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How medical billing companies can compete better in a growing market

With the market for revenue cycle management (RCM) expected to grow at a rate of 12.1%, reaching $238 billion by 2030,[1] the opportunity for capturing the market is significant for best-in-class RCM service providers.

Medical billing organizations aren't strangers to a challenge. They face numerous operational and functional hurdles such as inadequate service offerings, lack of technology, inadequate number of support staff, transparency, collaboration and keeping up with the ever-changing regulatory landscape.

Inadequate service offerings

The offerings leave a lot of manual work for providers rather than being comprehensive.

Lack of technology

Billing organizations can be slow to adopt and/or integrate new technologies into manual processes, which can stall their business growth.

Inadequate number of support staff

There aren't enough staff members to support customer inquiries or requests for assistance when organizations need it.

Transparency

Reporting doesn't necessarily meet client expectations and doesn't properly show the work completed.

Collaboration

Lack of communication back and forth about what's needed for clean claim submission and what's required of each side.

Before billing companies can consider major growth, they must first address these challenges and set themselves apart in an already crowded market. By expanding service offerings and increasing efficiencies, medical billing companies can position themselves for success in the evolving healthcare landscape.

[1] https://finance.yahoo.com/news/global-revenue-cycle-management-market-121500565.html#:~:text=The%20Revenue%20Cycle%20Management%20Market,period%20from%202023%20to%202030.&text=The%20global%20Revenue%20Cycle%20Management,driven%20by%20several%20key%20factors.

Must-have functions for a successful billing company

Billing companies can begin to assess their market position by ensuring they're operating well and can perform all basic must-have functions. Although some areas of these functions seem small or intricate, they're critical to making sure practices can be properly and fully paid for their services.

Basic functions include:

Patient access

Eligibility

Provide access to a single source eligibility solution to use at the front desk

Verify insurance information proactively before claim submission via clearinghouse or website

Care to claim

Charge capture

Translate codes provided by the practice into the charge entry

Accurately document and bill all required services

Claim submission and rejection management

Submit claims in a timely fashion once charge capture entry is complete

Resubmit clearinghouse-level rejections for payment

Claim to payment

Payment posting

Import electronic remits into practice management systems for auto-posting

Validate for accuracy and deploy patient statement billing

Denial management

Identify and address denied claims

Submit appeals and perform payer follow up

Level-up the customer experience

In order for billing companies to become differentiators and stand above the rising competition, they must develop lean internal processes and evaluate external investment opportunities. Working directly on the medical billing company challenges above can begin to improve your customer experience almost immediately.

Patient access

A crucial measurement for pre-claim effectiveness on the front end is a practice's **clean claim rate**. A high clean claim rate measures how accurately claims are submitted (without missing or incorrect details) on the first attempt. It signifies effective billing and coding, leading to quicker reimbursements and better overall cash flow. Conversely, a low clean claim rate can cause payment delays, increased administrative costs and potential lost revenue.

Here are some ways billing services can turn clean claim rates into better outcomes for their customers.

Proactive patient communications

When errors arise from inaccurate data, billing services must be proactive and establish effective communication methods with patients to obtain accurate patient information on behalf of the practice. Methods such as text, email and interactive voice response (IVR) phone calls are effective in ensuring items like demographics, insurance and medical history are up to date.

Prior authorizations

Prior authorizations are often required for treatments or procedures outside of the health plan's usual coverage. Providers must supply documentation for why the specific treatment or procedure is medically necessary. If an insurer won't issue a prior authorization for that treatment or procedure, the provider won't be compensated by the insurer.

Obtaining prior authorizations before all services is critical on the front-end of the RCM cycle. That may sound easy enough, but the MGMA 2023 Regulatory Burden report found that over 98% of executives find prior authorizations burdensome, with 92% having hired or redistributed staff to focus strictly on prior authorization requests.[2] Billing companies that provide this service can take significant weight off the practice's load.

Care to claim

A practice's **net collections rate** is another barometer for the efficiency of a practice's billing operations. The net collection rate shows the proportion of billed charges that have been successfully collected. There are several factors that impact the gross collections rate, but a lot can be managed in the middle of the revenue cycle.

Chargemaster review

Within a provider's practice management system, the chargemaster acts as a menu of sorts, automatically allocating specific charges for each diagnostic and procedure code. Those charges can fluctuate based on payer contracts, which is why it's critical to have a knowledgeable billing professional to minimize potential under-charging.

Next-level billing companies can allocate resources to perform a line-by-line review of a practice's chargemaster and provide direction or modifications to ensure compliance and increase cashflow for the practice.

Coding

Performing accurate and highly specific coding is crucial to obtaining a high clean claim rate. Billing services must employ coders who are certified and knowledgeable about International Classification of Diseases (ICD) and the Current Procedural Terminology (CPT) codes. However, finding certified professional coders is becoming increasingly difficult; the AMA found in 2023 that there's a 30% shortage in medical coders.[3]

Having a professional coder ensures details relating to procedures, specialties and payer billing guidelines are met and providers get paid correctly for their services. Coding errors can be costly and cause denials, which ultimately impacts revenue. So, while many are looking outside their practices for coding assistance, this service is becoming more of a luxury.

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[2] https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf

[3] https://www.ama-assn.org/about/leadership/addressing-another-health-care-shortage-medical-coders

Claim to payment

One measurement of effective post-claim management is a practice's **denial rates**, which represent the proportion of claims that insurance payers deny. It's calculated by dividing the total number of denied claims by the total number of claims submitted within a specific timeframe, typically a month or a quarter. This metric provides insight into the efficiency of the claims submission process and the effectiveness of interactions with payers.

It's also important for billing services to monitor and track the **accounts receivable (AR) aging over 90 days percentage,** or the proportion of outstanding AR that has remained unpaid for more than 90 days. The ideal number of **days in AR**, how long it takes for a provider to receive payment, is 30 days or less from initial billing to payment; but it can be a much longer process if there's missing information or claims are denied by payers. A high percentage of AR aging over 90 days suggests the provider is experiencing delays in payment collection, potentially leading to cash flow problems and adversely affecting the organization's financial health.

In addition to the basic back-end functions, billing services can alleviate administrative burden and improve revenue outcomes for a practice in several ways.

Denials management

Next-level billing companies have best practices in place to keep denial rates down, including conducting root cause denial analysis, staying informed of payer-related billing changes and leveraging pre-claim editing solutions to prevent denials in the first place.

There are many key performance indicators (KPIs) for denials, and it's critical to have someone on the team who can ensure data accuracy and regularly measure the correct data points to share with the team.[4]

Appeals

Appeals occur when a provider submits a claim to a payer and it's denied. The provider then submits additional information, which may have been missing or coded incorrectly, back to the payer as an appeal. This time-consuming process is fairly avoidable for most claims if more accurate information is provided in the initial submission.

Accounts receivable (AR) management

By scrutinizing and tracking days in AR, billing services can implement procedures and routines to reduce this metric, such as AR prioritization workflows which divides existing aging based on sets of priority rules to determine which claims need to be addressed first.

Mandatory training and recertification among billing staff are also crucial to eliminating knowledge gaps and preventing future billing issues. Ultimately, a reduction in days in AR can boost the financial performance of healthcare providers, ensuring their ability to deliver top-tier patient care.

[4] https://www.cognizantrcm.com/wp-content/uploads/2024-04-CRCM-AR-Recovery-KPIs-Infographic.pdf

Advanced and emerging technologies

Best-in-class billing companies must implement automation to mitigate the chance for human error. This allows for stronger safeguards during critical moments in the revenue cycle.

A key front-end example is clinical documentation and coding. Emerging technologies can assist staff with efficient charge capture and entry to make sure accurate documentation of services is rendered within the claim.

Eligibility bots

Robotic process automation (RPA), also known as "bots," fits well within the eligibility and benefit verification process. Advanced claim scrubbers can be set up to run electronic eligibility checks on every outbound claim. If there are obstacles with the patient's insurance, these claims can be rejected and placed in a queue for proactive outreach.

When electronic connections are not available via the clearinghouse, user interface (UI) bots that mimic user navigation can access payer websites and perform the verification as if front desk staff were doing the work.

AI-infused denial prediction

Billing services can continue to improve their clean claim rates by leveraging artificial intelligence. For instance, pre-trained machine learning-enabled claim outcome models can complete pre-claim edits to gauge a claim's potential for denial. Billing services can intervene with corrections to minimize errors and optimize results.

Claim validation and status bots

These bots validate and update charge details, including patient and procedure information, as well as insurance details. They can analyze hundreds of fields and apply complex rules.

Post-claim or back-end RCM automation and technology can streamline touchpoints for the status of a claim and the workflows required to get errant claims fixed and appealed. Bots that can mimic user navigation can gather the required claim status details from a clearinghouse and note-posting bots can update the claim notes with the respective status.

Payment posting bots and optical character recognition (OCR)

Auto-posting electronic remits have made the process to get payment information posted within practice management systems much easier; however, 12% of payers still have partial or fully manual paper remitting processes.[5] These processes require manual posting and can result in data entry errors and inaccurate patient statements. Bots can log into practice management systems to validate and post remits to balance charges.

Additionally, OCR technology can convert paper explanation of benefits (EOB) remitted claims into machine-readable files to maximize auto-posting opportunities.

Denial and payment auditing platforms

Practices can use denial and payment auditing platforms to monitor transactions, uncover payer trends, automate the discovery of denials and underpayments and streamline the appeal process with pre-populated appeal forms.

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[5] https://www.caqh.org/sites/default/files/2024-01/2023_CAQH_Index_Report.pdf

Taking the next step

There's a lot to consider when implementing new processes and emerging tech. Change management in an already high turnover workforce can be met with pushback, especially if the change means more diligence and scrutiny.

While various factors impact the cost, the Association for Talent Development found organizations spend an average of $1,252 per employee for training and upskilling to be more effective.[6] Additionally, development costs to implement basic software applications can range between $30,000-$100,000 depending on the project, while large-scale AI solutions can hit million dollar price points.[7]

Billing companies, like most organizations, find themselves weighing the balance of absorbing the costs of reskilling their workforce, implementing their own technology or finding a partner with trusted solutions that allow for scale and near immediate accessibility. There's more than one way to be best-in-class, but they all require an organization to make strategic, client-first moves such as mastering the basic must-haves and adding on services where they see the market need.

How Cognizant can help

Cognizant's TriZetto Provider Solutions offers supplementary RCM solutions for billing services to implement within their business to offer top-tier services to their physician practice customers. To learn how to separate yourself from the competition, learn more here.

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6 https://www.td.org/content/press-release/atd-releases-2016-state-of-the-industry-report

7 https://atlasiko.com/blog/it-community/software-development-costs/

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World Headquarters
300 Frank W. Burr Blvd.
Suite 36, 6th Floor
Teaneck, NJ 07666 USA
Phone: +1 201 801 0233
Fax: +1 201 801 0243
Toll Free: +1 888 937 3277

European Headquarters
280 Bishopsgate
London
EC2M 4RB
England
Tel: +44 (01) 020 7297 7600

India Operations Headquarters
5/535, Okkiam Thoraipakkam,
Old Mahabalipuram Road,
Chennai 600 096, India
Tel: 1-800-208-6999
Fax: +91 (01) 44 4209 6060

APAC Headquarters
1 Fusionopolis Link,
Level 5 NEXUS@One-North,
North Tower, Singapore 138542
Phone: + 65 6812 4000

WF 3012601