Key Strategies for Containing Days in A/R

hfma healthcare financial management association

Maintaining efficient billing and claims management processes is key to controlling accounts receivable (A/R) days and supporting strong cash flow. Yet all too often, the many hand-offs needed for accurate and timely payment suffer from inefficiencies, such as gaps in process, misdirected workflow, or bottlenecks. With this in mind, this HFMA Roundtable, sponsored by Recondo, highlights areas hospitals should target as they shape their A/R strategy, including reducing manual workload and learning from denials.

What are some of the biggest challenges in managing A/R days? What strategies are you finding useful to address them?

Timothy J. Reiner: One factor putting pressure on A/R days is our demographics. Adventist Health System has 45 campuses in 10 states, but most of the facilities are located in Florida and serve older populations. As a result, Medicare is a large portion of our business portfolio.

Medicare has begun performing prepayment audits for a third to a half of patients who undergo certain types of procedures, such as joint replacements or spinal surgeries, and it is holding payment until a full chart review has been completed. Medicare used to be one of the quickest payers to remit, paying between 17 and 21 days from submission of a clean claim. Because of the prepayment review, Medicare claims now pay in about 95 days.

The growth in the self-pay portion of our portfolio is also affecting days in A/R. Increasing numbers of patients have Medicaid or some other commercial coverage purchased on an insurance exchange. In addition to the traditional focus on collecting higher dollars from insurance companies, the revenue cycle has had to manage out-of-pocket copayments and payment balances for this new group of patients.

A strategy we are employing to respond to Medicare's prepayment audits coincides with our efforts to avoid appeals. We are focusing heavily on making sure we have the complete clinical picture for a patient before or at the time we schedule a procedure, including medical record information from physicians and surgeons. In the event we may be audited for a joint replacement, for example, we are proactively obtaining office notes from surgeons documenting the conservative therapies that were done prior to ordering a joint replacement.

Tools such as online patient portals, patient registration kiosks, and online payment capabilities are controlling the costs of collecting the patient portion of outstanding dollars. With these types of options, Adventist Health System has been able to add approximately $150,000 per month in patient payments and saved $0.06 to $0.10 on every dollar by avoiding assignment to a collection agency.

PARTICIPANTS IN THIS HFMA EXECUTIVE ROUNDTABLE

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Frances Voelker is senior director of accounts receivable, UPMC, Pittsburgh, Pa.

Frances Voelker: Managing A/R days is challenging because all aspects of the billing and claims management process need to be efficient. Eligibility and authorization information has to be up-to-date and current. The claim needs to be as clean as possible. Coding must be done promptly and compliantly. Prebill editing must be built in for various items.

UPMC has a suite of solutions that handle eligibility and authorization, coding, claims, transaction services, and denials for its 20 hospitals. These solutions have reduced days in A/R greater than 90 by 81 percent and reduced eligibility denials by 85 percent. The automated functions have cut the costs of billing and collection without reducing account volumes or revenues. In 2005, when UPMC centralized the business office and installed automated technology, the total number of FTEs was 452; at the end of FY 2014 it was 360, and most of the employees were absorbed in other parts of a growing organization. Net patient revenue per FTE in that time period grew from $5.9 million to $13.8 million.

What role is workflow automation playing in improving A/R management efforts?

Voelker: Automated processes simplify or eliminate routine manual operations. The electronic eligibility system, for instance, obtains benefits information from the payer's website, includes 270/271 EDI data, and verifies benefits information electronically. It processes more than 50 percent of cases automatically and brings back to the staff only those cases that require attention. If the patient's eligibility is clean, then no FTE needs to touch the claim. The system links directly with the payer's portal whenever there is an issue regarding authorization for service. Therefore, no FTE needs to enter payer portals to check on authorizations.

Brandon Childs: Many hospitals are focusing on their payer follow-up activities to improve staff productivity and reduce timely filing write-offs. In the past, hospitals would wait 30, 45, or 60 days for remittance advices to come back from payers and be posted to staff for follow-up. Today, many providers staff up to manually check payer websites for claim status. More progressive business offices are leveraging automated claims status checking using the actionable data from payer websites to drive "no touch" and "low touch" processing within their workflow tools.

Voelker: Our automated claim status system pulls information from the payer's portal that is more detailed than standard HIPAA ANSI 277 responses. So instead of getting a high level and vague ANSI 277 notification that "additional information is needed," the claims status system identifies what information the payer needs. If the payer needs an itemized bill, then the system can automatically pull the bill from our host health information management system and send it back to the payer through its portal. The same can be done with medical records requests. No staff member actually has to touch these types of claims, and requests for itemized bills or medical records can be fulfilled the same day they are received.

Sarah Knodel: Technology also plays an important role in automating core revenue cycle processes to improve performance and reduce expenses. Providers must develop exception-based workflows, where only accounts that truly require intervention will be worked by an employee. As an example, we have implemented claim statusing technology into our third-party collection workflow tool to reduce the number of manual phone calls being made to insurance companies and the amount of time collectors would spend logging into individual payer websites to obtain claim status. The screen scraping technology that has been integrated into our tool pulls detailed claims status information, and the status is cross-walked to a table we built that determines whether the account needs to be brought back for immediate review by the collector or if it can be pushed out for follow-up. With this automation, if a claim has been paid but payment has not yet been posted, then the claim never populates the collector's work list because there is nothing actionable to do. If the claim has been denied, then it is posted on the collector's work list immediately. If additional medical record information is needed or if there is some type of coordination-of-benefits question for a patient, then the system populates the account on the collector's work list for follow-up. Based on the specific current claim status, the logic in the system then prioritizes accounts, noting those that do not need to be reviewed right away as well as those that may benefit from review and intervention earlier than might normally be received. This automation, coupled with other process and technology improvements, has enabled us to reduce more than 60 FTEs in the business office while also continuing to meet our cash-collection goals.

April Langford: Even a hospital or a physician group that does not have the technology to link with payers' portals can benefit by having lower-level clerks process requests for itemized bills and letting experienced A/R staff work on the more difficult accounts.

What processes have you implemented to ensure the earliest notification of denials, and how are you learning from the denials loop to improve A/R efficiency?

Voelker: Because of the ability to automatically determine claims status, UPMC is able to start working denials as soon as one day post-billing. Rather than waiting 30 to 45 days for payer remits to be posted, staff can begin to correct internal issues immediately and prevent other claims that might be denied for the same reason.

With detailed information about the reasons for denials, we are able to evaluate very quickly where we have issues and how we can work better to get cleaner claims. We are always looking to push edits up front and make sure claims are correct the first time. We summarize and report information about denials on a monthly basis not only to individuals within the revenue cycle but also to heads of departments so we can work together as partners to resolve billing issues.

Reiner: The lack of standardization in the remittance codes on EDI 835 transactions makes it difficult to learn from denials. Even if the root cause of a denial is the same, payers often use different remittance codes or ways of describing the underlying problem. At Adventist Health System, we are attempting to normalize the information about denials in remittance codes after the fact. We have created a set of 42 root causes for denials, and we tag every denial with one of those reasons. Tagging them this way allows us to go back, irrespective of the source payer or patient's insurer, and begin an analysis that seeks to find and attack the problem where it originated.

Knodel: At the beginning of each month, a report is distributed with a detailed listing of all accounts by denial write-off type (e.g., medical necessity, lack of precertification, level of care, timely filing). We have an accountability structure for researching denials that result in write-offs. Each of our hospitals has its own denials write-off task force meeting, where leaders from related functions (access services, health information management, utilization review, and centralized business office) present the top 10 to 15 accounts within each category. The task force analyzes the root cause for the denial, so processes can be put in place to avoid recurrence in the future. A corporate task force also exists to ensure trends are discussed at the system level to identify common themes that may be impacting all facilities.

Childs: When you receive claims status within a few days of claims submission, you can work exceptions much earlier in the process to drive down A/R days. And when you receive a normalized reason for the denials—for example, need for an itemized bill, authorized days exceeded, undocumented medical necessity, and so forth—you can automate assigning work queues to staff that specialize in the area for follow-up.

Reiner: We are working on a more codified appeals process that standardizes the way we distribute workloads for submitting appeals. We have three levels of appeals and organize workflows to make sure we are doing everything we can to repair denials. With the first level of appeal, for example, we place time frames around the steps that should be taken to ensure we have an audit trail of how we submitted the appeal and when we followed up on it. If we send paper documents, we log the carrier and method of delivery of the appeal and track receipt of the package. If a payer allows the first level of appeals to be done online, then we record when we requested and how we tracked reconsideration of the denial on its portal.

Knodel: Similar to other organizations, Baylor Scott & White Health has dedicated clinical resources to help with appeal writing when denials occur. We have a denial resource center that is staffed with a paralegal, collections staff, and 13 nurses—some of whom are certified coders. This department has been highly successful at working to overturn millions of dollars in denials and is also instrumental in gathering information to provide upstream education to prevent future denials.

How can hospitals and health systems better work with payers to reduce A/R days?

Voelker: UPMC revenue cycle leaders meet with major payers on a weekly, biweekly, monthly, or quarterly basis. In these meetings, we review data that may help streamline the billing and payment processes and cut

costs. For example, when one payer routinely asked for medical records, we were able to show that medical record review in 90 percent of instances did not add meaningful information to claims review.

Knodel: Baylor Scott & White meets quarterly with most payers. These meetings include representation from our managed care department and from the revenue cycle leadership team. Additionally, if we have problem claims, particularly involving our larger payers, we prepare a spreadsheet that categorizes the claims according to certain criteria, such as dollar value or time in A/R. The spreadsheet shows payers where accounts are falling outside the expected payment time frames and focuses our discussions on how these issues may be resolved more smoothly. The goal within the revenue cycle is to share information with payers in a systematic way to make the payment process as smooth and efficient as possible and ensure controls are in place to be responsive to potential problems early in processes.

In addition, our managed care department issues an annual report card to our larger payers that includes financial reports that measure each payer according to the contractual terms for timely and accurate claims payment. Additionally, information is included from revenue cycle staff (including collectors, insurance verifiers, and utilization review nurses) regarding the ease of working with the payer, the quality and accessibility of information on a payer's website, and other factors.

Where are you seeing the biggest boost from technology in reducing A/R days?

Voekler: Integrating electronic transaction services into our workflow has had a significant effect. Before we implemented these services, our collectors would have to repeatedly call each payer or go to each payer's website for information, and the information they received would not be detailed enough to take action. Now collectors can determine the status of each claim without waiting for remittances, checking payer portals, or making time-consuming phone calls.

Reiner: A third-party scrubbing or editing system, in addition to robust internal editing processes, is extremely important for controlling A/R days.

What advice do you have for others who are examining automated resources for managing A/R days?

Knodel: Put every revenue cycle process under a microscope to recognize that while technology can improve automation, technology alone will not solve fundamental people and process issues that may exist within the revenue cycle and could be negatively impacting your ability to manage A/R days. To make the best use of technology, you have to simultaneously implement sound processes, provide ongoing training, and develop robust reporting to monitor performance to ensure you achieve the results that are expected. Also, as you evaluate each step in the revenue cycle, ask: Why is someone touching this? Can it be automated? The key is moving toward an exception-based workflow to improve performance at a lower cost. ■