NAPIER
Healthcare

WHITE PAPER

DIGITIZED
REVENUE CYCLE MANAGEMENT

WAYS TO INCREASE YOUR BOTTOM LINE

Introduction

Revenue Cycle Management (RCM) is witnessing an exponential rise in complexities due to the increasing number of providers, insurers and vendors. For providers, managing a high number of payers with varied payment terms is becoming an everyday challenge. While for insurers, understanding their insurance plans and choosing a facility with the best coverage is a tiresome exercise. Vendors are facing issues relating to claims accuracy, an increased number of claims and expectations of reduced approval time.

Furthermore, globally there has been a rise in the healthcare provider's service offerings. From tertiary care critical Hospitals to virtual care, there are multi-care models with unique and elaborate billing/RCM requirements.

In most developed countries, the Government plays a vital role in financing Healthcare for the population. This drives stakeholders to adapt, sourcing for an efficient software solution that can manage their end-to-end RCM cycle.

A survey of providers revealed the following as the common challenges faced in RCM practice:

49% Managing AR and bad debts

24% Upgrading to better technology

53% Reconciling collection

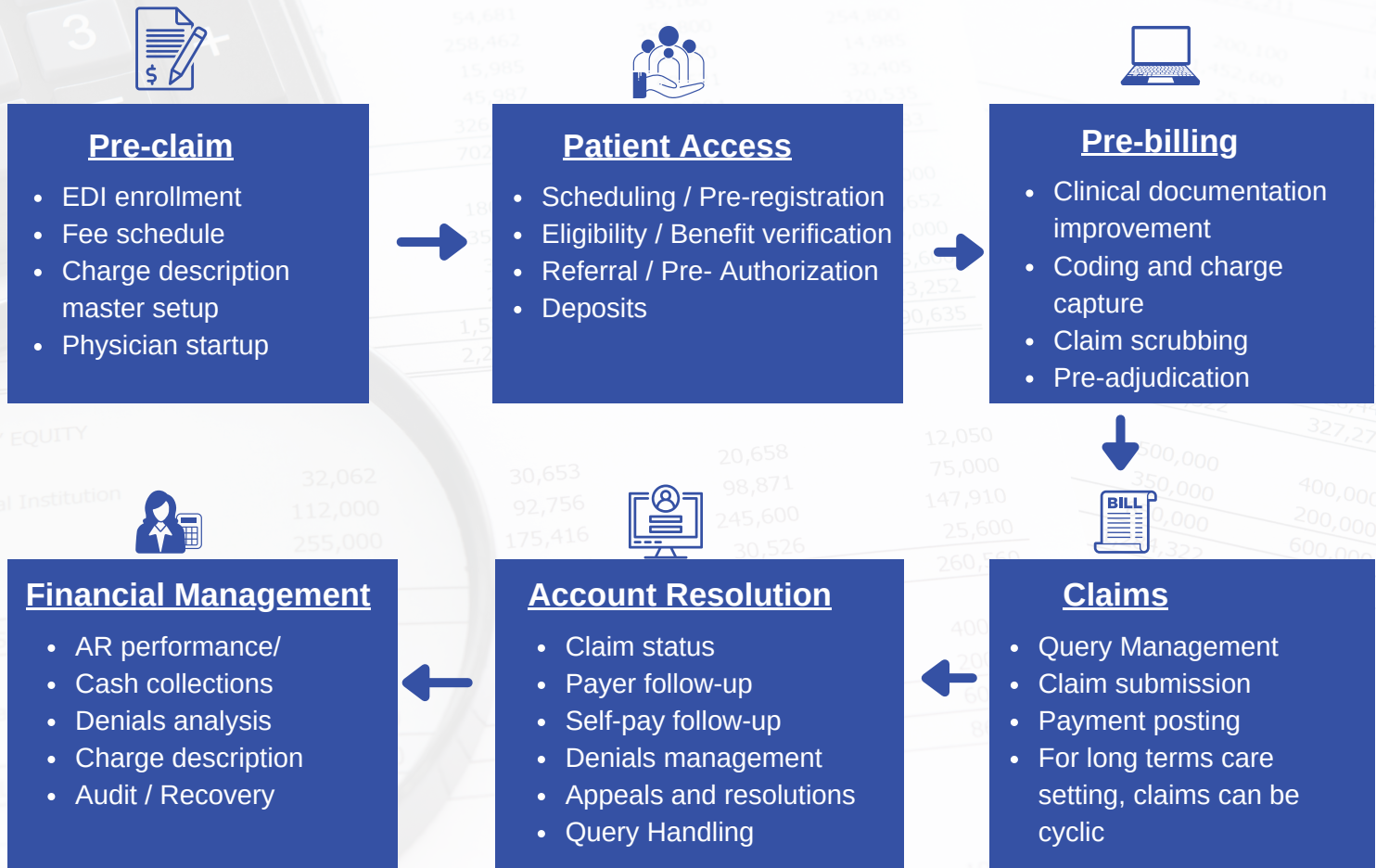**59%** Coding errors/other causes of delayed/denied payment

48% Fluctuating pre-authorization requirements

**28%** Preparing for new payment models

A general provider revenue cycle

Pre-claim
- EDI enrollment
- Fee schedule
- Charge description master setup
- Physician startup

Patient Access
- Scheduling / Pre-registration
- Eligibility / Benefit verification
- Referral / Pre- Authorization
- Deposits

Pre-billing
- Clinical documentation improvement
- Coding and charge capture
- Claim scrubbing
- Pre-adjudication

Financial Management
- AR performance/
- Cash collections
- Denials analysis
- Charge description
- Audit / Recovery

Account Resolution
- Claim status
- Payer follow-up
- Self-pay follow-up
- Denials management
- Appeals and resolutions
- Query Handling

Claims
- Query Management
- Claim submission
- Payment posting
- For long terms care setting, claims can be cyclic

Depending on the local authority and payer processes followed in the region, there can be multiple variations in every step.

Being agile is the key to successful RCM management

Possessing agility in adapting to new market trends is critical to ensure business sustainability. While it is straightforward to meet customer expectations through the provision of in-demand service offerings, it is not quite the same with new offerings. New offerings will require an understanding of the payer's systems, regulatory requirements and customer expectations. Faster adoption poses challenges related to effective planning and execution. Adopting a digitized solution seems to be a safer and simpler approach. This would involve minimum training, chances of error and reduced manual fatigue.
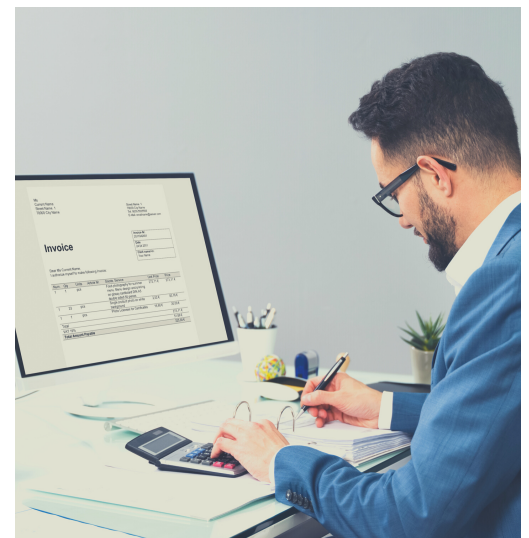
However, automation has its own challenges. The biggest challenge is having to deal with multiple vendors while trying to deploy a complete range of solutions. It is generally difficult to find a single platform capable of managing huge payer configurations with complex clinical and administrative workflows. RCM solutions using multiple vendors are more likely to report larger claim denials due to lack of coordination.

With all the above considered, the ideal answer to the RCM problems would be to find "A single platform that fully automates the RCM cycle end-to-end". There can provide opportunities for greater efficiency that includes reduced administrative overhead, improved revenue collection rates, optimized accounts receivable days, and increased patient satisfaction.

Benefits of adopting an integrated platform

1) Reduced administrative overheads

The quantum of administrative tasks required for successful completion of the RCM cycle has increased. The ever-changing "terms and condition" applied by the payers are adding to the process complexities. Close scrutiny of each claim has increased administrative burden and user stress. Every entry made or a missed entry in clinical records has the potential to lead to rejection. This has not only increased errors but has also made the process unpopular amongst providers.

A survey examining revenue cycle management processes found two-thirds of respondents felt that RCM is a vital part of their operation, yet only one third said their organization is "very or extremely" effective in managing their revenue cycle. By shifting to electronic transactions for administrative tasks like payment processing, CAQH (California Association of Healthcare Quality) estimates that payers and providers could save up to $10 billion each year.

2) Minimal training required

Training shortfalls have remained a constant impediment for all the RCM stakeholders. This is irrespective of the budget and time allocated for RCM trainings and knowledge sharing sessions conducted. Most of the internal and external audits recommend the need for effective training as a common area for improvement. Providers have notably extended their training plans to keep the staff abreast with new requirements and trends. Despite the added effort, outcomes are still far from being satisfactory.

Automation supports the Healthcare facility in effectively planning their training strategy.

- It reduces training needs as it takes away some administrative tasks from the users. It also frees the user to focus more on the critical parameters thereby reducing errors.
- With the help of AI technology, leaders can identify potential revenue leakage points. This would enable strategically prioritizing training needs.

3) Shorter AR Cycle

Providers are increasingly focusing on reducing the AR cycle to ensure business liquidity. Largely, longer AR cycles are a result of lack of clinical evidence for services codes claimed. Oftentimes, delayed claims and resubmissions are major factors that contribute to the extending of an AR cycle.

With the use of automation, providers can streamline various processes, promote handoffs of current and vital information, reduce first time rejection, and ultimately reduce the accounts receivable days. As a result, users will be more confident in processing data and this reduces the practice of multiple rechecks before submission. To support this, providers must place an additional focus on the acuity of documenting patient conditions.

Automation reduces the training needs and also frees the user to focus more on the critical parameters and error reduction.

4) Increase payer compliance

Payer systems are in a perpetual state of flux. Codes, expectations from providers and the way rules get applied are ever-changing. Coders and billers need to learn and incorporate these quickly to minimize denials.

Payer compliances loops in all stakeholders involved in patient care activities. Together, they are expected to process clinical and administrative information in the required format. Accomplishing this requires effective engagement, collaboration and better use of electronic health systems. Automating the payer "terms and conditions" reduces the turnaround time for implementing the expected changes with reduced chances of user oversight.

5) Improved revenue collection rates

Automation increases the accuracy of claim submissions by reducing human interventions. System based validations increase accuracy in repeatable tasks such as claim generation. Digitizing claim scrubbing activity promotes auto-correction, including correction done during submission/re-submissions. This results in submitting clean claims.

ML-based tools and predictive analytics can help providers find patterns in claim rejections. ML systems learn from providers' claims denial and rejection histories, then scan claims in real-time and flags potential rejection reasons for immediate remediation.

6) Boost Patient Satisfaction

Patients' conformance to the planned care has been a challenge in itself. With patients frequently changing their minds, it becomes difficult for providers to keep their systems current with updated information. By the time claims are submitted by providers, the underlying information would have been changed. As a result, the billers might pick the incorrect plan and proceed with submission. Ultimately, this results in a delay in service delivery that compromises patient outcomes and satisfaction.

By using an integrated RCM solution, healthcare systems can provide patients with a single consistent touch point to help reduce errors and communication lag. This helps to accelerate cash flow, improve patient satisfaction and reductions in penalties.

7) Reconcile financial outcomes

A structured reconciliation process is increasingly necessary as health care systems strive to achieve maximum reimbursement. Companies still relying on manual processes are faced with inaccurate and inconsistent data that can challenge the accuracy of the entire reconciliation lifecycle.

Data integrity can be enhanced through digitized platforms capable of handling complex data from varied sources. Unstructured data available in multiple formats are brought to one platform and put in an easy to comprehend format that makes data more meaningful, reliable and accurate. The costs associated with inaccurate reconciliations can be exorbitant, making it operationally and financially important to consider automating the process.

Conclusion

Revenue cycle management in the healthcare industry is known to be more complicated than that of others. The involvement of multiple stakeholders and interlinked clinical and administrative processes adds to the process complexity. Hence, an effective RCM can be easier achieved through sound policies supported by the right technology. Automated RCM solutions reduce risk, improves operational efficiency and expedites decisions making, ultimately leading to a better customer experience.

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Ms. Neha Musaddi, is a CPHQ & Six Sigma Black Belt certified healthcare professional. Having worked in Healthcare operations and Quality for over a decade, she has an in-depth understanding of healthcare practices, patient safety norms and patients expectation. She has experience in operationalizing allied care services within the healthcare facilities she has worked with, giving her exposure to allied care industry challenges and solutions.

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About Napier Healthcare

Headquartered in Singapore, Napier Healthcare Solutions is a specialist global technology vendor for healthcare providers. Since 1996, the Company has been enabling medium to large,
private and public sector hospitals and hospital networks across the globe to capture and work with clinical information, streamline workflows, reduce medical errors, drive cost efficiencies and maximize profitability.

Napier Healthcare's expanded portfolio today covers the information needs of acute care providers and operators of long-term care facilities, such as hospices and nursing homes, as well specific healthcare IT needs in other industries such as aviation and maritime. To find out how Napier Healthcare can help your organization to derive top dollar returns on IT investments, make your way to www.napierhealthcare.com today.

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