A RECONDO WHITE PAPER

Get Healthcare Revenue Moving Again

How Automated Payer Follow-Up Jumpstarts a Stagnant Claims Cycle

INSIDE:

Decrease payment time | Increase productivity | Discover exceptions-based claims processing

Introduction

Intentional or not, the current healthcare landscape seems designed to reduce the revenue physicians and hospitals earn per patient, no matter how high in quality the care or the cost in labor and supplies to deliver it. In a parallel development, the reimbursement process for this care is eroding the financial health of providers. Claims remittances commonly take up to 40 days or longer to arrive, leaving providers with few options other than to passively wait or pursue costly fixes such as staffing up internally or hiring third parties to follow up with payers, or communicate with payers via decades-old electronic data interchange (EDI) technology.

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The financial toll this is taking is enormous. In 2012, the nation's healthcare providers spent a cumulative $471 billion on billing and insurance-related activities; money that could otherwise have been redirected to patient care. This inefficient reimbursement climate isn't just threatening financial performance for individual hospitals and providers. It's draining the entire healthcare system.

In search of more affordable and effective solutions to payment delays, many provider organizations are automating the payer follow-up process. This white paper examines the claims status automation trend in depth to reveal a clear picture of the technology that is helping providers recapture a timely and efficient billing cycle.

Faster payments with exception-based processing

Healthcare payers often take up to 60 days just to notify providers whether a claim has been approved or requires further information. This delay not only creates chronic revenue shortages for providers, it restricts their ability to budget and plan for future investments in services. Compounding the delays is that once remittances do arrive, denials are poorly explained, if at all. This leaves many providers unable to quickly remediate problem claims or appeal them. It also shines zero light on denial reason trends, making it impossible to put improvements in place to prevent future denials.

Claims status automation solves these problems through a three-pronged approach: exponentially faster notification of claim status; detailed explanations of the problems with each denied claim; and workflow triggers that guide staff in remediating partially and fully denied claims. In the absence of such automation, providers instead take one of four actions (FIGURE 1). None are cost-effective. In fact, they are not effective by any measure.

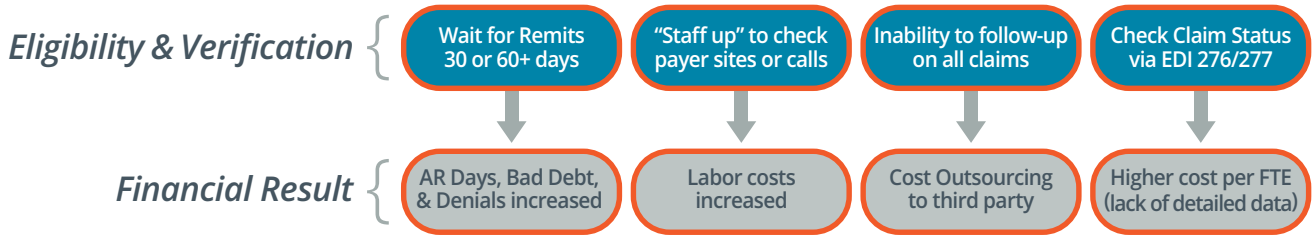


Figure 1

Waiting for the payer to give this insight is not a viable option

Let's take a closer look at the problems with the four standard approaches to claims status follow up.

The long wait. Every provider knows that the longer an account ages, the more difficult it is to collect. Insight into status on these claims is needed well before 30 days to keep it active and more likely to be paid in full. In short, waiting for the payer to give this insight is not a viable option. Additionally, even if the payer were to send notice of denials within 30 days, very few offer clear reasons for denial.

Staff up. The chief problem with assigning additional staff to continuously call and check in with payers is that providers have no way of knowing if staff are pursuing claims that have already been approved. It is not uncommon for employees to spend more than half their time following up on approved claims; a poor use of back office staff who should be focused on remediating only problem accounts.

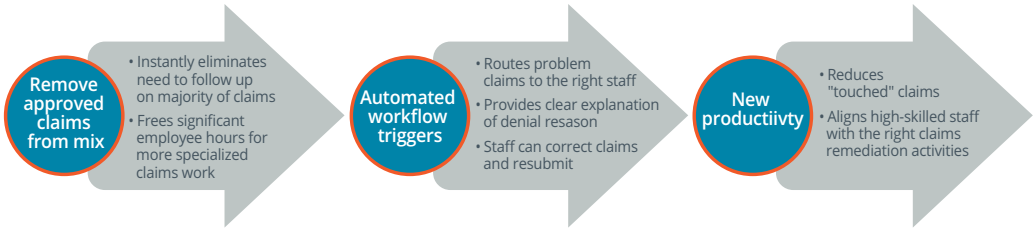
Outsource. Throwing additional manpower at the problem may somewhat lessen its impact, but will never solve it. Moreover, providers are now paying a third party to perform a blanket chase of all claims rather than focusing only on the exceptions. Outsourcing might make more sense if the third party had better access to payer data that could streamline the process.

EDI 277 Claims Status Transactions. The creation of electronic exchanges of information between providers and payers was intended to vastly speed up communication about claims status and other issues. When providers send an inquiry about a claims status – or what is referred to as a 276 transaction – the response is called a 277 transaction. However, the 277 response typically does not explain the reason for denial, only whether it was denied or approved. This means the whole process of getting paid is still far from over.

Claim Status Information	
Tot Claim Charge Amt: 14499.04	
Status Eff Date:	
Health Care Claim Status	
Status Code: 0	
Claim Status Category Code:	Finalized/Denial-The claim/line has been denied. (F2)

The key to speeding up claim payments is knowing soon after submission which claims are going to get denied, either partially or fully. In the absence of this information, providers spend inordinate amounts of time chasing after all claims—time that could instead be spent on remediating the ones slated for denial status. The answer is exception-based claims processing, which translates into a powerfully productive workday for claims remediation specialists.

Supercharged Workflows



How exception-based claims processing works

Hospital business offices that switch to an exception-based workplace eliminate the task that used to take up more employee than any other: manual, ineffective and costly follow up with payers.

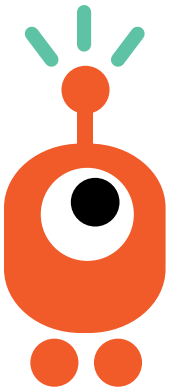
- Automated technology retrieves claims status data from payer websites and generates a list of accounts with “approved” and “denied” status clearly visible
- Half or more of the time staff previously spent on proactively verifying claims status is now eliminated
- Workflow triggers auto-route problem claims to designated staff for remediation, so staff can work particular problems one batch at a time
- Approval status and scheduled payment date auto-populated into system, creating first-ever “touchless” claims

New insight for claims submission improvements

A significant benefit of automated claims follow up technology is that root causes of denials quickly become very clear. This helps providers adopt any number of improvements in multiple departments. Further, the right people are now put to work exclusively on problem claims—turning your best employees into the true insurance coverage specialists they are.

Providers can also better predict cash flow, know how much to keep in reserve for contractual adjustments and make other financial decisions that were previously constrained by lack of insight into projected revenue.

The "Bots" behind Automated Payer Follow-up



Manual verification of claims status is a lengthy process. Staff must continuously log in to payer websites to see if statuses have been posted yet; a procedure that must be repeated for each payer—and there are hundreds of managed care plans. Automation replaces the need for people to perform this function ,and instead, uses sophisticated algorithms or "bots" that access the payer's website with the provider's credentials; query and retrieve claims status data as soon as it's posted; and then presents this data back to the Business Office in list form.

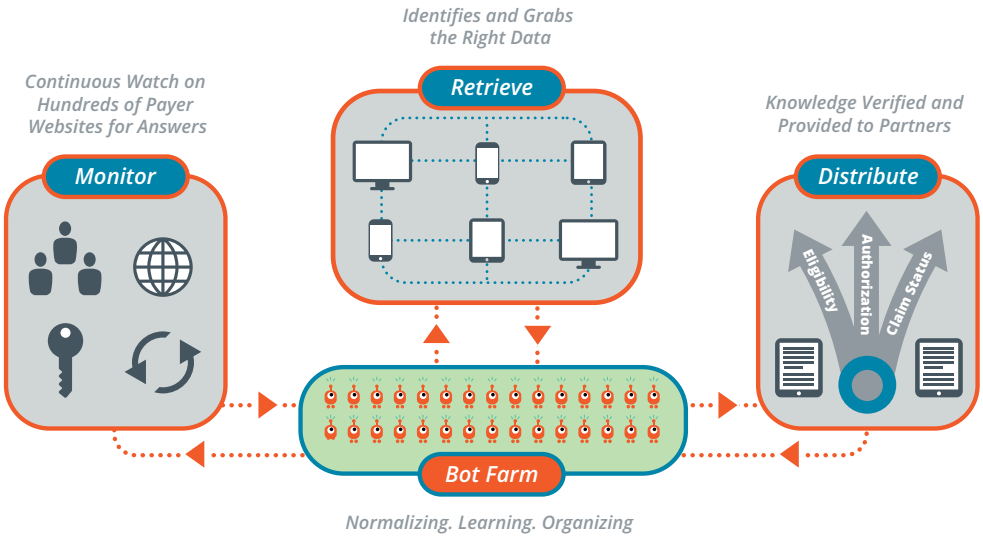
Note that this list can include patient claims from different payers; the bots normalizes the data into a standard format. The information in the list is unprecedentedly actionable. If a claim is flagged as "denied," for example, the full and detailed denial reason is included. This gives the Business Office advance notice, often weeks before receiving a remittance, of which claims have been denied and what needs to be done to fix them.

To summarize, the bots work in four primary ways to harvest claims status data from hundreds of payer websites.

- **Query** – the bots continuously monitor payer websites for new claims status information
- **Retrieve** – As soon as payers post claims status, the bots capture the data
- **Normalize** – The bots standardize data from hundreds of payers with different formats
- **Present** – Payer data is put into a consumable format and routed to the appropriate employee for remediation

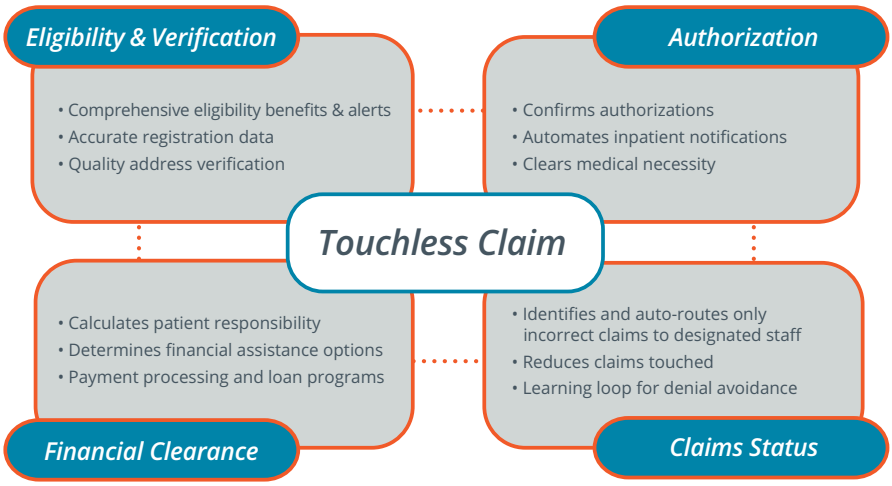
The idea to use website harvesting tools isn't new. But taking that rich data and applying rules to create smart workflow triggers is—along with replicating these processes among hundreds of payers at once. This is automated payer follow up technology designed to retrieve and leverage data at a massive commercial scale.

Automated Follow Up Technology in Action



The Big Picture

Revenue pressures are not expected to subside for healthcare providers anytime soon. Accordingly, they are looking for any area to implement efficiencies without compromising care. The financial department is a natural place to seek savings in time and money, and not just in claims status follow-up. Technology exists now that can automate the entire insurance billing and follow-up process enabling truly "touchless" claims.



A major market problem solved

The good news: true touchless technology is already here.

Long wait times for payments aren't just bad for the providers waiting to be paid. Such chronic delays weaken our entire healthcare system by threatening the financial sustainability of the hospitals and practices on the frontlines of delivering care.

A "touchless" approach to claims processing removes unproductive and time-consuming follow up with payers and replaces it with quick insight into every point along the way—including patient insurance eligibility, the patient's financial responsibility for services, authorization verification and claim status. Indeed, such data will be an expected feature for leading revenue cycle management systems in the near future.

The good news is vendors of these systems don't have to develop and test the technology behind this feature. It's already here and deployed within hundreds of hospitals—with thousands more expected to follow suit as payer transactions only become more complex.