Clean Claims:
How to be a Bill Editor Superhero!

EXECUTIVE SUMMARY

Hospitals and other Healthcare billers consistently struggle with the challenge of improving their Clean Claim Rate (CCR) in order to recover payment for medical services provided.

Failures in configuration or maintenance often result in underperforming claim editors – either routing claims for manual intervention that could be fixed automatically, or passing claims that will eventually be denied.

Understanding your clean claim rate, and focusing your organization's expertise on interpreting the outcomes, can reduce the effort required to complete billing functions and instead devote staff time to more complex, interesting, and valuable functions.

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INTRODUCTION

When hospitals look for performance improvement in the Patient Financial Services (PFS) departments, the task can seem a superhuman challenge. CFOs and Revenue Cycle professionals generally look to denials management, follow up tools and processes, or even outsourcing to drive incremental cash collections, expecting a Superhero to emerge, saving the day. However, these efforts often overlook the contribution that can be made by focusing on the billing process and the claim editor.

Too often, PFS departments accept the stock claim editor setup and the resulting clean claim rate as a given -- an immovable object that results from forces outside their control, like clinical departments, payers, and registration staff.

But just as Superman can leap tall buildings in a single bound, you too can be a Claim Editor Superhero! With some time and attention, you can use your billing editor to make significant improvements in your cash collections, reduce costs, and even increase employee satisfaction!

INDUSTRY CHALLENGES

One challenge faced by many hospitals in trying to evaluate the efficiency of their billing process is in the data behind or even the very definition of the Clean Claim Rate (CCR.) Most use the CCR provided by stock reporting in the billing editor, but the stock report may provide a distorted view since the billing editor is not the only place where claims can hold.

Typical clean claim rates

HFMA offers one good definition of a clean claim rate:

# of claims that pass edits requiring no manual intervention

divided by

# of claims accepted into claims processing tool for billing

A more advanced but also more complex approach, which may require different data sources and aggregation of various reports, would include all claims which stop in the process, such as those that are rejected by the clearing house.

The addition of new populations of manual interventions shift the definition to:

# of claims accepted into the payer adjudication system

divided by

that that move from DNFB to Billed AR in the core system

To illustrate:

From PAS System	100
Rejected by Bill Editor	5
Hit a claim edit	25
Rejected by Payer System	1
Total Touched	**31**
Total Claims	100
Total Unattended	69
Clean Claim Rate	69%

In this example, the stock report might only include the 25 claim edits in the numerator, yielding a CCR of 75%. HFMA definition would yield a CCR of 70% (5 Bill Editor Rejections + 25 Claim Edits.) The most robust definition would include the claim that was rejected by the payer system, leaving a CCR of 69%.

It is important to note that none of these measures are inherently better than the others – they just measure slightly different things and require different levels of expertise or effort to compile. While the advanced reporting would include any claim that requires intervention (failed claims report, Editor extracts, rejection reports, Medicare T-status report, and sometimes a subset of DNFB) the effort is significant. In addition to the basic data wrangling, duplication and formatting (claim numbers vs account numbers, multiple edits per claim, etc.) makes it extremely complex to accurately calculate and maintain.

Since the stock report is easy to access, and having a measure is better than no measure, organizations may reasonably choose to use whatever they can get to start and move towards refining the measure over time. However, keep in mind that the bias towards easy vs. accurate reports leads to benchmarks that are somewhat inflated. Many benchmarks suggest 90-95% is the right range for the CCR, but when more robust measures are included, the rate drops significantly. Even high performing organizations may only be in the 70-75% range. Determining whether your CCR is too high or too low is valuable, but just knowing your rate is a step in the right direction. Developing a consistent definition and measuring your CCR is the first step towards better performance.

The Villains plaguing Claim Editors

While you are striving for truth, justice, and the American way, villains may be wreaking havoc in your Claim Editing processes. These villains generally fall into one of two categories – Setup/Configuration or Maintenance.

Villain #1 -- Setup/Configuration

Many installations are supported, or performed, by vendors. Outside expertise is a common and reasonable choice, but it comes with risks. Outside consultants implementing claim editors may be familiar with the system and common billing requirements (like Medicare), but may not be sufficiently expert in the requirements of other payers – particularly regional payers – to appropriately configure the system. Regional expertise is especially important in mapping of claim classes and PAS Insurance Plan Codes. Poor mapping can prevent the right edits from running on the right claims (eg. Run NCCI and OCE edits on Medicare Advantage Plans, Medicaid, and Commercially Managed Medicaid plans but not Commercial plans.)

Medicare billing configuration is another area that can lead to problems if not managed carefully. Claim editing systems come with stock edits which largely follow Medicare guidelines. But if Medicare edits are missing or outdated when installed, corrections will have to be made in the FI system, meaning your claims data may get out of sync. Another common risk point is in Self-Administered Drugs, which must be billed correctly to stay in Medicare compliance. If not loaded correctly, they can create “unposted contractuals” that hold up patient balances at the time of posting.

Secondary billing must be carefully engineered -- either in the core system or the editor -- to pull primary adjudication details from the 835 and populate correctly on the secondary claim. Every claim needs to pass through the editor: for example, payers who still require paper claims should be configured to cross into the editor and print to paper from the editor instead of claim runs out of the PAS. This ensures *all* the edits run on *all* claims.

One aspect of the billing editor that can cause problems either at the time of installation, or during regular usage, are bridge routines. Bridge routines can be a powerful tool, but just like a nascent superhero, they need to learn to use their powers for good!

Bridges often get put in place for specific reasons, but if there is no documentation or if the situation changes, the bridge may become outdated, unnecessary, redundant, or even counter-productive. Over time, layer upon layer of bridge routines are added, sometime with conflicting goals or outcomes. This problem becomes particularly acute if further complicated by "tribal knowledge": for instance, staff responsible for managing the billing editor leave and a new person is assigned.

Over-reliance on bridge routines can create potential conflicts and maintenance headaches – dry land to Aquaman. We advocate diving into the ocean, and breaking such reliance: deal with issues when they arise. For example, Form Locator fields are best fixed to correctly populate in the PAS. This allows them to cross over to the editor *instead* of building a bridge routine to fix the problem.

Villain #2 -- Maintenance

If implementation and configuration are performed by outside staff without sufficient knowledge transfer, changing payer requirements can quickly make the editing system outdated – either stopping too many claims creating non-value-added work or stopping too few leading to high denial rates. Local staff also need expertise to perform regular maintenance. For example, if the system is not regularly maintained, it may end up with 300 different spellings of Blue Cross, and at least one of them will be pointed to the wrong payer ID. Simple problem, yet dastardly impact on your claims!

Payers can be an important source of maintenance information. The managed care department gets periodic updates from payers that can include new or revised billing guidelines. If a billing specialist is not getting those updates from managed care and incorporating those changes into the billing system, they are likely causing edits or denials – potentially both.

Batch failures are also a key performance indicator. If batches regularly process through the billing system and include a "sent" date, but fail to process on the payer side, there may be a maintenance issue. Batches without a payer acknowledgement need to be investigated, not just for the rebilling opportunity on those claims, but for the root cause issue that is causing the errors.

HOW TO INTERPRET YOUR CCR

It would be easy to assume that a higher percentage is better than a lower percentage, but we think the equation is a bit more complex. It is probably the case that as you pay more attention to the claim editor and work your edits to refine them, your CCR should go up. That's likely a good thing. But higher CCRs are not necessarily better and to fully evaluate the number, you need more context.

For example, a high clean claim rate might look like claims are sailing through the process, like Superman through a hail of bullets, on their way to getting paid. However, if your CCR is >90%, it may mean that there are too few edits: claims which should be stopped and fixed are instead passing through the editor cleanly – and face the dark fate of being denied by the payer.

On the flip side, a lower CCR could be indicative of highly restrictive edits, which should correlate to a lower denial rate. If your denials are high and your CCR is low, there are several potential problems, including:

- Claims that are passing through should be stopped
- Claims that are being stopped should be passed through
- Staff are working edits without fixing the problem and/or forcing claims through the editor
- Staff are working claims that could be fixed through the system, either through bridge routines in the editing system or through upstream fixes

Given the variability in payer environments and payer mixes, the optimal CCR is likely different for every institution. The optimal CCR uses the system to fix as many edits as possible, focuses staff time on claims that require human intervention, and minimizes denials. If you have it right, you should see some increase in the CCR early in the process, then a steady rate, and declining denial rates as the process matures.

With all that in mind, our experience shows the right rate is in the 80%-85% range. Any higher and you are at risk of denial; any lower and you may be doing manual work that could be avoided by proper configuration and use of the billing editor. Understand this, and your Superhero reputation will grow.

A CASE STUDY

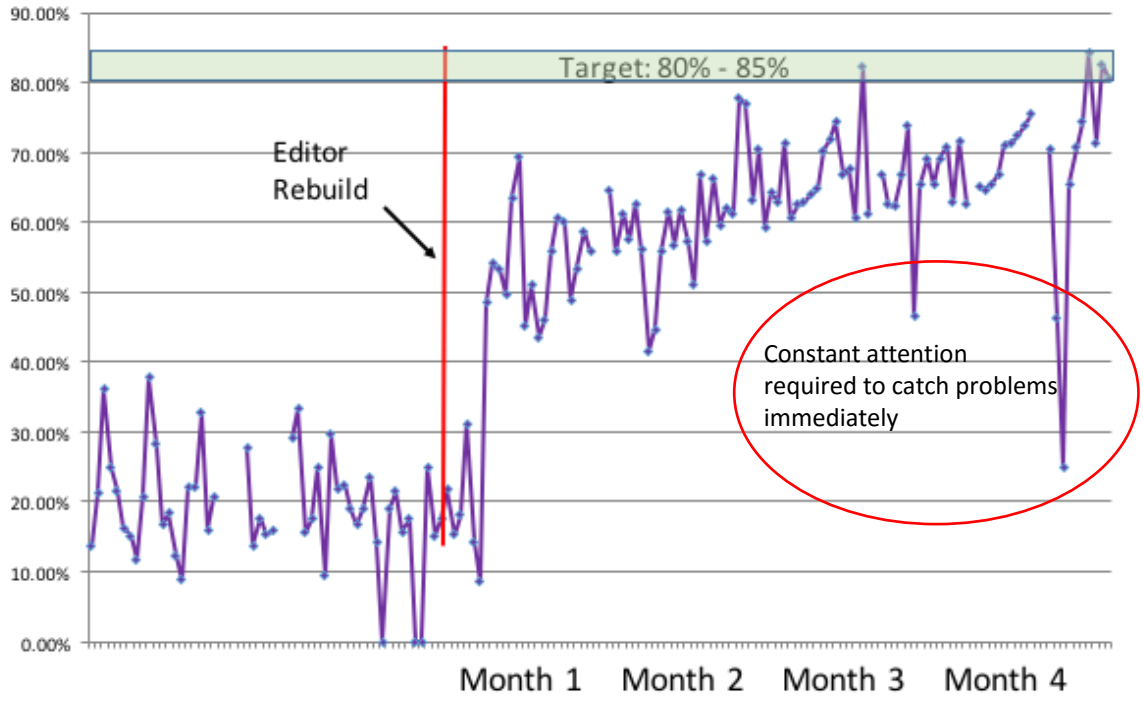
At one hospital where we worked, the historical average CCR of 22% meant thousands of claims -- more than 3 out of 4 -- stopped and had to be worked by staff before being submitted to a payer. We began tracking the edit rate and looking at the highest volume edits.

We convened regular discussions with billers and managers to review the edits and seek solutions. These meetings provided color behind the raw data and gave us rapid insight into new trends or issues as they arose. They also created a sense of ownership among the billing staff – when they ran into problems, they were not being told what to do about it, but were being asked to help craft the best solutions.

Our analysis validated the 80/20 rule, identifying a handful of rules that caused the majority of the claim edits. For example, 35% of the edits were the result of data not populating correctly from the host system. By fixing the data flow, we were able to eliminate virtually all those edits. Another 10% of edits were the result of the editor expecting information that was no longer necessary on the claim.

There were also edits which were not so substantive. In one case, nearly 20% of the edits were related to a bridge routine that was designed to put the two letter state abbreviation on the claim. At some point a typo had led to the routine only pulling one letter for some claims – when asked about it, staff were very proud to point out how many claims they fixed each day by adding the second letter!

By focusing on those edits and understanding the root causes and potential solutions, we fixed upstream errors, revised misconfigured edits and bridge routines, and drained the claims that were hitting edits. Within a few months, the CCR went from 22% to more than 80%.



By eliminating or reducing the edits that amounted to little more than busy work, the hospital was able to move claims out the door more quickly, accelerating cash collections. Furthermore, staff were able to focus on more complex (and interesting) edits/problems that had previously gone unresolved. The result was a virtuous circle of more improvements and solutions to more complex problems.

But this dramatic reduction in the amount of work required to clear claim edits also allowed the hospital to reorient staff time. As demand for working edits declined, so did the FTEs required to work them.

	Before	After	Change
CCR	22%	78%	+56%
Billing FTEs	9.5	2.8	-6.7

The additional staff was allocated to follow up work, which allowed the hospital to work a far larger number of claims and significantly increased cash collections in a short period of time. Fixing the CCR requires some investment in staff time and may require investment in outside resources from the provider of your claim editor or other vendors, but the return is significant.

TEN STEPS TO OPTIMIZE YOUR CCR

1. **Log CCR daily** -- Make sure you think about the CCR holistically, including all places where claims stop in the billing process. At the start, it might be difficult to get the full picture but a stock report from your editor is better than no report, and measuring results (field errors, claim edits, payer rejections) independently is better than just the stock report.

2. **Review the CCR regularly** – Make it a part of regular communication with billing staff and with leadership. Celebrate improvements and acknowledge problems as they arise, in the context of a solution to make the problem less of an issue. In addition to the CCR, some metrics to watch include:

    - Daily Field Errors
    - Daily Claim Submission:
        - What returns from the clearing house – have staff review and work.
        - Rejected Claims – one which never cleared the editor.
        - Medicare T-status claims

3. **Balance Claim Edits with Denials** – If your CCR exceeds 90%, it may be resulting in more denials. Review denial reports to see if there are issues that could be fixed prior to submission and think critically about where the issue is best resolved.

4. **Review the bridge routines** – Perform a comprehensive review of all bridge routines to determine what problem it is intended to fix and whether it is actually fixing it (or maybe making it worse!)

5. **Engage staff in the CCR discussion** -- Have daily meetings (15 minutes or less – we refer to these as "Huddles") with the billers to open communication regarding daily outcomes and what they are seeing on the claims. These meetings are crucial early in the process and should be valuable throughout, but you may eventually scale back to every other day. Going to a lower frequency risks making the "discussion" into a "meeting" and will change the feel for staff, likely to the detriment of the outcomes. Keep staff involved to identify common problems with claims and look for automation opportunities.

6. **Look for patterns** – while staff feedback may be the best way to identify patterns, use analytics as well. Look for common edits or trends in edits by payer, service area, biller, or root cause

7. **Systematize solutions** – Where you find a pattern of common edits, look for ways to eliminate the manual intervention required. That might be creating a bridge routine, but it might also involve changing something in the host system, or in an upstream manual process. Even changes outside of PFS or revenue cycle should be pursued.

8. **Fix Issues Early –** Where possible, fix issues in the host system or prior to the bill editor. This helps keep your system in sync with the bills that are being submitted and avoids potential problems in following the history of a claim.

9. **Document every change** – Create a change control log of what is being fixed, who is requesting the change, what benefits are expected, and the date of the change. A log can avoid confusion later on and help track how the system is being used. That insight can be invaluable when requirements change or when trying to solve a similar problem. The log can also assist in the explanation of positive outcomes in your cash receipts and accounts receivable aging.

10. **Repeat if necessary** – Improving the CCR is not a one-time effort. Changes with payers, staff, and internal processes create a constant churn of potential problems. Regular discussions with staff along with reviews of the overall rates and specific edits will catch those changes before they become acute.

CONCLUSION

It's a Bird, It's a Plane…

Too often the urgent need to "get claims out the door" interferes with the important need to manage the process consistently and comprehensively. The result can be a patchwork of process scotch tape and bridge routine band aids. Over time, those quick fixes can create conflicts and sometime fail to address the real problem, driving CCRs down to unacceptable levels. Solutions do not happen automagically, and require time and attention from management and staff to optimize the system, dig for root causes and solutions, and consistently track performance over time.

If you follow these steps and manage the claim editor appropriately, you can reduce claim edits, reduce denials, and increase cash collections. You may not be able to leap tall buildings in a single bound, but you will be a Claim Editor SUPERHERO!

FOR MORE INFORMATION

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We look forward to hearing from you!