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Telehealth Expands and Audits Have Started

Do you have a technology solution in your strategy?

The COVID-19 pandemic has accelerated the use of telehealth and telemedicine across the U.S. healthcare landscape. Providers and patients should both benefit from this new trend, as remote services are helping to effectively provide care and deliver a revenue stop-gap during this time of patients concerns with engaging the healthcare system and practicing social distancing. The question is whether everyone is prepared for this new reality of patient care, particularly Patient Financial Service and Revenue Cycle Management? Secondarily, do providers have the resources, processes and partners in place to support this “new normal”?

Telehealth is largely providing revenue continuity and continuation of care with doctors minimizing cancelled patients visits, improving patient satisfaction, prescribing valuable medications, and maximizing potential healthcare revenue at a lower cost of service. Given some of the additional impacts of the pandemic it is anticipated that behavioral health and post care rehabilitation will soon jump on the telehealth band wagon.

All of this is good news for health systems and consumers, but it comes with one caveat, the demand for telehealth after the pandemic ends will depend on whether payers will continue to reimburse telehealth at the current levels. At the moment, its payout is higher than in the past due to temporary waivers that are slated to evaporate once the public health crisis ends.

Hospital executives typically say that telemedicine improves a patient's access to care. But truth be known it doesn't always come with a positive impact on either specifically Patient Financial Services or more broadly Revenue Cycle Management. In the short-term providers have interpreted the opportunity with telemedicine to be somewhat of a "green field". It has been assumed that many bills will be paid at levels of service that historically would not have been reimbursed. Some have interpreted the "relaxed rules" to be an opportunity to be compensated for additional services since elective services have declined. In other words, telehealth offers several opportunities to improve profitability and hospital revenue.

A recent KLAS survey, hospital executives noted that telehealth, at 49%, was their number one "innovation priority". Let's add that more than twenty years ago, patient responsibility was in the 5% range. Today it is more like 20% and many predict that it will reach as high as 30% in 2021. That represents a potentially significant loss that hospitals cannot afford to just write off. Given this larger share of responsibility, patients are more receptive to the "telehealth consumerism" concept with not only the convenience but also a savings to the historical visit costs. These costs can include: lost work wages, transportation, and the total time invested in an in-person care event. Some have even coined the term with telehealth as the new "concierge healthcare service".

Current data shows the value of a telehealth model in our current healthcare landscape. The Medical Group Management Association has documented that many hospitals have no show rates as high as more than 50%. Best run practices are now showing a 12% no show daily rate for visits. Historically, even 5% was painful to the provider's bottom line. Telehealth is showing a minimal no-show rate, immediate access to care, and patients are enthusiastic about not having to deal with the complexity of a real time visit. A recent MD Live survey found that adults 18 to 34 prefer same day health visits which are far more likely in a telehealth model of care. An Intel study found that more than 70% of patients are more receptive to telehealth care, regardless of age. It truly is all about consumerism of healthcare.

As they say, "no good deed goes unpunished" and that has been true in healthcare revenue cycle for years. In spite of the recent flexibility to providers for reimbursing telehealth, providers are now facing the inevitable process of denials and audits. There is certainly some risk for providers, primarily due to their interpretation of the reasonable flexibility resulting from COVID-19. Additionally, CMS released the 2021 physician fee schedule on December 1st which included expanded telehealth services. Telehealth is growing and there are constant changes that will make these services a prime target for audits.

Recent audits are finding that PHI has been relaxed with telehealth, however that never meant that "over-coding" was not at risk. Recent examples in large health systems in OH, PA, AZ, FL, NC, and CA are finding that providers assumed the new COVID rules to communications to not factor in standard coding and documentation requirements. Simply to verify the appropriate level of service. Be on the watch that behavioral health and high-risk elective care will also have audit exposure. Many health systems have been sensitive and realize that documentation and coding is key to clinical and financial responsibility.

Do you have a technology solution in place to help meet these new audit challenges?

The most effective way for providers to prepare for telehealth audits, or any other type of audit is to implement a comprehensive audit management and response process. This will include identify dedicated staff and resources to receive, evaluate and respond to the audit requests and implementing a core audit management platform to make the entire process more efficient and effective. Today's audit solutions have the ability to aggregate multiple points of data form disparate systems to automate and streamline the audit response process.

The main benefit of implementing a comprehensive audit management solution is to protect valuable insurance reimbursement dollars. This has become even more important with the revenue challenges resulting from the COVID-19 pandemic felt across healthcare providers of all types. Additionally, audit solutions ensure compliance with time sensitive deadlines that often times accompany audit response process. With advances in artificial intelligence and process automation, clinical staff is freed to focus on more value-added tasks such as direct patient care. It is critical for revenue cycle leaders to measure and track the real-time financial impact of audit activity. Audit solutions can indicate current exposure in addition to predicting future exposure based upon relevant clinical indicators. Even if a provider's recent telehealth activity is not currently under audit, it may be a good idea to review submitted claims and plan for future audit activity accordingly.

There are several different audit and denials management solutions on the market today but the features, benefits and costs will vary depending on which solution a provider chooses to implement. When selecting a new platform there are several critical pieces of functionality that should always be included in a new solution. Possibly the most important is full interface connectivity between the audit and denials platform and other related solutions across the enterprise. The audit solution should be able to import claims, remittance and electronic documentation requests, while exporting billing indicators and claim referrals to either release of information or appeals management systems. When fully integrated, over 90% of required data can be sourced automatically without manual data entry.

If available, integrated release of information can be another valuable tool in the audit management and response process. Available electronic document transmissions can include, receiving initial documentation requests and the submission of medical records in response. For the Medicare Recovery Audit community this process is delivered through Health Information Handlers and the esMD Gateway. For Medicaid auditors and commercial payers, custom interfaces with their portals can be developed and integrated within the audit management platform. This capability can result in tremendous saving of time and money over the traditional paper-based approach to audit document transmission.

Having the right workflow tools in place can customize an audit management solution to meet a provider's individual and specific needs. Case management tools include custom account status models, integrated workflows, intuitive work queues and activity notifications as audits move through the response process. With customizable payer contract tools, the solution can be configured to the specific commercial payer audit and denial rules and requirements. This allows for a single platform to manage both government and commercial audit activity. The final piece of required functionality is a comprehensive reporting package. It is important to have access to real-time audit status, worker productivity, and financial impact to the health system.

Blueway Tracker from Bluemark has been an industry leading audit management platform for over a decade and it brings together all of the critical functionality into an easy to use and cost-effective solution. Even in these most challenging times, Blueway Tracker stands ready to help providers defend against all types of insurance audits.