OPPORTUNITIES FOUND:
IDENTIFYING REVENUE LEAKS IN AMBULATORY CARE PRACTICES

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Revenue leakage – those lost opportunities to collect money earned – has been a topic of conversation in healthcare for years. Granted, revenue leakage is a moving target, thanks to healthcare reform, constantly changing payer rules and frequent technology advancements. This pervasive problem, however, continues to tighten the squeeze on already compressed margins.

There are no easy answers, but there is tremendous upside to finally finding and fixing current revenue leakage root causes and preventing new sources in the future. After all, McKinsey & Company estimates revenue cycle inefficiencies including claims processing, payments, billing and bad debt – among the leakage sources explored in this paper – eat up 15 cents of every healthcare dollar.¹

**Where to concentrate first**

Since few areas of an ambulatory practice are immune to revenue leakage, the dilemma can be where to begin. A good first step is understanding the most common sources of revenue leaks. Here’s where many providers leave money on the table:

**Process-related leakage**
- Lack of automation
- Inability to work by exception
- Failure to appeal denials
- Manual claim status checks
- Inability to effectively find hidden coverage
- Inability to decipher rejection messages

**Payer-related leakage**
- Unrecovered payer denials
- Failure to complete payer credentialing
- Unverified insurance coverage
- Failure to meet timely filing requirements

**Patient-related leakage**
- Lack of understanding of medical bills
- Lack of finance options
- Patient responsibility write-offs
- Failure to collect payment at time of service

¹ “Hospital revenue cycle operations: Opportunities created by the ACA, McKinsey & Company,” by Matthew Bayley, MD; Sarah Calkins; Ed Levine, MD; and Monisha Machado-Pereira, McKinsey & Company
Lack of automation

It can be tough to quantify exactly how much revenue is lost through an organization’s everyday routines. Research confirms, however, that manual processes can significantly hinder a healthcare provider’s financial performance. For example, most medical practices lose 5-30% of reimbursements through inadequate claims processing, staffing, training and technology. When done manually, transactions between providers and payers such as eligibility verification, claim submissions, remittance advice and payment posting cost an average of three dollars more per transaction than those done electronically.

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Inability to work by exception

Many healthcare organizations work claims as if they were of equal importance and value, wasting time, and resources on those that are proceeding normally. The better approach is to work only the claims that need attention for a larger productivity return.

Failure to appeal denials

Two out of three denials are appealable. But because it costs an average of $25 and takes up to 75 minutes to research and manually process appeals, only 35% of providers try to plug the revenue leak. As a result, healthcare practices lose approximately 3% of net revenue to denials. On the upside, 90% of denials are preventable.

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To make matters worse, the Centers for Medicare and Medicaid Services (CMS) says just 70% of claims are paid the first time they’re submitted. Of the remaining 30%, 20% are denied and 10% are lost or ignored. Providers never resubmit 60% of denied, lost and ignored claims. Even if they do, they often don’t meet payers’ timely filing requirements, resulting in potentially serious revenue leakage.

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The American Medical Association’s (AMA) National Health Insurer Report Card substantiates CMS’ findings. They say major payers return up to 29% of claim lines with $0 for payment, often, but not always, because the patient is responsible for the balance. Up to 7% of nonpayments are due to claim edits and up to 5% are for other denials that can often be prevented.

2 “5 tips to improve your medical practice’s billing and collections,” MGMA Practice Blog, October 21, 2010
3 “2016 CAQH Index: A report of healthcare industry adoption of electronic business transactions and cost savings,” CAQH Explorations, 2017
5 “How to avoid ‘unclean’ claims,” by Amber Taufen, MGMA Connection Plus, March 28, 2014
6 ZirMed early adopter client research on Denial productivity ROI. June 2017.
8 “How to avoid ‘unclean’ claims,” by Amber Taufen, MGMA Connection Plus, March 28, 2014
9 “Billing & Collections Tips to Improve Your Accounts Receivable Management,” Fairfield County Medical Association, April 15, 2014
10 The Cure for Claim Denials,” by Richelle Marting, Family Practice Magazine, March/April, 2015
Manual claims status checks
Manually checking the status of an outstanding claim can take five to 12 minutes in phone calls and payer website visits for each claim, making it one of the most time-consuming components of the entire claim workflow. Worse, much of this time may be wasted if the claim is still processing. Automating claim status checking, which, by comparison, can take just seconds,\(^\text{11}\) can reduce unproductive time and shift staff attention to more valuable activities.

Inability to effectively find hidden coverage
Manually checking insurance coverage and sending 270 transactions can be time and labor intensive. On average, a phone call takes 30 minutes (and some payers limit the number of patients they will discuss per call) and website detection takes up to five minutes.\(^\text{11}\)

Other factors add to the complexity of identifying active coverage. Almost 30 million people change insurance plans every year, with 19.5 million projected to move in and out of Medicaid.\(^\text{12}\) If a patient doesn’t have Medicaid at the time of service, it may be applied retroactively up to three months after service if the patient meets the criteria making them eligible for coverage.

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Inability to decipher rejection messages
Claim rejection messages can be hard to understand and require additional research before issues can be addressed. This extra step delays resolution and payment, resulting in potential revenue leakage.

\(^\text{11}\) “2016 CAQH Index: A report of healthcare industry adoption of electronic business transactions and cost savings,” CAQH Explorations, 2017
PAYER-RELATED LEAKAGE

Unrecovered payer denials
More than 20% of healthcare claims are routinely denied and denials for some payers can be as high as 40%,¹³ making it one of the largest sources of revenue leakage. Providers spend an average of $25¹⁴ and up to 75 minutes to research, manually process and appeal each denied claim.¹⁵

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Failure to complete payer credentialing
Physicians and allied health providers must obtain a Provider Identification Number (PIN) before they can receive payments from Medicare, Medicaid, commercial or managed care insurance payers. Credentialing applications can be 30 to 50 pages long, but failing to submit them can have serious revenue implications.

Hospitals often allow physicians to practice at their facilities before they are enrolled with the organization’s insurance payers. Physician credentialing can take up to 120 days and many payers do not reimburse retroactively for services rendered without a PIN, which means the practice could face significant write-offs. To avoid this scenario and revenue leakage, providers must carefully factor physician credentialing into revenue cycle management.¹⁶

Unverified insurance coverage
Failing to verify patient insurance eligibility has a cascading affect on revenue leakage. When staff are unaware of patients’ co-pays and deductibles and fail to collect payment at the time of service, the cost to collect later goes up and the amount received usually goes down.

Unverified insurance coverage is the number one source of payer claim denials.¹⁷ Bad debt and write-offs may also occur from patients who are unaware they have insurance coverage or could qualify for Medicaid.

Failure to meet timely filing requirements
Every payer has their own rules on when claims must be filed. Missing deadlines can mean missed billing opportunities and revenue leakage. In addition to preventing late filings, providers’ claim systems should show proof of timely filing in case payers deny claims, saying they did not make the deadline.

¹⁴ “How to avoid ‘unclean’ claims,” by Amber Taufen, MGMA Connection Plus, March 28, 2014
¹⁵ ZirMed early adopter client research on Denial productivity ROI. June 2017
¹⁶ “Deep dive: What lies beneath the surface: Reassessing your credentialing process could mean more money in your practice,” MGMA Connexion, MGMA-ACMPE, April 2013
PATIENT-RELATED LEAKAGE

Lack of understanding of medical bills
Complex medical bills are another revenue leakage culprit. A survey of patients said 75% of bad debt is a result of unanswered billing questions. Without easy-to-understand estimates and statements, some revenue could be lost forever.

Lack of finance options
Almost half of U.S. adults say they could not cover a $400 emergency expense without selling something or borrowing money. This troubling statistic, paired with an average 255% increase in health insurance deductibles and a 58% increase in family coverage premiums since 2006, leads to fewer providers collecting the entire amount they’re owed. To help offset the risk and limit revenue leakage, healthcare providers have a significant stake in ensuring patients have practical financing options from which to choose.

Patient responsibility write-offs
Incredibly, providers write off almost half of patients’ responsibility for care as bad debt. Insured or not, more than 25% of adults in the U.S. struggle to pay their medical bills, thanks to tight budgets, higher co-pays and higher deductibles. Kaiser Family Foundation surveys show that from 2008 to 2015, the number of U.S. workers with deductibles over $2,000 grew from 5% to 19%, and the portion of patient responsibility written off as bad debt increased from 0.9% to 4.4%. Medical debt is the country’s leading source of personal bankruptcies.

This trend is expected to continue. Bad debt, which totaled $65 billion in 2010, is projected to rise to $200 billion by 2019, leading to costly write-offs for providers.

Almost half of U.S. adults say they could not cover a $400 emergency expense.

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23 “Average Hospital Revenue Cycle Leaves $22 Million on the Table,” The Advisory Board, June 27, 2017
24 “This is the number one reason Americans file for bankruptcy,” by Maurie Backman, USA Today, April 2017
25 “The Importance of Collections / Avoid Writing Off Copays,” by Heidi Jannenga, citing Nancy White, APTA Podcast, WebPT, March 25, 2013
Failure to collect payment at time of service
How providers attempt to collect is another source of revenue leakage. Those who allow patients to leave the care setting and send statements later are 20% less likely to collect, plus they may incur costs of $5-$10 to process and mail each statement.26 Even patients who are willing to pay may be thwarted by complex statements. One survey of patients said 75% of bad debt can be attributed to unanswered billing questions.27

Now for the upside
As the quantity and range of potential revenue leaks clearly demonstrate, ambulatory practices can do much more to improve their bottom lines than increase patient volume and cut costs. Stopping revenue leakage can generate significant incremental dollars, time savings and productivity improvements, helping recapture the 15 cents on every dollar being lost to revenue cycle inefficiencies.

Most practice administrators have a sense of where their biggest revenue leakages lie, and many use technology to address their revenue opportunities. The next step is to prioritize these opportunities based on their bottom line impact and the return on investment required to stop the leak.

26 “The Importance of Collections / Avoid Writing Off Copays,” by Heidi Jannenga, citing Nancy White, APTA Podcast, WebPT, March 25, 2013