

Ten Strategies for Capturing All Reimbursements

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Healthcare employs more people than most other sectors of the U.S. economy. Spending is predicted to rise to \$2.6 trillion this year and account for 18% of the gross domestic product. There are certainly plenty of opportunities to earn a good living taking care of others.

If asked, however, most people in healthcare would presumably say their initial reason for working in the industry had something to do with helping or caring for people. This is one of the reasons our nation's healthcare is the best in the world. It can at times also create an unintended conflict with a provider's fiscal health. Patient care and even certain aspects of patient satisfaction are completely dependent upon a facility's financial well-being.

In the past several months we've seen an assortment of macroeconomic factors affect hospitals, physicians and other providers' abilities to provide care and sustain their operations. Medicare and Medicaid reimbursements continue to decline. Investment income is disappearing. National unemployment is higher than it has been in many years, adding to the record count of uninsured Americans who still need care. Admission volumes are down. The increasing popularity of consumer-directed care, high-deductible health plans and health savings accounts has created more patient financial responsibility and less reliance on insurer reimbursements.

These factors have made an already complex and difficult proposition for healthcare providers even more overwhelming. Cancelled or delayed capital expenditures, layoffs, program cuts, and even bankruptcies and closures continue to dot the headlines. According to Thomson Reuters more than half of U.S. hospitals are reporting operating losses.

In many ways the healthcare industry's reaction to the current economic situation is telling of pre-existing problems. Many hospitals that entered the downturn in poor financial standing have simply not been able to endure the added pressures. Holes in hospitals' administrative and financial practices have been exacerbated. Best practices still exist, though, amid all the doom and gloom; according to the same Thomson Reuters report the half of the nation's hospitals show a profit, so they must be doing something right.

At the most fundamental level, in order to maintain long-term operational viability hospitals have to rededicate themselves to the financial side of healthcare. The hospitals currently operating at a profit presumably carried out this approach in times of prosperity and as a result are better prepared to weather unforeseen and uncontrollable financial pressures. That's not to say patient care should not remain priority one, but if the books consistently bleed red then there is ultimately no chance of fulfilling the core mission. Providers must operate as businesses first—even not-for-profits—and help their patients understand that without adequate payment for services they will cease to exist.

This is a real paradigm shift for many providers, but is never more true or important. During the more than 35 years I have worked in healthcare, I have seen the industry move through numerous peaks and valleys and each time have been fortunate to witness some best practices from providers who emerged successful. Healthcare may be more resistant to the cycles of our economy than some other industries but is clearly not immune. The one common denominator for successful providers is a strong emphasis on the financial side of the business, which naturally allows for better patient care and even patient satisfaction. In my experience there are several specific strategies providers use consistently to manage this balance.

Enhance internal processes to capture all reimbursements

Within an organization's existing patient population there are usually opportunities for additional revenue that can be capitalized upon with better processes.

- **Reduce claim denials and bad debt.** The more accurate a hospital can be on the front end, the lower the claim denial rate and AR days. Using technology to automate and replace manual processes can empower administrative and financial staff to work faster, more efficiently, and more accurately. Manual processes often lead to error, which leads to denied or rejected claims and potential bad debt, which is currently crippling hospitals.
- **Check every self-pay patient for Medicare and/or Medicaid coverage.** On average, 10% of patients who receive treatment as "self-pay" qualify for Medicare or Medicaid. Eligibility checks should be performed prior to service and after service, if necessary, to identify retroactive coverage. The federal government estimates that spending on Medicare and Medicaid will rise from about 4% of gross domestic product in 2009 to nearly 6% in 2019 and 12% by 2050, so providers should take every measure to capture legitimate reimbursements and avoid writing off debt. Doing so can be especially costly for safety net facilities serving a primarily indigent population. In a six-month period in 2008, New Jersey-based Meridian Health identified more than \$1.7 million in billable Medicaid charges it may otherwise have written off.
- **Verify medical necessity compliance.** Hospitals performing outpatient tests or treatments from physician orders should validate medical necessity compliance. Providers will not be reimbursed for denied claims and cannot bill patients without a signed advance beneficiary notice of non-coverage. The medical necessity validation process can be performed in advance of the patient visit for all scheduled procedures and just prior to service on unscheduled procedures. An automated medical necessity validation process and a smooth order entry process can dramatically improve hospital/physician relationships and save precious staff time.

Capture all relevant patient data prior to service

Fortunately most providers have recognized the need for collecting critical patient data up front. In any situation short of an emergency, proactive treatment should not be issued before a defined set of information is gathered and validated.

- **Avoid fraud and identity theft.** Confirm patient demographic information such as a social security number and an address to be certain they are who they say they are. Verify patient identity by reviewing photo identification for every patient. Theft and fraud is generally more prevalent during difficult economic times, and hospitals are likely targets for criminals seeking free care. The Federal Trade Commission's Red Flag Edits compliance enforcement deadline for having identity theft-related processes in place is May, so providers are now actually mandated to address these issues. It can also eliminate or reduce unnecessary administrative work.
- **Verify real-time insurance eligibility for all patients.** Make certain that every patient who presents as having insurance has his or her coverage validated. Gather up-to-date co-pay and deductible information during scheduling and pre-registration and verify again during registration or at the point of service. A patient whose eligibility has changed due to a recent job loss, for example, may not be inclined to divulge the most accurate information, and even with COBRA coverage, benefits can change.
- **Audit registrations for quality assurance.** Inaccurate information should be flagged and corrected before services are rendered and certainly before a claim is submitted to avoid unnecessary work and costly mistakes on the back end.

Tap into up-front revenue streams

The information described above can be leveraged to increase proactive front-end collections from insured and uninsured patients.

- **Provide patient payment estimates.** Reconcile charge master data with contracted rates and patient benefits to arrive at an accurate up-front price estimate. Consistent price transparency will have a substantial impact on the bottom line and on patient satisfaction.
- **Implement policies and processes for discount and charity care.** Enable front-end personnel to make educated decisions on the spot about whether patients qualify for free or discounted care based on credit scores and other information.
- **Increase collection points.** Accept patient payments in the form of cash, checks, and credit cards at locations throughout the facility. Offer convenience in the form of interest-free medical finance cards or payment plans with automatic recurring deductions. West Virginia University Hospitals nearly doubled its point-of-service collections in three years following the installation of credit card processing systems in its hospital and physician clinics.
- **Set the proper expectations with patients.** Uninsured and insured patients presenting in non-emergent situations should expect to pay for at least some portion of treatment. With accurate information, training, tools, and scripting front-end personnel should be comfortable and confident asking for payment. Patients will become accustomed to the policy and cash collections will rise.

By applying these best practices healthcare providers can mitigate the impact of a recession and protect their long-term financial outlook. No hospital or other healthcare facility can carry out its mission of patient care if it becomes financially insolvent.

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Back