



Building Claim Status

Agenda

- What is the purpose of claim status
- Claim status connection types
- Obtain and manage claim status results
- Build or outsource?

Today's goals:

- Educate members to identify Claim Status populations, and empower internal development

Claim Status Purpose

How do organizations benefit from claim status?

Cash Acceleration

Rationale:

Ability to quickly identify claims that have not been received or processed by the designated payor, prompting resubmission

Denials Management

Example:

Identification of denials before 835 is received/posted allows for expedited resolution. Lacks information denials are identified, documents are uploaded, and claim is submitted before denial is posted.

Work Queue Optimization

For Discussion:

Segmenting work queues by populations in need of manual resolution and populations that are pending adjudication/payment posting allows for a more targeted work force to focus on defective accounts

Claim Status RPA Justification

Why does claim status warrant automation?

High Volume

Rationale:

On a daily basis, the amount of accounts requiring a claim status greatly exceeds the break even point for ROI. Depending on the facilities NPR, conservatively, volumes of > 200 claims a day per payor are not uncommon.

Low Complexity

Example:

Even though added complexities of MFA & portal restrictions can be present, the complexity of obtaining a claim status from the payor portal is generally low. Because of this, build times are quick and maintenance costs are minimal.

Scalable ROI

For Discussion:

With standard processes being required for queue creation and returning the claim status result... claim status automations exist in a modular design. Meaning each claim status portal will share end points, even though their status methods are distinct.

Claim Status Connection Methods

What connection is right for your payer?

	Electronic Requests (API & X12)	RPA
Pros	- Provides Claim Status result that is sustainable for indication of "high priority/low priority" - Quick to implement - Streamlined results with little to no "run-time"	- Provides Claim Status result that is sustainable for indication of "high priority/low priority" - Has advantage of more information being available - denial reasons, service line details, etc
Cons	- Lack of payers available to provide results via API connection - Typically, results provide the minimum amount of information necessary (Paid/F1/etc) - Maintenance required to validate send/receive data	- Requires development time from engineers and solutions architect design - increased implementation time - Requires time to run automation, that needs to be scheduled and maintained - Multi-Factor Authentication/Portal Limitations

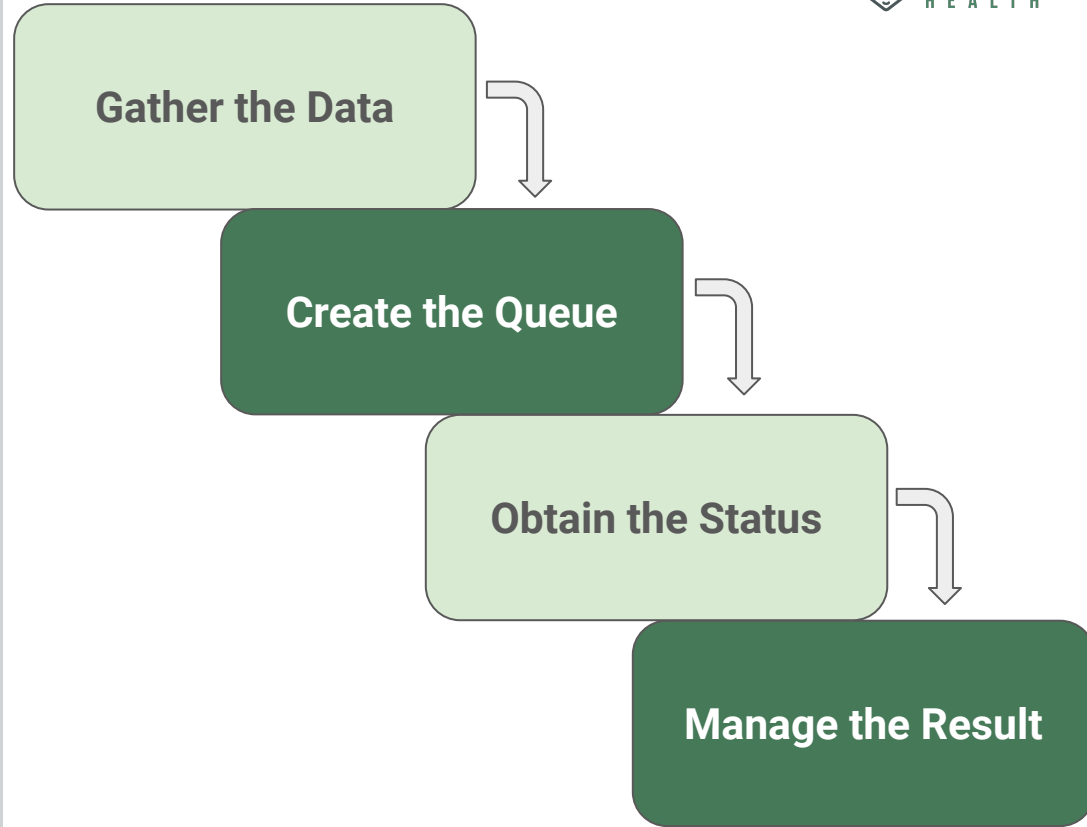
In short, electronic requests are quicker to implement and require less maintenance, but often lack additional details (or any details at all).

While RPA may take longer to implement, as well as require additional maintenance, having a blend of API's and RPA's makes for an efficient, and effective Claim Status process.

Discussion:

Has anyone identified and implemented an API that provides accurate Service Line details?

Claim Status Sequence



1. Gather the Data

Discussion: Are organizations currently leveraging an insurance dictionary for assignment of claim status connections? Average Adjudication times/Payor ID's?



Exports & Databases of importance	Details and Rationale for reference in data gathering
Aged Trial Balance (ATB)	• Gather demographic details that will be utilized in Claim Status searches ◦ (Pt Name, DOB, DOS) • COB details are required from ATB (or VFO files) to link accounts to the insurance dictionary ◦ (Current COB = 1, COB 1 Payer = Blue Cross MI)
Insurance Dictionary	• The insurance dictionary is a complete list of insurance plan codes, descriptions, financial classes, and specifically for claim status... payor ID's and Average Adjudication values • The Payor ID field is used to assign plan codes to either API or RPA, which is then connected to the distinct account listed from ATB ◦ (Blue Cross MI Plan Code = 12345, Blue Cross MI Payor ID = SB710)
Claims - 837 Data	• Gather claim details that assist in searching for the correct claim within the portal or API ◦ (Subscriber ID, claim charge amount) • Additional claim details are used in queue logic to ensure the most recent/applicable claim is being referenced in the search
Remittance - 835 Data/Transactions	• 835 & transaction details are used to ensure that we are statusing a claim that has NOT received a remit and/or has been posted to the account • 835 data can also generate additional claim status queues by identifying generic denials that would need supporting information from the payor to resolve

2. Create the Queue

Make sense of the data by organizing an efficient queue

Fields for Queue	Originating Field Location
Account Number	ATB - HAR/ETR
Patient Name	ATB - Patient First & Last Name
Date of Birth	ATB
Date of Service	ATB - Admit Date & Discharge Date
Payor ID	Insurance Dictionary - Clearinghouse/Availity
Subscriber ID	837/claims data
Claim Number	837/claims data
Total Claim Amount	837/claims data
Queue date time	Time stamp when queued for claim status

Considerations:

- “Action Type” crosswalk
- “Processed” details to avoid duplicates

Discussion:

What are concrete fields, details, or logic that should be included in Claim Status Queues?

2. Create the Queue - continued

837/835 logic to create a population that requires a status

Sample Data Set - Claim Status "Considered" Population

Claim Submitted between 7 and 90 days without remit and/or payment received

	<14 days	14-21 days	21-28 days	28-35 days	35-45 days	45-90 days	total
Payer 1	867	389	513	440	465	1106	3780
Payer 2	296	270	226	217	248	667	1924
Payer 3	473	59	136	191	104	396	1359
Payer 4	1021	483	33	158	154	9	1858
Payer 5	329	369	400	196	157	489	1940
	2986	1570	1308	1202	1128	2667	10861

	"Standard" Logic	Updated Logic	Difference	Reduction %
Payer 1	3780	2524	1256	33%
Payer 2	1924	1358	566	29%
Payer 3	1359	886	473	35%
Payer 4	1858	837	1021	55%
Payer 5	1940	1242	698	36%
	10861	6847	4014	37%

Payer Name	Avg Adjudication
Payer 1	21
Payer 2	21
Payer 3	14
Payer 4	14
Payer 5	21

* If utilizing a vendor, this is a great way to reduce transaction costs

3. Obtain the Status

Data gathered, queue generated, what else is there to consider?

Timing the “Run”

- Both processes are trigger based
 - pending nightly refresh/queue creation
- Both processes may encounter “down times” where a status is not possible
 - RPA: Refreshes/ High traffic server congestion/Volume restrictions and tracking
 - API: Refreshes/nightly processing
- Both process may require consistent trial and error to ensure the payer, data, and status location is correct

Discussion:

What other restrictions and/or down times have you experienced with Claim Status Automations?

4. Manage the Result

Results are stored, how do I leverage my claim status output?

Result Categorization

Requires Manual Review - high priority

Example: Primarily denials, but can have added logic for high dollar and/or timely filing to ensure extra attention is provided to the claim.

Pending or Paid - defer

Example: These are accounts that have returned a status of Pending, or a status of Paid within 28 days, that do not require an action and can be deferred out.

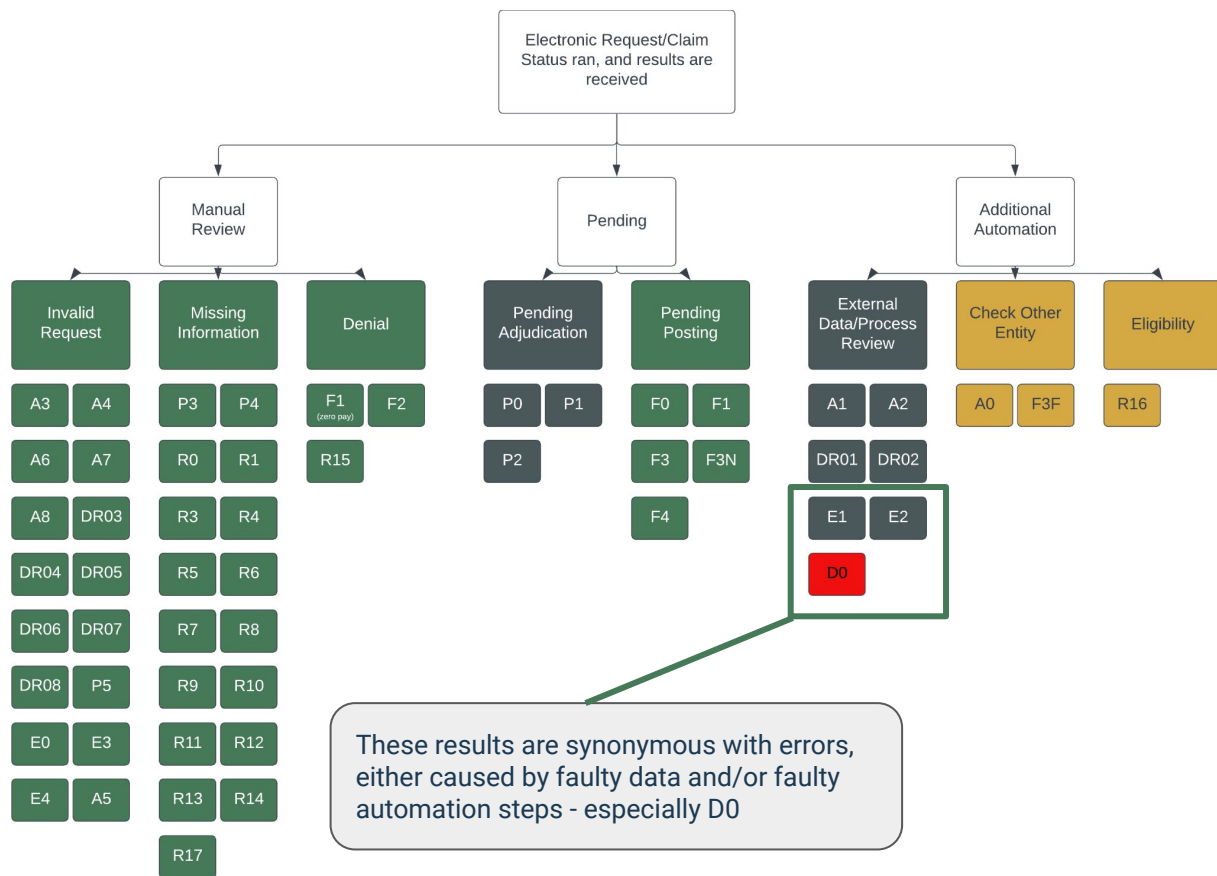
Additional Automation - external resolution

Example: There are three categories - two of which are related to eligibility and COB related denials/defects. This is where additional automation comes in - you can check claim status with another payer or queue an eligibility automation to check coverage details. The other category requires queue logic review and/or automation review.

Discussion:

What other categories of claim status come to mind?

4. Manage the Result - cont.



After first search...

... a **check once** result is obtained. Account is not searched again, it is escalated for work and/or is pending due to payment expected.

... a **check multiple times** result is obtained. Account is search every 7 days (max 3 cycles) OR until a new result is obtained.

... a **check elsewhere** result is obtained. Account received a status that requires an eligibility check and/or a claim status to a different entity.

Build Internally or Outsource?

What are the key factors when considering a Claim Status process?



Cost

Given the cost of development, maintenance, and overall platform deployment - Is it cheaper to select a vendor?



Time

Can your organization undergo downtimes to scope, design, and implement claim status automations/electronic responses?



Resource Readiness

Does your organization possess the expertise to create and maintain the automation and/or electronic responses?



Control

“Do you want to control your own process” or even more generic... “is it worth the effort?”

Tell us how we did



1 - Least valuable

10 - Most valuable

We value your feedback!



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H E A L T H

Benjamin Reigle | benjamin@tarpon.health

James Stanford | james@tarpon.health