

## **MARK YOUR CALENDARS!** **FLORIDA MGMA ANNUAL CONFERENCE** **APRIL 8, 9 & 10, 2009** **CARIBE ROYALE, ORLANDO**

We hope you are making plans to attend the 2009 Florida MGMA Annual Conference, April 8, 9 & 10 in Orlando. This year, we will be at a new venue, the Caribe Royale. As the name suggests, Caribe Royale Orlando Hotel has blended lush landscaping, cascading waterfalls and an array of amenities to create its own tropical rendition of classic hospitality. Situated on over 45 acres of stately palms and fragrant bougainvillea, and located just one-and-one-half miles from the Walt Disney World® Theme Parks, Caribe Royale Orlando accommodations feature suites and villas perfect for family vacations or business meetings, and state-of-the-art meeting and convention facilities.

The program committee will be chaired by Joanne Valentin and includes: Joan Bryan, Ann Crutchfield, Mike Franks, Sue Ottinger-Lupis, and Dorothea Wynne. Mark Mayfield has been secured as our opening speaker. His topic will be, *The Glass Ain't Half Empty...It's Just Too Big!* Mark will help you manage people, manage change and manage stress in this high octane, hilarious keynote presentation.

We hope to see you at the conference!



## DEBUNKING THE MYTHS OF AUTOMATED CLAIMS EDITING

With the continual expansion of quality reporting, pay-for-performance, and claims auditing programs happening nationwide, it is no surprise that submitting clean claims is a growing concern for many physician practices, even among smaller practices. But what is surprising is the common misconceptions held about front-end claims editing or "claim scrubbing" from practice managers, billing office managers, software developers, executives, clinicians and other healthcare professionals. It seems a large portion of the healthcare community has not yet fully grasped a complete understanding of claims editing automation.

A little more awareness about financial trends combined with substantially more knowledge about where the technology is today could 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, but there truly is so much more that healthcare professionals should know.

### "We're already scrubbing"

Too many healthcare organizations are under the impression that they've got claim scrubbing down already. Mistakenly, they are not aware of the major differences between a true claim scrubber and what's typically built into practice management systems (PMS) or offered at no-cost through a clearinghouse.

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 mechanics and formatting, a true claims editor will also check diagnosis codes, procedure codes, medical necessity and other edits.

### "We're not losing that much"

Contrary to popular opinion, there's a lot of money at stake just looking at the hard-dollar revenues many practices forego. According to 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.

When payers mark 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, the time spent waiting for the payment can lag. This can have a severe impact on cash flow.

### "We're already too busy"

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 to be much simpler. There's not an additional step added to the claims process; much of the work has simply been moved to the front end and streamlined.

Today's more advanced claim scrubbers offer virtually instant feedback with the ability to review ten claims per second and automatic recommendations for corrections. This reduces a large amount of time that is traditionally spent re-working bad claims and trying to figure out the problem or problems.

### "My staff can handle it."

Many practices assume that, because they have certified professional coders, they don't need claim editing software. Although it is very important to have certified coders, the truth is that it is humanly impossible to do what an automated claims editor does. Both are essential assets to submitting clean claims.

One of the biggest challenges to clean claims is the constant change on a daily basis. 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. 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, can do this automatically.

### "It costs too much."

As with any investment, one must consider costs along with the benefits. A return-on-investment (ROI) calculator isn't needed to see that sending clean claims the first time is more cost effective, but it certainly 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 in today's healthcare environment, and 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. The tools are out there. It's just a matter of selecting the one that offers advanced capabilities to keep up with evolving trends.

**-Marla Harmon and Stuart Newsome**  
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