SEE YOUR REV CYCLE DIFFERENTLY

CLAIM STATUS INQUIRIES

What's at stake for your organization?

WAYSTAR

Claim Management

When a provider manually contacts a payer to check the status of a claim, on average, it takes 14 minutes and costs the provider $7.12.[1] Multiply these numbers by millions of inquiries each year and it's easy to see how this process places tremendous strain on hospitals, health systems, physician practices and billing services.

There is a better way.

Read this guide to learn more about the problems with manual claim status inquiries—and how to better address this critical part of the revenue cycle.

What's inside

1 how providers **handle claim status inquiries** today

2 why **current processes are inefficient**

3 how to **solve claims status challenges**

1 2018 CAQH Index: A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings

1 How providers handle claim status inquiries today

According to the 2018 CAQH Index®, adoption of electronic claim status inquiries is only at 71%, leading to widespread revenue cycle inefficiencies.[1] Technology solutions are out there, but, as many healthcare organizations have learned, they aren't perfect. Here's how providers typically handle claim status inquiries and some of the associated pitfalls.

Claim management system-generated inquiries

Most claim management systems allow providers to manually generate and send 276 status inquiries, and get 277 response files from payers in real time. The process, however, is not automated, which makes it less efficient. Many provider billing teams don't proactively use this capability and make inquiries by phone and on payer websites.

173 million

In 2018, providers made 173 million manual claim status inquiries

Phone calls, faxes and emails

In 2018, providers made 173 million claim status inquiries by phone, fax or email.[2] It takes 14 minutes on average to check the status of a claim.[3] Most payers limit the number of inquiries allowed per call, meaning billing teams have to make more calls. After calling, staff members have to update claim statuses in their practice management (PM) system or hospital information system (HIS).

14 minutes

It takes 14 minutes on average to check a claim's status manually

Payer websites and portals

Going to a payer's website or portal is only slightly more efficient than calling. The quality of information can be unreliable, and keying mistakes increase the chances of getting incorrect statuses or not finding claims at all. Keeping track of multiple logins and credentials for all payers is time-consuming and creates opportunities for errors.

2 Why current claim status inquiry processes are inefficient

The quest for efficient claim management is as old as the payer system itself. Changes in the business of healthcare, however, have upped the ante. New financial performance demands are forcing revenue cycle, financial services and billing professionals to reevaluate manual processes and existing technology. Claim status checking is no exception—here's why.

Resources are stretched thin

More than 20 million new patients have entered the U.S. healthcare system in the last few years.[1] Providers feel the effects of the Affordable Care Act (ACA), lower payer reimbursements and strained resources every day. In many cases, because of limited staff, providers don't start following up on unpaid claims until after 30 days, which can increase accounts receivable (AR) days.

20 million

*More than **20 million** new patients have entered the U.S. healthcare system in the last few years*

Too much time yields too few results

As noted, there are many ways to follow up with payers: phone, fax, going to their website or portal, or submitting inquiries from a claim management system. The problem is, all of these require dedicated staff time, which can be significant. Worse yet, they often don't move the process forward.

Lack of follow-up processes costs money

Many providers don't have sophisticated processes or technology to help with payer follow-up. Manual follow-up protocols can help, but are fraught with problems. For example:

- Reminders that check claim status at preset times don't usually account for claim types.
- Resources may be wasted contacting payers who normally take longer to pay.
- Waiting to follow up on a set date (day 25, for example) can cause staff to miss an opportunity to prevent denials by returning requested documentation for pended claims.
- Resubmitting claims that have not received a remit restarts the adjudication cycle and adds costly AR days.

No prioritization leads to cherry-picking

Staff members who use manual claim status processes often have nothing to go on except a basic list of outstanding claims in no particular order. Staff members may cherry-pick to knock out their required workloads and miss high-yield accounts. Without claim status visibility, managers can't accurately prioritize accounts that need to be worked.

1 "Since Obamacare Became Law, 20 Million More Americans Have Gained Health Insurance," Fortune, Nov. 15 2018

3 How to solve claim status inquiry challenges

While advanced technologies and practices have revolutionized revenue cycle management (RCM) in almost every area, claim status monitoring remains one of the biggest challenges for providers. In fact, according to the 2018 CAQH Index, claim status inquiries has the highest savings opportunity per transaction of any revenue cycle task tracked in the index.[1]

To unlock these cost savings and smarter workflows, it's critical for providers to deploy technology that automates the claims monitoring process—technology that is highly efficient and flexible enough to meet the unique needs of your practice.

Here's a quick checklist of things to keep in mind when looking for an automated claim status inquiry solution.

A claims monitoring solution should:

- ☐ Allow you to **work by exception**, enabling your team to follow up on only those accounts that need attention. This enhances productivity by reducing time and resources spent on non-actionable claims, and limits revenue left on the table due to a lack of follow-up.
- ☐ **Automate status checks** accordingly by using your specific data to calculate average remit dates for commercial and Medicaid payers.
- ☐ Allow you to **schedule by account, payer and days at payer.** You shouldn't be tied to a limited, hardcoded schedule.
- ☐ **Produce actionable responses** by translating claim statuses from payers into plain English, helping your team understand nonstandard codes and categorize claims as needed.
- ☐ Help you **solve payer rejections** with easy-to-understand directions that are readily available while a claim is being worked
- ☐ **Alert you when payers "pend" claims** for additional information. Early notification allows you to respond before claims are denied.
- ☐ **Easily integrate** into existing workflows, whether you work within a practice management system or not.

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The bottom line

Healthcare providers lacking visibility into claim status have a lot to gain by automating the inquiry process and focusing on interventions that yield actionable results. Waystar's Claims Monitoring solution combines data intelligence, automation and flexible processes to save time, lower administrative costs, reduce AR days and deliver more revenue.

See just how much Waystar's Claims Monitoring could help you save.

Calculate now

EXPLORE OUR ALL-IN-ONE PLATFORM

Eligibility

Verify insurance coverage to reduce claim rejections and denials

Revenue Integrity

Find missing charges and capture revenue you're due

Claim Management

Automatically submit and track claims, and reduce AR days with intelligence-driven workflows

Denial Management

Prevent denials and automate appeals

Contract Management

Gain control over payer negotiations, manage your contracts and recover owed revenue

Patient Financial Experience

Collect patient payments, determine propensity to pay and improve the patient experience

Agency Management

Get insights into outsourced agency effectiveness

Social Determinants of Health

Use data on broad factors that influence health to improve clinical outcomes

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ABOUT WAYSTAR

Waystar simplifies and unifies the healthcare revenue cycle with innovative, cloud-based technology. Together, our technology, data and client support streamline workflows and improve financials for our clients, so they can focus on their patients.