

Reinventing Claims Management for the Value-Based Era

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Provider claims management as we once knew it is not enough to thrive in a value-based era. Here's what you need to know about taking claims management to a higher level.

Provider claims management can no longer exist as a silo. With the rapid transformation from fee-for-service to value-based models, denial rates remain high—nearly 1 in 5 claims—despite advances in technology and automation.¹ The complexity of value-based payment models almost guarantees an increase in denials, simply because there's so much to get wrong.

For provider CFOs and their organizations to be effective—and thrive—in this environment, the touchpoints across the revenue cycle continuum must be re-examined to see if there are opportunities for improvement that have not presented themselves in the fee-for-service era. One such area is claims management, which is ripe to be elevated into an integral part of a denials management strategy.

What are the implications for providers? Well, for perspective, consider the savings realized through electronic claims submission. CAQH

research reveals that submitting a claim manually costs \$1.98, compared to just \$0.44 per electronic transaction. Likewise, a manual claims status inquiry costs \$7.20 versus \$0.94 for processing electronically.²

This paper outlines the features and benefits of a technology platform that is geared toward elevating traditional claims management into the realm of strategic denial prevention and management, along with some recommended denial management best practices.

From Claim Scrubbing to Strategic Denial Management

Simple claims management as we know it is becoming obsolete. By “simple” we mean a claims process with a basic set of capabilities: creating claims, making limited edits, and ensuring that procedures are medically necessary. Today, a new class of integrated

¹ PNC Financial Services Group, “Automated Billing/Payment Process Can Reduce U.S. Health Care Costs without Sacrificing Patient Care,” November 2007

² 2015 CAQH Index™ Reporting Standards and Data Submission Guide—Health Plans Numbers of Transactions and Costs per Transaction Data for Calendar Year 2014, Version 1, March 13, 2015

claims and denials management solutions augment this traditional approach to include pre- and post-filing activities that help automate and streamline claim submission, proactively monitor status, and expedite the appeals process for those that are denied.

In its simplest form, denials management can be defined as a process that leads to cleaner submitted claims and fewer denials from payers. But there are a lot of interim steps and variables that lead to “clean” claims, and a growing number of factors that influence denials. With the shift to alternative payment models and increasing consumerism, it’s more important than ever for providers to process claims properly the first time and to keep staff intervention to a minimum.

A big part of denials management is to improve the quality of patient data at registration, the

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source of many errors that lead to denials. Nonetheless, integrated claim and denial management processes span the entire revenue cycle, and technology brings new opportunities to manage costs and improve efficiencies. For example, having the ability to manage claims within a unified platform that can share and integrate data with the organization’s EHR prevents the need to toggle back and forth between systems to determine the status of a patient encounter.

A comprehensive claims management platform that advances denials management efforts integrates the following capabilities:

- Eligibility verification prior to claim submission.

It sounds pretty basic, but eligibility and registration errors on claims continue to be the top reason for denials.³ Automating the real-time verification of eligibility data helps identify avoidable denials and alert staff to claims needing attention before submission.

- Maintenance of and compliance with often changing payer business rules and regulatory requirements, including Medicare and state-specific updates, so that claims go out as cleanly as possible on the front end. With multiple payers and a growing roster of alternative payment models, manual in-house maintenance of edits is becoming an overwhelming task.
- Digitization of attachments for Medicare pre- and post-payment audits, commercial claims adjudication and integrity audits, and workers compensation billing support. Integrating digital data exchange into the claims management workflow can help providers better control administrative costs, keep up with regulatory compliance, and help automate and streamline claims processing and reimbursement.
- Visibility into claim status lifecycle, with guidance for proactive follow-up. This lets providers only focus on those potential “problem” claims, and address any issues, before they are denied or delayed.
- Automation of repetitive and labor-intensive tasks such as checking payer portals or placing phone calls to determine the status of pending or denied claims. This helps drastically reduce the amount of staff time spent perusing payer sites, and sitting on the phone on hold when an answer can’t be found.
- Predictive intelligence to determine timing of payer acknowledgements and requests for additional information, as well as when payment will be provided. Analytics-driven claims management provides insight into how long responses should take, alerting providers when follow-up is required.
- Management of remittances from all sources. Automated management of transaction

³ HBI Academy Research, Registration Errors Significantly Impact Reimbursements

formats, adjudication information, remittance translation and posting can help reduce A/R days, boost staff productivity, and accelerate cash flow.

- Denial management and data analysis to guide corrective action and prevent future denials. Revenue cycle analytics can monitor the number of claims per physician, payer, or facility, enabling the health system to be proactive in interventions.
- Creation and tracking of appeals for denied claims, including pre-population and assembly of appropriate forms. This not only helps cut down on resource-intensive manual work and paper attachments, but streamlines the appeals process.

Tying these capabilities together within an exception-based workflow helps address the challenge by providing visibility into problem claims. At-a-glance access to claim status helps cut down on the back-and-forth between billing departments and payers, and allows staff to focus only on those claims that require attention.

Pulling it all Together

Once you've integrated these capabilities, what are some of the claims management best practices to improve denial management and prevention? Consider the following actions:

- **Embed denial management within the entire workflow**—Strong edits lead to clean claims, whether they pertain to Medicare, commercial payers or state-specific regulations. Edits should be constantly refined and seamlessly implemented, and pushed out to providers as often as possible—at minimum on a twice-weekly basis.
- **Adopt analytics-driven claims management**—Claims management systems and connectivity channels to payers (i.e. clearinghouse) produce a wealth of operational information, most importantly data evidencing the speed of the payment path and claim status. Analyzed and served up in meaningful formats, this data becomes targeted business intelligence that can help providers better see obstacles and identify the root cause of

denials and payment slowdowns.

- **Resolve issues before they result in denials**—Providers should know claims location and status at all times. For example, has the claim been released by the EHR system? Has it been received and approved by the payer—or does a problem need to be addressed? Has a problem been rectified? Has the claim been released to a clearinghouse? Historical trends establish guidelines for the timing of events (e.g., whether claim status or payment should have been received from a particular payer by a certain date).
- **Be ready to identify claims denials and submit appeals**—Nationwide revenue cycle statistics show that 1 in 5 claims are denied or delayed and can be avoided with the right software and better business processes. In addition, 67% of these denied claims are recoverable.⁴ Identifying denials and

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submitting appeals to supply information not included on the initial claim can recoup lost revenue. To help streamline the process, additional claims information, such as medical records or lab results, should be supported by structured electronic attachments rather than faxed paper records or uploaded files to payer portals.

A Little Prevention = Big Returns

Reducing and managing denials will have a significant impact on any healthcare

⁴ Haines, M., “An ounce of prevention pays off: 90% of denials are preventable.” The Advisory Board Company, December 11, 2014

organization's bottom line. First, it costs \$118 to rework a claim, and success rates vary widely.⁵ Additionally, when denials must be written off, the drop in patient revenue may total several million dollars for a medium-sized hospital, according to Advisory Board estimates.⁶

The new look and feel of claims management is moving quickly toward analytics-driven,

exception-based processing. By implementing and leveraging these capabilities and best practices in a cloud environment, providers can look forward to accelerated cash flow, reduced denials, increased automation with less staff involvement, and lower IT overhead.

⁵ Change Healthcare network data

⁶ Gooch, K., "4 ways healthcare organizations can reduce claim denials," Becker's Hospital CFO, July 26, 2016