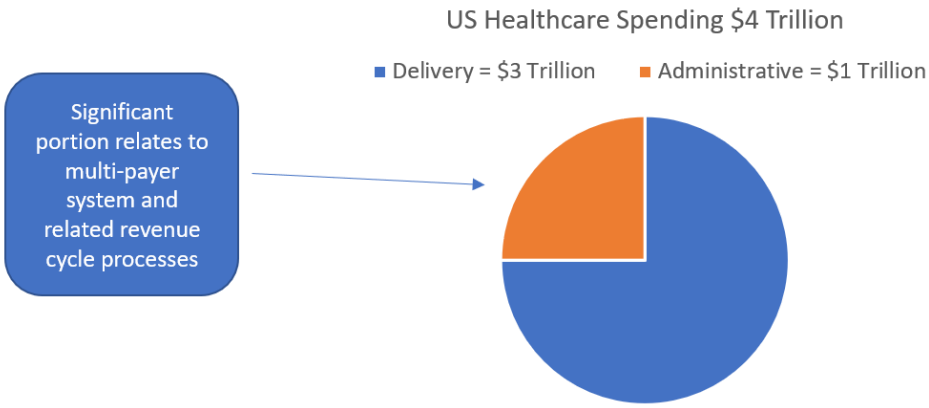
Wonder Why Healthcare Costs are so High in the United States?

- Healthcare costs in the US are the most expensive in the world – double all other developed countries
- One reason is that, of the $4 trillion we spend each year, $1 trillion is administrative costs
- A big reason why administrative costs are so high is because of the extraordinary efforts that Healthcare Providers must undertake to bill and collect for their services



Purchase transactions are generally similar across industries. Business-to-Consumer industries are usually cash or credit card. For example, we purchase many items with just the swipe of a credit card and paying our statement of charges at the end of the month. Business-to-Business industries mostly sell on credit. The seller has a price list, the buyer and seller agree on how many days to pay, the seller provides good/service to the buyer, the buyer receives an invoice from the seller, and the buyer pays the seller by due date. Pretty straight forward.

It is much more complicated in the healthcare industry. Generally, a Healthcare Provider gets paid a different amount for every patient and every procedure. They must undertake all of the following steps for traditional fee-for-service transactions:

- Patient (Buyer) gets service (treatment) from Healthcare Provider (Seller)
- Insurance Company (a third party) is invoiced by the Healthcare Provider for payment
- Healthcare Provider gets paid different amounts depending on the Insurance Company

- The Insurance Company often denies the invoice claiming that there are mistakes
- The Healthcare Provider does excessive follow up work to address these invoice denials
- Once approved, the Insurance Company informs the Healthcare Provider how much it allows to be paid
- But the Insurance Company often doesn't pay the full amount
- For example, Medicare pays 80% of the allowed amount
- Then, the Healthcare Provider needs to determine where to bill the balance
- Determinations must be made about whether the patient has additional insurance or needs to pay it directly (or some combination of that)
- The Healthcare Provider often has to collect from multiple payers for one transaction

Let's walk through a typical end-to-end patient treatment process for a Healthcare Provider transaction one step at a time:

1. Scheduling and Pre-Registration
2. Patient Check-in
3. Patient Encounter with Healthcare Provider
4. Preparation of Claim
5. Submit Claim to Clearinghouse
6. Insurance Payer Adjudication of Claim
7. Denial Process
8. Appeal Process
9. Collections from Payers
10. Payment Posting

(1) Scheduling and Registration

- Patient schedules appointment
- Healthcare Provider collects insurance information
- Healthcare Provider must have a contract with Insurance Company to accept patient and get paid
- If patient has multiple insurers (like having both Medicare and Medicaid), a Coordination of Benefits form must be prepared
- Healthcare Provider needs to check eligibility of patient to ensure in good standing with insurer
- What could go wrong?
    - Patient is accepted for appointment but has issues with insurance resulting in no payment to Healthcare Provider
    - Coordination of Benefits form is inaccurate leading to challenges with collecting from various payers

(2) Patient Check In

- Determine co-pay and any deductible to collect from Patient
- Obtain demographic information from Patient
- Get authorization from Patient to bill the Insurance Company
- Make sure to assign Patient to a credentialed Provider

- Every Healthcare Provider must be officially approved by every patient's Insurance company, or the payment will be denied by the Insurance company

- What could go wrong?
  - Inaccurate/incomplete information is obtained by Patient that leads to a payment denial by Payer (patient ineligibility)
  - Clinician is not officially approved (credentialed) by Insurer leading to a payment denial by Payer (provider not credentialed)

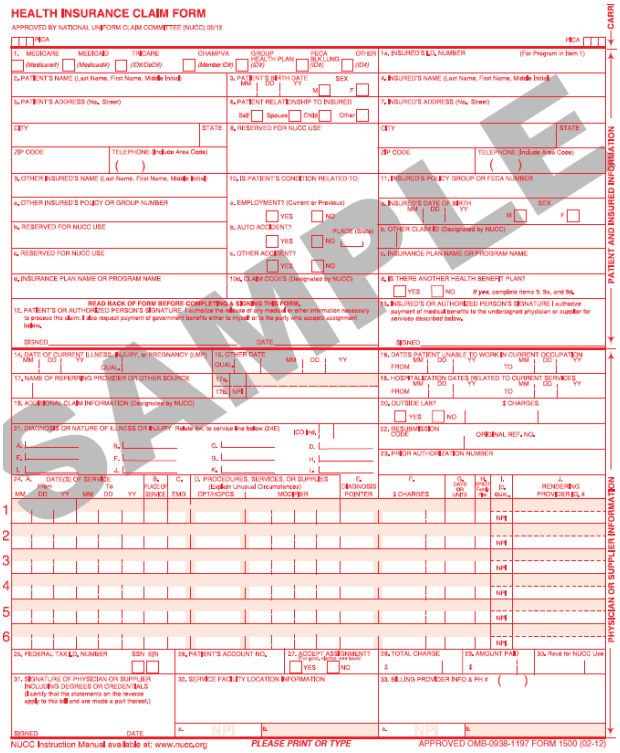
(3) Patient Encounter with Healthcare Provider

- Healthcare Provider must fully document information provided by the Patient and all steps taken during the encounter including amount and types of clinicians involved
- Diagnoses are assigned to one of 70,000+ ICD-10 codes
- Treatments are assigned to one of 7,000+ CPT codes
- Levels of complexity to treatments are assigned for purposes of payment rates related to Medical Decision Making
- Other modifiers are assigned to treatments that may be necessary for proper coding to get the correct payment
- What could go wrong?
  - Payer requests documentation and claims it is not sufficient support for payment
  - Wrong ICD-10 and CPT codes could lead to wrong payment and payment denials
  - Other assignments of information can cause denials and collection problems

(4) Preparation of Claim

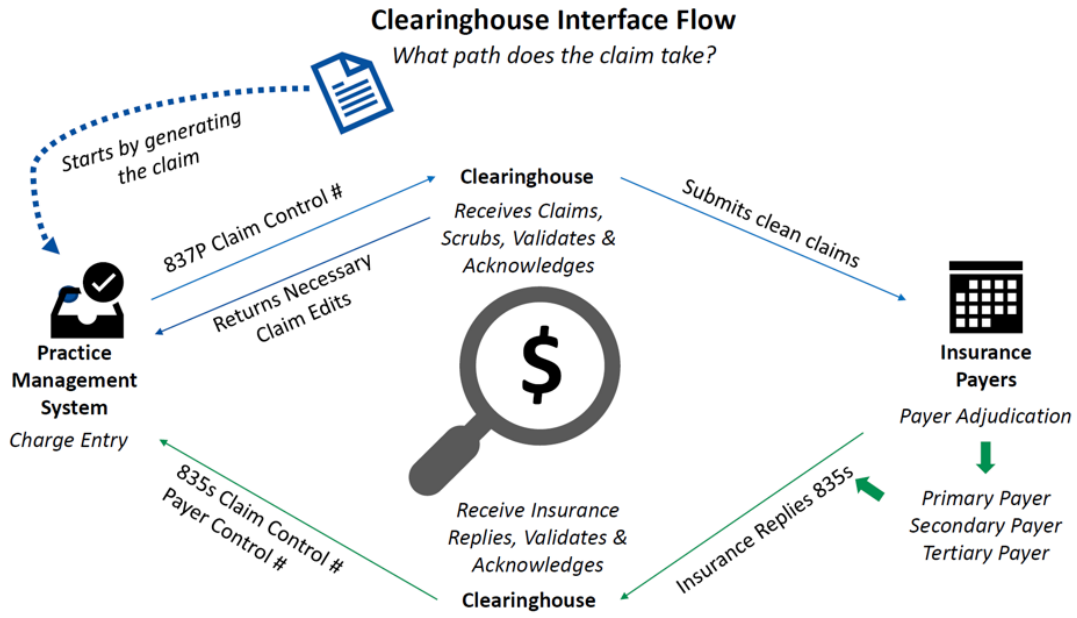
- A claim form needs to be prepared for every single encounter
- Payers can have different requirements making it difficult for the Healthcare Provider to know exactly how to prepare the claim, depending on the Payer
- Claim forms have dozens of entries that need to be completed
- General claim information includes details on the insurance, details on the patient, coding for the diagnosis, and coding for the treatment, the facility information where the patient was treated, the types of clinicians involved, etc.
- What could go wrong?

- There are many opportunities for mistakes given all the information that must be provided
- If information doesn't match properly (like a treatment doesn't go with a diagnosis), this will result in a payment denial



(5) Submit Claim to Clearinghouse

- Different Payers have different processes and systems for receiving claims from Healthcare Providers
- Healthcare Providers often use a Clearinghouse for sending their claims to various Payers
- So, a claim goes from the Healthcare Provider to the Clearinghouse, who might kick it back if errors are identified, then sends a clean claim to the Payer, who sends the reply back to the Clearinghouse, who then sends the reply to the Healthcare Provider
- What could go wrong?
    - Multiple-step and multiple-party process has many points where something could go wrong



Source: 2022 Medical Billing Training: CPB. AAPC

(6) Insurance Payer Adjudication of Claim

- Adjudication is the process of determining the validity of a claim and the amount the insurer will pay on the claim after the patient's insurance benefits have been applied
- When the adjudication process has been finalized, the payer sends the remittance advice (RA) to the provider and an explanation of benefits (EOB) to the patient
- The Explanation of Benefits (EOB) is a statement sent by an insurance carrier to the covered individuals explaining what medical treatments and/or services were paid for on their behalf
- A Remittance Advice is a statement sent by an insurance carrier to the medical provider which explains the adjudication decisions on those claims submitted by the provider
- The Healthcare Provider must react to the Remittance Advice in different ways depending on what is included on it:
    - Whether or not the claim will be paid or denied
    - If to be paid, the amount that will be paid
    - If denied, the reason or reasons for the denial
    - Request for more documentation, which requires additional work by the Healthcare Provider to get the claim approved

(7) Denial Process

- The denial process can be overwhelming for Healthcare Providers because of how many different reasons that Payers use to deny claims
- Some of the more common types of denials include, but not limited to:
    - Provider Credentialing – clinician that handled treatment was not officially set up and approved by the Payer for which the patient is insured
    - Patient Eligibility – insurance company denies responsibility for the patient
    - Coordination of Benefits – insurance company claims that another insurer and/or the patient are also responsible for some of the payment
    - Missing/Bad Information – claim is not complete or accurate
    - No Prior Authorization – many services performed require an additional step first that requires getting formal approval by Payer first (e.g., operation will not be paid if not properly approved in advance)
    - Missing Referrals – the referring physician information must be captured for each patient visit
    - Not Medically Necessary – Payer can unilaterally decide that the treatment performed was not medically necessary
    - Noncovered Service – a procedure was performed that the Payer claims is not covered by insurance
    - Coding Mistake – diagnoses and/or treatments are assigned to incorrect ICD-10 and CPT code

(8) Appeal Process

- Every Payer has a different appeals process that must be followed by the Healthcare Provider
- The appeals process has many steps and takes lots of time
- For example, the appeals process for Medicare can go through 5 levels:
    - 1st Level of Appeal: Redetermination by a Medicare Administrative Contractor (MAC)
    - 2nd Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)
    - 3rd Level of Appeal: Decision by the Office of Medicare Hearings and Appeals (OMHA)
    - 4th Level of Appeal: Review by the Medicare Appeals Council
    - 5th Level of Appeal: Judicial Review in Federal District Court

- State insurance commissioners are responsible for oversight of the appeals process for insurance companies
- Once a practice has exhausted the insurance company's internal appeals process, Healthcare Providers must move on to requesting support from the state insurance administration

(9) Collections from Payers

- At this stage, Healthcare Providers should have the information on how much they should collect, but there continues to be challenges
    - Payment is often coming from multiple Payers (like 2-3 insurance companies plus the patient's share)
    - It is not uncommon that the claims are underpaid
    - Collections can take time and often don't happen (especially in cases where the patient owes directly), which requires additional collection efforts

(10) Payment Posting

- Unlike companies in other industries that simply close out the Accounts Receivable for a transaction when paid, there are several accounting steps that Healthcare Providers may have to go through to post payments upon collection
- Payment Posting steps include:
    - Booking a Contractual Adjustment for the difference between what the Payer will allow and the Healthcare Provider's standard rate
    - Applying payment in pieces because portions of the money comes from multiple Payers and from the Patient
    - Deciding what to reserve for denials that may not be resolved
    - Writing off denied claims once it is determined that the claim will not be collected or only partially paid

What happens as a result of the extreme billing and collections process that Healthcare Providers have to manage?

- Initial denials of Healthcare Providers' claims happen 30% of time *
- Ultimate denials of Healthcare Providers' claims range between 8-17% of time depending on the region of the US (or an average 12.5%) **

    - On average, companies across other industries write off 1.5% of their receivables as bad debt ***
    - A 12.5% write off for a Healthcare Provider doing $100 million in revenue is $12.5 million that comes right off the bottom line
- Healthcare Providers are burned out with excessive administrative tasks that take away from Patient care
    - Doctors reported spending on average 15.6 hours per week on administrative tasks ****
- Patients are frustrated about confusing healthcare bills
- Our healthcare system is the most expensive in the world, with the administrative process being a large contributor to these costs (admin costs are estimated at $1 trillion annually in the US)

* https://www.drcatalyst.com/medical-claim-denials-appeals-statistics-that-you-want-know

** https://www.changehealthcare.com/insights/denials-index?_bt=635314569080&_bk=denial%20management%20in%20healthcare&_bm=b&_bn=g&utm_source=google&utm_medium=cpc&utm_campaign=2105__PR_REV_denials-index_PPC_MKTG&utm_content=ps_g--b&utm_term=denial%20management%20in%20healthcare-provider-software-analytics_search-denials-index&s_kwcid=AL!13512!3!635314569080!b!!g!!denial%20management%20in%20healthcare&gclid=EAIaIQobChMI2bTp1amf_AIVTxPUAR2mQgujEAAYASAAEgKB2PD_BwE

*** https://tsico.com/statistics-will-shake-accounts-receivable/

**** https://mobius.md/2021/10/09/how-much-time-do-physicians-spend-with-patients/