ADVANCED DATA SYSTEMS RCM

NOVEMBER 2023

MEDICSRCM *IN*SIGHTS

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

Beethoven would've had a lot of Procedure Codes

Born in 1770, LvB started to decompose (ugh) in 1827. But for a guy who lived for 57 years with his health issues at that time, he did okay writing 722 works, nine of which were full-blown symphonies (especially for the horn sections).

Anyway, going back to his health issues, how would we know what exactly they were? Enter genetics testing which was performed recently on preserved locks of Beethoven's hair. And from artists' depictions of him, it looked like there was no shortage of hair.

That genetic testing showed today, Beethoven would've had ICD-10s along the lines of K74.60 (cirrhosis of the liver), B19.0 (hepatitis B infection) and H91.3 (his very famous deafness). Along the way, it was shown there was an "extra-pair-paternity event" in his ancestry. In plain English, a male progenitor anywhere from his father, grandfather, great grandfather, or beyond was busy on the side.

What does this all mean? Nothing, other than it's just historically interesting, and that MedicsRCM and our team would've been able to bill The Maestro's claims for maximized reimbursement, collect his balances, and capture his clinical charting through the MedicsCloud EHR. In short, we could've made beautiful music together.

Click here for the University of Cambridge study.

2024 Physician CMS Fee Schedule Thumbnail

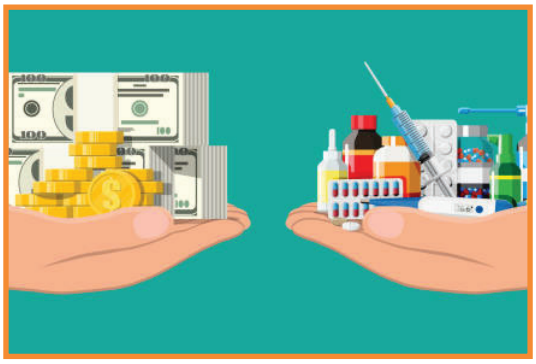
You're no doubt at least somewhat familiar with the upcoming PFS. Of course there's a lot of detail, but the thumbnail on it is the conversion fact of 3.4% translates into a decrease of $1.15, or to $32.74 from $33.89. The cut will affect mostly specialty practices with primary care and other healthcare entities not being affected.

Regardless of your specialty, 2024 will not be the time to submit claims just for the sake of submitting them. You'll want them submitted for maximized reimbursement, coded the best ways possible including for E/M coding, and with NCCI editing correctly followed to avoid unnecessary denials.

(MedicsRCM ensures claims are submitted for maximum reimbursement without over-coding, alerts on E/M coding, and ensure claims are properly bundled when appropriate for NCCI compliance.)

Click here for all of the details on the PFS from CMS.

The Healthcare Affordability Challenge



It might sound like an athletic event, but it's not. Or maybe it could be with patients having to jump through hoops to pay their responsibility balances.

The nitty-gritty is that, according a Health Affairs study, 27% of adults face at least one healthcare affordability challenge. And don't let the "at least one" wording fly under the radar since it infers there may be more than one such challenge for that 27%.

The challenge is based on patients having high out-of-pocket costs and existing medical debt.

As may be expected, low-income patients are the most affected but even middle-income patients made up a noteworthy percentage.

The findings highlighted the importance of Medicaid continuous enrollment to low-income populations who'd otherwise have no coverage at all.

Click here for the Health Affairs report.

(MedicsRCM clients have access to our patient responsibility estimator while scheduling appointments and anytime in advance, helping to prepare patients as to what they'll owe based on the appointment reason, and again on leaving once actual procedures were performed. Clients can also be alerted about out-of-network visits while scheduling.)

Medical Debt Removed from Credit Scores

A good follow-up to the previous article is how consumer credit scores have improved after the three major credit bureaus recently stopped including medical debt in those scores. The removal criteria is for debt under $500.00 and less than one year old.

That change alone improved credit scores on average from 585 to 615 points.

Click here for details from the Urban Institute.

Do you Know what you need to Know, Healthcare Analytics-wise?

According to a survey by AMGA, clinical staffing costs have increased by 10% this year as labor shortages It's one thing to know what you know. It's another to know what you need to know. On that note, according to HFMA, you must know five specific things. Here they are along with why you have to know them:

1. **Net Days in A/R**, or, where are your receivables in terms of how many days they're outstanding? Determine your net A/R then divide that by your average daily net patient service revenue. There are a number of things to include/exclude but ultimately, it's suggested days outstanding shouldn't exceed 50 at a minimum, and preferably be 30-40.

2. **Cost to collect**, or, how much am I paying to collect my own money? It almost seems like you shouldn't have to do that, but of course, you do. You'll need to calculate costs to perform eligibility verifications,

prior authorizations/pre-certs, patient accounting staff and costs, materials, envelopes, statements, and anything else involved in collecting revenue. That number should be about 2% - 4% of net patient revenue.

3. **Clean claim rate**: basically self-explanatory, it's the percentage of claims that are accepted cleanly on first submission. Understanding that 100% will never happen, the study says to shoot for a 90% clean claim rate with 95% as an industry standard.

   That said, a consistent 98% - 99% rate is possible when a reliable claim scrubbing tool is used, and when you can be alerted on claims likely to be denied before they're submitted. With that, you'd be able to proactively edit those claims, and then submit helping to contribute to a high 90s rate.

4. **Bad debt**: another one that's self-explanatory, it's the amount you're writing-off as being uncollectable for whatever reason. The study doesn't provide acceptable stats on this since every setting is different based on practice size, specialty, if it's a hospital, etc.

   In your world, you're dealing with two separate payer groups: insurance and patients. Of course the exception is if your patients are all self-pay. Other than that, as with clean claims above, nothing is 100%, meaning, you'll never have no bad debt. The idea is to keep bad debt as minimized as minimized can be.

   For insurance payers, having the scrubbing noted in #3 above, automated prior authorizations, eligibility verifications and out-of-network alerts on scheduling, and a denial preventer, and real-time claim tracking to ensure submitted claims are being processed will all go toward keeping insurance bad debt to an absolute minimum.

   For patients, having the personal responsibility estimator as noted and an ability to accept full or partial payments in advance as allowable by their insurance and per your financial policy, balance-due reminder texts with online payments, email statements if preferred, offsite paper statements as a backup, an ability to accept payments in any number of ways (even by gift cards and coupons as may apply to your specialty), all help contribute to a minimized patient bad debt number.

   Here's another "icing on the cake" feature: access to an accurate insurance discovery option for patients who don't have coverage listed. A good insurance discovery utility will find up to 30% of "uninsured" patients actually have insurance. Imagine finding 3 in 10 patients with out insurance really have coverage, and what a difference that would make?

5. **Cash Collection as a Percentage of Net Patient Services Revenue**
   This one's a little esoteric, but this KPI assesses financial health by understanding its ability for the organization to transfer revenue to cash. You get that number by dividing the total patient service cash collected by the average net patient service revenue statement.

   The total collected service cash is the monthly revenue from patient service payments posted to patient accounts, including undistributed payments, bad debt recoveries, Medicare DSH reimbursement, and Medicare IME payments. The value is net refunds.

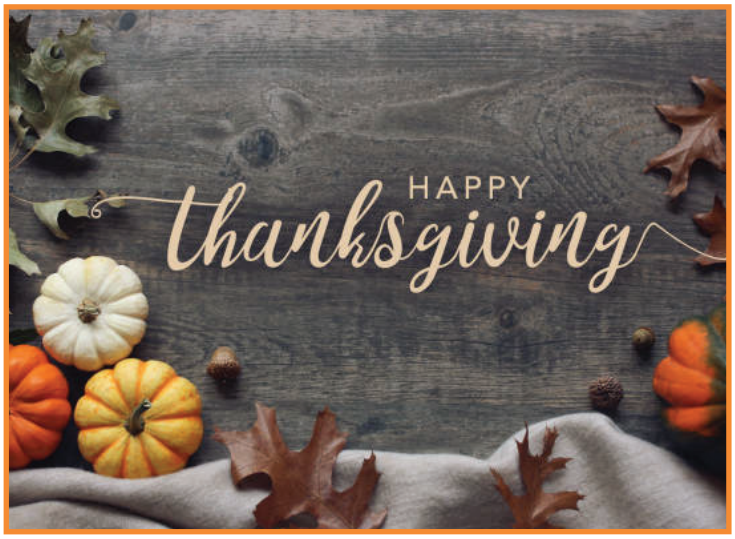
   There are variables again based on practice size, or if the organization is a hospital.

   In any case, the KPI should be close to 100%. Values between 90% - 95% might sound good, but they actually indicate revenue leakage.

(MedicsRCM helps in all five categories by supporting everything mentioned throughout. Our outsourced workforce consolidates in-house staffing, adding especially to #2 above, but really, to all KPIs listed. And,

the MedicsRCM team produces KPIs, analytics, dashboards, and reports for clients, and routinely reviews same with them to ensure financial and operational integrity, and to ensure there's no leaking. Clients can use the 21st Century Cures Act-certified MedicsCloud EHR, or keep their existing EHRs interfaced with us!)

Click here to access the HFMA report and details.



Wishing you a Happy Thanksgiving if you're reading this before the holiday, and hoping you had a great holiday if after!

Next: ADSvantage for December with new articles and insights.

Contact us at 844-599-6881 or email rcminfo@adsc.com for more about services and platforms from ADSRCM for driving revenue and productivity with our workflow and staffing solutions, or about transitioning to the MedicsCloud Suite if you still prefer to use in-house automation.