Clean Claim Rates: A Self-Diagnosis

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Self Diagnosis Steps

Hospitals can take a few simple steps to more accurately assess their facility's clean claim rate. On the surface, the billing editor may be calculating a *clean claim rate* based on the *percentage of claims sent out vs. total claims*.

However, this is likely misleading as many billing errors are found outside of the billing editor.

- *Quantifying the issues outside of the billing editor will help increase the accuracy of this calculation and ultimately increase billing efficiency.*

Pre-Transmission/During Transmission:

Below are steps management can take to assess and improve the clean claims rate prior to transmission:

1. *Review top billing errors* and determine if there are errors that can be completed *without manual intervention* by establishing new bridge routines.
   - Start by reviewing the top 10 -15 overall errors.
   - Then review errors for the top 5 payers to determine if there are payer specific errors that should be addressed.

2. *Discuss with the billing staff* what edits they review and close without taking action that can be eliminated to increase throughput.

3. Review total claims sent out of billing editor and confirm that all clean claims have successfully sent; *ensure there are no claims stuck in a pending status.*

Post Transmission and During Follow-up:

After transmission and during follow-up there are additional steps that management can take to validate the clean claims rate by ensuring claims are being received and accepted by the payers.

1. Perform payer-level reconciliation between number of claims sent to payer and number of claims payer shows as received and accepted.
   - *Investigate any differences.*
   - *Reach out to payer rep, if needed, to complete reconciliation.*

2. If payers have online claim "statusing" portals, review available online rejection reports and quantify these rejections (including the Medicare T-status file.)
   - *Track these rejections weekly to ensure they are worked timely*
   - *Where possible, implement edits within the billing editor to resolve these prior to sending the claim to the payer*

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Post Transmission and During Follow-up:

3. Ask payers for their top front-end rejections and then compare to what rejections are being sent back as post-transmission errors.
   - *If there is a difference, quantify and determine if edits can be implemented to catch these prior to submission.*

4. Review denials and classify those that are billing related. Typically these include those claims which specifically state missing/invalid revenue codes, HCPC, NDC codes, and modifiers.
   - *Quantify these denials and focus on the highest dollar denials first*
   - *Many of these can be avoided with additional rules in the billing editor.*

5. Take particular note of any payers who repeatedly state "No Claim on File" during follow-up.
   - *These payers may not be receiving these claims and there may be a broader issue with transmission or a payer code may not be set up correctly in billing editor.*

Self Diagnosis Wrap Up

Once facilities have gone through the exercise of reviewing the above items, begin to quantify each grouping and determine if these additional errors can be included into the clean claims calculation.

- *By adding these into the calculation and trending these over time problem areas can be addressed systematically.*

- *If these can't be easily added to the calculation, quantify them outside of the CCR, and trend separately.*

Results, Not Reports.

For more insights on this Self-Diagnosis and assessing your Clean Claim Rate, please contact us:

www.colburnhill.com/contact.html

or

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We look forward to hearing from you!

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