RFP building guidelines for charge and compliance management

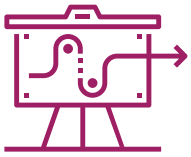
Hospitals need claims and billing systems with advanced functionality to help navigate the rapidly changing reimbursement rules and care delivery models that are profoundly affecting compensation.

This guide is designed to help you craft an RFP that will identify such next-generation solutions. A list of the top requirements follows, along with suggested questions to include in your RFP.

Charge-level bill audits

Look for a claims and billing solution that can automate the review of every bill for coding errors, missed charges, and overcharges – a capability that can recoup millions of dollars in lost revenue. The following questions can help hospitals find such a powerful automated solution:

1. Describe how and what your solution audits include before claim submission. For example, does it analyze all the way to the charge level?
2. Does your solution audit at the charge level for both inpatient and outpatient claims?
3. If your solution does audit for charge errors and omissions, what additional steps does it take after spotting one? For example, can it auto-route problematic bills to a specific person or department? How does it prioritize issues?
4. How clinically comprehensive are your charge-level rules? Please list your sources for rule creation.
5. How frequently are the rules updated?
6. Does your solution check for ICD-10 coding compliance? If so, please describe.
7. How does your company assist clients with implementing processes that support long-term success with the new technology?
8. How does your solution/company deal with systemic errors and omissions? Are you able to make or recommend permanent process improvements?
9. Can your solution identify and resolve charge and coding issues prior to claim creation?
10. Can your solution's results be integrated into our patient accounting system to streamline processes?
11. How does your company help clients understand the net revenue impact of correcting charge and coding issues?



Recoup millions

in lost revenue with the right claims auditing solution

Comprehensive payor edits

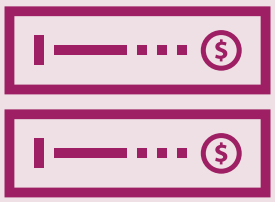
A data-driven solution that automatically and quickly reviews 100 percent of charges using thousands of rules – and is supported by a dedicated team of researchers who are constantly studying payor trends and their impact on the billing process – will keep millions of dollars from slipping through the cracks. To identify such a solution, consider including these questions in an RFP:

1. How comprehensive is the data that informs your claim edits? Does it include, at a minimum, the latest payor rules and codes? Does it also include data extracted from your hospital's EHR and patient accounting system? Any other systems? Please list all of your data sources.
2. Does your company maintain its own payor-specific claim rules and edits? Or does your company purchase claim edits from other sources? If so, please list sources.
3. How frequently are your edits updated?
4. Explain your company's process regarding how it maintains the edits for the Centers for Medicare & Medicaid Services (CMS) including:
   - National Coding Determination (NCD)
   - Medically Unlikely Edit (MUE)
   - Outpatient Coding Editor (OCE)
5. Does your company maintain Medicaid and Medicaid HMO edits? If yes, please describe the process.
6. Does your company maintain Medicaid edits for all states? If yes, please describe the process.
7. Do error messages display to specifically identify which edit is triggering the error? Is the payor-supporting documentation shown in the error message?
8. Does your company have the ability to compare different claim types and edit claims based on any discrepancies found across both claim types (for example, institutional and professional)? If yes, please explain.
9. What if I have questions about interpreting a payor rule or edit? Is there a knowledgeable person on hand to explain it to me?
10. How does your company advocate for customers with payors? Can you provide examples?

Powerful, seamless workflow capabilities

Achieve a "once and it's done" outcome by choosing a claims and billing solution that automatically assigns tasks to the appropriate staffer. Here are suggested questions to ask in the RFP:

1. Does your company offer consulting services that review the current organization and assist with making changes to align with best practices?
2. Does your solution automate processing of inpatient claims in addition to outpatient claims?
3. Does your company have the ability to provision/assign all bills/claims to an actual user once they have been imported into your system to drive ownership and accountability, or do billers choose their own assignments from a general work queue? How does the system determine workflow distribution? Can multiple criteria be utilized?
4. Does your company provide the ability to report on edits triggered for claims when they are being imported as well as any outstanding edits on a claim in real-time? Please explain.
5. Can your charge-level rules and payor edits be accessed and viewed in a non-programming or non-technical format so they are easy to understand?
6. Can a biller override an edit on a specific bill or claim without deactivating the edit for all? If yes, please describe the process.
7. Can your system identify duplicate claims within the system (not billed)?
8. Does your company provide services to check patient eligibility coverage prior to claim submission to a payor? If yes, list payors and explain the process.
9. Describe in detail how your company enables a client to assign and create custom work queues for claims that fail eligibility.
10. Describe your solution platform. Does it have a proven track record of integrating with patient accounting and other systems? To what level?
11. What other revenue cycle management solutions do you offer? How do they work with your claims and billing solution?



100% of charges

Do you have a solution that automatically checks charges for compliance with **thousands** of payor rules?

Clearinghouse Services

Efficiently submitting claims to your payor partners is a primary function of a claims and billing solution. With these questions, the RFP can determine if the vendor's clearinghouse capabilities will meet your needs:

1. Does your solution have a clearinghouse that facilitates claims transactions with payors that have different formats for claims, remittance status reports, and other electronic files? Does it provide clearinghouse reconciliation down to the claim level?
2. Does your company coordinate and facilitate EDI enrollments?
3. Describe in detail your company's balancing and reconciliation process for importing/exporting claim files.
4. Please outline the payor claim reconciliation process that ensures claims are never lost.
5. Does your company transmit 837 claims within one business day?
6. How often does your company transmit claims (i.e. hourly, once daily, twice daily)? Please explain in detail.
7. Please provide your list of payors, including a list of those with whom you are directly connected.

Advanced remittance and posting

The RFP should determine if the vendor has a "no claim left behind" philosophy that brings visibility to the payment status of every single claim. Ask these questions to assess that capability:

1. Describe your company's remittance management functionality. Please explain the process in detail.
2. What types of reports do you create from electronic remittance advice (ERA)? Please provide samples.
3. How are ERA enrollments handled?
4. Describe your company's solution for integrating claims, remittance and denial management.
5. How long do you retain historical remittance data?
6. Does your company have automated 276/277 claims status functionality? If yes, describe the process.
7. Is the automated 277 claim status linked to individual claims? Please explain.
8. Does your company have the capability to automate claim status and place responses into the claims follow-up system for action?
9. Can your system place account notes in the patient accounting system? If yes, please explain the process in detail.
10. Do you provide any other statuses outside of 276/277?
11. Please describe the top attributes of your solution that assure no claim slips through the cracks and goes unprocessed or unpaid.

Advanced bridge routines and custom edits

Hospitals can get the actionable data needed to implement permanent process improvements if they have this capability. In the RFP, these questions should be answered as applicable for both charge-level billing rules and payor claim edits:

1. Can **FACILITY NAME** access and view your company edits? If yes, please describe the process.
2. Can **FACILITY NAME** modify edits to create custom edits? Is there an associated charge? Please explain the process.
3. Can **FACILITY NAME** create custom edits without incurring additional vendor charges? If no, please explain and provide the associated costs.
4. Will the vendor assist **FACILITY NAME** in creating custom edits without incurring additional fees? If no, please explain and provide associated cost.

5. In the development stage, prior to the implementation, will your company be able to copy any existing custom edits into your system? If yes, is there an associated cost? Please explain the process.
6. Can your company supplement any information necessary for claim import that may otherwise be missing or invalid from the patient accounting system? Please explain.
7. Do the custom edits operate on all applicable HCFA 1500 form locators? Please explain.
8. Do the custom edits operate on all applicable ANSI 837 loops & segments? Please explain.

Direct to Medicare claims submission

For hospitals that treat a large number of Medicare patients, this is an incredibly convenient feature that lets billers upload claims right into Medicare's Direct Data System for same-day submission. A question inquiring if such a feature exists, and if it allows billers to check for eligibility and make corrections directly within the Medicare system should be included in the RFP.

FTE productivity improvements

Summary report intelligence is key to pinpointing problems, their root causes – and ultimately replacing them with improved processes. Here are the questions essential to determining the level of this capability in a claims and billing solution:

1. Describe and provide a sample copy of the standard and ad hoc reporting capabilities of your proposed software solution.
2. Is there a limitation in the number of records that can be retrieved when running a report (i.e. 1,000, 5,000, 50,000 etc.)?
3. Describe payor confirmation or acknowledgement reports. Please provide a sample of daily, weekly and monthly reporting.
4. Is there a charge for custom reports? If yes, please provide the associated cost.
5. Describe your productivity reporting. Please provide samples of reports.
6. Does your company provide dashboard reports? What functions (i.e. drill down capability) are available? What is the distribution frequency? If modifications are needed, is there an associated cost? Please provide a sample report.

Track record for positive financial impact

An RFP is an excellent place to ask for examples of customer successes, including clear measures of positive financial outcomes. These examples can demonstrate reduction in the number of A/R days, improvements in cash flow, dollar amount of newly identified missing charges, or any other important financial metric.

Your compensation is profoundly affected by rapidly changing reimbursement rules and care delivery models. **Make sure your RFP asks the right questions.**

nthrive™

Engage with nThrive

Visit www.nThrive.com **E-mail** solutions@nThrive.com

From patient-to-payment,℠ nThrive empowers health care for every one in every community.℠