10 WAYS To Accelerate Your Claims

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When your claims process is broken, so is everything else. Yet most healthcare organizations struggle with claims, resulting in administrative headaches, poor patient experience, and loss of revenue. I've seen it repeatedly in my 25+ years in the revenue cycle.

How can you accelerate your payment period, decreasing the cycle of sending a claim out and getting money in the door? It's a question everyone in the revenue cycle wants to solve. The problem? Everyone has a different answer.

Patient access will say:
"Get the right information from ordering physicians and have patients give us the right information."

Mid-cycle will say:
"Have compliant physicians and get the documentation where we need it."

Business office will say:
"Get everything right on the front end."

What that tells me is everyone is relying on someone else. The primary way we can actually improve the overall claims process is to focus on what you have control over: processes. You need to diagnose, address, and fix things as quickly as possible. What parts of the process could be smoother? How can you deal with changing claim volumes? Where are people making mistakes? How can you look at everything holistically — rather than segmented by teams or platforms?

How are you integrating automation right now? Are you still relying solely on basic robotic process automation (RPA) or your EHR's out-of-the-box tools? Or are you using advanced technology built on advanced artificial intelligence (AI), machine learning (ML), and large language models (LLMs)?

This resource details areas in which I've seen revenue cycle teams make improvements. With the right best practices, a more efficient staff, and the latest in automation technology, you can start accelerating claims processing now.

AMY RAYMOND

SVP of Revenue Cycle Operations and Deployments at AKASA

How To Streamline Your Revenue Cycle

When most people think of improving their claims processing, they go right to a healthcare organization's business office. But to improve your revenue cycle, you must ensure things are running smoothly across the front end, mid-cycle, and back office. How can you decrease errors and denials that cause significant delays, send out more clean claims, and get more cash in the door?

Here are some places to start.

Fixing Your Front End

Issues at the front end trickle down into the entire reimbursement process. When your front-end operations run smoothly, you set your other workflows and teams up for success. Get your claims process started on the right foot with these strategies.

01 Capture the correct information and verify

The reimbursement process falls apart if the patient's information and insurance are incomplete or inaccurate.

Are you collecting all the patient info you need for your payers? With payer rules frequently changing, it's easy for something to fall through the cracks. Track requirements and keep the information handy. Configure EHR-required fields and edits to support your teams' processes. Ensure you capture any necessary information when you talk to the patient — on the phone or in the office. Getting information after a patient leaves is significantly harder, which can result in a time-consuming phone tag game.

Insurance information also changes. Even if the patient has insurance on record with your organization, confirm it with them and get a copy of the cards. Double-check the expiration date, coverage, and eligibility while you have their attention.

Verifying eligibility is a crucial part of the patient process. Once you get the patient information, confirm eligibility and benefits (both immediately and monthly).

"Every contact matters. Every patient interaction matters. If you have a patient on the phone or in front of you, treat that like gold and get all the information that you can. Appointment calls and pre-registration/financial clearance contacts are fleeting moments, and it's better to get the information in the moment, rather than five calls later."

AMY RAYMOND

SVP of Revenue Cycle Operations and Deployments at AKASA

02 Obtain the right authorization ahead of time

Retroactive authorizations are stressful, time-consuming, uncertain, and often end in denials. Much like getting patient info during the first point of contact, it's better to get authorization the first time around — and as many days out from the scheduled appointment as possible (best practice is at least a week out from date of service). Otherwise, you're heading straight for a payer denial, which adds time and complications to your workflow.

Prior authorization is already a massive headache for RCM staff and patients alike, so the smoother this process, the better. Make sure it's standard practice to get the right auth ahead of time for patients. Keep an eye on your days out numbers to see if there's room for improvement.

Want to prevent denials on the back end? Start with a strong front end.

Top 3 reasons for denials, according to healthcare leaders:

1. Errors in patient access/registration *(i.e., eligibility or missing prior authorization)*
2. Lack of documentation to support medical necessity
3. Missing or incorrect patient information

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Document payer coverage changes and ensure they're easily accessible. Train specialists on common coverage for the major payers. Streamline how your team checks on prior auth status and divide the work across multiple resources in order to act faster on approved or denied auths.

It's not uncommon for coverage parameters to change, even between in-office visits versus hospital visits. This is why your specialists must stay in the loop with payers and never assume they know the coverage without first checking it.

03 Prioritize the patient relationship

Getting the correct patient information at the start, confirming insurance and eligibility, and starting things off correctly all stem from a great relationship with the patient. Ensure your team is friendly, answering questions, and providing stellar service.

Similarly, keeping the patient in the loop during the entire process is important. Let the patient know if there's an issue with auth, potential charges, etc. This not only builds a healthy relationship between your organization and patients, but also allows you to get ahead of any potential financial counseling-related matters. The more informed the patient, the more likely they are to prepare their finances and make arrangements to pay what they owe.

That's why looking for ways to improve your patient access function is critical: the more you can alleviate your team's auth burden (by making processes more efficient and bringing in the right automation), the more they can focus on being patient-centered.

"We often talk about how prior auth is critical for the patient. And it is. Financial clearance and financial counseling are also crucial to the patient experience. When we start our relationship off on the right foot and talk to the patient, getting the information we need, we're setting the stage for a smoother auth and claims process. Plus, we're increasing the chances of having time to deliver a truly outstanding patient experience."

AMY RAYMOND

SVP of Revenue Cycle Operations and Deployments at AKASA

OF AMERICANS ARE CONFUSED BY MEDICAL BILLS

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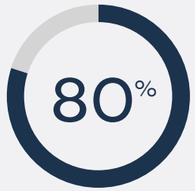

OF UNINSURED AMERICANS DON'T KNOW ABOUT PROVIDER FINANCIAL RESOURCES (PAYMENT PLANS OR FINANCIAL ASSISTANCE)

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How automation can help your front end

Patient access is complex. Its processes are costly, time-consuming, and require multiple touchpoints, often delaying or preventing patient care.

Automation is an effective approach for improving these workflows. But not just basic automation, like RPA, that healthcare has been using for years. True, AI-powered automation — built on newer technology such as machine learning and LLMs — is now capable of making a dramatic improvement to your authorization management.

For example, it can improve your prior auth workflows by identifying payer requirements, attaching needed clinical documentation, submitting requests, and checking statuses. All of this allows your team to dedicate more time to the patient experience and collect the correct information right out of the gate.

Mending Your Mid-Cycle

Streamlining the mid-cycle requires an increased focus on overall revenue integrity, including clinical documentation improvement (CDI) and coding. This means more emphasis on internal relationships and communication channels. Why? Improved coding and documentation means fewer denials, higher reimbursement per claim, and a better patient experience.

04 Focus on both DNFC and DNFB

Your days not final billed (DNFB) should be no more than five days. Unfortunately, it's easy to overlook the role of days not final coded (DNFC) when thinking about DNFB. Look closely at your coding team's workflows and handoffs to determine where backlogs happen.

If you focus too much on DNFB, you can miss inefficiencies in your coding process. Inaccurate or slow coding holds up the entire claim. Instead of focusing solely on DNFB, look at your DNFC metrics and if they can be improved. What does your coding team need to be more successful so that charts can be coded faster, improving time to reimbursement?

05 Minimize edits with effective processes

Most organizations have some form of mid-cycle automation in place right now that can reduce claim rejections. Despite this, denials often hang around 12%.

Effective processes and systems are critical if you want to address denials at this stage and in a timely manner.

Your CDI process is generally happening during a patient stay. So, the quicker you can get information from a physician and to coding, the better. (Every day that passes between the physician seeing the patient is another day the information isn't as fresh.)

After this, everything that's happened up to this point is reflected in the claim. Now, it's up to your systems, automation, processes, and some good old-fashioned people power to ensure things go smoothly.

Do you have the right processes in place for people to quickly circle back and get the information they need in the event of an edit? Are you leveraging RCM automation to assist with edits or help you attach suggested codes quickly?

"There's a sweet spot. You can't stop everything from getting billed, or it would take forever to get paid, and you wouldn't have the staff to work those edits. But are you stopping what needs to be stopped — for both clean claim submission and quality? Are you examining your denials to improve your edits? Are you looking into ways automation could connect these dots and make your mid-cycle more efficient? Achieving this balance in the mid-cycle is critical."

MINDY HARRIS
Director of Coding at AKASA

06 Ensure CDI specialists are laser-focused

Clinical documentation is critical to accurate billing and payer reimbursement. When the patient's record is incomplete and inaccurate, the entire billing process can be delayed, adding days in A/R.

Set your CDI specialists up for success by:

- **Establishing CDI standards:** For physicians and CDI specialists alike, standards are everything. Ensure everyone is on the same page when it comes to ideal turnaround times for notes, what constitutes "quality" notes and discharge summaries, etc.
- **Analyzing choke points:** Examine your current workflows and find places where things are held up. Are physicians and nurses getting notes to CDI specialists quickly? Is documentation present and available in the chart in real time? Are physicians responding to queries promptly?
- **Taking out noise:** CDI specialists often have to sift through every piece of documentation in a patient's record. Use advanced AI-powered automation to reduce their load and allow them to focus on getting the information they need as quickly as possible.

Advancements in healthcare RCM automation are enabling performance gains across nearly every workflow. Leveraging the right automation today will allow you to ease the burden on your CDI specialists, while setting you up for even further efficiency gains in the future.

How automation can help your mid-cycle

Coding is being hit hard by workforce challenges right now. You can't hire enough coders to keep your claims moving efficiently. Automation has to jump in.

While most organizations are using some form of mid-cycle automation via their EHR or computer-assisted coding (CAC) tool, it's often basic RPA that typically isn't advanced enough to tackle this complex work fully. More advanced automation can go the extra mile.

The right AI-powered automation can help your coding be both better and faster. Using advanced and scalable automation that leverages LLMs to improve coding processes will dramatically impact your operations and coding accuracy.

Automation via LLMs can help by reading and extracting information from dense clinical files, selecting the proper diagnosis codes to start building the claim, offering validation, reducing over- or under-coding, and providing confidence for compliance and audits. It's excellent at catching information-related errors a person can easily miss and improving charge capture. All of this results in achieving your appropriate revenue at a lower cost.

Bettering Your Business Office

Your back-office team creates the claim, making it an ideal focus for improving processes, reducing denials, and helping expedite claims processing.

07 Match the right skills with the right tasks

Back-office workflows vary, both in tasks and complexity. While other portions of the revenue cycle are often more predictable, the back office contains a number of complex, people- and technology-related issues with outside variables. Because of this, you must have the right people, processes, and technologies matched to the right task.

1 in 5
HEALTHCARE FINANCE LEADERS

MUST HIRE
30+ employees
TO STAFF THEIR REVENUE CYCLE DEPARTMENTS FULLY

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You can't easily hire more people in this current climate, so this isn't a problem at which you simply throw more RCM specialists. Instead, better utilize the team you have and fully leverage everyone's abilities, starting with proper deployment of advanced AI-powered RCM automation and beyond.

- **Match the right technology with the right task:** Automate as many areas as possible and augment existing back-office staff by automatically checking the status of claims, fixing eligibility errors, attaching solicited documentation, etc.
- **Automate for maximum effect**: Examine your current processes and specialists and look for where you're struggling the most. What areas are causing slowdowns or errors, or where are you lacking specialists? Start your automation efforts there.

The future is uncertain, and there's no telling if or when you'll be able to staff your back office fully. Or if they could ever handle your current volumes.

By optimizing your team and workflows as much as possible now, you're effectively future-proofing your RCM organization.

08 Cross-train your team

The ability to react quickly goes a long way when trying to streamline claims. This is difficult to do, especially when you're likely grappling with staffing challenges while payers continue to change their rules. Cross-training your team is vital.

Develop a plan to cross-train everyone on your team, with your more experienced specialists taking the helm. This will enable your team to fill in for one another, tackle more complex or varied tasks when time permits, and ultimately be more flexible.

A cross-trained team also has a more varied skill set. This can help you address the previous point — matching the right people with the right tasks. If everyone on your team is cross-trained and gets the opportunity to learn more, you can eventually have a team capable of handling virtually anything.

As a bonus, cross-training also benefits employee engagement, which can help reduce churn.

09 Get ahead of payer-related issues

Payers are a frequent cause of stress, especially in the back office. Not only are they the final say on denials, but they're also frequently changing rules.

If you know certain insurance companies are more likely to deny claims for a particular reason, take note and get ahead of the issue. Negotiations are never simple, so starting things off on the right foot and ensuring your claims are as payer-compliant as possible is key.

Work with your managed care and payer relations teams. Understand contract terms and utilize them when larger-scale negotiations are needed.

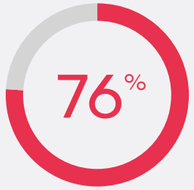
When denials arise, have the right people in place. For example, have people who know UnitedHealthcare inside and out, ready to hop on the phone when something is questioned.

Make it standard procedure to take notes on which payers frequently deny claims, why, what rules are changing, and so on. This makes for a handy cheat sheet and helps newer employees get up to speed

10 Improve denials resolution

Denials often feel like a moving target. That's because they are. Several factors make denials tricky to pin down:

- Reasons for denials are varied and plentiful, which leads to an RCM scavenger hunt for your team.
- Payers frequently update rules, forcing your team to stay on top of changes or run into a spike in denials.
- Denials are too complex for many forms of automation, like basic RPA, and require AI-powered automation.
- Denials require experienced RCM specialists, which are hard to come by in the wake of today's staffing challenges.



OF HEALTH LEADERS SAY DENIALS MANAGEMENT IS THE MOST TIME-CONSUMING TASK IN THE REVENUE CYCLE.

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Don't miss out on RCM automation

78%
OF HEALTH SYSTEMS ARE AUTOMATING THEIR REVENUE CYCLE

38%
ARE AUTOMATING DENIALS MANAGEMENT, SPECIFICALLY

Of those not automating denials:

44%
PLAN TO DO SO IN 2023

32%
PLAN TO DO SO IN 2024

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"All of a sudden, a lever gets pulled, and you've got a thousand denials on one payer for a certain reason that you didn't know was a problem before. You must respond quickly to the ever-changing payer requirements that result in denials. But that's the issue. It's not like we can't figure out how to work denials. It's not a static thing that you're responding to. Sometimes, changes are a corporate or legal issue. Otherwise, it's as simple as a side effect of frequent turnover in payers, resulting in new hires, mistakes, or new ways of doing things. Improving denials will have the biggest overall impact on your bottom line."

AMY RAYMOND
SVP of Revenue Cycle Operations and Deployments at AKASA

Beyond these reasons, there are potential pitfalls unique to your area, emergent denials challenges, and even turnover-related problems on the payer side.

There's no cure-all for denials management, but your team can better stay on top of them by coordinating a cross-departmental "task force."

Get stakeholders from all contributing departments: registration, coding, business office, etc. Have the team report on denials and trends as they occur across the revenue cycle. Take note of where denials emerge and why. From there, have your denials "task force" work together to create solutions for avoiding each denial type, documenting the solutions as they arise, updating edits, and developing training processes.

This collaborative approach reduces the likelihood of these denials occurring in the future and results in great training material for new hires down the road. And, by taking the time to find solutions for these various cross-functional denials now, you're saving the time you'd typically waste by putting these fires out as they arise, again and again.

As part of your denials management strategy, don't neglect the importance of having the right people focusing on the right work. Denials management requires the most subject matter expertise of any RCM task, after all. If someone excels at denials, have them cross-train other employees to help build this expertise across your department.

An added perk of all these efforts? Many denials aren't appealed because organizations simply don't have the staff or time to work on them. The combination of having the right people in the right place, supported by the right automation, and your task force solving denials ahead of time, will help you find the time to appeal the denials that do occur.

How automation can help your business office

How many open recs do you have right now in your back office? With current staffing shortages, teams are struggling to keep up with new claim volume. They don't have enough time dedicated to working claim status, follow-up, and solicited claim attachment requirements from payers.

Advanced AI-powered automation built for the business office can help with all of that.

It can assist by automatically performing tasks such as obtaining up-to-date claim status information, ensuring timely rebills of corrected claims, finding and including the right attachments for claims, and responding to payer follow-up requests with a touchless experience for the health system staff.

This frees up your team to focus efforts on the business office's more complex, revenue-generating, and patient-facing elements.

Accelerate Your Claims With AKASA and AI

"The most efficient RCM team is touching the tasks they need to and nothing more. Without automation, this means touching too many claims. When automation enters the picture and takes on much of the busy work, your team is suddenly free to focus solely on the tasks that require the one thing automation can never provide: the human element. This collaborative relationship is the best and only way to accelerate claims and reimbursement in today's environment."

AMY RAYMOND

SVP of Revenue Cycle Operations and Deployments at AKASA

Accelerating claims means accelerating the cash flowing into your organization — and accelerating answers for patients during oft-uncertain times. But the task of streamlining cash flow is a large one, with no single solution and no shortcuts.

This ebook's tips can help you put in place a number of processes and practices that can result in a smoother-running RCM department and revenue cycle. But automation can take your efforts even further.

AKASA can deliver advanced, AI-powered automation — backed by our team of RCM experts — that can accelerate your claims.

Our automation solutions — **Auth Determination & Initiation, Auth Status Check, Claims Status, Eligibility Denials Resolution, and Claim Attachment Resolution** — help providers speed up the revenue cycle and reduce denials. These solutions do so by securing timely prior authorization, automatically checking claim status at the right time, and addressing coverage-, eligibility-, and missing documentation-related denials — ultimately accelerating claims resolution, lowering A/R days and cost-to-collect, and increasing reimbursement.

Unlike clearinghouses and guided software workflows that require staff to still do the work, AKASA works like a team of skilled virtual full-time employees (FTEs), ensuring operations continue around the clock. We do the work for you — and don't just offer you a software workflow application that still requires input and maintenance.

With AI-powered automation, AKASA has helped clients see:

- **$30M gross yield increase**
- **13% decrease in A/R days**
- **86% efficiency improvement**
- **1,800+ hours of staff time saved per month**

Don't let an inefficient revenue cycle hold your organization back from bringing in the cash flow it needs. Every day you wait to address these problems is a day your queues grow, your accounts age, and your leadership becomes more frustrated. Look at your revenue cycle holistically and start to make changes that will help you function more efficiently.

Learn how the healthcare and AI experts at AKASA can help your organization accelerate claims to new speeds.

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START THE CONVERSATION