Five risks of relying on your patient accounting system for claims and billing management

Implementing a new enterprise patient accounting system (PAS) is a significant undertaking for health systems of all sizes, and providers naturally want to get the most value from their investment. Yet, health care leaders often decide to use new patient accounting systems like Epic or Cerner as their claims and billing engine without a complete evaluation of whether the PAS can meet all their needs.

Indeed, there are significant risks in "making do" with a system that lacks the capability to validate that all bills are clinically complete, with no missing charges or over charges, or that fails to drive a high first pass payment rate.

If your organization is evaluating your options for claims and billing, consider the following summary of risks associated with relying solely on a PAS for these important revenue cycle functions.

1 Increased denials

The health system revenue cycle is full of challenges that can lead to denials. Incomplete patient coverage, billing errors, medical necessity issues and missing information all create reimbursement issues. While any claims system can automatically check a claim against rules or edits to validate accuracy, the secret sauce to decreased denials is the content of the edits library.

It must be a strong, comprehensive library that addresses any payor and all reimbursement models. It should be updated constantly as new information is published. PAS vendors typically are not experts in this area, leaving your organization responsible for researching and implementing new rules – a hefty burden to carry. On the contrary, dedicated claims and billing vendors have hundreds of edit

5 risks

- Increased denials
- Lost or delayed revenue
- Higher cost-to-collect
- Less efficiency in revenue cycle operations
- RAC audits and repayments

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researchers and content specialists. These teams are focused on global and specific payor requirements, medical necessity rules, interpretive payor edits, reverse-engineered edits, eligibility requirements and regulatory policies. Their goal is creating a set of edits to drive not just clean claims, but also a low denial rate.

If the system isn't supported by **clinically based charge-level rules**, charges will continue to be left off bills and at risk of never being collected.

2 Lost or delayed revenue

Charges are left off bills every day, and some organizations wrongly assume it's a reality of doing business. Whatever the reasons, failing to accurately capture and bill all patient charges the first time can lead to substantial revenue loss, decrease patient satisfaction and create serious noncompliance risks. Automatically auditing bills at the charge-level is a good place to start, but once again what makes the process worthwhile is the library of rules that drives those audits. If the system isn't supported by clinically based charge-level rules, charges will continue to be left off bills and at risk of never being collected.

3 Higher cost-to-collect

If your staff isn't able to keep up an accurate rules library to maintain low denials and rejections, extra time will be spent researching, correcting and appealing those claims. Re-work also is introduced if missing charges are identified after the claim has already been submitted. It's much less costly to get the claim right the first time, so that re-work is eliminated and your payment comes back faster.

4 Less efficiency in revenue cycle operations

To keep up with the demands of the changing health care environment, your health system must constantly improve your revenue cycle. Insight from reports on staff productivity, monthly transaction volumes, claims errors and payor payment trends all can help an organization thrive. This kind of information, however, isn't typically tracked as part of the functionality in a PAS. The following are examples of data that may not be available:

- Outstanding or unbilled claims – At any given time, can the system display how many claims have not yet been sent to the payor, how old they are and who is responsible for them? Can this information be displayed both by claim volume and dollar value?
- Improper billing – Can the system report on the most common issues being flagged for correction on your claims and bills? Can it tell you the departments that are the biggest offenders with missing and over charges?

Without these important data feeds, it's impossible to identify the root causes and take action upstream. Only with the right data can a financial leader make the best operational decisions.

5 RAC audits and repayments

Without a robust rule library checking claims for accuracy, your health system is exposed to the potential forfeiture of reimbursements if a claim is paid based on improper data. While audits in today's environment are difficult to avoid, you can mitigate the risk of take-backs by having a strong rule set to validate claims for accuracy before they are submitted.

Protect your ROI

While using a PAS for claims and billing may seem appealing, the risks it brings to the financial performance of your organization are real. Denials, increased accounts receivable (A/R) days, higher cost-to-collect and exposure to audits are all revenue cycle challenges that could become overbearing without the right partner in place. nThrive helps your health system achieve a high patient accounting system ROI by safeguarding revenue integrity and by providing accurate data flow between the patient accounting system and financial solutions. We offer patient-to-payment℠ revenue cycle management solutions that increase collections, decrease A/R days and accelerate cash flow – all of which are critical to your health system's financial health.

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