Insights and actions for successful results

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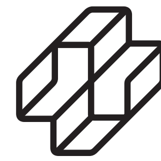

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Dispositional Receivables Management Can Improve Collections

By Brian Robertson and Zane Newitt

A "high-to-low, old-to-new, and one-by-one" follow-up approach is outdated in today's environment.

Today's healthcare financial leaders can easily become preoccupied with consumerism and the uncompensated care crisis and its resultant decrease of profit margin. But too often that means the third-party follow-up strategy is left as status quo. Providers are combating self-pay, bad debt, and charity care issues by leveraging more advanced account segmentation and stratification strategies. Ironically, similar approaches are rarely applied in the third-party arena where recurring new net revenue can be secured by revisiting a more contemporary and strategic insurance follow-up strategy.

Balance and Age

In most patient financial services (PFS) departments, insurance follow-up is driven by two variables: balance and age. And whether follow-up is performed from hardcopy work lists or driven by complex automated workstation configurations, the outcome is that insurance representatives manage accounts that are "driven" to them on an account-by-account basis.

For example, the "insurance bulldog" in every PFS department gleefully (and often audibly) celebrates the resolution of a long-fought appeal for denied days with a problematic payer. The celebration is short-lived, however, as the workstation spits out another account the next day with the same denial and the process must start over. Much energy and cost could have been avoided had both accounts (and other similar accounts) been attacked at the same time using a more logical approach to account management.

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COMING IN MAY

Hospitals exhibit great and increasing variability in gross charges for imaging procedures and even greater variability for in-network commercial payment received. Learn more in the next issue of *Revenue Cycle Strategist.*

HFMA Resources

HFMA's payment reform retreat examined healthcare finance leaders' perspectives on the principles of an ideal payment system as well as its elements and the potential barriers to implementation. For a summary of the findings, visit www.hfma.org/library/revenue and click on "Pricing" and look for the title.

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"High-to-low, old-to-new, and one-by-one" follow-up protocols do not empower insurance follow-up teams to:

- Manage cash based upon prioritizing accounts with the highest propensity to pay. (High-balance accounts are often not the most collectible.)
- Ensure that all accounts are in some stage of follow-up. One-by-one account follow-up results in a high percentage of accounts that are sitting in black holes or hitting a work list for follow-up and simply never being touched.
- Group like accounts for collective account resolution. Age is less important than disposition. By grouping accounts in like dispositions (e.g., all Payer X accounts pended for coordination of benefits), insurance representatives can resolve multiple accounts with one follow-up intervention to the payer.
- Understand the composition of the accounts receivable (A/R). Aging and balance do not empower the insurance representative, team leader, and ultimately senior leadership to understand the story of the A/R and use critical thinking skills to resolve greater volumes of accounts with less time and expense.

Disposition and the End of Standard Aging Reports

By leveraging technology and shifting the mindset away from the blunt indicators of aging and balance, PFS insurance follow-up teams can move to a dispositional receivables management methodology. In this new approach, like accounts are grouped for collective follow-up based on where they sit in the conversion cycle. In lieu of alpha splits, balance thresholds, and age as the primary variables for prioritizing accounts, a more structured approach based upon disposition and collectibility is deployed.

Insurance account representatives can manage their receivables as a business with segmented periods. The representatives can cycle their own accounts based upon disposition similar to the following.

Promise to pay accounts. Technology buckets all accounts with a promise to pay disposition assignment across all aging categories and balance thresholds. Staff can then conveniently ensure secured accounts are being paid per the expected receipt date and escalate delinquent accounts to a supervisory or provider relations role.

Adjudicated accounts. Accounts that have been adjudicated but that may have a payment discrepancy are aggregated and forwarded to the payment discrepancy resolution rep/team.

Denials. Soft denials are grouped by payer, denial category, or denial type. Soft denials are managed by the insurance representatives collectively (instead of one by one), and qualifying hard denials are forwarded to the denial management specialist for advanced denial recovery efforts.

Pended accounts. Pended accounts are the "sweet spot" where accounts are won or lost. Payers and staff are tempted to play the "pended game," where by grouping all pended accounts across the aging curve, staff can move an account into a more determinable disposition (ideally, promise to pay), and leadership gains insight into how and why accounts are unnecessarily extended within the adjudication cycle.

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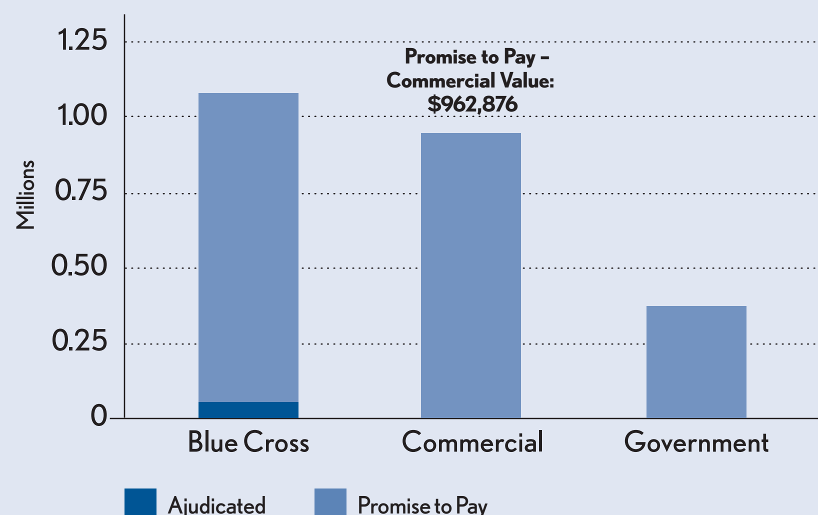
Promise to Pay by Payer

This structured approach to prioritizing accounts is based on their disposition and collectibility.



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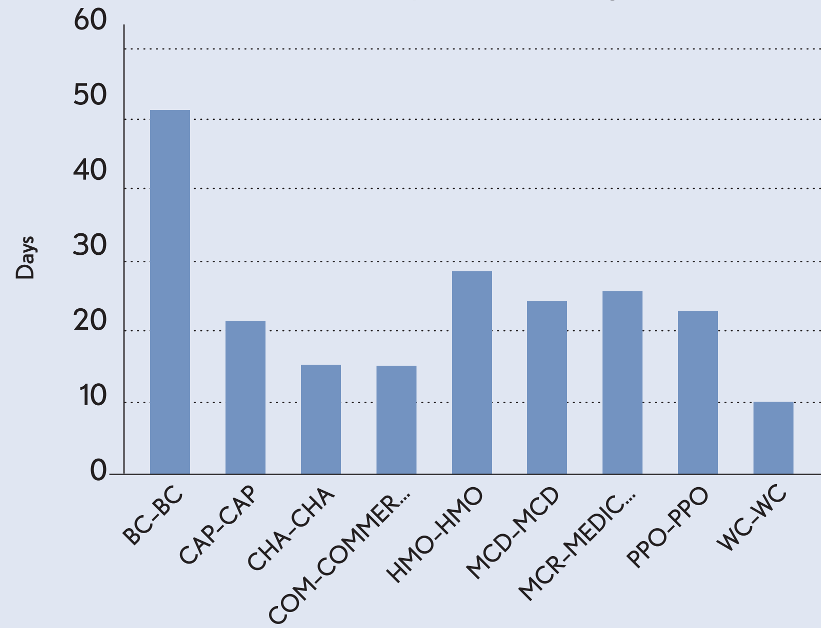
Inactive and invalid accounts. Here, exception management meets dispositional management. Accounts not statused are aggregated for immediate intervention, and similarly, accounts with wrong or inactive status codes are grouped for statusing and reintroduction into the adjudication cycle. As a result, black hole accounts are managed daily and prevented.

New business. Last, accounts assigned for first follow-up are grouped. This segmentation approach helps the representative because the scripting for first follow-up efforts is different from that for accounts in other dispositions. As a result, a like technique can be used on a number of similar accounts, resulting in less toggling between old denials and new clean claims for a crisp, organized approach.

Technology Always, Automation Sometimes

Insurance follow-up requires some technology investment to cross walk 200 to 300 activity/status codes, marry 835 transactions to dispositional categories, and aggregate the data for a visual understanding of the A/R.

Complex workflow configurations may be fancy, but more often, they are difficult to build and simply ineffective. Health information system (HIS) platforms should assign the first follow-up date aggressively and at the payer level. (Why wait 20 days to make an initial determination on an account that can be statused online at day eight?) The insurance representatives should then be empowered to cycle their accounts using the simplicity of a status code and follow-up date. Some accounts require intervention in three days; others have a normative follow-up technique at day 45. The disposition should drive the follow-up, and business intelligence—not HIS platform transactional rules—should drive accountability.



The combination of a structured day where dispositions are managed in periods or segments, combined with staff empowerment to cycle their own accounts, strikes the balance between the need for accountability and truly making staff their "own CFO." The value of such an operating model has prongs into payer score carding, cash forecasting, and staff qualitative accountability.

Payer Score Carding/Profiling

As statuses are applied to accounts (through both electronic remittances and staff applying status codes), daily interactive payer topics emerge. The hours spent on analysis, account sampling, and data mining disappear as leaders are able to engage payers using the power of business intelligence right from the representative's desktop. Leaders no longer rely on the leverage of payer data and basic aging information. Instead, the following types of data-driven conversations can now proactively occur:

- It takes an average of six touches to resolve an account. Why?
- The average inpatient account is pended twice for informational requests already found on the uniform bill. How can we prevent this unnecessary extension of the adjudication cycle contractually?
- Accounts for the employer group are denied 40 percent more frequently than other groups in the same zip code. Why?
- Seventy percent of claims with revenue code X adjudicate with no follow-up by staff. Let's discuss further discount opportunities for collaborative reduction in cost to collect.

Cash Forecasting

Triangulation studies that model net revenue, perform hindsight analysis, and then splash the results against the open receivable are powerful for setting both cash and net revenue and provisional reserve estimation targets. However, the "real life" element is often lacking. With a dispositional approach, the veracity of the model can be checked concurrently with actual cash forecasting at the staff level. By simply applying a "Promise to Pay Current Month" or "Promise to Pay Subsequent Month" disposition on qualifying accounts and aggregating the data, a new layer of cash forecasting emerges. If forecasts are off, the assignable cause may

be performance, payer, or modeling. The power comes in understanding the cash position daily and not waiting until month-end to intervene.

Dashboarding and Powerful New KPIs

Through dispositional segmentation, a number of new insightful key performance indicators (KPIs) emerge. These KPIs, when combined with traditional indicators, create a powerful suite of metrics that empower staff and leadership to truly migrate toward a data-driven performance management culture. Suggested KPIs include:

- Total touches by insurance rep to target
- Total touches to resolve (an account) by insurance rep
- Resolved accounts with no follow-up
- Delinquent promise to pay accounts
- Disposition by payer
- Aging by payer by disposition
- Disposition by rep
- Disposition by rep by disposition
- Average time in disposition by rep
- Average time in disposition by payer
- Days in revenue outstanding by insurance rep to target
- Cash by rep to target
- Conversion rate by rep to target

A Data-Driven Environment

Many complex components make up the revenue cycle, but no factor is more important than the systems and processes used for follow-up and collections to ensure that payment is received for services provided. In this new climate of accountability and data-driven decision making, new solutions and strategies are needed to revolutionize the collections effort. Using a dispositional-based approach can help transform the collections process into a data-backed, result-driven environment where all levels of staff are accountable to the success of the organization.

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