New Claims Paradigms
Encounter Based Editing and Working the Claim Status

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New Claims Paradigms
Getting claims paid right the first time around.

This presentation is intended to educate the provider community regarding how “encounter based” editing can successfully achieve the highest claims validation rates through edit and data synchronization.

New Claims Paradigms
Getting claims paid right the first time around

This presentation is also intended to educate the provider community regarding how working with the claim status transaction can successfully lower denial rates by building an earlier follow up process.
How many systems does it take to create a bill?
How many people?
How many manual processes?
How much paper?

The New Claims Paradigms
Encounter Editing
• Upfront Billing
• Integrate Eligibility
• Automate Compliance Checks
• Validate Address
• Charge and Code Edits
• Analysis reporting
• Image Paper

What is your DNFB?
Where are your Denials
HIPAA TRANSACTIONS – The Touch-Free Billing Process

New Claims Paradigms

The New Claims Paradigms
Automating Eligibility

- Provides up-to-date eligibility requests and responses.
- Breath and Read
- Update Mainframe with Reply
- Back end Reporting
- Follow Up
New Claims Paradigms

Denial Attack Stages

1. Scheduling / Admission
2. Registration
3. Order Entry
4. Medical Records
5. Pre-Final Bill from HIS

STAGE 2
- Correct Coding
- LMRP
- Compliance
- Charge Edits
- Compliance Edits
- Payer Edits

New Claims Paradigms

Compliance Tools

- Manual compliance inquiries can be submitted real time
- Include medical necessity (LMRP, LCD's) IP-only procedures and CCI alerts
- Printing of ABN (Advanced Beneficiary Notice) waivers for non-covered charges
Physician Report Card

New Claims Paradigms
Denial Attack Stages
**HL7/ADT**

- If the patient's state (PID-11, component #4) does not start with "NH", then emergency contact field (NK1-2) cannot be blank.
- If the patient is 18 years or older, then field ZSI-1 must be an "18", otherwise, it CANNOT be an "18".
- If the assigned patient location field (PV1-3) begins with "CCT", then the attending doctor field (PV1-7) must begin with "NAME:DOCTOR"
- The guarantor’s address field (GT1-5, component #1) cannot contain any series of two or more X’s. For example, XX, XXX, XXXX, X.
**Some Software Programs Used by Coders**

- Program used for abstracting.
- Program used for a Grouper, Integrated Codebook, Coding References.
- Program used to check LOINC, NCDI articles for medical necessity for CPT & HCPCS codes.
- Program Used to view purged, scanned records if needed (for replying to denials or RAC letters).
- Program to listen to dictations that have not been transcribed if transcription is behind.
- Program – To review dialysis records if patient goes from ED or other clinic to dialysis on the same account.
- Program – To view scripts and reports for medical imaging outpatient services.
- Program – To view OR documentation for IP, ASU and Endo patients if documentation is not complete in the paper record.
- Program – To view nursing documentation, MAR, CPOE, Resp (to calculate Vent days), PT, OT, ST, Nutrition documentation.
- Program – To view L&D OP, IP; maternity, nursery, Peds documentation for IP.
- Program – For all documentation at the ACP clinics.

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**Systems Integration**

Integrating the data, linking images and workflow to individuals prior to the bill drop.
HIPAA: Touch Free Billing Cycle
EDI is the Key

- Testing, Production – maintain/measure, need to ensure the process is working as designed
- Attack with the system, not with more staffing.

HIPAA TRANSACTIONS – The Touch-Free Billing Process

Start Working with the Claim Status
Health Care Claim Status Changes

- The tracking mechanisms were improved in the 5010 transaction. Specific trace numbers can now be recorded in the request and response by the physician and payer.

- The ability to report a patient control number and a clearinghouse claim identifier was added.

- **Contact your software vendors:** Does your license include regulation transactions and did the upgrade include the 999 & 277CA and 276/277?

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276/277 Transaction Set Review

- Correct claim in the same billing cycle
- Can prioritize follow-up and look at more accounts at an earlier age
- Pre-payment and/or post-payment
- New tools get staff thinking
- Takes time to build but well worth it
- Send files as desired or scheduled to know what a Payer is going to do or determine what they have already done

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Strategy for Sending the 276 Claim Status Request

- Generated from Billing System?
- Generated through Clearinghouse?
- How many Days Post Billing by Payer?
- Generate from Open Trial Balance?
- Incorporate with 835 Claims Status Reason Code?
Implementing the 276/277-A Win-Win for Payers and Providers

- Greatly Reduce Phone Calls by Provider to Payer
- Greatly Reduce Need for Website Usage
- Greatly Reduce the Need to Submit Provider Review Forms
- Expend Payer and Provider Resources Resolving True Problem Accounts

Utilizing this Transaction

- Eliminate denials
- More money sooner
- Less manual follow-up

Interpretation of 277 Responses

- Receipt, Control, and Balancing
- System of internal checks and balances
- Flags out of balance situations
Challenges to Effective Use of 277
Claim Status Response

- Line Item Response
- Claim Level Response
- Level of Detail Provided by Payer vs. Level of Detail Needed by Provider
Implement your process by payer

- Payment in Full
- Denial in Full
- Partial Payment
- Pended
- Suspended...

Documentation of the 277 Response

- Work with IT and your Vendor to Determine
- Ability to Post all 277 Responses to Billing System
- Update a note field
- Use Response as Follow Up Tool
- Analyze, track and trend data

Instituting Process Change Through Analysis of 277 Response

- Quantitative Analysis and Trending of Payer 277 Claim Status Response
- Examples of Claims Status Response that Should Invoke Process Change
  - Member Not Found
  - No Authorization Obtained
  - Pre-Existing Condition
- Reduce
  - Untimely Billing
  - Untimely Follow Up