The Critical Role of Reference Data for Effective Claims Processing

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Comprehensive Reference Data Management Strategy

Health Language®

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Introduction

Poor code set data quality and consistency are often the root of many problems in claims processing workflows within payer organizations. These problems can be pervasive – experts estimate 1 in 5 medical claims submitted to health insurers are processed incorrectly, costing up to $15.5 billion in unnecessary administrative expenses annually.

While health plans are working hard to enable automated information exchange between providers and other healthcare stakeholders, the lack of semantic interoperability between their internal IT systems remains a major challenge. This has led to enduring operational issues within the claims processing workflow that lowers their auto-adjudication rates and increases claim delays.

An auto-adjudicated claim costs about $.90 to process whereas a claim that requires manual intervention costs a staggering $20 per claim.

While best practice is to have an auto-adjudication rate of 85%, it’s important to acknowledge that this is typically a stretch goal due to the high rates of inaccuracies in claims data. In fact, up to 60-70% of provider-submitted claims have incomplete or incorrect data. This can dramatically impact health plan margins, as well as negatively impact relationships with providers.

To address these chronic operational inefficiencies and glean more value from existing IT investments, health plans must implement a strong, enterprise-wide reference data management strategy that allows common meaning to be derived from different systems, processes and stakeholders.

Addressing the coding problem

Discrepancies in code sets between systems is a common source of claims-related frustration for payers. When health plan information systems contain even slightly different code sets or groupings, claims are not easily auto-adjudicated, and as a result wind up pended for manual review, causing unnecessary costs and delays that trouble payers and providers alike.

Consider the example of pre-authorization for treatment: When a pre-authorization is approved, a specific range of CPT® or diagnosis code groups are approved along with it. It is common for providers to submit variations of those codes that are valid. Nonetheless, in situations where the codes don’t match exactly, that claim is suspended. This scenario requires payer organizations to allocate valuable clinical resources and staff time to resolve the issue, often requiring hours of back-and-forth work between the health plan and provider staff. The claims process can be delayed weeks or months, contributing to provider abrasion and regulatory penalties in some states.

Coding discrepancies occur for a variety of reasons, yet virtually all of them could be mitigated by implementing strong data governance processes across the organization. The siloed nature of information systems used by payers is well-known, but the use of custom code groups and the requirement to manage frequent code updates from regulatory bodies also contribute to significant challenges.

Fortunately, technology has emerged that can automatically update code sets based on the latest information from standards bodies and intelligently map comparable codes to those specifically authorized, enabling IT systems to finally talk to each other so operations can run smoothly.
Following are three aspects of claims processing that are ripe for improvement with a reference data management solution:

1. **Content updates**

   Enterprise code set management is a substantial undertaking for most payer organizations due to the sheer volume of codes that must be maintained. For example, ICD-10 codes alone include over 70,000 codes, while CPT includes over 10,000. Code updates are released regularly by the standards bodies such as the Centers for Medicaid and Medicare Services (CMS) and the American Medical Association (AMA), and plans must quickly implement these updates into their own systems to ensure claims can be processed correctly.

   But health plans don’t need to agonize over the time-consuming and error-prone code update process any longer. Technology is available today that automatically detects and acquires updates from the standards bodies, ensuring the validity and accuracy of codes used in claims processing and reporting without the administrative stress. This technology can also intuitively identify how those updates impact various custom code groups used by plans to organize codes into more manageable lists of related diagnoses and procedures.

2. **Resource allocation**

   Depending on the size of the health plan, hundreds of individuals, representing multiple departments including product development, business engineering, and account management may be involved in the process of updating codes and code groups. These stakeholders may influence several lines of business including commercial, senior, and state products. A similar picture emerges when it comes to claims resolution, which requires significant time from clinical staff. By deploying technology to automate and streamline these processes, staff resources can be allocated much more strategically, allowing teams to stay focused on high-value business initiatives.

3. **Provider satisfaction**

   With a strategic combination of technology and data governance processes in place, plans can take aim at dramatically reducing the manual rework associated with claims processing and simultaneously support their provider partners. Next-generation technology has been purpose-built to not only centralize vast amounts of siloed data but also extrapolate semantic meaning from it. Health plans can now be better equipped to improve claim accuracy and turnaround time as well as reduce provider abrasion by ensuring payments are paid accurately the first time.

**Conclusion**

A comprehensive reference data management strategy that delivers high quality terminology and common meaning for health data enables payers to pay claims more accurately and efficiently, lower administrative costs, facilitate positive collaborations with providers, and ultimately support value-based reimbursement models. Further, a single source of truth ensures that new codes can be incorporated across all payer systems at the same time, minimizing risk of disruption and maximizing claims processing efficiency in 2021 and beyond.
Health Language

Health Language provides an innovative suite of healthcare solutions designed to improve your organization’s data quality and enable semantic interoperability.

Our solutions help health plans, providers, and health IT vendors transform data from abstract to actionable to effectively optimize reimbursement, manage risk, support quality initiatives, comply with regulations, improve operational efficiencies, and enhance analytics.