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HEALTHCARE PROVIDER

Regulatory Impact on Revenue Cycle Management—Think You're Prepared? Think Again

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TAKING THE GUESSWORK OUT OF GROWTH

The new healthcare regulatory reforms will have far-reaching effects across the industry, but the most noticeable consequence for providers will come in the area of revenue cycle management. Changes to multiple systems, processes and procedures will be necessary to achieve compliance, including optimization of data management, coding and billing procedures, and critical IT systems. Those providers who lack a solid plan of attack face not only the risk of noncompliance, but disruption to the revenue cycle and potential revenue erosion.

The three biggest regulatory shifts mandating changes to revenue cycle management are the introduction of ICD-10 coding and the implementation of both payment reform and HIPAA EDI Standards, Version 5010. In many cases, preparing to accommodate the expanded skill sets and the specialized changes being made to technology will require the knowledge and expertise of third-party entities, but providers themselves will ultimately be responsible for ensuring the accuracy of their information. What follows are the highlights of some of the pending changes and insights as to what healthcare organizations should be doing now to prepare.

ICD-10 - EXPANDED CODE SETS, EXPANDED CHALLENGES

Replacement of the current ICD-9 code sets with the new ICD-10 standards is scheduled for October 1, 2013.[1] According to the American Medical Association, the new system will use a total of 155,000 diagnosis and provider codes as opposed to the 18,000 currently in use with ICD-9. In the long run, the increased specificity of the expanded code sets promises to provide greater accuracy and control over the claims process, but the immediate changes required to achieve compliance will have far-reaching effects across provider organizations.

Medical coders, for example, will require substantial time to train and prepare for work with the expanded code sets. In addition, education on anatomy will be necessary for most coders to become proficient in the ICD-10 system. Some sources[2] estimate that inpatient coders will need as many as 50 hours of training, to learn the new code sets, a number that has risen over time as a better understanding of ICD-10 has emerged.

The consequences for inadequate preparation are many and include diminished productivity and possible compliance errors, increased denials and appeals due to incorrect coding, and suboptimal reimbursements due to delayed and inadequate coding. Preventing errors will necessitate true coding proficiency, something that will require practical experience in addition to training and education. To ensure the highest degree of accuracy, coders should be required to demonstrate proficiency in a learning environment before beginning work on actual patient records. By engaging an independent third party with extensive ICD-10 coding expertise to audit the coders work and administer competency testing, providers can be certain that coding professionals are up to the level of ICD-10 standards and diminish the chance of revenue erosion.

The requirements of ICD-10 extend beyond the coding department, making preparation across medical and office staff critical. Registration personnel, hospital clinicians and physicians will need to be trained in new data capture requirements. Finance, billing and collections staff will need to understand the impact on billing and reimbursements, particularly the impact on net income. Payer contracts will need to be reviewed and updated to be compatible with ICD-10 coding as well.

Information systems that are used to calculate contractual allowances will need to be tested for accuracy in advance of the ICD-10 implementation in order to ensure that net revenue is accurately stated. Since all third-party payers will be affected by ICD-10, providers should engage a third party to perform a payment variance audit.

HIPAA EDI STANDARDS, VERSION 5010 ENHANCE PRECISION OR RISK REJECTION

Effective January 1, 2012, all providers will be required to use 5010 transaction standard formats when submitting electronic claims or the claims will be denied, regardless of the payer. Reaching full compliance by this date will require many providers to make changes to their current systems and processes with a much greater emphasis on improved data precision. For example, a patient's name and date of birth must match Social Security records exactly to prevent processing delays or costly denials on claims. Providers should begin reviewing their Master Patient Index now, to eliminate duplicates and ensure that all records are consistent with Social Security databases.

[1]American Medical Association Publication, "Preparing for the Conversion for ICD-9 to ICD-10: What You Need to be Doing Today", (April 13, 2010)
[2]Anita Majerowicz, "Developing an ICD-10-CM/PCS Coder Training Strategy", (April, 2011)

With the ability to transmit more detailed information, the 5010 standards will enable providers to accelerate their cash flow and facilitate the components of payment reform, including bundled payments, pay for performance, and the requirements of Accountable Care Organizations (ACO).

To enjoy these additional benefits, providers need to perform a comprehensive assessment of their current revenue cycle operations. In most cases, significant re-engineering will be required to establish a patient–centric model that improves efficiency through a more effective use of technology. Providers who wait to start implementing these processes may not be adequately prepared to meet the 5010 transaction requirements.

THE COMPLEX ROAD TO PAYMENT OPTIMIZATION

In the long term, payment reform is meant to reduce costs and improve quality, but will intensify existing revenue cycle challenges while concurrently adding new ones. Increases in patient financial responsibility, reductions in payment amounts, increased regulations and greater claim accuracy requirements will impose further demands. Additionally, providers will need to administer the new requirements of bundled payments, billing for multiple payers and ACOs.

For example, participation in an ACO will, among other things, require providers to act as both provider and payer, administer bundled payments, and provide detailed reporting on clinical and financial outcomes. Providers will need to either build or buy administrative services for the adjudication of claims, distribution of payments related to bundled payments, consolidation of charges for services of multiple providers, and development of new payments models. Implementation of the necessary information technology will be a prerequisite to all of these requirements.

These preparations will require significant investment. A recently published study by the American Hospital Association[3] indicated that providers would need to invest over $10 million to start an ACO. Most providers are not positioned to make a financial commitment of this size and will need to outsource the administrative aspects of ACOs to a third party to take advantage of the lower service costs.

The decisions required to implement any type of payment reform are complex and can't be made overnight. Providers, who have not begun to weigh their options, determine a course of action and consider the possible unintended consequences and solutions, may find themselves unable to meet the compliance demands or sustain long term success.

As the details of the new regulations become clearer and the time for preparation shrinks, healthcare finance executives are facing the need for a comprehensive overhaul of their RCM systems. Massive changes to both technology and processes are imminent and those organizations who are not committed to early preparation will face compliance issues, disruption to revenue flow and possible penalties as they take on the very large task of revenue cycle management in a time of reform.

[3]American Hospital Association Press Release, "New Study Finds the Start Up Costs of Establishing an ACO to be Significant", (May 13, 2011)

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