Managing Your Revenue Cycle:
What You Should Expect from Your Clearinghouse

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Physician practices are caught in an unusual business predicament: Even as the demand for services increases, profitability is being squeezed by declining payer reimbursement rates and rising operating costs. Add to that industry transitions like ICD-10 which require changes to all administrative and clinical operations of the practice, necessitate significant training time and expense, and will cause dips in productivity as staff becomes accustomed to the changes. Further complicating matters is the growing trend toward increased patient financial responsibilities, both with insurance benefit plans and self-payment. With more direct patient billing comes more risk; patients are, in essence, becoming individual, small-dollar payers who can burden your accounts receivable (A/R) efforts.

As a result, proactive revenue cycle management (RCM) now plays a larger role than ever in practice profitability. Big or small—general practice or sub-specialty—success ultimately depends on receiving full, timely reimbursement from payers and minimizing patient A/R exposure risk. Having the proper clearinghouse in place is vital to a practice's financial health since it enables you to fully understand and manage your entire revenue cycle, including all aspects of A/R, patient billing, remittance and appeals. For these reasons, it's imperative to understand the features and benefits you should expect from your clearinghouse solution.

What You Should Expect from Your Clearinghouse

By increasing revenue capture, accelerating cash flow and reducing the cost of managing claims, a clearinghouse can improve practice profitability. As you consider how your clearinghouse is performing, think about your entire revenue cycle and workflow. Let's walk through a typical patient encounter, and look at the associated RCM features you should expect your clearinghouse to provide:

Pre-Encounter Administration:

A significant—and increasingly larger—portion of your reimbursement should be collected at the time of service. To do this effectively, it requires access to current, accurate eligibility information when the patient walks in the door. Health benefit information can help with that. Clearinghouses that provide batch and real-time eligibility solutions put critical insurance benefit information—including coverage dates and benefit ceilings, for example—in your hands before you render services. This helps alleviate one of the most common reasons for claims rejections and denials—ineligibility.

Verifying eligibility on the front-end can also explain which services require co-pays or co-insurance and deductibles the patient may be responsible for. Some practices are asking for customers' credit cards at the time of check in so that amounts the patients are responsible for can be collected at the time of service or automatically charged once insurance benefits are exhausted. This process is helping to increase collections and decrease patient bad debt.

Patient-Provider Encounter:

Compliant coding of patient encounters is essential—both for speeding up reimbursement and lowering potential audit risk. Make sure that your clearinghouse provides a robust set of claim edits. The best edit suites grow with "experience." In other words, every time a claim is rejected by one user, the rejection is incorporated into the edit database—increasing the first-pass rate for every user of the clearinghouse. A better first-pass rate can significantly accelerate your cash flow and decrease days in A/R because the sooner a claim is accepted at the payer, the sooner it can be adjudicated and the faster you can get paid.

Back-Office Administration:

After a patient encounter, numerous features enable improved RCM from the back office. As you assess your clearinghouse, pay particular attention to:

- **Claims submission and editing.** Ideally, you want every claim sent electronically from your clearinghouse to the payers. If this is not possible, your staff may need to manually submit your claims on paper or via the payers' websites, which can greatly reduce staff productivity. In addition to electronic claim submission, your clearinghouse should provide an initial response in seconds versus day(s), indicating acceptance/rejection based on the clearinghouse's claims scrubbers and edits. Pinpointing and correcting these front-end rejections online prior to the claim being sent to the payer will improve your first-pass rate and reduce denials, ultimately resulting in accelerated cash flow and improved days in A/R.

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- **Payer remittance, automated posting.** Electronic remittance advice (ERA) can accelerate cash flow by automating the process of receiving and posting insurance payments. Ensure that your clearinghouse provides ERA connections to all of your key regional and national payers so that the remittance can be automatically posted to outstanding claim balances in your practice management system and you will not have to manually process them. Automatic posting increases staff productivity and frees up employees to work on more revenue generating activities. Your clearinghouse should also include online-ERA management tools that enable you to categorize and correct your denials, manage your appeals process, find payments easily and print EOBs for a single patient.

- **Secondary claims submission.** In this era of declining payer reimbursement, it's increasingly important to have a robust electronic secondary submission solution that brings in all earned revenue without the expensive, time-consuming hassle associated with manual secondary filing. Secondary claims can represent a significant amount of money left on the table, so having a partner that streamlines this process can ensure a healthier, more accurate bottom line. The key to reaping the benefits of electronic secondary claim submission is having the necessary connections from your clearinghouse to the payers, as well as dedicated secondary edits to ensure faster submission and higher first-pass rates for those claims.

- **Denial prevention and management.** Unfortunately, payer rules are constantly changing so practices will never be able to eliminate all denials. Most denials can be prevented, but having the right tools can help you manage the ones that cannot. Your clearinghouse should be able to help with both of these scenarios. A good claims scrubber and eligibility solution, as mentioned above, are key to ensuring that your claims are clean and that the patient is eligible for services rendered. By identifying these issues prior to sending the claim to the insurance company, you greatly reduce the chance of it being denied. For claims that are denied, an easy-to-use denial management tool can help you identify the issue and create a compelling appeal letter pre-populated with claim and remittance information. It's imperative that you are able to track your denials so that you can address them, confirm each denial was responded to and hopefully prevent them from happening again. Your clearinghouse's denial management tool should include this functionality so that you can track and appeal denials automatically versus manually.

- **Patient billing.** Tracking patient payments is a labor-intensive, cost-consuming proposition. The good news is that there are payment solutions that securely store patients' debit/credit card information at the time of service and charge the cards once patient responsibility is known. These solutions can significantly reduce patient billing and collection costs. If you cannot eliminate patient statements entirely, you may want to consider whether outsourcing patient statements to a clearinghouse could prove faster and more cost-efficient for your practice.

- **Core reporting.** Accurate, easy-to-generate business intelligence lies at the heart of any successful RCM endeavor, so reporting tools are vital. Your clearinghouse should deliver flexible and transparent reports on a regular basis that show how your practice is performing. Ideally, these reports will be dynamic and can be pulled in real-time as opposed to static ones that only look at the past month or year. In addition, you should be able to see all statistics about your cash flow on one report to help you understand the financial health of your practice.

- **Practice analysis.** Your clearinghouse should have advanced tools that allow you to spot rejection and denial trends so that you can make the changes necessary to increase reimbursement and improve staff productivity. In addition, these analytics and benchmarking tools should aggregate over time to help you track results of your internal changes. Some clearinghouses also provide reports that measure a practice's overall performance and provider productivity.

Additional Expectations

Your clearinghouse needs to provide you with the features and functionality to efficiently and effectively manage your revenue cycle. However, do not underestimate the importance of client service and your vendor's ability to handle industry transitions.

- **Client service.** When you are having an issue with a payer, a particular claim or anything else that

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could possibly affect your reimbursement, you should be confident that your clearinghouse's client service team can help you resolve the issue quickly. Industry-leading client service teams are comprised of seasoned professionals with a minimum average of five years of electronic data interchange (EDI) experience. In addition, these individuals are application experts who can resolve at least 95% of problems on the first call or email.

With the amount of mergers and acquisitions taking place in the healthcare industry, it's no surprise that there has been a great amount of employee turnover. However, these changes should not be felt by you in any way. Regardless of who answers your client support inquiries – the vice president of the department or a representative – they should be able to answer your questions or find someone who can respond to the issue quickly and efficiently. Your practice's financial health should not suffer because your technology providers are experiencing "growing pains."

- **Transitions.** There are a number of surprises in healthcare on a daily basis, but one thing is for sure: changes are coming and at a quicker pace than in the past. Practices need technology partners that they can rely on to help them through transitions like 5010 and ICD-10. Past performance is the greatest predictor of future success (or failure), so make sure that your clearinghouse is prepared to handle all the changes coming down the pike. If your vendor had issues with 5010, ask what plans they have to ensure that the same problems do not occur during the ICD-10 transition.

In Summary

A good clearinghouse streamlines your entire revenue cycle process. It is transparent: it lets you see the entire life cycle of every claim to ensure you are appropriately paid for all services rendered. It provides customizable workflow tools that help you analyze and increase productivity.

In addition to technology that allows you to manage every aspect of your revenue, you should expect nothing less than exceptional client service, timely answers and solutions to revenue cycle issues from your clearinghouse. You deserve a partner who cares as much about getting your claims reimbursed as you do—regardless of what changes are occurring throughout the industry or with their staff.

About Navicure

Navicure's web-based healthcare billing and payment solutions help healthcare organizations of all sizes increase revenue, accelerate cash flow, and reduce cost in the course of managing insurance claims and patient payments. Serving more than 50,000 healthcare providers nationwide, Navicure's technology solutions automate account receivables processes, including claims management; patient eligibility verification; remittance and denial management including automated secondary claims filing, appeals, and posting; reporting and analysis; and patient payment collections at and near the time of service. Navicure's solutions are supported by its unique 3-Ring® Client Service which guarantee that a client service representative will answer every client call in three rings or less, even during times of transition such as 5010 and ICD-10.

Navicure is the exclusive billing and payment solution of the MGMA AdminiServe® Partner Network and an MGMA Executive Partner. The company received "Best in KLAS" distinctions for the claims and clearinghouse services market segment as part of the 2008, 2010 and 2012 Best in KLAS Awards: Software & Services report (www.klasresearch.com). KLAS is a leading source of information on healthcare information technology vendor performance. Navicure also received the 2013 Gold Stevie Award for Healthcare Customer Service Team of the Year as part of the 2013 Stevie Awards for Sales and Customer Service.

Navicure is the founding sponsor of www.icd10hub.com, a free educational website devoted to making physician practices' transitions to ICD-10 easier. Additionally, *ICD-10 Analyzer* by Navicure (navicure.com/icd10analyzer) is a complimentary online tool that enables medical billers to identify the ICD-9 codes that will most impact a user's payer reimbursement and suggest corresponding ICD-10 codes. Navicure continues to be ranked among the fastest growing companies nationally in the Inc. 5000 and Deloitte Fast 500 rankings. For more information, please visit www.navicure.com.

Clearinghouse Report Card

All clearinghouses are not the same. How does yours stack up? See appendix below to grade yours.

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Clearinghouse Report Card

A+?

What grade would you give your clearinghouse on the following?

	Pass	Fail
Client Service • Calls answered by a live person in 3 rings or less • Client Service Representatives have at least 5 years of EDI experience		
Revenue Cycle Management Technology • Immediate status notification of submitted claim (accepted vs. rejected) • Online claim correction • Ability to appeal denials with pre-populated letters		
Claim Processing Performance • 100% confident that claims are sent to payer • Outbound claim delays identified within 24 hours • Proactive alerts regarding national and regional payer delays		
Reporting • Reporting dashboard that easily tracks claims from submission to payment • Able to work rejections off one report • Customizable reports that fit into your workflow (e.g. sorting by provider, payer, highest billed amount, etc.)		

Payer Connectivity
• Electronic connections to all payers (regional and national) for:
  ○ Primary claims
  ○ Electronic remittance advice (ERA)
  ○ Eligibility
  ○ Secondary claims		

Transitions • Good track record for handling transitions (e.g. 5010, NPI) • Confidence with preparedness for upcoming ICD-10 transition		
Education • On-demand webinars – both educational and product-specific • Practice management resource guides/white papers • ICD-10-specific resources, blog and webinars • Ongoing practice management blog		

All clearinghouses are not the same.

How does your clearinghouse stack up? Industry-leading clearinghouses receive passing grades on **all** of the above items, not just a few. If you don't think your clearing-house is making the grade, you may want to consider looking at top-ranked solutions.

Find top-ranked solutions by:

- Asking for referrals from similar practices
- Reviewing customer satisfaction surveys
- Contacting KLAS Research, an impartial research firm that evaluates clearinghouses annually
- Reaching out to professional organizations
- Visiting trusted Internet sites

Your clearinghouse is integral to your practice's financial success. Ensure that it's up to the task. **At Navicure, we're confident that we are and would welcome the opportunity to prove it to you. To learn more, please contact us at 1-877-NAVICURE or sales@navicure.com.**

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