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White Paper

Automated Patient Access Solutions for Orthopedics

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Our examination of the patient onboarding process in orthopedics, from verifying insurance details to prior authorizations to addressing CDSM implementation, provides substantiated improvement solutions that streamline the overall workflow, improve reimbursement, and will strengthen the bottom line. By identifying challenges that orthopedic practices often encounter and outlining automated and fully integrated solutions, including Artificial Intelligence (AI) assistance and machine learning where appropriate, we create an onboarding flow that improves revenue while enhancing the patient's experience.

Recognizing the current challenges, the Centers for Medicare and Medicaid Services (CMS) extended the mandatory CDSM implementation date to January 1, 2022. This extension is intended to give both ordering and furnishing providers ample time to negotiate the technological and workflow challenges before there is a monetary impact for Medicare patients.

The Business Paradigm is Shifting in Healthcare

As the growing trend of patient consumerism continues to alter the care atmosphere, orthopedics groups around the country are striving to maximize the patient experience through not only their clinical successes, but also through their approach to the healthcare payment lifecycle. This paradigm shift is requiring providers to reorient their patient access focus to more fully support the patient. Increasing the quality of time spent on educating the patient, estimating amounts potentially due more fully, and reducing surprise billings are some ways that orthopedic practices are developing stronger partnerships with patients.

A major shift is in healthcare insurance coverage policy, High Deductible Health Plans (HDHP) are not only here to stay but are increasing in popularity with each successive "open enrollment period" as employees look to reduce their monthly premium costs. HDHPs with annual deductibles of $6K or more per person sound inconsequential when people are examining their options during open enrollment, but often families don't have accrued savings sufficient to meet the limits when catastrophe strikes.

Defining Patient Access in Today's Orthopedic Practice

To define our focus for purposes of this discussion, let's look at the initial establishment phase – patient access – where we examine the steps required to ensure maximum reimbursement as a patient is initialized into the orthopedic practice. As the orthopedics reimbursement landscape evolves and profit margins continue to tighten, forecasting and strategies turn towards new technologies and streamlined procedures as the way forward.

Successful initiatives focusing on the patient encounter, from the initial patient access point through Revenue Cycle Management (RCM), are renewing interest in the efficiencies gained by automating redundant, time-intensive processes. As an example, industry-wide over 79% of prior authorizations (PAs) are still generated and submitted manually[1] even though insurers have the capability to process PAs electronically.

Outlining the Components of Patient Access

Insurance Verification & Benefits
It is critical that accurate and current patient demographic[2] and insurance information is collected and used to onboard the patient into the orthopedics reimbursement system to ensure valid billing information is obtained regarding:

- Insurance eligibility dates
- Co-pays and co-insurances
- Deductibles
- Secondary insurance and coordination of benefits
- In-network vs. out-of-network coverage
- Referral requirements
- Prior authorization requirements

Without this key information, revenue reimbursement may be denied through the contracted insurance payers.

Prior Authorizations
The PA process is without a doubt the least respected function that takes place in any practice. It is rightfully seen as disruptive to the patient's care and experience, a roadblock to necessary procedures and equipment (often determined after the patient encounter), and an uncompensated use of physician and staff time. [3]

A recent AMA Prior Authorization Physician Survey[4] found that 92% of patients experience a care delay due to requirements for PA. And equally troubling, that a significant number of patients abandon care all together, negatively affecting clinical outcomes.

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As stated above, further complicating the PA process is the fact that according to the 2020 CAQH Index, only 21% of providers are using a fully automated electronic process.[5] This means that an average of 15 hours per provider of staff time per week are used to manually process the required PAs and it probably is significantly more in a surgery-rich specialty like orthopedics.[6]

Patient Pay Estimates

Today, fully 35% or more of the total cost of healthcare may be the patient's responsibility – this includes services an orthopedic practice provides and should be compensated for – and, to be fair, the patient should be aware of this amount before committing to potential care. While there are always unforeseen circumstances that arise, a large percentage of costs can be well researched and pinpointed ahead of the actual initial visit.
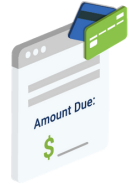
It has long been customary for many practices to notify patients of pending amounts due as they arrive, which is often a shock to the individual and sets up an adversarial relationship from the start. But what if a more proactive approach is used where the patients are notified about payments ahead of an appointment and payment is discussed and arranged at that time?

This allows the patient to digest the amount, ask questions, research their insurance plan, and become an active participant in the process. It also encourages staff to identify potential concerns and to offer arrangements that reinforce an obligation, such as 50% now-50% at time of service or third-party financial plans.

Clinical Decision Support Mechanisms

Appropriate Use Criteria (AUC) and CDSM have entered the education and operation testing period lasting until the end of 2021. For orthopedic providers, whether ordering advanced imaging services or performing the tests themselves, this will require changes to the diagnostic process (to include consulting AUC) and forwarding certificates of adherence to radiology for Medicare eligible patients as the ordering provider, or generating and acknowledging the certificates as the rendering provider.

While inpatients and certain emergency patients are excluded from this change, all other Medicare patients fall into the CDSM category whether in a hospital setting, group practice setting or imaging center.

The unique structure of the CMS-defined process presents challenges for the providers who actually perform the tests since they are financially responsible to code claims based on having received the CDSM certificates from their ordering orthopedic provider. However, they are relying on the ordering provider to consult the AUC and then generate and forward the actual certificates themselves via their software through CMS-approved vendors.[7]

Orthopedic groups that perform these imaging tests in house find themselves in the somewhat unique position of possibly being both the ordering and rendering provider.

Leveraging Automation, Artificial Intelligence, and Machine Learning

With what's available today, it's important to define the three types of technology and outline how each could benefit the process of patient access flow. Using HL7 or API-based integration that guarantees 100% HIPAA compliance, functions are completed in real-time, followed up as necessary, and status automatically reported at completion.

Automation – By using automated electronic processes, redundant human burdens are eased and actions of the workforce are mimicked. Automation is used to determine insurance eligibility, prior authorization, and patient responsibility for pre-collections.

Analytics – Digital data collection is designed to enhance productivity through analyzing patterns, trends, and statistical information. Data Analytics is used to quantify outcomes based on performance and to develop predictive scenarios that enhance RCM results.

Artificial Intelligence – By identifying patterns through computational analyses, AI can make predictions that support and amplify those made by humans alone. For patient access, that means predicting risk and behavior, and forecasting potential outcomes for RCM purposes.

Best Automated Practices for Orthopedics

The efficiencies recognized and benefits enjoyed by automating each function within patient access during the onboarding process include increasing revenue captured, savings or redirection of front and back office professionals' time, reduction in denied claims and follow up, and a vast improvement to the patient experience.

Improved Insurance Verification and Patient Eligibility

Accurate and immediate verification of a patient's eligibility is paramount in kicking off the entire reimbursement process. As the basis for any good RCM system, the patient insurance information should be gathered thoroughly with copies of insurance cards and ID's becoming part of the patient's permanent records and double-checked at each visit.

Today's automated processes allow the insurance to be verified before the patient's visit and, again, when the patient arrives to ensure that no changes in eligibility have occurred and an up-to-date remaining deductible amount is obtained. Additionally, insurance verification and eligibility through an automated software solution not only greatly reduces the administrative burden of manual verifications, but also can be integrated with pre-auth and patient pay functions.

More Accurate and Timely Prior Authorizations

By intuitive and seamless processing of PAs in real-time with full transparency, AI-assisted technology allows requests to be submitted to the appropriate payer, monitored and followed up intuitively, with alerts and notifications updated continuously.

To proactively address the multi-layered issues surrounding preauthorization, it's helpful to identify the challenges currently being experienced in the overall PA process. By automating the PA process, significant time is saved by eliminating manual, burdensome workflow. Once isolated, then rethinking operational flow and zeroing in on a solution becomes more effective.

With a deliberate and strategic approach, you can improve patient access and see benefits in the healthcare billing lifecycle workflow, including:

- PA's processed in real-time
- Clarity in patient appointment scheduling
- Lower denial rates
- Increased revenue
- Improvements to A/R and Days Outstanding

Obtaining pre-authorization continues to be an ongoing struggle for most orthopedics groups today. The process is labor intensive and time-consuming, often requiring many hours of constant follow-up by business staff that takes time away from patient care.

With improvements in today's technologies, bold new AI-automated software options are being implemented in orthopedics groups around the country that are capable of processing PAs in real time, eliminating inefficiencies in obtaining care and capturing revenue that has been previously forfeited.

Meeting the Challenge of CDSM

Looking through the practice lens of orthopedics, the AUC Program and CDSM were conceived as a process that would complement and elevate the referring provider's diagnostic practice, strengthen the Medicare patient experience, and reduce needless advanced image testing. The requirement impacts all physicians, APP, and facilities billing Part B Services to Medicare.[8] Note that exclusions are being made for emergency patient encounters, inpatient services billed through Part A, and ordering professionals with significant hardship, such as rural proximity to services.

When reviewing and evaluating a comprehensive CDSM solution from the CMS published list of approved vendors, consider a partner that offers these valuable components:

- A comprehensive and up-to-date library of AUC's sourced from multiple qualified Provider Lead Entities (qPLE's)
- A bi-directional, integrated clinical dashboard that provides immediate access to current patient information for both furnishing and ordering physicians
- Coverage of all priority clinical areas as detailed by the CMS, including hip pain, low back pain, shoulder pain (to include suspected rotator cuff injury)
- Ability to support referring providers within their EHR/EMR systems

- Ability to generate compliance certificates required for reimbursement
- A qPLE that meets all security requirements and HIPAA compliance standards

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Accurate Patient Pay Estimates

Once your admissions professionals have secured a valid PA and verified eligibility, an automated patient portion estimate now becomes available and patients can be informed of their financial obligation. At this point, the onboarding staff can proceed to collect the amount estimated to be due according to your well-defined financial policies, i.e., collection, payment plan, financing, etc.

A Case Study in Orthopedics

As the population continues to age and there are more and more active seniors opting for elective joint replacement surgeries, prior authorizations are sure to grow in number. What is now a difficult and burdensome system being handled manually in most cases, promises to become overwhelming unless streamlined and automated.

As demonstrated in the following case summary, by bringing electronic prior authorizations into the mix, these orthopedists were able to position for future insurance demands.

A large East Coast Orthopedic Group with 70 providers at 11 locations providing orthopedic services, as well as imaging, rehabilitative, and primary care services, faced a growing backlog that hampered patient access and stymied throughput, the average prior authorization took 11 days and resulted in frustrated physicians and patients.

By leveraging an AI-driven solution to automate and standardize the prior authorization task, their process became more reliable saving over 80 hours per week of staff time, the equivalent of $70K+ annually, with increased accuracy.
To learn more about orthopedic-specific prior authorizations, check out our case study.

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In Summary

While many in orthopedics feel they already have effective and extensive experience in onboarding patients, today's technology offers improved and streamlined opportunities to assimilate patients efficiently. These automated solutions not only improve the patient's experience during pre-registration, but greatly impact RCM in a positive and worthwhile way to produce the end result—an improved bottom line.

Today, a strong and healthy orthopedics group relies on state-of-the-art operational processes to ensure maximum revenue reimbursement. With the ongoing changes in the healthcare industry, being up to speed on technological advances allows a practice to meet revenue challenges head on as well as giving providers and staff the opportunity to commit to higher-level functions that truly improve the patient care continuum.

Contact us today to discuss best orthopedic practice solutions for patient access technology.

Learn More

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