

A Clear View Of Healthcare Claims

*An Inside Look at The New Tools and Solutions
Health Insurance Companies Are Utilizing to
Operationalize Back-Office Processing*



Healthcare organizations today are challenged to process high volumes of claims quickly and accurately. However, the reality is most insurance companies struggle with a system for claims that involves confusing, complex steps and manual procedures. This often results in an error-prone, inefficient structure with dramatic variations in performance.

Eliminating claims errors would save \$17 billion annually.

- *National Health Insurer Report Card*, AMA, 2011

To address this growing complexity, managers and quality auditors have been looking for ways to increase accuracy, efficiency and visibility into claims analysis and management.


The goal is to stop claims operational issues before they start by monitoring and actively managing processor behaviors and productivity, and identifying opportunities to improve accuracy, compliance and productivity.

Having a way to operationalize back-office claims processing and reduce the steps needed to process claims presents a significant opportunity for health insurance companies to increase ROI.

By deploying back-office analytics, which literally record the screen of processors, tracks processor desktop

behaviors, and automates tedious time consuming tasks, healthcare insurance companies have been able to systematically improve claims processor accuracy, compliance and productivity.

This E-book will address the current realities and challenges healthcare providers are facing with healthcare claims management. It will highlight the cutting-edge tools and solutions leading healthcare providers are using to have visibility into common errors and take corrective measures to address the inefficiencies.



According to an analysis of six commercial insurers, the average claims-processing error rate for the six commercial insurers that were analyzed both in 2010 and 2011 was 19.3% — an increase of 2% over last year.

- *National Health Insurer Report Card*, AMA

Challenges/Opportunities With Current Healthcare Claims Analysis Models

Research shows that every error on a healthcare claim can be a costly one. According to the annual *National Health Insurer Report Card* (See Sidebar: Current Claims Processing Gets Poor Grades) published by the American Medical Association (AMA), 19.3% of medical claims processed by the nation's largest commercial health insurers is inaccurate. The report found a 2% rise in claims processing errors over last year's findings, which added an estimated \$1.5 billion in unnecessary administrative costs to the health system. The AMA estimates that if all health insurers were able to eliminate all claim payment errors, the health care system would save \$17 billion a year.

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The reality is the majority of avoidable healthcare claims errors are the result of manual mistakes — an inefficiency that can be addressed.

In addition, the claims analysis issue is only getting more complex, and provider visibility into problem areas does not exist today. The increasing compliance requirements require greater documentation and create the potential for an increased number of costly errors.

Fact: Most healthcare organizations lack the basic operational metrics found in other industries such as Claim Adjustment Rate, measured at the processor level. Without these critical metrics, managers don't have the operational knowledge they need to improve quality levels. Managers are forced to spend extra time and money spot-checking and auditing claims processors as a stop-gap solution.

In the current model, health insurance providers have to perform forensics on each claim in order to go back and understand the trail of who processed the claim and where the error occurred.

Attaining higher claims accuracy and a consistent approach among claims processors is in everyone's best interest, especially for insurers that can reduce claims adjustment costs, penalties, interest and call-center costs from better claims accuracy.

The good news is that analytics solutions are enabling healthcare providers to create automated workflows, which are helping to reduce costs and claims errors. Desktop analytics enable healthcare insurance companies to easily trace back to where an error occurred and correct the problem using performance management tools.

With complete visibility into the current processes, managers and auditors can establish best practices for performance management. They can then operationalize these best practices and processes and automate the next-best actions to improve the speed and accuracy with which claims are processed.


These tools have improved the ability to:

- ▶ Identify the **best practices** by claim type from high quality/high throughput processors.
- ▶ Offer **visibility into the work habits** of high throughput/high quality processors.
- ▶ Provide visibility into the **step-by-step processing actions** of processors for incorrectly paid claims.



Current Claims Processing Gets Poor Grades From AMA

REPORT CARD



Consider the facts from a recent American Medical Association's Health Insurer Report Card that compiled a random sampling of approximately 2.4 million electronic claims accumulated from more than 400 physician practices in 80 medical specialties providing care in 42 states:

- ▶ On average, mistakes occur in 5% to 10% of all claims submitted.
- ▶ Healthcare claims errors waste billions of dollars every year. Estimates of the growing increase in inaccurate claim payments will cost the healthcare industry an additional \$1.5 billion in needless administrative expenses in 2011 alone.
- ▶ The U.S. healthcare system wastes between \$600 billion and \$850 billion annually due to errors and inefficiency.
- ▶ The majority of insurers failed to improve their accuracy rating in this year's report versus last year.

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Next Gen Healthcare Claims Management

New, automated claims analysis solutions allow companies to leverage the innovation of the cloud to reach disparate, back-office claims processing operation anywhere, at any time, across all technologies and locations.

By eliminating the need for capital expenditures or on-premise maintenance – and minimizing IT investment – these cloud-based solutions accelerate project funding and implementation by making these workflow tools palatable and scalable for healthcare organizations of all sizes.

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The closed-loop performance management transforms the claim audit process from “forensic science” to a repeatable, operational system for processing and analyzing complete claims.



A Breakdown Of The Typical Claims Analysis By Role

The “old” claims analysis model looks like this:

- ▶ Prioritize and distribute claims.
- ▶ Claims are worked by processors.
- ▶ Claims are finalized by the processor.
- ▶ Potential error(s) are identified by the provider.
- ▶ The claim is updated/resubmitted for adjustment.


**Claim Prioritized &
Distributed**

**Claim Worked by
Processor**

**Claim Finalized by
Processor**

**Potential Error(s)
Identified by the Provider**

**Claim Updated/Resubmitted
for Adjustment**



Patient: 01608034780
Claim Number:
Date Claim Received: 06/09/10

DATES OF SERVICE	PROCEDURE CODE	
05/21/10-05/21/10	82272	PULMONARY
05/21/10-05/21/10	94010	PULMONARY
05/21/10-05/21/10	94375	CARDIOVASCULAR SERV
05/21/10-05/21/10	93000	CARDIOVASCULAR SERV
05/21/10-05/21/10	36410	VENIPUNCTURE
Total:		

With the new, automated model, processors are visually reminded on their desktop of critical processing steps, and those steps are automatically performed to drastically reduce errors.

These tools enable healthcare providers to put operationalized performance management in place, which provides visibility into activity at the desktop level.

These new automated solutions provide real-time guidance to achieve operational goals via desktop automation and eliminate the need to work backwards to try and understand events or to develop a hypothesis of events surrounding a claim.

Claim Analysis By Role

Through the use of screen recording technology, an analyst or manager can now literally “see” what happened on the claims processor’s screen, eliminating the painful and time-consuming process of sifting back through paper trails and reports.

Automating the claims process redefines every step of the health care claim analysis. And by doing so, it reshapes the role of everyone involved in processing a claim.

With real-time guidance, the claims processing operation functions more efficiently, and each role has greater visibility into shared workflows and best practices. Here is a look at the benefits by role:



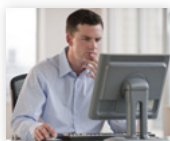
- ▶ **Processors** can review their own behavior and productivity scores, which allows them to make the right changes in their own workflow and correct their own behaviors.



- ▶ **Managers/Supervisors** can see problems within claim categories or by reason of denial of claims via a screening processor. They also can identify problem areas in quality and/or bad behavior patterns, and implement targeted coaching to help increase team productivity.



- ▶ **Analysts** can identify root cause of claims rework, predict workload based on historical data, and get insight in order to make adjustments.



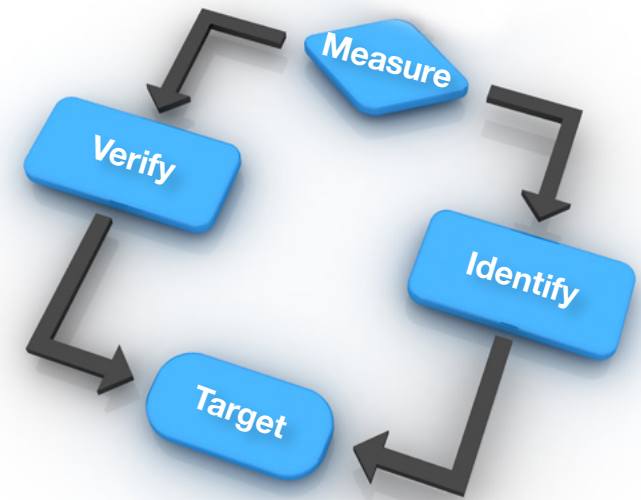
- ▶ **Auditors/Quality Monitors** will be provided with visibility into each manually adjusted claim. They can search by claim id, see a list of actions taken on certain claim, and play screen recordings of full life cycle of a claim.

New Models: Combining Actionable Data With Targeted Coaching & Performance Management

Automated solutions are cost-effective and drive a higher ROI than the current manual, error-prone processes currently employed by most healthcare providers.

By adding analytics, screen recording and coaching/performance management, automated tools support repeatable workflows by:

- ▶ Measuring performance (behaviors, value add metrics, etc.)
- ▶ Identifying problem areas (claim types, time of day, etc.)
- ▶ Drilling to actual claims/non-processing segments
- ▶ Performing targeted processor coaching
- ▶ Verifying processor improvement, thus re-evaluating coaching



Coaching sessions can be created from the dashboard and Next Best Action report. This allows managers to drive more effective training sessions.



Next Gen Health Care Claims Management

In addition to improved accuracy, compliance, recording of claims process, automation reduces costs with improved efficiency, accuracy, and cycle times.

By utilizing desktop analytics, automation, and screen recording, in addition to performance management, leading companies are reducing errors as well as claims errors.

An automated and repeatable structure to claims also streamlines audits and leverages existing controls to comply with new and changing regulations, prevents SLA and compliance violations and corresponding lost revenue, and improves business relationships while enhancing customer service.



CASE STUDY



Here is an example of how automated healthcare claims analysis can improve a healthcare claims organization's performance by gaining visibility into the claims management process.

A large health insurance company processes millions of claims per month across its multiple claim processing centers nationwide. Many of these processors work from their home offices and have very little interaction with management. Due to a lack of visibility, the company cannot view steps taken by processors if they incorrectly process a paid claim. Furthermore, the company cannot observe the work habits of high-performing processors and identify these best practices to improve the performance of lower-performing processors, improve policies, and establish operational best practices.

In order to improve claims payment accuracy and lower the overall cost to pay a claim, the company deploys a claims management solution. Now management has complete visibility into processor desktop activity to properly identify best practices and compliance violations for coaching and training. The solution also provides a screen capture for auditors to view and uncover any payment-processing errors that may occur.

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Conclusion: Using Analytics To Drive Next Best Action

In the healthcare sector, change has become the norm due to reforms. Healthcare providers now need to consistently measure improvement nearly every area of the enterprise. Insurance companies are under continual pressure to improve performance and visibility, as well as compliance for any type of oversight. With so many areas to address seemingly all at once, analytics capabilities are imperative.

Analytics and automation helps providers aggressively demonstrate a measured improvement by streamlining operations, uncovering process gaps, and raising the bar on medical loss ratios and interaction improvements across member servicing.

In the current environment, most insurance companies are operating in the dark with no real visibility into where errors and problems are causing inefficiencies. With next-generation healthcare claims management, auditors and managers will have “next best action,” capabilities to coach processors on how to handle complex claims and avoid common errors.

While it is unrealistic to think that errors will be completely eliminated, these next-gen tools will help providers remove the guesswork that currently goes into claim reviews and audits. These desktop solutions will allow insurance companies to take corrective measures to identify and rectify errors, and then record and coach processors to prevent those problems from occurring in the future. These automated systems will also help to identify best practices by claim type from high quality/high throughput processors

The increased visibility delivered by these tools will remove performance variability, help processors and agents improve performance, reduce operating costs and allow insurance companies to redeploy people into areas where their skills can be best utilized.



About



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Enkata is a leader and innovator in cloud-based customer experience analytics. Our solutions give customer-centric companies visibility into the entire customer experience across each customer touch point – social, self-service, live assistance, and retail sales and service operations. Customers achieve impressive gains in customer service industry rankings while reducing the cost to service each account. Enkata's Customer Journey Cloud is a set of analytics-powered solutions that capture unstructured data from voice and desktop sources used to improve operational process and employee performance. Fortune 100 companies trust Enkata to examine millions of customer interactions each day, ensuring that each is delivering value to their customers. For more information, please visit www.enkata.com.