

REVENUE CYCLE PRINCIPLES SERIES

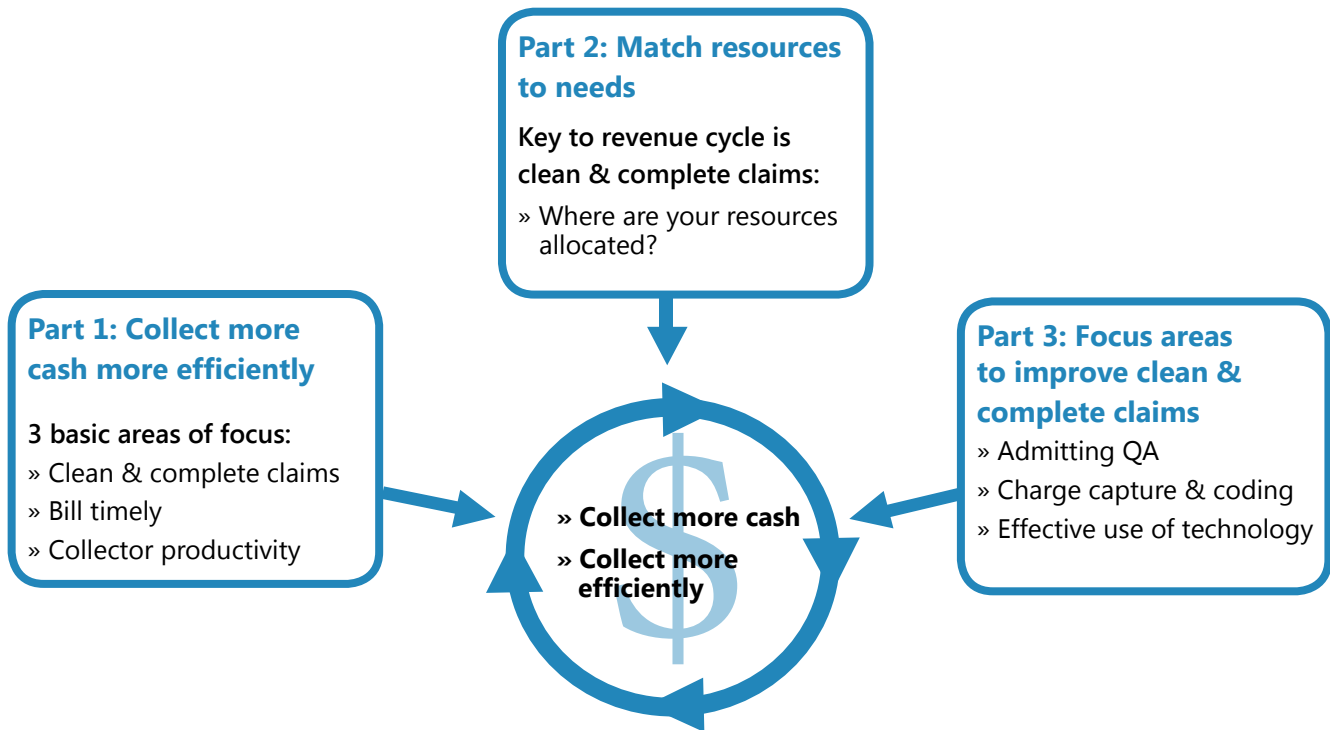
Part Four

Boost collector productivity through segmenting and value-added processing

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Revenue Cycle Principles Series — Part Four

Boost collector productivity through segmenting and value-added processing



Introduction to Part 4:

The first three segments of this series has focused on the importance of producing clean and complete claims; making sure that we allocate the necessary resources to achieve this and finally to make sure that the process has the right structure to ensure success.

One of the points made in the first segment was that the best way to achieve collector productivity was to have a comprehensive program focused on clean and complete claims the first time. Outside of the fact that there are countless studies that have proven this point, pure common sense will tell you that rework is far more time consuming than getting it right the first time.

Unfortunately it seems unlikely that we will achieve a completely error free revenue cycle in the near future. The complexity of the process; the manual nature of the constituent parts and the payor provider dynamic all contribute to the fact that even the most efficient hospital still needs collectors to resolve claims. The task is then how to make them more productive.

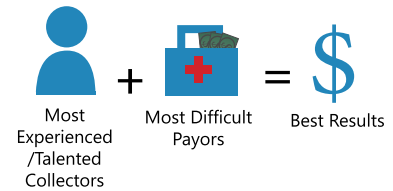
How do we improve collector productivity?

One of the keys to improving the back end of the process – collector productivity – is to match your resources to the areas that fit their talent/experience level. Much of what is done in the collection process is relatively repetitive and can be done by less experienced collectors. There are also technology solutions that can automate certain of the non value added processes, thus allowing your collection staff to focus on the tougher to collect payors/accounts.

Segmenting payors by level of difficulty

Most hospitals deal with a wide range of payors in the collection process. There is often a high degree of variability within the group of payors as to how long they take to pay; what is considered a high \$ claim; requirements to pay the claim without medical records and what the resolution process is. It is probably not a positive fact for the healthcare industry that Medicare is typically the most efficient payor.

Segmenting the payors into buckets like – 1) most difficult 2) medium difficulty 3) least difficult will allow you to then match your best collectors to segment 1) and so on. Today there are companies that have been started just to help hospitals segment their payors into similar buckets – I am not sure it is that complicated. Take a list of your Top 10 Payors and sit down with your collection staff and ask them to assign each one to a group – they will do a pretty effective job in less than 10 minutes. To validate this, you can calculate what the average number of days it takes for claims to pay for each payor. It should match fairly closely to your collector’s survey.



Once you have done this, you will probably realize that not every claim for the toughest payor is difficult to collect – it is often just a subset – say high \$ claims. You now have a segmented roadmap to match up to your talent and experience level. The matrix is also a useful tool for deciding where to slot in new employees. Some facilities have even used this as the basis to start hiring a pool of entry level people that are entirely focused on the easy payors and the parts of the collections process that don’t require high levels of experience to add value – e.g. statusing of claims.

The result should be a well thought out matching of talent and experience to deal with the thornier claims and payors – improving cash collections and potentially lowering your cost to collect. This one project thus meets both of the overriding principles – more cash, more efficiently.

Using technology to focus on value added processes

As with any part of healthcare today, there are various technologies in the marketplace that have been designed to improve a process. The collections arena is no different. In the previous parts of this series we have mentioned some that can assist in making sure that claims are clean and complete – these are the most important tools for improving collector productivity.

There are however some newer tools that can dramatically improve collector productivity by automating some of the processes that are currently being done manually.

Automated claims statusing

Claims statusing is a task that takes up a significant amount of a collector’s time. A typical patient claim status takes 7-10 minutes via a web portal and roughly double that amount when done telephonically. The information is then taken and either copied into the patient accounting system or transcribed into the patient’s account. Unless there is something immediate that the collector can do with that account, the collector has added little or no value to the process.

There are tools available that can automate this process ([myClaimIQ AutoStatus](#)). Either through a direct connection to the payor database or through automating the web data extraction process, the account status can be extracted and put back into the patient accounting system without any collector intervention. The process is typically done

overnight with each response mapped to the hospital's standard collector codes. The automated functionality also eliminates any possibility of keying data errors back into the patient accounting system.

This process then allows the collectors to focus on value added activities like dealing with the harder to collect claims. The responses from the payor are also now in a separate database and can thus be used as a denial management tool and/or a QA function.

Integrated eligibility checks & denial management

The results from the auto status tool typically fall into 3 areas:

- 1. Needs immediate action** - Payor doesn't recognize the claim, or recognizes but denies claim
- 2. Needs follow up** - Payor recognizes the claim but has not determined the status
- 3. No follow up unless payment not received** - Payor pays claim as planned

In the case of point 1 – claim needs immediate action, it is now possible to use the tool to automatically route the claim to either the denials team or to have the eligibility status of the claim run against the payor database as this is the most common cause of claims rejecting initially.

The eligibility step can be automatically done through the software, thus saving a collector from doing another repetitive data entry function.

Estimated payment contract compliance prior to payment

Software that calculates payment compliance to managed care contracts has been in place for a long time now. It is typically used once the payment has been received from the payor. This can now be moved forward in the timeline to the point where the payment data is received by the AutoStatus tool. **This then streamlines the process and saves the facility 14-21 days in addressing any payment related issues.**

Each of the 3 areas that we have addressed under technology have been focused on eliminating or reducing non value added tasks that are being performed by experienced and expensive collection staff.

Conclusion

I think everyone would agree that a significant amount of work is done in healthcare and in the collection process specifically where the tasks performed are extremely routine and the person performing them doesn't necessarily add any value to the process – it is merely data extraction and data transfer. Unfortunately in most cases these tasks are performed by highly experienced and well compensated employees.

In certain instances (like claims statusing) some of this can be replaced by technology. In the areas where experience and expertise counts it is thus prudent to match your resources appropriately by segmenting your receivables by payor.

The combination of segmentation and using technology appropriately can produce meaningful results in accelerating the cash cycle and also reducing the cost to collect.

For more information, contact us today at 800-228-0647 or email sales@ht-llc.com

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