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A Product Suite Automates Key Revenue Cycle Functions

*DaVincian Technologies, Inc. Approach Eliminates Denials,
Improves Financial Outcomes and Strengthens Patient
Relations.*

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Executive Summary

Findings

- Of the 15 billion claims submitted last year in the United States anywhere from 25 to 40 percent are rejected or denied, according to several studies.
- Managed care suffers a 12 percent denial rate. Fifty percent of claims are never followed up, even though 67 percent of the claims are recoverable.
- A small hospital can lose as much as \$3.3 million a year on claims' denials.

DaVincian Applications

- **R-TIME Revenue Orchestrator™**, a suite of three modules available for purchase separately, offer revolutionary revenue cycle management controls and oversights.
- Collectively, the products help hospitals stop potential hard denials from occurring – denials that cannot be resubmitted and which represent as much as two percent a provider's revenue.
- The products also eliminate soft denials from occurring, denials that can be recovered by reworking and resubmitting claims to insurers.
- The modules are *Guardian™*, *Discovery™* and *Challenger™*.

Guardian™

- The primary application, *Guardian™*, prevents denials and underpayments by continuously monitoring key registration data for problems before the service is provided to the patient.
- *Guardian™* distributes work based on missing or incorrect data to the right staff while continuously monitoring the work for timely completion and escalating tasks to a manager if not completed in a timeframe set by the organization.

- The application tracks contract management rules for different insurers, triggering workflows based on absent data while informing revenue staff what insurers require for error free submissions.
- *Guardian™* also serves as a customer relationship management tool which helps hospital staff to communicate with customers, prior to treatment, about how much their insurer will cover and the amount that will be their responsibility.

Discovery/Challenger

- *Discovery™* is a configurable repository where powerful analytics are applied to all of a provider's billing and payment information, to create knowledge from data. By constantly monitoring claims for delays, denial codes and remarks in receivables data, *Discovery™* offers up-to-the-minute claims inventory status.
- *Discovery™* can be used to automatically infer knowledge from a payer's payment history to automatically configure the rules that *Guardian™* uses for denials prevention.
- *Challenger™* expands upon *Discovery™* to provide a rules-based follow up and collections tool that increases productivity by automating and monitoring the management of denied claims.
- *Challenger™* identifies how appeals were handled in the past to determine the best strategy for an appeal to achieve the best results. It guides staff with a step-by-step workflow for following up on appeals and denials.

A Product Suite Automates Key Revenue Cycle Functions in Healthcare

DaVincian Technologies, Inc. Approach Eliminates Denials, Improves Financial Outcomes and Strengthens Patient Relations

Introduction

One of the major challenges in the health care industry is managing the complexity of third party billing with systems and tools that in most cases are over 20 years old and originally developed in an era before managed care and payer cost containment. Each insurer seems to have its own rules on how to report and bill for a procedure or visit. Every year hospitals lose millions of dollars by failing to comply with these rules, money that could be spent to improve profitability, productivity and for investment in more effective technology.

The opportunity for mistakes is frequent and bountiful. Of the 15 billion claims submitted last year in the United States anywhere from 25 to 40 percent were rejected or denied, according to several studies. Tragically, half of claims are never followed up, even though 67 percent of the claims are found to be recoverable. A small hospital can lose as much as \$3.3 million a year on claims' denials.

One reason for such a high percentage of inaccurate claims is the lack of investment by hospitals in more sophisticated Revenue Cycle applications. Many hospitals still use registration and billing systems that were designed more than 20 years ago. These patient financial systems rely extensively on time-consuming, manual processes for data collection, analysis and resubmission involving the challenge of denials.

Adding to this dated methodology has been “best practices” approaches often combined with specialized tools and services which, despite being well-intended, have dramatically failed to reduce claims’ denials to any measurable degree, as the aforementioned data reveals. Best practice guidelines are often deployed for several months before being filed away as problems expand and change.

Smart health care providers, however, have turned to revenue cycle management software offering operations reporting, payment and remittance reporting, financial and claims denial management. DaVincian Technology, Inc., based in Austin, Texas, is a relative newcomer in the revenue cycle management field. Yet the technology comes out of a successful revenue cycle management project at Kaiser Permanente managed by DaVincian founder, president and CEO Albert Scarasso.

The company offers a revolutionary web-based three module application suite – called R-TIME Revenue Orchestrator™ –that automates claims reporting, and uses a rules based approach with real-time monitors to replace eyeballs and data mining software to spot problems in both claims and pending services, effectively creating a sophisticated and automated framework to challenge and prevent denials.

Most notable is the fact that DaVincian’s ability to edit pre-service compliance data can be integrated with existing registration and scheduling systems to validate insurance coverage and medical necessity, ensure the completion of all required authorizations, and provide the basis for a discussion related to a patient’s financial responsibility.

A technology such as DaVincian has developed will be required as health savings accounts grow in popularity and deductibles grow beyond the nominal payments of years past. Consumers are pressuring providers now to offer

information on how much they will pay when they contract for services, not after those services are delivered. DaVincian's suite offers that data, as well as an ongoing scorecard of a client's claim repayments, denials and status of claims.

The purpose of this white paper is to address each of DaVincian's products in greater detail, from how they operate within the revenue cycle to how they can work for your financial division. The paper will address how the application suite "infers knowledge" on claims to prevent their rejection or denial. By detecting and solving claims' issues before they reach insurers DaVincian saves clients from lost or delayed revenue. If those same claims are rejected, the same software suite provides the kind of information to turn denials into acceptances.

Within as little as 90 days, DaVincian customers see the results of fewer denials and greater recovery of problematic claims.

The R-TIME Revenue Orchestrator™

DaVincian's suite is called **R-TIME Revenue Orchestrator™**. As a whole, it offers a set of tools to automate the revenue management process across the enterprise. The application suite's three modules – *Guardian™*, *Challenger™* and *Discovery™* -- offer a real time window into the entire revenue stream, from what has been submitted to what has been paid, from what has yet to be submitted to what has been rejected.

By breaking down the complex workflow in health care into a set of dependent interactions, **The R-TIME Orchestrator™** allows each interaction – including each claim – to be easily managed, tracked and completed. Moreover, events within the claims' process trigger the software to make changes on the fly without human intervention.

The key to **The Revenue Orchestrator™**'s success has been its ability to incorporate data from different sources and legacy systems, to test data with knowledge stored by the system and to quickly create workflows along with tasks pulled into work lists distributed by skill or role. DaVincian deploys a building block approach to workflow that requires no programming. These building blocks can be quickly assembled and deployed to adapt to a client's unique environment without the need for costly programming support.

Clients are not required to buy every application in the suite. Some clients purchase only *Guardian™*, for example, before making a decision on whether to purchase additional products. With interoperability a key, the DaVincian software solutions work with other revenue management solutions and all legacy registration and billing systems.

Guardian™

One approach to revenue cycle management features preventing problems before they emerge. An enormous amount of paperwork, time and headaches can be avoided by submitting accurate bills that have been vetted against current payer policies and requirements. Catching problematic claims before they reach insurers should be the goal of every health care provider.

One of the application suite's modules, ***Guardian™***, serves two important functions. The software's primary duty is to prevent denials and underpayments, by continuously monitoring key registration data for problems before the service is provided to the patient. A secondary attribute of *Guardian™* is as a customer relationship management tool which helps hospital staff and health care customers understand, prior to treatment, how much insurers will cover and how much they will pay.

Denials are a major issue for many health care organizations. The lack of insurance coverage or a failure to obtain an authorization from a payer can result in a “Hard Denial” that cannot be recovered via an appeal. Studies show hard denials put as much as two percent of a provider’s revenue at risk of no reimbursement. Other types of errors, such as incorrect demographic data can result in a “Soft Denial” or a claim that needs to be reworked and resubmitted for payment. In addition to delayed cash flow avoiding soft denials can save anywhere from \$8 to \$28 dollars per claim.

Guardian™, which can operate in conjunction with legacy registration and scheduling systems, achieves results by applying pre-set rules and lessons to registration data before the service is provided. The application analyzes service data from booking processes and legacy registration systems to insure collection of appropriate pre-registration and registration information. **Guardian™** rules identify missing information or status conditions that could result in denials.

Just as importantly, **Guardian™** distributes work based on missing data to the right staff while continuously monitoring the work for timely completion and escalating tasks to a manager if not completed within a timeframe set by the organization. If insurance eligibility is not verified for a patient the software sends a notice containing specific edit details, a problem description and steps for remediation automatically in real-time to the registrar for immediate corrective action or to the appropriate staff member for a follow up.

The application tracks contract management rules for different insurers, triggering workflows based on absent data while informing revenue staff what insurers require for submissions

For example, **Guardian™’s** rules can determine if a claim is about to be sent to the wrong payer .By testing registration information against eligibility responses

from a payer, **Guardian™** alerts the user that the payer plan assigned on the registration does not match the insurance type on file with the payer.

Without **Guardian™**, this type of error results in misdirected claim submissions, inaccurate contractual estimates, and non-payment of the claim. With **Guardian™**, however, the problem is averted, and the correction is made before billing. Based on the organization's preferences, the system can even be set up to make the correction itself, without user involvement

For years health care critics and advocates have lobbied for a more transparent system that allows consumers to know prior to care the cost of treatment and the portion they will likely pay. As described, **Guardian™** helps health care organizations achieve this elusive goal by reviewing patients' coverage – gathered from rules provided by insurers – before treatments and services occur. This allows consumers to budget for health care and creates a much better relationship between them and hospitals and doctors.

Discovery™/Challenger™

Discovery™ is a configurable repository where powerful analytics are applied to all of a provider's billing and payment information, to create knowledge from data. **Discovery™** allows an organization to quantify payment and denial trends by payer, service area or any other parameter available to provide a high level view of where problems emerge. By constantly monitoring claims for delays, denial codes and remarks in receivables data, **Discovery™** offers up-to-the-minute claims inventory status.

Through configurable dashboards that can be established to meet the needs of managers or executives, the software provides drill-down capabilities showing a view of specific account detail with just a mouse click. The application is often used in conjunction with **Guardian™** to identify problem areas for early phases of a deployment strategy that targets high dollar value problems.

In addition, **Discovery™** can be used to automatically infer knowledge from a payer's payment history to automatically configure **Guardian™**'s rules to prevent specific problems from recurring. For example, if a payer starts denying a procedure for a lack of an authorization where one had not been required before, an alert can be generated that not only identifies a new authorization denial, but also asks if the user would like to deploy a new **Guardian™** rule that monitors those transactions in the future.

Challenger™ expands upon **Discovery™** to provide a rules-based follow up and collections tool that increases productivity by automating and monitoring the management of denied claims, by directing staff in the appropriate steps for appealing a claim and by the tracking of appeals, and recoveries.

Challenger™ has several unique features. One is identifying how appeals were handled in the past to determine the best strategy for an appeal that will achieve the best results. Through advanced automation, **Challenger™** monitors progress, escalates tasks and distributes workloads to appropriate staff members within and across departments. Repetitive tasks are automated, such as the routing of requests for additional documentation.

Beyond workload distribution, **Challenger™** even guides staff with a step-by-step workflow for following up on appeals and denials. By automating tasks and directing staff to the best process for correcting claims, filing appeals and identifying underpayments, **Challenger™** increases business office efficiency while enhancing collaboration among internal departments and providers.

Finally, **Challenger™** allows users to set threshold parameters that, when met, trigger automated alerts. When a denial amount is reached in a category, a message is sent to a designated person, who can then take action to avoid further problems or ameliorate those in the pipeline.

Conclusion

Outside of offering stellar care to patients, health care providers have an important secondary role: Self preservation. A well operated provider will earn more money; have greater expansion opportunities, higher salaries and stay in business longer than clients and hospitals that do not pay attention to the bottom line.

With the increasing complexity of third party reimbursement and the parallel advent of consumer driven healthcare, automating the revenue management side of the business is an important consideration. Managing the revenue in this environment with outdated legacy systems will result in lost revenue.

The **DaVincian R-TIME Orchestrator™** offers a rare application suite allowing for an integrated automation of all the important revenue cycle functions, from prevention of denials at the source to identifying, managing and enabling appeals. The result will be greatly improved cash flow and business office productivity through automation and a more solid bottom line that captures as much revenue as possible from insurers and patients.

(To schedule a sales call or demonstration with DaVincian Technologies, Inc. please call Anthony Scibelli, Vice President of Business Development, at 518-885-9813; by email at ascibelli@davinciantech.com.

For more information about the company go to www.davinciantech.com.