WHY YOUR REVENUE DEPARTMENT STRUGGLES

AND HOW TO FIX THE PROBLEM

pVerify®

Helping Healthcare Providers Improve Revenue Results™

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You're not alone.

If you're a healthcare provider, you're probably frustrated with the performance of your revenue team.

But with ever-changing payer rules, insurance companies have stacked the deck against them.

We can help.

For over 15 years, pVerify has provided solutions that help revenue teams collect what is owed to healthcare practices.

Level the playing field

It is a constant struggle for healthcare groups to get paid for their services. Insurance companies seem to have ever-changing payer rules. Often, the billing staff isn't aware of the modifications. These oversights cause claims to be rejected or denied.

When this happens, it sets off a cascade of time-wasting events for revenue teams. Healthcare companies that reduce front-end billing errors will significantly improve their revenue collected.

But even with perfect insurance and benefits data, rejected and underpaid claims will occur. So, revenue departments must also implement more efficient claim resolution processes.

Only then can revenue departments collect all the revenue owed for services provided.

This eBook will look at today's healthcare revenue landscape and then discuss the steps your group can take to level the playing field with insurance companies.

Takeaways from this eBook:

- Why revenue departments constantly struggle to collect expected revenue
- How medical groups can improve this situation by making one change
- Ways to enhance the claims management process
- Steps to reduce revenue management costs while increasing collections

CHAPTER 1

The drain of inaccurate insurance information

Flawed insurance and verification data affect more than just the billing and collections staff.

Incorrect and incomplete data has a spillover effect that negatively impacts everyone in an organization.

Lower clinical staff productivity

Lower staff productivity is arguably the biggest drain caused by inaccurate insurance data.

That's because healthcare groups with faulty data treat patients whose plan doesn't cover a particular service or procedure.

This translates into lost medical staff time—time that could have been spent providing reimbursable services.

Worsening aging reports and increased write-offs

The lost productivity from incorrect insurance data extends to the RCM staff.

Team members spend precious hours reworking rejected claims. That includes countless hours on hold waiting to get the necessary information from payers.

Billing staff is often overwhelmed with the volume amount of rejected claims. This leads to worsening aging reports, followed by increased write-offs.

Faulty insurance and benefits data leads to a cascade of time-wasting events for everyone in an organization.

Lost revenue means lost opportunity for growth.

Inaccurate Financial Reports

Incorrect insurance data prevents a healthcare group from having accurate financial reports. That leaves them with an unclear view of the practice's financial health. This misleading data often leads to poor management decisions.

Under-collected Co-Pays

Patient co-pays are an essential revenue source. However, with patients changing health plans, providers often have outdated co-pay information. Without this, groups lose significant revenue each day by under-charging for co-pays.

We'll now look at ways your team can fix the flawed insurance benefits data problem.

CHAPTER 2

Fixing your inaccurate insurance data issue

By concentrating on front-end billing mistakes, medical groups can eliminate about 70% of the issues that cause rejected or denied claims. Your group has probably made one step to reduce these errors is implementing Real-Time Eligibility (RTE).

Real-Time Eligibility Verification

Real-Time Eligibility (RTE) Verification is a process that enables healthcare providers to electronically confirm patients' insurance coverage before their appointments or procedures.

This technology promised to reduce billing errors and lower revenue management staffing costs significantly. Yet healthcare groups still struggle in this area. So, what is the problem?

The devil is in the details.

Even though Real-Time Eligibility can instantly access and transfer payers' information into a healthcare group's EHR, it is still up to billing staff to pick out the correct insurance information.

Nearly all RTE Verification solutions deliver their data in hard-to-read formats that require highly trained billing specialists to interpret accurately. This situation leads to the persistent issue of problem claims.

All RTE Veri ication Solutions are not Created Equal

One issue that hinders efforts to improve revenue cycle results is that nearly all medical groups use the Real-Time Eligibility (RTE) Verification solutions their medical billing clearinghouse provides. (Clearinghouses are the intermediary between providers and payers.)

Clearinghouse RTE solutions do connect with insurance companies' databases. But the problem is that they deliver too much irrelevant patient information to your team. Only highly trained revenue staff members can consistently identify the critical data. This situation leads to constant errors on the front end of the billing process.

Automating Prior Authorization

Another reason healthcare organizations struggle with front-end billing errors is the increasing requirement for Prior Authorization (PA). Obtaining prior authorization involves many steps, each ripe with the potential to cause delays.

Automating all or part of your PA process can significantly reduce the time staff members spend extended periods on hold, trying to speak with payer representatives.

We'll now look at other steps your RCM team can take to improve financial performance and productivity.

Most RTE solutions deliver insurance details in hard-to-read formats. This makes it tough for billing staff to pull out the data accurately.

This situation leads to billing errors, problem claim issues, and lost revenue.

CHAPTER 3

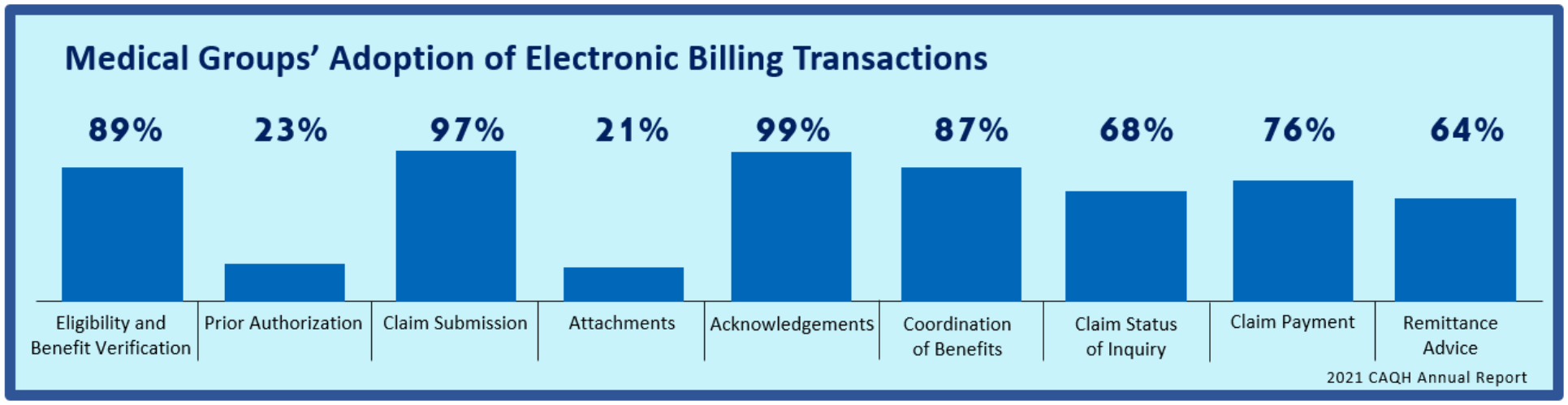
Improving your Rejected Claims Process

Reducing front-end insurance data errors has the most significant impact on improving revenue management results. But healthcare groups must also implement more efficient processes for addressing problem claims.

In their 2021 Annual Report, the Council for Affordable Quality Healthcare (**CAHQ**) estimated that the billing administrative sector could reduce almost half of its annual spending on its activities by fully transitioning to electronic transactions.

Below is a graphic that shows the elements involved with claim management and medical groups' adoption of Fully Electronic Administrative Transactions across the spectrum.

CAQH estimates medical groups can reduce their billing administrative costs by 48% through implementing electronic transactions across their claims management processes.



Without electronic claims status inquiry, staff often work on problem claims that have already been resolved.

Most medical groups are already employing electronic transactions in several areas. Below we discuss the most critical ones your revenue department should implement if they haven't done so.

Electronic Prior Authorization (PA)

Implementing electronic Prior Authorization (PA) stands out as the most significant opportunity to improve revenue results.

PA can be difficult to manage because the requirements vary widely from one insurer to another. But the technology now exists to automate much of this process.

pVerify offers advanced technology that often detects if Prior Authorization is needed. If PA is required, our solution retrieves the necessary data and electronically delivers it to the revenue team.

This capability significantly reduces the number of services performed without the necessary PA and shrinks revenue staff's time reworking claims.

Electronic Claim Status Inquiry

Electronic claim status inquiry automatically gives billing staff updates on the status of their submitted claims. It also provides access to notes and financial data.

With this information immediately available, billing departments can use an **Exception-based collection approach**. This means they can only focus on exception claims (i.e., problem claims).

Electronic Claim Payments

The primary benefit of electronic claim payments is that providers get paid more quickly. This improves cash flow significantly. Electronic payments are also more efficient and provide for better management and control.

Electronic Remittance Advice (ERA)

An ERA is an explanation from an insurer about a claim payment. It explains how the payer has adjusted claim charges based on contracted rates and what secondary payers owe.

Having this information readily available is vital for having a more efficient revenue team.

Stopping Routine Underpayment from Insurance Companies

Implementing Electronic Transactions across your revenue management has another crucial advantage—eliminating insurance companies' routine underpayment of claims.

Most billing staff are overwhelmed and don't have time to fight for incremental differences and just write them off. Insurance companies are aware of this situation.

It's no coincidence they under-reimburse providers. Giving billing staff instant access to critical information will enable your revenue team to develop workflows to end the chronic revenue loss from the underpayment of claims.

Giving your billing staff instant access to data across the claims management process will enable them to develop workflows to end routine claim underpayment by insurance companies.

Using an inferior RTE solution is like a surgeon operating with a knife and fork when what's needed is a computer-guided micro-surgery instrument....Things will not turn out well.

CHAPTER 4

What to fix first

To solve your group's revenue management shortcomings, you must go to the root. We've learned the problem starts with incorrect and incomplete insurance on claims. The source of that problem is the inadequacies of the Real-Time Eligibility (RTE) Verification solution groups use. Almost all medical groups get their RTE services from their clearinghouse.

Years ago, clearinghouse RTE tools for insurance eligibility and benefit verification worked well enough.

But with today's growing complexity and payers changing their rules, clearinghouse RTE solutions aren't up to the task of teasing out all the needed patients' insurance information.

It's the equivalent of a doctor performing surgery with a knife and fork when what's needed for a successful outcome is computer-guided microsurgery instruments.

If you're frustrated with your group's revenue management results, it's time to upgrade your RTE solution. The next chapter offers a buyer's guide for researching your options.

CHAPTER 5

A Buyer's Guide for a RTE Verification Solution

Making the right decision when selecting a Real-Time Eligibility (RTE) Verification solution is critical to maximizing your revenue management department's performance. It is arguably the most important purchase your group can make.

There are many options available. Of course, you want to make sure the new solution does the basic things well. But it's essential to learn a solution's capabilities in challenging scenarios.

List of Payers

For an RTE solution to be effective, it must connect to an extensive library of insurance company databases. The more payers the solution connects with, the better.

pVerify connects with over 1,500 healthcare payers—the most of any company offering healthcare RTE solutions.

This coverage ensures our customers receive the most comprehensive insurance and benefits verification results.

To download our payer list, **click here.**

A comprehensive list of insurance companies is critical for an effective RTE solution.

History with Payers

Look for RTE solution vendors with a long history of working with insurance companies. That's because every payer, electronic and non-electronic, has its quirks. Learning these idiosyncrasies take time. RTE vendors with an extensive history of working with payers will likely provide more complete and accurate data results.

pVerify has specialized in healthcare RTE solutions since 2006. We have performed over 300 million electronic verifications for our customers. Each one of these informs and improves future inquiry results.

Multi-level Verifications

Today's RTE solutions must be able to tackle multi-level verifications. They need to parse out and retrieve patient data for: **Network, Payer, Location, Plan, Service & Procedure, Benefit Limitations, Coordination of Benefit scenarios, If-then Situations.**

pVerify's RTE solutions use human-enabled AI and machine learning to deliver the most comprehensive insurance verification results in the healthcare industry.

Learn more about pVerify's Advanced Eligibility Verification.

pVerify connects with over 1,500 insurance companies, more than any other RTE solution available.

Our payer list ensures the most comprehensive verification results.

Most medical groups are using multiple RTE Verification providers.

With pVerify, you need only one. This means reduced administrative costs.

One Source RTE Provider

Many medical groups use more than one Real-Time Eligibility Verification (RTE) supplier because their clearinghouse solution doesn't meet all its RTE needs. This increases a medical group's costs.

pVerify offers the most comprehensive set of advanced Healthcare RTE solutions available. That enables us to be a one-stop supplier for all your RTE needs.

Expansive Service Type Verification

Some clearinghouse RTE solutions limit their search results for one service line. You must pay for each service type. This increases RTE Verification costs significantly.

pVerify offers up to three service lines results for each patient search. This saves medical groups thousands of dollars on yearly RTE Verification costs.

Readable Results

The critical problem with most RTE solutions is that they deliver patient insurance data that requires highly trained and seasoned billing staff to tease out accurately.

pVerify's advanced technology eliminates the need for seasoned billing staff to sort out the information accurately. Our solution even presents insurance and benefits specific to patients' plans, including co-pays and deductible amounts for both in-network and out-of-network patients.

To learn about pVerify's Advanced capabilities, click here.

Medicare MBI Lookup

CMS replaced the SSN-based HICN with a new, randomly generated Medicare Beneficiary Identifier and now requires the MBI ID for all Eligibility Verification, Claim Submission, reopening requests, and prior authorization requests.

pVerify offers a scalable solution for obtaining the new Medicare MBI ID and your patient's MBI number quickly and easily by submitting the patient's name and SSN/HICN. Learn more about our Medicare MBI Lookup.

Inpatient SNF

If a patient is currently admitted to a rehab facility, Medicare Part B cannot be billed, as there is an active claim for Medicare Part A. Providers servicing Medicare patients need to know ongoing SNF details or risk not getting paid.

pVerify offers the only solution that provides details on currently admitted Skilled Nursing Facility and Hospital patients as early as 72 hours after a patient's initial admission.

To learn about pVerify's Inpatient SNF capabilities, click here.

Our team of insurance eligibility experts craft solutions to your exact RTE verification needs.

We deliver the data results to wherever you need them in your processes.

pVerify builds your verification specialists deep knowledge into a powerful Business Rules Engine. This saves times and improves each search result.

Patient Insurance Coverage Discovery

Patient insurance discovery can help to increase reimbursement revenue by finding accounts eligible for payment as primary, secondary, or tertiary coverage— through either private insurance or Medicaid and Medicare. This leads to fewer accounts going to collections or being written off.

pVerify offers an effective patient insurance discovery tool for medical groups to treat financially at-risk patients while minimizing potential revenue losses. To learn about pVerify's Insurance Discovery capabilities, ***click here****.*

Patient Payment Estimator

Having an accurate and easy-to-use Patient Payment Estimator is essential today. Unfortunately, many RTE solutions don't have multi-level capabilities to provide correct patient payment estimates.

pVerify's RTE solution has the technology to access the multiple layers needed to provide your revenue team with the data required to provide accurate estimated patient payments. ***Click here*** *to learn more.*

Business Rules Engine

Experienced verification specialists have a wealth of knowledge that enables them to excel at their job. Look for an RTE vendor that can add your verification specialists' expert knowledge into a Business Rules Engine that automatically returns the current patient benefits.

pVerify's works with your revenue team to instill their detailed knowledge into your RTE solution. ***Click here*** *to learn more.*

Flexibility of Delivery Options

An important consideration in choosing an RTE vendor is the options your revenue management staff will have in accessing and retrieving the needed patient data.

pVerify offers customers ultimate flexibility in using our advanced RTE technology. It is available only through a full-service SaaS model, or the data be delivered into a revenue department's current system workflows.

Free Trial

Switching RTE solutions is a lot like driving a new car. It's a big decision. You would never buy a car without first taking a test drive. It should be the same before purchasing a new RTE.

pVerify offers a free trial of its RTE solution. Your revenue team will be able to see for themselves the vast difference our advanced eligibility tools make in reducing rejected claims and increasing revenue.

Clearinghouse RTE solutions charge for each service line search.

With pVerify, you reduce costs with our expanded service line results.

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Since using pVerify, we have significantly reduced claim rejections, lowered administrative costs by reducing the time it takes to verify eligibilities, and improved our cash flow. pVerify’s has contributed immensely to our practice, and I am so happy that we began using their solution.

Beth Carvajal

PRACTICE MANAGER

Pediatrics of Associates of New York City

We have been using pVerify for eligibility transactions for the past ten months and have loved the product. It is very user-friendly and gives accurate information. Our staff could use the product the same day after being trained. I cannot say enough good things about pVerify and their team.

Lisa Glantz

FRONT OFFICE MANAGER

Ridgecrest Regional Hospital

Valley Behavioral Health has partnered with pVerify utilizing their Eligibility Verification Custom Excel Batch tool since November 2018. The company was professional, attentive, and listened to our needs. Within two weeks, they built us customized discrete eligibility data that’s provided a great ROI. They remain diligent and quick to respond to our needs.

Kathy McCall

DIRECTOR OF REVENUE CYCLE

Valley Behavioral Health

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Ready to get started?

Call us at 800-974-2995 or info@pverify.com

Medical groups deserve to be paid everything due to them. If you're frustrated with your group's current revenue collection outcomes, we can help.

SCHEDULE A DEMO TODAY!

Helping Healthcare Providers Improve Revenue Results™

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