

Reimbursement Revelations: The Five Myths of Automated Claims Editing

Each in their own way, practice managers, billing office managers, software developers, executives, clinicians and other healthcare professionals hold an assortment of different misconceptions about front-end claims editing or ‘claim scrubbing.’

Even among smaller physician practices, advanced claims editing is becoming more commonplace. But as we’ll see, there is a difference between advanced and basic. The healthcare community has not fully grasped distinctions like this one – or the general state of claims editing automation – and the implications.

A little more awareness about financial trends combined with substantially more knowledge about where the technology is today will go a long way. Given the pressures behind the trends and capabilities the technology is making possible, a more thorough understanding can mean a stronger business operation for many organizations.

Claims editing software allows a practice to analyze claims for accurate coding and correct formatting before submission to payers or clearinghouses. These software applications generate reports which tell the organization which claims are payable and which are likely to be rejected. And that’s as far as industry awareness goes.

Healthcare professionals need to know that there is a difference between basic edits for formatting and more advanced coding edits. They need to know exactly how much revenue is at stake. They need to know about the real-world impact on workflow. They need to know what the vast knowledge bases behind advanced claims editing software are capable of. And they need to compare the return on investment versus the high cost of doing nothing.

Myth #1: “We’re already scrubbing.”

Too many healthcare organizations think they’ve got claim scrubbing down already. Unfortunately, there’s a huge difference between what’s typically built into practice management systems (PMS) or offered at no-cost through a clearinghouse. You get what you pay for.

Some software packages that claim to edit are simply looking for the easiest, most basic of claim-level technical edits and file-format edits. They may check to see that you entered a number in a certain field, but they won’t verify that it’s correct. An advanced scrubber will verify that all necessary data is present and that it’s all appropriate for that provider, procedure and payer. Rather than just technical and formatting, a true claims editor will also check

diagnosis code, procedure code, medical necessity and other edits.

If it sounds too good to be true, it probably is. If a small, start-up vendor is offering claims editing, investigate further. Unless they’ve acquired the technology from a developer partner, it’s probably very basic. An advanced, state-of-the-art solution will be years, or decades in the making. It’ll be driven by a comprehensive, proprietary database compiled by teams of clinicians, certified professional coders and other experts. In addition, the claim scrubber will be constantly maintained by a medical review committee as rules and regulations change.

Myth #2: “It’s no big deal.”

Contrary to popular opinion, there’s a lot of money at stake just looking at the hard-dollar revenues many practices forego. Consider typical denial rates. Ten-percent is not unusual, and reports of up to 40 percent are common. Assuming two-thirds of denied claims could have been successfully submitted, a significant portion of revenue is impacted.

In part, it’s a question of cash flow. Once the payer marks a claim as pended, rejected, or flagged for inquiry, the initial response from the payer is much slower. When you factor in the days for appeal and re-submission, cash flow comes to a trickle.

In part, it’s also a matter of being able to work more claims. Practices with front-end claim scrubber systems will tend to have a higher percentage of paid claims compared to those that don’t. Fewer denials translates into more time to realistically re-work them – rather than just writing off the lower-value claims or the more challenging appeals.

Myth #3: “It’s too hard, and we don’t have time.”

The way the technology has evolved, it’s no longer the case that editing claims has to be complicated or time-consuming. In fact, correcting them prior to submission is far quicker and simpler.

Practice staff who are used to waiting for pended, rejected, or flagged-for-inquiry claims and then waiting again after re-submitting them will find claim scrubbing a dramatically accelerated process. Those used to researching rejection codes; determining the required correction; and re-filing the claim will find claims editing a breeze. It’s not a matter of adding another step to the claims management process; it’s actually a matter of moving much of the work to the front end – and streamlining it.

Today’s more advanced claim scrubbers will review ten claims per second. That’s virtually instant feedback. Re-working the bad

(No code currently exists for this symptom, but probably should)

claims may require a few minutes, half a day, or longer; it depends on the volumes and the specialty. It's important to remember, however, that one can immediately transmit the 'good' claims. Also, most advanced systems enhance re-work because, in many cases, the system can recommend corrections. This minimizes the required detective work. Worst-case scenario: claims editors create a very short delay that prevents a much longer delay.

The underlying software has advanced to the point where claims editors can work in one of two ways. An external, 'stand-alone' solution takes an original claim file, scrubs it, and returns a detailed report. In these cases, a practice needs only to be able to locate their claim file, which, at most, requires a call to the PMS or clearinghouse vendor. An integrated solution, on the other hand, lets you view edits and make changes directly in a PMS or claims management system.

Myth #4: "My staff can handle it."

Many practices assume that, because they have certified professional coders, they don't need claim editing software. It's absolutely not an insult to them to disagree. Why? Because it is humanly impossible to do what an automated claims editor does.

More often than not, billing staff are shocked at the results after a demonstration. Changes to filing guidelines, increasing complexity, payer-specific rules and other factors have created a universe of millions of possible coding and medical necessity edits.

One of the biggest challenges to clean claims is the constant change on a daily basis. Busy offices often can't find the time to designate one person to track insurance guideline changes through Web site postings, mail and EOB data. An intelligent claim scrubber, backed by expert resources, will track and follow insurance payment policies.

In any case, at most billing offices, coders aren't working denied claims. To make matters worse, the staff working denials typically doesn't communicate with the coders because of the hassle factor. So the same mistakes occur over and over. A legitimate claims editor package will allow the medical practice to customize edits to

its particular needs, preventing the recurrence of errors.


Myth #5: "It costs too much."

As with any investment, one must consider costs along with the benefits. You don't need a return on investment (ROI) calculator to see that sending clean claims the first time is more cost effective. But it helps.

Consider a hypothetical but realistic example, Main Street Clinic, with five physicians each averaging 500 claims per month. If the average claim charge is \$75, and only 80 percent are paid on first filing, that's an initial monthly loss of \$37,500, 60 percent of which may be recoverable upon re-filing. But factor in a conservative industry estimate of \$20 per claim in labor cost to re-work them, and that's a cost of \$10,000. Total monthly loss? \$25,000.

With an advanced claims editor and a more reasonable, one-percent rejection rate, that loss drops to only \$1,875. Considering that fees should amount to several hundred dollars per month, the revenue savings alone outstrips the cost many times over.

Clean claims have taken on a new urgency for a variety of reasons. Reimbursement pressures, mounting for years, are nearing a critical mass. New programs such as CMS' Physician Quality Reporting Initiative and pay-for-performance programs generally are expanding. Compliance and accreditation are more critical for patient safety.

The barriers to entry – the obstacles healthcare organizations face in getting started with claims editing – have all but disappeared. Despite the daunting complexity, there's no legitimate reason why correct coding of claims should persist as the weak link between care delivery and reimbursement. 

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