



WHITE PAPER

INSURANCE WORKFLOW

**DRIVING EFFICIENCY  
IN CLAIMS OPERATIONS**

**EXECUTIVE SUMMARY**

Today, insurers around the world face a common challenge – to grow the business while remaining profitable. Uncertain economic conditions, regulatory pressures, operational inefficiencies, and the need for improved transparency and risk management only add to the complexity of this task.

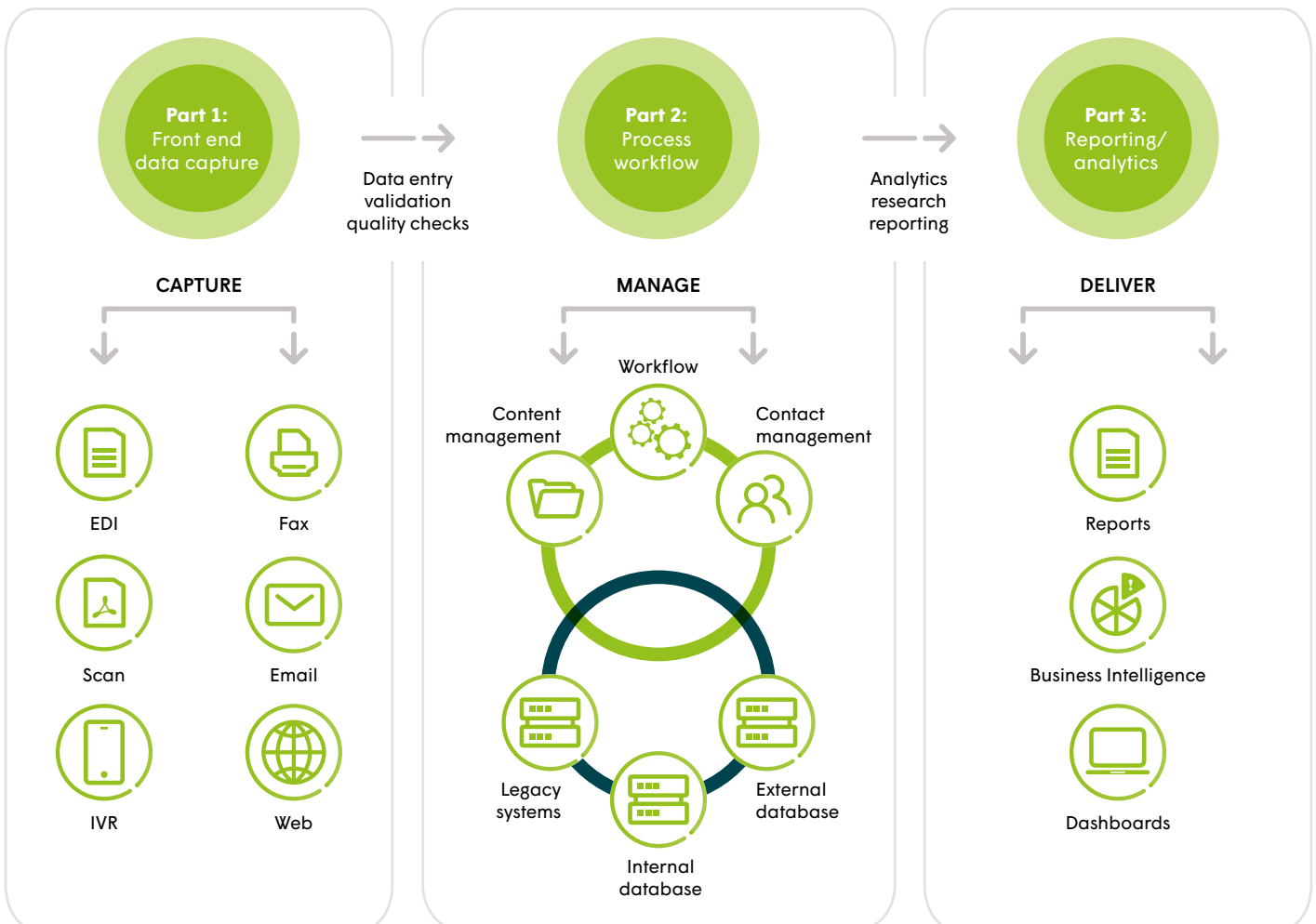
For health insurers to remain viable in this era of complex regulatory mandates and healthcare exchanges, they must review all areas of their plan to seek efficiency improvements and optimize processes to drive down costs. It is no longer an option to sit on the sidelines. Health insurers must automate and streamline to succeed.

In this report, FIS provides best practices and practical advice that health plans can readily implement in their efforts to reduce complexity, improve efficiency and streamline operations. These recommendations will touch on:

- Increasing auto-adjudication rates
- Automating pending claims processing in real time
- Integrating and automating across multiple disparate systems and functions
- And more...

In this first edition, we will focus on the front end of the claims ecosystem – Data Capture. In future reports, we will address process workflow improvements in managing and storing claims information, and how you can deliver better, more actionable results on the back end. (See figure 1.)

Figure 1: Claims ecosystem



## Status quo is not an option

The American Medical Association's (AMA) sixth annual check-up of health insurers and their patterns for processing and paying medical claims released in June 2013 estimates that \$12 billion a year could be saved if insurers eliminated unnecessary administrative tasks with automated systems for processing and paying medical claims.

The claims ecosystem offers many opportunities to improve efficiency. As a best practice, insurers should start on the front end of the claims process – data capture – to ensure accurate and timely data that ultimately feeds into and affects the entire ecosystem.

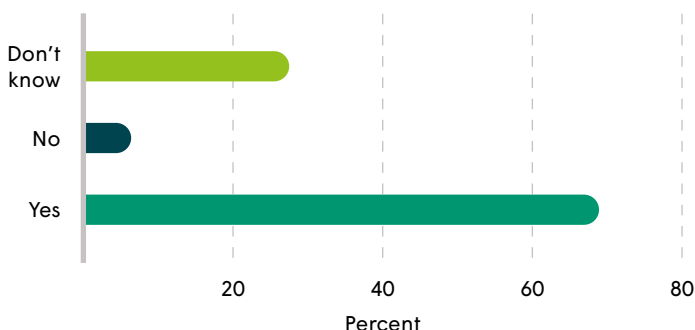
Whether taking in claims, enrollment forms or other correspondence via paper or electronic format, it is critical that you capture the most accurate information at the onset.

Automating and streamlining the front end of claims operations can yield:

- Improved accuracy
- Higher through-put
- Lower error rates
- Improved service

Underscoring the need to improve efficiency, a recent poll indicated that two-thirds of respondents currently have a plan in place to increase efficiency across claims operations. However, a third do not currently have a plan in place or are uncertain. (See figure 2.)

**Figure 2: Do you currently have a plan in place to increase efficiency across your claims operations?**



## CASE STUDY

Tufts Health Plan improves efficiency and productivity with FIS' data capture solution, increasing throughput from 55-60 documents to more than 150 documents per hour per keyer while reducing the plan's error rate from three percent to 0.2 percent.

## Best practice 1

### Increase speed and accuracy while reducing costs

You've heard the phrase "garbage in, garbage out." Nowhere is that more evident in an insurance plan than in the front-end of claims processing. Whether paper-based or electronic, if your input is not clean and accurate, then your downstream processes will be negatively impacted. Errors cause rework, auto-adjudication rates plummet, efficiency declines.

- What if you could improve the accuracy of front-end data capture?
- What if you could streamline processes on the front end to further increase efficiency and auto-adjudication rates?
- How might your bottom line be impacted by efficiency gains across claims operations?

Whether taking in claims, enrollment forms or other correspondence via paper or electronic format, it is critical that you capture the most accurate information at the onset.

Claims must be adjudicated in a timely and cost effective manner. The quality and accuracy of claim data going into the adjudication process remains a key factor in downstream efficiencies that drive internal administrative cost, as well as member and provider satisfaction. The number of ways to submit and code a claim is multiplying, further driving the need for consistently capturing high quality claim data from the onset.

The following suggestions will help ensure more accurate data submission.

- Standardize incoming claims and related documents before they are scanned into your claims system.
- Employ auditing tools for paper documents before they are scanned to prevent duplicate documents, forms, or batches from entering the system.
- Incorporate advanced features such as bar code reading, patch page detection, unique document control number assignment and imprinting, and advanced image enhancement.
- Employ Optical Character Recognition (OCR) to enable both machine and handprint recognition to reduce manual keying. Your OCR should include Intelligent Character Recognition (ICR) engines and Natural Handwriting Recognition (NHR) engines to further reduce manual keying.
- Process all transactions – whether from paper, EDI, or web forms – through the same rules engine, ensuring one accurate and consistent upload to back-end systems.

By minimizing front-end data capture submission errors, health insurers can increase auto-adjudication rates, reduce costs and increase provider and member satisfaction dramatically.

For many insurers, claims are still being processed largely on a manual basis, and those firms should be eager not only to reduce errors but reduce the cost of processing. Manual processes might cost about \$9 per claim; whereas it's less than \$1 for electronic processing. Those costs include staff resources, postage and other factors.

KUNAL PANDYA, AITE GROUP,  
AS PUBLISHED INSURANCE NETWORKING NEWS,  
MAY 1, 2012

## Best practice 2

### Expand your auto-adjudication universe

Improving the first pass adjudication rate for claims remains the most direct method to reduce inventory backlog and achieve faster turnaround time with less human intervention. Automating as much of the process as possible on the front end will ensure higher auto-adjudication rates and fewer human errors.

Once the claim intake process is streamlined to increase auto-adjudication rates, health payers can further increase the number and variety of claims that are automatically processed by applying a catalog of efficiency rules and automated action steps. These include:

- Automate claims with pend-codes that have repeatable rules-driven cleanup processes.
- Take claims that were “dropped out” into buckets and apply rules to automatically analyze, update and post corrections to those claims.
- Organize pended claims for human correction, creating a sequential approach for processing.

Apply these best practices along with a process engine across your entire line of business to further improve adjudication rates. Automating claims processing for a given line of business ensures quicker claim resolution. You might also explore cross-departmental claim management, which can monitor claims from submission through to payment. Create a predictable claims process to track, adjudicate and measure claims as they flow through your entire organization.

In an updated survey of health insurance claims receipt and processing, America’s Health Insurance Plans (AHIP) reveals increasing claim auto-adjudication rates over the last several years. The study estimates that approximately 79 percent of all claims were adjudicated automatically in 2011, up from 75 percent in 2009, 68 percent in 2006 and 37 percent in 2002. Among electronic claims, the auto-adjudication rate was 80 percent in 2011 and 2009, while for paper claims it increased to 53 percent in 2011 from 37 percent in 2009.

Figure 3: Automating adjudication processes; cutting manual claims processing in half



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### Best practice 3

#### Efficiently manage claim exceptions

Pended claims, particularly moderately complex ones, can significantly increase costs and negatively impact service levels. They can also lead to late payment penalties. Even with best efforts to process each claim in one automated pass, some claims still pend due to an exception in adjudication which requires closer inspection.

Here are some suggestions on how to streamline exceptions processing to further improve efficiency:

- Route claims to the most appropriately skilled reviewers
- Ensure claims are worked in priority order rather than staff preference
- Work pended claims in a consistent and efficient series of steps

Claim exceptions don't have to weigh down your throughput. By automating key processes, you remove the guesswork for your employees. Pended claims get worked faster and more efficiently.

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### Best practice 4

#### Effectively manage claim interactions

Members or providers often have further inquiries about a claim after it has been submitted. These inquiries also may come from within the organization: customer service may be researching a claim for a member; appeals and grievances could request more detailed claim information; or an account manager may ask questions on behalf of a commercial group. Regardless of the source or nature of an inquiry, each interaction must be accounted for in order for the plan to respond accurately and quickly.

To improve response times, employ proven collaboration patterns and consistent history trails as the foundation for managing claim inquiries. In addition, you should:

- Identify trends in claim interactions that can be managed proactively.
- Integrate and automate across multiple disparate systems, departments and functions.
- Process medical review requests for multiple claims simultaneously.
- Route work in multiple directions and track where you are every step of the way simultaneously.

In addition to improved customer service, plans can further improve compliance by meeting response criteria for audits and National Committee for Quality Assurance (NCQA), Star Ratings, Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures.

## Best practice 5

### Prepare for the long haul

Many external forces continue to impact the health insurance industry, including new financial models with providers or mergers among healthcare companies. One area constantly tested through this change is the claims payment process – new product configurations, payment fee schedules and the need for faster claims turnaround add to the already-complex process.

To prepare for the long haul, insurers should:

- Develop a long-term plan that incorporates market, regulatory, operational and technical drivers.
- Integrate the claims value chain end-to-end for greater member and provider satisfaction.
- Increase claims automation and integrate disparate systems from multiple vendors to eliminate redundant processes.
- Enhance your claims process with methods such as Lean and Six Sigma.
- Establish and maintain a Center of Excellence for claims founded on continual improvement.

## Get started today

We've shared a number of best practices and practical advice with you today. Now it's time to act.

Where do you start?

- Assess the situation
- Determine where to focus
- Establish Key Performance Indicators (KPI)
- Consider your options
- Create a plan
- Execute... Just get started!

Start by taking a step back and assessing your current situation. Are too many claims dropping to pend? Are your error rates out of line? Are your keyers spending hours on a \$10 claim discrepancy?

Once you determine where to focus, establish some baseline metrics. How will you determine success? If you choose to address adjudication rates, measure your current state first pass adjudication. Perhaps measure how many claims require manual processing today. KPIs will help you set a goal and monitor success along the way.

Then consider your options. What will you do? You can do nothing and things will continue status quo. Maybe you decide to tackle these problems in-house with your own team. Does your team have the knowledge or bandwidth to accomplish your goal? Perhaps you partner with a vendor or even outsource the work completely. Will working with a third party get you to your goal faster?

Once you decide how to proceed, work with your team or your partner to create a plan. Know upfront what you want success to look like. How will you show management that you have succeeded?

Finally... EXECUTE! Just get started!

Whatever your plan, FIS can help you succeed. For over twenty years, we have helped over 100 health plans improve efficiency and reduce costs by automating and streamlining business processes. Providing health plans with efficiency and cost savings expertise through software applications and consulting services, we help plans connect people, processes and information to improve interactions inside the plan and with their providers.

Are you ready to drive efficiency across your claims operation? Call or email us today to for an assessment of your claim processes.

### About FIS' Solutions for Insurers

FIS empowers insurers across life and annuity, health, property and casualty business lines with solutions that support their end-to-end process needs. Our integrated products and services enable companies to increase system and process efficiency, control costs, manage risk and capital better, improve business decisions, design more competitive offerings, and engage successfully with their customers. We provide comprehensive support across the functional ecosystem, including actuarial and risk, finance and accounting, investments, reporting and compliance, policy and claims management, and member services. FIS partners with insurance firms at over 1500 sites in more than 65 countries, helping them to stay ahead of change and meet their goals.

### About FIS

FIS is a global leader in financial services technology, with a focus on retail and institutional banking, payments, asset and wealth management, risk and compliance, consulting and outsourcing solutions. Through the depth and breadth of our solutions portfolio, global capabilities and domain expertise, FIS serves more than 20,000 clients in over 130 countries. Headquartered in Jacksonville, Florida, FIS employs more than 55,000 people worldwide and holds leadership positions in payment processing, financial software and banking solutions. Providing software, services and outsourcing of the technology that empowers the financial world, FIS is a Fortune 500 company and is a member of Standard & Poor's 500® Index. For more information about FIS, visit [www.fisglobal.com](http://www.fisglobal.com)



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