Todays health plans are under increasing pressure to reduce costs—while complying with regulations, maintaining or improving quality, accuracy, consistency and service to members and providers. Aggregate claim processing costs represent a significant opportunity for savings, and the effectiveness of claims processing has a direct effect on the level of satisfaction members and providers report for the plan. Where better to initiate a cost reduction effort than in the claims processing function?

The processing cost of a claim that adjudicates on the first pass—which accounts for between 60 to 70 percent—is estimated at $2.50. Conversely, a manually processed claim resulting from an exception or "pended" from the core system—which accounts for between 30 to 40 percent—costs $28, according to research from the Gartner Group. Health plans can save millions of dollars a year by reducing the number of claims that are pended, and by handling pended claims quickly and efficiently through improved automation.

Although there are shared understandings in the marketplace regarding the most common errors and causes of manual rework and pended claims, there is no standard method for achieving the goal of reducing claim-processing costs. No health plan is exactly the same, targets the same market, offers the same product mix or adheres to the same best practices, nor are the claims themselves "cookie-cutter."

Billions of Claims Processed Annually
According to the Center for Medicare/Medicaid Services, at least six billion health care claims are filed per year. That's six billion claims submitted by providers—and six billion processed by health plans. Consider this: if, as an industry, health plans reduced the average cost to process a claim by twenty cents each, the industry would save $1.2 billion.

Cross-departmental commitment to constant improvement is one of the best indicators of a health payer's overall success in reducing claims processing costs. Payers that create an environment and a culture that invites change have better results. This spirit of leadership needs to be channeled and harvested by technology that is intelligent and powerful enough to help people become more effective, enabling the plan's workers to collaborate with suppliers to improve the quality of their inputs. Payers who modify their processes as market demands change and further opportunities for improvement are identified have a clear advantage. By implementing process and content management software, claims leaders can both reduce the incidence of manual processing and reduce its cost when it inevitably occurs.

The Claims Process Has Many Steps
Each transaction, from data entry to adjudication, is a step in the claim processing procedure. Claims managers have their production schedules and quality goals and need to lead the organization to develop and implement the optimal way for the individual health plan to meet those goals.

The flow of work in the claims processing procedure consists of four major steps:
1. Claim intake: The claim and key data contained on it enters the process either electronically or on paper.
2. Claim preparation (or pre-adjudication audit): The claim is prepared for payment such that it has the best chance that automated processing is completed on the first pass through the core system.
3. Claim adjudication in the core system: The claim passes through the core system and is paid, denied or pended.
4. Pended claims management: Claims that were suspended for any number of reasons are reviewed and re-processed manually.

Paper Handling Means More Opportunity for Errors
Claim intake can be defined as the receipt and entry of claims data into the process flow. The goal of claim intake is to maximize the efficiencies of people and technology to initiate a rules-driven process while securing mission-critical claim data. When claims are submitted via electronic data interchange (EDI), claim intake includes the ability to render data provided on an EDI stream to the appropriate claim form, saving it as a tagged image so that it can be viewed online as easily as a paper claim. With paper claims, optimal claim intake leverages such technologies as document scanning and imaging and Optical Character Recognition (OCR) capabilities.

Follow That Claim, an American Medical Association report, reported that 30 percent of all paper claims submitted to health plans are rejected. Health plans save money and decrease errors when providers sub-
mit claims electronically instead of on paper. Higher first-pass auto-
adjudication rates for EDI claims also benefit providers.

Paper handling introduces more opportunity for errors into the process. If 40 percent of the claims for a plan that handles one million claims a month come in on paper, that's 400,000 paper claims a month. If plans have to key in data from 40 fields on the Centers for Medicare & Medicaid Services form—even if they use OCR technology and just spot-check fields for quality—that's 16 million opportunities for error on the inputs to the process per month!

Plans can provide incentives for accuracy and EDI claims submission, but cannot mandate it. Payers can encourage reduction in the amount of paper claims submitted by requiring, encouraging or rewarding providers that submit claims via EDI. Blue Cross of Idaho was highly successful in increasing the volume of claims received electronically when it implemented a three-prong approach. First, Blue Cross of Idaho educated providers on the benefits of electronic claims submission. Second, the plan identified a list of software vendors that worked well with their core systems and encouraging providers to adopt those systems. Lastly, Blue Cross of Idaho provided online tools for providers to correct EDI claims. As a result, EDI claim submissions increased from 59 percent to 79 percent, reduced the number of rejected claims, improving providers' cash flow and saving providers and Blue Cross of Idaho money.

Blue Cross and Blue Shield of Texas created a cash flow-related incentive for providers. For providers that submit at least 85 percent of claims electronically for three consecutive months, Blue Cross and Blue Shield of Texas pays the claims via direct deposit, rather than by cutting and mailing a paper check. This puts money back in the providers' practice sooner.

Managing Paper
Although health plans try to reduce the amount of paper being submitted, they inevitably need to manage paper in such a way that its content moves swiftly and securely through the organization. One of the best ways to manage paper is to scan it into an imaging system as early as possible—either in the mailroom or by the administrator of a department—before it gets distributed to individual workers. Moving paper claims through the organization as digital images helps prevent loss or delays and improves compliance with Health Insurance Portability and Accountability Act (HIPAA) and prompt-pay regulations. Digitized claims can be more easily tracked, reported and protected from aging. And, digital information can be protected more easily from disaster and from unauthorized access.

A robust imaging and document management system not only helps health plans manage claims that are initially submitted, but also provides a system to organize documentation that may be submitted later such as to support a claim review. Such a system matches incoming mail or faxes to pended claims folders and notifies the claims analyst that additional information is in the folder for review, preventing delays and helping payers to complete claims reviews quickly and accurately.

The goal of claim preparation or pre-adjudication edit is to increase the percentage of claims that adjudicate on the first pass and reduce the overall cost of claims processing. An industry study cited in Health Management Technology estimated that securing accurate patient information at this stage could prevent as much as 90 percent of claim denials.

Good claim preparation helps reduce the number of preventable denied claims by validating member/provider data, dates of service, Current Procedural Terminology (CPT) codes, etc. It can also help identify duplicate claims. Systems that leverage core system data to validate and correct data or suggest changes to repair the claim prior to adjudication aid this process.

The most successful plans are those that involve providers in the process of editing claims prior to adjudication by deploying a secure environment in which providers are permitted to correct errors before suspect claims are sent to the core system. One major Pennsylvania health plan and the University of Pittsburgh Medical Center created a dashboard to view claims status and history. A major payer in Michigan collaborated with fourteen providers to create an electronic "bucket" for claims that didn't pass initial edits. The providers access, rework and resubmit claims in real time. The plan reported a $14.3 million savings by avoiding rework, collection agency fees and bad debt.

Processing by the health plan's core system is the third major step in claim processing yet is not one that will be addressed here. Most health plans report blended auto-adjudication rates in the core system between 60 and 75 percent, with paper claims' percentages being lower than EDI claims. For a plan processing one million claims a month, that's between 250,000 and 400,000 claims monthly to process and re-submit to the core system in a timely fashion. These large numbers present an enormous opportunity for improvement for most plans.

Control Labor Costs When Claim Volumes Grow
As stated earlier, manual processing of a pended claim costs health payers approximately $28 each compared to $2.50 for claims that adjudicate on the first pass. Most core systems were not built to manage exceptions, so the $28 cost consists mostly of labor.

To control their labor costs even as claim volumes grow, plans should begin by re-evaluating their processes and pended claims categories or reason codes. Some exceptions can be avoided systematically or by reviewing internal procedures or data. One large regional insurer increased its first pass adjudication rate from 44 to 60 percent, by editing its pend codes which created the capacity of 10 knowledge workers.

Many payers manage pended claims inefficiently by printing a pended claims report, distributing pended claims across the team, and completing the work from paper. Technology that automates manual tasks and matches talent to task, assigning a claim to the analyst who is best trained to complete it, is key to providing long-term benefits to payers. Such technology facilitates inter-departmental problem resolution and maintains a complete audit trail of claims resolution activity.

In the most efficient scenario, technology enables pended claims (our forth step) to be processed in an online work environment that pulls pended claims categorically from the core system, creating an electronic folder for each pended claim. That folder will contain the original claim and any claim data relevant to resolving it. Health plans that combine the machine-like efficiency and accuracy of straight through processing with the reasoning power of knowledge workers by implementing process and content management software maximize the use of all of their resources. That's claim processing in the real world.

Kathleen D. Rohrecker is vice president, Marketing and Strategic Initiatives at Softheon, Hauppauge, N.Y.