How to avoid disruption in your claims processing and cash flow

Few areas of the revenue cycle impact the speed of payment as much as claims processing. Even small gaps or deficiencies in the workflow can create redundancies, delays and rework that cost health care systems millions. By focusing on key areas of vulnerability, your health system can accelerate cash flow and reduce the risks of audit and denial.

1 Get automated

Most claims are submitted electronically,[1] but there are pockets of opportunity in the claims process for further technology adoption.

Cash posting

Electronic claim remittance advice and posting/receiving payments represent significant savings and efficiency opportunities for many health care providers. An automated solution such as nThrive's Claims Remittance Management captures 835 transactions directly from payors – eliminating follow-up calls, improving your health system resource usage and cash flow consistency.

Claims status

Accessing accurate claim adjudication status is expensive and challenging. Manual processes, payor complexities and lack of data to create exception-based work lists slow resolution and cash flow. The solution is to acquire claim adjudication status from payor websites so collections staff can follow up only on outstanding claims and correct issues faster. Health systems accomplish this with nThrive's Claims Management, which automates detailed status capture, accesses status information several days earlier than HIPAA transactions are typically provided and focuses collections

4 keys

Get automated

Monitor your metrics

See what's happening upstream

Keep up with payor rules

only on those requiring manual intervention. The results are accelerated cash collections, fewer accounts receivable (A/R) days and lower cost to collect.

Missing charges

Failing to accurately capture and bill 100 percent of patient charges can cost substantial revenue, decrease patient satisfaction and create serious noncompliance risks. Plus, the Centers for Medicare & Medicaid Services (CMS) bases reimbursements on regional averages; if your health system does not report costs accurately, it can hurt future reimbursements. Auditing patient charges manually – even with the largest teams – is not feasible. An automated solution such as nThrive's Charge Capture Audit identifies potential lost revenue and charge issues before claims are submitted to improve billing compliance and revenue capture. Charge Capture Audit uses thousands of rules to review every bill and flag charging issues based on clinical practice guidelines and Medicare coding requirements. By identifying the net revenue impact of missing charges based on your health system's specific contract terms, staff can easily prioritize their corrections focus.

Secondary claims

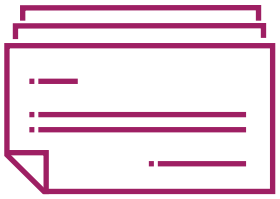
Many health systems struggle with generating secondary claims when secondary insurance is provided, which can either minimize or further delay reimbursement. nThrive's Claims Management automatically creates a secondary claim as soon as a copy of the remittance advice from the primary payor is received, speeding up billing and net cash collection. For Medicare Part A, the tool automatically creates a secondary claim prior to remittance to increase efficiency.

2 Monitor your metrics

With so many moving parts in the claims process, your health system must rely on detailed reports to drill down into the real issues affecting profitability. A few key metrics should be monitored regularly.

Clean claim rate

Most U.S. hospitals' clean claim rate averages 75 to 85 percent.[2] Providers whose rate is below par or not trending in the right direction should consistently analyze payor rejections to find the root causes of unsuccessful claims and adjust upstream processes to improve claim quality. Investing in a claims processing solution with robust editing capabilities should improve clean claim rates solidly into the mid-80 percent range, if not higher. nThrive's Claims Management, a Web-based platform, improves billing accuracy and compliance with extensive editing capabilities including provider- and payor-specific edits, Ambulatory Payment Class (APC), Medicare Code Editor (MCE), Outpatient Code Editor (OCE) and Correct Coding Initiative (CCI) edits.



40%
of payments are still made with checks

First pass pay rate

Because of payor issues, even clean claims can be subject to denial or revision. Therefore, the first pass pay rate may be a better indicator of how efficient the claims process is. If your health system is under the industry benchmark of 90 percent, you might consider nThrive's Claims Management Reporting to monitor performance and identify problem areas such as insurance eligibility verification, required authorizations, accurate patient information and correct coding.

Denial rate

While an ideal claim denial rate for a health system is 2 percent, federal studies show actual denial rates range from 11 percent to 24 percent of claims and are often higher with certain insurers.[3] These issues make it critical for your health system to correct denials issues now. By employing a solution such as nThrive's Collections Management, your health system can reduce write-offs and improve cash flow. Collections Management automates and accelerates the identification and resolution of claim and service-level denials by analyzing payor adjustment codes on remittance advice and processing denials according to provider-driven parameters.

CLEAN CLAIM RATE

3 See what's happening upstream

Not all claims inefficiencies are born in the claims department. Incorrect patient data from the patient accounting system is just one source of rejections down the road. Monitoring upstream functions can help prevent time-consuming claims corrections and resubmissions.

Patient registration

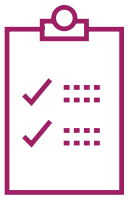
Seventy percent of data needed for billing originates at registration. The national average registration error rate is 46 percent, and about half of all denials could be prevented with accurate registration. Simple ways to increase efficiency, compliance and patient satisfaction are to establish registration data quality metrics, thoroughly train front office employees and give them technology and processes to accurately register patients. nThrive's Registration Quality Management delivers rules-based automation to enable staff to correct errors real-time or in batches, which improves efficiency and quality, eliminates manual registration quality audits and reduces billing hold times.

Patient accounting system

Errors detected in the backend of the revenue cycle during claims processing should be corrected at the point of origination. These typically occur as a result of inefficient processes, handoffs and workflows in the patient accounting system, the "source of truth" that various revenue cycle departments and technologies rely upon. nThrive's Claims Management identifies process errors upstream and minimizes the ripple effect of making redundant corrections throughout the revenue cycle.

Revenue cycle audits

Every aspect of the revenue cycle – from patient access and case management, to financial counseling and revenue integrity, to health information management and patient financial services – affects financial performance. Improving only high return on investment (ROI) areas leaves providers at risk amid growing pressures from new payment structures and new health care reform performance measures. nThrive's Revenue Performance Improvement Consulting provides a comprehensive analysis of overall revenue cycle activities to identify, track and quantify key performance indicators against industry best practice standards, reducing total cost to collect by 10 percent, and increasing net revenue by up to 5 percent.



50%

of denials are preventable with accurate registration

4 Keep up with payor rules

Billing and coding rules must cover millions of claim and billing scenarios and be crosschecked against numerous code tables to identify errors before submission. Constant payor rules changes require many health systems to hire full-time staff just to keep up.

Proactive clearinghouse and claims processor

A claims clearinghouse decreases the risk of human errors, which is the number one cause of rejected claims. A claims processor handles large volumes of claims automatically and usually has a direct link to Medicare. A proactive claims processor and clearinghouse such as nThrive's Claims Management conducts daily reviews of changing payor rules and edits, maintains the claims system so your health system does not have to and performs advanced eligibility edits to verify patient eligibility before claims are submitted. In addition to automatic edit updates, nThrive provides a dedicated research team versed in payor reimbursement rules and trends. They send bi-weekly update advisories to providers, which help them make permanent improvements and achieve higher first pass clean claim rates and reduced payor denials. Because of their volume, proactive claims processors and clearinghouses can serve as advocates on behalf of your health system and payors to communicate industry issues and improve claims processing.

Efficiency drives performance

Fewer denials, reduced audit risk and accelerated cash flow can all be achieved by closing gaps in claims processing. Revenue cycle performance initiatives are most successful and cost effective when delivered through a single point of accountability for integrated consulting, technology and services. nThrive is a proven leader in revenue cycle performance solutions to address your health system's patient-to-payment℠ specific needs, whether functional or comprehensive.

1. 2013 U.S. Healthcare Efficiency Index: Electronic Administrative Transaction Adoption and Savings, revised May 5, 2014.
2. "How to Improve Your Clean Claims Rates," by Mary Guarino, Healthcare Information and Management Systems and Society, October 19, 2010.
3. GAO report: http://www.gao.gov/new.items/d11268.pdf.

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