Real-Time Claim Adjudication: Deal or No Deal?

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This article will discuss one practice's quest to improve its financial health through implementing a new process called real-time claim adjudication. The article presents actual processes as implemented, describing in detail the "nuts and bolts" from an operations perspective. Finally, the discussion summarizes the many positive impacts the practice has experienced, including obvious financial rewards and unexpected accolades from patients.

Key words: Real-time claims adjudication; front desk collections; total claim management model; accounts receivable follow-up.

When the consultant who was helping us reengineer our accounts receivable (A/R) processes mentioned real-time claim adjudication (RTCA), we did the head-in-the-sand thing. "Surely," we thought, "if we never mention this, it will go away!" Well, we underestimated her persistence, because she began bringing it up each time we talked together. We could think of several reasons that it just wouldn't work. Primarily, we were convinced that our practice was much too busy to ever be able to submit claims at the time a patient checks out. And what about the need to do double entry of claims—once with the payor and then again in the practice management system? Surely, she must be crazy—or she must think we are!

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Well, how wrong we were, for we had underestimated everyone. The consultant persisted, and our A/R team took the challenge and ran with it. We are happy to share our story with you, for we have been nothing short of shocked by the results of implementing RTCA in our practice.

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BACKGROUND

We are a five-provider practice located in South Carolina doing a large percentage of business with Blue Cross Blue Shield (BCBS) of South Carolina, which offers RTCA through its Web site. Additionally, several other payors (e.g., United Health Care, Humana) have this capability, and we developed a plan to implement them on a rolling basis, beginning with BCBS of South Carolina. Our goal was to pilot this process and determine if the benefits outweighed the costs both financially and from a staffing perspective.

We considered a few important factors before moving forward: physician support, a metric, and staff readiness. Obtaining buy-in from the physicians was easy, as it did not involve changing any of their processes and had the potential to decrease administrative burden and increase overall practice profitability. We created a spreadsheet to track front-end collections by staff member and established a baseline in order to track progress. The staff considerations were a little more challenging, due to the fact that the entire A/R team dynamic needed to change dramatically.

The A/R team had already migrated to a payor-specific total-claim-management model beginning with posting explanation of benefits (EOBs) through working the actual accounts. This had been working well, and the team was truly improved in this new environment. With RTCA, the A/R work happens upstream, with the goal of never making it on to a "follow-up" list to be worked.

Therefore, the individual responsible for working claims for BCBS and other payors with RTCA capabilities moved from the back office to the checkout area. We empowered the A/R team to decide who would be taking on this project. A champion emerged, and we were on our way with redesigning the total process.

PROCESS

Pre-Visit

The process champion checks routing slips and identifies patients eligible for RTCA. If the individual is an established patient, the champion checks the payor's Web site to see if the patient has been added to the payor's practice-specific Web site database. If not, the champion adds demographics to the site's database.

Visit—Check-in

When a new or established patient checks in, new patient information is scanned, and demographics are entered into the practice management system.

Visit—Checkout

At checkout, the patient is greeted, and the process of RTCA is described in a very positive manner. New patient demographics are entered into the payor's database at checkout by the staff designated to implement RTCA. We tried to do this in advance of checkout, but just haven't been able to consistently make that work.

Once the demographics have been input, the claim is entered (CPT code, diagnosis code, etc.) while the patient is at checkout. While we acknowledge our appreciation for the patience of the patient, the claim is being adjudicated, which takes fewer than three minutes.

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Two copies of the EOB are printed; one is filed, one is given to the patient. If there is a balance, payment is requested. Our experience is that about 98% of patients pay and appreciate having the process completed. Best of all, no statement will be mailed, and no claim will ever make it to our A/R tracking process!

If the claim is denied, the claim status is checked, which will often explain the reason for denial. We give a copy of the EOB to the patient, along with an explanation, and request payment. When appropriate, the patient is asked to follow through on the denial. (Most denials
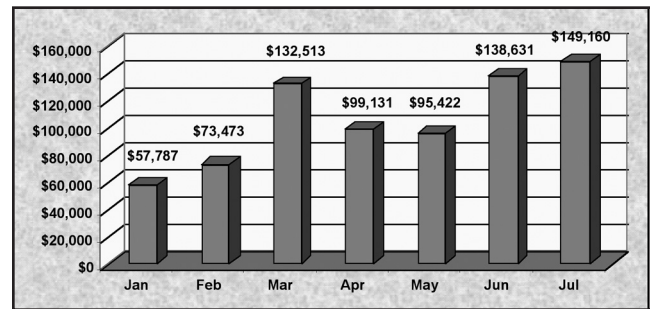
Figure 1. Greenville Ear Nose and Throat time-of-service collections, January through July 2007.

have to do with a request for information from the patient.) This has been amazing for us, as we discovered that patients truly appreciate having an "in-person" explanation of the denial. And since the explanation comes from our A/R team member, the patient receives the best help available, as this individual really understands how to best resolve these issues. As we all know, reading an EOB is complex, even for those of us in the business. Assisting patients in this way has enriched our relationship and improved our cash flow. We have had patients thank us, resolve the issue, and return with payment and/or an explanation of what actions they have taken to resolve the denial—and they are not on our payroll!

The "filed" EOB copy is stapled to the routing slip and marked with *Entered on Web site (*"EOW"). The charges are posted in the practice management system, and we select "print hard copy claim" so a duplicate claim is not generated during electronic claims submission. Many claims are adjudicated as pending. These are primarily out-of-state claims, and we are working with the payor to decrease these types of claims. In this instance, we apologize to the patient, give the patient his or her EOB, and tell the patient we will send a bill.

Post-Visit—A/R Follow-up

Once charges have been posted into the practice management system, the EOB is removed and is sent to the insurance department for follow-up. Every claim that was approved for payment is tracked to ensure that payment is received. Currently, we are on a paper payment system with payors, and payment is received in 3 to 7 days. Once we implement electronic fund transfer, we should receive payment on the same day. Pended claims are followed-up by the RTCA A/R team member.

IMPACT/FINDINGS

At first blush, the obvious "big bang" would seem to be front-desk collections, which we can certainly attest is true. Our front-desk collections increased 52% in a three-month time period (Figure 1). Although some of this improvement is related to other reengineering process

improvements, much of it can be tracked back to RTCA. Of course, this cash flow improvement will only increase our gross and net collections and decrease our total A/R. We anticipate that days in A/R will decrease as well, due to fewer accounts in the "to be worked" category. Lastly, the amount of accounts sent to collections should decrease while the amount of accounts paid in full at time of service increases.

Some of the subtler impacts include the hard dollar savings associated with general A/R processes. These savings include, but are not limited to: cost of sending out statements, cost of working accounts, savings relative to sending accounts to collections, and cost of claim submission. Based on these savings, we anticipate that our practice will enjoy a cost savings of approximately $100,000 annually. Additionally, we experienced some other results that we did not anticipate.

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Response has been overwhelmingly positive on the part of patients; we have experienced a 95% positive feedback rate from patients, and only about 2% have been unprepared to pay at the time of adjudication at checkout. In addition, we save time and money relative to processing refunds when patients have overpaid due to correctly collecting from patients at the time of service. Also, phone calls have decreased as the number of statements has declined—patients have nothing to question! And as we already mentioned, dealing with denials has been an enormous opportunity for us, as we are able to communicate directly with those patients right then and there.

Lastly, and most surprisingly, the patients have been very impressed with our ability to adjudicate claims at the time of service. We have had very few problems col-

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Some Payors that May be Offering RTCA

- BCBS South Carolina
- Humana
- United HealthCare
- Tricare

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lecting from patients when we can hand them an EOB and explain to them their balance. One of our patients who had an appointment at 7 a.m. said, "BCBS is open now?" as we processed her claim. Other patients have commented on how convenient it is to take care of the patient portion at the office instead of waiting for a bill and an EOB. Patients have thanked us for adjudicating their claims, which is not what we were expecting. We were anticipating some push-back from the patients as they would not be accustomed to this process, since so few practices have implemented RTCA. Kudos from the community for being technologically savvy has only generated more interest from the staff in moving more payors to this platform.

CONCLUSION

RTCA makes a medical practice more like all of the other businesses in the free world: we get paid when we deliver the service. It changes the way our patients think about their bills and the way our staff views collecting from patients. Expecting payment at the time of service is becoming the rule, not the exception, and that is extremely healthy for our business. The payors offering this capability are listed in the box above. In our market, we are very busy jumping through "administrative hoops" created by the payors, which ultimately increases our overall practice expense. Payors offering RTCA help us decrease our administrative burden, which is very positive for the practice and ultimately for the patients. We are now asking payors that do not offer this capability "why?"—and we will be pushing for this at every opportunity. ∎