



Why every CFO should care about the big data on hand **now**

Big Data Payday for RCM

This white paper is a practical assessment of the applicability of big data in hospital, health systems, and physician practice business offices *today* without taking on additional systems or staff to accomplish that. Furthermore, it highlights areas of application presently overlooked by virtually everyone taking an interest in big data as it applies to the landscape of healthcare.

For the savvy CFO, VP, or administrator looking to reduce or eliminate denials at their root thereby markedly improving the cash flow of the organization, this white paper introduces the methodology to do that immediately by quickly and easily using the big data presently on hand and available.

Introduction

The capture, storage, and application of data towards the generation of measurable value in the healthcare environment are paramount, and all healthcare entities that see patients are already capturing and storing this data. The buzzword for this collection of information is “Big Data”, and there seems to be no shortage of articles, blogs, white papers, etc., underscoring the importance thereof to forward-thinking enterprises. Most

point to a necessity for the prioritization of major expenditures, whether for software and systems or personnel, in order to be able to make use of big data in a way that yields the desired value.



The Impact of Big Data

Big data is often pointed to as the future of business. Said to be poised to change life as we know it, we all contribute to the body of data collectively recognized as “Big Data”, and healthcare is no exception to that. With virtually every healthcare entity creating and storing volumes of usable information, big data stands to impact the industry unlike anything else to date, especially in the areas of meaningful use, quality outcomes, and population health. Of equal or greater value is the potential for big data to boost revenue cycle performance and cash flow of

hospitals, health systems, and physician practices. But what exactly is “Big Data”? Information is said to be part of and contribute to big data if it has five specific characteristics—volume, variety, velocity, veracity, and value.

- **Volume** – The sheer quantity of data generated is important in that it must be significant in order to sufficiently expose the larger trends and commonalities and facilitate action categorically. The “Big” term in the name ‘Big Data’ is itself indicative of size as a necessary characteristic.
- **Variety** – Modern healthcare information, the majority of which is either unstructured or not of a common format, is derived from a myriad of sources. Because of this, much of the available data goes unused or, at best, is used in a singular dimension. Yet, the very usefulness of big data is in the disparity of the information of which it’s comprised.
- **Velocity** – Data is generated and assimilated in different ways and at differing speeds. Yet, its value in the big data body is in the timeliness of its availability and usage.
- **Veracity** – In order to be useful, information must be true and reliable. Quality of the information used has a direct impact on the reliability and actionability of the results derived from the data.
- **Value** – Information typically has a dollar value attached thereto, whether because the data itself can be bought and sold or because it can be put to use to yield cost savings, improvement in business processes and results, etc.

In the revenue cycle management process, the focus of this paper, the value of the data and resulting opportunity is actually increased realized income, as opposed to *just* cost savings and waste reduction, which is typically where the majority of value is seen in healthcare information.

The Size of the Problem

“The reimbursement challenges ahead to get paid may require several new RCM applications, and the blunt realities that Black Book warned of from the 2014 surveys are showing signs of occurring... failing RCM systems will close marginally performing hospitals for good and will get CFOs fired,” warns Doug Brown, Managing Partner of Black Book.

Seemingly contrary to that warning, denial rates have declined in recent years, largely due to automation and advancements in revenue cycle technologies. Yet, the best performing organizations are still reported to have denial rates slightly below 5%. More average performers accept denial rates in the 5-10% range, and poorer performing healthcare organizations’ denial rates exceed 10%. According to a report published by the IRS, the average total revenue for hospitals in the U.S. in 2012 was \$179 million, which means that even the best performing organizations average nearly \$9 million in denials annually. The dollar value attached to denials for more marginal performers could be double that figure or greater.

With millions of dollars at stake, especially in the face of shrinking margins and declining reimbursement, recouping as much of that amount as possible is important although, that, too, comes at a cost. The commonly-accepted dollar metric for denial rework is \$15 per denial, which further compounds the denial management challenge and leads many organizations to abandon the pursuit of denials altogether. The greater opportunity here is reducing or eliminating denials permanently at their cause.

The Solution

The opportunity to harvest and examine denial data to reveal key issues that can be translated into actionable items is available now, regardless of the number of disparate systems used. Simply put, the variety, sophistication and accessibility of big

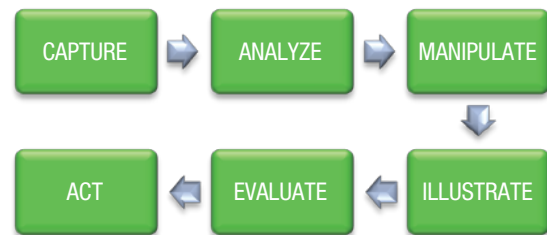
data is transforming denial management, allowing administrators and physicians to view their performance on a granular level and to respond with action that resolves denials permanently at their root. Big data analytics, the process of examining big data to uncover hidden patterns, unforeseen correlations and other actionable information, can make clinical operations more profitable, decision-making more informed and management more results-focused by utilizing claims and remittance data to create predictive and prescriptive models.

To accomplish this, one must first recognize and embrace the opportunities technology provides. With so much emphasis placed on the implementation and incorporation of technology into the clinical space in recent years—be it by government mandate, insurance carrier requirements, or corporate strategic priorities—the necessary infrastructure and data gathering framework is in place and in use daily. One need but choose to make use of the information at hand to solve costly and burdensome denial problems.

A commonly accepted financial methodology is to focus reporting on gross receipts—what income is *expected*—upon which income projections and planning is based. Not given nearly as much attention, however, are the pitfalls and snags along the way that diminish receipt on those charges. This approach of using your data as a vital additional ingredient of the analysis and subsequent reporting does just that, enabling transformative denial management impacting both ends *and* the bottom line.

Historically, business offices have looked at charges/denials as individual events to be managed independent of other similar events. By analyzing the data on hand, however, a broader view can be taken, facilitating the detection of larger trends, commonalities and issues represented by the individual types of denials,

allowing assignment of protocols and fixes that will have predictive, widespread results. This shift positively affects denials, yielding an exponential impact in the form of the categorical reduction or elimination thereof.



The Approach

Every organization has the ability to use its big data as a powerful denial management tool *now*. Below is an outline of a simplified plan of action. The specific approach will vary a bit based upon each unique situation, but the goal is the same—to tap into your big data to reveal actionable results that will best support your organization.

- **Capture** – From manual billing to the most sophisticated combination of systems, remittance data is readily available. The task is to gather this information to a common location and format such that it can be aggregated in order to be studied and analyzed.
- **Analyze** – Once gathered to a standard place and format, the information can be sorted, categorized, and prioritized according to issue type, point of origin, financial impact, etc.
- **Manipulate** – With the data sorted and categorized, trends can begin to emerge, allowing for the highlighting of the top issues. Some examples could be credentialing, non-payable coding combinations or eligibility issues. Whatever the issues, they likely account for a disproportionate percentage of the organization’s unrealized income.

- **Illustrate** – Upon identifying the top issues, the information should then be organized so as to tell the story in a meaningful way, specific to the organization (by physician, department, location, service, codes, carrier, etc.; by graphing, charting, listing, etc.). A dashboard view of this more easily facilitates understanding and resulting conversation toward resolution.
- **Evaluate** – With an understanding of the problem, the next logical step is the development of a remediation plan. Operational flows can be examined, processes can be changed or improved, additional training can be obtained, etc.
- **Act** – With a plan formulated, the final step is to put that plan into action to achieve the desired results around enhanced denial management, tools, and protocols.

The Challenge

The approach delineated above seems easy enough, so why isn't everyone doing this already? After all, with millions of dollars at stake, the payoff definitely warrants it.

The answer goes back to the "Five V's" discussed previously. While volume, variety, and velocity of the information available are necessary characteristics of the data if it's to yield value, each of these aspects brings with it its own element of complexity that must be dealt with in order to achieve the desired outcome. The **volume** of data, while absolutely important here, can certainly be overwhelming, especially if derived from multiple systems and information sources.

Similarly, the **variety** of the information is a characteristic that enhances its usefulness, but the lack of a common data format often makes it very difficult to aggregate in order to achieve the benefit that a multi-faceted view offers. With many

hospitals having multiple RCM and EHR systems, this challenge is routinely seen. In fact, according to Black Book's 2014 State of the Revenue Cycle Management industry annual report, almost 98% of business managers indicate that their financial software and workflows are unprepared to meet the requirements to participate in an ACO, and 81% of practice managers of physician practices (independent, networked, large group or part of a hospital system) are bracing for diminishing-to-negative profitability next year due to inefficient or underperforming billing systems and declining reimbursements. These further illustrate the challenge with variety of information sources.

The reliability, or **veracity**, of the information can compound the task at hand by requiring quality analysis of the data used in order to qualify the results. However, this characteristic of the data can actually deliver an ancillary output in the form of identifying pitfalls in the front-end information inputs if the complexity of the analysis is sufficient to ferret out such along the way.

Finally, understanding the **value** attached to the specific information used can be a powerful contributor in the prioritization of actions in the remediation plan is the value of the input data is understood along the way. To successfully navigate these complexities in order to achieve the desired outcome, the task should be approached thoughtfully with appropriate planning and readiness to engage the appropriate resources at points along the way, including analysts, accountants, RCM experts, coders, and billers.

The Business Side Approach

As healthcare professionals, patients are, of course, the primary focus, and big data holds promise to enhance treatment for them. But, it can do so much more than that *now*. Big data can support your most productive and prosperous clinical operations, and it will dramatically improve your bottom line.

Imagine affecting change efficiently to hundreds or thousands of like issues with one learned fix or pulling 200 records for auditing risk management instead of 20,000 and getting more effective results. The Business Side, Inc., is doing that today for hospital and physician practice clients.

We're removing the challenges detailed above and delivering a dashboard view that allows our customers to quickly pinpoint the

source of problems in a particular department or group of providers or with a particular insurance carrier. Our methodology allows organizations to easily monitor very specific financial metrics and uncover areas in need of attention. We have the expertise and experience to support your organization as you step into the world of big data. You have the information, and we have the keys to unlock its power for your benefit. ■

To learn how **The Business Side** can deliver a payday for your organization, call **1-888-696-2455 x1035** or email us at **info@TheBusinessSide.com**.

THE BUSINESS SIDE
Revenue Cycle Specialists

About The Business Side, Inc.

The Business Side, Inc., a premier revenue cycle management firm, is a leader in full CBO outsourcing for hospitals, healthcare systems, specialty clinics, and related areas of patient care. As well, they specialize in high-value, high-touch project work that others simply can't deliver, such as Credit Balance clean-up, A/R catch-up, and Pre-visit Eligibility Verification, among other services. Additionally, TBS is expert in RAC Audit analysis and appeal preparation.

Established in 1996, The Business Side is dedicated to working with organizations to examine their Revenue Cycle Management processes and deliver solutions leading to better, faster payment. TBS is committed to the delivery of highly-customized, value-focused services that result in efficiency gains, increased corporate and governmental compliance, and overall improved financial performance of their healthcare clients.