WHITE PAPER

# Eligibility Verification: How to Ensure No Cash is Left Behind

For home healthcare agencies (HHAs), claims denials are an unavoidable cost of doing business; after all, claims can be denied for a number of reasons – errors in patient intake, a change in a patient's coverage, or improper billing, to name a few. When denials go unchecked, however, they can have a severe impact on an agency's revenue stream, causing an estimated 3 percent loss in gross revenue.[1] That's why industry recommendations generally hold that home healthcare agencies keep claims denial rates under 3 percent.[2]

So why don't agencies do more to track and reduce denials? Likely because there are many obstacles standing in the way of easily managing eligibility and appeals.

## The strain of monitoring eligibility on staff productivity

Staff can put a lot of time and energy into monitoring patient eligibility to avoid denials. With nearly half of all Medicare users now covered under Medicare Advantage[3] – 31.2 million seniors and growing – billing agencies have an increasing number of reimbursement requirements and rules to comply with to avoid denials. Medicare Advantage options also can lead to users shifting coverage more frequently, to cut costs or adapt to a move.[4]

Determining which patients have switched payers within their billing period, canceling claims, rebilling invoices, and updating records within the electronic medical records system can create chaos and stress for staff and pull their attention away from more meaningful tasks. With staff so stretched, HHAs often find themselves short of the qualified staff they need[5] to tackle the manual process of the constant, recurring eligibility verifications to avoid unnecessary denials.

## The inefficiency of manually generating claims

Many organizations require manual input of claims, which can decrease organizational efficiency. Additionally, manual entry opens the door for human error that can lead to increases in denials. In fact, it is estimated that as many as 90 percent of denials are preventable, and between 30 and 40 percent of denials are due to registration errors.[1] When each claim needs to be handled individually, with staff manually verifying eligibility and inputting information – often the same information in multiple places – time is wasted. Staff that are stressed for time, or caught in an endless cycle of data entry, can make errors in patient or payer information that lead to denials.

## Lack of visibility into denials

Without mindful denial management, organizations lack insight into patient eligibility or the causes of their denials. Many payers don't publish their rule changes, which leaves healthcare agencies in the dark when they are filing claims. Or, patients are unaware of the shift between home health benefits and Medicare Advantage. This leaves HHAs with a lack of insight into their patients' eligibility. That lack of insight ultimately leads to increases in denials that agencies feel helpless to combat.

## Easily reduce denials with the right systems

The challenges facing HHAs looking to bolster cash flow by reducing denials can be overcome with the right software and applications. By integrating revenue cycle management into electronic health records system, HHAs can efficiently manage and reduce denials. An integrated revenue cycle management (RCM) system addresses many of the problems HHAs face, such as determining claims eligibility and identifying primary causes of denials. And when RCM works seamlessly with an agency's EHR system, the claims process flows more efficiently because information doesn't have to be entered multiple times, and many of the processes that consume staff time are

## User-friendly interface from KanTime

Kantime's user interface features automation that alerts users to changes in payer eligibility. Interactive dashboards provide quick and easy monitoring of changes and gains in eligibility, along with real-time alerts, and they can be configured to help users answer questions about a patient's eligibility history and see when a patient's eligibility has changed, has losses or gains, or has not been verified or checked. The dashboard also adapts automatically to shifts in Medicare, Medicaid, and other payer policies, and features widgets to ensure Notice of Admission (NOA) are filed on time and billers are aware of any pending claims.

## Faster claims processing and easy denial monitoring with Inovalon

With Inovalon Claims Management Pro integrated into the KanTime platform, HHAs can configure the timing of batch eligibility and have responses pulled directly into the KanTime system, allowing for real-time eligibility verification, access to historical eligibility responses, and management of failed eligibility issues in a dedicated work queue. Additionally, Inovalon analytics allow organizations to have insight into why claims are being denied so claims and claims processes can be altered in the future to reduce denials.

With a KanTime and Inovalon integration, billing staff can generate and transmit 370 files and receive automated 271 response files within KanTime, saving the step of having to access the information via a clearinghouse gateway or portal. The integrated systems also eliminate the need for manual eligibility checks and automate revalidations with quick, comprehensive search options that scan databases in seconds to deliver detailed and accurate coverage information.

## Improving efficiency and reducing denials for an increased focus on patient care

With KanTime and Inovalon, HHAs can reduce staff stressors, minimize revenue cycle delays, and increase cash flow, profitability, and efficiency. Using KanTime and Inovalon technology, organizations can spend less time worrying about recurring verification checks and focus their time and effort on what matters most: delivering quality patient care.

Learn more about the partnership or call 855-799-1879 today for a demonstration.

# SOURCES


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