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MEASURING RETURN ON INVESTMENT UTILIZING A MEDICAL BANKING IOS

A Value-Driven Working Guide For Banks and Medical Providers

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Executive Summary

This document will guide the business office staff in developing a cost-benefit analysis utilizing a “medical banking inter-organizational system” (MBIOS). MBIOS is a management model that integrates banking technology with patient accounting operations. This guide will help both the banker and medical provider to uncover new value. A brief historical narrative is provided for the senior management team, followed by a series of value discussions and Worksheets that will aid in developing ROI assessments.

The Opportunity

Medical providers are positioned to reap significant and sustainable operating cost reductions through imaging and EDI implementation in medical remittance processing. A good place to understand the value of this approach is Medicare.

In 1992, HCFA (now CMS) required FIs to supply electronic remittances (i.e., “835s”) to requesting medical providers. Many providers reacted by “operationalizing” the 835 via automation of manual and error-intensive patient accounting tasks. The reduction in operating costs was substantial yet today, 60% of the typical provider’s revenues are still largely paper-based (i.e., EOB/P or statement; see Exhibit 1). At least two critical path areas must be addressed to accomplish 100% automation:

- Aggregating all remittances into a single digital file for easy and highly efficient posting and downstream processing
- Re-engineering point solutions to process this digital stream and to extract increasing operational value based on internal strategy

The Medical Banking Project

The Medical Banking Project is policy research and strategic advisory firm that advocates a critical role for banks to transform healthcare. The firm has over 177 members and has transformed to a member-driven organization that attempts to facilitate new “medical banking” models in order to mitigate redundant paper processes in healthcare, and to rationalize costs in other areas. The mission of MBProject is “to convert digital savings into charitable resources”. MBProject focuses on three areas currently: (1) educating banking and healthcare constituencies about the opportunity to transform healthcare using banking systems; (2) implementing a medical banking platform that can serve as reference architecture for policy, commerce and academia; (3) deploying a bank-driven platform into the community safety net to promote better community healthcare.

MBProject has a long history in healthcare remittance management and advocates an end-to-end, HIPAA-compliant, architecture for remittance processing leveraging banking solutions. Our work was conceived prior to HIPAA – the medical industry’s new series of privacy, transaction and security rules. In fact, we have been researching this area since 1992, driven by the simple fact that when medical remittance processing is done correctly, it yields permanent reductions in day-to-day operating costs.

Exhibit 1: Major Financial Classes of Medical Providers
(light gray = mostly paper-based processing)

Financial Class	% of Gross Revenues
Medicare	40%
Medicaid	10%
Commercial (including HMOs, worker’s comp, etc.)	40%
Self-Pay (patient-owed balances)	10%

Quick Assessment

If Medicare “turned off” its Electronic Remittance Advice process, how would this impact A/R days? How many new FTEs would be required? Would secondary billing be impacted? How about the timeliness of processing rejections? (See Exhibit 2 for Medicare Case Study.)

Because 40% of the average provider’s cash flow comes from Medicare, the impact of automating remittances in 1992 was substantial. Today, we have the ability to duplicate this benefit by automating the remainder of the provider’s remittance volume.

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Exhibit 2: Medicare's 835 – A Case Study

Pre-1992 Business Process	Post-1992 Electronic Business Process	Relevant Industry Facts
Funds were delivered to the provider mostly utilizing ACH	No change; funds delivered in the same manner	
The Remittance Advice (RA) corresponding to the funds was sent via US Postal mails to the provider.	Medicare makes a new application called "PC Print" available to healthcare providers who wish to pick-up the remittance electronically. Most institutional providers quickly implement the technology. Essentially, this moved the expense for printing EOBs from Medicare FI to the provider.	The federal government mandates that "fiscal intermediaries" (i.e. firms that administer Medicare funds) make an "Electronic Remittance Advice" (ERA) available to medical providers. The federal government encourages the growth of ERA technology by creating incentives for providers to receive their Medicare funds faster when they pick up the ERA via electronic means.
The Medical Provider's business office staff manually keyed each remittance into the hospital's patient accounting system.	A new breed of "bolt-on" vendors create specialized applications that emulate "keystrokes". The applications automatically post the ERA to the provider's system. In addition, the applications automate a series of processes that can only occur based on the information in the ERA.	
The Medical Provider's accounting staff manually process contractual allowance debits and credits. This may take a period of days (in some cases, weeks) after receipt of the large remittance file before completion.	The "bolt-on" applications automated contractual allowance processing immediately upon receipt of the ERA. Within minutes the process is completed.	This account, which becomes the subject of increased interest due to fraud and abuse regulations, is based on the provider's negotiated fee schedule with Medicare. Reducing errors becomes a corporate governance issue. Automated processing reduces error rate.
The Medical Provider's staff manually key in rejection notes so that staff can take steps to follow-up on charges rejected by Medicare (i.e., appeals to Medicare; adding non-reimbursed charges to the patient's bill; etc.) Again, the process takes days to complete.	The "bolt-on" application automated reject note posting immediately upon receipt of the ERA. Staff can now immediately takes steps to resolve problem accounts.	
The Medical Provider's staff manually moved the remaining liability on an account (i.e., the portion of the claim owed by a secondary insurer), to another "Payor Class" in the patient accounting system. This restarts the aging process.	The application automated "financial class updates" immediately upon receipt of the ERA. Much better picture of the provider's cash position.	
The Medical Provider's staff, when a secondary insurance was indicated, would make a copy of the paper remittance (blacking out all non-relevant information), correlate the remittance with the original bill, and send both via mails to the USPS.	The application automated "secondary or supplemental billing". What took many providers months to perform, now takes place within hours.	

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The Remittance Management Life Cycle

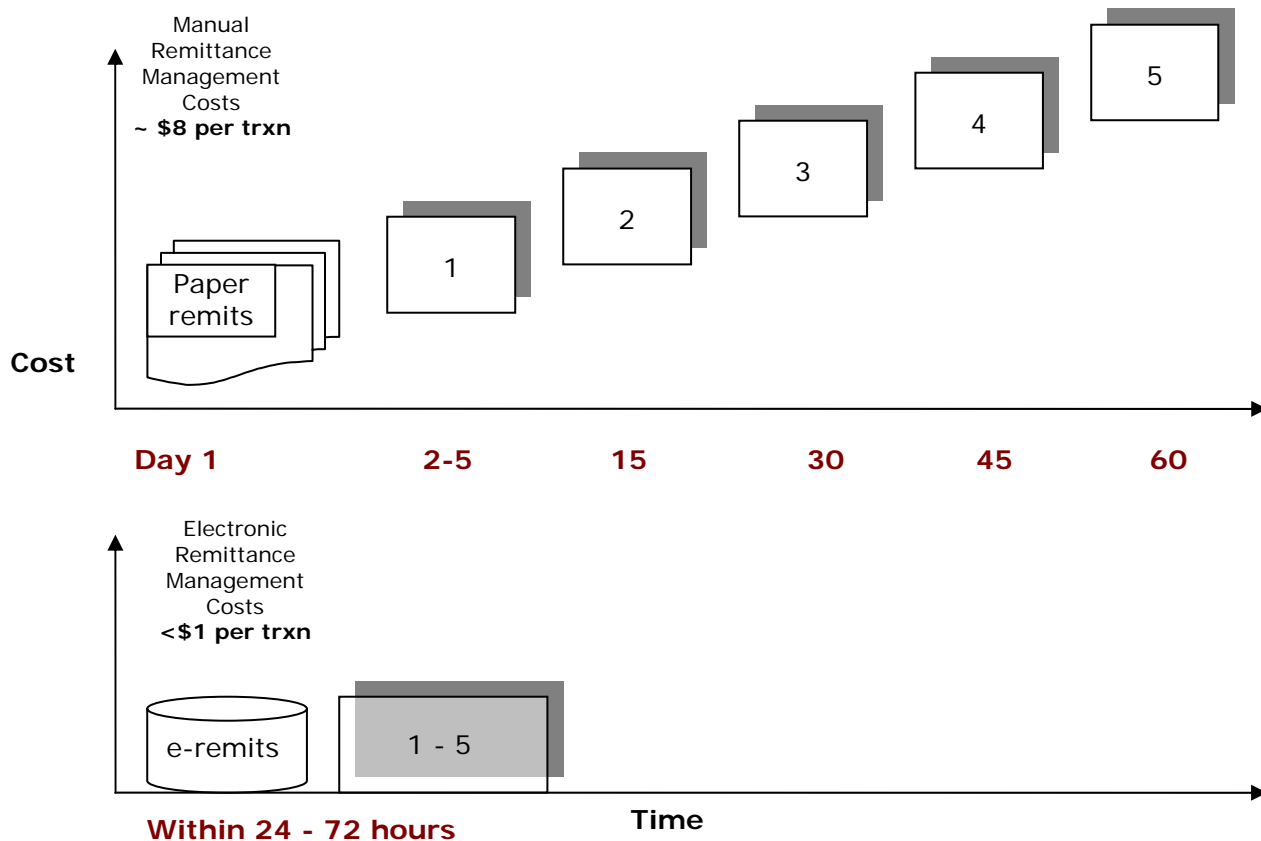
While there are a number of revenue cycle practice areas that are vital prior to receipt of a remittance, the focus of a “medical banking inter-organizational system” (aka MBIOS) is on business office processes *after receipt of a remittance* – the remittance management life cycle.

According to one hospital association, 70% of the costs incurred by the business office occur after the remittance is received. This is because the remittance provides a road map for the business office for further work on claims that are paid inaccurately (under-paid, over paid or not paid at all).

The areas of practice/expense after cash posting of a remittance may be classified as follows:

1. Contractual Allowance Processing
2. Reject Note Posting
3. Financial Class Updates
4. Secondary Billing
5. Patient Statement Billing

Exhibit 3: Remittance Management Cycle



Note the difference in time (and corresponding costs) when these functions are done automatically. The next few worksheets will help to determine how a provider’s organization can benefit from automated remittance processing systems using a bank lockbox to aid the process.

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Worksheet 1: DIRECT COSTS - LABOR

1. What is the daily number of remittances processed by your business office staff?

(NOTE: Please further refine this number to include cash posting *only* versus "full posting". Full posting refers to using the paper EOB to post cash, contractual allowances, reject notes and, if required by your HIS version, to move the account to a new financial class (i.e., self-pay or secondary insurer).

a. **Cash Posting Only** _____

b. **Full Cash Posting** _____

2. How many FTEs (full time equivalents) are responsible for cash posting? _____

Calculation >>>

2.1 Divide item 2 by 1b = _____ number of daily full cash postings processed per FTE.

2.2 Next, divide item 2.1 above by 8: _____ full cash postings per FTE per hour.

3. What is your manual error rate for full cash posting? _____ in 10 full cash postings

(NOTE: The cost for manual errors in full cash posting is hard to estimate. The number includes the time required for researching blatant errors (i.e., posting payments to the wrong account) and many other errors (i.e., the expenses incurred in dispute resolution with an insurer only to find that the contractual amounts were inaccurately posted. A good rule of thumb is that manual errors increase costs by a minimum of 10%. A conservative factor is 1 in 10 cash postings are associated with some kind of manual/clerical error).

Calculation >>>

3.1 Divide item 2.2 above by 10 and enter here: _____

3.2 Subtract the result in 3.1 from the result in 2.2 to arrive at the *Adjusted Remittances Posted Per FTE per hour*. Enter that number here: _____

4. What is your average annual cost for one cash posting position? \$_____

(NOTE: Please use a fully loaded cost, including LIBOR and/or special costs at your institution or practice.)

5. What is your average annual cost for maintaining one cash posting position? \$_____

(NOTE: What are the costs for office space, supplies, etc., as well as prorating management costs? This is dependent on location, however, a good rule of thumb is a minimum of \$6,000 per FTE.)

Calculation >>>

5.1 Add items 4 and 5 to arrive at the average annual cost per FTE: _____

5.2 Divide item 5.1 by 2080 to arrive at cost per FTE per hour: _____

5.3 Divide items 5.2 by 3.2: _____ *Labor Cost Per Full Cash Posting*

The Power of the Medical Remittance

The MBIOS model supports high quality remittance file creation and operationalization of the file for the provider. This involves four layers of increasing value:

EOB Conversion/Data Perfection

A properly configured electronic file is often difficult to create based on EOB data alone. That is why the bank implements a series of business processes, including 835 validation (for each 835 in system), comparison with the original claim, a series of recognition engines and semi-automatic key entry routines that minimize exceptions. Each line item on the EOB is typically subjected to this process. Ideally EOBs that are the most difficult to perfect will take a maximum of 10 minutes to create.

Automating Workflows

Even with a properly configured file, cash posting must be responsive to the policies and procedures uniquely adopted by the provider’s office. These policies are often sensitive to government regulations as well (i.e., fraud and abuse, Medicare policies, etc). By integrating banking technology with existing tools that are already widely deployed in the industry, banks can adapt to diverse legacy systems and streamline the workflows depicted in Exhibit 3.

In addition to cash posting, banks are beginning to implement technologies to more efficiently automate denial management, COB processing/secondary billing and statement fulfillment. Imagine structuring workflow queues so that accounts are automatically aggregated by FTE, literally minutes after being scanned through a lockbox. Another area of focus in medical banking is strategic capital sourcing, giving providers the option to advance funds on an ongoing or ad hoc basis. In many scenarios, banking technology will augment and not replace existing point solutions (i.e., cash posting). Typically services are accessible via secure Internet-portals.

Exhibit 4: Benefits of Medical Banking

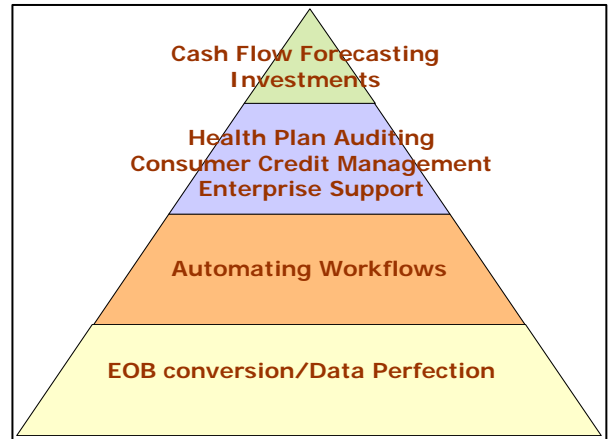


Exhibit 5: Partial Overview of Data Elements That Increase File Value

Financial Class	Data Requirements for Cash Posting & Subsequent Automation of Workflow	Likely source for required data elements
Commercial Payers (i.e., Aetna, Cigna, Travelers, etc.)	Utilize regular and situational data elements in 835 based on provider’s business rules	The original medical claim
HMOs	Standard 835 likely satisfactory most of the time	Paper EOB flowing through lockbox
Self-Pay	Very similar to non-medical invoices; Cash posting for self-pay is the least complex of all medical remittances	Paper EOB flowing through the lockbox
Workers Compensation	Utilize many situational data elements in the 835 standard based on the provider’s internal business rules	The original medical claim (and attachment image in some cases)

Advanced Value Paradigms

As banks help providers to operationalize up to 100% of remittance volumes, other programs become possible. This includes real time reimbursement auditing, specialized consumer credit management programs and enterprise support systems (i.e., financial modeling of existing or prospective clinical modalities).

The bottom line is better cash flow. Some banking systems will integrate new capital programs that providers can use in ways to tackle problem cash flow cycles. The platforms will integrate with numerous funding resources (“funding” means A/R securitization, financing or factoring.)

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Worksheet 2: OPPORTUNITY COSTS FROM TIMELY POSTING

This worksheet will help you to assess the costs you incur by not using a fully automated cash posting system. The primary assumptions are: (1) You will post all available remittances for which your bank account has been credited within 24 hours after you receive them; and (2) Your exceptions for paper and electronic remittances will approximate less than 1% using the bank's data perfection technology.

1. How many paper remittances do you receive (not post) daily? _____

(Note: For this purpose, a remittance is equivalent to one patient payment for one specific care episode as delineated by dates of service).

2. Enter the number of paper remittances that you post daily: * _____

(*Note: Please multiply item 3.2 from Worksheet 1 by 8 to estimate daily count.)

Calculation >>>

2.1 Enter the difference between items 1 and 2 above: _____ *Non-applied and/or inaccurately applied daily paper remittances*

3. How many electronic remittances are you receiving from payers today? _____ Daily

(Note: If you are processing Medicare, Blue Cross or other payers today, enter volume here. To get an average daily count, divide the total monthly electronic remittance volume by 22).

4. Of these, what % are you able to process per day? _____% of "full cash posting"

(Note: If you are having trouble with file data, transmission drops, reject note problems, etc., the amount posted should be adjusted. For example, a number of providers indicate that The 835 is unable to accommodate all of the payer's adjustment codes. Have you developed an adequate cross-table to address this issue? Based on the collective experience of providers, we suggest a ratio of $\leq 70\%$ for full cash posting of all-payor ERAs; 90%+ for Medicare.)

Calculation >>>

4.1 Multiply items 3 and 4: _____ *Electronic Full Cash Posting Count Per Day*

4.2 Subtract item 4.1 from item 3: _____ *Non-applied and/or inaccurately applied daily electronic remittances*

5. Please enter the amount of one Net A/R Day at your organization: \$ _____

(Note: Please make sure this is equivalent to one net A/R day.)

Calculation >>>

5.1 Add items 2 and 4.1 above: _____ *Daily Adjusted/Applied Remittance Count*

5.2 Divide One (1) Net A/R day by the result in 5.1: _____ *Average Dollars per Daily Adjusted/Applied Remittance Count*

5.3 Add items 2.1 and 4.2, and then multiply the sum by 5.2: \$ _____

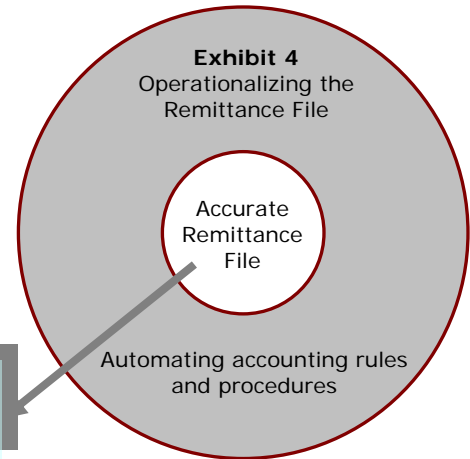
5.4 Multiply item 5.3 by X% to obtain opportunity cost based on cost of money: \$ _____ (Note: Use an acceptable interest rate to calculate the *Annual Opportunity Costs of Non-applied and/or inaccurately applied daily remittances.*)

Operationalizing the Remittance

Will providers constantly assume a defensive posture in response to administrative changes spurred by HIPAA? Or is it possible that the provider can take control of HIPAA's push towards "electronification" as the industry transforms from paper to digital processing? The bank positions providers to do just this, by optimizing the value that can be extracted from the EOB.

Providers can use banking solutions to transform their cost structure utilizing smarter remittance management tools and processes. Some have determined that, as a result of HIPAA's push towards digital processing, there will no longer be a need for paper EOB processing through the lockbox. There are at least three critical path issues that contradict this argument:

Distributing images to accelerate denial management



- (1) Issuing an electronic remittance advice (an "eEOB") for many health plans is still difficult. Many still require more time to create a usable file.
- (2) While some of the largest health plans can originate an 835, these files are variable enough from plan to plan to warrant manipulation prior to integration within the patient accounting system.
- (3) The provider needs to aggregate as many commercial remittances as possible to achieve the same kind of ROI relative to government remittances. Because the lockbox gathers all paper remittances flowing into the hospital, it provides the necessary ROI.

Imaging is Vital for Easing Transition to Digital Processing

Even when payers achieve 100% compliance with the HIPAA-mandated Implementation Guide, the provider's internal application will need to be able to intelligently sort through the 835 variations to transfer the inherent value of automation. As a result, even where the second critical path area mentioned above is surmountable (i.e., providers with well-financed IT areas), a transitional technology needs to be in place.

An image-enabled lockbox service can be a central driver for optimizing business office productivity. Images are routed through intelligent character recognition engines that digitize EOB data. This digital stream allows the provider to duplicate the tremendous cost efficiencies that they currently enjoy from Medicare electronic remittances.

Operationalizing the EOB

Looking down the road, bank-driven denial management modules increase productivity by allowing managers to program "dynamic workflows". For example, each EOB is combined with the original claim, and then forwarded to the appropriate billing staff based on reject note codes or other variables (i.e., amount of claim) set-up by the patient account manager. All of this happens automatically, driven by imaging at the lockbox location.

Medical banking services can support a robust menu of denial management options that dramatically reduce EOB research, retrieval, appeals and other downstream workflow processes. More specialized workflows can be set-up as well. Collectively, these programs support a transitional strategy from paper to digital processing for the provider's office that is scalable from the solo practitioner to large institutions.

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Worksheet 3: PAYER IMPLEMENTATION COSTS

1. What are your initial internal costs to implement 835 protocols and/or programming for each payer, including payer meetings, parallel testing and other costs?

Cost Components	Time	Costs
IT Staff		
Patient Accounting Staff		
Management		
Software/Hardware/Licenses	n/a	
Other		
1.1 Total Implementation Costs		

2. Enter the average annual number of commercial payers you do business with: _____

Calculation >>>

- 2.1 Multiply items 2 and 1.1 to arrive at your internal cost to automate remittance management using HIPAA's 835s for all of your commercial payers: \$_____

3. What are your ongoing, annualized maintenance costs?

(Note: Payers often change systems or processes and this may affect the value on the 835. This represents an ongoing process across all payers. Resources need to be dedicated to maintain the quality of data and the connection infrastructure and protocols, as well as continuously gather relevant data from internal sources to ensure that the data being collected sufficiently operationalizes the 835 transaction.)

Cost Components	Time	Costs
IT Staff		
Patient Accounting Staff		
Management		
Software/Hardware/Licenses	n/a	
Other		
3.1 Total Maintenance Costs		

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Worksheet 4: IMAGING AND EOB WORKFLOW COSTS

1. How do you process your commercial EOBs today?

Ref.	Current practice	Relative cost	Approx. Industry Cost to handle each EOB*	Are you operationalizing e-remittances?
1	We do not use a lockbox. EOBs are filed manually after we process them in accounting area.	Highest	\$8+	No
2	We do not use a lockbox but we do image all EOBs and make this available via a single CD ROM to our staff	Higher	\$8+	No
3	We use a lockbox but only receive EOBs after the checks have been processed. They come to us in a filing box.	High	\$8+	No
4	We use a lockbox. They image EOBs for us and send us an end-of-day CD-ROM which is shared/copied by our staff.	Medium	\$6-8	Somewhat
5	We use a lockbox. They image EOBs for us and make these available on-line through the bank's imaging platform.	Medium to Low	\$4	Yes
6	We use a lockbox. They image EOBs and key all of our EOB data, sending us a file that we can use to post our remittances.	Low	~\$2.50	Better
7	MBIOS typically offers a fully operationalized process for remittances (i.e., does all of the above, and supports dynamic workflow queuing to optimize staff follow-up efforts in managing denials; other functions).	Lowest	< \$1	Best

*Costs are estimates based on research conducted by the Medical Banking Project, Bankers EDI Council and other industry groups.

Calculation >>> (Rule of Thumb)

- 1.1 Select your current mode of processing remittance from 1-7 above: _____
- 1.2 Multiply the appropriate cost component by Worksheet 1, item 1b: \$_____

2. How quickly do you make EOB images available to staff? ____ day(s) after receipt from USPS/lockbox

(Note: Obviously, this affects downstream accounting processes (i.e., denial management, contractual allowance processing, etc.)

Calculation >>>

- 2.1 Multiply Worksheet 2, item 1 by your answer to number 2 above: _____
- 2.2 Multiply item 1.1 by Worksheet 2, item 5.2: \$ _____
- 2.3 Multiply item 1.3 by 4% to obtain opportunity cost based on cost of money: \$ _____ (use what you feel to be an acceptable interest rate here)

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3. Please complete the following schedule of costs:

(Note: If you image your EOBs, please describe your imaging equipment: Name, model, date placed in service, speed, initial capital cost.)

	Costs
Annual maintenance cost of imaging platform (if using)	
Annual staffing cost (Clerical and patient accounting staff time spent filing, retrieving EOB documents. Please fill this out if you are using, or not using, imaging equipment.)	
Network, telecommunications and other technical costs	
Variable costs	
3.1 Total Costs	
3.2 If you image EOBs, enter % of time your equipment is placed into service for EOB related activities	%

Calculation >>>

3.3 If you use imaging equipment, multiply items 3.1 and 3.2 above for Total EOB-related imaging costs: \$ _____

3.4 Add item 2.3 and 3.3 for *Total EOB Imaging and Workflow Costs*: \$ _____

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Public Relations – The Power of Good Will

A key differentiator of any service is customer service. An increasing number of healthcare providers are finding that attracting the good will of the community is essential. Good will is just good business.

In healthcare, the pathway towards happier patients can be hard to find. Yet some hospitals and provider groups are routinely highlighted by consumer rating organizations, like US News and World Report's Top 100 Hospitals, or HON's Most Wired Hospitals. How do they do it? Will implementing a bank-driven system lead to increased patient satisfaction. If so, how can this be measured?

The MBIOS concept was encouraged by healthcare stakeholders who wanted far better response times in the communities they serve, as voiced during CFO focus groups conducted by the Medical Banking Project. A streamlined claims process yields much happier patients.

Consider your last patient visit and the trail of paper that followed. If your disputes were handled differently, including prompt secondary bill processing, would you have had a better experience? In fact, the market isn't waiting for providers to come up to speed in this area. Today, consumer-driven models are flourishing (i.e., Health Savings Accounts) and patients are becoming responsible for more out-of-pocket costs. A consumer-sensitive IT strategy for accurate and timely management of claims is not only good for cash flow, it also gains good will in the community. The bank clearly understands this area, a vital issue in the banking world as well, and is well positioned to support this important goal.



Worksheet 5 – COSTS TO RESOLVE PATIENT COMPLAINTS

1. If you log patient complaints relative to erroneous cash posting, denial management errors and/or timeliness of secondary billing, can you provide an average number of complaints per patient visit (or account)? _____ complaints per patient visit
2. Please complete the following schedule of costs:

	Costs
Annual maintenance cost of customer support center (if using)	
Annual staffing cost (Clerical and patient accounting staff time. Please fill this out if you are maintaining, or not maintaining, a CSR center.)	
Network, telecommunications and other technical costs	
Variable costs	
2.1 Total Costs	
2.2 Enter the % of time you spend resolving complaints related to EOB issues (i.e., errors, failure to submit secondary bills, etc.)	%

Calculation >>>

- 2.3 Multiply items 2.1 and 2.2 above for *Total EOB-related Patient Complaint Resolution costs*:
\$ _____

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MBIOS Investment Summary

Cost Structure Comparison

Using the Worksheets you completed, please fill out the following schedule of costs to arrive at your operations' Return on Investment and monthly savings utilizing MBIOS. Feel free to model your costs over a period of three years using this spreadsheet.

	Bank Fees to Operationalize Remittances	Worksheet references	Internal Unit Costs to Operationalize Remittances		
			Year 1 Costs	*Year 2 Costs	*Year 3 Costs
Per Transaction Fee/Expense	\$ XX/ERA \$ XX per imaged EOB	Enter item 5.3 from Worksheet 1 here→			
**Incremental costs you will incur annually based on level of automation					
Installation	\$ XX	Enter item 2.1 from Worksheet 3 here→			
Maintenance	\$ XX monthly	Enter item 3.1 from Worksheet 3 here→			
EOB Imaging and Workflow Cost	\$0	Enter item 3.4 from Worksheet 4 here→			
Opportunity Cost	\$0	Enter item 5.4 from Worksheet 2 here→			
Patient Complaint Cost	n/a	Enter item 2.3 from Worksheet 5 here→			
TOTAL Year 1 (Initial set-up plus ongoing costs)					
TOTAL Year 2 / 3 (Ongoing costs)					
Average Annual Costs (SUM Y1, Y2, Y3/3)					

*To model accurately, increase labor costs annually in accordance with internal labor policies.

** For a snapshot of current costs, use 100% of the costs calculated in the previous worksheets if not using a lockbox today. If using a lockbox with imaging, use 80% of Opportunity and Patient Complaint costs. For Years 2 and 3, you can use a decreasing % as more of carriers are automated.

Provider Return on Investment

	Work-sheet Ref.	Annual Volumes	Trxn Fee	Estimated Annual Trxn Fees	1 Additional Fees Annualized	2 Annual Investment	3 Avg. Annual Costs	4 Annual Savings
Volume of Paper Remittances	(Item 1, W2 X 261=)		X \$.XX					
Volume of Electronic Remittances	Item 3, W2 X 261=)		X \$.XX					
TOTALS								

1	Additional Fees Annualized = (\$monthly maintenance feesX36) + (\$Set-up Fee)/3 year time frame
2	Total Est. Annual Trxn Fees + Additional Fees Annualized
3	Multiply your annual volume by your average per transaction expense from worksheet above; and then ADD this result to your Average Annual Costs (calculated above)
4	Subtract Your Avg. Annual Costs from the Annual Investment to calculate your annual savings

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New Goals for Your Operation

Charting Expectations

With programs like this, it is sometimes useful to chart expectations, acceptable timelines and determine how to mutually measure progress. This graph provides draft metrics that should be changed based on the client. The metrics should be periodically reviewed during the implementation.

New Goals	Timeline	Client Goals	Timeline	How to Measure Progress
To reduce wide variation in electronic remittance advise and paper documents: <ul style="list-style-type: none"> ▪ We will attempt to reduce all remittance documents to two types: with and w/o service lines ▪ We will attempt to reduce all adjustments into one of five categories: Contractual Obligations, Patient Responsibility, Payer Initiated, Corrections and Reversals, Other 				
To convert 60% of all-payor remittances to an electronic file within 24 hours of provider receipt; the remaining 40% within 48 hours				
To reduce to only one portal, all the connection points necessary to concentrate 100% of the provider's paper and electronic remittances				
To simplify processing and adjustments				
To decrease reconciliation times by 15% (by holding data until both payments and remittance data have been credited to the provider by bank)				
To submit secondary claims at least 5 days faster than current process through automation				
Accelerate cash posting by 5 or more days through conversion of paper remits to electronic remits and simplification of remittances				
Reduce cash posting errors by at least 50%				
Reduce unapplied cash by at least 1 day				
Reduce patient complaints by at least 20%				
Reduce research effort by 50%				
Reduce payment posting staff by 20%				

GLOSSARY

ANSI X12N 835

This refers to the medical payment and remittance transaction that was mandated under HIPAA. ANSI stands for the American National Standards Institute. X12N is one of 12 subcommittees under ANSI that are responsible for implementing EDI in various industries; X12N refers to the Insurance Subcommittee. 835 identifies the type of transaction standard as the medical payment and remittance transaction.

EOB

"Explanation of Benefits". This paper document is used to provide detailed information back to the healthcare provider on medical procedures that were fully or partially reimbursed, or not reimbursed, by an insurer. It is used to establish subsequent workflow activities by the patient accounting office.

ERA

"Electronic Remittance Advice". This is a general term for the electronic equivalent of the paper Explanation of Benefits (or Explanation of Payment).

Fiscal Intermediary

Agents contracted by Medicare to administer funds under Title 18 of the Social Security Act. Fiscal Intermediaries (or FIs for short) are typically commercial insurance carriers that have claims administration experience.

Secondary Claim

The balance of a medical claim that is not paid by a primary carrier or the patient (i.e., self-pay or non-reimbursable items). Secondary billing is required when there are two or more health plans in a household.

MBIOS

Stands for "Medical Banking Inter-Organizational System". Based on research in other industries, MBIOS refers to EDI linkages in two adjacent industries that rationalize cross-industry workflows, and dramatically reduces costs for processing, opens up new marketing channels and provides other benefits to the underlying actors.

Medical Banking™

"The latent integration of banking technology, infrastructure and credit resources with healthcare administrative operations." See www.mbproject.org for further information. *Medical Banking™* is a trademark of the Medical Banking Project, aka MBProject.

