FinThrive™

Lifecycle of a Claim

Your path to payment

Uncompensated care reached
$42.7 billion in 2020.

It's time to break this cycle of inefficiency, so finance can flow freely, without complication.

Today's payer mix has shifted. Providers depend on cash flow from patients. But patients don't pay like commercial payers—they often pay slower, which drives up costs to collect. While patients should pay within their ability, many don't, as the bill is confusing, arrives late, or simply isn't a priority. Those who can't pay are often unaware of the help and resources that may be available.

An in-depth look at the lifecycle of a claim may uncover new opportunities for protecting your earned revenue. This guide walks you through each stage of the claim lifecycle—highlighting key market trends and offering best practice tips to boost profitability and reduce denials.

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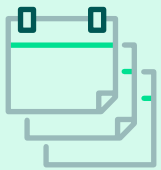
Lifecycle of a Claim

For healthcare providers and patients, the best-case scenario is when a patient can make educated decisions about where to receive care, and understands their costs, financial responsibility and insurance or charity eligibility up front. Optimizing operations, reducing costs to collect and better engaging patients in the financial aspects of their care often leads to a more positive patient experience. That's why it's important to evaluate every step in your claims process.

As an industry, billions of dollars are left unaccounted for each year. **Uncompensated care has been on the rise for most of the past 20 years**, and rose to $42.7 billion in 2020 from $41.6 billion in 2019.[1]



The lifecycle of a claim is typically 30 to 90 days.

The ideal processing timeframe is within a **45 to 60-day window**.

Scheduling/Pre-Registration

Choose a provider

With the rise of consumerism in healthcare, patients want to make their own informed decisions regarding care. This can be accomplished when they:

- Have access to **transparent pricing**
- Know their expected out-of-pocket costs in advance
- Feel empowered to **manage the financial aspects** of their care

78% of U.S. consumers want to know the cost of their care services before their appointment.[2] It's critical to ask patients for payment upfront. Providers have a 70% likelihood of collecting payment at the time of service, and only a 30% chance of collecting after a patient leaves.[3] Transparency in cost and billing is paramount for providers as well. One in 10 patients who shopped for care indicated that it caused them to change both the healthcare provider and the facility for their care.[4] If that's not grabbing your attention, **93% of consumers indicate the billing experience is a major factor** in returning to a healthcare provider.[5]

Best practice

Provide a **patient-facing estimation tool** on your website, enabling those shopping around for a provider to gain a clear, upfront understanding of costs. Ensure your organization meets both requirements of the price transparency mandate.

Registration

Know payment responsibility

Patients want to know how much they're expected to pay, and what financial assistance or payment plan options are available to them before treatment is provided. Being able to meet patients where they are financially with tailored payment plans, including self-service options, can improve their engagement.

Half of denials are caused by front-end revenue cycle process shortfalls. Of these, over one in four are due to registration errors.[6] Ensuring all registration information is right the first time prevents rework downstream—saving time and money.

Collecting payment within the first 60 days is key. Accounts more than 90 days overdue have a 50% collection rate, and those more than 180 days have a 20% chance of collecting.[7]

Slightly over half (53%) of survey respondents said they were **provided with clear information on their expected out-of-pocket costs** prior to treatment.

Best practice

Upfront **patient engagement and education** go a long way. It's critical to have an end-to-end eligibility solution to identify, validate, and in some cases, discover insurance to avoid denials downstream. Ensure your staff can verify patient demographic information and insurance eligibility, screen for charity care, and provide accurate estimates of financial responsibility and payment options. Ask for payment—even if it's just the deductible or coinsurance.

Charge Capture

Code it right

When charges aren't accurately documented, it can impact a hospital's bottom line. Undercharging and overcharging are both issues that can affect profitability. The revenue cycle has many moving parts involving automation and human intervention. The opportunity for error is high, potentially leaving billable dollars behind.

More than two-thirds of revenue cycle leaders said 1%–10% of their total charges were under-coded, and 56% said 1%–10% of their total charges were over-coded.[8] This not only represents leaked revenue but presents significant compliance risk as well.

Up to 1% of net patient revenue is lost because of errors related to charge capture.[9]

Best practice

Performing a regular audit of charge captures—both in-house and by partnering with a vendor—can help streamline internal workflows, reduce lag time and improve the revenue stream.

Coding and Documentation

Substantiate the claim

There's a common saying in the healthcare market that goes, "If it's not in the chart, it didn't happen." Coders rely on dictation and charge entry from multiple sources—the EHR, physicians, clinicians and other journal entries—making the risk of human error high. The Department of Health and Human Services found "**billing error rates ranging from 7% to 48%**."[10]

It's imperative to have tools and checklists in place to ensure charges are captured and documentation supports the care provided. Medical necessity denials represent one of the largest denial categories, with poor documentation being a main driver.

Billing error rates

Best practice

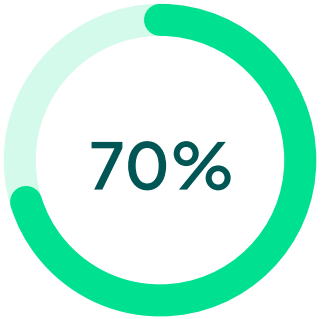
Consider having a Clinical Documentation Integrity Program and a technology partner that helps you defend your earned revenue. Physicians are focused on diagnosing and delivering care; less so on coding a chart to ensure payment. With experts on hand to identify documentation deficiencies and code care to the highest specificity, you can better protect earned revenue for care provided.

Discharge

Ask for payment

At this point, care has been rendered, the patient is ready to go home and there's a clear breakdown of payment responsibility—especially if you've found all eligible coverage and verified demographic information. If there were no pre-admission financial discussions, this is the last chance to engage a patient face to face to determine their unique financial situation and put a personalized payment strategy in place—including charity care, needs-based discounts and payment plan, if necessary.

According to the Academy of Healthcare Revenue, "**Providers have a 70% chance of receiving payment at the time of service if they request it**—but only a 30% chance of collecting after a patient leaves the building."[11]



Chance of receiving payment at service **if requested**

Best practice

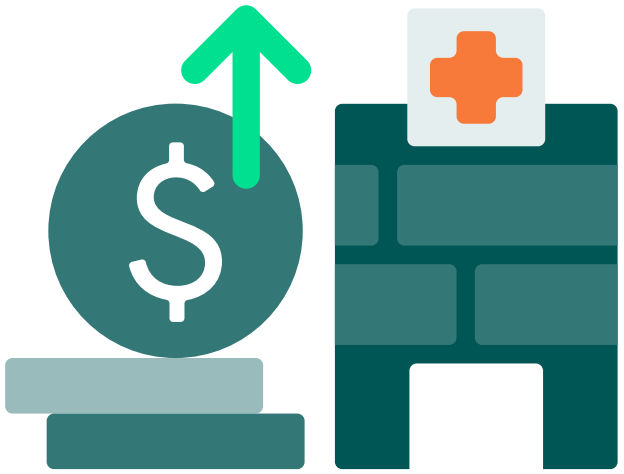
Once the bill is in the mail, it's harder to have a conversation about payment options. Have this conversation in person—and collect before discharge, if possible. According to a Becker's survey, almost **70% of patients** indicated they are more likely to pay a medical bill faster when provided a cost estimate prior to service.[12]

Claim Build/Scrub

Follow billing rules prior to submission

There are hundreds of insurance carriers with thousands of plans, all with different rules. Having a claims scrubber in place enables a provider to ensure the claim will be submitted clean and has all the necessary elements for payment. These edits need to be updated frequently to reflect the ever-changing payer environment.

It's industry best practice to have a 90%+ clean claim rate, which means one in every ten claims will deny for some sort of claim edit.[13] More touches to the claim lead to less productivity and throughput, driving up your cost to collect.



Best practice

Try to achieve a 90%+ clean claim rate. When staff doesn't touch or manipulate the claim for payment, rework can be avoided and the **cost to collect can be significantly reduced**.

Final Bill

Get everything in order

Patients expect correct billing statements that account for all relevant benefits. When the final bill drops—typically three to five days after service—it's often too late for a provider to make corrections.

5%–10% of claims, on average, are denied.[14]

Best practice

Before you send the bill, be sure it's going to the right place and includes the correct information and amount. Conduct necessary analysis and fix potential errors early to ensure it's as accurate as possible.

Adjudication

Shore up final costs

By now, all insurance benefits and discounts should be calculated and in place. Taking time to identify and correct missed charges, denials and underpayments often leads to claims being paid faster.

One in five claims have missed charges or aren't paid properly.[15]

The average 350-bed hospital may be leaving $22 million on the table by focusing on cutting costs over optimizing revenue cycle processes.[16]

Claims with missed charges/ not paid properly

Best practice

Be smart about which claims will yield payment and quickly optimize your internal processes. If it hasn't been done already, be sure to check potential coordination of benefits opportunities for **further reimbursements**. In addition, end-to-end eligibility solutions can validate medical benefits and/or discover insurance to ensure claims are submitted to the correct payers, even if insurance is unknown to the patient or provider.

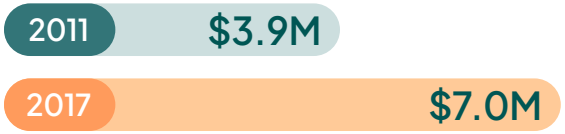
Appeal and Follow Up

Learn the rules

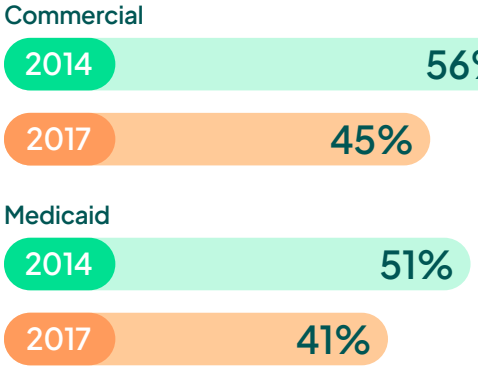
Hospitals are losing on appeals and it's getting harder to collect payment on claims later. Often, when payer rules aren't followed, providers aren't getting paid.

Not only are denials increasing, but they are also getting harder to resolve as the appeal overturn win rate is declining significantly. The **commercial overturn rate is down 11%**, while the **Medicaid overturn rate is down 10%**.[17,18]

Hospital Denial Write Off 2011: 2017



Appeal Overturn Rate



Best practice

While it can be hard to get paid on an appealed claim, there's a lot to learn from evaluating and optimizing your process on a consistent basis. Leverage a third-party resource to ensure you're adhering to specific payer rules and identifying denial and underpayment root causes. This can help improve your upfront processes and adapt your collection strategies moving forward.

Cash Posting

Get your A/R in order

As costs to collect continue to rise and conversions to new patient accounting systems or EHRs (Electronic Health Record) take hold, more providers are looking to outsource their A/R. Per a Healthcare Black Book survey, **nearly all (98%) hospital leaders are considering partnering with an outside vendor to improve cost efficiencies**.[19]

Best practice

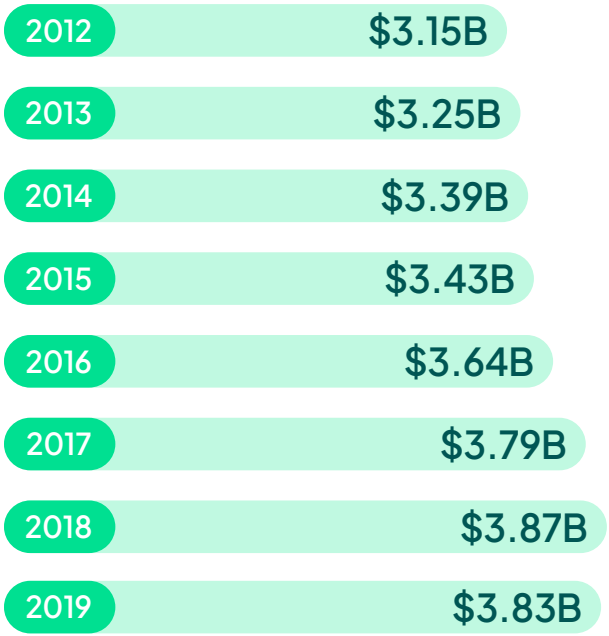
Look for partners with **technology-driven solutions** that combine data, analytics and workflow, allowing accounts to be worked faster and at a lower cost to collect—even small balance accounts and those difficult to resolve. Additionally, partners should deliver advanced reporting and insights, such as denial and underpayment root causes and payer scorecards. These can help you understand the drivers of your A/R and refine your revenue cycle processes and performance.

Month/Year End

Optimize and audit

Government reimbursement opportunities are difficult to attain due to their inherent complexities and frequently changing rules. There's money to be recovered and the onus is on providers to be savvy with their collection efforts.

Total Reported MCBD
in Federal Fiscal Years



Best practice

Perform a thorough monthly audit of reimbursements to identify trends and **recover more reimbursement opportunities**. Denials, underpayment and reimbursement optimization efforts represent three critical areas to **drive revenue recoveries** for your organization. Hundreds of thousands of dollars are left on the table by not exploring these areas for yield.

About FinThrive

Our goal is to help customers protect revenue, prevent lost dollars and drive significant yield throughout the lifecycle of a claim—from **patient pre-registration** to **post-service reimbursement**. We deliver a clean claim rate unmatched in the industry. We do this through our market-leading revenue management solutions and data assets, and by deploying proprietary methodologies that help providers.

Our technology helps your people track every individual dollar throughout the enormity of this complex system. We believe revenue management technology will drive the future of healthcare.

FinThrive paves the way for a healthcare system that ensures every transaction and patient experience is addressed holistically. Our end-to-end revenue management platform provides financial teams and stakeholders with greater reliability and control to deliver better outcomes for everyone. With our vision, technology, experience and scale, we're advancing the healthcare economy.

We're proud to:

- Partner with more than **2,850** hospitals and health systems
- Serve more than **650,000** physicians and other healthcare providers
- Report customer recoveries of over **$1.2 billion** annually, equating to more than **$10 billion** to date
- Offset national uncompensated care by more than **2.5%** annually

We rethink revenue management

For more information, visit finthrive.com

Request a **revenue recovery review** at solutions@finthrive.com.

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