



## **Free Data is Never Free:**

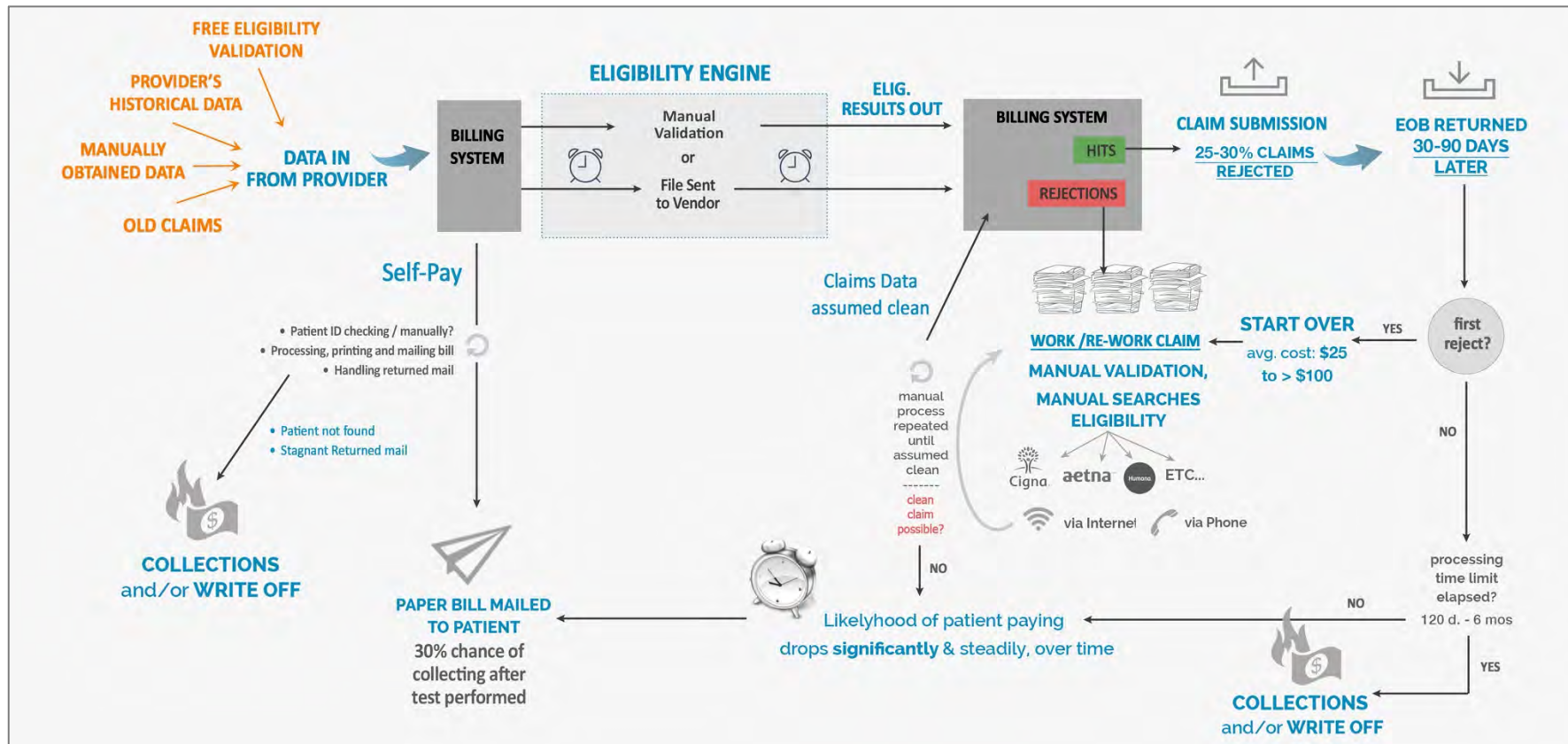
The financial and operational effects of error-prone patient validation and stale data



**White Paper**  
Fall 2021

# An outdated and broken system of collections and billing procedures

Depicted is an outdated and broken system of claims management, billing and collections.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Chaotic and outdated claim management, billing and collections procedures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.

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## Some of the bigger issues with the current process:

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- 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

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## Chasing Symptoms

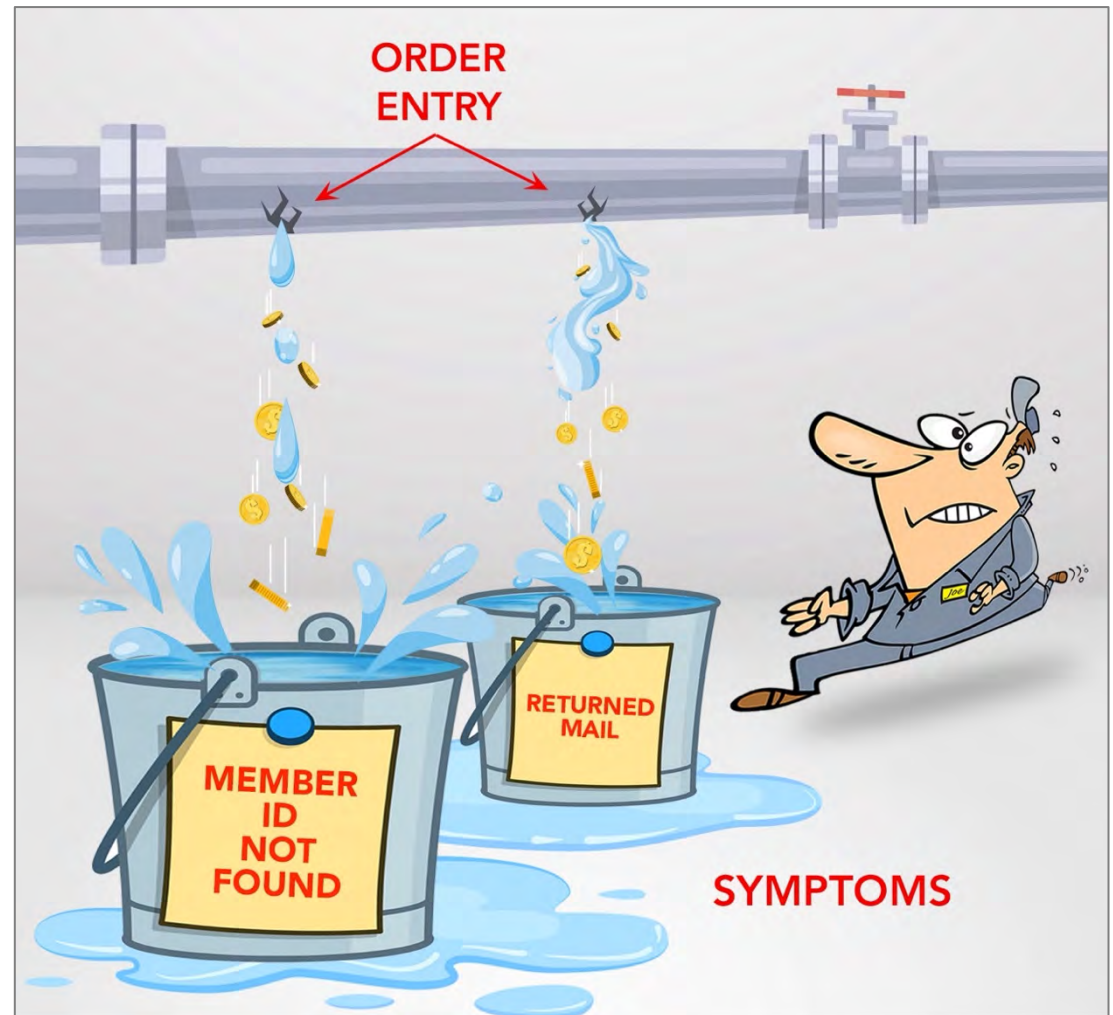
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This chaotic system did not develop overnight. It is the consequence of years of addressing symptoms of the problem rather than the root causes and developing micro-procedures to address pieces of the problem in an attempt to keep them from growing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

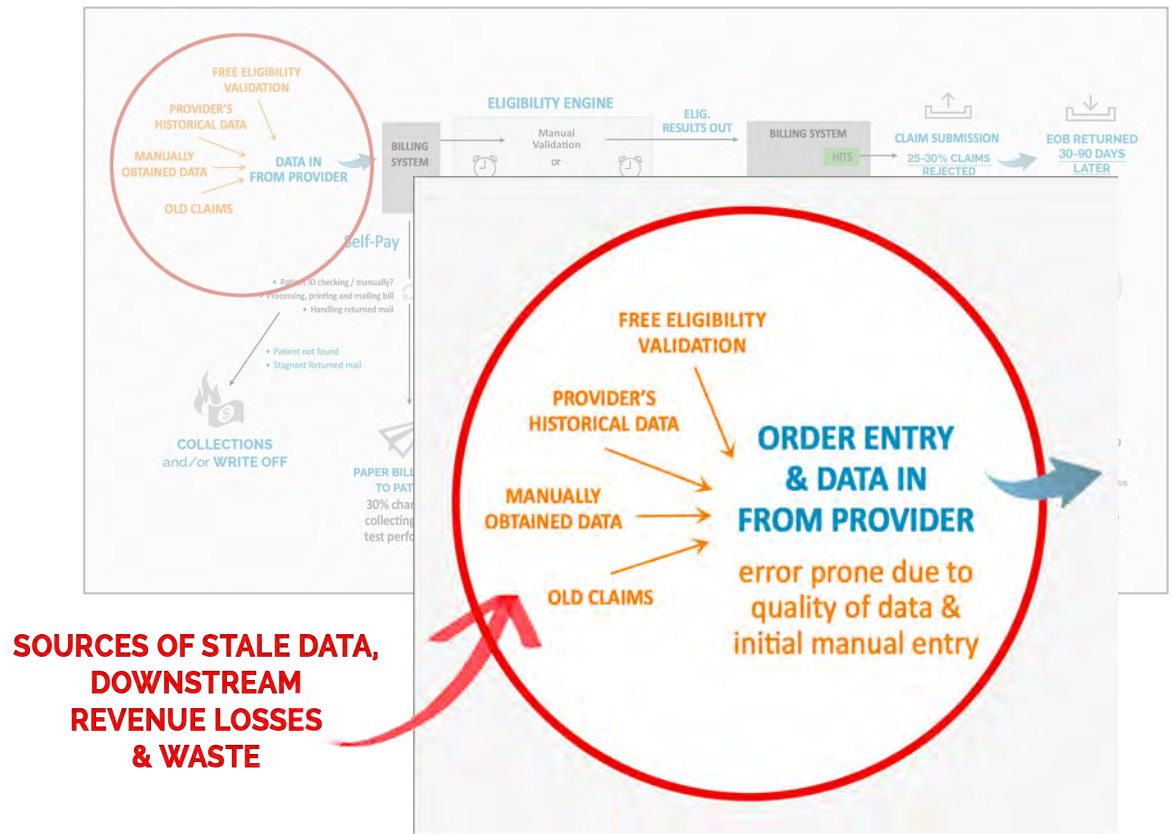
- Member ID not found
- Returned mail
- Ineligibles



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



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## You get what you pay for..... or don't

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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