Insurance Discovery

WHITE PAPER

Sealing Silent Leaks in Your Revenue Cycle

Identifying Overlooked Insurance Coverage to Boost Your Bottom Line

Uncompensated care is a growing financial burden for healthcare organizations, costing tens of billions annually. There is no singular cause of this problem. Instead, many individual parts of the entire revenue cycle are susceptible to revenue "leaks" that can (and often do) accumulate into significant losses.

> **"Uncompensated care is costing tens of billions annually.**

One efficient solution with multiple uses for reducing uncompensated care? **Insurance discovery**.

With insurance discovery technology, hospitals and health systems have a strategic solution that can identify hidden or forgotten insurance coverage, preventing revenue leaks and ensuring healthcare providers receive proper reimbursement for services rendered. Insurance discovery may be applied at multiple points within the revenue cycle.

When a problem has ballooned into "billions of dollars" big like uncompensated care has, attempting to tackle it can feel overwhelming. Instead of attempting to eradicate uncompensated care completely, it helps to break the problem down into smaller parts. Understanding where insurance discovery can enhance RCM transforms the challenge from daunting to something you can actively tackle and make progress on.

Uncompensated Care & Silent Revenue Leaks

A "silent revenue leak" is a missed opportunity to collect on a patient's account due to gaps in revenue cycle processes. Even the healthiest revenue cycles experience silent revenue leaks, as gaps in revenue collection are an inherent part of the process.

These leaks are particularly problematic because they often go unnoticed until revenue losses have already accumulated. Insurance companies will never remind you to follow up on a claim or advise you to adjust your process to ensure the hospital receives maximum compensation. Even minor lapses in denials management or patient data accuracy can contribute to rising uncompensated care. Insurance discovery is an excellent tool with multiple applications for managing these silent leaks.

Get Started Today

OfficeAlly.com/Leaks

Office Ally

Common Causes of Revenue Leakage

Individually, these causes may not seem like a big problem. But together, these often-overlooked areas of revenue leaks can have significant financial consequences.

- **Incomplete or Inaccurate Patient Data:** Patients may provide outdated insurance details, or front-desk staff may input incorrect information.
- **Undetected Coverage Lapses or Changes:** Insurance plans change frequently, and providers may not be aware of active coverage updates.
- **Denials Due to Outdated Eligibility Information:** Claims are often rejected due to verification issues. These issues include, but are not limited to, incorrect patient demographics, missing demographics and/or changes to policy numbers.
- **Lack of Coordination Between Departments:** Billing and patient intake teams may not be properly aligned, causing critical insurance data to be overlooked.
- **Retroactive Medicaid Eligibility Not Captured:** Many Medicaid patients are approved for coverage months after receiving care, yet providers may not retroactively bill for services rendered.

The Financial Impact of Uncompensated Care

YEAR	UNCOMPENSATED CARE
2017	$38.4 Billion
2018	$41.3 Billion
2019	$41.61 Billion
2020	$42.67 Billion

The financial strain of uncompensated care is substantial. In 2020 alone, U.S. hospitals provided $42 billion in uncompensated care, a number that continues to rise. The financial impact on hospitals' already thin profit margins includes:

- Increased A/R days, delaying revenue collection
- Growth in bad debt accumulation
- Higher administrative costs associated with manual eligibility verification
- Reduced profitability and operational inefficiencies
- Greater financial pressure on healthcare systems, particularly those serving underinsured or uninsured populations

Many providers find they are always trying to do more with less. In today's healthcare revenue environment, finding and recovering uncompensated care can mean the difference between turning a profit or operating at a loss. To see how one organization tackled this challenge, read the real-world example on page 5.

The Power of Insurance Discovery to Help with Revenue Recovery

Insurance discovery leverages advanced technology to uncover billable insurance coverage that might go undetected. By integrating with existing revenue cycle management systems, insurance discovery solutions provide real-time insights into patients' eligibility status, significantly reducing revenue leakage.

Real-World Use Cases: Identifying Forgotten Insurance to Protect Revenue

The following real-world use cases highlight common instances that contribute to the larger problem of uncompensated care. By mitigating each occurrence with insurance discovery, providers can plug one leak at a time, leading to long-term cost savings. Once insurance discovery is a regular part of a provider's RCM repertoire, it can be proactively used to keep the financial ship in great shape.

Verification of Benefits

At the beginning of the revenue cycle, hospitals must verify whether a patient has active insurance on the date of service to ensure accurate claim submission. It is a waste of time and money to circle back on a claim that should have been clean and accurate from the start.

By verifying patient information before the appointment, hospitals can ensure they have the correct demographic and insurance information from the patient, and a payer will cover the visit. This enhances the ability to collect payments efficiently and reduces claim denials due to incorrect insurance information. Implementing an automated, cascading process, from benefit verification to insurance discovery for accounts with unverified eligibility, further optimizes the workflow.

Monthly Insurance Monitoring

Insurance coverage can change month-to-month. Patients may switch jobs, age into Medicare, or lose Medicaid coverage due to eligibility issues. Moving from one insurance plan to another can lead to coverage gaps that cause unpaid claims.

Providers should constantly monitor patient rosters to ensure their insurance information is accurate and current. Running an automated monthly check using insurance discovery ensures billing teams have the most current information and reduces the risk of unpaid claims.

Medicaid Monitoring
People frequently gain and lose Medicaid coverage depending on their life circumstances, employment status or shake ups in the healthcare system like Medicaid unwinding. Medicaid coverage is often found through insurance discovery, so it's worth double-checking, even if the patient has already identified a primary source of coverage.

Insurance discovery reviews patient rosters for retroactive Medicaid coverage, identifying billable insurance up to three months before the date of service. This helps healthcare providers recoup revenue they may have otherwise lost due to a lack of retroactive billing. It can also identify nuances, like if partial coverage turns to full or traditional care turns to managed care (or vice versa in either of these scenarios).

Denial Avoidance
The best way to avoid denials is to submit a clean claim the first time around. Insurance discovery can re-validate patient eligibility before claim submission, reducing claim denials due to eligibility issues and leading to fewer billing disruptions.

Denial Management (Post-Claim Submission)
Claims denials are inevitable, but many go unaddressed, leaving valuable insurance revenue on the table. Insurance discovery can search denied claims for coverage so the hospital can resubmit the claim to the correct payer. If the claim is processed, the hospital receives its reimbursement.

However, if the claim is denied again, billing staff at least know their files have the patient demographics and insurance information. Ruling out eligibility issues is a "top of the funnel" approach to understanding why a claim was denied. At that point, teams can examine other potential causes for denial like medical coding.

Coordination of Benefits Verification
Billing payers in the correct sequence is key to optimizing returns. When insurance companies are billed out of order, they may refuse to pay the claim altogether, leaving providers with the full cost of a patient visit. Misaligned or outdated coordination of benefits can also result in

Medicaid Unwinding

The unwinding of pandemic-era protections has resulted in significant changes to Medicaid enrollment. In April 2023, a record 94 million people were enrolled in Medicaid. Today, that number is down to 79.4 million people.

According to a KFF report, tens of millions of individuals have faced renewal processes, often for the first time in years. Key findings include:

- **High Disenrollment Rates:** Approximately 74% of disenrollments were procedural, meaning individuals lost coverage due to incomplete or incorrect paperwork, not because they were ineligible.
- **Coverage Gaps:** Medicaid churn became a significant problem as half of all people disenrolled were still eligible, but had to wait for bureaucratic holdups to re-obtain coverage.
- **State Variability:** Renewal outcomes vary widely by state, with some achieving higher success rates in re-enrolling eligible individuals than others.

Medicaid unwinding showed providers need to have tools in place now to avoid unexpected complications with coverage in the future. Screening, enrollment and application tools must securely handle data and patient communication tools must provide secure, user-friendly ways to communicate with patients. Perhaps above all, providers must continue to advocate for patients, helping them maintain Medicaid enrollment via education and financial counseling programs.

Office Ally remains committed to helping healthcare providers and payers rise to meet these challenges and "future-proof" their organizations. Learn more at OfficeAlly.com/MedicaidRedetermination

two payers covering the same claim, higher insurance premiums for patients, and major, ongoing billing headaches for staff.

Insurance discovery checks the coordination of benefits for accuracy and flags instances where the primary payer is misidentified. This helps avoid improper billing that can result in extended A/R days and cash flow bottlenecks.

Limited Demographic Information
Insurance discovery can find active, billable coverage even when only partial patient data is available, increasing the likelihood of claim approval. Instead of chasing a patient around trying to get one more piece of demographic information, Insurance discovery streamlines the process, guiding the account directly to reimbursement.

The Business Case for Insurance Discovery

Implementing a multi-vendor insurance discovery model is a smart, strategic approach for any provider. Leveraging a vendor for a secondary or even tertiary review has a positive impact on finding coverage other vendors missed, maximizing reimbursement opportunities and ensuring providers recover as much revenue as possible.

Financial Benefits

Securing Cash Flow Well into the Future: Found insurance coverage decreases accounts receivable (A/R) days by ensuring that claims are sent to the right payer. Fewer A/R days means more rapid payments and more secure cash flow for your organization.

Increased Revenue Recovery: Insurance discovery identifies overlooked billable insurance, turning self-pay accounts into reimbursable claims.

Reduced A/R Days: Faster identification of active insurance leads to quicker reimbursements, improving cash flow predictability.

Greater Profitability: By minimizing revenue loss, healthcare organizations can maintain more stable and optimal financial operations.

Operational Efficiency

Fewer Manual Eligibility Checks: Insurance discovery reduces administrative workload and frees staff resources.

Enhanced Denial Prevention and Management: Real-time insurance verification minimizes claim denials due to eligibility errors.

Streamlined Workflows: Staff can focus on high-value tasks instead of dealing with insurance eligibility-related bottlenecks.

Improved Patient Financial Experience

Fewer Billing Surprises: When insurance coverage is correctly identified up front so it can be billed correctly, patients are less likely to receive unexpected medical bills.

Increased Satisfaction and Trust: Patients appreciate transparent and accurate billing processes, strengthening provider-patient relationships.

Improved Collections and Patient Payment Plans: Providers can structure financial discussions based on known insurance coverage rather than uncertainty.

Why Choose Office Ally's Insurance Discovery

Hospitals run at a breathtaking pace with continual multiple distractions. The increased administrative burden hospitals face contributes to the culture of deferring important but non-urgent tasks in favor of addressing immediate, pressing needs.

Plugging revenue leaks is often classified as a want, not a need. However, without small steps to tighten things up, providers will never stop the flood of uncompensated care costs.

Office Ally is a healthcare technology company that deploys mission-critical software solutions for healthcare providers. Our tools are used every day by healthcare organizations to simplify administrative workflows, deliver high-quality care and recover revenue.

Insurance Discovery from Office Ally identifies patients with active billable insurance coverage on their date of service that was previously unidentified. Whether running behind an existing vendor or acting as the primary vendor itself, Office Ally provides the level of service hospitals and providers of any size need. Key benefits include:

No Implementation Requirements

Designed for ease of use and maximum efficiency, Insurance Discovery requires no IT resources or complex implementation, making it accessible for providers of all sizes. With a go-live timeline of less than 30 days, the solution seamlessly integrates with any file specification that includes basic patient data such as name, date of birth, gender, admit and discharge dates, ZIP code, account number and total charges.

High Accuracy, Low False-Positive Rates

With over 20 years of expertise in healthcare revenue recovery, our proprietary algorithms deliver high accuracy and minimal false-positive rates. This advanced technology consistently identifies active insurance coverage that other vendors might have overlooked.

Leveraging extensive data and decades of team experience, Insurance Discovery delivers an impressive 10–30% hit rate, even when applied after other vendors' systems. Our focus on quality enables us to eliminate false positives, identify confirmed active coverage from the source of truth and provide white-glove customizations for our end users.

No Upfront Fees

Providers only pay when revenue is successfully recovered. A free preliminary assessment helps validate potential revenue opportunities, with results typically delivered within 7–10 days. This win-win setup ensures that Office Ally's success is aligned with the provider's financial outcomes.

Customizable Workflows

You know your patients, services, and revenue streams better than anyone. Office Ally enables you to use that knowledge by creating customizable workflows that guide the search for potential coverage. Office Ally can enable searches emphasizing facility and patient information, state regulations and payer details. The combination of your institutional knowledge and our intelligent technology empowers you to find previously unknown insurance coverage as revenue sources.

Insurance Discovery Case Study

A large East Coast health system consisting of 14 locations sought a new vendor to initiate a secondary audit to validate the efficacy of its existing vendor. The system had concerns that the existing vendor was underperforming, which was especially concerning in light of the rising costs of uncompensated care. Silent revenue leaks were plaguing the health system, leading to large amounts of unnecessary lost revenue at different points within the revenue cycle.

Challenges

The company started seeing a higher number of self-pay accounts from their expansion.

The existing vendor was driving results based on eligible individuals, not eligible claims.

Trying to recover uncompensated care with their current vendor demanded more resources from the hospital.

Results

87,000
Self-pay accounts reviewed

21.2%
of claims over 1 year were found billable with active coverage on date of service

10-30%
average in newly identified eligible claims historically

$3.14
million in payments identified for recovery

The hospital used Office Ally's Insurance Discovery to conduct a comprehensive review of over 87,000 of the facility's self-pay accounts (100%) going back 1 year. Of those accounts already worked by another vendor, 21.2% had "ACTIVE" coverage on the date of service and were left on the table as a loss to the provider. The return for the facility was significant and swift. A report with eligible claims data was provided to the hospital to bill upon execution of the agreement, and the assessment was completed within 10 days of receiving the target data file. Multiple silent revenue leaks were plugged as a result of Office Ally's services.

Comprehensive Coverage Discovery & Monitoring

Insurance Discovery goes beyond traditional discovery methods of only the top commercial payers by scanning all commercial, Medicare (including Managed Care) and Medicaid coverage that may have been missed during patient access.

Additionally, automated monthly monitoring continuously tracks coverage changes, ensuring providers stay updated on patient eligibility throughout the claims process.

Free Assessment

We'll prove our solution with a free assessment. To get started, we only need a BAA, a secure HIPAA-compliant web portal or SFTP and a target data file. The process usually takes 2-4 hours of staff time to implement.

In 7-10 days, you will receive a detailed assessment report to validate the quality of our findings. If additional revenue opportunities are found, providers benefit from improved revenue recovery. If not, the free assessment confirms that existing systems perform optimally, offering peace of mind without financial risk. It's a win-win!

Identifying Forgotten Insurance to Boost Your Bottom Line

Uncompensated care remains a persistent challenge for healthcare organizations, but insurance discovery technology presents a powerful solution. By proactively identifying overlooked insurance coverage, providers can plug pesky leaks one at a time and recover revenue that would otherwise be lost.

Move confidently into commitment with a free assessment from Office Ally. If you're considering auditing your current process and/or confirming existing insurance discovery vendor efficiency, we can help you verify your system has the most robust solution in the marketplace.

Contact Office Ally today to learn how Insurance Discovery can transform your revenue cycle strategy.

About Office Ally

Office Ally is a leading provider of healthcare technology solutions, offering a comprehensive suite of products and services designed to streamline administrative workflows and improve revenue cycle management for healthcare providers. With a focus on delivering innovative and user-friendly solutions, Office Ally empowers providers to enhance their operational efficiency and deliver high-quality care.

For more information, visit www.OfficeAlly.com/Leaks.

Get Started Today

OfficeAlly.com/Leaks