Getting ‘Real’

ABOUT CLAIMS PROCESSING

Real-time adjudication largely remains a claims transaction fantasy, but snarled operations and new reimbursement models cry out for it.

By Gary Baldwin

When the topic turns to real-time claims adjudication, Bryan Braswell gets to the point—as fast as the technology itself. He’s not interested.

Braswell is director of business services at OrthoCarolina, a large physician group based in Charlotte, N.C. With 180 physicians, 100 physical therapists, and some 80 other care extenders, OrthoCarolina sends the lion’s share of its claims to less than 10 payers. The idea of processing a claim instantly—so the practice would know expected reimbursement and its patients would know their obligations before heading home, all within seconds of submission—would be seem to be appealing. After all, real-time adjudication is designed to streamline both the revenue cycle for the provider and turn the health care encounter into a more customer-friendly transaction for the patient, one similar to common retail transactions where the cost of goods and services is known immediately, not the health care norm of days or weeks later. But Braswell’s not buying. “If it led to real-time payment, we might consider it,” he says. “But I don’t see the value unless you are getting the money back at the same time.”

Braswell has plenty of company. Real-time adjudication has been bandied about for years as the ideal insurance transaction for physician practices and outpatient service providers (even die-hard champions acknowledge that inpatient claims are far too complicated to document, let alone process prior to discharge in real-time). Yet the technology has little uptake in the industry. Despite a multitude of potential benefits (improved cash
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flow, decreased operational costs, and less patient confusion over bills), only a miniscule portion of health claims are adjudicated while the patient is still on-site.

Patients routinely wait weeks to find out what they owe; providers are stuck with expensive collections efforts; payers must contend with the expense of resubmitted claims. No one is particularly pleased with the health care revenue cycle.

So why hasn’t the industry made greater headway toward real-time adjudication? The reasons for the lack of uptake are as varied as the revenue cycle is tangled. Workflow issues among providers, compounded by their inadequately architectured practice management systems; overly complicated claims management systems (and policies) among payers; and the very complexity of health care billing overall all stand in the way.

Nonetheless, payers—and even providers like OrthoCarolina—are attempting to build alternatives that attempt to address the problems that real-time adjudication targets. Both providers and payers see a future—one coming quickly—in which real-time adjudication, or at least something like it, will be critical to the longevity of the industry.

Financial snarls

For many observers, the financial snarls that real-time adjudication target cry out for electronic efficiency. “Claims inefficiency is an immense problem,” says David Cutler, professor of applied economics at Harvard’s Kennedy School of Public Health, a champion of more streamlined business operations. “We spend more on administrative cost than we do heart disease and cancer; claims adjudication is the biggest part of the expense.”

National physician groups, including the American Medical Association, have long contended that cumbersome insurance transactions—which result in claims being paid incorrectly or reworked multiple times—not only drive up costs across the board, but result in poor consumer service as well. “The AMA has been working for several years to achieve a more transparent pricing system that allows medical claims to be submitted and settled in real-time at the patient’s point of service,” an AMA spokesman says. “This type of streamlined medical pricing supports genuine consumer-directed health care that would allow patients to know their total out-of-pocket costs prior to treatment and help give them greater control over their health care dollar.”

The AMA says its “Heal the Claims” campaign, an effort involving both physician practices and insurance companies, is resulting in some headway toward that goal. Each year the Chicago-based physician group publishes a national insurance report card, laden with pages of data about the frequency of claims errors and timeliness of payment. Between 2011 and 2012, claims errors dropped substantially, with the number of claims paid incorrectly cut in half. But transactions are far from speedy. In 2012, according to the AMA, initial median response time by payers to provider claims ranged from six days to two weeks, depending on the payer.

Those time frames are a far cry from the instantaneous response offered in a real-time transaction. “There are obvious benefits to real-time adjudication for providers and patients—it improves the revenue cycle for providers and eliminates patient surprise when they get the bill later,” says Matthew Ketterman, director, payer and vendor portfolio, at Availity, a claims clearinghouse which offers real-time adjudication and related services. “But it is a chicken and egg situation. You need enough payers to support real-time adjudication for practice management system vendors to see the value of building the necessary interfaces. For the provider to buy the system, the vendor has to sell it at reasonable cost. If enough providers demanded it, more payers might offer it. But many payers don’t, so it’s not worthwhile for providers.”

For physician practices, workflow

Cerner Embraces Real-time Adjudication

Like most large companies, EHR vendor Cerner runs its own self-insured health plan for employees and their families. Its 18,000 plan members have access to two on-site clinics at Cerner’s Kansas City, Missouri headquarters. Most of the clinic services are provided for free to plan members, says Roger Kaltefleiter, vice president of Cerner HealthPlan Services, the EHR vendor’s corporate arm which serves as third-party administrator. Members, however, must pay for some services, including chiropractic care and lab work. And for those services, Cerner calculates member obligations using real-time claims adjudication. “We use it to determine member responsibility and how many flex spending or health care reimbursement account dollars are available,” Kaltefleiter says. “If they don’t have enough funds, we collect at the end of the visit.”

The TPA does process claims for the other services to track utilization, but since members don’t have to pay, it’s not necessary to adjudicate the service real-time, he explains. “We do about 5 to 10 real-time transactions a day,” he says. Providers use a Cerner system to document care and have arranged their workflows such that visits are documented and coded while members are present. At the front desk, staff plug in the member’s ID, and then the Cerner EHR feeds relevant claim information into a claim form. A EDI feed transmits the claim to the TPA’s benefits administration system and the front desk staff get the response back immediately online. At the same time, the clinic gets a remittance advice on its reimbursement for the service. The TPA is its migrating customized benefits administration system to a new system from El dorado, one with real-time adjudication capability already embedded.
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### Real-time Adjudication Payer’s ‘Future Desired State’

As far as health plans go, WEA Trust is not exactly a household name. “We are a niche player,” says Bill Jollie, COO. WEA was formed 43 years ago by Wisconsin educators—then predominantly female—to provide hard-to-get health and other insurance products. Based in Madison, the payer now includes 100,000 members, and has expanded to state employees. “We pay out 2.2 million claims per year for professional and hospital services and another 1.5 million pharmacy claims,” Jollie says.

Despite its size, the plan is thinking big—and ahead—when it comes to expediting claims transactions. “Real-time claim adjudication is our desired future state,” Jollie says. “We have already done the heavy technical lifting and we have the information system to adjudicate claims in real-time. But we must get our own business process more closely aligned with the provider.”

WEA Trust’s core system, from HealthEdge, has been configured to enable RTCA. And Jollie says the plan is rewriting its provider contracts to mesh with the capability. Within three years, he figures that real-time adjudication will become a regular part of the operation.

The plan already provides real-time eligibility checks, responding instantly to queries sent from providers, predominantly via clearinghouses. Many providers send the eligibility queries in batches, just as they do claims. Jollie would like to open up the payer’s claims transaction systems and grant providers direct access to it via a Web-based service. That would not only reduce costs (clearinghouses typically charge a transaction-based fee for routing claims), it would enable the health plan to send responses back via its own data repository and affix more information to its electronic answers. For example, the plan currently has the capability to return “patient accumulations,” or data about an individual’s progress toward meeting an out-of-pocket maximum, a running tally driven in part by applying any co-insurance requirements against allowed charges as they accrue.

Jollie envisions adding even more data to its real-time claims transactions in keeping with forthcoming accountable care contracts wrapped around consumer-driven benefit packages. For example, a member contract might call for a reduction in copay if the member demonstrates compliance with a treatment plan established by a physician. When the patient schedules an appointment with the physician, the provider office would notify the plan, which in turn would return eligibility and copay information, based in part on the member’s progress. At the conclusion of the visit, the provider and patient would get a remittance advice, showing the patient’s financial responsibility and the provider’s payment. “All in real-time,” Jollie says.

He acknowledges that his vision of the ideal payer-patient-physician transaction would be a quantum leap for many. Providers are used to sending batch claims transactions via clearinghouses, and clearinghouses typically would not support individualized real-time transactions.

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A major health payer that has long championed real-time adjudication is Humana, which serves 12 million members nationwide. Humana began offering the services six years ago. “We were one of the first,” says Jackie Hardison, I.T. director. “We wanted to reduce the complexity of the claim process and improve the provider office experience.”

In the Humana set-up, a provider either submits a claim via its practice management system, or through a dedicated Web portal. Within a few seconds, the practice will receive an electronic response detailing the total charges, the allowed charges and the member responsibility. “We wanted to make the health care encounter more like a retail experience,” says Hardison.

Humana does process several thousand claims a day in real-time, Hardison says, mostly for routine office visits. But it’s a drop in the bucket of its overall claim volume—which averages up to 400,000 claims a day; adds Sid Hebert, director of Humana’s ICD-10 implementation team. Hebert points to inadequately architected practice management systems as the main reason more physicians don’t use the ser-
vice. “Most systems are designed to batch claims and send in groups,” he says. “The system cues up the files, does background processing and then releases the batch out to a clearinghouse.”

Humana’s real-time transactions run through Availity, a clearinghouse the payer launched in conjunction with Blue Cross of Florida to support real-time adjudication and other real-time services, such as eligibility checks. Availity now serves a network of 1,300 health plans, 1,000 hospitals and 200,000 physicians, according to Ketterman.

Among the plans, only Humana, Blue Cross Florida and United Health Care offer real-time adjudication, he says. On their behalf, Availity adjudicates about 150,000 monthly claims in real-time, he says, with about one-third originating through a Web portal and the remainder originating in one of seven practice management systems that support the transactions. The real-time claims transactions comprise a small fraction of Availity’s overall volume. “The majority of practice management systems don’t have the capability,” Ketterman says.

**Logical questions**

Many payers—Medicare among them—have yet to follow Humana’s lead and offer real-time claims adjudication. Although payers can usually verify eligibility in real-time, their core claims processing systems often do not have the capability to fully adjudicate a claim, says Seib. “Payer claims systems have a ton of logic written into them,” he says. “Trying to replicate that logic in a real-time manner is hard. Until they rewrite their entire claims system, applicability will be limited.”

Beyond technology limitations, the very complexity of the health care revenue cycle poses a major barrier to adjudicating individual claims instantly. Just getting a claim to a payer’s adjudication gateway can be a time consuming process. “A lot of third parties are involved in the processing of a single claim and that becomes problematic,” says David Hawkes, executive vice president, product development at Eldorado, a payer claims system vendor offering real-time adjudication. “Often a claim is taken in by a payer, and the payer will route it via a batch file to a PPO network to gather pricing information about what is allowed. Traditionally, PPOs are very secretive about what they have contracted with providers and they demand that claims come to them from payers. They don’t want to let the information out.” Beyond that, fraud and abuse edits come into play, Hawkes adds. “The sheer number of players in the process makes it difficult to move claims in real-time mode.”

Eldorado’s software is used by some 75 health plans and third-party administrators of self-insured plans, but among them, only one does any real-time adjudication of claims, Hawkes says (see sidebar, page 38). That will likely change in the advent of accountable care, he says. “We will see the model become more prevalent in the ACO where the provider is part of the payer organization,” he predicts.

Hawke’s foresight is not lost on the industry—payers, clearinghouses and providers are all scrambling to understand the impact of accountable care reimbursement models on their operations. They’re developing alternatives to real-time adjudication that attempt to streamline a claims process widely acknowledged to be cumbersome and consumer unfriendly. Seib at InstaMed says it behooves the industry to move closer to the retail experience consumers are used to. “Look at Best Buy,” he says. “You can go in and buy something with a credit card and the store has a high degree of assurance they will be paid. Health care is more complicated, but creating that level of assurance for providers is the problem we are trying to solve.
And there are ways to solve it outside of real-time adjudication.”

Toward that end, InstaMed offers a “patient estimation” service. Using the service, providers enter patient demographics and what services will be provided for a given visit. The inquiry is dispatched via a practice management system to the clearinghouse, which begins the process by sending an eligibility query to the payer. After verifying eligibility, InstaMed calculates the likely patient obligation using a set of standard charges from the provider and then applying a pricing discount. “Providers have complex contracts, so we often just focus on the top 20 services they do,” says Seib. “We want an estimation that is ‘good enough,’ just to set some expectations for the patient. The accuracy of the estimate is plus or minus 10 percent.”

The results come back quickly and providers do not have to enter the coding information required to fully adjudicate the claim in order to receive the patient estimation, Seib says. “We set up a template for the most visits. We have to make it simple.”

Most providers run the estimation before the patient has left the practice. Patients can either pay by credit card, or set up a payment plan with automatic payments—that can be adjusted once the actual claim goes through and patient obligations are known precisely. Other than running the eligibility inquiry, the clearinghouse does not have to send any transactions to the payers to complete the estimation, Seib says. “We estimate based on our own data and the fee schedules from providers.”

Variances in the estimates usually occur in cases where the patient has used up their benefit allotment, such as allowed trips to a physical therapist, Seib says. He says price estimation works best with simpler procedures and office visits, but can be applied to a wide range of specialists.

Passport, another clearinghouse, also offers a patient estimation service on a subscription basis. It’s used by hospitals more than physician groups, says Marcus Padgett, vice president, revenue cycle. But estimating the final cost of hospital services can be all but impossible, he acknowledges.

“Hospital claims are more complicated,” Padgett says. “The patient may have co-insurance, where the patient pays a co-pay plus a percentage of the total. Knee replacement costs can vary by 50 percent.”

**In seconds**

Passport can return its price estimation within seconds, crunching its own numbers against the eligibility information returned by the payer in real-time, Padgett says.

For providers, knowing the patient obligation at the time of service would help, adds Carl Ascenzo, partner at Boston-based NewVantage, an I.T. consulting firm.

“Knowing the patient liability at the time of service prevents them from having to chase the patient later,” he says.

But payers themselves face many challenges in adjudicating claims, adds Ascenzo, the former CIO at BlueCross BlueShield Massachusetts.

“There are many considerations the payer can’t resolve, such as coordination of benefits if the patient’s primary insurance is through another company, or other claims from the patient that have come through and pended, that could change the amount of the patient deductible.”

Ascenzo doesn’t envision much expansion of real-time claim adjudication, but does see growth in real-time adjudication’s cousin, auto-adjudication.

In auto-adjudication, once a claim arrives at a payer’s doorstep, it can pass through payer processing systems and wind up being settled—without human intervention. Auto-adjudication doesn’t happen instantly, as claims run through various edits in batches, but eliminating human review is far more cost-effective and the process can expedite payments, experts say.

Auto-adjudication doesn’t depend on a provider keying in and submitting a claim in real-time, as a payer could auto-adjudicate claims being sent in batches overnight from clearinghouses or directly from providers.

A claim may pass through multiple layers of edits and benefit checks, which are parsed electronically.

Auto-adjudication can also help providers, despite their resistance to real-time adjudication, adds Pat Kennedy, founder of PJ Consulting.

Health plans that promoted real-time adjudication found few takers because of workflow issues, he contends.

“Doesn’t want, need or use real-time adjudication,” he says.