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Large, FQHC-qualified, Community Clinic Group Reclaims \$600,000 in Lost Revenue in Two Months Using Advanced Claims Revenue Cycle Management.

by **AnnMarie Carlisle**, Director of Billing Services
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Neighborhood Healthcare, a large group of community clinics in California's San Diego and Riverside counties, serves a population that is largely below the poverty line. We primarily offer outpatient medical services as well as dental and behavioral care, but we also operate a hospitalist program that provides some inpatient care.

As a community healthcare provider, we constantly operate on razor-thin margins. Any hitch in the revenue cycle could very well threaten the ability to deliver on our mission to provide quality healthcare and promote wellness to everyone in the community who requires it.

NEED FOR A CHANGE

Any major changes within our organization must be driven by a great need and for Neighborhood Healthcare, our need was clear — we were not being paid on up to 60 percent of healthcare claims we had submitted for payment, which, if allowed to continue for too long, would have been a death sentence for our organization.

What made things particularly difficult was that, rather than receiving denials on these claims, which would have drawn our attention to a specific problem that we could take action to correct, we received no indication that they had reached their respective payers at all. It was only when we verified our receivables that we were finding our claims had not been paid.

A number of issues appeared to be conspiring against our best efforts to submit accurate claims. First, we are a federally qualified health center (FQHC) — a Medicare designation for organizations that receive grants

under Section 330 of the Public Health Service Act. As such, we deal with many more diverse payer sources.

We also have many little nuances to dance around to get paid, such as sliding fee scales based on a patient's family size and income, enhanced Medicare and Medicaid reimbursement schedules and drug purchasing options that must be accounted for in our revenue cycle management and claims editing and remittance systems.

We had recently moved to a newer version of our practice management (PM) system and we were submitting claims through a clearinghouse. It soon became clear that neither system was prepared to deal with the adjudication complexities presented by our FQHC status. In fact, we would often boot up our old PM system and generate bills to ensure we had at least some revenue flow.

Finally, we were using a claim editing system that resided in our PM system with the "standard library" of diagnoses and procedural rules that guides how we are to code our claims. Unfortunately, given the sheer volume of codes and rules that often vary from payer to payer, our claim editing system could not be updated in a timely manner.

A FOCUSED SOLUTION

Faced with an ever-increasing shortfall in receivables and the inefficient use of staff resources required to research lost claims, we reviewed our options, which included going back and hand-writing all claims. We even considered litigation against our clearinghouse because of a lack of resolution to our claims submission problems. Our first choice, however, was to find a claims editing system and submission network that would simply work with our complex processes.



A ClaimRemedi Case Study

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For more information on ClaimRemedi's Revenue Cycle Management for insurance claims, visit www.claimremedi.com.

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We required a solution that could handle the many vagaries of our claims submission, including EDI File structure syntax, HIPAA-specific syntax, situational data, external code sets (e.g., CPT, ICD-9), lines of service and payer-specific requirements, both published and unpublished. In our discussions with other community health organizations and our research of applicable systems, we came across a company that specializes in editing and adjudication of claims submitted by FQHC-qualified community clinics.

With my CFO's approval, in March of 2007, we deployed the Claim Management /Editing Solution and Electronic Claims Submission Network from ClaimRemedi, Inc., a California-based provider of revenue cycle management solutions. We chose ClaimRemedi due to their strong background with community clinics.

BACK ON TRACK

Coming off the claims processing hassles we had been through for more than two years, I was prepared for the worst. Our conversion to a new claim editing and submission solution proved to be fairly hassle-free compared to our previous experience building an edit library for our PM system.

First, we considered how to extract the files from our PM solution for the editor to read, which delayed the rollout a bit due to the large number of files and data we needed to deliver to our new solution provider to get the system up and running properly. Then, we configured the system to save files as requested by the user at run time, rather than defaulting to our PM system's proprietary format. After a few test batches to find and correct the issues, the transition proved successful without any major hitches. Immediately, we began submitting our current claims with our new solution with the hope that we could get revenue flowing and ensure that we remained solvent.

With cash flow back on track in a matter of weeks, we set about attempting to receive the money previously lost in failed claims transactions. However, this introduced a new set of problems for our small staff, as we faced a major challenge in determining which claims were actually denied and would need to be written off as bad debt and those that were simply not processed. In order to facilitate this effort, we decided to focus on the “low-hanging fruit,” processing Medi-Cal, Medicare and Medicaid claims through ClaimRemedi.

In the first two months alone, we recovered nearly \$600,000 in back claims. And, while we'll never know how much was lost previously, I anticipate that we will generate more than \$1 million in additional revenue by resubmitting claims with our new editor. In addition, I was able to cut in half (from three to one-and-a-half) the number of FTEs dedicated to claims corrections, reallocating these staffing resources to other revenue cycle areas.

AGENT FOR CHANGE

Our new editing system is more than a revenue-generating tool. Not only does it help generate cleaner claims, it helps us effect change in our revenue cycle processes and the PM system. For instance, when we submit the claims, the editor will flag the specific field that has a problem within the claim and categorizes the error as a warning or a fatal flaw. Correcting the problem ensures that we are able to process the claim and, more importantly, get paid on initial submission.

The undocumented rules, which are updated weekly, not only accelerate the claim adjudication process, but have also maximized our rate of payment – a valuable improvement to our revenue cycle.

The currency of information the editor uses to verify claims is also beneficial to ensure our staff is up-to-date on the latest coding changes. For instance, we use the editor to identify changes in critical claims items such as diagnosis codes. From this, we can update our library that resides in the PM system to ensure that we do not use old codes.

Our new system has caused us to ask ourselves if our internal edit library is really designed correctly or whether we can make it more user-friendly and useful. It's even caused us to look more closely at the different payers we deal with and how we go about managing our partner relationships.

Since going live with our new claims editing and submission solution, I no longer hear from my CFO three to four times a day. The claims we process reach their destination with significantly fewer errors and, ultimately, fewer denials.