operating margins by resolving insurance claims quickly and effectively.

For more information, visit: www.pararevenue.com/

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