

Revenue Cycle Management Tools from MedAptus Optimize Charge Capture for Physician Groups, Outpatient Hospitals and Infusion Services

As the old saying goes, no margin, no mission. Electronic medical records can help providers do the right thing clinically, but they have limited capability to capture and manage the charges of ever-increasing complexity that fund those clinical services. Revenue cycle management tools from MedAptus get providers paid correctly and promptly for the work they do, keeping them in business and delivering patient care. We spoke to David Delaney MD, chief medical officer of MedAptus of Boston, MA.

Tell me how your career evolved from being a full-time practicing physician to chief medical officer of MedAptus.

I grew up a hobbyist around computers. Even in medical school I did part-time consulting, building applications for researchers to help them manage data. I did a medical informatics fellowship at The Center for Clinical Computing and then a job at Beth Israel working under John Halamka, where I was 50% clinical and 50% IT. I was involved with PatientSite, which was one of the first patient-centered portals.

Our clinical department was losing money. I wrote a simple, Web-based application that allowed direct input of charges. We went firmly into the black that year with exactly the same volume and same number of providers because we were getting paid more. It was powerful to see the result, which was that we were able to reinstate bonuses.

The folks at MedAptus contacted me in 2004. I talked to some of their clients, who were ecstatic about the typical multi-million dollar impact. I ended up joining.

One of our differentiators at MedAptus is our revenue cycle focus. There have been a number of people who do charge capture, but it's typically a side job for them.

Our most mature product is Professional Intelligent Charge Capture, which captures professional charges at the point of care. It then sends those charges to administrative staff, who reconcile them and perform exception-based charge management with a very sophisticated administrative module.

The second major product line is Facility charge capture. It focuses on the outpatient facility -- basically, provider-

MedAptus FAST FACTS

PRODUCTS

Practice Plus Edition, Inpatient Edition, EMR Edition, Enterprise Edition, Facility Edition, Infusion Services Edition.

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NOTABLE CLIENTS

Beth Israel Deaconess HealthCare, Caritas Christi Health Care, Dana-Farber Cancer Institute, Dartmouth-Hitchcock Medical Center, MD Anderson Cancer Center, University of Minnesota Physicians, University Physician Associates/UMDNJ.

based billing, otherwise known as split-billing or technical billing -- for hospitals providing outpatient services. It provides the ability to capture hospital-based outpatient revenue. It's integrated with the professional revenue cycle, but can be used free-standing as well.

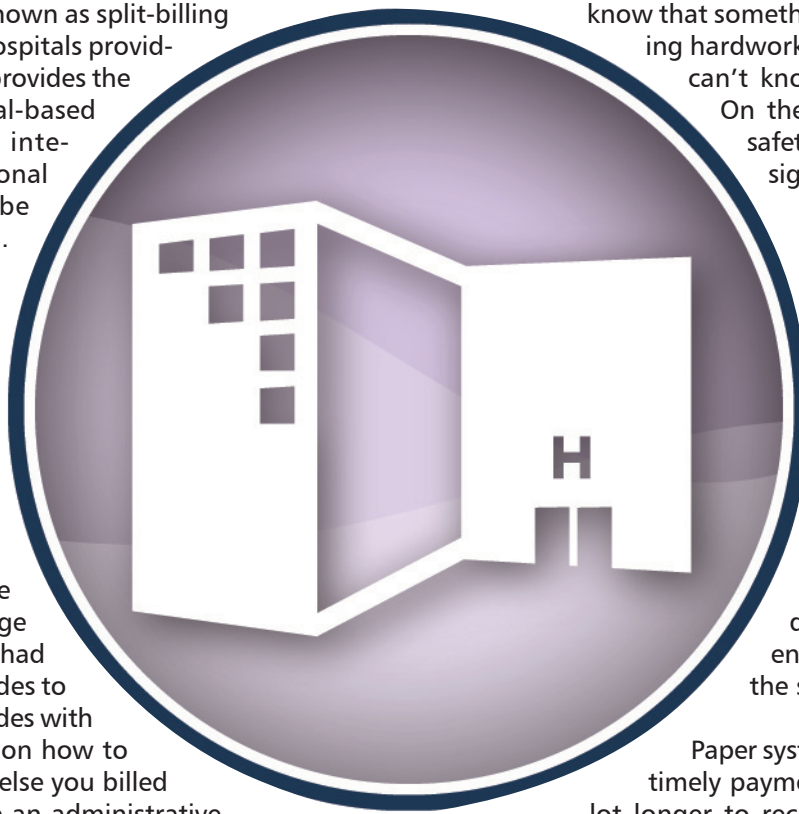
The last product is our Infusion charge capture. That grew out of a co-development process with Dana-Farber Cancer Institute. They were already using our Professional product and were very happy with it, but were looking to solve the challenge in infusion charge capture. Infusion coding had gone from a handful of codes to a complete hierarchy of codes with a bunch of dependencies on how to bill things based on what else you billed previously. It had become an administrative nightmare because of the amount of training to get the nurses to understand it. Our product started with a simple premise – it will ask the nurses what they did and for how long and the coding engine translates that into compliant codes. Despite continual regulatory changes, the user interface remains constant.

What are some of the challenges that you see providers facing in terms of capturing charges?

First and foremost, we are providers of healthcare. A sick patient always takes precedence. Administrative things naturally end up being a second-tier focus and it's easy to miss or forget charges.

On the outpatient side, you have a list of appointments. With good administrative help, they will make sure there's a charge for every one of them. You have a mechanism to do reconciliation. It's very manual and labor-intensive, but it can be done.

The inpatient side of the world is troublesome because you don't know the true denominators. You have a lot of events that you can't predict, such as curbside consults. I see a colleague in the hallway and I ask him to see my patient. There's no record of that anywhere to reconcile against. That provider might put in a line or do a procedure bedside and there's no record for the administrators to



know that something happened. Despite having hardworking and talented staff, they can't know what they don't know. On the inpatient side, there's no safety net, so you end up losing a significant number of charges.

Another challenge with paper-based systems is providers' tendency to put off documenting charges because it's an annoyance. They let it build up and then try to go back and do charges for a period of time. Then providers cannot accurately remember what they did. They forget to put in procedures and defensively down-code and end up not getting paid for all the services rendered.

Paper systems create a challenge with timely payment. Not only does it take a lot longer to receive payments for services rendered, but you risk running into filing deadlines. Add in multiple payers, each with their own shifting rules, and it's challenging to know how to properly charge.

For the most part, docs just don't even pay attention to that. They trust the coders to do it. The coders tend to know that stuff cold, but the problem is by the time they get the charges, it's a week or two after care was rendered, making it harder to find out exactly what happened at the point-of-care.

Do hospitalists and anesthesiologist have similar issues?

Yes. There's tremendous benefit for both to move to an intelligent charge capture solution because on the inpatient side, it's a dynamic environment, hard to reconcile.

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The second someone stops creating a charge with the intent to go back and do it later, a good percentage of the time, the charge will never be put in. For inpatient providers, it's fundamental to provide them an easy, intuitive mechanism to capture the charge as quickly as they can after a service is rendered.

Most EMR products today include charge capture functionality. Do products like MedAptus run the risk of becoming obsolete as

more facilities add EMR tools into the workflow?

No, I actually think it's improving our opportunity. We're now in Version 10 of the product and are integrated with many EMRs.

EMRs are like motherhood and apple pie. They're very good for patients and society. But speaking firsthand as a physician who has gone from paper to an EMR, they are not quicker than paper. They take more time. EMRs are focusing their efforts on trying to improve the time factor in order to improve adoption.

The revenue cycle stuff is very much its own domain. The solutions the EMRs come up with are basic. They can capture charges, but with the revenue cycle, you can't settle for adequate in terms of your charge capture capability.

With EMRs, we've got the carrot now and the stick is coming. Now more than ever the need to get accurately paid for the work you're doing is paramount to survival. This is no longer a "nice to have."

With healthcare reform, we'll soon have 30 million additional covered lives coming into the system. There's not much more in terms of additional dollars forecast to be paid. They're trying to pay for it based on efficiencies generated from the EMRs. Payments, at best, are going to be static and are probably going to drop.

These factors make it imperative to have a well-honed system that makes charge capture intuitive and results in getting paid for all services rendered. A couple of percentage points could be the difference between making a thin profit and not surviving.

What type of financial gains and productivity gains can your clients expect when implementing products from MedAptus?

This has been very well studied throughout the years by independent resources. The numbers vary between \$15,000-25,000 per doctor, per year. That's top-line cash collected, year-on-year contract value and volume-adjusted. The net of it is our docs get paid \$15,000-25,000 more a year for

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the same amount of work they were doing previously.

We also provide significant cash acceleration effects from the capture of charges, typically on the date of service, and rapid submission. The time from service to receipt of payment drops significantly. That lag day decrease will typically drive another \$8-10,000 per doctor in terms of a one-time cash improvement.

It ends up working out nicely because that cash influx per doc is a multiple of the entire cost of the system. People can essentially be cash-neutral, actu-

ally throwing off cash within months of going live, which makes it a powerful mechanism for funding EMRs and other IT initiatives.

The administrative cost is the last piece. We've found that healthcare is always hungry for bodies. Even though we end up decreasing the need for people around the revenue cycle, they end up being re-tasked to other purposes that drive additional revenue.

Billing rules continue to be more and more complex, and soon the industry will move to ICD-10. What's involved with researching and main-taining the various charging rules?

To say it's not trivial is a large understatement. Everyone in the company is steeped in the revenue cycle, which has allowed us to not only survive, but thrive and help our customers manage these challenges.

Regarding ICD-10, we view it as an opportunity. Clearly there is a lot of work involved in migrating systems and preparing for ICD-10, but one of the real challenges with charge capture today is that the ICD-9 vocabulary is very limited. It's several decades old and there are not enough codes to adequately describe what physicians see. There are a lot of mappings where a doc might be looking for a particular entity, and it might map to a "not otherwise specified" or "not elsewhere classified" code which is confusing.

ICD-10 provides much better specificity, so that when a doc locates a code, it will look much more like what they're



looking for. That's definitely going to be a large benefit for providers.

When you look at driving rules and creating intelligence, the more specific codes allow us to leverage our intelligence in the system to an even greater extent.

Do you have clinicians helping you figure out the codes and billing rules?

For the billing rules, we have a combination of technology that we license. What's out there is good, but it's not where we need it to be, so we have built additional rules that represent our intellectual property, understanding of the marketplace, as well as client experience. We continuously hone our rules based on feedback from administrative folks across the country as well as our client services staff.

My role is to help understand when and how we should reach out to doctors with this information. You have to be very careful when you reach out to a user with an exception because you risk fatiguing them if you do it too often. And if you hit them with something that they don't understand and can't answer, it leads to frustration and lack of adoption.

Just triggering a rule and pushing it out to the doc – that's half of what you need. The other half is knowing when not to ask the doc the question. In other words, parsing out an administrative question versus something the doc can help with. Our goal is whenever the alert pops up for a provider is for it to be relevant and easily answered based on care. We're not trying to make physicians coders. What we are trying to do is ask information at "the golden moment" – the point when they know everything about the encounter.



That understanding, the nuance and the art form of how and when to present information to the providers, is a big differentiator for us.

MedAptus was recently awarded a patent for technology to process and reconcile professional technical charges. What makes this technology unique?

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Patient: Reading, James (39M) 12111123 DOB: 12/13/1970
Render Date: 07/12/2010 PGL: Adams, John / Cardiology / MedAptus North Office
Reason for Visit: Referring MD: Referring UPIN:

▶ Visit Info

Add Message Messages (0)

Charges (2) Custom Fields PQRI (0) Editing Information Encounter History

Procedure: Add Shortcuts Diagnosis: Add Shortcuts

99212 -Outpt/Office Visit, Estab Pt, Lvl 2 (10 min; 2/3: Hx:Prob Focus Ex:Prob Focus MDM:Straightfwd) Actions

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Mods	Add Shortcuts	<input type="checkbox"/>			
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93000 -ECG, Routine w/Interp+Rpt; 12+ Leads Actions

Units	Price	Link All	Order	Code	Description
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Time 0:00	POS 11	<input checked="" type="checkbox"/>		250.01	DM I, Uncomplicated, Controlled
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The patent highlights our facility charge capture product and the processing of facility charge capture information based on professional information. It's leveraging knowledge across systems to intelligently capture the facility charges.

We're very proud of doing that, obviously. It's recognition that what we're doing is unique out there, and is leading the way in terms of applying technology to automate these processes.

You mentioned healthcare reform. How will it affect physician revenues and the demand for products like yours?

There are certainly a lot of models out there, everything from nuances of fee-for-service to a completely capitated model where point-of-care charge capture would largely become irrelevant.

I think that what you can safely say about healthcare reform now is that we're paying for quantity of care and not quality. One of the chief challenges is realigning that so folks are paid for delivering quality.

It seems more likely that will occur in a step-wise fashion from how we're charging today, because margins are so thin for providers. It would be extremely challenging to radically change things because folks are barely hanging on as it is. The system has to realign how its paying to drive quality.

Things like pay-for-performance are early steps. Obviously, Accountable Care Organizations are getting a lot of play and you have Medical Homes as well. If you look at the commonalities of all of those, it's trying to get more efficient care and then rebating some of the cost-saving steps to providers, trying to align interest toward quality rather than quantity.

None of these things change the need to be able to capture your primary service, because all these additional bonuses are going to be percentage points on top of your base revenue, which is still going to drive your success or failure in the marketplace.

Every payer has its own approach, measures, definitions and codes to appended onto claims. Operationally, it becomes a nightmare and bordering on impossible without a strong use of technology to take advantage of these one to two percentage points of payment.

Let's say a patient has CHF. The insurer is Aetna. Well, I think they have a pay-for-performance program on CHF, but what is it, and what are the choices of where the codes have to append?

We're not trying to make physicians coders. What we are trying to do is ask information at "the golden moment" – the point when they know everything about the encounter.

The cool thing we're doing with technology is to automate these rules in the background. They only fire if a provider is subscribed to that payer's pay-for-performance measure and that particular patient qualifies for it. The provider gets a simple list of choices and the appropriate code gets added on to the back end. That is a real-world example of how we're enabling people to survive this shift from payment for quantity to payment for quality.

Is there anything else that you'd like to add?

We are certainly very excited by the marketplace, especially with EMR adoption uptick and health reform. I think everyone is very interested in optimizing their revenue cycle to get everything they can.

THE BOTTOM LINE

MedAptus provides flexible, scalable, point-of-care solutions for sophisticated charge capture automation that eliminates manual processes and increases payments.

Improved charge collection increases the bottom line and the reduced charging workload allows adding new services that benefit patients.

Revenue cycle management is critical now, but will be a key to survival once healthcare reform starts making rapid and unpredictable changes that will affect the financial well-being of providers.

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