

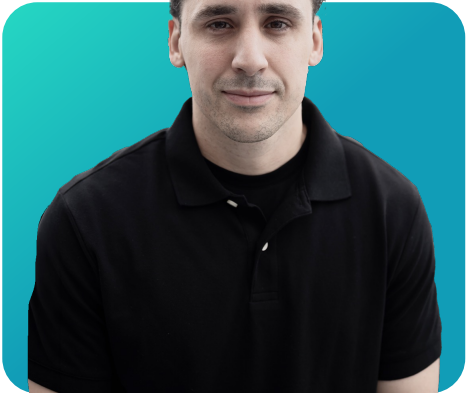


Turning your EMR Into a Revenue Engine

Practical Optimization Strategies for Medicaid & VA Success



Frank Ripoll
Account Executive



About Frank

Frank Ripoll is a Senior Account Executive at Paradigm, where he works with home care providers to strengthen revenue cycle performance, streamline operations, and support long-term growth. Since joining Paradigm in 2023, Frank has helped onboard more than 100 providers and has worked closely with agencies to resolve reimbursement challenges, recover delayed revenue, and implement scalable processes that drive measurable results. Outside of work, Frank enjoys fitness, endurance training, film, entrepreneurship, and gaming.

Company
Paradigm

Role
Account Executive

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Agenda

- Overview
- EMR = Source of Truth
- The Home Care RCM Lifecycle
- Best Practices
- Operationalizing RCM
- Leveraging Data
- Common Pitfalls to Avoid
- Wrap Up and KAHOOT!

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The Payers

- | | |
|--|--|
|  Overview |  Medicare |
|  VA |  Medicare Advantage |
|  Medicaid |  Other Programs |

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The Systems



EVV Aggregator



PRISM Portal



Payer Portals



The Clearinghouse

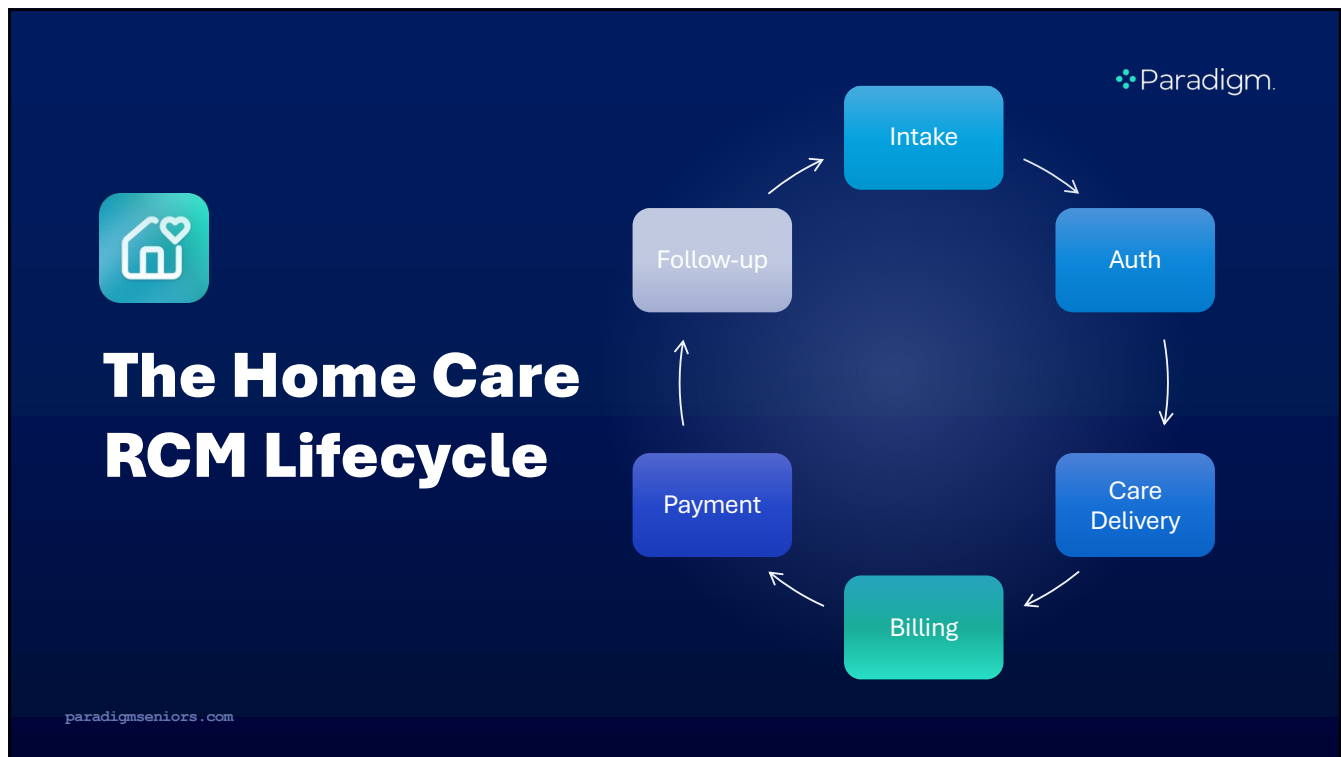
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Your EMR = Source of Truth

- Patient information
- Caregiver/practitioner information
- Plan of care
- Assessment/Care notes
- Authorization
- Dummy In, Dummy Out
- You pay a lot of money for these systems make them work for you!

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Best Practice

#2

Authorization Management

Ensure services are authorized before delivery



Track

- Units, dates, and service codes
- Monitor expiration dates
- Align schedule with authorized hours

Risk: Providing unauthorized care = non-billable services

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Best Practice

#3

Documentation & EVV Alignment



Ensure caregiver documentation matches

- Authorized services
- EVV records



Common issues

- Missed clock-ins/outs
- Incorrect service codes

Tip: Perform real-time validation before billing

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Best Practice

#4

Clean Claims Submission

Submit claims accurately the first time



Key components

- Correct payer formatting
- Matching authorization details
- Valid modifiers & codes
- Timely filing limits matter

Goal: Increase clean claim rate

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Best Practice

#5

Denial Management

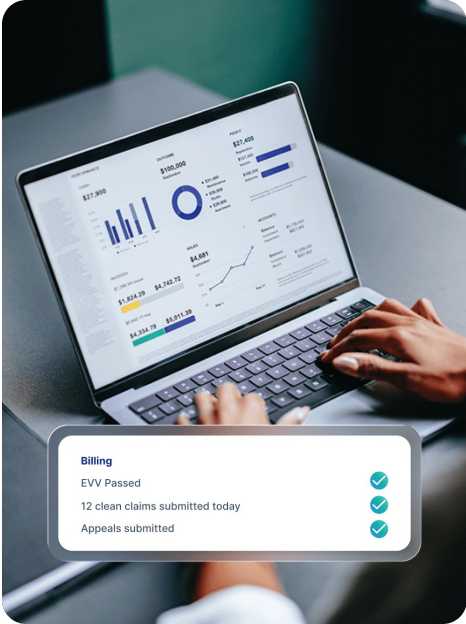


Track and categorize denials

- Authorization issues
- Eligibility issues
- EVV mismatches
- Root cause analysis
- Timely resubmission

Denials are data - use them to improve processes

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Where Agencies Lose Revenue



Eligibility not verified correctly



Authorizations missing or incorrect



EVV mismatches



Billing errors or late submissions



Denials not followed up

Most issues are operational - not payer-driven

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Operationalizing RCM for Consistency

- Standard operating procedures (SOPs)
- Defined roles & responsibilities
- Cross-team communication (intake, scheduling, billing)
- Regular audits and QA checks

Goal: Reduce variability and human error



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Leveraging Data - Key Metrics to Track:

- Days in A/R
- Clean claim rate
- Denial rate

Tip: What gets measured gets improved

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Common Pitfalls to Avoid

Reactive vs proactive processes

Lack of payer-specific **knowledge**

Poor communication between departments

Inconsistent workflows

Ignoring denial trends



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Support

How Paradigm Supports Agencies

End-to-end RCM support

Payer expertise (Medicaid, MCOs, VA, MA)

Scalable processes

Dedicated account management including Provider Coaches

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Key Takeaways

- RCM is a process, not a task
- Most revenue loss is preventable
- Standardization drives results
- Data + discipline = financial health
- Small improvements = big impact



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Pause! Ready to play?

Grab your phone - we're jumping into a quick game of Kahoot.

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Let's
continue the
conversation.

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Questions? & Next Steps

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