Keeping It Clean: How to Improve Claim Collection Rates

By Karen Bowden, RHIA

Like the rest of the US economy, the healthcare industry is facing some harsh economic realities today. Credit is tight and the public sector continues to slash spending, requiring healthcare providers-especially hospitals-to rein in costs and protect revenue.

In times like these, hospitals cannot afford to leave money on the table, and efficient revenue cycle management is of the utmost importance. An effective process is vital, including generating clean claims.

Many hospitals continually lose significant revenue by generating a high percentage of "unclean" claims that create resource-intensive rework, increase A/R days, and ultimately reduce profitability.

From the perspective of a hospital, a clean claim is one that is paid in full the first time it drops. For US hospitals, that happens, on average, 75 percent to 85 percent of the time.[1]

Fortunately, about a third of what hospitals initially forego in unclean claims is recoverable by correcting rejections and resubmitting the claim. This can potentially add an additional 5 to 8 percent of claims revenue to the bottom line. Not only is this a valuable source of capital when funding is scarce, it is a hedge against the financial impact of rising regulatory risks, such as audits implemented by Medicare Recovery Audit Contractors.

Improving revenue cycle effectiveness usually includes a combination of strategy, process management, and technology.

The Challenge of Producing Clean Claims

To hospitals, the most challenging hurdles to improving clean claims rates are:

Frequency and volume of changes to coding and billing rules. For coding and billing staff in US hospitals, the number of changes or edits made by payers to their reimbursement policies can be overwhelming. Just keeping track of the many sources that communicate those changes, including the Centers for Medicare and Medicaid Services (CMS), its fiscal intermediaries, third-party carriers, and other private payers, is a full-time job.

Tracking the many Web site postings, e-mail alerts, newsletters, and billing manuals that report these changes is a daunting task. As a result, most new edits published by the various payer organizations go unnoticed until the volume of denied or rejected claims reaches a point where it can no longer be ignored.

Unpublished payer edits. While CMS strives to make edit logic widely available for most of its edits through CCI/OCE, national coverage determinations, and return to provider documentation, some edit logic is incomplete or delayed, leaving providers with no clear way of knowing why certain claims are failing or how to fix the problem.

Commercial and managed care payers are worse when it comes to unpublished edits, because they claim proprietary privilege when it comes to their claim adjudication practices and the rules by which they pay or reject claims are not available to providers.

Administration focus on days in discharge not final billed. One of the most common and closely watched key performance indicators for hospital administrators is the number of days from patient discharge until a final bill drops, which hospitals always strive to keep as low as possible.

When organizations focus on this to the exclusion of other metrics such as first-pass pay rates for claims or denial volumes, claims are billed quickly instead of cleanly, which means more denials, more resources devoted to reworking claims, aging

receivables, and ultimately lost revenue and increased costs.

Generating Cleaner Claims: A Practical Strategy

With so much room for error, many hospitals recognize the value of using prebilling claim-scrubbing technology to automate the process of flagging claims with errors before they drop and routing them to appropriate staff for correction before claim submission.

The good news is that revenue-cycle technology has advanced in recent years to the point where a 95 percent claims collection rate is not an unrealistic goal. When applied in combination with sound analytics and billing best practices, the revenue gains can be significant.

A best practice strategy for improving clean claim percentages involves four key steps outlined below.

Discovering and implementing all payer edits. Managing the volume and variety of published and unpublished edits from public and private payers is one of the biggest obstacles to generating clean claims. Therefore, a prebilling claim edit process must:

- Include all local payers and Medicare administrative contractors
- Track all published sources of edits, including newsletters, Web sites, and correspondence
- Identify relevant Medicare edit logic that refers to fiscal intermediary standards and regularly check for changes at this level
- Analyze all denials to deduce unpublished edit logic
- Determine when unpublished edit logic is contradictory to any contractual terms and initiate disputation processes when called for

These steps are essential for a truly thorough clean claim submission process. However, most hospitals lack the internal resources to research, build, and maintain a complete all-payer, all-claim scrubbing system.

An effective revenue-cycle management solution or business process outsourcer that specializes in hospital revenue management can often provide intelligent analytics, workflow management, and more comprehensive and continuous updates.

Understanding the root cause of internal errors. Achieving and sustaining a high claims rate also requires careful analysis of root causes for why claims are hitting specific edits. The most critical reports to run for getting at those causes will be commonly hit edits by:

- Payer
- Reason
- Payer by reason
- Clinical area from which they originate

These four views are the key ingredients for developing a corrective action process that will allow future claims to sail through edits and generate fast cash collection.

Look for patterns that indicate high frequency and high dollar impact to triage areas of highest impact first, and then define the root cause and corrective action required to fix each issue at its source.

Implement a workflow to rework claims in a timely and compliant manner. With the right information and analyses of error trends, hospitals are better equipped to efficiently rework claims and recover revenue. A consistent workflow for claims rework helps to keep things moving and reduces the probability of error. Best practices include:

- Grouping claims by issue
- Assigning issues to one accountable person
- Monitoring aging to identify factors that contribute to A/R days
- Stepping in when necessary to resolve large claims held up for small charges
- Establishing a five business-day standard for releasing claims

- Staffing effectively with team members capable of working both front- and back-end processes with a plan for gradual, human resource reduction

Setting policies for continuous improvement. Hospitals that encourage a culture of continuous improvement are best positioned to optimize revenue flow from claims. This requires a process based on consistent policies that fosters ongoing learning and provides the flexibility to meet changing organizational requirements.

The most effective policies share several factors:

- A well-documented claim-correction process
- Capabilities for identifying trends by payer
- A focus on separating internal and payer issues and resolving them independently
- Effective contract negotiations based on accurate documentation of all payer-related issues
- Creating a culture of accountability for departments, teams, and individuals
- A high permanent fix rate for claims based on the effective tracking of preventable denials

Keeping Pace with Change

Even putting current economic pressures aside, evolving reimbursement trends and rising compliance and accreditation standards have elevated the urgency of the clean claims problem. It is no longer reasonable to assume that staff alone can keep pace with the volume and frequency of change in the healthcare reimbursement environment.

With advances in revenue-cycle technology that can be implemented without undue capital or IT investments, the major roadblocks to improving clean claims rates have been lifted. Hospitals will find it is well worth the revenue to invest in partners, products, and process improvements to ensure they are operating at optimal fiscal efficiency tomorrow.

Note

1. Chuang, Kenneth H., Wade M. Aubry, and R. Adams Dudley. “Independent Medical Review of Health Plans Coverage Denials: Early Trends.” Health Affairs 23, no. 6 (Nov.-Dec. 2004): 163–69. Available online at www.healthaffairs.org.

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