

Managed Care Report

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CLAIMS MANAGEMENT: Stop Paying Improper Claims -- Retool Your Reviews Approach

Judicious IT use, a strong staff and robust provider relations spell efficiency and productivity.

Your plan has solid underwriting and a good number of benefits designs. But attracting beneficiaries, though crucial, represents only part of the equation for success. Optimizing your claims processing and challenging claims (and winning) are equally necessary to stay in this hyper-competitive game.

You can amp up these departments in your plan by applying a two-pronged angle of attack. First, lock in place the technological elements that help you to process clean claims faster while simultaneously locating consistent problems. Second, strategize your claims adjudication so that your plan doesn't immediately go after physicians when you spot a problem -- make the changes at the coding and especially billing levels instead.

Make IT Systems Work Together With Your Human Resources And Product Offerings

Of course, claims processing is increasingly a technologically-driven system. Your plan won't bring about terrific results just by purchasing the most elaborate or expensive products, however. Here's what you need to know to maximize the value of the IT you have.

Link IT to plan offerings: The degree to which your company highly customizes benefits is important, contends **Abbe Sodikoff**, national territory manager for Chicago-based consulting firm **Jacobson Solutions**. If your company presents employers with products that they can comprehensively adapt to their specific needs, then you do need more sophisticated systems and software. On the other hand, if your plan acts principally as a third party administrator, you should be able to do well with "very minimal" systems, Sodikoff counsels.

Match staffing to IT needs: If you set up your claims-processing IT to sort claim rejects by specific codes, then you need to make sure you train your staff to manage that level of data, says **Rick Jacobson**, CEO of **Jacobson** Solutions. “They have to be specifically trained to deal with narrow definitions of claims problems that come into their ‘bucket.’”

Human resources specialization becomes especially important if your organization operates a more specialized structure. “If your health plan deals largely in Medicare claims or in certain types of plans, then your staff needs to be expert in their understanding of how those claims work, from the beginning of the process to the end,” Sodikoff notes.

Define your IT goals: How you develop and use your staff boils down to how you deploy your auto-adjudication systems--specifically, how you define the system’s success or failure. “Health plans approach auto-adjudication very differently,” explains Sodikoff. “Many see an adjudication rate of 60 percent and want 95 to 100 percent--they’re striving toward the ideal that no person touches the claim.”

Again, your plan offerings come into play here. If your plan generally functions as a third-party administrator, or if your benefits packages aren’t especially flexible--that is, complicated -- you can expect more from your auto-adjudication system. On the other hand, while a 95 percent auto rate looks super-efficient, if your benefits are relatively flexible, you’re probably missing some problematic claims on the review end, Sodikoff maintains.

Take The Long View To Maximize Claims-Challenge Efficiency

Too often, plans attempt claims challenges in a somewhat haphazard fashion--assessing claims on an individual basis, taking the fight to specific providers and failing to use external resources to bolster investigations. But there are a few easy steps you can take to ensure that you’re pursuing the most actionable courses in this area, says **Merit Smith**, vice president and health care practice director at the Dallas-based **Robert E. Nolan Company**, a management consulting firm.

Understand the sequence of claim-generating events: Managed care organizations tend to overlook the circuitous path a procedure takes to become a claim, says Smith.

Keep in mind the number of steps between the procedure and the claim. "You've got to trace the line," Smith urges. The information detailing the procedure or evaluation and management action runs from the physician to the coders to the billers to your plan, and "at each stage error and confusion sets in," he notes.

With this sequence in mind, you should direct your pattern analysis first toward billers, not physicians, Smith advises. Looking at billing issues can allow you to pinpoint flaws in claims preparation more easily than you could by reviewing providers from the start, and you can gather more actionable data, he explains.

Draw on other resources to clarify problems: You can enlist other groups to help you make the case that there's a problem at the coding or documentation level, Smith says. "Quasi-governmental and regulatory organizations and entities can provide better clarity on issues like documentation of coding modifiers nationally. They can bring more authority to the discussion than you can on your own."

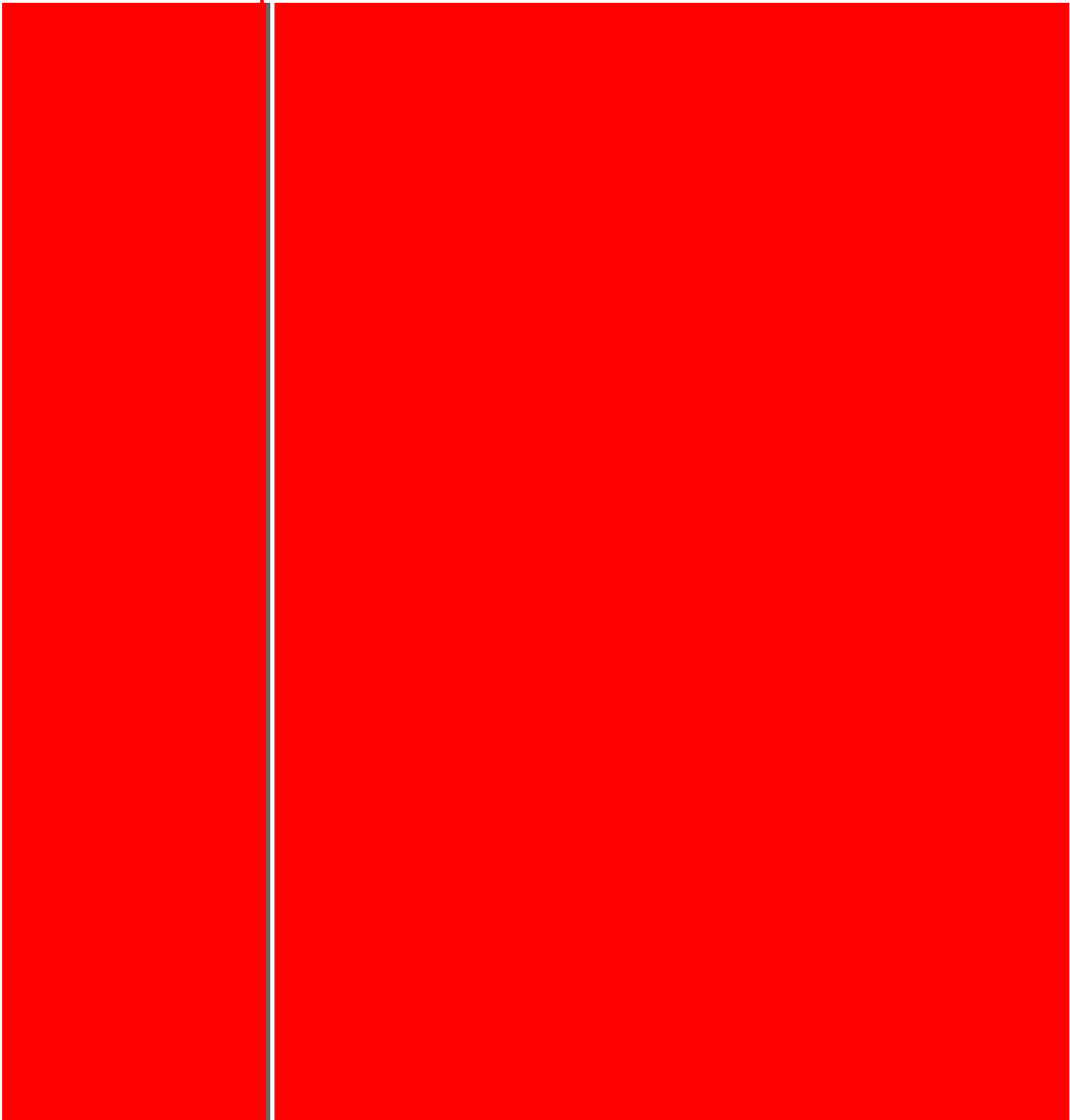
Tip: Bringing in how-to documents such as the **Centers for Medicare & Medicaid Services' Medlearn Matters** articles, the **National Correct Coding Initiative** or the **American Academy of Family Physicians** can help to convince providers, coders and billers that they need to address a systematic problem, Smith says.

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Volume 21, Number 4/Managed Care Report

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