Free Data is Never Free:

The financial and operational effects of error-prone patient validation and stale data

tevix MD
ACCURATE DATA MAKES THE DIFFERENCE

White Paper
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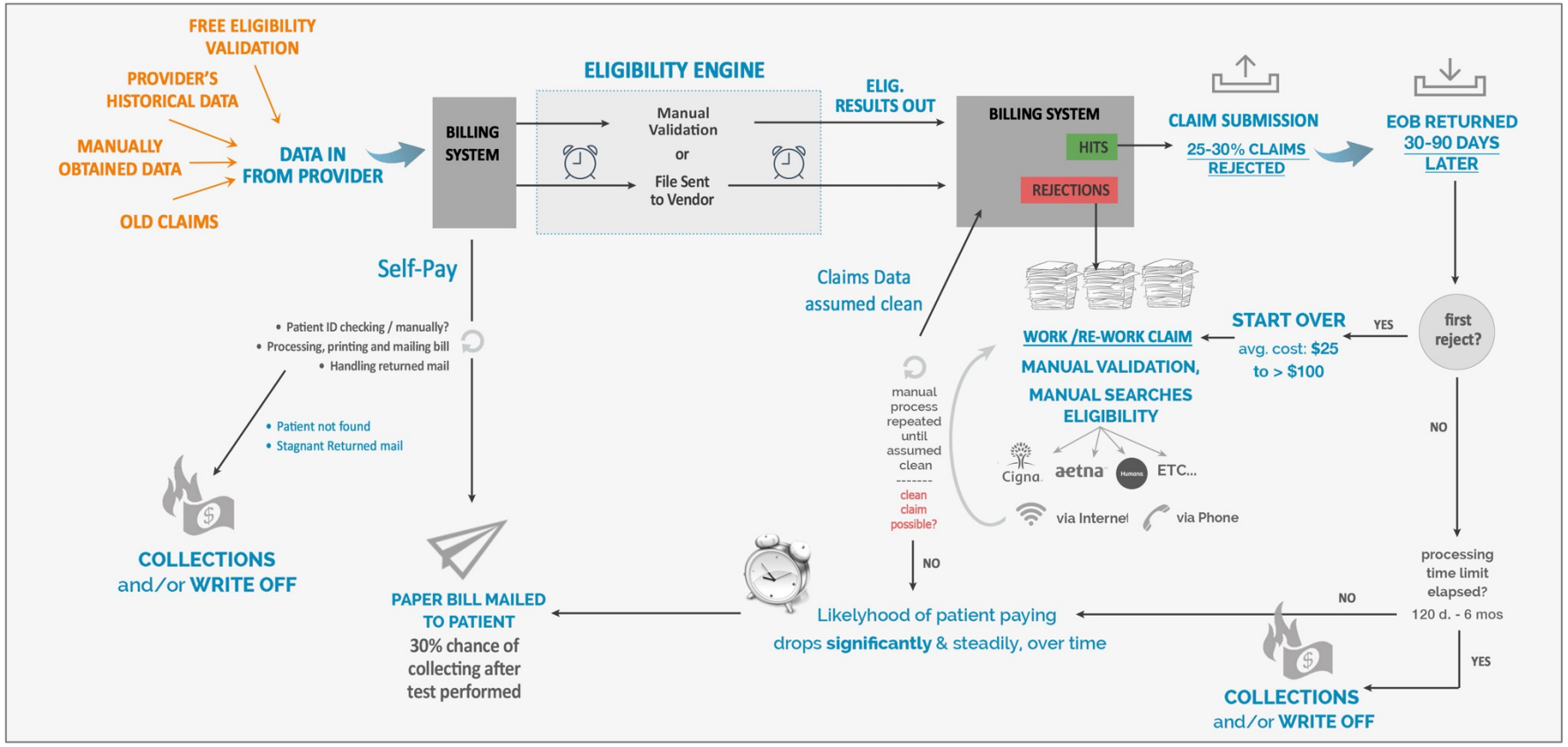
An outdated and broken system of collections and billing procedures

Depicted is an outdated and broken system of claims management, billing and collections. It is chaotic to say the least and yet it remains the standard operating procedure for a good portion of providers, labs and healthcare systems.



Chaotic and outdated claim management, billing and collections procedures

Taking a step back and looking at the larger picture, it's easy to identify the areas where time, effort and money are wasted along this workflow.

The most glaring problems involve efforts by staff which are redundant, error-prone, heavily time consuming and/or completely unnecessary given available technology. In addition, as a result of this broken process a high level of patient dissatisfaction due to non-transparent pricing for services, surprise bills and collection notices is created which can lead to a backlash in social media and/or with regulators, putting your business at risk. The good news is that a large portion of this mess is avoidable.

Some of the bigger issues with the current process:

- Error-prone and stale data sources
- Error-prone manual data entry
- Time-consuming manual research such as internet lookup and phone calls
- Duplication of efforts by staff in different departments
- Avoidable claim submissions
- Delayed patient billing
- Patient complaints and dissatisfaction
- Revenue-eroding collections

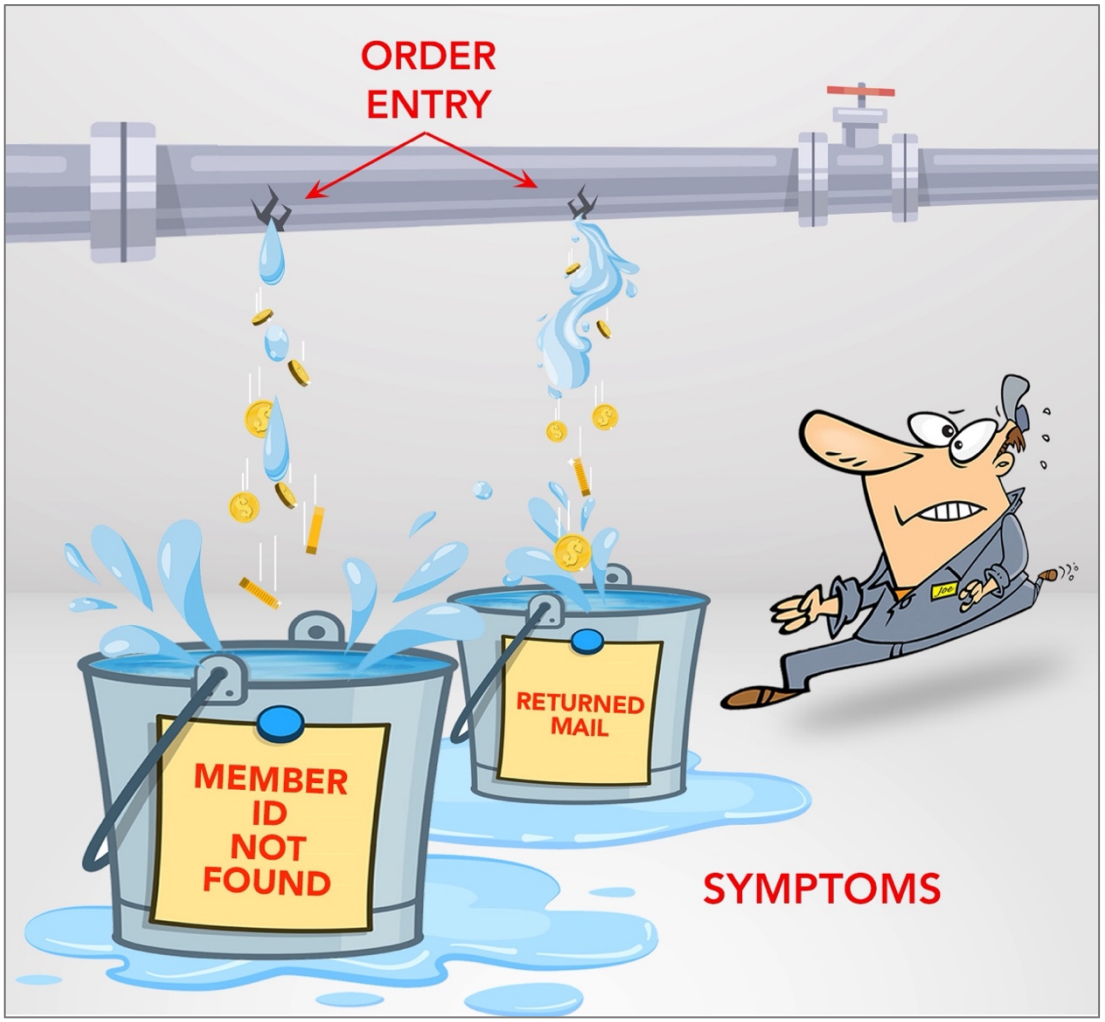
Chasing Symptoms

This chaotic system did not develop overnight. It is the consequence of years of addressing symptoms of the problem rather than the root causes and developing micro-procedures to address pieces of the problem in an attempt to keep them from growing out of control.

It's like getting more and more buckets to collect water from a leaky pipe rather than fixing the leaks with a newer and better pipe.

The most serious symptoms include:

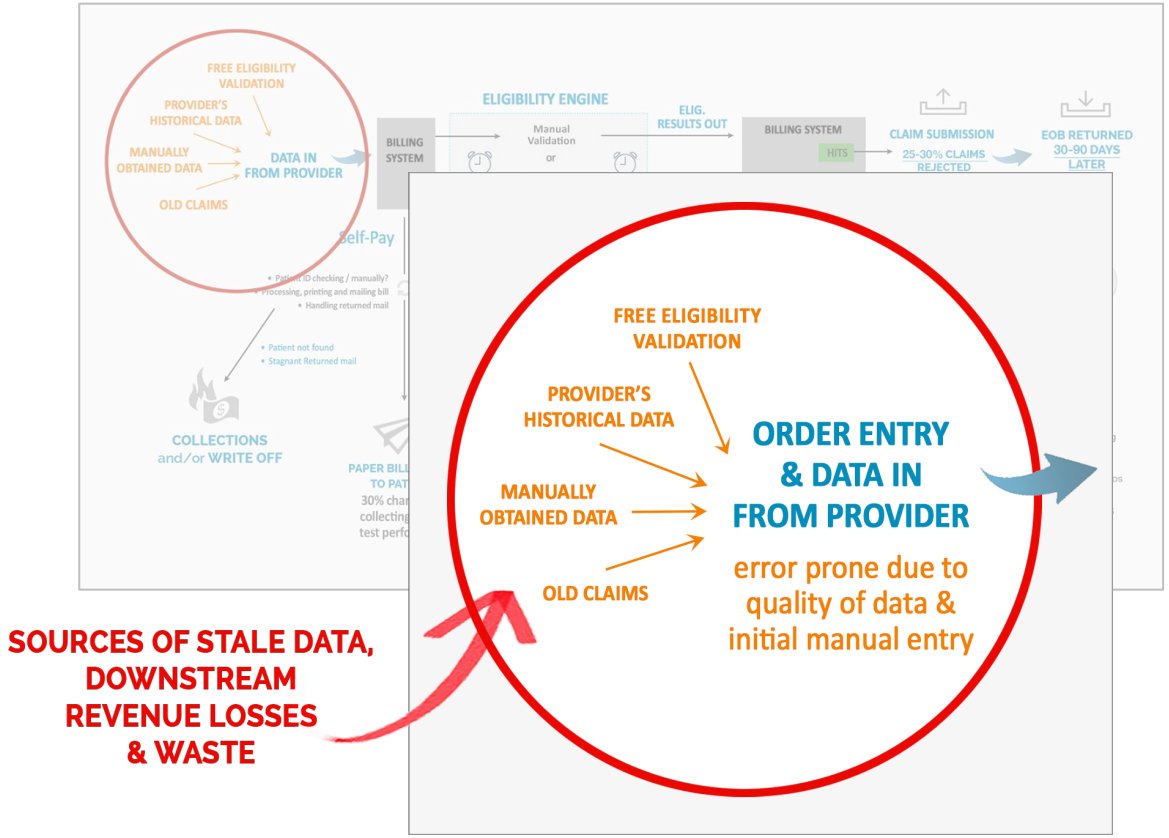
- Member ID not found
- Returned mail
- Ineligibles



These challenges are not the problem, they are symptoms of the problem, and years of using ad-hoc solutions to try to patch the “leaks” has created a mess of billing and collections procedures for providers.

The good news is that the rejected claims, returned mail and denials that continue to accumulate -- and which account for enormous revenue losses, cash flow shortages and write-offs -- can be significantly reversed by focusing on the root causes:

- poor quality/stale eligibility validation
- missing demographic validation
- out-of-date demographic data
- bad timing



You get what you pay for….. or don't

The habit of addressing the leaks while missing the broken pipe has become a costly and wasteful approach to billing and collections procedures. With profit margins and cash flow at their lowest ever it's easy to understand how revenue cycle, billing and operations managers who are driven to cut costs at every corner are enticed by offers of free or cheap patient eligibility validation or relying on old in-house data.

The problem is free eligibility validation is *never* free. The ultimate cost of error-prone and incomplete data and delayed availability can make the initial claims validation issues worse, resulting in more rework, lost time, and lost revenues from uncollected payments.

This is particularly true with outdated or error prone data sources, which can come from:

- Vendors offering free or cheap validation:
  "*sign up and we'll throw in eligibility validation for free*!" There's a reason it's free.
- Providers' own stored data
- Old claims
- Manually obtained data
- Anything manually typed in

Often missed are the downstream effects of validating patient eligibility using stale data, namely: operational inefficiencies, higher operational costs and revenue losses.

Subtle and common patient data errors that lead to claim rejections and returned mail

Public Name -vs- Payer Name

In the world of patient validation people have two names: a public name and a payer name (the exact name of the insured in the payer's records)

Most validation sources retrieve the public name which may be slightly different than the payer's records. Such as:

> *A wrong or missing middle initial, a maiden name, a misspelled first name such as Mark vs Marc or Cindy vs Cindi*

Even the slightest inaccuracy triggers a rejection.

Public Address -vs- Payer Address

Common sources for address information deliver a public address which may or may not match the payer's records.

Making it worse are the severe repercussions of Covid-19. Millions more people than average are moving and this wreaks havoc on patient demographic records.

Job Changes

Further, millions more people than usual have lost or changed jobs - estimated to be at least 20% - more than 50 million people have lost or changed coverage during the pandemic.

More specifically, stale data leads to rejected claims, extra work for staff, added expense to collect and reduced cash flow (revenues). Just look at the 2020 cost of preparing and managing claims, reworking rejected claims and self-pay collections efforts:

CLAIM PREP COSTS

		MANUAL	ELECTRONIC	TIME SAVED
INITIAL CLAIM	Identity Validation ***	$3.00	$0.30	9 min
	Eligibility Validation *	$5.83	$0.82	12 min
	Prior Authorization *	$10.26	$3.64	12 min
	Claim Submission *	$3.30	$1.19	5 min
	Claim Status Inquiry *	$6.65	$1.10	18 min
	Claim Payment *	$3.76	$1.19	4 min
	Remittance Advice *	$3.76	$0.94	6 min
	TOTAL COST initial work	**$36.56**	**$9.18**	**66 min**
RE-WORK REJECTED CLAIM	Re-Validation ***	$8.83	$1.12	21 min
	Resubmission *	$3.30	$1.19	4 min
	Collections Agency **	$15.00	$15.00	n/a
	TOTAL COST rework	**$27.13**	**$17.31**	**25 min**
	TOTAL rejection + rework	**$63.69**	**$26.49**	**63 min**

DOES NOT INCLUDE costs for: attachments, coordination of benefits or explanation of benefits.

* Source: CAQH 2020 Index

** Based on 30% fee on $50 avg invoice

*** Based on 10 min @ $18/hr for manual -vs- 1 min electronic

If an average invoice is $150, how much margin is being eaten up by just chasing the money?

This chart accounts for the time and the *cost* of time for validation and claim prep/follow-up; it does not account for…

- the cost in resources
- the revenue losses due to reduced or non-payment by the patient
- write-offs when last-ditch collection efforts fail

To make matters worse, stale data is not the only concern for providers trying to minimize claim rejections and maximize operational efficiency. Poor validation sources generally fail to deliver some critical pieces of information making it impossible to determine who foots the bill in a timely manner, and it is a common cause for returned mail, among other things.

Typical and costly information shortcomings from poor validation sources:

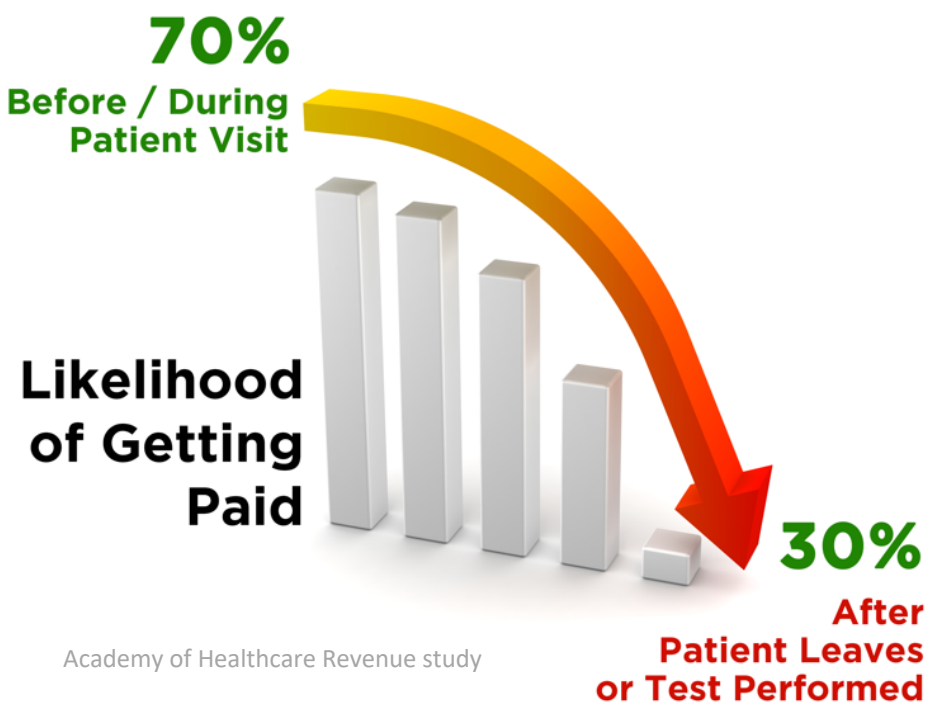
- Missing real-time remaining deductible status and co-pay amount
- Missing real-time demographic validation
- Missing SSN
- Missing Medicare Beneficiary ID (ssn is no longer accepted)
- Missing Medicare Plan ID

This is important because since 2014 the patient has out-ranked third-party payers as the third largest payer after Medicare and Medicaid; third-party payers now rank fourth.

It is now more imperative than ever to know who is financially responsible for the bill, and to know this early on in the patient engagement process, not 30-90 days after services are rendered or tests performed.

-- HFMA/Arkansas Study

Good timing is as important as knowing who's responsible

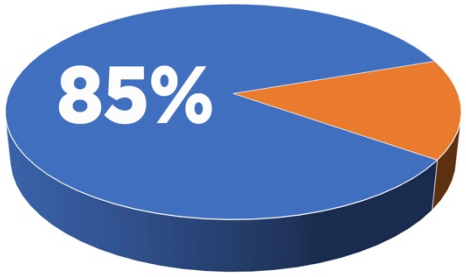


Academy of Healthcare Revenue study

Clean data is only half of the picture; good timing is the other half. Another big flaw in the outdated and chaotic billing and collections system is that by the time the provider realizes that the patient is responsible, their ability to collect the entire invoice has been reduced dramatically.

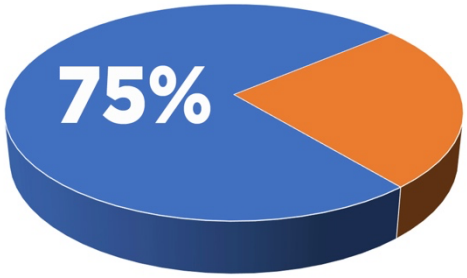
So not only do providers need to get their hands on *complete* and *error-free* data, but it must be accurate *at the time of validation (real-time) and available when they need it, early on in patient engagement*.

With the emergence of widespread high-deductible plans, *reliably* knowing when the patient is financially responsible, for how much, and earlier in the picture all help the provider retain more of the revenues for their services, simplifies AR and supports a more transparent relationship with the patient / improved patient satisfaction.



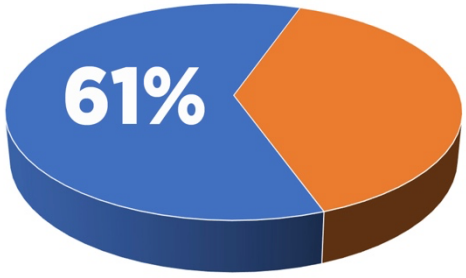
85% of consumers want to know their payment responsibility up front

Consumer Healthcare Payments Survey 2018



75% of patients say that understanding their out-of-pocket costs improves their ability to pay for healthcare

Consumer Healthcare Payments Survey 2018



61% of consumers would consider switching providers for a better healthcare payments experience

Consumer Healthcare Payments Survey 2018

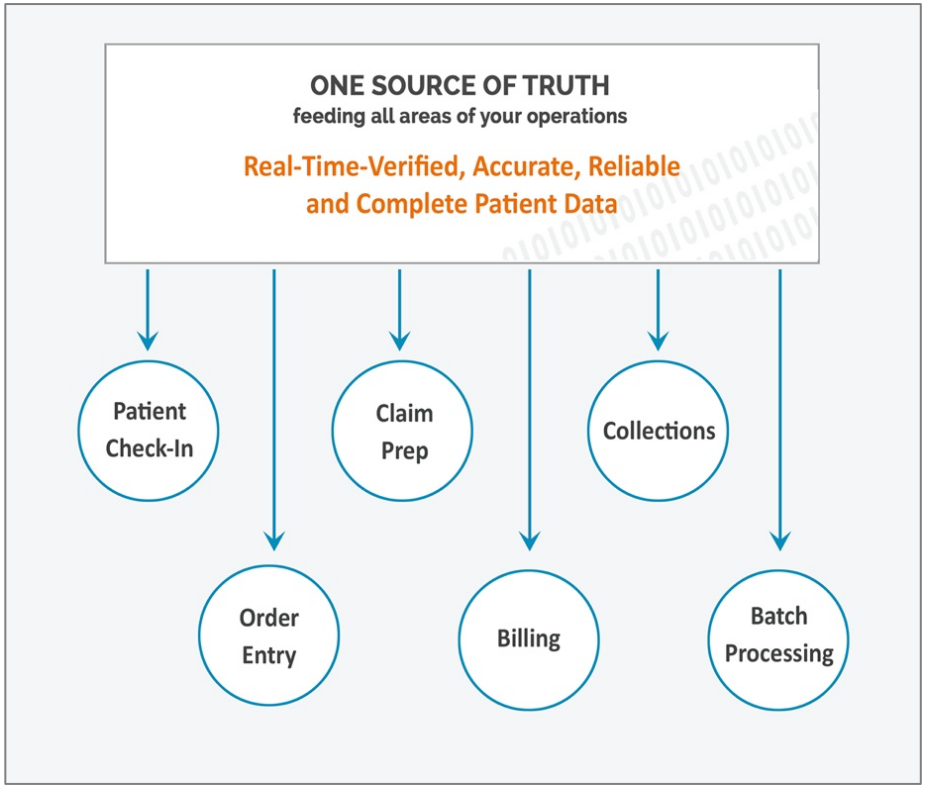
So, whether claims are submitted or the patient is self-pay/insured self-pay, we find that poor validation sources dishing up stale and incomplete data are a major culprit in elevated claim rejections, returned mail and operational inefficiencies, which in turn result in substantial downstream costs and unhappy patients making free validation *anything* but free.

With so many moving parts that contribute to errors and misinformation, it is important for providers to get three things right in order to simplify and clean up collections and billing procedures:

1. Acquire *complete* patient eligibility and demographic information that is error-free as of the moment of validation (real time).

2. Validate as early as possible in the patient engagement process.

3. Once reliable validation information is acquired, make that verified data available across the workflow to create a consistent, single source of truth for all departments, thus eliminating unnecessary and redundant efforts by staff.



By getting these three pieces right, the provider…

- Knows who is responsible for the bill at the time of service
- Can invoice patients at or very near the time of service, if necessary
- Can have confidence that the cleanest possible claim goes out the first time and with much less effort
- Keeps errors out of their system
- Reduces redundant efforts by staff
- Can simplify operational procedures and costs
- Develops a better relationship with the patient regarding payment
- Avoids chasing patient payments

Accurate and timely information is power

Bottom line: knowing who is responsible for the bill as early as possible and having access to real-time, error-free patient data, right when you need it, can mean the difference between poor financial and operational performance and an efficient, streamline workflow with positive bottom-line results.

Stop managing the leaks!

Founded in 2014, tevixMD is a national provider of the most accurate, real-time patient eligibility, identity and demographic verification. Our validation is available on demand, when you need it, using just the patient's name and zip code or date of birth.

Advanced, patented search algorithms set tevixMD validation apart. Our proprietary validation process ensures that you know who is responsible for the bill before or at time of service and have confidence that you submit the cleanest claim possible the first time.

tevixMD validation doesn't dip into stale databases – we re-validate, real time, with every search request.

Reduce rejections, improve reimbursements, streamline workflow and billing processes with tevixMD and realize a significantly more profitable bottom line.

Start seeing results sooner than you can imagine.
Set up a discovery meeting and live demo today.

Learn More: www.tevixMD.com