In today’s modern healthcare system, a healthy and efficient revenue cycle is a vital component of an organization’s overall financial health. Claims management is one area that must operate smoothly to support a healthy cash flow. However, the average submission to payment time is 24.6 days post submission.*

One major roadblock to remittance is the time it takes customers to manually follow-up with payers to check claim status on pended or denied claims. Today’s approach is to submit a 276 EDI Health Care Claim Status Request. The 277 Claim Status Response may or may not result in helpful information to resolve any outstanding issue with the claim that is precluding reimbursement.

Due to the lack of detailed information about the claim, customers must usually take additional steps to follow-up with payers through costly phone calls and lengthy searches of payer websites. Ultimately, the current method can be

<table>
<thead>
<tr>
<th>Payer</th>
<th>277 / 835 EDI Response</th>
<th>Status Amplifier Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payer A</td>
<td>16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.</td>
<td>REJ: Itemized bill required. Resubmit with itemized bill.</td>
</tr>
<tr>
<td>Payer B</td>
<td>96: Non-covered charges. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)</td>
<td>SF: This Claim is being denied because our records indicate you have primary medical insurance with another company (other than Medicare).</td>
</tr>
<tr>
<td>Payer C</td>
<td>95: Plan procedures not followed.</td>
<td>1005: These benefits were reduced due to failure to obtain pre-certification approval as outlined in the plan.</td>
</tr>
<tr>
<td>Payer D</td>
<td>16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.</td>
<td>E5904: Final Benefit determination cannot be made until we receive specific requested medical information.</td>
</tr>
</tbody>
</table>

* Figure 1
Example Claim Status Response Comparisons.
inefficient and time consuming, potentially delaying payment and impacting cash flow. **The Solution**

RelayAssurance Plus Status Amplifier™ is a web-based, claim status inquiry system that enables healthcare delivery organizations to gather thorough and easy to use information about pending claims from proprietary payer portals as soon as one day post claim submission**. Unlike manual processes that require a web query or lengthy phone call to payers, Status Amplifier helps customers gather batch or individual claim status via the use of automation. The enhanced visibility into claim status information helps customers gain access to the right information, earlier; enabling them to take early and targeted strategic action on problem claims and helps them to ensure an efficient claims management process.

**Status Amplifier Helps:**
- Provide access to claim status as early as one day post submission**
- Process automated batch or individual claim status inquiries
- Deliver improved resource utilization — work smartly
- Drive exception based workflow
- Avoid inefficient and time-consuming manual claim status inquiry processes

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**figure 2**
Traditional Model.

**figure 3**
Status Amplifier™.

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* RelayHealth Data 2014
** Ovation Revenue Cycle Services Case Study, 2013