Maximizing Healthcare Payment Automation

A BancTec White Paper
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Introduction

The payments process within the U.S. healthcare industry is still paper intensive; in fact, McKinsey Quarterly states that more than half of the transactions are paper based. In addition, there is a lag if the payment is paper and the remittance is electronic.

Among the challenges that plague the healthcare industry's quest to automate the payments process are the following factors:

+ Because Explanation of Benefit (EOB) forms arrive in many different formats, it is difficult to build automation around the process, and it remains for the most part a manual process.
+ In instances where there is electronic remission of remittances, organizations cannot automate handling of 835s that lack all the data required for posting in a Patient Management System (PMS).

Without a fully automated process, healthcare providers encounter issues such as the following:

+ Average time to reconcile accounting payment is 22.5 days (more than three weeks from the time a payment is received until the money is deposited)
+ Escalating administrative costs due to payments reconciliation, denial management, and rebilling disputed claims, and standardizing of 835s
+ Financial losses due to a high percentage of write-offs
+ The process of matching remittance payments received to the actual services provided is a major problem due to the high volume of paper documents
+ Decreased cash flow
+ No visibility into the true collected revenue of the organization
+ Reduced productivity
+ Decreased customer/patient satisfaction

Companies grappling with the challenges of full healthcare payment automation are in a situation similar to Dorothy in the 1939 movie, The Wizard of Oz.

Carried away from her home by a tornado, Dorothy didn't know how to accomplish her objective of getting back home again. So she ended up going on a risk-filled, lengthy journey trying to get home.

She didn't know there was an easy solution that would have gotten her home quickly without the problems she encountered on her journey.

Similarly, many U.S. healthcare providers, billing companies, and banks serving healthcare providers don't realize there is a solution available today enabling them to avoid the costly, time-consuming journey to their desired destination of full healthcare payment automation.

In contrast, with full healthcare payment process automation (FHPPA), healthcare providers can realize benefits including:

+ Increased revenue through better cash flow resulting from decreased receivables days outstanding and improved collections with less write-offs and payment errors.
+ Reduced costs with more efficient management of denials, elimination of misplaced records and facilitation of secondary billing
+ Increased efficiency through automation providing faster processing and improved flow of information. On average, offices can see productivity increased by 40% with existing staff.
+ Reduced risk and ability to meet regulatory requirements with increased internal controls and better documentation.

This paper discusses the barriers to full healthcare payment process automation and a cost-effective, simple solution for overcoming the barriers.

Barriers to Full Automation

Barrier #1: The Claims Process
Filing claims for reimbursement, checking the status of claims, associating payments, denying or rejecting claims received with patient records, posting adjudication data to those records, reconciling payments sent to financial institutions, and storing/retrieving patient accounts are dreadfully labor-intensive processes when conducted manually.

Today's claims process is further complicated by the diverse requirements for related activities such as billing, payment, and notification of the large number of health plans. These plans require that providers and their staffs stock multiple types of forms, be expert in the variety of government and industry requirements, be an authority on the wide ranging coding schemes, as well as maintain billing and payment manuals for each health plan. The claims process, from end to end, remains complex, complicated, and manually costly and inefficient.

Barrier #2: The Payment Challenge
There are numerous barriers to improving efficiency for providers in the processing of payments:

+ Complexity and variation in paper EOB documents
+ Terminology diversity
+ High number of exceptions (denials)
+ Multiple payments and payers for the same service
+ Detail information required from the EOB that may not be there

The current belief is that automation can greatly reduce the labor required for these processes. This is especially true if every health plan becomes automated around a standard model so that healthcare providers are not required to deal with different requirements and diverse software. Automation of the payment and remittance advice process can provide many benefits:

+ Healthcare providers can post claim decisions and payments to accounts without manual intervention, eliminating the need for re-keying data
+ Payments can be automatically reconciled with patient accounts
+ Resources are freed to address patient care rather than administrative work

Barrier #3: The 835 Standard

The Accredited Standards Committee (ASC) X12 Subcommittee established a workgroup in late 1991 to develop the Standard 835 since there was no existing standard capable of handling the large datasets necessary for healthcare. Based on the (ASC) X12 format, the 835 Standard is now used to make a payment or to send an Explanation of Benefits (EOB) remittance advice. The ERA (Electronic Remittance Advice) can only be sent from a healthcare insurer to a healthcare provider, either directly, through a clearinghouse or through a financial institution.

The 835 Standard is used to simplify the content and the transfer of information regarding medical claims.

Former name	Electronic transaction equivalent	Description
CMS 1500	837 P (professional)	Professional
HCFA 1500	837 P	Professional
UB 92	837 I	Institutional
UB 04	837 I	Institutional
270/271	(batch requests or single query)	Eligibility verification
276/277	(batch requests or single query)	Claim status
Electronic Remittance Advice (ERA)	835	Electronic explanation of how a claim was processed

Barrier # 4: Data Security & HIPAA

There are numerous things to be considered when automating financial processes in the healthcare industry. Aside from keeping the medical documentation secured, remittance advices contain Patient Health Information (PHI) and should be handled with similar security processes and controls as the banking industry's SAS-70, PCI, and SOX requirements.

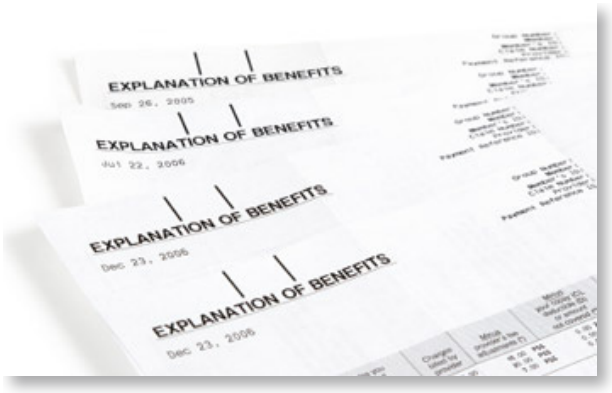
HIPAA (Health Insurance Portability & Accountability Act)	Ensures the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits.
SAS- 70 (Statement on Auditing Standards No. 70)	Provides guidance to auditors of financial statements of an entity that uses one or more service organizations.
PCI (Payment Card Industry)	Requires encryption of personally identifiable information across public networks to render cardholder data unreadable anywhere it is stored.
SOX (Sarbanes Oxley)	Public Company Accounting Reform and Investor Protection Act

HIPAA's privacy regulation is an attempt to address a growing public concern that advances in electronic technology and the resulting evolution in the healthcare industry may result in a substantial loss of the privacy surrounding patient health information.

+ A national survey conducted in January, 1999 found that one in five Americans believes their health information is being used inappropriately. California HealthCare Foundation, "National Survey: Confidentiality of Medical Records" January, 1999 (http://www.chcf.org)
+ 84% of those surveyed in 1999 agreed with the statement that they had "lost all control over their personal information." The Standards for Privacy of Individually Identifiable Health Information; Final Rule; 45 CFR Parts 160 and 164; p.82465

The Privacy Rule – pp. 82615-82616 states:

+ Since the EFT is used to initiate the transfer of funds between the accounts of two organizations, typically a payer and a provider, it includes no individually identifiable health information – not even the names of the patients whose claims are being paid.
+ The ERA, on the other hand, contains specific information about the patients and the medical procedures for which the money is being paid and is used to update the accounts receivable system of the provider.
+ This information [ERA] is always needed to complete a standard Healthcare Payment and Remittance Advice transaction, but is never needed for the funds transfer activity from the payer to the provider.
+ Providers, payers, and financial institutions must establish procedures to ensure the protection, confidentiality, integrity, and availability of healthcare information.



Barrier #5: EOB Complexity
EOB simplification is desirable for full automation. In recent years, numerous private companies provided a resource to simplify document types for automated processes with minimal success.

No standards exist for the paper EOB being produced by the variety of health insurance payers in response to claims sent by providers. Some payers simply send a check with only minimal data required to process the payment in the providers' accounts receivable systems. As a result, numerous misinterpretations of payment posting data have resulted in the loss of revenue to the provider because they are not clear on how to read the payer's response.

The challenge is that varied formats of EOB documents create roadblocks to getting accurate information converted from all insurance payers into one standard. The lack of regulatory compliance is the real issue in processing the paper-based EOB. There is no regulation to mimic the data found in the standard ERA. Data elements can be located at the whim of how the payer defines the format. Denial codes are proprietary to each payer. This creates a difficult task for the provider to determine proper payment. Several payers do not even include the original CPT (Current Procedural Terminology) code as billed on the EOB remittance. Reconcilement of the claim is difficult at best and many times the shortfall is simply written off.

The first assumption was that EOB processing was like invoice processing. After research and many failed attempts, it has become clear that this is not invoice processing. An EOB is more akin to a stub coupon or coupon associated with a check. The balancing mechanism is used in this instance because the check and the EOB need to be balanced to each other. This was difficult due to only one side of the process being seen and never reconciled back to the actual deposit into the providers' account.

The Solution for Full Automation

Healthcare providers need the following elements in their operations to overcome the problems of lack of full automation:

+ EOB conversion from paper to electronic forms
+ Automated matching of remits (835s) to payments (837s)
+ Production of HIPAA-approved 835s
+ Consolidation of ERAs
+ Enhanced denial identification and management tools
+ Instant access to exceptions for payment recovery and faster processing
+ Conversion of Remark Codes to ANSI standard responses
+ Online access to archived documents for a complete view of medical billing financial transactions

A solution now exists that addresses all of the payment processes U.S. healthcare providers face. In addition to substantial cost reduction and enabling increased cash flow, it has the following benefits:

+ A complete outsourced solution
  - Nothing for users to install
  - Easy Web access to all management reports
+ Quick implementation and scalability
+ Provides regulatory compliance
+ 48-hour turnaround of claims matching, balancing, and 835 synchronization
+ Improves the efficiency of filing secondary claims
+ Bank agnostic

The solution reduces DSO and increases payment velocities. Healthcare providers using this solution will be able to deposit their funds one or two days earlier and start generating sooner than with the traditional manual process.

Once posted, all EOB data is hosted online for immediate viewing using a Web-based portal. Users can view any EOB data by simply searching for a patient's name or account number.

Conclusion: Where to Turn Next

This white paper has identified the barriers and requirements for automating the healthcare payments process, along with some of the benefits of BancTec's Remittance Automation service as the solution.

BancTec offers healthcare providers what they have been looking for in a payment processing solution. Like the Wizard of Oz, our solution is not to replace any system with a magic wand; instead, we partner with our clients to enhance what they already have.

While on her journey down the yellow brick road to see the Wizard of Oz, Dorothy encountered many problems and delays.

She didn't need magic from the Wizard; she just needed him to show her that she already had the solution to get home simply by clicking her ruby red slippers.

About BancTec

BancTec is a global leader in transaction automation and outsourcing for the most demanding business processes. Headquartered in Dallas with offices around the world, BancTec applies specialized technology and expertise to streamline payment and document processing for clients in 50 countries, helping them to drive revenues, achieve savings and efficiencies, and improve customer service. BancTec delivers industry-specific solutions and outsourced services for organizations in the financial services, insurance, healthcare, utility, transportation and government sectors. The company operates more than a dozen outsourcing service centers worldwide, leveraging a common technology platform to ensure reliability, security, and consistently high levels of performance.

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