

Unraveling the Claims Snarl

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This story is part one of a four-part series on revenue cycle management. Part two, which will appear in the June issue, will focus on health plan contracting.

With the nation in a deep recession, health care providers are looking for new ways to improve their cash flow. Many are taking a very close look at their revenue cycle management practices, identifying logjams in the multi-step process of preparing a claim and getting paid.

MaryAnn Hastings, director of the central billing office at Methodist Medical Group in Peoria, Ill., offers advice based on her involvement in revenue cycle turn-around projects at several providers: "You have to start by analyzing and identifying the root cause of cash flow problems," she says. "Is it the processes, the technology, the people or all three? Address your processes first. That will tell you what you need to do with technology. And that will tell you what you need to do with people."

A key component of the financial turnaround at the 144-physician practice was much more aggressive editing of claims on the front end, before sending them to payers.

For many providers, thorough checking of claims upfront is a missing link in the payment chain, says Pat Kennedy, president of PJ Consulting, Rockville, Md. "All providers need to have software to make sure they are coding claims according to their contracts with payers, according to industry standards and according to payer rules and regulations," he says. "The more they can do on the front end to create a clean claim, the more it will speed up their cash flow."

In addition to paying closer attention to the coding and editing of claims, more providers are automating the process of confirming insurance eligibility before patients arrive for care. And some are moving toward filing claims directly to certain payers using Web portals, rather than relying on a clearinghouse—a trend many payers support.

"We hope to see clearinghouses used less over time," says Bart Strickland, director of commercial EDI services for Blue Cross and Blue Shield of South Carolina, Columbia. He likens the use of a clearinghouse to the old game of whispering a message to a group of friends gathered around the campfire, each one passing what becomes an ever-changing message to the next person. "The more steps there are, the greater the chances for error or for the message not getting delivered," he says.

A growing number of payers also are using new technologies to speed up claims adjudication. And to close the loop, providers and payers are working together to adopt electronic remittance advice as well as electronic funds transfers - eliminating mountains of paperwork in the process. Plus providers are taking steps to make their back-end collections efforts more efficient (see story June 2008 issue, page 30).

What's the Problem?

Why is submitting a bill and getting paid so difficult in health care? For starters, these bills are far more complex than those in other industries. But too often, "providers and payers don't talk," which leads to problems and delays, says Steve Schaefer, vice president of finance at 336-bed Virginia Mason Medical Center in Seattle. The hospital found that when it held face-to-face meetings with one of its major payers, it was able to eliminate wasteful steps in claims processing (see sidebar, page 32).

But beyond a lack of communication between providers and payers, a key reason for claims processing difficulties is "a lack of awareness at the granular level of how information flows within your own organization," Schaefer stresses.

Virginia Mason, along with a growing number of other hospitals, is re-engineering revenue cycle management, applying lean manufacturing principles developed by automaker Toyota. The idea is to "mistake-proof" all the processes involved.

"One of the problems in health care is that we lack engineers," Schaefer says. "A lot of folks are either clinical or clerical in nature. When you get into claims processing, the leaders may have engineering minds, but they may lack a systematic method for process improvement. Often, the CFO gets the job because of their personality. We have become a personality-driven industry rather than one having a systematic methodology."

The Beginning

An important first step in improving cash flow is gathering all necessary demographic and insurance information before care is delivered.

In re-engineering revenue cycle management, Christus Health, a 40-hospital system based in Dallas, is now focusing on front-end processes, with a goal of pre-registering as many patients as possible, says Amy Tsui, director of revenue cycle consulting.

The hospital chain electronically verifies insurance eligibility using software from Passport Health Communications Inc., Franklin, Tenn. It also uses an application from Transunion, Chicago, to help determine if a patient is eligible for financial aid from various sources or qualifies for the organization's charity program. The application creates a score of a patient's ability to pay their bills.

Christus Health also recently implemented Accureg software from Mobile, Ala.-based Database Solutions that produces daily reports on information missing from registration records. Similar to editing software that scrubs claims for accuracy, this application pinpoints missing demographic information early in the game, an important first step in the preparation of an accurate claim, Tsui says.

Some smaller group practices, which have far fewer resources than a single hospital, much less a 40-hospital chain, nevertheless are taking steps to gather more information upfront.

For example, Desert Ridge Family Physicians uses payers' Web sites to verify insurance eligibility for every patient before they arrive, says Tiffany Nelson, M.D., founder of the Phoenix, Ariz.-based practice. The four-physician group offers same-day or next-day scheduling. So it's important to gather as much information as possible immediately after a visit is scheduled, she says.

Similarly, the pediatric practice of Peter Masucci, M.D., in Everett, Mass., conducts real-time eligibility checks using a service from athenahealth Inc., Watertown, Mass. If the online check fails to confirm eligibility, staff members then call the payer or patient to resolve the issue before the visit, says Donna Masucci, office manager.

Coding Challenges

The doctors at Desert Ridge also take the extraordinary step of selecting the codes used in claims through an electronic health records system.

The software, from NextGen Healthcare Information Systems Inc., Horsham, Pa., presents templates for selecting diagnosis and procedure codes. Although the application also can automatically suggest proper codes based on clinical data selected from point-and-click records templates, physicians generally choose the codes and associated levels themselves, Nelson says. That's because any free text entered in the record isn't reflected in automatically-generated code suggestions. The codes selected then flow to a NextGen practice management system for billing.

The four young physicians at Desert Ridge launched the practice when they finished their residency training, where they became familiar with the power of software, Nelson says. So coding their own claims and using electronic records seemed like natural steps to take, she adds.

"Every doctor should take a coding class and do it themselves," Nelson argues. "They'll get paid much more if they do it themselves rather than having someone else enter the codes," she adds. That's because doctors are more familiar with the nuances of all the treatment provided, she contends.

But most small group practices take a far less automated approach to coding, relying on business office staff to enter codes in claims by hand.

At Masucci's practice, the doctor and two nurse practitioners use an electronic records system, accessed remotely via the Internet, from athenahealth. But they still use a paper encounter form to check off the appropriate codes, says Donna Masucci, the office manager.

A biller starts populating a claim form by clicking on the patient's name in the practice management system, also from athenahealth. This pre-loads demographic and insurance information to the electronic claim form. The biller then types in the appropriate codes off the paper form.

The office manager is looking forward to using a new version of the records software, now in development, that will enable doctors to select codes, which will automatically be loaded into a claim.

Accurate Edits

One of the biggest challenges in creating a clean claim, many financial managers say, is accurately editing all information to meet payers' up-to-date requirements. Even though HIPAA standards created more uniform claim formats, payers still vary widely in their specific data demands.

At the Masucci practice, improved editing using revenue cycle management software from athenahealth has played a vital role in improving cash flow. Athenahealth frequently updates the edits, pinpointing the data each payer needs. The practice now has the equivalent of 21.3 days worth of revenue in accounts receivable, down from 69.2 days before using the software, the office manager says. And it now gets paid for 99% of submitted charges, up from 62% before the automation effort.

Similarly, Desert Ridge uses claims scrubbing functions within its practice management system, from NextGen, to identify errors in claims that can be fixed before the bills are shipped out the door. It had the equivalent of 12 days in accounts receivable for December 2008.

When Hastings took over billing at Methodist Medical Group in Peoria, she faced the challenge of fixing a 37% claims denial rate. A key component of the turn-around effort was adding revenue cycle management software via the application service provider computing model to supplement its aging practice management system.

The software, from Navicure Inc., Duluth, Ga., takes billing information from the practice management system and scrubs it, alerting the biller to the need for corrections or additions. Navicure's edits are updated daily, Hastings notes. "They constantly monitor rejections from payers."

Next, the claim goes to Navicure's clearinghouse, where the claim is scrubbed yet again.

Today, the 144-physician practice has a 2% claims denial rate. Methodist now averages 33 days in AR, down from 55 days before using the Navicure software. The billing office staff has dropped to 23 from 38.

One downside to the current arrangement, Hastings points out, is that any corrections highlighted by the Navicure software have to be re-entered in the original billing document generated by the practice management software, from Tampa-based Sage Software Healthcare Inc.

This spring, the practice is switching to practice management software as well as clearinghouse services from McKesson Corp., San Francisco.

It's also ending its use of Navicure's claims editing software. But just in case the new services aren't up to par, Hastings negotiated a contract that enables her to drop McKesson's clearinghouse and return to Navicure's editing software and clearinghouse within six months.

Using software to more thoroughly edit claims can cut the amount of time it takes to get a bill out the door, says Teresa Taylor, director of physician billing for Shenandoah Memorial Hospital, Winchester, Va. She uses software from HealthPort, Alpharetta, Ga., to help with billing for 19 physicians who work at practices the hospital owns. The ramped-up editing has led to an 18-day cut in AR days, she says.

Convoluting Process

For hospitals, preparing a clean claim and tracking it until it's paid can be a time-consuming challenge that involves grabbing data from multiple systems.

To streamline that process, DCH Health System, a four-hospital system in Tuscaloosa, Ala., uses "electronic financial record" software from CareMedic Systems Inc., St. Petersburg, Fla. The software creates a database for storing all data related to a patient account, says Michael Wilson, director of business services.

The database can accept scanned images, such as for explanation of benefits documents from insurers, as well as data from a variety of systems. This makes it easier to prepare bills, eliminating the need for tedious searches for paper documents and data in its patient accounting system, Wilson says.

The software can track trends, such as patterns of claims denials, that help Wilson fine-tune processes to help ensure more claims get paid the first time.

Since installing the application, the hospitals have seen a \$2.1 million increase in monthly cash flow. But in a sign of the times, that increase didn't fall directly to the bottom line. That's because the hospitals have seen a major spike in service to the uninsured as well as bad debt for self-pay portions of accounts, which offset the cash flow increase from the payers.

When it comes to editing claims, the mantra of many financial experts is becoming "the sooner, the better." As part of its re-engineering efforts, Virginia Mason Medical Center has taken steps to "move as many claims edits as possible upstream so the process can be mistake-proofed," says Schaefer, the vice president of finance. "I can put oil in the Mississippi River and it will flow downstream to the delta," he says. "I can remove the oil in the delta. But why not take care of it upstream? I want everything caught in our claims before they are transmitted."

In addition to edits in its patient accounting system, the hospital added an extra layer of editing using software from RelayHealth, a unit of McKesson Corp.

This extra editing, and other re-engineering steps, have helped the medical center cut its hospital days in AR to 46 days, down from 79 seven years ago.

Making the Connection

For much of the 1990s and beyond, many provider organizations focused on making the transition from mailing in paper claims to submitting them electronically through a clearinghouse. Now that the vast majority of claims are submitted electronically, some hospitals and clinics are looking for ways to connect directly to some payers, skipping the clearinghouse step.

For example, Christus Health's 40 hospitals still use claims editing software from The SSI Group Inc., Mobile, Ala., to prepare all its millions of claims. But the hospitals now sends claims directly to certain major payers' portals, rather than through SSI's clearinghouse. It continues to use the clearinghouse for smaller payers.

Shifting from clearinghouses to a more direct approach gives the hospitals more control and generally enables them to confirm more quickly that a payer has received the bill, says Frank Smith, the chain's director of shared services.

In addition to potential delays in provider/payer data transactions, a significant source of potential lags in cash flow is the inefficient adjudication of claims. Many payers are weighed

down by older information systems that can take days to determine whether a claim should be paid, and for what amount.

A small handful of payers are beginning to experiment with real-time adjudication of simpler physician claims. For example, the pediatric practice of Peter Masucci, M.D., gets immediate responses on claims for the few patients it sees who are enrolled in high-deductible plans from United Healthcare, Minneapolis, and Humana Inc., Louisville, says Donna Masucci, the office manager.

The clinic's practice management software alerts its staff members that these types of patients may be eligible for auto-adjudication, triggering submission of the claim immediately through athenahealth, she says.

Other payers are using technology to squeeze time out of the adjudication process.

For example, Blue Cross and Blue Shield of South Carolina is striving to adjudicate all claims the day they are submitted. It's encouraging providers to submit claims, directly if possible, several times each day.

When the payer receives a claim directly from a hospital, it immediately sends a message acknowledging that it has been received. This acknowledgement may include an automatic rejection of the claim if it's obviously missing information, says Strickland, the director of commercial EDI services.

Then within a few hours, the Blues plan sends the hospital a more detailed claims status report, enabling the hospital to "see which claims were clean and will be paid in full" and which ones are still pending, he explains.

The payer sends out electronic remittance advice, with the complete results of the adjudication, in a batch on Saturdays, so hospitals can review them Monday morning. "We haven't seen a strong demand from hospitals for instant access to full remittance advice," Strickland says. Nevertheless, the Blues plan hopes to eventually transmit remittance advice within a day of receiving a claim.

The South Carolina plan self-developed most of the software that handles claims processing. But it uses an application from Viatrack Systems, Martinez, Ga., to clarify remittance advice. The software automatically converts the relatively complex data in a standard HIPAA transaction to more easily readable prose that helps patients and collectors alike, Strickland says.

For physicians, the Blues plan offers the option of keying in claims on a Web site and saving templates for use on future claims. Then the clinic gets instant feedback on whether the claim is complete.

But not all payers can afford to develop or license applications and invest in the necessary servers to support them. Just as many smaller group practices are turning to ASPs to control their I.T. costs, so too some payers are relying on ASPs as a low-cost way to modernize claims adjudication.

One payer that has turned to an ASP is Atlanticare Administrators Inc., a Hammonton, N.J.-

based third party administrator that manages health plans for self-insured companies. The TPA uses software from Bloodhound Technologies, Research Triangle Park, N.C., to review all the elements of claims for accuracy and completeness, says Doris Signorini, business process applications manager. This takes two hours or less—far less time than it would take three or four in-house staff members to edit claims with software, she says.

The TPA also uses ASP software from Ebix Health, Pittsburgh, Pa., for its core claims processing system.

By using the applications, the TPA has cut the amount of time it takes to process a claim from a week or more to about three days, Signorini says.

For more information on claims processing and financial systems, visit the revenue cycle management and electronic data interchange channels at healthdatamanagement.com.

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