CARESTACK

Maximize insurance reimbursement

Improve profitability through clean claims

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Why are clean claims important?

A clean claim is defined as *"a claim which has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment."*

There are several elements required for a clean claim, and dental bills are denied if these elements are incomplete, illegible, or inaccurate. A clean claim should:

- Identify the provider and facility in order to verify, if necessary, the affiliation status
- Identify the patient and insurance plan subscriber
- List the date and place of service
- Only be for covered services for an eligible individual under the insurance plan
- Substantiate the dental necessity and appropriateness of the service provided, if necessary
- Contain sufficient information to establish that prior authorization was obtained, if authorization was required
- Identify the service rendered using a generally accepted system of procedure or service coding
- Include additional documentation based on services rendered as reasonably required by the plan
- Have providers who bill a dental plan within one year — or a stipulated period — after the date of service

Ensuring a high **Clean Claim Rate** (CCR) is vital for the operational health of dental practices. CCR is a crucial revenue cycle metric that indicates the quality of claims-related data being collected and reported in the form of a claim as it begins its journey from the provider to the clearinghouse and on to the payor. CCR is calculated by dividing the number of claims that pass all edits, thus requiring no manual intervention, by the total number of claims accepted into the claims processing tool for billing.

Median income for dentists:

$216,000 in 2005

$205,000 in 2019

Dentist revenues are robust, but profitability is declining

Time spent in reworking claims resulting in more payroll, lost productivity and delayed payments.

Common causes for rejections

- Code isn't valid for the date of service
- Code isn't valid for patients age/gender
- Invald Fee/ Total claim charges are zero
- Entity date of birth invalid or missing
- Insured zip invalid
- Billing provider invalid or missing
- Invalid procedure code
- Subscriber and Subscriber ID not found

A 100 percent CCR may not be realistic, given that payor requirements are always changing, and upstream errors and data quality issues are tough to overcome entirely. However, by having the right combination of people, processes, and technology, practices can target and achieve CCR rates of nearly 90 percent. This would enable the practice managers to have better predictability and tighter control over their revenues and operational costs, thereby increasing the bottom line and competitiveness of the practice.

At CareStack, we are uniquely positioned to help fast-growing dental practices continuously improve their CCR. This is facilitated by:

- A modern technology foundation that enables aggregating and analyzing data across all locations of a practice
- A simple interface that prioritizes usability and accessibility to this data for all types of business users
- Multiple layers of built-in claim scrubbing logic that covers provider setup, practice setup, payer setup, patient demographic and eligibility information, as well as documentation specific to services
- Ability to create and customize workflows around lists and notes to enable users to communicate and collaborate efficiently across geographies and time zones

In the subsequent sections, we shall go deeper into the claim scrubbing process and how it is facilitated by CareStack.

Rejections and denials

Two major reasons lead to the re-processing of claims — rejections and denials. While these terms are often used interchangeably, they are different and require distinct solutions.

Rejected claims

These are claims that have come back due to missing or invalid information required for an insurance carrier to properly process a claim. A claim that has been rejected has not been entered into the payor's adjudication system. *As far as the payor is concerned, that claim doesn't exist.*

Rejections happen at two touchpoints in the claim management workflow:

At the clearinghouse

These rejections typically include payor related information that the clearinghouse builds into edits to prevent claims from being passed on to the payor, only to be rejected by the payor. For example, if a subscriber ID is required to have an alpha prefix and a provider submits a claim that is missing that prefix, the clearinghouse edits catch that error and return the claim as rejected.

At the payor

These are commonly related to patient demographics, and eligibility issues discovered when the claim reaches the payor. The most common patient-related rejections are also the most preventable. “Subscriber and Subscriber ID Mismatched” or “Not Found” are usually an indication that the patient was not eligible at the time of service or that there is a data-entry error in the patient’s demographics. These rejections can be prevented by solely making sure that eligibility is verified at the time of service. It’s all too common for practices to lose revenue on visits due to the failure of eligibility verification, and then falling behind in reworking the rejected claims.

Denied claims

These are claims accepted by the payor, but returned to the provider with either no payment or partial payment after adjudication. Denials must be either adjusted off, appealed, or reopened if the provider has a valid reason. A claim that has been processed and denied cannot be corrected and resubmitted as a rejection.

There are generally no appeal rights for claims that have been denied for delayed filing, so it is crucial to make sure that rejected claims are corrected and resubmitted as soon as possible.

CareStack provides a number of verifications and validations in the claims workflow to ensure that rejections — from the clearinghouse and the payor — are minimized.

Common causes for denial

- Policy benefits have been exhausted
- Missing/invalid information on provider
- Missing/invalid patient details
- Incomplete/Invalid documentation
- Not eligible due to patients age
- Missing/incomplete/ invalid type of bill

CareStack-enabled claim scrubbing process

A combination of the following enables claim scrubbing in CareStack:

Checklist-driven training and onboarding

Accurate initial software setup

Built-in billing validations

Configurable billing rules

Claim-level validations

Checklist-driven training and onboarding

When your practice is onboard the CareStack platform, your existing data — including the provider, patient, and insurance information — is migrated as-is. We have tied up with two of the largest clearinghouses in the United States to provide electronic claims, eligibility, and ERA services, and our customer support team members take you through any new credentialing and enrollment requirements if you are crossing over from another clearinghouse service. This ensures a smooth transition into our platform and eliminates any possibility of errors in setting up new providers or locations even before you start billing.

Accurate initial software setup

Immediately after data migration and credentialing, the application setup begins. In this phase, our customer support team works with the practice champion to ensure that the following entities are set up accurately in Practice Settings in CareStack:

- **Insurance carriers:** name, address, insurance ID, and eligibility forms
- **Insurance plans:** plan type, benefits coordination method, pre-auth requirements, and fee schedules
- **Providers:** details include name, DEA, NPI, State License Number details
- **Billing codes:** details include ADA billing codes, CMS billing codes, ICD 10 diagnostic codes, along with their associated expiry date, chart drawings, and sales tax
- **Claims:** details include default claim type and electronic attachment (NEA) rule setup

During the initial setup, the CareStack team ensures that the data associated with each billing entity — including provider, payor, and plan — is accurately created so that at the time of billing, any rejection or denial due to wrong data is minimized.

Built-in billing validations

CareStack's built-in features validate billing information at the point of care-coordination itself. This ensures that the users are immediately informed about the possible impact of their action on billing, thereby enabling decision-making as early as possible in the workflow.

Some of these features in CareStack are:

- **Smart Code Logic** while charting
- **18-level rule hierarchy** to accurately calculate fees during treatment completion
- Visual cues for identifying manual changes in fees
- Ability to re-estimate fees on change of insurance
- Preset tooth and surface-level validations for each procedure code, to ensure accurate claims, Validating the expiry of procedure code based on Date of Service, to eliminate accidental billing and check-out of expired codes
- User prompting to validate the address of the patient before they leave the office

Configurable billing rules

In addition to the built-in validations, users can also set up their own rules in CareStack. This comes in the form of two features:

Care audit rules: This feature, which can be turned on and off, enables users to define messages for a particular procedure code. These messages are displayed when each code is being checked out. This information is also available on-demand for users wherever they are in the application, aiding them in identifying dependencies or alternatives to the billing codes at the point of completion, thereby reducing billing errors.

Eligibility rules: These rules are set up manually or electronically while verifying patient eligibility. Like care audit rules, these also present themselves automatically during the different stages of treatment completion and billing. By prompting the user about payer-specific rules in relation to many factors, such as frequency, age, time limitations, exclusions, and bundling, this allows users to make corrections while checkout even before a claim is generated.

Claim-level validations

During the claim-creation process, all setup-related activities are validated further. This includes:

Claim form validations: Information about entities such as treating provider, billing provider, place of treatment, and orthodontic claim-related information are validated when each claim is generated in CareStack. Claims that require immediate action are made available as a filtered list. These claims

are submitted to the clearinghouse only after users complete the missing information, thereby ensuring a high First Pass Acceptance Rate.

Integrated attachment validations: All required additional documentation, such as x-rays and narratives, is validated by integrating third-party services like NEA. As soon as a claim is created, the user is redirected to a filtered list of claims created by the automatic validation process. These claims can only be submitted after the required attachment is added by the users.

Avoiding rejections

In the claims process, most rejections occur due to missing or invalid data. Other errors that lead to rejections include the use of wrong date format, the invalidity of zip codes and inconsistencies in user data.

With built-in validation features and rule-based data capture, many of these rejections can be avoided. If credentialing and provider setup is carried out accurately in the onboarding phase itself, the chances of rejections shrink to a great extent. The claims process can be made smoother when crucial information fields (such as Subscriber ID, NPI no) are made mandatory in the process of onboarding.

Carestack offers a suite of tools that work to minimize errors due to missing data. In the CareStack system, crucial data fields are required to be filled before proceeding to payment or claim creation. This includes the patient's complete name, date of birth, SSN, subscriber ID and so forth. CareStack's comprehensive eligibility forms ensure that every single detail about the patient's insurance plan is captured as a part of rejection prevention. During onboarding, the CareStack support team facilitates provider credentialing and initial set up of all the codes and rules.

Avoiding denials

When it comes to denials, the lack of supporting documentation, data inaccuracies, improper dental coding, and untimely filing of claims are seen to have the most profound effect. Another aspect that affects denials is the change in regulations and policies in claim processing.

Features such as code-level rules allow the user to assign a date of service to procedure codes. Which automatically renders the code invalid on expiry. Age restrictions can also be implemented using the same rules. Additional documentation like x-rays, charts or EOBs can be made mandatory for specific codes to aid in better claim processing. Eligibility rules, once set up by the user, monitors the frequency of code usage for specific procedures.

CareStack's features are built for denial prevention. Rules assigned during set up flag expired procedure codes and alert users trying to check out them. CareStack employs Care Audit Rules, a system-wide rule manager that can suggest alternative procedure codes and prompt users with informative messages on checkout. The inbuilt document manager can be used to upload, save and organize crucial documentation that can be attached to claims using technologies like NEA FastAttach.

The CareStack impact

All CareStack customers have an FPAR surpassing

80%

70% of these customers have an FPAR exceeding

90%

For our large customers, with over 1000 claims a month, FPAR is more than

85%

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