PLUTUSHEALTH

# Achieve Clean Claims in 2023

## Ways to achieve clean claims and maximum reimbursement

How to get maximum revenue, reduce denials, increase clean claim percentage beyond 95%, and increase profitability.

The revenue and profitability of healthcare businesses rely on the number of proper claims filed and reimbursement on them. This guide has every piece of information you need to achieve your goal of “100% reimbursement in the first submission” by following these specially handcrafted tips, you will:

- Bring claim rejection <5%
- Minimize the time and cost required in follow-ups
- Remove the common claim submission errors

The guide will help you with tips to find and prevent standard rejections and denials. It will address the concerns caused in the patient visit cycle.

Significantly improve the net collection rate while minimizing the time and money required for getting paid from the claims. Everyone wants maximum revenue with minimum resources. Let’s get started!

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# Knowing the claims process

## Are claim denials and rejections the same?

A clean claim contains all the essential information requested by payers sent on or before the due date. Rejections and denials are often considered the same. These terms are used interchangeably, but there is a difference in both these terms. Considering both denials and rejections the same and not understanding each concept minutely will cause a significant impact on the net collection rate.

### Denials

The payer accepted this claim initially but returned with partial or no payment is called denied claim. A denied claim cannot be corrected and resubmitted. It needs to be adjusted, appealed, or reopened with a valid reason

### Rejections

A claim which is returned by an insurance carrier due to missing or inappropriate information is called rejected. For the payers, this claim does not exist. The rejected claim has not entered the payer's adjustment system

# What are the stages of rejection?

- **Within practice management system**

  The system checks the patients, providers, and payer information

- **Clearinghouse**

  A place where detailed claim scrubbing is done

- **Payer**

  If the patient is not eligible or demographics are missing

The practice management system should reject the claim which is not properly filled before sending it to the clearing house.

A streamlined practice management system conducts internal audits and finds all the errors before submitting the claims. Missing provider NPI is the most common reason for claim rejections from the practice management software. Thoroughly finding payers, providers, and patient demographic before submitting the claims will save a lot of time and money. It is the first and most crucial step in achieving clean claims and getting FPAR greater than 95%.

# More than half of the rejected or denied claims lose revenue

The second stage where rejection happens is clearinghouses. The rejections at clearinghouses happen if the payer information is missing or not mentioned properly. Clearinghouses prevent rejections at the payers. Clearinghouses catch all the minute errors like missing alpha profit information or demographics. The billers can correct these errors and resubmit the claims.

The last stage where rejections happen is at the payer's end. Here the main cause of rejection is missing or incorrect patient demographic information and patient eligibility issues. All these common rejections can be easily avoided. If the subscriber ID of the patient is missing or it does not match with IDs, it indicates either the patient was not eligible for the service or the demographics entered are incorrect. These rejections can be avoided by doing a thorough patient eligibility and verification check before proving the services to the patients. Healthcare providers lose a huge revenue on visits because they fail to check their eligibility, and not resubmitting the corrected claims on time.

*Working on just one denied or rejected claim per work can save thousands of dollars*

**PLUTUSHEALTH** Plutus Health provides the best solutions for rejection and denial management. We verify patient eligibility at the time of appointment to avoid claim rejections and revenue loss

# What is an appeal, re-submission, or corrected claim?

Rejected claims do not reach the payer's system: for them, these claims do not exist. Healthcare providers can efficiently work on the rejected claims and resubmit them after making all the necessary corrections. Providers must systematically check if the claims were rejected or denied when finding and submitting old claims.

Denied claims have entered the payer's system and come back with partial or no reimbursement. Denied claims, in most cases, cannot be resubmitted. Only a few payers allow resubmission that too if you are replacing or correcting the claim by including the original **reimbursement code** and **claim numbers.** Denied claims need to be appeared or re-opened depending on the reason for denial.

Only the claims submitted on time and accepted by the payers' system are considered clean. There are no **appeal rights** for the claims that are denied if not submitted on time. It is vital for the providers to correct and submit the rejected claims on time.

A clean claim is one that a precisely filed on time, has cleared the scrubbing process of clearinghouses, is accepted by the payer's system, and gives complete reimbursement.

# Clearinghouse enrollment and credentialing

## What are the most common causes of claim rejections?

- Improper setup of payers and providers in billing software
- Credentialing errors
- Demographic errors
- Patient eligibility errors
- ICD and CPT coding errors

The most noticeable impact on revenue loss is enrollment rejections and credentialing errors. If proper credentialing is not done, providers lose thousands of dollars, and the claims get rejected by clearinghouses. The claims do not reach the payers on time and get denied. It results in partial or complete payment loss.

## What is credentialing?

The process of proving that the healthcare provider is qualified and educated to treat the patients is **credentialing**. Healthcare providers must submit a particular set of documents related to education and training, depending on their specialty.

But credentialing does not mean the healthcare provider can start billing the payers for the services they provided to the patients. Credentialing is followed by **provider enrollment** – requesting entry into the health insurance network.

Most private and government payers require approval to start accepting the claims from the healthcare providers. Private players have terms and condition s which healthcare providers should accept on a written contract before they start getting compensation for their claims.

## Clearinghouse enrollment

Credentialing and provider enrollment should be completed before the **clearinghouse enrollment**. If the clearinghouse enrollment is not done, the claims get rejected. If the claims manage to pass the clearinghouse, they get rejected or denied at the payers.

## How to check if the provider is credentialed and enrolled with the payer?

Practices must also check if all the patient, provider, and payer information are properly entered into the practice management software. Healthcare \providers must review the documents initially submitted to the payers. If the providers are not credentialed and enrolled, their claims will be rejected with a message, “claims not approved by electronic submission on behalf of the entity.”

## Example of clearing house rejection

Payer has set up their Type 1 (individual) and Type 2 (group) NPI with different payers. In this case, healthcare providers should not correct their issue claim by claim but should set up override or edit to fix the errors.

## What areas impact your FPAR (First Pass Acceptance Rate)?

The primary aim of healthcare providers is to get full reimbursement on their claims and achieve the highest FPAR. Here are the areas that impact your FPAR and should get thoroughly verified before submitting the claims for approval.

- **Practice information**

  Practice name: Address (with 9 digits zip code); Tas Id and Group NPI

- **Provider information**

  Provide name: Address (with 9 digits zip code); individual SSN and NPI

- **Payer information**

  Payer ID: Address (with 9 digits zip code)

You must review the provider's and payer's information added to your practice management system and check for all the information mentioned above to avoid rejections due to missing or inappropriate information.

## Ways to increase clean claims percentage

Filing a clean claim which does not get rejected or denied requires a team effort, and all the departments should work collectively to increase your FPAR. Here are the top three areas that affect the clean claims rates in practice.

- Patient demographics

- Eligibility verification
- Claims scrubbing

You should establish strict rules and guidelines for all the processes followed in your practice right from the movement patient calls to the movement the claim is filled, and you receive full reimbursement.

**You can easily file clean claims and achieve a high FPAR**

## Patient demographics

Claims get rejected the most as the patient demographic and insurance information is incorrect or missing. Rejections can easily be prevented by following these steps:

- Verify patient details on every visit
- Industry professionals with a deep understanding of medical billing should thoroughly verify the claims before they get submitted

The billers will take comparatively less time to review patient demographic details and insurance information than to find the reason for claim rejection and fix them.

List of patient demographics that are vital to achieving your clean claim goals:

- Name
- DOB

- Gender
- Payer Scenario
- Policy Information

## Eligibility verification

Patient's eligibility must be verified before the provider starts offering their services. Eligibility should be verified at the following steps:

- Patient's first contact with you
- When scheduling the first visit
- 1-3 days before the first visit
- On the day of the visit (only if the new calendar month has started after the last verification)

Eligibility verification is not perfect. There might be errors at times in the payer's system. Eligibility verification will increase your FPAR and decrease loss in revenue due to data entry errors and lack of coverage.

## Claim scrubbing

Claims often get rejected or denied due to minor coding errors. These errors can be easily detected through processes like claim scrubbing before submitting to the clearinghouse. Claim scrubbing can help in LCD/NCD, CCI, HCPCS/CPT-4, State Medicaid edits, and revenue code validation. Claim scrubbing can easily detect the following things that are the leading cause of rejections and denials:

- Invalid CPT codes
- Missing CPT codes
- Removed diagnosis and CPT codes
- Improper diagnosis codes
- Bundling errors
- Invalid modifiers

## How to monitor and resolve rejections?

### Form a rejection prevention team

Preventing claim rejections is the most crucial step toward clean claims. Healthcare providers must form a rejection prevention team that would work seamlessly towards the goal of getting the highest clean claims ratio. The team should include the **front desk, billing, clinical, and management**. The most significant advantage of creating a group is it eliminates the loopholes in the claim submission and billing process. Streamlining each step will make the billing and claim submission process smooth from when the patient visits until the payer realize complete payment.

Third-party RCM service providers like Plutus Health build the most robust team, eliminating rejections and taking your practice to new heights. Healthcare providers should have complete transparency in the billing process and have open communication between the third-party RCM providers and their staff. Having proper communication significantly increases the clean

claim percentage. There should be an end-to-end feedback system where rejected claims are thoroughly analyzed and compared with claims accepte d in the first attempt and given full reimbursement. The analysis makes your process more agile and gets the FPAR your practice aims for.

## Data analytics

Healthcare providers must track their rejections and categorize them based on the visit cycle: where they got rejected and the reason for rejection. This data can deliver meaningful insights to the staff and can be leveraged to train the team on how to work more efficiently.

## How to analyze the data and address issues to the source

After compiling the data, the team should find out the most common rejections and address the source of the patient visit cycle. Eligibility and demographic errors are the most common reason for rejection. Practices should concentrate more on eligibility so that they would be able to find and eliminate complicated rejections. Demographic entry errors also need o be thoroughly identified and worked on to reduce the trauma of finding the errors from the complete process.

Once the common errors get eliminated, practices can focus on significant issues like coding, compliance, and documentation. Focusing on all these things will eliminate more than 99% of the claim rejections.

## Conclusion

To get the most satisfactory outcomes and apply the understandings from this guide, identify a few categories where you lost the maximum revenue or the most number of claims got rejected. Pinpoint the root cause of those claim rejections and focus on fixing them. You can enforce the new strategy and steps to eliminate those errors and file a clean claim. Once the errors are eliminated and the process gets streamlined, repeat the process for another category.

Achieving clean claims and the highest FPAR is a team effort. You can set small challenges for the team and reward them if they can pass them. Challenges like not more than '20 claims would get rejected in every 2000 claims filed' would help you slowly reach your clean claim goals. Choose the steps that best suit your practice, but remember keeping a constant check on analytics and measuring the results will take you closer to objectives.

**Plutus Health has provided the best medical coding and billing services to healthcare providers in the US for 15+ years. Claims submitted by our experts receive the highest FPAR**