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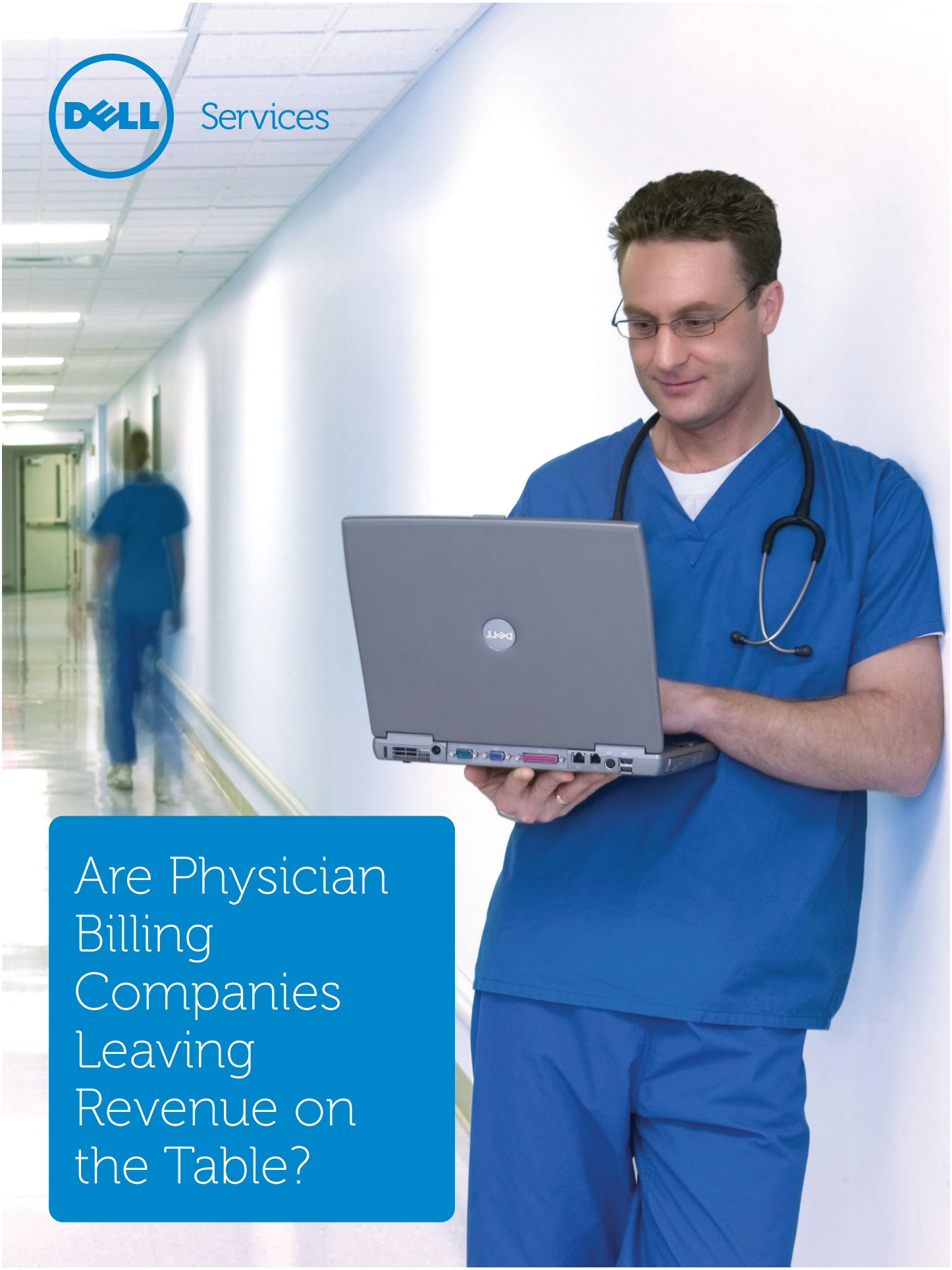

Are Physician Billing Companies Leaving Revenue on the Table?

A critical look at the prevailing payer-provider information environment

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Is automation of the billing cycle by itself sufficient to build a competitive advantage? Why do you continue to see an efficiency gap despite several rounds of automation between Payers and Providers?

This paper looks at these issues and multiple dimensions of the problem, including Accounts Receivables (AR) and Denials Management, which continue to play a pivotal role in improving the practice's revenue. Effective revenue cycle solutions center around a three-pronged approach to process management:

1) Understand the payer-provider environment

2) Build inclusive processes to collect difficult dollars

3) Develop a high-efficiency, lower-cost global delivery model based on predictive workflow processes

Executive Summary

A common perception among healthcare revenue cycle management practitioners, particularly those working on the physician revenue cycle, is that automation of the billing cycle by itself is sufficient to build a competitive advantage. However, even after more than two decades of efforts in automating and fine-tuning billing processes, there is still a substantial efficiency gap between payers and care providers. Many of these issues can be attributed to fundamental conflicts in the operational, strategic, and even political focuses of these two industry groups.

Not for a moment are we implying that process automation is a flawed strategy, rather our contention is that automation alone is not enough. Efficient revenue cycle processes also require proper management of operations based on industry best practices. Revenue Cycle Solutions providers working on the physician side should typically use a blended approach to help their customers process and retrieve revenue from claims.

The Payer-Provider Environment: Providers should be cognizant that they work in an environment that has partially contradictory goals to their counterparts, the payer organizations. The implication of this, as any AR manager will attest, is that there are leaks, even in the best automated provider-payer communications processes, that need constant attention through the AR management function.

Recovering the Difficult Dollars: As more processes get automated, a natural hierarchy of the dollars to be collected is formed. The more difficult dollars at the top of what can be described as the receivables pyramid and are often hard to tap, while dollars at the bottom of this pyramid tend to flow in more easily using current automation levels. While recovering the easy dollars is good, it is not sufficient. Logically, while most operations are built to focus on the bottom of the pyramid, the most successful practices involve advanced workflow processes to address the more difficult dollars at the top. It is most often how well revenue is retrieved in this delta that defines the difference in success or failure.

Global Delivery Model (GDM): Finally, deploying collection resources through a Global Delivery Model (GDM) can move an organization closer to optimizing efforts and collecting more of what is due in an efficient and cost-effective manner. The best approach is to balance GDM resources alongside proven processes. Simply stated, AR management systems that do not take advantage of a GDM model will probably incur added labor expenses and a GDM approach that does not leverage advanced workflow processes will wear down the arbitrage benefits over a period of time.

The Historical Perspective

The physician revenue cycle industry was largely paper-based just 10 years ago. However, over the past decade in a move towards automation, electronic submission of health insurance claims has more than tripled - and the percentage of claims that providers submit within the first week after service has doubled.[1] In addition, the percentage of overall claims received electronically had grown to approximately 40 to 60 percent in a 2007 study. It seems safe to say the number would be even higher today.[2]

These trends have been followed by an increased adoption of automated Electronic Remittance Advice (ERA), which drastically reduced payment posting time, and the error rate came down to less than 2 percent compared to the traditional 25 percent. It is estimated that 93 percent of providers will be able to receive payments through ERA by the end of 2009.[3]

In more recent times, these two distinct waves of automation have been followed by a third wave, Electronic Funds Transfer (EFT). EFT has further reduced the procure-to-pay cycle time in the healthcare industry and in doing so, has drastically reduced check-processing time and related errors.

The past decade can be considered as the period of intense collaboration through automation between providers and payers. It is easy to imagine that these advances have drastically reduced unpaid claims and therefore, reduced the labor-intensive AR and Denial Management functions. Even with these positive advances, some of the stinging realities that still prevail in the industry are:

- **A payment gap continues to exist between payers and providers:** Because of factors intrinsic to the payer business model, payers are not sufficiently motivated to bridge the gap more than what may be absolutely necessary because to do so could have a negative impact on their short-term financial performance.
- **AR management continues to play a pivotal role in maximizing revenue:** Since each phase of automation-based improvements reach a natural threshold of performance based on payer-driven constraints (and motivations), it is natural that management approaches will continue to evolve and increase in complexity to drive future efficiencies through the AR function.

- **Leaving money on the table:** When physician Revenue Cycle Solution (RCS) provider companies cut resources too severely on AR management, it often leaves a large pool of receivables uncollected, which creates a tangible revenue loss for their customers.

Cause Analysis

Physician RCS companies have traditionally put all their eggs in the "next wave of change" basket, such as HIPAA-driven automation, dot-com environments, and payer reforms. By looking for the next trend, they focus on the forest and have lost sight of the trees. In other words, physician RCS companies are looking towards the long-term direction of the industry to solve problems that are best addressed using a sound day-to-day operations strategy.

This big picture view disregards everyday realities and can only be considered as myopic. The industry-level changes that they continually seek will not take place any time soon (if at all) due to many key factors as discussed below.

Provider-Payer Strategic Conflict

The first error lies in the assumption that providers and payers have the same strategic goals. Though it is true that both camps aggressively pursue operational efficiency to reduce costs and improve their bottom line, closing the billing-payments gap really only benefits the providers. This is because when payers decrease revenue cycle time and settle claims faster, the value gained in greater efficiency is eroded through reduced cash on their balance sheet. In a world that is run on short-term results for key business stakeholders, the high cost of liquidity due to aggressive payment of claims could be suicidal for payer companies.

Provider Manual Processes

Secondly, even with gains in automation over the past decade, claims processing continues to require a large element of manual intervention. In addition, many claims are notoriously subjective because of archaic data collection methodologies and confusing approval requirements as defined by payers.

These one-off processes are subject to error at multiple points as shown in the following Figure 1 Manual Processes in the Provider Revenue Cycle.

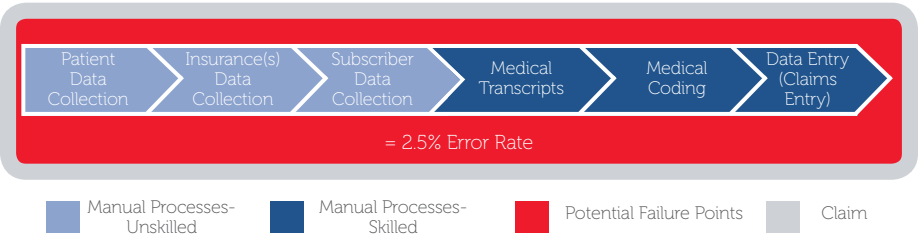

Figure 1 Manual Processes in the Provider Revenue Cycle

Payer Complexities

It is estimated that the overall healthcare transaction exceptions rate is 20 to 40 percent versus only 1 percent in retail.[4] Healthcare transactions include a myriad of activities required to successfully process a service rendered by a provider (examples: eligibility verification, terminology standardization, submission of proper forms, claim adjudication, payment).

Slowdowns and exceptions can result from any of the following:

- Lack of transparent claims adjudication documentation from the payers
- Rapidly changing rules in payer adjudication related to codes and plans
- Plan and coverage changes of the beneficiary based on job and location change
- Changing national and state regulations around payment for procedures

The first two points are highlighted from the findings below.[5]

Category	Payer Ranked #1	Payer Ranked #10
First Pass Rate	96%	92%
% Patient Responsibility	2%	9.9%
Denial Rate	5.3%	9.3%
% Non-compliance w/CCI	0.2%	1.2%
Denial Transparency	87.1%	79.4%
% Claims Requiring Medical Documentation	1.6%	2.4%

Figure 2 Relative Performance of Payers Source: athenahealth PayerView

A quick review of the data above highlights three key trends:

- There is a sizable performance gap between payers ranked #1 against those ranked #10 indicating that the numbers get progressively worse at a steep rate below the top ranked payers.
- The figures reflected in the Top 10 among more than 2000 insurance companies do not inspire confidence that the overall provider and payer segments are working in the same direction.
- Apart from patient responsibility, all the categories listed above require the AR management function.

Barriers to Solving the Problem

It is important to understand why practices and billing services have traditionally looked to improve their electronic claims systems, along with increasing their ERA and EFT rates. Most practitioners would agree that electronic communication in the claims processing cycle reduces manual intervention, which decreases errors, improves cycle times, and reduces costs. Although the focus of the industry lies in receiving and sending claims electronically, it is obvious that sending clean claims and receiving electronic payments is only half of the solution.

The other half of a successful revenue cycle program involves AR management techniques to work through claims that were filed, but did not get paid, such as pended claims and denied claims. While some practices are still looking to severely curtail or eliminate the AR management function, in doing so they are creating several complicated operating issues for reasons outlined below:

Paper Seen as the Enemy

The premise behind driving automation into the revenue cycle is that when paper becomes electronic, errors are eliminated. This is true until you consider the contradictory payer-provider environment. The assumption that eliminating paper and automating processes eliminates bad AR is not accurate for the simple reason that manual errors are a relatively small portion of the equation with well-run operations showing a less than 1 percent error rate – in reality pended and denied claims form the larger challenge.

Analytics - The Lonely Ally

Physician RCS companies have invested heavily in technology to provide in-depth analysis of denials and have built dynamic processes to autocorrect denials for similar future claims. While this approach is highly logical, unfortunately it has not made the desired impact on denial rates because of a highly volatile and dynamic environment where the rules are not visible and change often, and where each patient account and treatment has nuances beyond automation.

Expensive Labor and Skills Shortage

AR and denial management labor is expensive and the required skill sets are often in short supply at physician practices or RCS companies. Labor resource shortages are a primary reason why provider representatives are forced to look at other options.

Justifying AR Management Expenses

While it is true that AR management processes add to the provider's costs, they are necessary as well. While there may be a temptation to assign AR management functions a priority down the ladder, to do so significantly dilutes revenue cycle effectiveness. It is easy to see that strong AR management practices have a direct implication on revenues, especially to help counteract conflicting industry goals, along with the continuing manual nature of working through claims creation and payer complexities. Therefore, the mandate should not be to dilute or eliminate AR management work, but rather to find creative and cost-effective ways to work the claims with greater efficiency and stronger results.

Mandate for Provider Billing Companies

Industry figures show that it takes an average of 2.8 billing cycles[6] (the number of times a claim is sent before it is zeroed out), to get a claim paid. While this number seems high at first glance, it is believable when evaluated against the context of three primary reasons for claim disconnects:

1. Strategic conflict
2. Manual processes
3. Payer complexities

The first step to enhancing collections is to be aware of the factors that create delays -- any aging report beyond 30 days and going into 250 days would serve as proof points to these realities.

Understand the Problem

It is imperative that each RCS company performs its own study of the payers they deal with on a regular basis. Denial reasons are different each year. Denials vary by plan and year, coding rules change, and submission guidelines are often incomplete, do not exist, or are dynamic in nature. The list could go on and on. The key point is that fixing denial categories one at a time will not produce picture perfect receivables. If it did, RCS

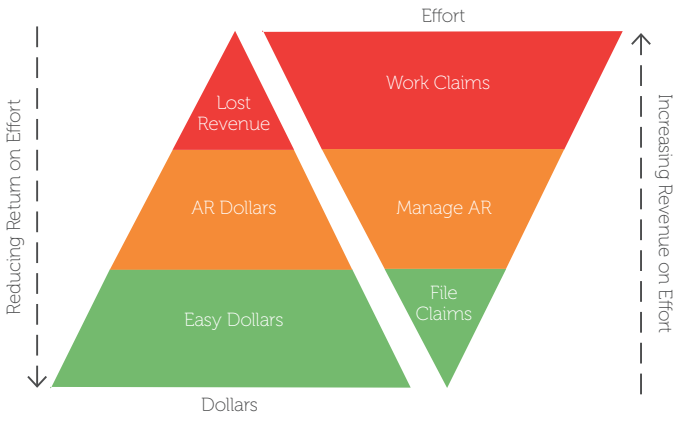

Figure 3 The Inverted Pyramid- What Truly Increases Revenue?

"Denial reasons are different each year. Denials vary by plan and year, coding rules change, and submission guidelines are often incomplete, do not exist, or are dynamic in nature."

"It is the ability to build strong and smart processes at the top of the inverted pyramid, symbolizing effort, which squeezes AR to maximize cash collections."

"...in today's challenging economy, the extra funds collected may be the only ones available to invest for needed quality-of-care improvements in the practice."

companies would be out of business since each problem could be progressively automated and eliminated. It is important for all stakeholders in the physician billing process to understand that problems lie only partly in how claims are sent. An equally important part of the process is how claims are worked.

Shift Focus to the Difficult Dollars

As discussed, automation between provider and payer offices is just one aspect of the solution, which provides a strong basis at the bottom of the pyramid to collect what we are calling "the easy dollars." To address the middle portion of the pyramid requires building an analytical engine along with AR management processes that bring the organization closer to its target goals. Even with those systems in place, there is still a considerable amount of revenue left at the top of the pyramid when an RCS company stops after only collecting the most accessible dollars half way up the pyramid. Reaching the top of the pyramid requires additional work to get all or most of the claims collected.

The balance of effort that goes into squeezing out extra receivables can be seen as an inverted pyramid as shown in Figure 3. As is evident from the diagram, while returns may diminish towards the top of the revenue pyramid, they are still highly profitable if collection effort expenses are in equilibrium to return.

Traditionally, RCS companies lose revenue at the top of the pyramid because their organization is built to focus on and retrieve the easier AR dollars. It is the ability to build strong and smart processes at the top of the inverted pyramid, symbolizing effort, which squeezes AR to maximize cash collections.

In other words, systems and processes need to be built from top to bottom with an eye on the tough dollars rather than from the bottom up with a myopic eye on the easy dollars. Just about any operations or finance manager knows that the last few percentage points on the collection continuum often make the difference between profitability and loss, and possibly even survival. In addition, in today's challenging economy, the extra funds collected may be the only ones available to invest for needed quality-of-care improvements in the practice.

Work the Claims

While analytics are extremely important to organizing data in meaningful ways, the importance of analytics is directly related to productive action taken. In the medical billing environment, one key measure of effective technology is a function of the tangible business results achieved through analysis. A provider or billing company can have a dynamic mechanism for corrective action for future claims, but this automation offers no guarantee of the desired result (such as reducing denials) because they are up against a moving target in terms of payer rules.

When the right workflow process is added to the analysis function, a claims management team can synergistically combine elements to make a dramatic difference in the company's collections success. A disciplined Claims Follow-up Cycle as indicated in Figure 4 plays a key role.

Workflow Process

While technology is still used as a foundation process tool, contributing factors including current industry conditions and people-based skills are the context to optimize resources and maximize revenues. In other words, technology is much less an analytical tool and more a real-time predictive tool to ensure that the wrong accounts get into the right hands at the right time through a series of algorithms. Accounts, based on payer, plan, CPT code, diagnosis code, modifier, and a myriad of other factors carry a high-risk index (difficult dollars) and are routed based on similar predictive indicators to the appropriate resource defined by training and experience.

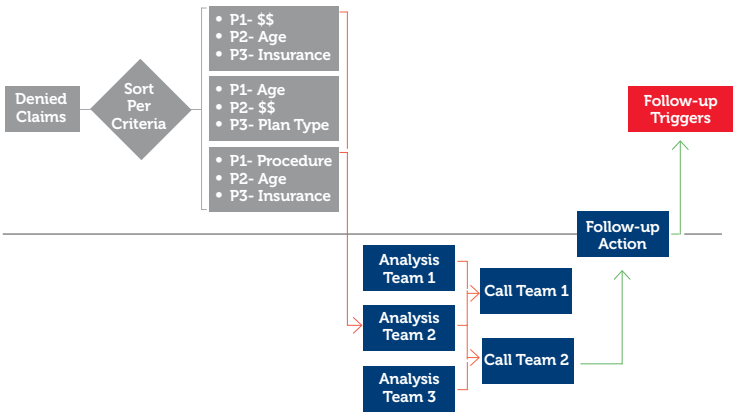

Figure 4 Claims Follow-up Cycle

Global Delivery Model

Combining technology and talented resources is especially advantageous within the framework of a Global Delivery Model (GDM) where frontline technology-based expertise and project management services can be leveraged in the U.S. combined with extended workforce resources provided from cost-advantaged locations. A balanced and effective GDM is an important strategy because the costs required for meeting the goal of collecting the "difficult dollars" is far more palatable when delivered with less expensive labor. By contrast, solutions that solely require investments in a local workforce face the issues of high labor costs and even, possibly, a shortage of the required skills. In addition, when labor is cheaper, there is far greater flexibility to invest in pursuing the "difficult dollars."

Focus on the Right Areas

We have discussed several intrinsic issues that will continue to create revenue cycle challenges:

- There is a definable conflict in goals between payers and providers that make AR, denial management functions, and payment delays an integral part of the revenue cycle process.
- Although much progress has been made in electronic automation, provider processes often remain manual by nature, a challenge which can only be overcome by combining technological, financial, and political change in the insurance industry.
- Payer payment policies continue to remain dynamic at best and nearly non-existent in many situations, and billing companies have to equip themselves to work through these challenges.

- Providers and their billing representatives should continue to focus on increasing their effectiveness through process engineering and analytics, while understanding that some efficiency threshold points are being reached.
- Analytics through automation has its limits and does not fully equip providers to eliminate denials.
- Labor shortages and associated costs do not justify leaving revenue on the table for both the provider and their representatives.

Summary

It is important for physician billing companies to change their perspective on the issues surrounding claims collection that they face and act accordingly:

- It only makes sense for billing companies to understand that they are up against a dynamic industry with conflicting goals between payers and providers.
- Billing companies should build an operations model that includes targeting and collecting the difficult dollars since the technology and processes to bring in the easy dollars are already in place.
- Automation of AR management processes provides opportunities to work more claims under a tighter schedule to improve Days in AR and collection percentage, the two most important performance indicators in the industry.
- A real solution to improve the nature of payer operations is to work claims through a mature, automated, transparent GDM that helps answer the labor costs question.
- If your organization is not equipped to build your own GDM and accompanying workflow processes, it may be worthwhile to consider a Revenue Cycle Solutions provider who can help.

In conclusion, an effective revenue cycle program should balance:

1. Understanding the payer-provider environment
2. Building processes designed to also collect "difficult dollars"
3. Using a high-efficiency, lower-cost GDM

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As today's healthcare reimbursement system becomes more complex, the bottom line is to achieve prompt and appropriate payment for services. In this context, a well-performing revenue cycle process is vital and improvements are critical to success.

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- Customized solutions that combine on-site and off-site staff to ensure maximum cash recovery, quick resolution, and a successful conversion process
- Best practice processes and metrics for lasting improvement in revenue cycle performance
- Long-term relationships that provide cost predictability, results, and risk-sharing
- Higher returns on investment as a result of one of the highest recovery rates in the industry
- Measurable and sustainable improvements with revenue cycle key performance indicators

From insurance eligibility to cash collections to a full receivables management program to denial management, Dell Services works side-by-side with each customer to achieve sustainable results.

About the Author

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Satish Ponnaiya has more than a decade of experience in provider services delivery operations. Satish is responsible for evaluating market trends and developing the strategic vision and roadmap for the global Dell provider services delivery team. He is responsible for developing innovative products/service offerings for our provider clients and driving internal process efficiencies through resource optimization and application of automated methods. In addition, Satish provides guidance to the development of our training plan, sales support operations, and developing thought leadership on provider processes.

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