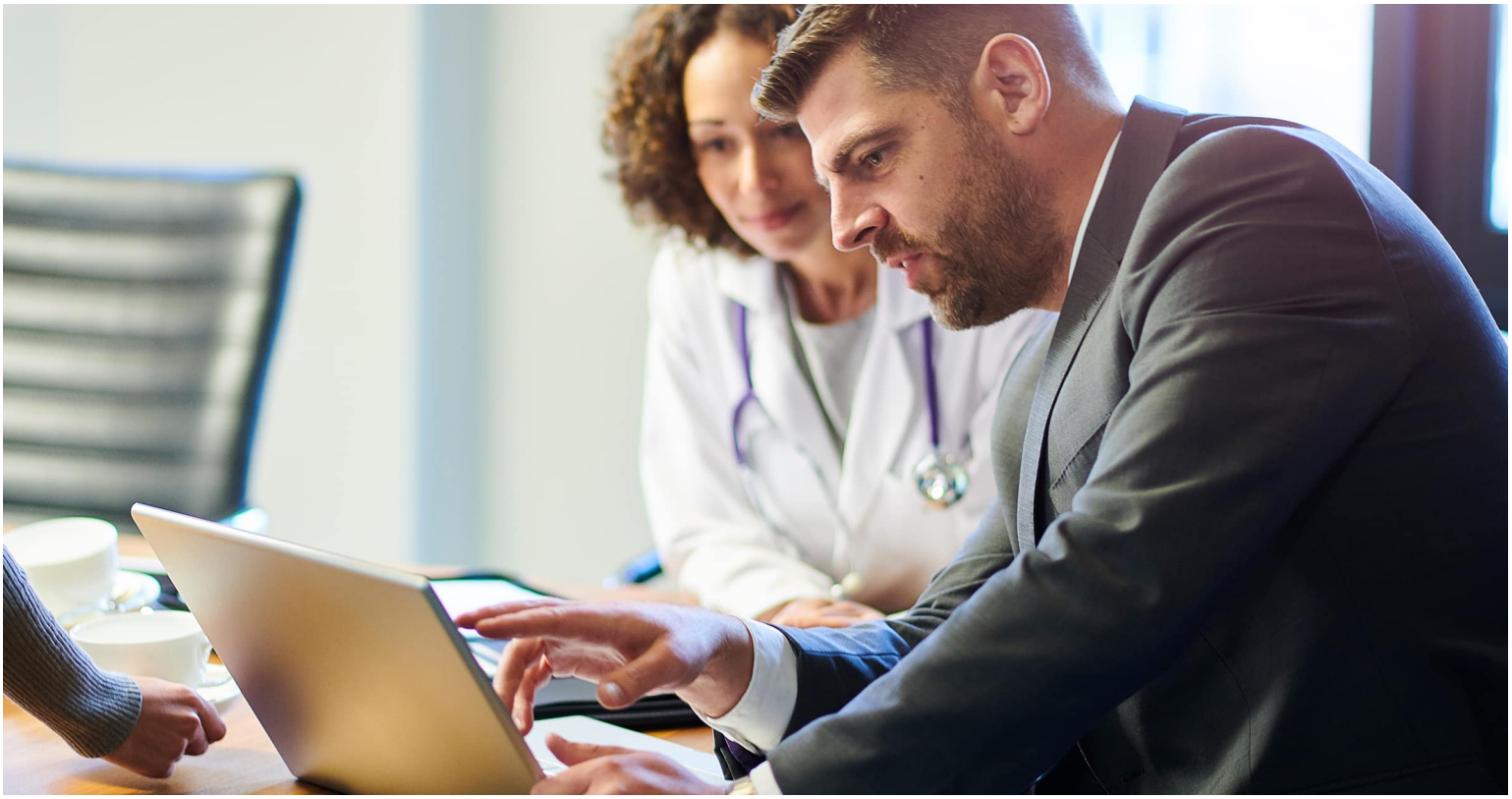
$2+ Million Annual Revenue Gain through Operational and Accounting Improvements.



A payer sought to expand its claims administration for provider practices, but was experiencing multiple revenue cycle issues. Freed significantly improved the payer's accounts receivable processes, preserving the firm's expansion plans and leading to a $2+ million improvement in annual revenue.

Problem to Solve

Independent physician associations, management service organizations, PPOs and health systems all compete for the same providers. Often the ability of one organization over another to attract and retain providers comes down to that organization's ability to provide high-quality services and positively impact providers' cash flow.

One payer, providing services to several hundred small- to medium-sized provider practices, sought to expand its

claims administration services. However its expansion efforts were hampered due to multiple revenue cycle issues. Increased payment turnaround times, aging accounts receivable (AR) and high denials led multiple participating providers to express concerns and consider changing their claims administration support. The payer's leadership launched an immediate and comprehensive effort to identify and correct these issues.

Lacking sufficient internal resources to address its claims and revenue cycle challenges, the payer engaged Freed Associates (Freed) to optimize its claims workflows, close out aging accounts and implement automated posting of health plan payment denials. Freed was chosen based on its significant operational and revenue cycle expertise and its promise to quickly achieve positive results.

Strategy and Tactics

Freed began work by planning to achieve multiple, specific quick "wins," based on analyzing the company's AR processes and aging. The goal was to identify the root causes of the AR issues, then devise ways to reduce or resolve these issues.

Freed quickly identified challenges in the AR postings, prompting a recommendation for the claims team to partner with its IT team to improve the turnaround time of AR postings. Freed also identified multiple process and technology issues, made recommendations for addressing each, and escalated operational bottlenecks that were not receiving sufficient attention and support. For example, there was a backlog of claims due to pending medical correspondence seeking additional input before claims could be processed. Based on a backlog of provider service inquiries to the payer about denials and related payment delays, Freed also analyzed denials and their root causes.

In addition to addressing the payer's immediate AR needs, Freed also identified several ways for the organization to optimize its future operations. This work included reviewing claims team member functions and workloads, identifying operational challenges with the team's current staffing model and recommending actions to address staffing and workflow deficiencies. Particular attention was paid to the correlation between staffing numbers, work volume, and specific payer turnaround time.

Based on the analysis of claims function staffing and workload, Freed identified opportunities for improving denials management, and provider performance and payment contract variance reporting. Freed also suggested ways for the client to improve provider relationships. This included providing value-added services, such as educational offerings on denial management and revenue management.

Results

Through Freed's analyses and recommendations, the client significantly reduced its volume of open AR and lowered its claims workflow turnaround times, thus improving both reimbursement collection and delivery to participating providers. Based on this work, and a series of related program enhancements, this program

ultimately achieved a $2+ million improvement in annual revenue for its provider network program, and achieved record monthly claim volumes. These enhancements preserved both the payer's reputation and long-term potential of its provider network program.

