HOLMES MURPHY

THINKING AHEAD

BEST PRACTICES FOR CLAIMS PROCESSING

SWBA BENEFITS ADMINISTRATION WORKSHOP

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CLAIMS PROCESSING – A BLACK HOLE OF MYSTERY

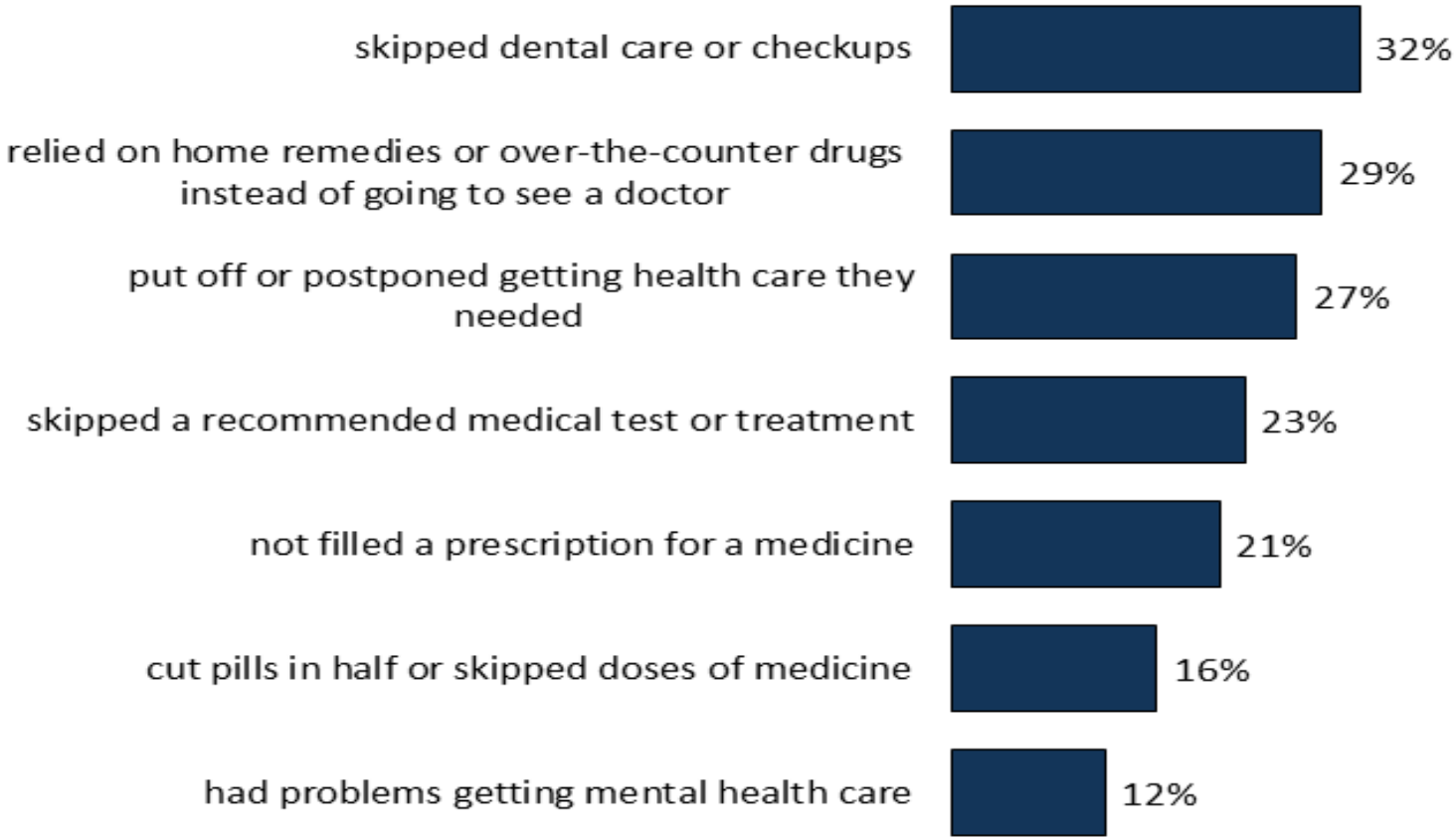
U.S. HEALTHCARE SYSTEM – A TRILLION DOLLAR INDUSTRY…AND GROWING

- ✓ PROJECTED TO GROW BY AN AVERAGE 5.6 PERCENT ANNUALLY OVER THE NEXT 10 YEARS
- ✓ BY 2025, HEALTH CARE WILL ACCOUNT FOR 20% OF THE GROSS DOMESTIC PRODUCT

Figure 5

Some Americans Report Putting Off or Postponing Care Due to Costs

Percent who say, in the past 12 months, they or a family member living in their household has done each of the following due to cost:



SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)

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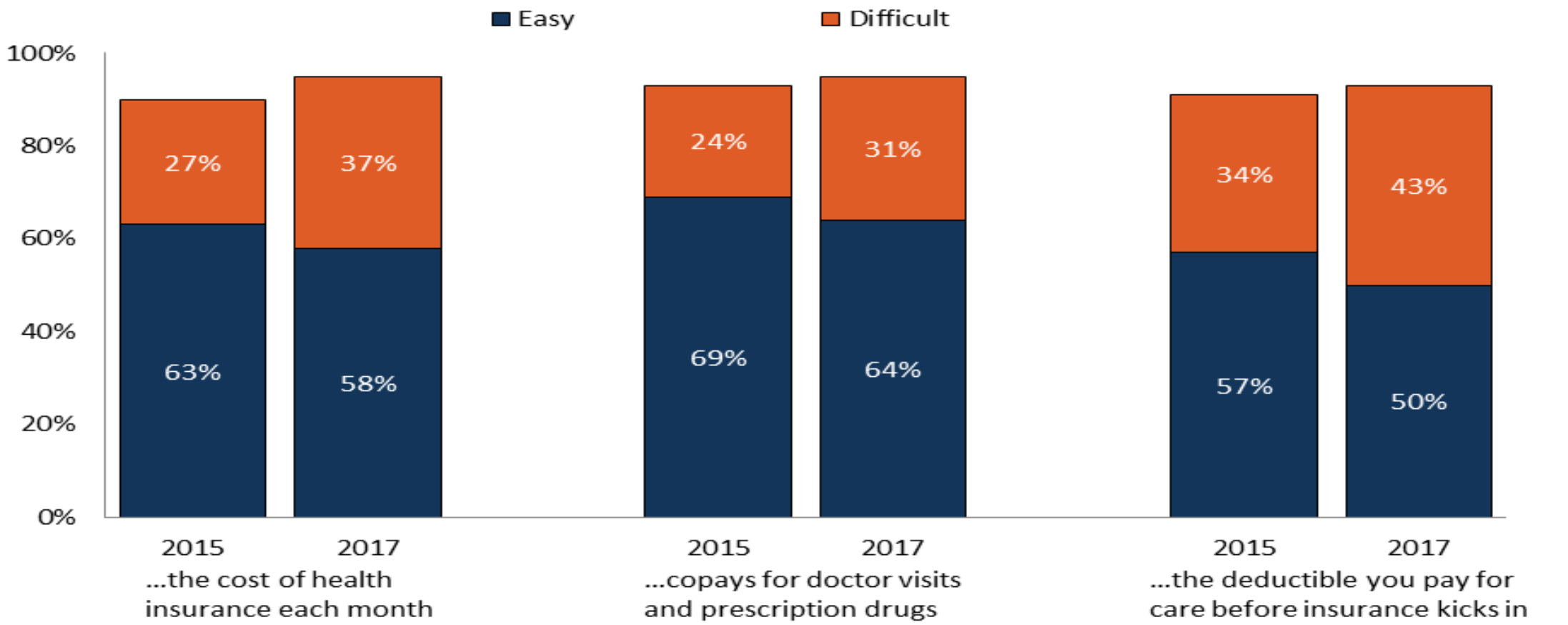
Figure 2

More Insured Americans Now Report Difficulty Affording Health Care

AMONG THE INSURED: In general, how easy or difficult is it for you to afford to pay…



NOTE: Don't have to pay (Vol.) and Don't know/Refused responses not shown.
SOURCE: Kaiser Family Foundation Health Tracking Polls

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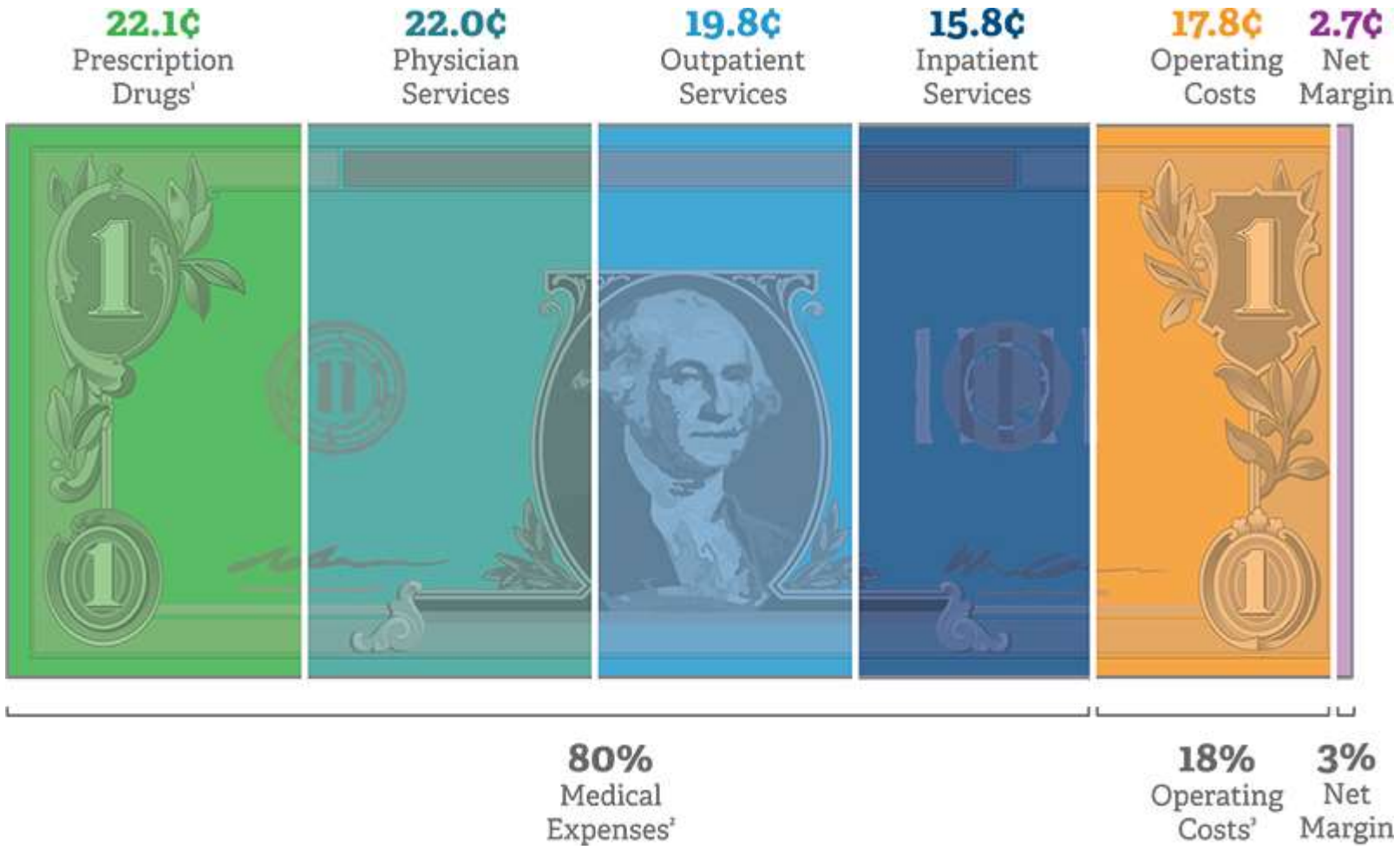
Where Does Your Premium Dollar Go?



Source: AHIP Infographics, https://www.ahip.org/health-care-dollar/

THE HANDS THAT TOUCH A CLAIM

- ✓ RECEPTIONIST
- ✓ FRONT OFFICE STAFF (COLLECT NAME, ADDRESS, DOB, REASON FOR VISIT, INSURANCE INFORMATION, SSN) – FORMS BASIS OF MEDICAL BILLING PROCESS
- ✓ FRONT OFFICE OR FINANCE STAFF CONFIRM FINANCIAL RESPONSIBILITY
- ✓ BILLING STAFF – RESPONSIBLE FOR FAMILIARITY WITH INSURANCE PROVIDER/TPA BILLING REQUIREMENTS
- ✓ MEDICAL CODER – TRANSLATE DIAGNOSES AND MEDICAL PROCEDURES PERFORMED INTO MEDICAL CODES THAT ALLOW A CLAIM TO BE SENT AND PROCESSED ELECTRONICALLY; ASSESSED FOR BILLING COMPLIANCE

THE HANDS THAT TOUCH A CLAIM

- ✓ **HEALTHCARE CLEARING HOUSE – THIRD-PARTY LIAISON TRANSMITS CLAIM FROM PROVIDER TO INSURANCE COMPANY, FLAGS FOR ERRORS**
- ✓ **WITH HIGH-VOLUME INSURERS, CLAIMS MAY BE SUBMITTED DIRECTLY TO THEM**
- ✓ **ONCE CLAIM IS RECEIVED BY INSURER, IT BEGINS ADJUDICATION PROCESS**
  - ✓ Amount paid determined by policy (plan setup) coverage, whether another insurer is involved, whether individual is eligible
  - ✓ Did the provider's office fill out the claim completely and correctly?
  - ✓ Is additional information required prior to payment?

THE HANDS THAT TOUCH A CLAIM

- ✓ **MEDICAL BILLER CHECKS AGAIN WHEN CLAIM PAYMENT IS RETURNED TO THE PROVIDER – ENSURES ALL PROCEDURES LISTED ON THE CLAIM APPEAR IN THE INSURER'S PAYMENT TRANSACTION**
- ✓ **APPEAL PROCESS CAN BEGIN OVER DISPUTED CLAIMS**
- ✓ **BALANCE-BILLING HAPPENS WHEN LEFTOVER CHARGES ARE PASSED ON TO THE PATIENT**
  - ✓ In Texas, Gov. Abbott signed a bill into law that expanded existing protection against balance-billing
    - ✓ *Patients get help contesting medical bills of more than $500 when they come from any out-of-network provider working at an in-network hospital*
    - ✓ *Insured patient remains in the financial clear while hospital and health insurer negotiate a payment*

Healthcare Claim Lifecycle

Medical report received for Coding

Coding performed and sent for charge entry

Claims created and sent to Insurance company

Insurance company sends payment

Receive and post the payments

Analyze, if discrepancies in payment

Call Insurance company for clarification

Receive clarification and make adjusting eritry

A doctor treats a patient.

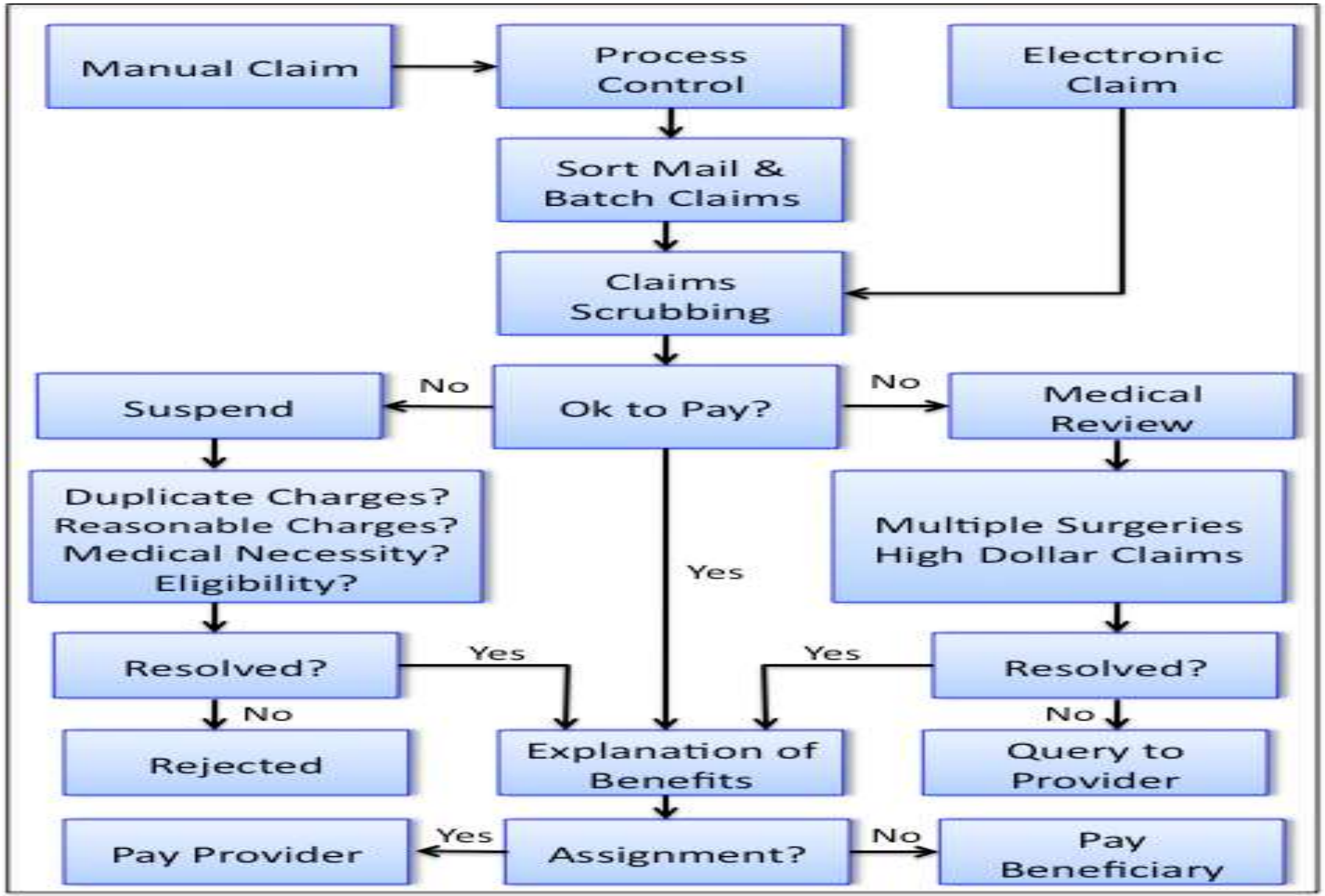
A medical transcriptionist transcibes the treatment into a medical report.

WHAT CAN A CARRIER DO WITH A CLAIM?

CLAIM IS SENT TO CARRIER/TPA – LIMITED AVAILABLE OPTIONS

1. PAY BILL IN FULL
2. DENY CLAIM DUE TO BILLING ERROR; CLAIM RETURNED TO PROVIDER TO BE CORRECTED
3. REJECT CLAIM OUTRIGHT; MEMBER PAYS FOR SERVICES
4. PEND CLAIM TO OBTAIN ADDITIONAL INFORMATION

PROMPT PAY LAWS IN MOST STATES PROVIDE REQUIREMENTS FOR TIMELY PAYMENT, INFORMATION GATHERING AND DENIALS (FI CLAIMS)


Manual Claim
Process Control
Electronic Claim
Sort Mail & Batch Claims
Claims Scrubbing
Suspend
No
Ok to Pay?
No
Medical Review
Duplicate Charges?
Reasonable Charges?
Medical Necessity?
Eligibility?
Yes
Multiple Surgeries
High Dollar Claims
Resolved?
Yes
Yes
Resolved?
No
No
Rejected
Explanation of Benefits
Query to Provider
Pay Provider
Yes
Assignment?
No
Pay Beneficiary

WHAT DOES A CARRIER DO WITH A CLAIM?

- BETWEEN 3-7% OF HEALTH CARE CLAIMS ARE INACCURATELY PAID
- CARRIERS LOSE ROUGHLY $6 PER CLAIM TO REPROCESS CLAIMS
- ESTIMATED 1 IN 5 MEDICAL CLAIMS SUBMITTED ARE PROCESSED INCORRECTLY

SOURCES: OPTUM, INC.; STERN, A. U.S. DOCTORS SAY 1 IN 5 INSURANCE CLAIMS MISHANDLED. REUTERS, JUNE 14, 2010

WHAT CAN AN EMPLOYER DO?

- **CONTROL COSTS THROUGH PLAN DESIGN**
- **CONTROL CLAIM VOLUME WITH HEALTHIER EMPLOYEES**
- **USE VENDOR ASSISTANCE**
  - Patient advocacy – can locate in-network health care providers, help select high-quality cost-effective vendors, assist employees with questioning carrier EOBs
  - Set up dependent audit – remove non-eligible dependents from plan on a regular basis
  - Establish regular claims review process with carrier – identify high-usage codes (e.g., orthopedic surgery)
  - Put targeted wellness/DM programs in place to address medical issues before they become claims
  - Specific audits for claims in excess of $100,000 and $200,000

Cost Management – Very Best Practices

Patient Advocacy
And Navigation

Claims Review, Audit,
Medical Necessity
Review

Claims and Dependent
Audit

Claims Audit For
All Claims In Excess
Of $100,000

Claims Audit For
All Claims In Excess
Of $200,000

Employer