White Paper

THERAPYBRANDS

ABA Billing:

Credentialing, Contracting, & Revenue Cycle Management KPIs

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Executive Summary

Practice management solutions are spearheading the transformation of current administrative and clinical healthcare practices. Revenue Cycle Management (RCM), credentialing, and provider enrollment are some of the most valuable supports offered. These components are instrumental in keeping operations running smoothly, otherwise, the financial wellbeing of an ABA agency could be in jeopardy. The inspiration for the white paper is contributed to a webinar hosted by Therapy Brands where content expert, Deb Stall (2021), was invited to present on provider challenges within the revenue cycle and offer practical solutions past providers had successfully utilized. The growth of RCM services has skyrocketed since COVID-19 began and is likely to take ownership as a pillar in supporting ABA providers to regain stability and financial health in the year to come.

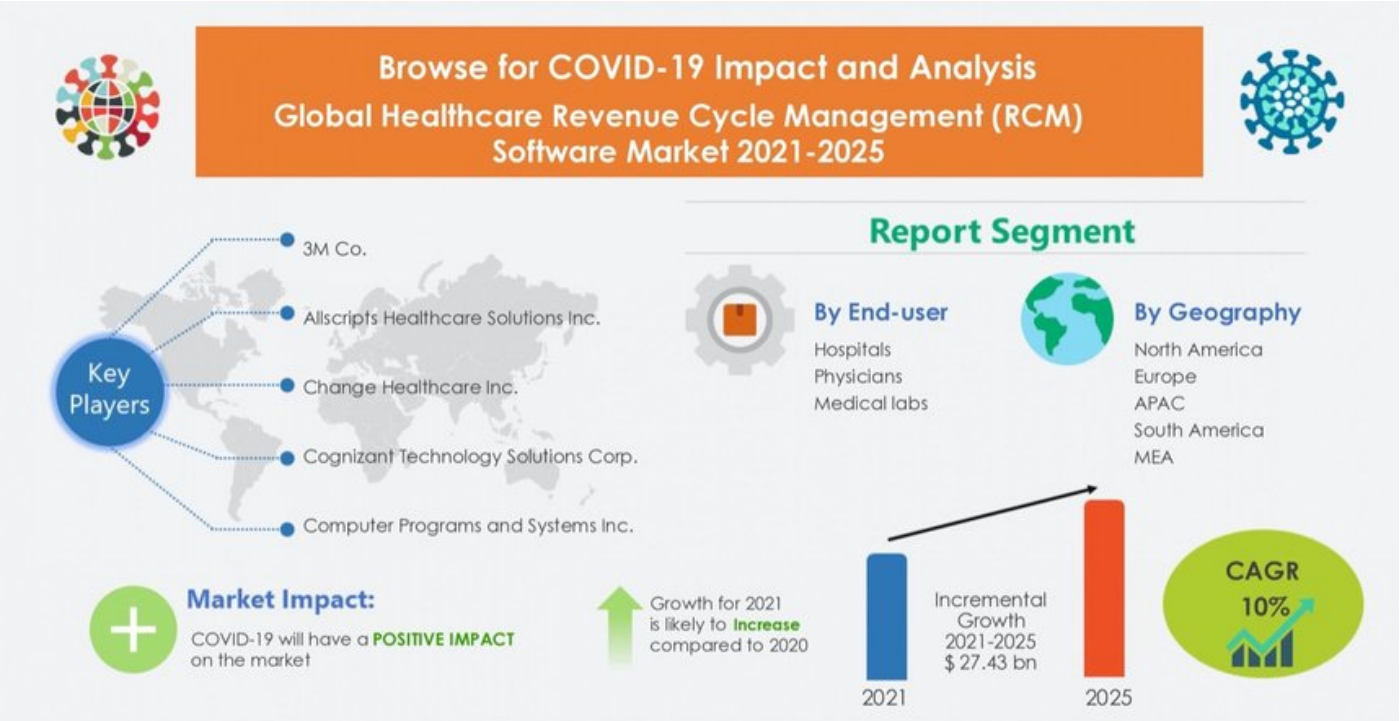
Introduction to ABA Billing RCM KPIs

RCM Growing Popularity During COVID-19

Combining innovative software for revenue cycle management (RCM) and practice management solutions within behavioral healthcare organizations is viewed favorably by both consumers and healthcare providers. By now, most ABA providers are relatively familiar with the front-line healthcare software and electronic technology transforming the behavioral healthcare system today, even if they have not first-hand experience. On the other hand, after COVID-19 invaded our communities, general knowledge was no longer sufficient. ABA providers needed to become content experts and do so quickly. The future of an ABA organization depended on whether the resources readily available are sufficient to meet the technological demands and updated payer guidelines.

New Service Codes Lead to Increased Denials

ABA providers quickly realized the COVID-19 updated procedural codes and modifiers were somewhat ambiguous. Guidance from payers was inconsistent since descriptions of service codes can lead to different interpretations, if not adequately defined. Every agency, provider, and payer were understaffed and desperately grasping at straws trying to determine the best course of action. Updates were frequently occurring as the latest information poured in, not only from funders but from local, state, and federal agencies like the CDC and WHO. Behavioral health providers began to see a large influx of denied claims. During the pandemic, revenue cycle management grew increasingly popular and has not showed signs of slowing down.



Projected Growth of RCM Software

The figure above, courteously of Technavio (2021), announced its latest market research report titled Healthcare Revenue Cycle Management (RCM) Software Market by End-user and Geography - Forecast and Analysis 2021-2025 (Technavio, 2021).

> *With the continuing spread of the novel coronavirus pandemic, organizations across the globe are gradually flattening their recessionary curve by leveraging technology. Many businesses will go through response, recovery, and renewal phases. Building business resilience and enabling agility will aid organizations to move forward in their journey out of the COVID-19 crisis towards the Next Normal, (Technavio, 2021).*

The projected incremental growth for RCM services from 2021 through 2028 is estimated at 10% for the compound annual growth rate (CAGR). This data represents the adaptation our nation is undertaking to be prepared for the unpredictable future.

RCM KPI Cultivates Resiliency for ABA Providers

For ABA business owners, understanding and implementing a structured approach for vital procedures is fundamental. First, Stall (2021) advises to begin the provider credentialing process first, followed by the contract negotiation, and lastly, provider enrollment will be completed. When approval is given by the funder, the services can begin. The duration of completing these steps from start to finish can vary greatly depending on the protocols in place. If the ABA providers and businesses lack a basic workflow and general foundational knowledge of how to complete these processes, inevitably ABA agencies and providers are contributing to the delay in accessing medically necessary services.

Learn the Key Differences for Workflow Development

The workflow for setting up payer-funded ABA treatment consists of credentialing, contracts, and provider enrollment processes. It is important to understand the key differences between these terms and gain a strong foundational knowledge of what information is needed for each step (Stall, 2021). Furthermore, these three procedures could greatly influence how much revenue is earned, or lost, across the years. Becoming familiar with these terms will help ensure the trajectory of revenue will have a consistent and upward trend while minimizing unpaid claims and denials which tend to take a toll on ABA organizations.

Credentialling Defined

Credentialing consists of confirming the credentials of the certified or licensed provider, as well as thoroughly reviewing their background and assessing the providers' validity. Obtaining credentials with an MCO will typically involve providing the following types of information (Stall, 2021):

- Education History
- Clinical Work History
- Clinical Specialties
- License Information
- Liability Insurance
- Background checks

Provider Enrollment Defined

With respect to provider enrollment, the following steps would take place (Stall, 2021):

- The provider applies to take part in a specific health insurance network
- Once the provider is approved, they can bill for services rendered.
- During this process, the provider can expect to sign a contract and have an on-site visit completed by the payer.

Payer Contracts Defined

Payer contracting occurs when the provider and payer negotiate reimbursement rates for the services provided. This process typically involves the following (Stall, 2021):

- Application Forms
- Business Information
- Tax, EDI, and EFT Information
- Contract Review and Forms
- Provider Data Rosters

Overall Enrollment Process Timeline

Variables Influencing Credentialing and Provider Enrollment

Different variables have the potential to interfere with the credentialling and the provider enrollment process. In terms of providing an exact timeline from start to finish, this is not necessarily feasible; however, general averages will be provided below (Stall, 2021):

Respective Enrollment Process Timeline

- **Few to No Barriers Experienced:** When the process is streamlined and the ABA providers are met with few to no barriers, it can be reasonable to expect approval anywhere from 4-12 weeks after all documents have been sent correctly.
- **Barriers Experienced throughout Process:** If inaccurate or missing information was provided, then it is reasonable to assume it could be up to 6 months for approval to be granted (Stall, Therapy Brands webinar, 2021).

Common Credentialling Issues

In the webinar provided by Stall (2018), she provided real-life examples of shared challenges experienced by some of her clients during the enrollment process, as well as strategies to reduce future occurrences of similar issues. The list below includes errors commonly made during the credentialing process, which contribute to credentialing, enrollment, and delayed services for clients.

Common Provider Issues

- Inaccurately entered provider data
- Missing information such as educational history or clinical work history
- Outdated certifications or licenses
- Failure to provide proof of liability insurance
- Background check delays
- Lack of practice management tools for tracking the credentialing process
- Lack of staff available to manage and perform the credentialing process

Mistakes Overflow Contributing to Delays

For ABA providers to enter the enrollment phase smoothly, credentialling mistakes will need to be minimized, if not eliminated entirely. If mistakes were made and not corrected during credentialing such as data inaccuracy, incomplete forms, or outdated provider information, these inaccuracies will overflow into the contract and enrollment phase (Stall, Therapy Brands webinar, 2018).

Save Time and Strive for Clean Claims

Putting in a little extra time up front can save a lot of time and headache later. This is especially true when submitting claims or credentialing forms to a payer. ABA providers who enter subsequent phases and are collaborating directly with the payers will experience more substantial delays in the overall enrollment and credentialing process. It could be difficult to schedule convenient times to review the denied claims with the payers, which was exasperated during COVID-19 as many began working from home. Providers typically need to gather additional information before correcting

claims and send it back in for review, which can extend the process greatly if both sides are short-staffed. Credentialing errors can easily seep into the next phase of the process creating significant barriers, which is why it is vital to evaluate mistakes and prevent the same or similar mistakes from occurring in the future (Stall, Therapy Brands webinar, 2018).

How Credentialing Delays Impact Stakeholders

ABA providers are sympathetic to the many challenges families face on a day-to-day basis and eager to provide support as soon as possible. It is not unusual for families to reach out during times of crisis, desperately seeking guidance on how to best support their loved ones. Time is of the essence when families self-refer or are referred by another medical provider. The consequences of a lengthy credentialing and enrollment process create a ripple effect that can be felt by everyone involved.

How can one error could impact every stakeholder involved?

- **BCBA/Behavior technicians:** When behavior technicians or behavior analysts are hired and given a start date, this insinuates they will start relatively soon. In preparation, they are likely to give notice to their current employer but ultimately find themselves waiting weeks or months for credentialing verification to be complete. Inevitably, this forces many great technicians and clinicians to accept employment elsewhere to ensure a steady paycheck is received.

- **ABA agencies:** ABA providers struggle to keep employees on board if the process of becoming credentialed goes on for weeks or even months, as said above. When situations like this arise, swift but risky decisions can be made which could result in the forfeiting of reimbursement for services given, or even jeopardize compliance with a payer (Stall, Therapy Brands webinar, 2018).

- **Financial implications:** There is a higher probability of ABA providers experiencing financial losses as well. This is especially true if the agency provided paid training, but the employees resigned while waiting to be credentialed. The cost of hiring and training a new employee when these delays occur can add up considerably for an ABA agency. ABA providers may also feel financial strain if they have clients receiving services that will not be reimbursed.

- **Client and family impact:** The clients and their families are the ones left in the center ring waiting patiently. The delay of services can drastically affect the trajectory of a child's progress. A seasoned Behavior technician can capture and contrive at least 50-75 learning opportunities per hour. For a child with special needs, this would be thousands of learning opportunities lost due to difficulty with time management & task execution (Stall, 2021):

Solution-Oriented Approach

Tips for Selecting a Managed Billing Specialist

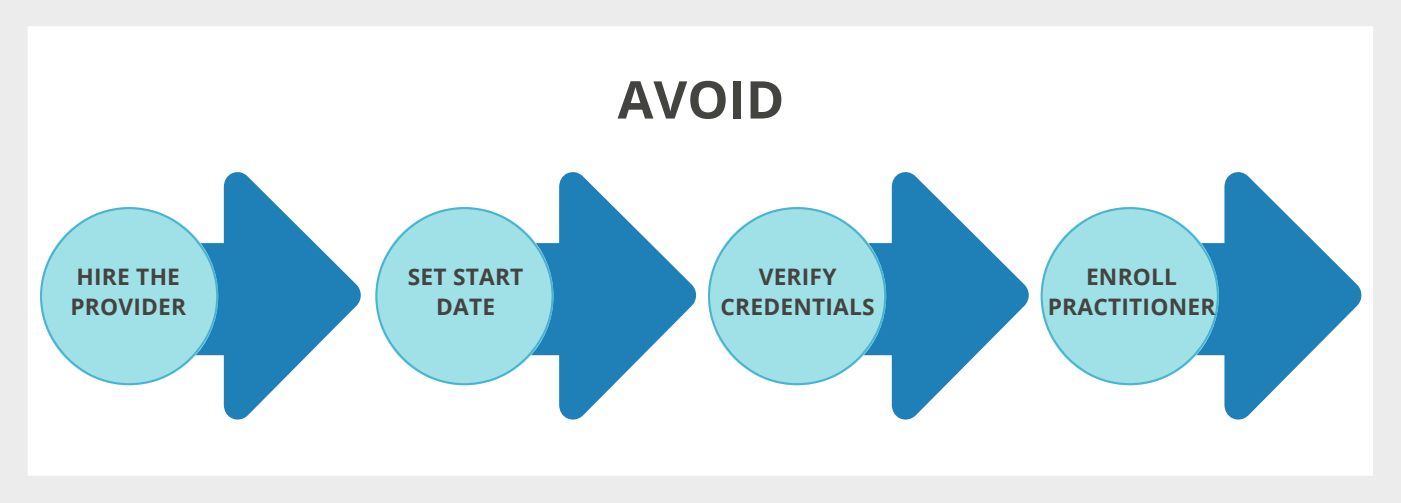
ABA agencies have the potential to maintain, and even increase, the financial stability and longevity of their business by incorporating a Billing Specialist early on to support the RCM for their business and ensure every claim is paid. Therapy Brands released an article titled, “A Guide to Selecting a Billing Service,” to help providers assess key elements when looking to partner with a billing service. Resources centered around the consistent implementation of streamlined guidelines and tools created to track and manage credentialing processes, ABA providers will not only increase the efficiency of the process but more importantly the accuracy in which the process is completed. Stall (2021) discusses key elements needed to be efficient and accurate, which will be reviewed in more detail below (Stall, Therapy Brands webinar, 2021).

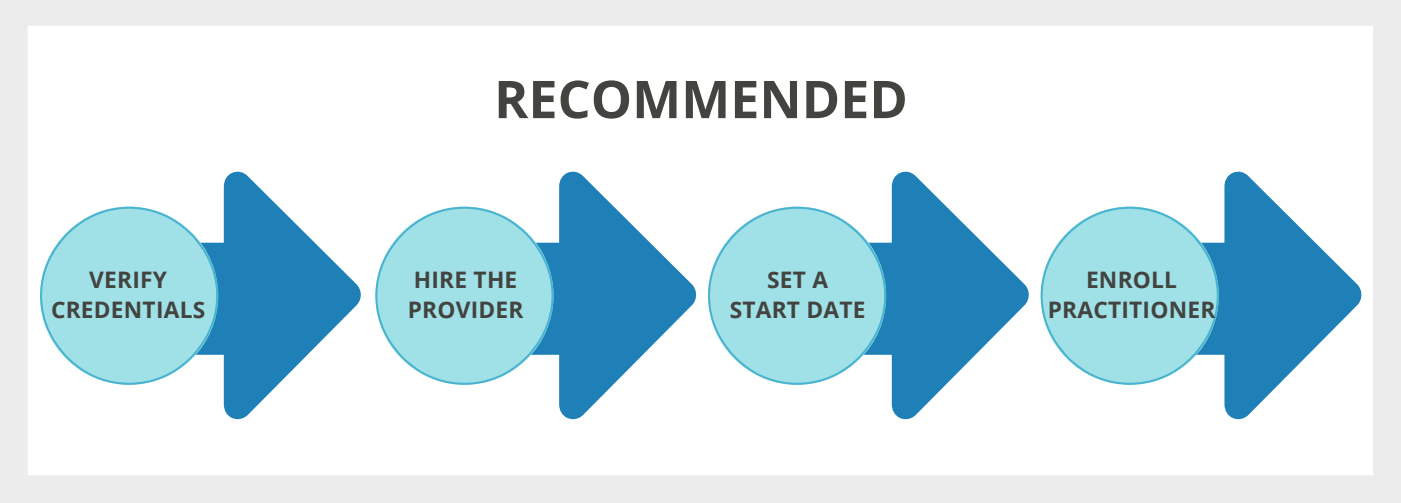
Rejuvenate Your Credentialing Process

Time management is one of the biggest challenges with ensuring timely credentialing. Some healthcare agencies, such as hospitals and specialized care providers, fall short in terms of providing concrete guidelines and workflow policies to support the staff who will undertake credentialing responsibilities. Stall (2021) evaluated the typical process for hiring and credentialing and formulated an innovative approach in the order of which the steps are conducted.

Credentialing Visual Support for Time Management

The below image represents the credentialing process workflow Stall (2021) recommends avoiding based on the potential risks discussed above, followed by the recommended sequence to implement.



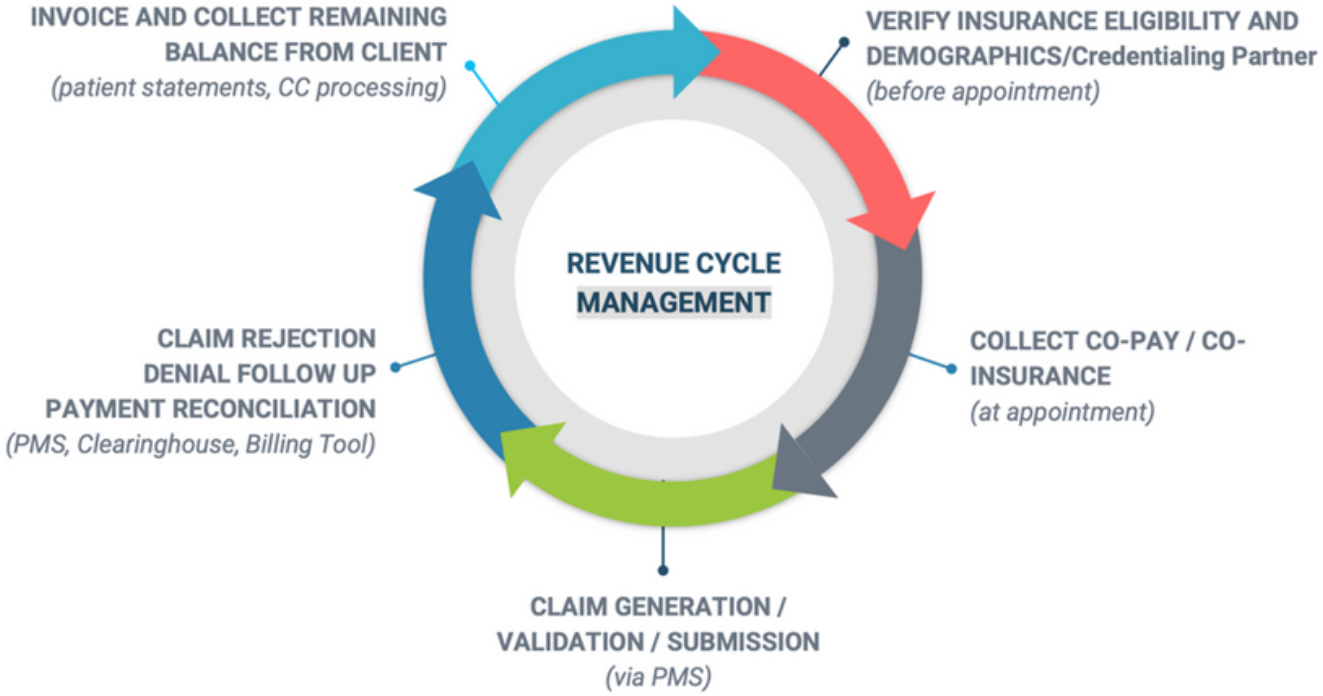


Strategies to Overcome Additional Credentialing Issues

Below are a few practical and forward-thinking solutions for ABA providers to consider implementing to remediate lengthy credentialing delays, frequent staff turnover, or potential monetary loss as suggested by Stall (2021).

- **Licensing and contact** information should always remain current
- **Branch out by creating an in-house credentialing department** or invest resources to outsource the work to an agency that has the tools and specializes in credentialing, contracts, medical billing, etc.
- **Develop a system to remain up to date** on special state compliance guidelines
- **Invest in a credentialing system** or make sure your vendor has the tools needed to accurately track the credentialing process

Armed with the knowledge of the overall credentialing, contracting, and provider enrollment process, ABA providers can confidently evaluate their internal systems and strategies what tools and resources may work best to streamline the process within their agency.



Solution-Oriented Approach

Therapy Brands Billing Management Process

The figure above illustrates the RCM process implemented by several practice management agencies powered by Therapy Brands. Every step of the RCM workflow is instrumental and designed to support behavioral health agencies increase or maintain key performance indicators (KPI), including accurate and prompt submission of medical claims, as well as reimbursement of services.

Build Relationships Through Transparency

Revenue cycle management (RCM) and key performance indicators (KPI) software foster a collaborative and transparent agency environment where employees and patients feel informed and humanized during discussions regarding benefit coverage and consumer costs. An environment where ABA providers focus on meeting patient needs by providing quality services under a sound foundational structure. A structure designed to pre-emptively avoid barriers that are notorious for contributing to denied claims, elongated credential and enrollment obligations, and avoidable revenue loss.

Leverage Internal Departments

Many of these challenges can be overcome by refining internal guides and training initiatives, creating specialized departments within the organization to lead a project geared toward updating and streamlining the RCM process, or outsourcing to a reputable agency knowledgeable in technology advancements and automated solutions to undertake the task of end-to-end revenue cycle management (Stall, 2021). Fortunately for ABA providers, the vision of solutions geared toward business sustainability and customer-focused, compassionate care has arrived.

Revenue Cycle Management & Key Performance Indicators

National Rural Health Resource Center defines RCM as, "all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue," (NRHRC, 2021). RCM begins from the moment an appointment is scheduled and ends when all claims have been paid. The basis of RCM is a combination of the management of funder contracts, customer service, and compliance with healthcare guidelines and regulations (NRHRC, 2021).

Revenue Cycle Key Performance Indicators

What are key performance indicators?

Key performance indicators are financial measurements designed to evaluate the performance of revenue cycle management (Stall, Therapy Brands, 2021). Practitioners in the behavioral health industry are enthusiastic about data collection; particularly, behavior analysts. One of the most interesting aspects of behavior modification and data analysis is that ABA practitioners can creatively derive many foundational principles of behavior analysis and apply them to many distinct aspects of life. The below lists provide a high-level overview of the assessment, implementation, and maintenance of treatment goals in ABA:

- Evaluation of current levels to assess baseline
- Implementation of specific strategies outlined to mitigate deficits
- Analysis of data to find potential trends or patterns
- Frequent monitoring and reevaluation of data to promote data-informed decision making
- Repeat this process until optimal levels are reached.

Comparably, the same foundational steps to identify 'target behaviors' when working with children with autism, can also be applied to aiding with naming key performance indicators, especially in terms of the individual financial needs across various agencies.

Using Behavior Analysis Tools for Denial Data

Utilizing a similar behavior analytic method as reviewed above could benefit an ABA agency by supplying unambiguous data to evaluate before deciding which KPIs metrics will be most valuable to track for their organization. Revenue cycle management procedures (RCM) combined with key performance indicators (KPIs) pinpoint specific financial measurements. When used consistently, these tools are invaluable to support the ability of an ABA organization to remain open and operational (Stall, 2021).

Examples of RCM KPI identified for behavioral health agencies:

- Cash as a % of the net revenue equaling 95% or higher
- Accounts receivable over 90 days old equaling 20% or less of total AR
- Cost to collect which includes all functions related to RCM equaling 10% or less
- Billing Accuracy by sending clean claims at a rate of 98% or higher

KPIs Maintenance

Once the best levels are reached, KPI's and Fidelity checkless are great measurement tools to ensure these levels are maintained across time. A Fidelity checklist paired with KPIs creates a secondary method of assessing the continued effectiveness and performance maintenance of the key indicators. Implementing such tools aids with promoting consistency of peak performance levels.

RCM KPI Challenges for Behavioral Health Providers

Precise and prompt management of an organization's RCM KPI is crucial in terms of achieving and sustaining maximized revenue performance while reducing the future probability of mistakes that could result in financial losses. In terms of naming the gold star RCM KPI, this most likely is not feasible, as there does not appear to be just one measurement that will provide an all-encompassing snapshot of the RCM's current performance (Stall, 2021). Although, there is a combination of RCM KPI which appears to be effective when implemented concurrently. Stall (2021) suggests the following RCM KPI measurements aid in tracking the performance and progress across the RCM include:

- **Accurate reimbursements** are essential, as well as promptly filing appeals for mistakes made by the payers to recoup funds in a timelier fashion and reduce the risk of missing the deadline to file for an appeal.

- **Create a system for tracking denials** and analyzing trends. This information can then be used to develop guidelines for how to avoid activities that lead to denied claims.

- **Know the precursors to RCM performance descent** and proactivity plan for such an occurrence to mitigate any significant impact on the organization.

- **Cash acceleration** is another beneficial activity that can increase RCM KPI. This process consists of "resolving older claims before missing filing and appeals deadlines from payers (Stall 2021)." When conducting this process, providers can also make note of any trends so more appeals can be filed to maximize reimbursement efforts.

- **Evaluate and analyze KPIs** often to promote optimal RCM performance.

Denial Avoidance vs. Denial Management

It is important to schedule recurring tasks to ensure the RCM KPI data is analyzed at least once per month; however, once per week is recommended (Stall, 2021). Frequent monitoring assists with proactively identifying precursors and making timely modifications to divert potential loss of revenue. The overall goal is not to have denials to manage. In LaPointe's 2016 online article "How to Access Revenue with Improved Claims Denial Management", she shared the following:

> *A 2014 Advisory Board study showed that 90 percent of claim denials are preventable. Some of the most common claim denial reasons can be rectified by correcting claims management workflows, including claims submission and patient registration procedures. (LaPointe, 2016)*

Stall (2021) refers to this process as 'Denial Avoidance' in comparison to 'Denial Management'. ABA providers who successfully define, find, track and report denials across a multitude of various aspects will most likely be a valuable resource for analyzing process breakdowns and creating proactive solutions for performance improvement (NRHRC, 2021).

RCM Terms to Know

Whether an ABA agency decides to create an internal RCM KPI team to handle all the front-end and back-end administrative tasks or chooses to outsource the tasks to a reputable practice management agency, one thing is certain and that is the ABA practitioners need to stay up to date on the different GWYN revenue cycle management terms (link RCM glossary here), local and state policies, as well as payer guidelines. The chart below defines some of the important terms used commonly when working within a healthcare agency.

- **Copay:** The set amount a member will pay at the time of service.
- **Deductible:** The amount a member will pay before insurance begins reimbursing services.
- **Coinsurance:** The percentage of the remaining charge the client will pay after meeting their deductible.
- **Out of Pocket:** The maximum amount a client will pay during the policy.
- **Contractual Obligation:** The difference between what you charge and the allowed contract amount.
- **CARC Codes:** Claim adjustment reason codes which explain what factors caused the payor not to pay the contract did amount.
- **CPT/HCPCS Codes:** Claim adjustment reason codes explain what factors caused the payor not to pay the contract did amount.
- **Taxonomy Code:** A 10-character code that designates the providers or facility classification and specialization.

Rapport and Customer Service Impacts Future Revenue

As explained by the National Rural Health Resource Center, superior customer service along with creating a welcoming patient experience has become an essential part of running a successful healthcare agency. Being transparent and providing as much information upfront about the services, costs, and benefits of their health insurance builds trust and patient-provider loyalty. Patients know they have more options today in terms of insurance coverage.

More Insurance Options Could Impact Revenue

More families appear to be turning to independent policies and the marketplace (NRHRC, 2021). With this new age of insurance upon us, it is critical leaders for healthcare agencies to take the time to train their employees to ask the right questions and adequately describe assorted services and benefits to help ensure there will not be any misunderstanding of costs when the first invoice is received, which could jeopardize the patient-provider relationship almost instantly.

Determining Eligibility

Predictive Strategy When Identifying Trends

Understanding the trends in denials provides the opportunity for ABA practitioners to gather all the correct information and ask the right questions at the start of the RCM process. Many claim denials can be preventable, as indicated by the 2014 Advisory Board study, (LaPointe, 2016). Furthermore, the 2013 MGMA health insurance report card said the number one reason for claim denial was due to missing information, which included absent or incorrect patient demographics and technical errors. Subsequently, MGMA cited duplicate claim submission and services not covered as other reasons claims were denied.

Why is Eligibility Critical?

Determining eligibility is critical prior to the service being rendered. About 8% of claims are denied due to eligibility problems. Yet, researchers reported that only 79% of providers are assessing whether the patient is eligible prior to being seen by the provider (LaPointe, 2016). Since missing information and eligibility determination appears to be the biggest issue with claim denials, Stall (2021) has supplied some example questions to ask during the phone calls made to payers when assessing eligibility:

Eligibility Questions (Stall, 2021):

- Does your health plan have benefits for outpatient mental health in an office setting?
- Are you in-network with the member's plan?
- Does your health plan need pre-authorization? Does the policyholder plan cover your specialty through EAP (Employee Assistance Program)?
- Are there exclusions to the policy or maximum benefits?
- Are there authorization limits on the member's health plan?

Summary

ABA providers who choose to take the next step and join the community of providers already benefiting from RCM KPI and performance management software will provide an overwhelming sense of financial security. Open the door to quality support and welcome a billing specialist in today. Partnering with a billing specialist provides a sense of security and confidence knowing the most important part of the business is in the hands of experts, who support the services provided and want to see you succeed.

Therapy Brands is who to call when needing a reliable, trustworthy company to help you grow and sustain your business for years to come. Therapy Brands offers an assortment of quality Practice Management Software (PMS) options for a variety of health care providers. The image below demonstrates the assorted products and how the products can be individualized and tailored to your company's specific needs.

Whether your practice needs help with billing, revenue cycle management, scheduling, authorization management, payroll integrations, ABA data collection, staff supervision solutions, document storage, parent portals, telehealth options, SOAP note templates, or HR software, Therapy Brands have you covered! (Therapy Brands, accessed January 2022).

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