Five ways to minimize compliance and reimbursement risk

Your health system can not escape the realities of today's complex medical billing and reimbursement process. The challenges are well defined, but it can be difficult to know where to focus to minimize risk and maintain a sound financial base. Outlined below are five essential actions that can help minimize your risk of payment delays and errors that negatively affect cash flow.

1 Identify issues upstream

Despite all the talk about claims errors, the truth is that many occur before they reach the claims department. Mistakes are often made during patient registration, eligibility verification, physician documentation, coding and other upstream processes, making it all the way to claims before they're caught. Claims personnel can identify and correct some issues themselves, but they often have to go back to the physician or coder, creating costly reimbursement delays. By analyzing each phase of the billing process and establishing vigilant corrective feedback loops, your staff can identify areas of risk and correct them with training, technology or refined processes that verify the information sent to claims is complete and accurate.

Upstream watch outs

- Is your chargemaster compliant and complete?
- Is your pricing defensible?
- Do you have a workflow process to communicate updates such as chargemaster changes or claims edit advisories to end user departments? Are these updates made consistently throughout the patient accounting system and revenue cycle management systems?
- Are you able to track and report communication and changes for audit purposes?

5 ways to minimize risk

A daily audit of **100%** of bills saves millions

2 Improve charge capture processes

With so many compliance and reform challenges out of your health systems control, it's good to know you can positively affect revenue by shoring up internal processes. One opportunity is to capture all charges for services provided that are missing from patient bills, a common misstep that costs health systems millions of dollars each year. Closing the gap isn't easy, since thousands of rules and clinical scenarios make it impossible for nurse auditors or other personnel to keep up – or know what to look for. Automated charge capture audits on 100 percent of inpatient and outpatient bills can flag issues based on clinical practice guidelines, all payor coding requirements and contract terms.

Charge capture watch outs

- Can you prioritize which accounts to audit for coding, missing charges or over charges?
- Are you able to perform daily audits on 100 percent of your bills – both inpatient and outpatient – with multiple parameters?
- Can you quantify and report ROI (gross and net revenue) on your current charge capture activities?
- Are you able to focus chart audit activities where net revenue and compliance opportunity is the greatest?

3 Strengthen the claims edit library

If your denials and rejection rates are high, it's time to question why your claims management system is letting bad claims get out the door. Without a robust library of edits to catch errors before the claim is submitted, billing staff can be caught in an endless loop of re-work. To be effective, claims edits must go beyond the verbatim published rules to also account for the various interpretations available plus those unexplained, unofficial payor rules that can wreak havoc. Accuracy and timeliness also are important when maintaining the library.

Claims edit watch outs

- Are you relying solely on your own staff to maintain and update claims edits? Are they able to keep up?
- Does your edits library include data extracted from your hospital's electronic health record and patient accounting system? Any other systems?
- Do you have payor-specific criteria for submitting claims from all your payors?

4 Improve reporting capabilities

Ignorance is rarely bliss in the medical claims world. The only way your health system can manage claims risk is to monitor the effectiveness of your billing system, spot immediate performance problems and emerging trends, and take corrective action. There are a number of standard metrics that should be tracked, with the most important being first pass claim payment rate, denial rate, time to pay rate, error rate and productivity rate. Trending is key; performance rates in isolation may not tell the whole story of improvements or backsliding over time.

Reporting watch outs

- Do you have established metrics for your organization?
- Do you have the capabilities to analyze and act on results?
- Are your reports already days or weeks out of date by the time they get to you?

5 Automate clinical documentation

Clinical documentation is an Achilles' heel for many health care organizations. What started as a way to track patients' conditions and care has expanded into a major cog in the claims and reimbursement process. Complex rules, regulations and clinical protocols have made compliance difficult and led to human errors that trigger claim rejections and denials. Automating procedure documentation and coding improves your data capture at the point of care to eliminate duplication and submit more accurate and complete medical records the first time.

Clinical documentation watch outs

- Do your coders and clinical documentation specialists have a positive and collaborative relationship?
- Are you aware of specific compliance risks of current documentation processes?
- How much time do your physicians spend looking for codes and completing documentation?

Begin taking these **five essential actions** today to minimize your risk of payment delays and errors that negatively impact cash flow.

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