



NAVIGATING **THE** **FASTEST ROUTE** TO REIMBURSEMENT

Reveal hidden coverage to collect more, faster

Hospitals are losing billions of dollars every year from uncompensated care. According to the Department of Health and Human Services, \$27.3 billion was lost in 2014 alone. And with the advent of insurance marketplaces and the expansion of Medicaid, this problem will only intensify if hospitals and health systems cannot find better ways to identify coverage to capture reimbursement.

Traditional processes of finding coverage are complex. They can lead hospital staff down the wrong road, wasting time and stalling (or even stopping) cash flow. However, there is a way to U-turn this process. Automated insurance coverage discovery solutions that effectively streamline the reimbursement process can get providers to the right revenue destination. Like a GPS, these solutions will point providers in the right direction sooner so millions of dollars in revenue can be recovered quicker than ever.

Detours and dead ends

According to a recent Healthcare Financial Management Association (HFMA) survey, 86% of revenue cycle leaders state pre-service verification for prior authorization is extremely important.¹ Therefore, in order to

maximize reimbursement and reduce uncompensated care as early in the process as possible, hospitals and health systems must rapidly identify the fastest and easiest routes to payment.

Most billing offices have legacy, labor-intensive processes in place to get coverage established, but they cannot

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quickly react to new information received between the time a patient presents coverage for service and the time a claim is paid. Timely updates are essential to determine who pays each claim and how long it takes, yet they are difficult to track manually. Mismatched benefits result, causing major detours and dead ends in the collection process. In a recent HFMA article, Oschner Health System identified that "denials due to the lack of timely filing processing represented the greatest number of write-offs."²

The first line of defense against slow collections and claims denials is simply asking patients about their coverage



early and often. However, these simple eligibility checks are often hindered because patients are unaware of their current coverage options. Patient may present themselves as self-pay when, in fact, they may qualify for Medicaid. Or perhaps a patient recently switched employers and forgot to tell the hospital to change insurance. These honest mistakes misdirect hospital staff from the very beginning.

Estimates based on inaccurate coverage information can also cause bottlenecks in point-of-service collections and breakdowns in the overall patient experience. Often during the registration process, patients are told they will owe only a small copay. This could be true; but if there is a problem with identifying coverage, patients are faced with large bills they can't pay several weeks later—if at all.

In addition, pre-certifications and prior authorizations for service may become meaningless if providers pursue the wrong payers. Each payer has its own definition of medical necessity and

Providers can explain patient responsibilities more clearly with the most up-to-date information and keep cash flowing by:

- 1) Collecting copays and/or high-dollar deductibles in advance of service
- 2) Presenting financial aid options
- 3) Discussing reasonable payment plans to fit within a patient's budget

rules for clinical documentation. While authorization may have been received from one payer, changes in coverage may force the entire approval process to begin again with no guarantee of payment. Proper coverage (and accompanying rules) must be identified within certain time constraints to secure proper authorizations. Otherwise, a provider may have no choice but to bill the patient for services originally thought to be covered. Finding different coverage late in the game brings forth urgency as the clock is ticking. Knowing about this change early can help get the correct coverage in place and meet the plans'

rules before denials or out-of-timely-filing write-offs occur.

The lack of proper authorizations for services can lead to a tremendous amount in hospital write-offs. The Ochsner Health case study also stated "its highest opportunity for growth was around authorization adjustments."² Although Ochsner had a mature pre-service authorization process, 24% of the overall write-offs were attributed to authorizations. With a back-end coverage discovery solution, the health system could have leveraged savings sooner and reduced the amount of out-of-timely-filing write-offs.²



Re-routing to recover more, faster

There is an easier way to get what's owed to you: back-end coverage discovery solutions. They improve the efficiency of claims reimbursement by automatically identifying and scanning previously unknown sources for accounts not captured on the front end.

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By doing so, new opportunities for payment are recognized faster, allowing hospital staff to redirect efforts down the right avenue sooner. High-quality back-end coverage discovery solutions explore all possible ways to recoup third-party reimbursements.

Here's how they recover more, faster:

- Pinpoint patient demographic discrepancies between hospital and payer data
- Identify cases where a standard eligibility request would not yield a return
- Locate commercial policy ID numbers for patients believed to be uninsured
- Verify coverage of accounts against the Medicare Common Working File and Medicaid databases

If these checks occur as close as possible to discharge, insurance information, rules and estimates can be updated and cash flow can improve. Providers who use these systems are able to optimize timetables and reduce the risk of out-of-timely-filing denials.

They don't have to wait weeks to be alerted to coverage issues, get a phone call back from the patient, or receive insurance denial letters. Jonathan Wiik, principal of revenue cycle management at TransUnion Healthcare, explained the benefit of this process simply: "You can prevent downstream denials significantly if you can get the right insurance at the right time with the right person before an out-of-timely-filing write-off."

Once proper coverage is identified, hospital staff simply employ the new payer-specific processes to keep claims moving smoothly through the system. Retrospective authorizations are tough, but if a patient fails to present accurate coverage at the onset, back-end discovery solutions can help staff pursue payable coverage from other appropriate sources. When found, staff can insulate payment earlier by quickly changing gears, asking the right questions and following payer-specific protocol.

Back-end coverage discovery solutions help streamline reimbursement processes and recover far more revenue than traditional methods.

They are:

- Automated
- Efficient
- Smart



Finding an alternate route

Due to the differences between payer-specific rules for medical necessity and documentation, retrospective authorizations cannot always be attained. In these situations, back-end coverage discovery solutions may not be able to find alternate payment options. At this important juncture, staff can look for financial aid or begin self-pay discussions. It is imperative these patient conversations happen sooner rather than later, as studies have proven the longer it takes for providers to send bills to patients after services are rendered, the less likely they will be to collect. Wiik confirms that "the more information you have up front, the better conversation you'll have, and the faster you'll bill the correct guarantor, and receive payment from the insurance or patient."

Back-end insurance coverage discovery solutions offer powerful analytics to identify the root causes of slowdowns and breakdowns in the revenue reimbursement process.

Procedures are updated and workflows are improved. Additionally, data from these solutions can be leveraged to improve the patient experience.

The insight gleaned from discovery reports can accelerate decision-making and help providers become better at preventing uncompensated care dollars.

Hospitals and healthcare centers can look like heroes when they uncover previously unknown payer sources. It reduces the patient's financial obligation and creates more positive feelings, putting everyone on the road to recovery faster.

The Road ahead

The idea behind insurance back-end coverage discovery solutions is simple. When coverage is identified, payers can be billed earlier and revenue can be realized sooner.

A good solution acts like a GPS system by identifying the most direct route available to secure payment without traffic jams or detours.

With a back-end coverage discovery solution, providers see great improvements in total collections because better coverage information is available closer to when services are rendered. Not only does this accelerate overall cash flow, but patient experience also improves. Providers can help patients gain a better understanding of their overall coverage, financial aid options, total balance due and available payment plans. "At the end of the day," Wiik says, "you need a solution that puts your patients in a better place with funding mechanisms that are known."

Easy money can be found by converting uncompensated care accounts to Medicaid, Medicare and/or commercial insurance; health systems typically boost conversion rates between 1-5% after the adoption of a back-end discovery solution. Outside of the downstream denial avoidance, net Medicaid payments can also rise by as much as 2% overall, making a huge impact on the bottom line without having to add staff or work to anyone's plate. "In fact," says Jason Lerch, another principal at TransUnion Healthcare, "in every market across the country, these tools routinely identify coverage that associates, Medicaid eligibility, early-out and collection agency partners simply cannot find."

Plus, denial rates can be affected. Some providers experience reductions as large as 2%. That's not to say back-end discovery solutions prevent denials, but they help providers load the correct coverage into their systems so proper authorizations for coverage can be obtained upstream of a denial. This represents hundreds

of thousands of dollars in unrealized revenue. A discovery solution on the back end will reduce the number of accounts that go past timely filing, as the hospital never knew about the coverage. When a back-end coverage solution is in place, it can refer the coverage prior to its timely filing deadline and avoid downstream revenue risk.

There are countless benefits to implementing back-end automated discovery solutions. Traditional insurance verification processes are cumbersome and overwhelming, making it difficult for hospital staff to focus on the right people and right job at the right time. But by leveraging technology that finds hidden coverage, hospitals and health systems are presented with a clear map and directions on how to reduce the time it takes to resolve eligibility problems and collect more money with fewer resources.



1. TransUnion Healthcare. Healthcare Market Perception Survey #2. Oct 1, 2015. Raw Data.

2. Burns, Wendy, and Alicia Harmon. "Reducing Administrative Write-Offs Through Improved Denial Management." HFMA Magazine. July 2016. HFMA, July 1, 2016.



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