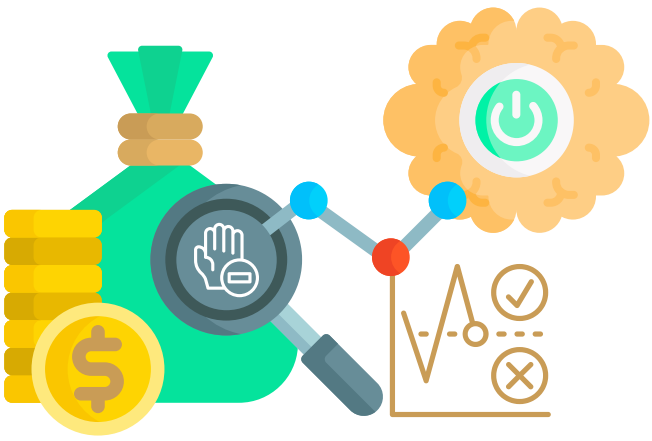
PLUTUSHEALTH

Excellence in Healthcare Revenue Cycle Management

Denial Management in Revenue Cycle Management

Workflows, Strategies and Automation



Medical providers will benefit greatly from following best practices in revenue cycle management. In this guide, our experts share their best practices for each stage of healthcare RCM. These steps will enable your organization to work smarter and increase profits.

UNDERSTANDING DENIALS IN REVENUE CYCLE MANAGEMENT

Denials in revenue cycle management occur when an insurer refuses a claim from a healthcare provider. A denial means that the provider doesn't get paid. However, providers can use denial management to resolve and prevent denials – and maximize revenue.

Revenue cycle management (RCM) describes how a healthcare organization oversees financial transactions for patient services.

Efficient RCM is crucial for healthcare organizations because it underpins their financial stability and encompasses nearly all departments, such as patient registration, billing, and payment collection. RCM objectives include maximizing revenue, minimizing errors, and ensuring compliance.

"RCM is a complex ecosystem made up of many interconnected departments that all work together," says Kenneth Jeremiah, Associate Director of Transitions at Plutus Health. Jeremiah has more than 17 years of experience working on RCM on both the provider and payer side.

Insurance payments represent a huge revenue source for most healthcare organizations. To receive payment, a provider must submit a claim describing the services and providing the invoice. Unfortunately, insurance payers reject many claims.

"A claim can turn into two things — revenue for the organization or a denial," says Steve Kennedy, Associate Director of Revenue Cycle Management at Plutus Health. "Denials occur when the payer says that the claim has an error, whether it's technical or stems from a clinical disagreement between the provider and payer."

Fortunately, you can reduce denials by adopting a savvy approach.

"Denial management aims to comprehensively understand each denial, analyze denial trends, and establish preventive measures," Kennedy says. "Ultimately, it aligns with RCM's primary objective: maximizing cash flow, interpreting and mitigating common denials, and preventing future denials."

Kennedy adds: "Without an effective denial management process, denied claims can accumulate rapidly and significantly impact the organization's operations and cash flow. Surprisingly, most denials stem from preventable issues within the patient care workflow." Those issues can appear minor but later balloon into a denial, says Doug Waldorf, Director of Client Success at Plutus Health.

“Forty to 60% of denials come from small errors on the front-end of RCM, or the things that happen before a patient walks through the door to receive care,” Waldorf says. “These types of claims are preventable and represent a huge opportunity to either lose money as a denial or gain it as revenue. In either case, denials significantly impact cash and collections.”

Unfortunately, some healthcare providers lack effective denial management and instead accept write-offs.

Providers give in because of RCM’s complexity, especially when dealing with insurance companies. RCM means dealing with multiple stakeholders, keeping up with frequent policy changes, and having sophisticated tools to manage the process.

"Many departments contribute to denials, from check-in teams to schedulers, pre-billing, coding, and more,” Jeremiah says. “Being on top of the process isn’t easy, but it is worth it. A robust denial management process is like changing a tire on a moving car; it's a significant investment upfront, but it can translate into substantial returns."

Jonathon Curlett, a longtime healthcare executive with experience working for providers and payers, shares a similar perspective:

"Providers should closely scrutinize every denial that comes their way because it represents a claim left unpaid, resulting in revenue loss. Denials also potentially shed light on weaknesses within your processes. Dedicate time to proactively tackle denials from the outset, whether it involves new patients, software enhancements, or vendor relationships.”

Curlett adds: “This proactive approach not only has a financial impact by securing the claim but also reduces administrative expenses, streamlining the claim submission process and enhancing overall operational efficiency."

KEY TAKEAWAYS:

- **Denial management resolves and prevents claim denials – and maximizes revenue.**
- **One key tactic is to analyze denied claims to prevent the same problems in the future.**
- **The goal is to keep your denial rate under 5%.**
- **Automate your denial management to streamline the process and sniff out claim issues in advance.**
- **Outsource your RCM and denial management so you can focus on patient care.**

STEPS IN THE RCM DENIAL MANAGEMENT PROCESS

In RCM denial management, providers should follow four key steps. First, identify why a claim was denied. Second, manage the claim by addressing the problem. Third, monitor other claims for the issue. Last, prevent future denials by creating a strategy.

“Insurance companies have an incentive to only pay the appropriate claims,” says Curlett. “They can’t expect the provider to police themselves. If there’s anything wrong with your claim, they will find out and deny it accordingly.”

That’s why it is essential to respond effectively.

"Whenever we receive a denial, we consistently follow a set of key steps to make sure the denial turns into revenue," Jeremiah says. "We pinpoint the root cause of the claim denial, take prompt corrective actions, and then incorporate this valuable data into our prevention program, aiming to reduce the number of incoming claims in the first place."

Here are the major steps in the RCM denial management process. Some organizations find it helpful to split up the steps under the IMMP process: Identify, Manage, Monitor, and Prevent.

- **Identify**

In the first step, you identify the claim problem
When payers deny your claim, they add a claim adjustment reason code (CARC) to an explanation of benefit (EOB) form. The code outlines the reason why the payer denied the claim.
Kennedy explains: "When we submit a claim to the payer, it may get denied for various reasons. Common causes include lack of prior authorization, non-coverage of the service, or technical constraints on how and where it can be provided. Even minor errors like a misspelled last name or an incorrect insurance policy number can lead to denials.
The denial management team's main task is to interpret the CARC code to understand the reason behind the denial. "Understanding the CARC code can be intricate," Kennedy says, "but our primary goal is simply to comprehend why the payer denied the claim.
"Jeremiah adds: "Often, the denial management team needs to contact the payer to understand the issue."

- **Manage**

Now that you know why the payer denied your claim, you take steps to resolve it and receive payment. You create a plan to rectify the error and resubmit the claim. Another name for this is "appeal management."
"Usually, the payer allows you to correct and resubmit your claim under a defined timeline," explains Waldorf. "Understanding and adhering to this timeline is incredibly important. If you don't resubmit on time, you forfeit your right for payment."
Most clinics and healthcare providers handle many claims at once. So, they prioritize claims and follow a workflow to ensure they address denials on time and don't leave money on the table.

- **Monitor**

In this step, you monitor denials to understand their types and volumes. Then, you categorize the denials by type, date received, date appealed, and outcome.
You also categorize the insurance payers and reasons for denials. With this intelligence, they can talk to the insurer about better ways to reduce claim denials.

Steps in Denial Management

- **Prevent**

In the final step, you implement a full prevention plan.

“Many claims are preventable,” Kennedy says. “Prevention is all about taking measures before we even file the claims and ensuring our pre-billing process is strong.”

Kennedy explains that prevention starts with strengthening the front-end processes.

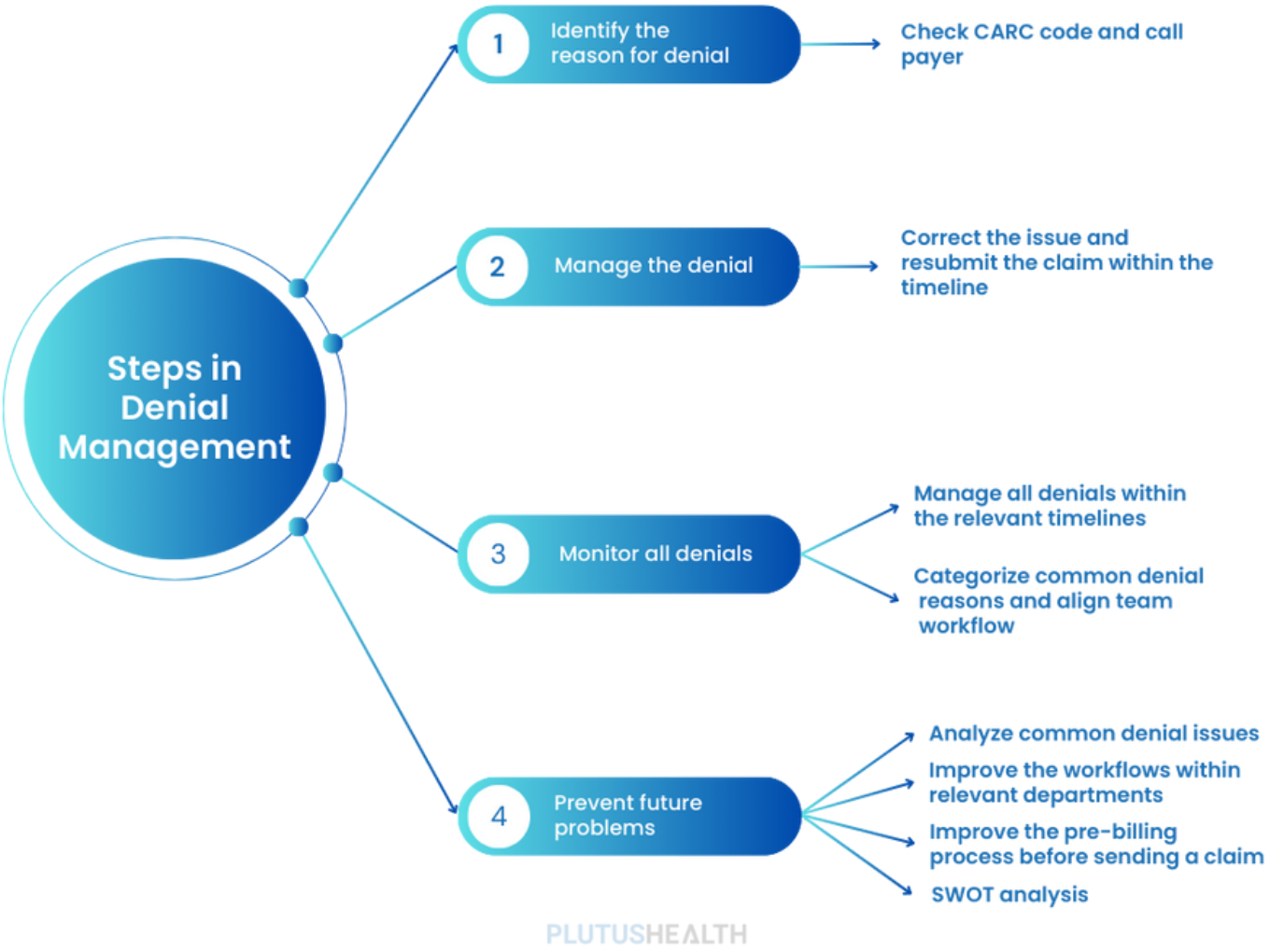
“This phase, which we call pre-billing, encompasses multiple checks and balances, card copy verification, confirming members' eligibility and benefits, and completing all necessary preparations before providing services.”

The work continues even after scheduling appointments.

“We conduct code verifications to determine if they are billable to the specific payer,” Kennedy says. “We perform all these validations before proceeding with claim submission, emphasizing our commitment to proactive measures from the outset."

People will inevitably make mistakes, but that doesn’t have to snowball into bigger problems.

“A good denial management team will learn from their mistakes,” says Jeremiah. “Successful organizations with strong denial management practices use past data to uncover common system weaknesses. For example, if multiple claims are denied due to prior authorization issues, the pre-billing team becomes extra careful in checking for this problem."



TYPES OF DENIALS IN RCM

Some professionals talk about two types of denials: hard and soft. Hard denials usually relate to clinical issues, and it isn't easy to appeal them. Soft denials concern minor technical errors that are easily correctable. You might also hear terms like clinical, technical, and administrative denials.

However, Waldorf says those designations don't come up much in denial management.

"A denial is a denial," he says. "In practice, we don't formally categorize denials as 'soft' or 'hard'— we try to appeal all possible denials. However, because different denials demand different workflows, we do occasionally use the terms when we are communicating with external stakeholders, like healthcare organizations. It helps us explain how we plan on handling different denials they might have."

Here's a more detailed review of denial terminology:

- **Hard denials:**

Technically, a hard denial is a firm refusal to pay the claim. Contesting these types of claims requires a formal appeal process from the provider. In many cases, this process can be so cumbersome that the provider skips it and abandons the claim, resulting in lost revenue.

Usually, hard denials result from the provider failing to meet pre-authorization procedures, the payer determining that the service is not covered, or the provider filing the claim too late. Within hard denials, there are two subcategories: preventable and clinical denials.

  - A preventable denial refers to a denied insurance claim that could have been avoided or mitigated with appropriate measures. These measures often involve ensuring accurate patient information, correct coding, thorough documentation, adherence to insurance policies, and timely claims submission. By proactively addressing these factors, healthcare providers can reduce the likelihood of preventable denials and optimize their revenue collection processes.

  - Clinical denials are hard denials that occur when a payer refuses to reimburse because they don't agree with the clinical reasons that the provider used to justify treatment. For example, a lack of medical necessity, uncovered services or incorrect coding may lead to clinical denials.

- **Soft denials:**

In contrast, a soft denial refers to a type of denial in which an insurance claim is rejected or denied by a payer for reasons that are typically administrative or procedural. Unlike hard denials, which are more definitive and usually require formal appeals, soft denials are often considered temporary and can be corrected or resubmitted with additional information or clarification.

RCM Denial Scenarios

Common RCM denial scenarios relate to mistakes like missing information or coding errors. Also, patient eligibility and prior authorizations will result in denial.

Jeremiah explains the claim journey: “When a healthcare provider submits a claim to the payer, a clearinghouse electronically transmits the information. If the clearinghouse detects an issue, it rejects the claim and returns it to the provider for correction. If the claim successfully passes through the clearinghouse, it sends the claim to the payer.”

Jeremiah continues: “At this point, the payer enters the adjudication phase, where they meticulously evaluate and decide whether to accept or reject the claim based on policy terms and medical necessity. If the payer denies a claim that had previously passed the clearinghouse, it typically signifies that the provider did not adhere to the correct submission process."

Here’s a summary of the major reasons why payers deny claims.

- **Missing and invalid information and missing modifiers**

The problem might be a blank field, like a Social Security number or demographic information. Or it could be an incorrect plan code or a technical error like a missing modifier, which is a two-character code indicating a service change without a corresponding code change.
Other common issues include a missing or misspelled last name, or no date listed for a medical emergency or condition onset.
Incorrect information for date of birth, gender and other patient details will prompt a denial and require claim adjustments. Also, be sure to enter claim numbers, insurance payer details, group numbers, diagnosis codes, and more.

- **Eligibility**

Eligibility issues usually arise when your team doesn't understand the patient's coverage. Usually, this happens when the provider doesn't confirm the patient's insurance information. Sometimes, the issue can be as simple as a misspelled last or first name, making the payer look up a different patient.

- **Medical necessity requirements**

The policy does not cover a medically unnecessary healthcare service, and the payer disagrees with the physician about what services a patient needs to treat the problem.

- **Coding & modifier errors**

Medical coding professionals convert the details of a patient's appointment into claim codes. Medical coding covers every encounter with the patient and the provider, from admission to treatment and release. Some coders might fail to match the diagnosis code with the procedure performed. If the coder never corrects the mistake, the insurance company likely will reject the claim because the treatment doesn't match the health condition.

- **Uncovered services**

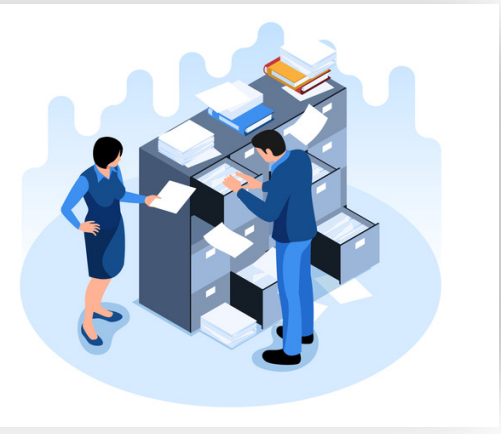
Here, the payer deems the medical service is outside the approved list of covered procedures and services.

- **Prior authorization not received**

Payers deny claims when healthcare providers don't follow prior authorization guidelines. These guidelines can be tricky. According to the AMA, 64% of physicians don't know which procedures or tests require prior authorization.

- **Failing to file the claim or resubmit the claim on time**

You must submit your claim within the time window that the payer provides. If you submit too late, the payer will deny your claim, even if nothing is wrong with it. This rule also applies to any claim edits you make when appealing a denial.



IMPACTS OF DENIALS ON REVENUE CYCLE MANAGEMENT

Health providers face challenges when an insurance company denies a claim. For example, the denial delays their payment and disrupts their cash flow. Also, it increases the provider's administrative costs. However, you can counteract these problems with denial management strategies.

Kennedy explains that the impact of denials becomes severe at certain levels.

"If we experience a denial rate of one percent, it isn't a problem because that means we've successfully processed 99% of claims," he says. "However, when this rate exceeds approximately 5%, it significantly impacts the organization."

Denials can even cause financial instability.

"It hampers our ability to cover day-to-day expenses, maintain our revenue cycle, manage office costs, and more," Kennedy says. "It restricts our financial capacity to sustain operations, pay employee salaries, and deliver care."

He adds: "You can't avoid all denials. But you must keep it to a level that doesn't significantly impact your organization. Otherwise, your revenue will remain 'stuck' or even lost."

FINANCIAL IMPACT OF DENIALS

Claim denials can significantly affect a healthcare organization's financial health. When denial rates exceed 5%, they restrict cash flow and limit resources for employee salaries and patient care. In the long run, denials reduce the organization's revenue.

"I've seen so many healthcare organizations get caught up in a tidal wave of denials," says Curlett. "It overwhelms them, and their problems compound. Eventually, they start bleeding cash because they can't keep up with the claims."

OPERATIONAL IMPACT OF DENIALS

Denials delay cash flow and affect a healthcare organization's day-to-day operations. Managing denials also places an added burden on staff. Instead of dealing with other tasks, they must focus on denials.

"Handling denials is an administrative challenge that can significantly impact operations," says Curlett. "When a payer sends an EOB (explanation of benefits), your team has to decode it and understand the situation. Occasionally, this involves clinicians, diverting their time away from their primary focus, which is patient care. The goal is to streamline your team's work to ensure smooth claim processing and minimize disruptions to operations, especially for clinicians."

STATE OF DENIAL MANAGEMENT IN 2023

In 2023, most healthcare experts see denial management as a top challenge. Denials significantly affect the finances and day-to-day operations of most healthcare organizations. Luckily, new tech is starting to automate denial management.

In 2023, Plutus conducted a survey and published the results in a whitepaper, “Diagnosis Critical: Revenue Cycle Management Challenges Among Healthcare Providers in 2023.” This survey examined healthcare organizations in various states, including Georgia, Illinois, California, New York, Florida, Texas, and others. It specifically looked at organizations with annual revenues ranging from $25 million to $5 billion and RCM teams of 50 or more members.

The survey's key findings underscored that many healthcare organizations struggle with denial management. Fortunately, promising technology is on the horizon with the potential to automate much of this process and, ideally, reduce the average denial rate.

Here are the key findings from the Plutus Health Revenue Cycle Management Challenges Index:

- **Denial management is one of the greatest challenges in RCM.**

Of the providers surveyed, 59% said insurance denials were the greatest challenge facing their RCM. And 42% of healthcare providers stated that their RCM denial management process was regularly backlogged.

- **Providers are losing money.**

The impact is so significant that 22% of healthcare organizations said they lose between $500,000 and $1 million in revenue annually due to denied claims.

- **Providers aren't taking advantage of technology to automate and improve denial management.**

Despite 43% of healthcare providers saying denial management is their biggest RCM priority in the next year, only 15% of respondents plan to use robot process automation (RPA) to improve the RCM process, and only 10% plan to use AI .

Industry Benchmarks for RCM Denial Management

RCM professionals use benchmarks to assess how well organizations are handling claim denials. Three common ones are the denial rate, clean claims rate, and denial resolution time.

Here are fuller explanations of the most common industry RCM denial management benchmarks, with the key standard. We provide benchmarks from the Healthcare Financial Management Association (HFMA), a professional organization dedicated to helping healthcare finance leaders navigate the complex financial landscape of the healthcare industry.

- **Claim denial rate:** Percentage of claims that payers deny. The lower the denial rate, the better.
  HFMA Benchmark: 5% or less

- **Net collection rate:** Net percentage of claims reimbursed after denials, adjustments, and write-offs.
  HFMA Benchmark: At least 95%. Ideally, 97 to 99%

- **Clean claims rate:** Percentage of claims an organization submits without errors or omissions that the payer accepts and processes after the first submission.
  HFMA Benchmark: 98%

- **Days in accounts receivable (A/R):** The Number of days a payer takes to pay a provider for a service.
  HFMA Benchmark: 30-40 days or less

- **Denial resolution time:** Denial resolution time: Number of days to resolve a denial.
  HFMA Benchmark: 85% of denials resolved within 30 days

BEST PRACTICES FOR DENIAL MANAGEMENT IN RCM

Best practices will improve your denial management process. For example, establish a denial management team to prevent denials. Monitor your progress with industry performance metrics.

Managing denials can be complex, with nuances depending on your unique situation. Nonetheless, certain best practices can enhance denial management for any organization.

Industry Benchmarks for RCM Denial Management

- **Develop a zero-tolerance mindset for preventable or avoidable denials.**

"Healthcare organizations that view denials as the exception rather than the rule achieve remarkable reductions in their denial rates," explains Waldorf. "These proactive organizations strive to keep denials below 5%, or even as low as 2%, refusing to accept denials as an inevitable outcome."

Preventable denials are the result of actions or inactions in the RCM process. These errors fall within the organization's control. This mindset will motivate your team to implement the best practices.

- **Shoot for industry benchmarks.**

Keep your teams motivated to match or exceed industry standard KPIs like denial rate, overall claim denial rate, and denial resolution time.

- **Start monitoring and managing denials as soon as possible.**

“The sooner you can tackle a denial, the better,” Curlett, a seasoned healthcare executive, says. “Denials may not come in until a few weeks after the patient's initial visit at the earliest. This means you might have repeated the same mistake with other patients by then. And if you need to involve clinicians, the longer you wait, the harder it is to get their attention and have them remember what happened.”

- **Regularly monitor denial management KPIs.**

“Remember, RCM incorporates many distinct departments that all contribute to whether a claim is approved or denied,” explains Jeremiah. “Each department uses KPIs to make sure they’re doing their job well. If each department meets these RCM KPIs , your overall denial rate should be below 5%.”

- **Learn from your denials to inform prevention.**

“Every denial teaches you something,” Curlett says. “It's a signal that something in your process needs attention. Maybe you can improve patient eligibility checks or enhance the authorization process. It might even point to credentialing issues that require resolution.”

Curlett adds: “The most effective denial management teams extract insights from each denial to inform their prevention strategies. That's the path to reducing your denial rate."

STRATEGIES FOR EFFECTIVE DENIAL MANAGEMENT IN RCM

The first strategy for effective denial management is to embrace a mindset aimed at preventing denials proactively. Then, develop workflows that support this mindset. Use technology to support your staff and automate parts of the process.

Here's a summary of key strategies that RCM experts use to tackle denial management:

- **Develop automated workflows and keep your staff focused on mitigating denials.**

"In the optimal workflow, approximately 95 to 98% of claims smoothly pass through the RCM process without issues," Waldorf says. "The automated systems flag potentially problematic claims. Once these issues are identified, a human — not a machine — can use their expertise to assess the claim's potential for denial and devise appropriate remedies."

- **Leverage RCM technology to automate parts of denial management.**

Providers are under mounting stress with workplace challenges, low margins, and higher denial rates. Technology can create efficiency in the revenue cycle and take some of the workload off your staff. Deploy automation and analytics-driven workflow solutions so providers can prioritize and meet the scale at which they need to operate.

"Organizations that build models take historical data and use it to predict which new claims will be denied," says Waldorf. "This is emerging technology, but the organizations that invest in it also happen to flag risky accounts and keep their denial rates very low."

- **Enable staff training and development.**

Numerous people influence RCM and denials management. A dedicated, trained team helps ensure your organization stays ahead of the curve on tech and policy changes.

- **Create payer-specific teams to expedite the process.**

It can pay to have specialists for different insurers or categories, like Commercial vs. Medicaid, or even Aetna vs. Signa vs. United, Curlett says.

"They become specialists in the nuances of each carrier and health plan or Managed Care Organization (MCO)," Curlett says. "Contracts can vary slightly, the claims submission process might differ, and the portals for submission can vary. Team members need to acquire expertise in the procedures unique to a patient's insurance, adding an extra layer of complexity. It's not just about denial management; it's about tailoring the process to the specific insurance carrier."

HOW TO AUTOMATE DENIAL MANAGEMENT IN RCM

Healthcare organizations can use AI technology to automate their denial management. This technology helps in many ways: It can identify risky claims. It can make appeals easier. And it can prevent denials.

Automating denial management brings several clear benefits. This technology minimizes mistakes caused by repetitive data entry, freeing up your staff to handle more complex tasks. It also enhances your RCM understanding, aiding your team in making informed decisions to reduce denials.

The statistics back up the effectiveness of automating denial management. According to a 2023 survey by Plutus on Health Revenue Cycle Management Challenges, 30% of healthcare organizations reported that artificial intelligence (AI) and robotic process automation (RPA) led to quicker cash flow and improved collections.

However, many organizations hesitate to embrace automated denial management and may feel uncertain about where to start. Here are some practical examples of how you can use the latest technology to automate denial management and meet your revenue goals:

- **Use AI to predict denials before they happen and improve prevention practices.**

Emerging technology is poised to improve efficiency even more, particularly when identifying and flagging denials.

For example, artificial intelligence (AI) software helps optimize healthcare RCM. Specifically, AI-driven “denial predictions” can identify problem claims in process and pull them out of the workflow to get a human’s eyes on them.

Waldorf describes AI as a remarkable opportunity for healthcare organizations.
“AI can gather vast amounts of data and, by analyzing historical denials, identify claims that the AI recognizes as susceptible to rejection,” he says. “The AI will collect and scrutinize the data, construct an algorithm, and subsequently employ this model to flag problematic claims. Organizations adopting this technology are experiencing a significant reduction in denial rates."

- **Implement RPA (robotic process automation) to monitor KPIs and streamline tedious RCM tasks.**

Top-tier RCM software employs RPA bots to centralize and streamline various tasks, all within a unified dashboard.

For example, analytics software helps streamline denial management processes by automating data analysis and offering insights into denial trends and patterns. This comprehensive software promptly identifies flagged claims within vast datasets, resulting in optimal efficiency and staff workflows.

Jeremiah, Associate Director of Transitions at Plutus Health, describes how AI can help an accounts receivable agent conduct a comprehensive pre-call analysis before contacting the payer.

“At Plutus, we created 'Zeus ,' an AI-powered virtual calling bot explicitly designed to automate your healthcare billing tasks. This innovative bot will have the capability to make calls on behalf of providers and engage in conversations with IVR (interactive voice response) systems and payer representatives, much like a typical accounts receivable agent. The AI bot can extract information from these conversations and convert them into text format. This technology is expected to significantly enhance the efficiency of our calling procedures, allowing our staff to allocate more time to tasks that demand greater attention.”

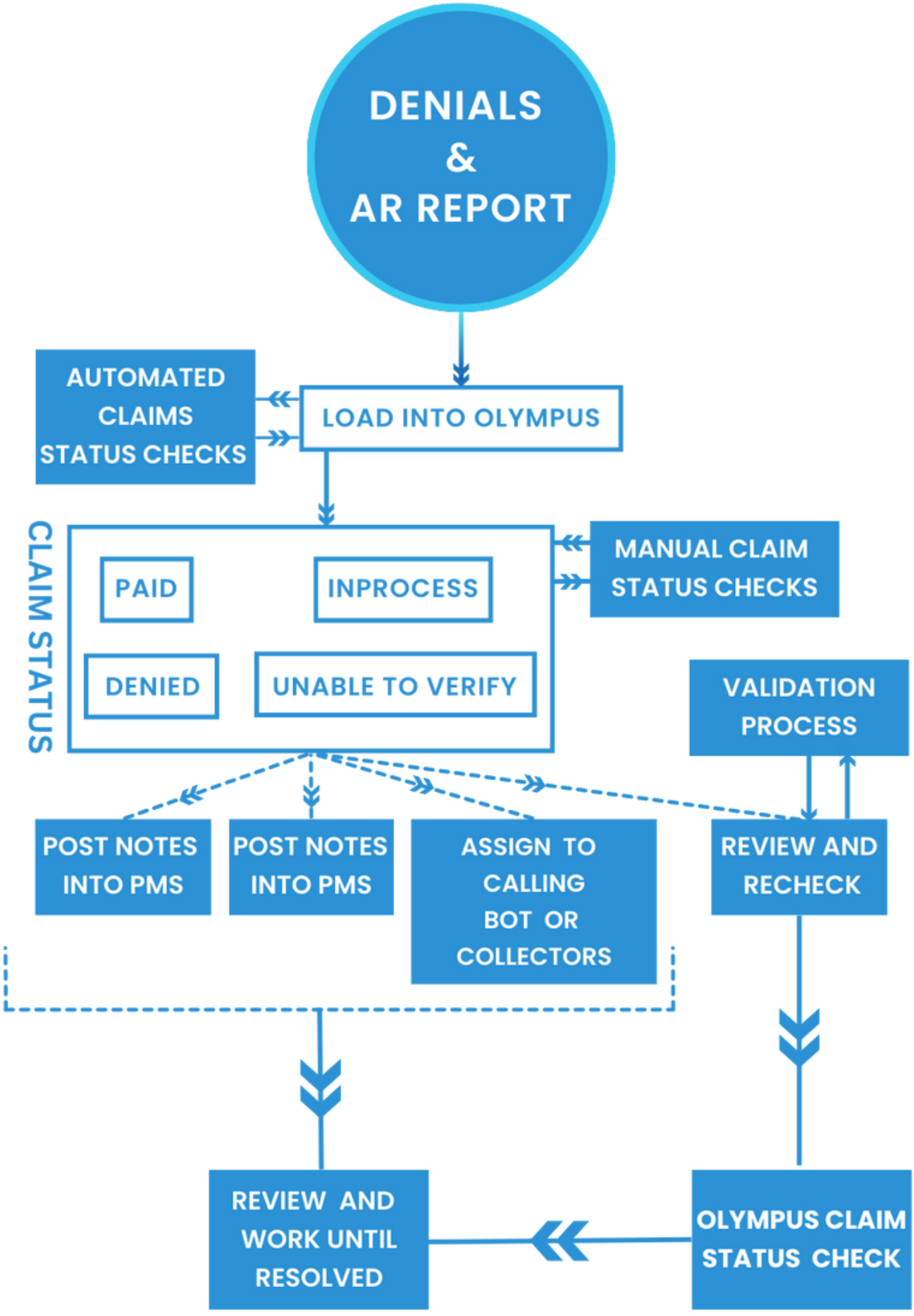
He continues: “Each RCM department also enjoys its customized dashboard equipped with key performance indicators (KPIs) to track, alongside bots designed to streamline the most laborious tasks, such as managing electronic health records requests, conducting revenue analysis, and automated charge posting. This meticulous approach translates into fewer errors at the front-end, significantly reducing denial rates."

Determining Whether to Outsource RCM Denial Management

Many practices can't handle denials efficiently due to limited tech and staff. Outsourcing RCM denial management to experts is a common and appealing option. It helps deal effectively with evolving regulations and payer rules.

Many healthcare providers outsource their RCM tasks, including denial management, to a third-party company specializing in RCM management.

"The cost-effectiveness and efficiency of handling RCM in-house depend on your team's skill set,” Curlett says. "Deciding whether to handle RCM in-house or opt for outsourcing is a complex decision that hinges on the unique circumstances."



Here's Curlett's advice to help you make an informed decision:

- **Assess your organization's core competencies.**

Are you equipped with the expertise and resources to efficiently manage RCM internally? Understanding your strengths and weaknesses is crucial.

- **Do the math.**

Calculate the total cost of managing RCM in-house, including salaries, training, software, and infrastructure. Compare this to the cost of outsourcing, which often saves money due to economies of scale.

- **Consider your ability to scale.**

Will your in-house RCM solution be scalable to accommodate an expanding operation? Outsourcing partners can often adapt to changing needs more easily.
It's important to recognize that low patient volume can also present challenges for an in-house RCM team. If your organization experiences fluctuations in patient numbers, an internal team may struggle to manage billing and collections effectively during less active periods.
That means you may need to reassign them to other tasks temporarily. And you may need to hire additional staff when things get busy again.
"Outsourcing RCM offers flexibility, letting you adjust services as required, minimizing the impact of low-volume periods on your organization's financial well-being," Curlett says.

- **Consider your ability to focus on business. Consider how managing RCM aligns with your core business goals.**

Outsourcing lets you concentrate on your primary activities while experts handle the financial side
"There are advantages to maintaining an in-house RCM team," Curlett explains. "But, having a trusted partner who understands your processes can be invaluable. They can swiftly adapt, reallocate resources, and scale quickly with your volume."

Key Services That an RCM Partner Should Provide

If you decide to outsource your RCM, here's a list of services to seek from a prospective partner:

- **Offers full-cycle RCM**

Full-cycle RCM is the end-to-end process of managing a healthcare provider's revenue cycle. It goes from patient registration through payment collection. This comprehensive approach encompasses all the financial and administrative steps in healthcare billing and reimbursement.

In contrast, some healthcare organizations outsource only a specific component of the revenue cycle, like coding or billing, to another organization. This approach can suit organizations with very specialized needs, but most experts don't recommend using it because it could create a disjointed RCM system and might create inefficiencies and bottlenecks.

- **Expertise and experience**

Find a company with a good track record in managing RCM tasks for similar healthcare providers.

- **Compliance and data security**

Any reputable RCM company will have robust processes to comply with all relevant healthcare regulations like HIPAA to protect patient data and privacy.

- **Billing and coding expertise**

Verify that the RCM company has skilled professionals in medical billing and coding. Accurate coding is essential for optimizing revenue.

- **Credentialing services**

Many healthcare organizations will benefit from an RCM that offers credentialing services to ensure that healthcare providers are properly enrolled with payers.

- **Customization and scalability**

The best RCM companies offer custom strategies to match your organization's needs. Additionally, it's worth asking whether the RCM company can scale with your company as it increases.

- **Customer support and communication**

Assess the level of customer support and communication the RCM company offers. Prompt and clear communication is vital for addressing issues and questions

- **Reporting and analytics**

Ensure that your RCM provider provides performance reports that include KPIs, accounts receivable health status, and financial analytics.

- **Automated denial management**

Modern RCM companies offer automated denial identification so you can catch problems before submitting the claim.

TURN TO PLUTUS FOR EFFECTIVE RCM DENIAL MANAGEMENT

You don't need to handle RCM denial management on your own. Rely on Plutus Health's AI-driven solutions to cut your denial rates and capture revenue you may be leaving on the table.

Plutus Health delivers tailored, comprehensive denial management solutions for every use case and client. Our comprehensive approach will reverse denials and resolve deficiencies in your existing processes to prevent recurring denials.

Plutus Health's newest innovative technology, Zeus, can be deployed to streamline your revenue cycle management. Zeus is a family of 60 bots that use RPA and machine learning (ML) technologies to reduce human error and minimize denials.

Our approach works for companies of all sizes. For example, in collaboration with a substantial ophthalmology practice, Plutus identified errors, enhanced workflows, and improved the billing process while minimizing common, preventable denials.

The outcome is impressive: The practice reduced its denial rate from 29% to 8% in just six months, resulting in monthly savings of $12 million.

Similarly, we helped a smaller company identify and overcome its unique workflow challenges, achieving a remarkable 2% denial rate — a rarity in the industry.

Join these and many more organizations and practices as a Plutus partner. You'll optimize your RCM to ensure a fast, effective workflow so you can focus on high-quality patient care.

Schedule an Expert Call