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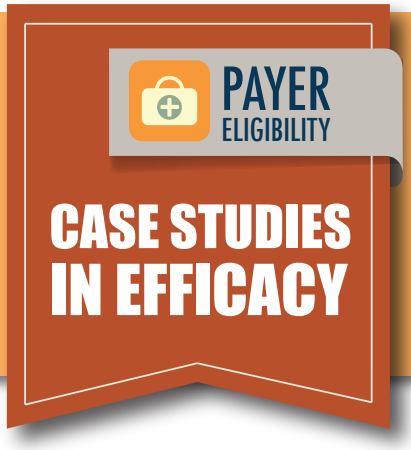

ELIGIBILITY DISCOVERY

A Secondary Payer Review

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ELIGIBILITY DISCOVERY

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OVERVIEW

Medidal's insurance and eligibility discovery service finds previously unidentified Medicare and Medicaid claims eligibility on accounts that have been written off by the hospital.

In this case study, we will examine one facility's decision to engage Medidal to perform a second review of their primary payer service vendor's work, to see if additional eligible claims in unidentified self-pay accounts were missed.

THE CLIENT

The client is an acute care standalone facility in north-central Florida offering a range of services, from emergency and sports medicine to midwifery and critical care. The hospital has 421 beds and over the 15-month review period in question, had more than 46,000 accounts identified as self-pay.

SITUATIONAL ANALYSIS

The high number of accounts relegated to self-pay status presented opportunities--not only through incrementing expected revenue, but also to establish a baseline understanding of actual coverage availability vs. true self-pay status to inform financial models.

The competitive landscape is dotted with vendors that advertise payer search services; however, many base results off the number of eligible individuals found--not the number of eligible claims. These services frequently include a high number of ineligible claims that then further require additional facility resources to discover.

This is a subtlety often overlooked when vetting potential vendors, one that directly impacts internal resource allocation and payment certainty; Availability of individual coverage does not translate to payment eligibility for that individual's claim. Software solutions utilized by vendors to run eligibility checks are not all created equal, but it is the solution that will determine the service's speed and efficacy.

With these considerations in mind, potential vendors were vetted against key selection criteria:

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VENDOR SELECTION CRITERIA

1. **A thorough understanding of HIPAA and CMS regulations, security & compliance standards.** Strict HIPAA adherence is, of course, absolutely required. Failure to monitor this landscape and implement changes as needed not only minimizes successful underpayment adjustments, but can put both the company and client at risk.

2. **A track record of success.** Payer success is easily defined: facilities want the vendor that will provide the most claims and dollars--legally and quickly. As noted previously, the vendor's technology will largely determine the number of eligible claims discovered & paid. Not all solutions are created equal.

3. **Speed and accuracy.** Automated solutions reduce human error and can conduct full, comprehensive reviews of 100% of the claims much more quickly; services that rely largely on manual processes typically "cherry pick" rather than perform full review. For payer discovery, each day that passes can mean more untimely claims and lost revenue.

4. **End-to-end process management.** Perceived reduced up-front fees can actually shift costs back to the client; cost benefits gained through outsourcing may be reduced due to the use of in-house resources & training. Many services will also look only at a sampling of claims, usually those with the highest potential dollar value, often resulting in substantial missed volume revenue opportunities.

SOLUTION

The hospital selected Medidal, a healthcare technology services company that met all of the vendor requirements and whose proprietary software solution was developed for intelligent payer claims discovery. Medidal reviews 100% of uncompensated accounts for claims through its eligibility service, and typically find 5-12% of reviewed result in newly identified eligible claims.

Additionally, because Medidal performs eligibility services via batch processing, involvement from the hospital's IT staff were not necessary to run the service.

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RESULTS

Medidal conducted a comprehensive review of over 46,000, or 100 % of the facility's self-pay accounts between September 2011 and November 2013, and found 11.3% of those were eligible claims.

The return for the facility was significant and swift. A report with eligible claims data was provided to the hospital to bill within a week of receiving the initial batch file.

The result: additional payments exceeding $2.9 million for the hospital.

ABOUT MEDIDAL

Medidal Corporation is a healthcare technology services company that offers revenue cycle solutions existing healthcare systems were not designed to accommodate. Over the past 10 years, their "intelligent" software algorithms and compliance & insurance expertise have resulted in an innovative suite of product offerings that are best in class.

Medidal has electronic transaction capabilities for Medicare and Medicaid in all 50 states and the District of Columbia. The engineering team practices agile development methodologies, which coupled with rigorous industry & standards monitoring, ensures their Transfer Recovery and Eligibility products remain on the cutting edge of technological innovation and automated revenue cycle solutions.

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