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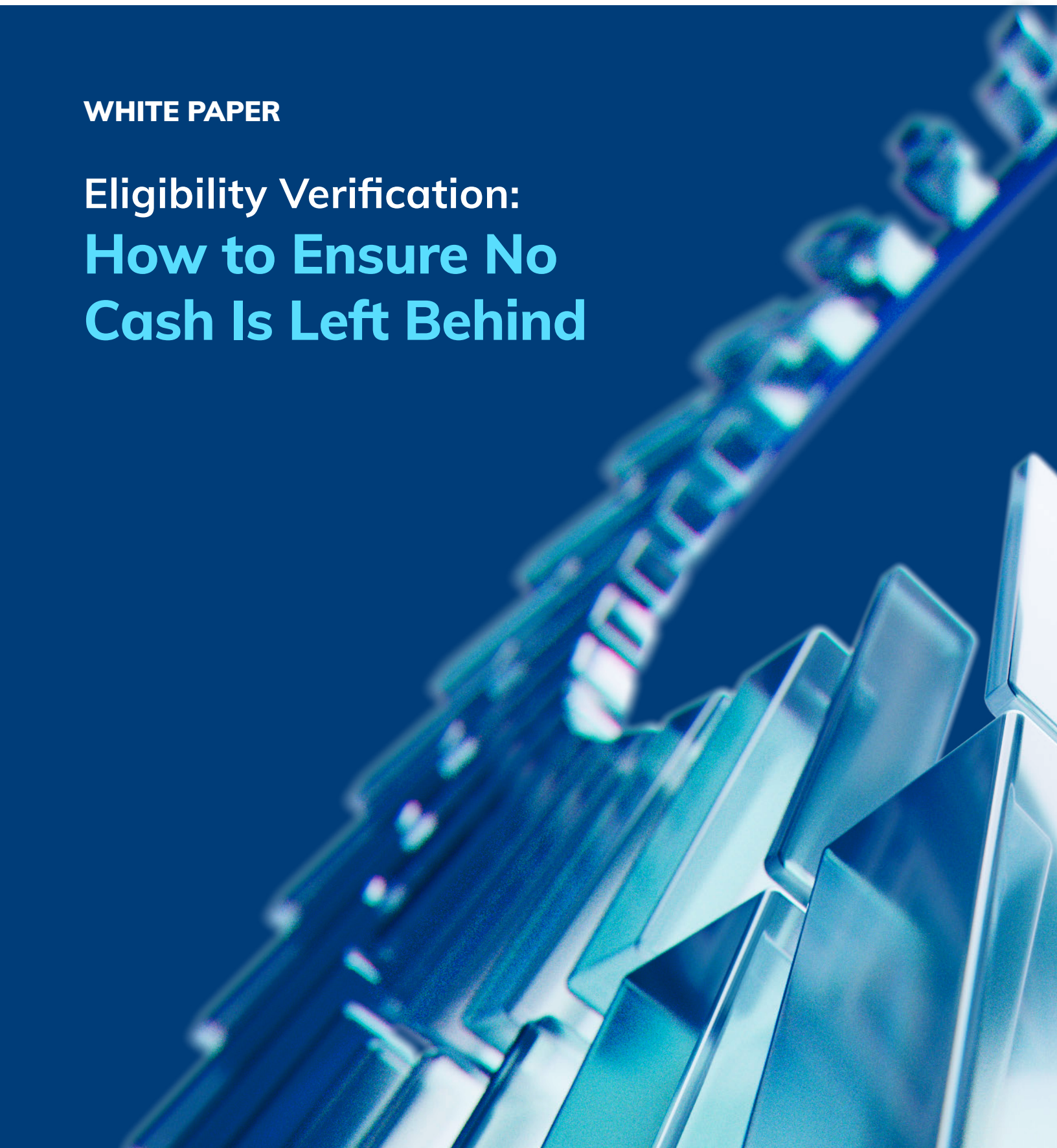
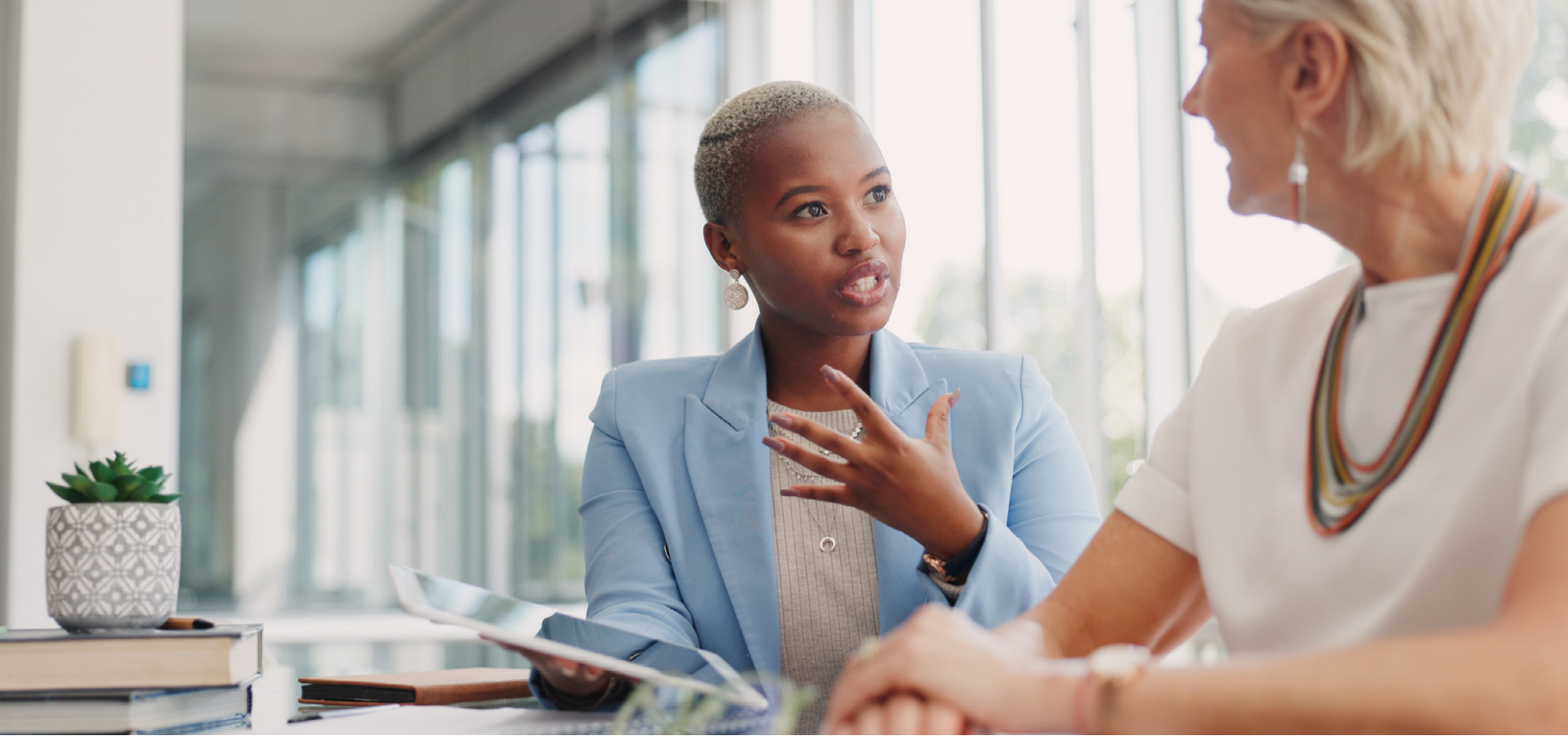
WHITE PAPER

Eligibility Verification: How to Ensure No Cash Is Left Behind





For home health 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. And when denials go unresolved, they can have a severe impact on an agency's revenue stream, which is why industry recommendations generally hold that HHAs keep claims denial rates under 3%.[1]

So why don't HHAs 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 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 – 31.2 million seniors and growing[2] – 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.[3]

Determining which patients have switched payers within their billing period, cancelling claims, rebilling invoices, and updating records in the electronic medical records system can create chaos and stress for staff, and pull their attention away from more meaningful tasks. With staff stretched so thin, HHAs often find themselves short of the qualified talent they need 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 80% of denials[4] happen because of errors during the intake and admissions process. When staff is manually verifying eligibility and inputting information – often the same information in multiple places – time is wasted, and mistakes are likely. 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.

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Lack of visibility into denials

Without mindful denials management, organizations lack insight into patient eligibility or the causes of their denials. Many payers don't publish their rule changes, leaving HHAs in the dark when they are filing claims. Similarly, patients are often unaware of the differences between home health benefits and Medicare Advantage. This leaves HHAs with a lack of insight into their patients' eligibility, which 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 an electronic health records system (EHR), HHAs can efficiently manage and reduce denials. An integrated 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 tasks that consume staff time are automated.

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. requirement, there is much focus on race and ethnicity and health plans are working on imputing data at least from indirect sources.

Faster claims processing and easy denials monitoring with Inovalon

With Inovalon's Claims Management Pro integrated into the KanTime platform, HHAs can customize 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.

The KanTime and Inovalon integration empowers billing staff to 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 solutions also eliminate the need for manual eligibility checks and replace manual insurance discovery methods with quick, comprehensive search options – scanning databases in seconds to deliver detailed, 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. Organizations using KanTime and Inovalon software 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.

1. "Home Health Strategies for Managing Denied Claims," Ryan Capretta, Richter LTPAC Performance Advisors, April 6, 2022, https://blog.richterhc.com/home-health-strategies-for-managing-denied-claims.
2. "Medicare Advantage Membership Grows 7% for 2023," Bob Herman, Stat News, Feb. 17, 2023, https://www.statnews.com/2023/02/17/medicare-advantage-membership-grows-7-for-2023/#:~:text=Nearly%2031.2%20million%20seniors,government%20data%20analyzed%20by%20STAT.
3. "7 Signs You Should Get a New Medicare Plan for 2023 During Open Enrollment," Maryalene LaPonsie, ForbesHealth, Oct. 25, 2022, https://www.forbes.com/health/medicare/new-medicare-plan-during-open-enrollment/
4. "Missing or wrong data at admissions costs SNFs millions," Danielle Brown, McKnight's LTC News, May 23, 2022, https://www.mcknights.com/news/missing-or-wrong-data-at-admissions-costs-snfs-millions

About us

Inovalon is a leading provider of cloud-based SaaS solutions empowering data-driven healthcare. The Inovalon ONE® Platform brings together national-scale connectivity, real-time primary source data access, and advanced analytics into a sophisticated cloud-based platform empowering improved outcomes and economics across the healthcare ecosystem. The company's analytics and capabilities are used by nearly 20,000 customers supporting more than 53,000 sites of care. For more information, visit www.inovalon.com.

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