

automating claims management improves revenue cycle

Web-based technology can help healthcare organizations manage claims and internal workflow processes more efficiently.

Ensuring that payers cut checks for services rendered has become an increasingly challenging task. The complexity of the payment environment has prompted many providers to employ innovative strategies that enhance revenue cycle management. Hawthorn Medical Associates (HMA), based in Dartmouth, Mass., has turned to automated, web-based technology to enhance claims and remittance management, while streamlining related internal workflow processes.

AT A GLANCE

- > One healthcare organization was able to improve revenue cycle operations by automating its claims management.
- > Using web-based technology enabled the organization to streamline internal workflow processes, redeploy staff, and reduce overhead costs.
- > As a result, cash flow increased 7 percent, and A/R days dropped 16 percent.

The results have been impressive. Cash flow is up 7 percent, while denials and days in accounts receivable (A/R) are down about 26 percent and 16 percent, respectively. In addition, HMA has been able to redeploy staff and cut overhead costs associated with traditional billing and accounting functions.

Situation: Lost Claims Equal Lost Revenue

For many years, HMA relied upon a legacy clearinghouse for claims submission, but leadership grew increasingly frustrated with the vendor's limitations.

Primary among these concerns was the clearinghouse's inability to file electronic claims with one of HMA's top three payers. This deficiency slowed payment and led to an unacceptable number of denials because the payer would report it had no record that certain claims had ever been received. Without electronic tracking and confirmation, HMA could not prove timely submission, so thousands of dollars in legitimate fees remained unpaid each month.

Reporting capabilities were also inadequate. The vendor lacked the functionality necessary to compile and summarize information vital to strengthening the bottom line. For instance, claim denials were contained in paper explanations of benefits (EOBs), which the clearinghouse provided in batches on a payer-by-payer basis. To uncover practicewide trends that affected claims submitted to all insurers, billing staff would need to manually review each EOB, extrapolating discrete pieces of data. This time-consuming approach greatly hindered HMA's ability to analyze its own performance and uncover strategies for improved accuracy and productivity.

The manual process also caused a tremendous lag between the time HMA submitted a claim and when it received information about a denial—often 30 to 60 days. The billing office would be unaware of problems during the interim and could begin the appeal process only after receiving the EOB, which further prolonged the payment cycle.

Because HMA depends upon complex manual processes, managers also found supervision of accounting and billing staff difficult. Department heads were not able to readily monitor the volume of claims that needed to be reworked or the numerous appeal letters that needed to be drafted, for instance. They were, therefore, unable to evaluate staff productivity or success in capturing outstanding payment.

Assessment: Determining a New Direction

As part of a comprehensive reorganization of the central billing office in early 2006, HMA determined it needed to evaluate the relationship with its clearinghouse, and investigate alternatives to improve operational and financial performance. During this period of assessment, leadership focused on two primary areas: technology systems that facilitated the electronic transfer of claims information, and current workflow processes that either contributed to or impeded efficient revenue cycle management.

Technology considerations. Initially, leadership tended to simply adopt a more sophisticated practice management system, utilizing advanced functionality to produce cleaner claims. After a review of top systems, however, the practice remained unconvinced that such a system alone would fully correct the problems it was experiencing or support aggressive efforts to optimize revenue.

The root of the principal problem—lost and delayed claims—lay with limitations in clearinghouse functionality. The vendor was able only to move data during electronic transactions, but could add no value to ensure the content of the data was formatted or reported correctly. This problem

would remain as long as HMA relied upon the same clearinghouse.

Workflow processes. During its analysis, HMA uncovered tremendous inefficiencies in workflow. The lack of easily accessible information meant the billing/accounting department was mired in paperwork and

ever-changing payer policies and coding edits. Medicare revises its edits quarterly, while private payers can institute changes even more frequently.

Action: Making the Transition

Following this assessment, HMA reviewed industry literature and networked with col-

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manual processes:

- > Since some claims could not be transmitted electronically, staff members had to complete paper claims forms manually.
- > The absence of simple reporting functionality meant select employees were required to don a detective's hat—uncovering reasons that individual claims were denied and backtracking with clinical staff to find information that might make the claim payable upon resubmission.
- > Even after gathering additional data, staff members had to invest significant amounts of time writing appeal letters, which also contributed to payment delays.
- > Staff members devoted considerable time to identifying internal patterns that contributed to denials—receptionists at the front desk repeatedly entering insurance data incorrectly, for instance, or physicians forgetting to add necessary modifiers on procedure codes.
- > Several staff members were charged with periodically going through EOBs from all payers and compiling reasons for denials. They then pulled together reports manually to assist HMA in pinpointing departments or individuals that might need further training and supervision. Finally, HMA assigned several staff members exclusively to keeping current on

leagues to arrive at a better approach. These activities introduced top management to the concept of web-based revenue cycle management solutions, which offer real-time access to claims status. The dynamic nature of the technology provides up-to-the-minute reports and allows billing managers to mine relevant data based on a wide range of variables.

After comparing the two approaches, HMA decided not to move forward with a planned \$2.5 million practice management system upgrade. It instead invested these resources in web-based revenue cycle management technology on a “per physician/per month” basis.

Making the transition to the web-based system meant a lower upfront capital investment and less disruption to workflow than installing new practice management hardware and software. HMA estimates it saves \$200,000 or more a year in costs that would have been associated with a system hosted on-site.

HMA contracted with its new partner in March 2006 and was fully operational within six weeks. The practice supplied payer and provider data to the vendor,

which then guided the transition with virtually no disruption to cash or workflow. All training was provided online. HMA identified “super users,” who were given advanced instruction and who, in turn, trained other staff members.

Upon implementation, HMA reorganized the billing and accounting departments, redeploying billing staff or eliminating positions, as appropriate. The reorganization allowed HMA to reduce FTEs from 48 to 30 during 2006. Nine of these positions, representing an annual expense of \$500,000, are directly attributable to implementation of web-based revenue cycle management.

Some staff members were initially hesitant about making the transition to a web-based system. Even though they had been using an electronic system, they were intimidated by the concept of performing a greater percentage of their job in cyberspace. Others were understandably concerned that greater reliance on an electronic process would mean their positions would be eliminated, which indeed occurred in some instances.

Staff also recognized they would be held accountable for financial performance in a different way. Volumes of data—about denied claims, follow-up activity, and write-offs, for example—that had been previously unavailable would be easily accessible to supervisors and managers. HMA leadership determined that it would benchmark performance in many of these areas and establish targets for improvement. Natural human resistance to change was heightened when staff realized they would be held to new, quantifiable standards.

Results: Reaping the Rewards

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Within weeks, HMA came to the conclusion that its clearinghouse approach to revenue cycle management was more antiquated than it had realized. One member of the management team likened the transition to moving from a dial-up Internet connection to DSL.

The practice was immediately able to transmit claims electronically to all payers, which significantly reduced delays and denials. Information that was previously inaccessible was delivered to staffers’ desktops in real-time so they could correct problems immediately. As a result, HMA’s claim denial rate dropped, almost immediately, from 10.5 percent to 7.8 percent.

Claims with incorrect information hit an edit upon submission to the revenue cycle management vendor, and were instantly returned to the billing staff for review and correction. Because billing staff was immediately alerted to potential problems—often before the claim was actually forwarded to the payer—they could review the information, check with administrative and clinical personnel to ensure accuracy, and make appropriate corrections. Instead of waiting 30 days to 60 days for an EOB and then reworking the claim, HMA staff could turn denials around in 72 hours or less.

The availability of denial information provides value to HMA beyond immediate claims submission considerations. Aggregate data that disclose ongoing problems and internal bottlenecks have helped the practice improve internal processes—in

both the clinical and administrative settings. Errors can be traced to personnel who handled the claim. If a member of the front office staff repeatedly fills out patient demographic data incorrectly, supervisors can intervene and provide additional training. Likewise, if a specialist continually overlooks frequency limitations on certain diagnostic tests or studies, physician leaders can produce documentation about billing regulations and offer direction about what conditions must be met to justify billing the service rendered.

HMA also has improved its efforts to collect payment from secondary payers. Processing and filing secondary claims was traditionally a time-consuming and tedious task. Billing staff were required to retrieve and copy paper remittance, manually highlight relevant patient data, and cross out information unrelated to the secondary payer before submitting the claim. Although still not seamless, the new system has improved the process by allowing HMA to extract relevant data from electronic remittance advice to create a customized “mock” EOB for the secondary payer.

Streamlining these aspects of revenue cycle management has produced significant improvements in HMA’s financial performance. Net gains include an increase in cash flow of 7 percent and a reduction in A/R days from 36.89 percent to 31.09 percent.

Lessons Learned

Three areas are vital to successful adoption

HMA REVENUE CYCLE IMPROVEMENTS AFTER IMPLEMENTING WEB-BASED CLAIMS MANAGEMENT

Metric	Traditional Clearinghouse	Automated Revenue Cycle Management	Change
Denial rate	10.5%	7.8%	-25.7%
Billing staff/FTEs	48	30	-37.5%*
Days in A/R	36.89%	31.09%	-15.7%
Cash flow	Proprietary	Proprietary	+7%

*Saving \$500,000 per year.

of revenue cycle management technology.

Relationship with the vendor. It is important not only that key practice staff develop a good rapport with the implementation team, but also that practice leadership have access to the vendor’s senior-level managers. Implementation of revenue cycle management affects a broad range of work processes, many of which are unique to the practice. HMA worked closely with top developers and executives to ensure that the new system fulfilled its requirements as closely as possible.

Upfront workflow analysis. Bringing an entirely new system on board affected every aspect of HMA’s revenue cycle—from front desk through collections. This meant staff

members were often required to make adjustments to their day-to-day workflow as it related not only to the revenue cycle management system, but also to other technologies (such as the existing system). Taking time, in advance, to review workflow and project what changes might be necessary can make the transition smoother—and can speed ROI.

Identification of required “business intelligence.” The new system offered HMA the opportunity to extract greater volumes and greater varieties of data about each stage of the revenue cycle. It is important to understand what types of analysis the practice wants to conduct from the onset. This knowledge allows the vendor to develop specific reports that will deliver the desired

information from day one.

Leadership at HMA is delighted at the financial and process improvements that have resulted through implementation of automated revenue cycle management technology. This innovative approach has enabled HMA to post charges, receive and resolve denials, and ultimately get paid much more quickly. ●

About the author



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About Navicure

Navicure is a leading provider of Web-based account receivables management solutions that help physician practices increase practice profitability through improved claims reimbursement and staff productivity. Serving thousands of physicians in practices nationwide, Navicure’s solutions automate receivables processes, including patient eligibility verification; primary and secondary claims reimbursement; rejected and denied claims management; electronic remittance posting; claims and remittance reporting and analysis; and patient statement processing. Based in Duluth, GA, Navicure was ranked #1 among the *Deloitte Fast 50* in 2007. Navicure was ranked 40th nationally among the 2007 *Deloitte Fast 500*. For more information, please visit www.navicure.com

