ZERO-BALANCE CLAIMS REVIEWS

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A CRITICAL BACKSTOP FOR AR MANAGEMENT STRATEGIES

As payer rules and coding have become more complex and internal pressures mount to keep accounts receivable (AR) days low, denial rates and resulting write-offs have continued to climb for most hospitals. Between 2011 and 2017, denial volume soared by nearly 80 percent for the average hospital.[1]

The financial impact of these late or foregone collections is significant. Even though 90 percent of denials are preventable, and two-thirds are recoverable, 65 percent of claim denials are never corrected and resubmitted for reimbursement.[2] A recent survey of hospital executives found that 30 percent of facilities had bad debt of between $10 million and $50 million.[3]

AR STRATEGIES FOR AGED ACCOUNTS

Today, in the wake of often-severe cash flow problems triggered by the COVID-19 pandemic and other operational and regulatory challenges, a growing number of hospitals are partnering with third parties to implement comprehensive AR management strategies that can help reduce denials and ensure facilities collect every dollar they're entitled to.

These integrated approaches typically incorporate both internal and external elements: Hospital billing staff focus exclusively on the newest claims, then turn 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 from closed balance accounts.

BOOSTING CASH FLOW WITH ZERO-BALANCE REVIEWS OF CLOSED BALANCE ACCOUNTS

One 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. Thorough, closed-balance reviews can validate claims integrity and maximize contractual revenue for 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 hospitals 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.

FOUR STEPS TO IMPROVING COLLECTIONS THROUGH AN EXTERNAL ZERO-BALANCE REVIEW

Most healthcare systems or organizations typically don't have the time, resources or expertise to conduct in-depth reviews of denied or unpaid aged claims. External reviews consequently can provide the extra scrutiny needed to potentially capture revenue from denied, underpaid and unpaid claims. Zero-balance reviews of closed balance accounts performed by an experienced partner represent a final safety net at the end of the revenue cycle management process, again freeing up staff to concentrate on fresher, higher-dollar claims.

Here are the four primary steps that should be included in a zero-balance review:

1. Scrutinize contracts

Specialists review all payer contractual agreements to identify areas of underpayment risk. This process is conducted in conjunction with hospital contracting staff and attorneys to help clarify the facility's expectations or intent with respect to specific contract provisions.

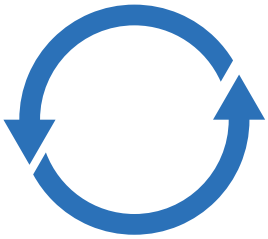
Not infrequently, specialists identify ambiguous language that leaves the facility vulnerable to underpayments or common reimbursement methodologies that can be exploited by payers to reduce reimbursement. Contract problems sometimes can be as simple as a grammatical error or word choice: A clause that should have included 'and' instead of 'or,' or vice versa, depending on the anticipated scenario, can lead to reoccurring underpayments. Language like this may be causing significant underpaid revenue unbeknownst to revenue cycle staff.

Experts also flag any coding changes that may have occurred since the contract was executed to ensure updates have been made and reimbursements continue to be paid at appropriate levels.

2. Evaluate discharge files

After the contract review is completed, zero-balance specialists download a full set of discharge files for a specific timeframe, usually two full years of data for all payers, including Medicare, Medicare Advantage, Medicaid, Medicaid HMO, and commercial carriers. ParaRev processes the data files through a proprietary application that has been custom-programed with each payer's contract specifications.

This process produces an independent payment analysis that isn't reliant on the hospital's contractual expected amounts to identify both underpayments and areas where the hospital's model may be deficient or inaccurate. Given the inherent limitations of existing billing platforms in calculating complex reimbursements—such as payments due from a secondary payer or more accurate outpatient coding—greater accuracy is usually achieved.



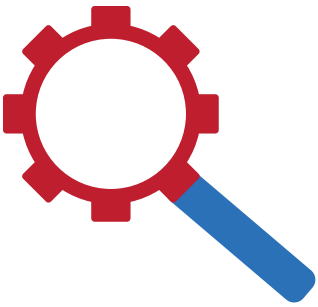
3. Perform an in-depth, 360-degree review

Once the subset of closed accounts is identified for potential additional revenue, an in-depth review is performed to pressure-test the integrity of the claim and the subsequent reimbursement. This step relies on the external team's collective experience to research each claim and maximize the revenue potential unique to that claim and payer, focusing on industry changes, coding best practices, and the contractual intent for each hospital. When accounts are verified through this review as underpaid, ParaRev's experts work with the payers to deliver the additional revenue to the hospital's bottom line.

4. Recommend improvements

From this extensive review process and subsequent trend analysis, recommendations can be made about how hospitals can optimize collections through implementation of coding best practices for specific procedures or drugs. One example: a hospital may not be billing properly for expensive new drugs that are FDA-approved but do not have an HCPCS code assigned. Medicare and most commercial payers have specific, often complex requirements for reimbursing for unclassified drugs, and external experts can help in resubmitting claims with this correct coding to achieve proper reimbursement.

In addition to flagging coding mistakes, the zero-balance claims analysis also identifies payer deficiencies, whether they're one-off events or reoccurring, systemic issues. Working withing appropriate contractual claim and appeal submission timeframes, ParaRev will work with the hospital staff to resubmit corrected claims to the payer, and, in instances when the payer is at fault, bring the problem to the attention of provider relations and help prepare for arbitration if necessary.



A SECOND SET OF EYES

The zero-balance review can produce immediate benefits, in terms of recovered reimbursement on written-off claims, as well as longer-term reductions in inaccurate coding, denials and write-offs. Working in partnership with hospital staff, experts identify process improvements and help implement staff training to reduce and eliminate denial root causes.

Ultimately, zero-balance reviews provide expert oversight to scrutinize the all-important denial arena. This can help produce lasting solutions that improve collections while ensuring optimal compliance. Amid the current challenges in healthcare, this capability helps hospitals not only collect every dollar they are owed, but also allows them to focus on other, equally pressing areas of operations.

ParaRev can help you progress toward the goal of zero-percent write-offs through our comprehensive AR solutions. We're able to resolve all claims, regardless of size or age quickly, and conduct zero-balance claims reviews and root cause analysis to ensure you're collecting every dollar you deserve. Contact us today to learn more.

For more information, be sure to watch the recorded webinar "Zero Balance Insurance AR: Learn how most hospitals are leaving money on the table."

[1] Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018

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

[3] "Bad Debt Exceeds $10M at a Third of Organizations, But Lack of Confidence Exists in How Much is Recoverable," Cision PR Newswire. June 19, 2018.

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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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