Revenue cycle processes have had to continuously evolve over the years to keep pace with the rapid changes occurring in the healthcare industry. As a result, RCM vendor partners are now utilizing technology that hospitals do not have access to on their own. To be successful in this new climate of increasingly complex payment models, providers need to focus more on how to streamline their processes to optimize reimbursement rather than on insurance denial management.

One way to do this is to leverage the technology available through end-to-end partners. These three tools address some of the most pervasive issues in today's revenue cycle landscape and allow healthcare facilities to spend less time focusing on payments, and more on patients.

Descriptive Analytics | Improve Payer Reimbursement Rates & Simplify Denial Management

Reduced A/R days and improved cash flow are the lifeblood of any healthcare organization. More than ever before hospitals need assistance navigating increasingly complex payment models. A successful denial management process is not about working denials as they occur, but rather systematically gathering the data required to eliminate them. Descriptive analytics technology can effectively cure the root cause of denials, rather than addressing the symptoms.

Descriptive analytics is a preliminary stage of data processing that creates a summary of historical data to prove insights into trends and causes. Descriptive data analytics tools can enable your organization to thoroughly analyze your 835 files and provide robust reporting that can result in actionable steps that greatly reduce days in A/R. By tracking every claim that has been denied you can quickly identify trends that can be used to establish billing rules specific enough to dramatically improve first-time billing of the claim and to prevent future denials.

Most provider systems do not actively track denials and staffs are often overwhelmed with data that is difficult to utilize. Descriptive analytics tools can capture data properly, allowing you to determine the cause of low reimbursement rates rather than focusing on appealing individual denials.

Dialer Technology & Speech Analytics | Optimizing Patient Communications for Higher Recovery & Satisfaction

To date only the largest healthcare organizations employ the use of dialer technology in-house. This tool can be used to employ algorithms based on past data and modeling to optimize patient calls. With an increasing focus on patient engagement and satisfaction, it is critical for your organization to be communicating with your patients in the most productive way possible. Whether it is the use of intelligent agent assignment on inbound calls or the development of campaigns to target specific goals on outbound calls, monitoring and optimizing patient communications can ensure call quality and a great patient experience in real-time.

One of the most powerful features of select dialer systems is speech analytics. These programs can analyze millions of hours of calls daily and put those insights to use for your organization in several ways:

Comparative Analysis: If one of your goals is to improve patient collections, a comparative analysis of trending language from top-performing representatives or collectors can provide insights into the differences in the speech of both the patient and the agent in those interactions. Comparative analysis can also be used to find the best solutions to emotional calls, what phrases lead to payment in full more often, and even what your optimal discount percentage is, allowing you to drive continuous improvement.

Agent Coaching: Once language trends and call patterns have been identified through comparative analysis, the data can be used to train all representatives to optimal performance. Other coaching applications include monitoring calls for the appropriate phrases that ensure compliance and with your financial policy, and to track individual agent improvement over time.

Customer Service Improvements: Speech analytics tools allow for constant monitoring to ensure the highest level of service on every call. Monitoring patient calls can help you dig deeper into the problems causing longer than normal calls, complaints, or patient confusion.

Having the ability to gather and analyze information from your calls can help you create initiatives that not only improve recovery and patient satisfaction, but also optimize the time spent on the phone for the greatest outcomes.

Propensity to Pay Scoring | Prioritizing Accounts to Collect More Self-Pay After Insurance Balances

Once you know what should be said to a patient to optimize their call, you must then decide which patients to contact first to make the best use of your staff's time. The amount of money and time spent to collect on an account should be directly related to the amount that can be collected. The only way to know this prior to contacting the patient is to determine their propensity to pay.

Scoring models are rampant in the industry and some healthcare organizations have even developed their own. While no two models are the same, using analytics and testing the attributes fueling your model can help pinpoint what works best for your demographics. While the patient's payment history is arguably the most important factor, the greatest benefit comes from evaluating information from several sources. Our experience is that the focus of a great scoring model should be on the patient's ability to pay rather than their credit capacity, which is typically based on credit scores.

Additionally, it is not enough to score an account only when it becomes delinquent or when it is placed in bad debt. Patient's financial situations can change quickly, so these scores require regular monitoring to be effective. Best practice is to determine a score variance that is significant enough to warrant re-scoring and monitor accounts weekly for changes of that magnitude. A system like this benefits from outsourcing to a partner that can handle regular audits for information accuracy.

The issues of reduced reimbursement and increasing denial rates and bad debt are expected to continue, if not get worse. In order to leverage these technologies, among many others, more hospitals than ever before are opting to partner with end-to-end revenue cycle management vendors.

Learn more about these technologies and how they can help you turn your patient information into actionable insights that drive a healthier bottom line in our Healthcare Data Analytics & RCM white paper.

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