

A ClaimRemedi White Paper: Total Claims Management

The Problem:

Over 25% of all healthcare insurance claims are denied when first presented for payment. Effectively, a fourth of provider “invoices” are returned unpaid. No other industry faces a collection problem of this magnitude.

The choke-hold on provider revenue doesn’t stop there, but is further aggravated by:

- 40% of denied claims are never resubmitted.
- Increased staff time to rework denied claims.
- Ever changing billing requirements.

The Solution:

ClaimRemedi’s Total Claims Management

ClaimRemedi’s mission is to partner with our customers by offering a suite of value added services that will enable them to:

- Accelerate cash flow by getting more claims paid on first submission.
- Manage by exception — quickly identify claims that need attention, along with the necessary work management tools to assign and follow-up on those claims.
- Train staff on the most common reasons for claim denials — for reducing future claim denials.
- Quantify all aspects of the claim side of their business.

Connectivity to all commercial and government payers for professional, institutional and dental electronic claims processing, eligibility verification, claim status inquiries and electronic remittance advice processing.

Eligibility verification that provides fast and easy access to payer eligibility and benefit information:

- Reduce registration errors and lack of insurance verification.
- Verify that subscriber information is correct and complete before claims are submitted.
- Establish co-payment and coinsurance amounts.

Unparalleled payer specific claims scrubbing and on-line editing features that significantly reduce the number of denied claims. ClaimRemedi actually scrubs claims much like the payer back-end processing systems — except up front, at the time claims are submitted.



THE HOME PAGE

The Home Page gives you a quick overview of your claims processing — and can be configured to meet your specific needs.



VIEW CLAIM STATUS FEATURE

The View Claim Status feature lets you track claims on-line from claim submission through to adjudication.

Staff assignments and notes for follow-up can be added as needed.



ANALYTICS

Analytics lets you find and quantify any information about the claim side of your business – and includes access to all 837 institutional and professional claim fields.

A powerful “point and click” edit feature allows you to quickly locate and correct any errors before claims are submitted:

- Get more claims paid on first submission.
- Reduce overhead costs associated with having to rework and resubmit claims.
- Reduce total claim submissions.

Customized claim and payer specific solutions to meet your needs. Is your billing system sometimes unable to correctly report payer specific required information? We know payer requirements vary and we will work with you to implement solutions on our end to fix those problems.

On-line claim management and tracking that enables you to manage your claims by exception:

- Quickly identify and assign newly rejected, suspended and denied claims to your staff for follow-up.
- Determine the status of any claim in process.
- Add notes for follow-up.
- Manage claim work flow and monitor follow-up by your billing staff.
- Maintain claim history audit trails.

An abundance of easy-to-use analytical tools and reports that give you ownership of your claims processing—instead of the other way around:

- Train your staff on the most common reasons for rejections/denials.
- Measure staff productivity.
- Manage your denials.
- Create reports using any claim field.
- Compare reimbursements and denials by payer.
- Generate audits itemizing all error corrections, payer responses, assignments and notes – the who, what and when – for either a single claim or a group of claims.

