ADVANCED DATA SYSTEMS RCM

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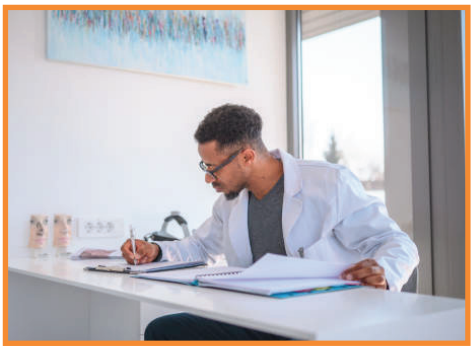
MEDICSRCM *IN*SIGHTS

Articles of interest in the World of Revenue Cycle Management, Billing, Consolidated Workflow, and Industry News

Presented by ADS RCM and our MedicsRCM services with best wishes for a happy, healthy, prosperous, and profitable 2023

The Art & Science of Benchmarking Productivity



According to a *November MGMA poll*, 36%, or more than one in three medical groups were on track to miss their 2022 productivity goals. As a batting average in baseball, that's a hall of fame stat. In medical operations management, it's cataclysmic.

If you think "cataclysmic" is too overdramatic, consider this: productivity affects everything important.

When productivity is up at peak levels, you're generating revenue, your workflow is humming, and your resources and assets are not sitting idle waiting for the next thing to happen. Your scheduler is tight, you have an almost zero no-shows, and you're seeing the most patients possible without cutting corners. Your in-office and telehealth encounters are efficient with EHR data captured during the encounter such that claims are submitted quickly and cleanly without having to revisit them later that night, over the weekend, or on holidays.

Your productivity shouldn't be bogged down with denials, appeals, prior authorizations, eligibility verifications, claim tracking, finding missing insurance information, and fielding patients' balances-due and statement questions.

And, when your patients can self-serve on any number of functions using a portal in advance of arrival and a kiosk on arrival, they basically become an extension of your staff by **doing their own work** adding to ***your*** productivity.

Eyeballing or working off gut feeling isn't benchmarking. Benchmarking is benchmarking and for that, you'll need KPIs, analytics, statistics, and reports.

You may even want to access your or your RCM company system's audit trail (assuming there is one) to see what your staff is doing system-wide based on their logins. If there's a lot of "busywork" which can often be combined with bottlenecks in workflow as patients and staff stagnate, that becomes a huge drag on productivity.

Between compiling your financial and operational metrics and workflow KPIs (again, assuming you can do that) and generating audit trail reports, you should be able to solidly benchmark your productivity. If the picture presented isn't pretty or if you can't produce a picture at all, those are separate problems.

We'll improve your ability to drive productivity and prove it through solid and actionable benchmarking. And, we'll guarantee to increase your revenue in 90 days.

A Positive Financial Experience Benefits Patients and *You*!

The importance of providing your patients with a positive financial experience is undeniable because by doing so, you're providing yourself with the same thing!

So, give patients the experience they need because they represent a double-edged problem:

1. The first edge is that for some time, patients have been among the highest of payer groups, being responsible for more and more of their healthcare costs. Some sources report that patients are actually the third highest payer group behind Medicare and Medicaid.

2. The second edge is how patients have their own financial issues, not helped by inflation. Often, patients find themselves having to choose between food, shelter, and healthcare.

Every patient dollar is meaningful, from collecting copayments at time of service to ensuring they pay promptly the instant balances become their responsibility. Some suggestions include you:

- ✓having an easy-to-understand payment policy that's acknowledged (signed) by patients; be sure to include your out-of-network (OON) and self-pay rules, and your expectations for being paid as post-insurance balances become their responsibility

- ✓getting OON and eligibility alerts and displaying copayment amounts as part of scheduling or at least at any point prior to appointments; for OON you should be able to display providers who are in-network for the patient, if any (OON alerts will help you comply with the No Surprises Act!)

- ✓accessing a responsibility estimator ideally while scheduling appointments or anytime in advance giving patients a good approximation of what they'll owe based on the appointment reason(s); this eliminates surprises and may even enable you to obtain some or all of that estimated responsibility amount in advance as allowable by the payer

- ✓explaining or displaying responsibility amounts as patients leave now that actual procedures have been performed

- ✓sending balance-due texts and/or emails as soon as balances become your patients' responsibility with an ability for patients to pay directly back through those texts/emails; alternatively you'll want to have a patient portal with an online payment feature

Nothing beats open, honest communication combined with strategies and the technology tools mentioned for driving patient payments. We know it works because we support everything mentioned and our clients have tightly-managed patient A/R stats.

Population Stat on Medicare and Medicaid

According to the US Census, the country's population count for 2022 was 333,287,557. Divided by two, that's 166,643,778.5 people. Perhaps one person isn't half the person they were in 2021.

In any case, the number of people on public health coverage (Medicare, Medicaid, and the Children's Health Insurance Program/CHIP) as of September, 2022 totaled approximately 156 million which means almost half of the US population is on one or a combination of those programs.

A number of ramifications are involved in these stats, not the least of which is how 18 million people may lose Medicaid coverage once the pandemic's public health emergency (PHE) ends a*ccording to a study conducted by the Robert Wood Johnson Foundation*.

Women and Negative Nuances in Health Insurance Coverage

Women's health varied by health insurance coverage in terms of uninsured women experiencing more disparities in preventive care, and those with coverage reporting how they were unaware (surprised) by the limits of their coverage according a Kaiser Family Foundation (KFF) report.

Among several other disparity examples, women were more likely than men to learn their prescription medications either weren't covered or they had a high out-of-pocket cost before coverage. Women also had a higher incidence about service they thought were covered but weren't, and that their payers weren't going to cover tests or imaging as recommended by their providers.

Click here for the full KFF report.

Remote Patient Monitoring = Powerful Engagement and Additional Revenue

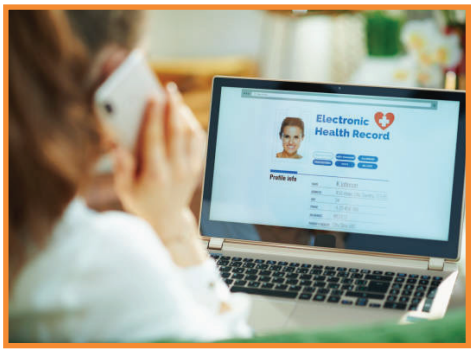
Today, your effort to more solidly engage patients and derive additional revenue without expending in-office resources should include a utility for remote patient monitoring (RPM) in addition to technology you might already be using such as telemedicine, portals, kiosks, and interactive appointment and balance-due reminder texting.

RPM provides your patients - and you - a convenient way to keep them monitored and healthy while you derive revenue for doing so without requiring in-office resources such as intake, reception, equipment, and provider and administrative staff.

If your RPM option includes the equipment needed, implementation, training, support, and the monitoring itself as needed for proper reimbursement, all at no additional cost, it becomes that much more valuable to you. There wouldn't be any out-of-pocket costs to launch and provide RPM services for your patients and you.

An RPM program for you as described is nothing to think about: there's zero cost to you with the RPM's revenue cycle management company or vendor absorbing everything including the monitoring which is critical since RPM coding must be correct. Your patients will appreciate the convenience of not having to come into the office for vitals such as blood pressure, glucose, weight, temperature, and oxygen readings whether or not traveling is a problem for them. And by patients not coming in, you're not expending the in-office resources as described above.

Your virtual patient care landscape can be dramatically enhanced with our RPM option which operates as described. It's the perfect adjunct to our telemedicine app, or it can be used separately. And, our portal, kiosk, and interactive texting complete the patient engagement circle while driving revenue and efficiency for you.



No Shortage of CMS Initiatives Requiring your Attention

The 21st Century Cures Act. The No Surprises Act. The Appropriate Use Criteria Act (aka, clinical decision support). If any or all of these apply to you and you don't have your Act(s) together, you'll be on the wrong side of the penalty line. And you certainly can't forget about 2023 MIPS reporting which is very much alive and well (thanks for asking).

Each one of these requires multiple paragraphs to fully describe and do justice as to why they exist, but we've encapsulated them into one paragraph each:

- ✓**Cures Act:** is all about patients' records being accessible (not blocked) by everyone in their care network including their providers, hospitals and other inpatient facilities, and emergency rooms; another aspect of the Cures Act is to make healthcare costs transparent to patients enabling them to shop economically for whatever care is needed

- ✓**AUC Act:** will require providers who refer Medicare/Medicaid patients for advanced imaging (CT, MRI, PET, nuclear) to first obtain an approval code from a certified (qualified) clinical decision support system (mechanism) confirming the decision to order the study based on the patient's diagnosis and history; imaging centers will have their claims denied without that approval code

- ✓**No Surprises Act:** calls for eliminating surprise billing (out-of-network) such that patients don't receive statements often with exorbitant balances due for services about which they had no knowledge

- ✓**MIPS Reporting:** Your 2023 MIPS stats will need to be reported with a higher degree of completeness and complexity in order to avoid a 9% penalty in your 2025 Medicare reimbursements (reminder that MIPS penalties are always reflected in the second year of the calendar year being reported); you'll want to obtain your additional reimbursement incentive for quality reporting or at least remain neutral; you'll definitely want to avoid the penalty

You can certainly read chapter and verse about them on *www.cms.gov*.

The bad news is, you'll have to comply with any that apply to you or face financial penalties for not doing so. The good news is, we'll help you comply with any or all of them:

- ✓MedicsRCM clients can use the MedicsCloud EHR from ADS; it's 21st Century Cures Act-certified ensuring they compliance with this initiative

- ✓The MedicsCloud EHR has an embedded qualified clinical decision support mechanism (qCDSM) option if needed that will instantly produce (or not produce) a qualifying G code as needed when referring patients for advanced imaging as described

- ✓The ADS MedicsPremier financial/operational platform we use, and to which clients also have full access, has a rules engine-driven patient responsibility estimator enabling you to obtain out-of-network alerts in advance exactly as called for in the No Surprises Act

- ✓Our platforms will automatically compile and track your 2023 MIPS data with our MIPS team offering input as well into how reporting improvements can be made in order to obtain an incentive or at least remain neutral without being penalized

We not only help our clients derive more income while operating efficiently, but we also help them on the clinical side with the highly comprehensive MedicsCloud EHR for clinical charting and reporting!

Contact us at 844-599-6881 or email rcminfo@adsc.com for more about MedicsRCM's services and our 90 day guarantee to increase your revenue, or about the MedicsCloud Suite if you prefer using **in-house automation**.

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