

Provider

.....
 Revenue Cycle Management

Denial Prevention, Management and Analysis **Revenue Cycle Visibility to Help Reduce Denials, Delays and Downtime**

Cash delays and shortfalls are increasingly dangerous situations for healthcare providers. Labor costs are rising and pushing operating expense to a new level. The squeeze on margins is extreme. One critical factor in reducing financial pressure is by decreasing and preventing claim denials.

Strategically pursuing denial prevention can have a far-reaching, positive impact on the efficiency of the entire revenue cycle by helping to identify processes and errors that cause denials as well as removing other barriers to prompt payment or staff productivity. Claim life cycle visibility paired with advanced automation and workflow can help optimize staff time and ensure claims needing attention are managed effectively and in a timely manner.

RelayHealth offers analytics-driven revenue cycle solutions to guide strategic action and increase operational efficiency to prevent many denials, and manage those that do occur.

Denial Prevention

Revenue cycle success starts at registration and continues throughout the claim cycle. Accuracy of patient financial information up front can help result in reduced denials, fewer rejected claims, and fewer returned statements. “Cleanliness” of a claim is the key component in stopping denials before they start and is impacted by several areas:

- Registration data quality assurance
- Prior authorizations
- Pre-authorization and medical necessity management
- Eligibility / benefits coverage
- Clinical documentation
- Coding
- Claim editing
- Other regulatory requirements

RelayClearance Plus is an integrated suite that provides patient financial visibility to help accelerate reimbursement. The solution offers denial prevention

Key Functionality:

- Registration data quality control
- Pre-and post-service eligibility checks
- Authorization requirements and availability
- Comprehensive claim edits
- Integrated, exception-based claims management and follow-up
- Real-time, strategic denial analysis
- Quick drill down to root cause of issues



capabilities to assist in identifying processes and errors at the beginning of the revenue cycle, to provide accurate data for all your downstream processes. RelayClearance Plus also helps manage the cumbersome and time consuming pre-authorization and medical necessity processes by determining if a pre-authorization is required and on file with the payer (figure 1). It monitors payers for pending pre-authorization decisions and updates the HIS/Practice Management system with payer results. It also assists with the checking of medical necessity and automatic creation of necessary ABNs, to help reduce denials, improve reimbursements, and support users' efforts toward meeting compliance goals. Lastly, RelayClearance provides standardized, detailed eligibility payer response screens to provide staff with consistent views so the most pertinent information is available at your fingertips. And by integrating with your HIS, it confirms eligibility throughout the revenue cycle for more accurate downstream billing.

RelayAssurance Plus helps reduce denials and improve first pass claim acceptance by

figure 1
Determine if pre-authorization is required and on file with the payer.

leveraging comprehensive edits covering payer, Medicare, provider-specific and state-specific requirements. Additionally, integrated post-service eligibility checks serve as a final safety net for eligibility-related denials caused by lapses or

reductions in coverage. RelayAssurance guides billing staff in correcting claim errors of all types, including those originating from coding and clinical documentation deficiencies, to help keep the payment cycle moving.

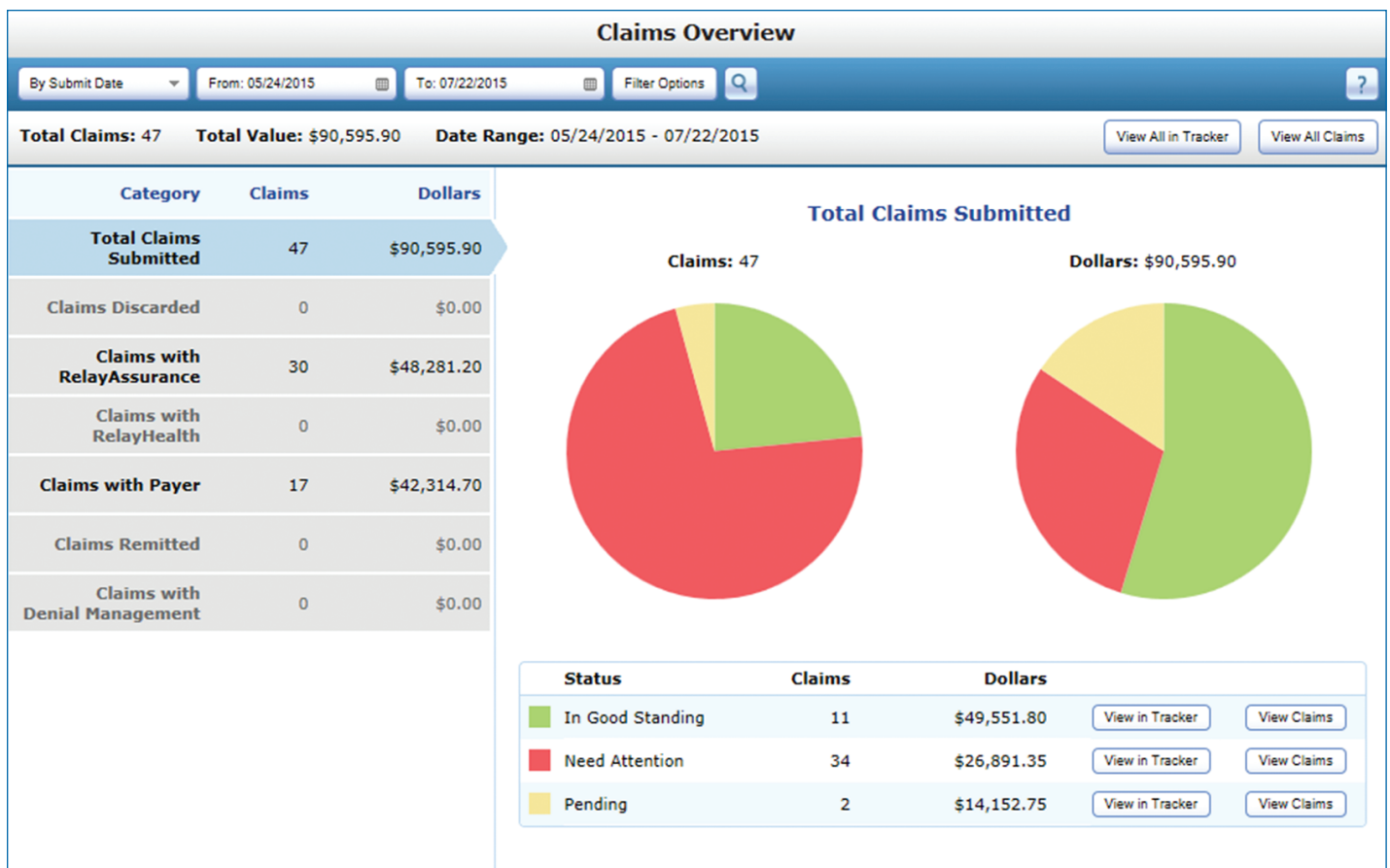


figure 2
Gain visibility into when claims are headed for trouble and react early to avoid delays.

Claims Tracker													
By Submit Date		From: 05/24/2015	To: 07/22/2015	Filter Options									
Total Claims: 47		Total Value: \$90,595.90		Date Range: 05/24/2015 - 07/22/2015		Claims Overview							
Actions					RelayAssurance			RelayHealth		Payer		RelayAssurance	
CPID	Payer Name	Patient Name Control #	Dollar Amt	Dates of Service	Received	In Process	Released	In Process	Transmitted	Received	Accepted for Adjudication	Remitted	Denial Management
3502	BLUE CROSS PPO	NELSON, MARTIN L CTMVFP6312	\$32,436.30	03/12/2015 03/14/2015	✓	✓	✓	✓	✓	✓	⊗		
3500	MEDICARE	JONES, MICHELLE L CTMVFP5181	\$13,577.75	07/07/2015 07/07/2015	✓	⚠							
3501	MEDICAID	ELLIS, CHRISTINE J CTMVFP6040	\$11,838.10	06/25/2014 06/30/2014	✓	✓	⊗						
3500	MEDICARE	OWEN, JAMES B CTMVFP5745	\$4,435.85	07/07/2015 07/07/2015	✓	⚠							
4456	CHAMPUS	JEFFRIES, JEFF D CTMVFP3901	\$3,118.50	04/05/2015 04/05/2015	✓	⚠							
3501	MEDICAID PCCM	BROWN, STEPHANIE S CTMVFP5316	\$2,441.40	03/20/2015 03/20/2015	✓	✓	✓	✓	✓	✓	⊗		
1474	MEDICAID	BAYS, IAN CTMVFP1128	\$1,848.00	04/28/2015 04/28/2015	✓	⚠							

figure 3
See clearly where each claim is in the process.

Denial Management

Despite efforts to employ the most advanced technology and streamline processes, denials will still occur. The key to minimizing the negative impact of denials is advanced workflow to help staff manage claims in the most efficient manner possible.

RelayAssurance Plus helps identify partially paid and denied claims and provides tools to help optimize efficiency in the claim follow-up process. The Reconciliation Manager helps drive exception-based workflow, just-in-time claim follow up and early intelligence into claims headed for trouble. This enhanced workflow guidance in RelayAssurance is empowered by fully integrated remittance management, pervasive payer connectivity and predictive analysis of over three billion financial transactions. RelayAssurance provides enhanced visibility into the claim life cycle and integrated, actionable analytics to help optimize staff time and reduce payment delays.

Visibility into All Claims

The Reconciliation Manager Claims Overview (figure 2) provides a quick view of the status of all claims. A user can drill down into claims that need attention and focus on addressing issues, such as denials, rather than searching through a large volume of claims that are progressing as they should. Visibility into

remittance codes from the ASC X12N 835 enables quick identification of denials and payment reversals for immediate follow-up. This intelligence helps increase staff productivity by helping providers reduce phone calls to payers and enabling them to handle all claims at the proper time.

Individual Claim Insight

The Reconciliation Manager Claims Tracker (figure 3) drills down to the individual claim and gives users a visual indicator of where the claim is in the life cycle and shows if it is progressing as expected. Color-coded alerts indicate issues or potential issues requiring immediate action. Denials meeting the criteria assigned via the managed claim

assignment functionality will appear in red in the dashboard and tracker view, so the appropriate staff member can begin to work the denial immediately.

Customizable Experience to Meet Unique Needs

User profiles are designed to associate RelayAssurance users with specific types of claims based on claim criteria, payers and facilities. By setting up user profiles, managers can also use payer status rules to automate the process of assigning claims, creating workgroups, monitoring workload via the Assigned Claims Dashboard (figure 4) and quickly reassigning claims to balance workload when necessary.

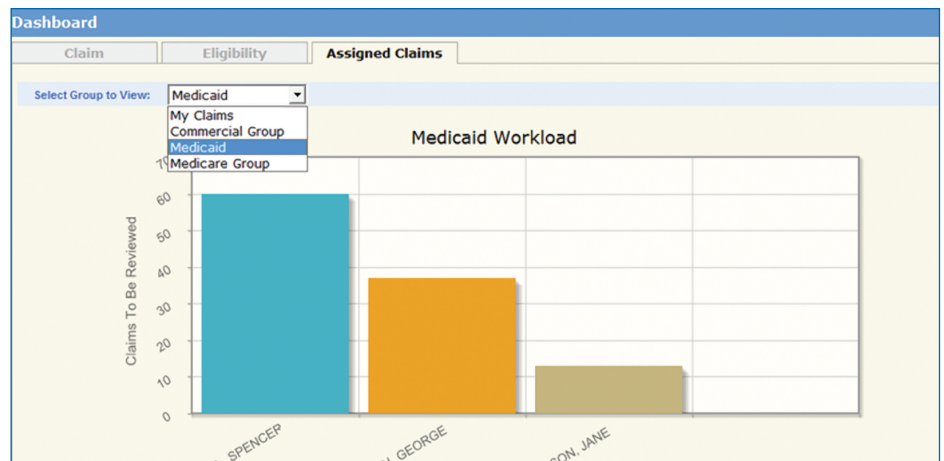


figure 4
More easily assign claims and balance workload to help optimize staff utilization.

RelayHealth Solutions Help:

- Provide accurate data for downstream billing processes
- Manage time-consuming pre-authorization and medical necessity processes
- Improve first-pass claim acceptance
- Quickly identify partially paid and denied claims
- Optimize staff time
- Reduce payment delays
- Guide strategic process improvements

Denial Analysis

The *RelayAnalytics* suite provides revenue cycle leaders with strategic, near real-time insight into performance with the ability to drill down quickly into root cause of denials, including those originating in patient access areas related to eligibility and registration.

RelayAnalytics™ Pulse provides easy monitoring of overall denial rate and gives context to performance with comparative intelligence from across the industry.

Additional insight helps pinpoint the areas contributing to the denial rate and the dollar value of making improvements.

RelayAnalytics™ Acuity offers a denial reporting bundle (figure 5) to gain strategic insight into denials by payer, category, specialty, service line and more. Equipped with data, revenue cycle leaders can take prompt action to correct processes contributing to denials and help prevent future denials from happening.

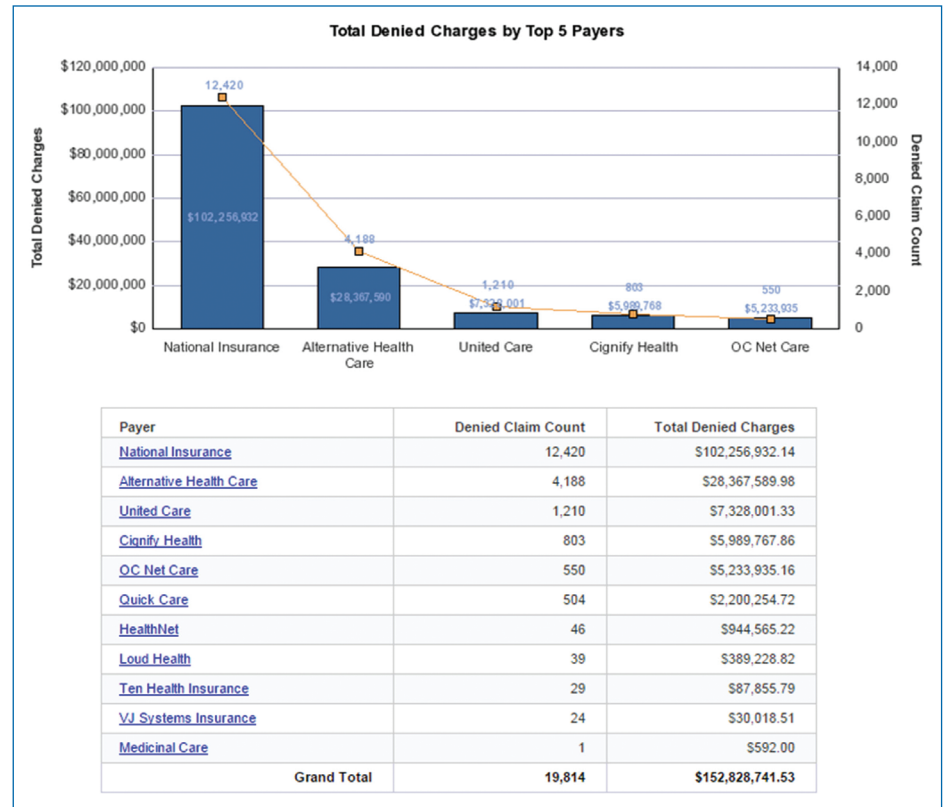


figure 5

RelayAnalytics Acuity Denial Summary by Category is an example of a standard report in the denials reporting bundle. Each report can be easily customized to add more information for deeper insight.

RelayHealth Financial

11475 Great Oaks Way, Suite 400
 Alpharetta, GA 30022

www.relayhealthfinancial.com

To learn more, contact a RelayHealth Solutions Advisor at **1.800.752.4143**

Connect with us:

- ✉ rhfinancial@relayhealth.com
- 📺 www.youtube.com/user/RelayHealthTV
- 🐦 twitter.com/RelayHealth
- 🌐 www.linkedin.com/company/relayhealth

© 2015 RelayHealth and/or its affiliates. All rights reserved.

RHF-DPMA-PB-1015