5 things to look for in a next-generation revenue cycle management system

Most healthcare leaders would agree that enhancements in revenue cycle management can help providers tackle new market realities. But deciding which changes to make can keep healthcare leaders up at night. What does it take to stay ahead of the curve in revenue cycle performance? How can a hospital know that its revenue cycle efforts are leading the organization in the right direction?

Adoption of next-generation revenue cycle management systems will become critical for all hospitals within the next five years, according to The Next Generation Revenue Cycle Management Index, a report released last year by the Healthcare Information and Management Systems Society. An increasing number of uninsured patients, impending national healthcare reform, the move toward consumer-directed health care, the proliferation of pay-for-performance programs, and the switch to ICD-10 coding all pose challenges for hospitals that make adoption of next-generation revenue cycle management systems an imperative. But how can providers ensure they are getting what they need from a next-generation system?

Here are five key attributes to look for in a revenue cycle management system.

1. The Ability to Provide Real-Time Information
Access to real-time information enables providers to make necessary interventions within the revenue cycle in time for their actions to make a difference. For example, if a provider is experiencing a large number of denials with a particular payer, a revenue cycle management system that offers real-time information could alert the provider to the fact that the payer’s reimbursement policies have changed. As such, the provider could make the adjustments necessary to receive payments on all claims. Often, outdated revenue management systems generate reports that either do not contain the key information needed to pinpoint problems in the revenue cycle or provide this insight too late for the provider to take action.
Such access also can improve the patient-provider relationship. For instance, with current information at their fingertips, access management professionals can tell patients at the point of care exactly what services are covered by their insurance providers and the amount for which they will be responsible. Real-time monitoring also makes it possible to ensure that patients and staff members provide needed information at every step of the process, reducing the need to backtrack later. For example, if a patient provides an erroneous Social Security number, the system will immediately demand a valid entry. When relevant patient information is not collected early in the process, providers deal with inordinate delays and significant rework.

2. Exception-Based Workflow

Often, existing revenue management systems require a significant amount of manpower to complete routine tasks such as claims processing. Processes that have been left out of the electronic workflow must be performed manually elsewhere, and automated processes that are performed in a variety of disconnected systems require a great deal of staff oversight.

However, when exception-based workflow is built into a revenue cycle management system, processes are automatically completed as long as all variables fall within a pre-established acceptable range. To ensure high performance, these processes typically are automated based on industry best practices. The systems are configured so that staff members are called upon or notified only when an “exception” warrants their personal attention. As a result, staff members can focus on specific objectives that drive the highest value to the organization.

Exception-based workflow is particularly valuable in the revenue management realm. Consider that with a traditional system, users would apply surrogate indicators, such as account aging, to determine whether an account needs to be resolved. For example, if an account ages more than 30 days from the claim submission date, a collector may contact the payer (via phone call, web inquiry, or transaction under the Health Insurance Portability and Accountability Act [HIPAA]) to obtain the status of the claim. As such, all claims older than 30 days would need to be reviewed to find the exceptions that require further intervention.

Conversely, with exception-based workflow, a HIPAA claim status inquiry is automatically transmitted on all claims that have aged more than 30 days, and accounts requiring additional work are sent to a collector’s worklist. The system then prioritizes tasks, directing staff members to work on the highest-dollar accounts first. This approach allows providers to more expediently collect the money owed to them while expending fewer human capital resources.
The approach also allows for more effective management of staff. With traditional systems, managers must develop and run reports to identify precisely how staff members should be deployed. With exception-based workflow, the information system performs this work, making it possible to more effectively utilize revenue cycle staff without constantly running reports.

3. Features that Support Financially Aware Care

Too often, care is provided without an understanding of reimbursement or payer responsibility. When clinical and financial systems are integrated, however, clinicians no longer need to make care decisions in a financial vacuum. Instead, they can make clinical choices with an understanding of the patient's financial means.

Consider the following scenario: A clinician wants to prescribe a certain medication, but the revenue cycle management system indicates that the patient’s payer will not cover the prescription. With this information in hand, the physician can work directly with the patient to ensure that the patient will pay for the medication out of pocket, or develop an alternate treatment plan. Such efforts should result in increased compliance—and better patient care.

The integration of clinical and financial information also can help make physicians aware of payer requirements. For example, some payers might require that a patient have an X-ray before undergoing more advanced imaging modalities such as magnetic resonance imaging. If the physician is cognizant of such requirements, the treatment plan can be constructed to meet the payer's specifications—helping to ensure that the patient will not be saddled with unnecessary payment responsibilities.

Sometimes simply telling the patient that a test or treatment is not covered at the time it is ordered will prompt the patient to take financial responsibility for the care or service. However, when patients do not understand their financial responsibility at the time of treatment, they are much less likely to meet their financial obligations down the line.

4. Virtual Business Office Functionality

For most organizations, claims processing is a long, labor-intensive process that requires the following steps:

- The patient is discharged or care has been completed.
- The revenue cycle management system begins prebill editing, if appropriate.
- In the event prebill editing fails, the document is sent to a worklist for editing until accepted.
- A bill is created.
- A claim is generated in the provider's accounting system.
- The patient account system performs the claim-editing process.
- If the claim fails, it is sent to the biller worklist for cleanup.
- A paper claim is produced.
- An electronic claim file is produced.
- The claim is sent to a claim system for editing.
- The edited claim is sent to a clearinghouse.
- If the claim is rejected, a paper report is generated.
- Corrections are made in the provider claim system, and the claim is resubmitted.

With virtual business office functionality, however, all of these processes occur in the background. The revenue cycle management system provides continuous claims processing and editing, eliminating the need for subsequent claims scrubbing down the line. The claim is, in essence, created at the point of patient discharge. As such, the claim is submitted immediately instead of six days after service has been delivered, which is the typical lag time associated with traditional systems.

5. Functionality that Supports an Enhanced Online Consumer Experience

Consumers typically do not have the information that enables them to fully engage in clinical and financial decisions—a situation that often results in frustration and dissatisfaction with the healthcare provider.

With easy access to integrated information, consumers can simultaneously manage their healthcare finances and become more involved in clinical decision-making. The following functions in a
next-generation revenue cycle management system
could promote such involvement:
> Self-scheduling and self-registration
> Pricing and quality transparency
> Out-of-pocket expense estimation
> Self-service direction-finding, check-in, signature
capture, and payment
> Point-of-service claim adjudication
> Electronic funds transfer from health savings
accounts
> Appointment scheduling
> Online bill pay and account management

With such functionality in place, consumers are able
to become active participants in their care and
develop positive relationships with providers.

Staying Ahead of the Curve
Certainly, the challenges inherent in today's health-
care environment are forcing healthcare organiza-
tions to find ways to become financially fit. Healthcare
providers that sit on the sidelines and ignore the need
for enhanced revenue cycle management may find
themselves struggling to get their organizations back
into the game. In contrast, organizations that reinvent
their revenue cycle processes with advanced IT sys-
tems can confidently move toward a successful
future.

Loren Buysman is president, revenue solutions, McKesson
Provider Technologies, Alpharetta, Ga.
(loren.buysman@mckesson.com).

Custom Reprints Available
Check out HFMA's new, expanded options and reduced pricing for reprints of
articles published in hfm Magazine and other HFMA publications.

To obtain an information sheet, including
pricing and answers to FAQs, e-mail
dkarmowski@hfma.org or call (708) 492-3387.