

What is a Clearinghouse for Medical Claims, and what do they do?

Why Clearinghouses Transmit Electronic Claims to Insurance Carriers, and Why the Service they Provide is Essential to Medical Practices.

There are as many different types of claims clearinghouses as there are various types of medical claims; like pharmacy claims, dental claims, DME claims, in-patient facility claims, and out-patient medical professional claims. But the simplest way to explain what an insurance claims clearinghouse is and what they do is to paint a picture of the problem they solve –their piece of the puzzle.

Imagine several million licensed healthcare professionals each using a different claim software, sending medical claims to over 4000 different insurance carriers, daily – across fifty different states – each state having its own insurance regulations; and then each carrier having its own internal software infrastructure.

In essence you have the perfect recipe for an information super disaster. If on average just 10 medical claims per day are sent to 5 different insurance carriers by every practice, you have millions of insurance claims daily heading to the four corners of the earth. Now, compound this scenario with the many phone calls and claim resubmittals that each claim error produces until all reimbursement issues are resolved and the bill is finally paid.

For years this was carried out on paper –an absolute nirvana for the U.S. Postal Service, who just so happens to have the infrastructure to handle it. And on a good day they do. But the manpower required for thousands of insurance carriers to handle all the paper work and phone calls that each claim error produces represents a huge cost to Healthcare, which we as beneficiaries pay by way of insurance premiums (here, a medical office manager would say: “Just pay the darn claim and I wouldn’t have to call!), but that would eliminate the problem: Somehow, deep in our subconscious, it appears that we really need all those auditors, adjusters, underwriters, actuaries, reviewers, and insurance bureaucrats, et al.

GOING ELECTRONIC

Enter the advent of healthcare claims being transmitted electronically. Great you say. Except that you no longer have the US Postal Service to do the transmitting. Electronic claims clearinghouses were devised by Medicare and large insurance payers to step in electronically where the postal service was unable to; to pre-screen for claim errors and act as air traffic controllers so to speak of electronic claim submissions.

Most simply, clearinghouses are aggregators (senders and receivers) of mountains of electronic claim information almost all of which is managed by software. And as each claim can trigger numerous actions, large clearinghouses today process trillions of transactions each year. Clearinghouses are essentially electronic stations or hubs that allow healthcare practices to transmit electronic claims to insurance carriers in a secure way that protects patient health information, or protected health information. Additionally, clearinghouses offer medical billers and billing managers a way to consolidate all their electronic claims and manage them from a single location, from an online dashboard control panel, similar to online checking.

HOW A MEDICAL CLAIMS CLEARINGHOUSE WORKS

Here’s the nuts and bolts of how it works. The medical billing software on your desktop creates an electronic file (the claim) also known as the ANSI-X12 - 837 file, which is then uploaded (sent) to your medical billing clearinghouse account. The clearinghouse then scrubs the claim checking it for errors (arguably the most important thing a clearinghouse does); and then once the claim passes inspection, the clearinghouse securely transmits the electronic claim to the specified payer with which it has already established a secure connection that meets the strict standards laid down by a HIPAA. (Medical claims are also known technically as ‘HIPAA Transactions’ and it is because of HIPAA that we cannot send claims for patient billing to insurance payers simply by email.)

At this stage, the claim is either accepted or rejected by the payer, but either way, a status message is usually sent back to the clearing house who then updates that particular claim’s status in your control panel. Now you have an accepted or rejected claim. If rejected, you have a chance to make any needed corrections and then re-submit the claim. Ultimately, assuming there are no other corrections required, and the patient’s insurance was verified beforehand, you’ll receive a reimbursement check or Electronic Funds Transfer (EFT) along with an explanation of benefits (EOB). All very simple, right?

The same sort of activity takes place every night within the federal banking system as our checks and banking activities are sent electronically from local banks to central ACH repositories (Automated Clearing Houses) and then on to banks of origin across the country, and then back to local banks – all done electronically, and somewhat instantly, all behind the scenes.

Thus today, you have many dozens of regional medical billing clearinghouses throughout the country all serving the same role; that of scrubbing medical claims and then transmitting the electronic claim information securely to the insurance carrier for reimbursement.

You might think: “That’s nice, but why do I need one?”

The best clearinghouses today offer high value features that provide a whole new level of revenue cycle management intelligence that makes their services extremely compelling from a financial perspective and also highly desirable from an office-staff efficiency point of view. The average error rate for paper claims is 28%. But using the right clearinghouse can reduce that to 2-3%.

Here are some highlights to look for in a premium health care clearinghouse:

- **Eligibility Verification** – Determine patient portion before appointment
- **Electronic Remittance Advice (ERA)** – Automatically updates Payments & Adjustments
- **Claim Status Reports** – Know the status of a claim at all times
- **Rejection Analysis** – Have error codes explained in plain English
- **Online Access** – Edit and correct claims day or night online
- **Printed Claims** – Have claims automatically dropped to paper when necessary but still be able to track and manage them online.
- **Patient Statement Services** – Have your patient statements put on ‘autopilot’ at a cost less than what you can mail them out yourself.
- **Real-time Support** – The best clearing houses offer 1-on-1 personal support and training provided by experienced billers.
- **Affordability** – When you take into consideration the cost of purchasing forms, the cost of printing, envelopes, postage, and time spent; a clearinghouse ends up costing far less than processing paper claims, plus electronically you have the many added benefits.

Claim Clearinghouse Main Benefits

Here are the main benefits of submitting electronic claims through a clearinghouse – in a nut shell.

Using a clearinghouse to send medical claims electronically:

- Allows you to catch and fix claim errors in minutes rather than days or weeks.
- Results in fewer denied claims and significantly higher claim success.
- Rapid claims processing: Filing claims electronically can reduce reimbursement times to under ten days.
- Submit all your claims at once in batch instead of submitting them separately one at a time.
- Reduces human error and the need to manually re-key transaction data over and over at each payer’s website.
- It provides a single location to manage all your electronic claims.
- Vastly improves provider relationships with insurance carriers.
- Avoid prolonged wait-times being on hold with Medicare and Blue Cross inquiring about claim errors.
- If you subscribe to the best clearinghouses, you’ll be speaking with a knowledgeable support person within just a few rings.
- Shorter payment cycles lead to more accurate revenue forecasts.
- Reduce or eliminate need for paper forms, envelopes and stamps.
- Plain and simple, using a clearinghouse greatly simplifies and speeds up your claims processing.

But you may ask (legitimately) “If I can submit my claims directly at a payer’s website for free, why should I pay a clearing house?”

ADVANTAGES OF GOING DIRECT:

Some large payers such as BlueCross do their own claim processing and allow you to submit claim information directly to them. Here are the advantages:

- Ability to submit claims directly to the payer without a middleman.
- Free claims. No recurring fees.

DISADVANTAGES OF SUBMITTING DIRECTLY TO PAYERS

Human error (mistakes, typos, omissions, etc.) are the number one cause of insurance claim rejections. Submitting claims directly at the payer's website means manually re-keying transaction data over and over, which vastly increases the opportunity for claim errors. Going direct to each payer means repeating this process afresh each time you want to add a new medical claim.

Submitting claims directly to more than a single entity also puts an extra, unnecessary burden on billing staff who are forced to remember multiple transmission methods, multiple logins and passwords, multiple file names and file types, and to memorize each carrier's often cryptic error codes, and then interpret each carrier's often confusing claim status reports. Here are a few disadvantage highlights:

- Lack of centralization (claims and claim data at many locations)
- Hidden costs. Sometimes you must purchase additional software components, which can impact your regular software support fees.
- Unnecessarily added confusion of multiple accounts to log into, and multiple data entries, which increase the opportunity for errors.
- Lost claims and a lack of essential tools required for efficient claim management.
- Little or no support.
- Maximum Risk to the Revenue Cycle with little or no offsetting benefit.

In the end, it becomes difficult to calculate the actual cost of 'free' when it translates so fundamentally to lost claims, wasted time, frustrated staff, increased billing errors, increased claim denials, and lengthened payment cycles. There may be good and bad clearinghouses, but submitting claims to more than a single entity (e.g. a clearinghouse) begins to look like inefficiency gone to seed. However, the advantages of submitting claims to a single entity are clearly evident.

So, in conclusion, millions of electronic claim errors each day would simply overwhelm health insurance carriers who neither have the manpower nor the infrastructure to handle the myriad of medical practitioners (each using a different claim software) daily sending electronic claims (in slightly different ways) across 50 states that are each regulated differently. So there exist a desperate need for the centralization, standardizing, and the secure transmission of medical claims via these important intermediaries we call a clearinghouse.

How To Tell If You Need One

You can easily tell if you would directly benefit from subscribing to an medical billing clearinghouse service by answering a few questions:

- Does your practice bill (or plan to soon bill) electronically?
- Does your practice bill a number of insurances, or just one?
- Is your staff experienced at billing electronically? (The less experience, the greater the need, and greater the benefit).
- What is your claim volume? The cost of a clearinghouse is often offset by no longer having to send in paper claims.
- Would it help to quickly and greatly reduce medical claim errors?
- Would it help to drastically shorten reimbursement times?
- Do you have better things to do than be on hold with carriers trying to figure out claim errors?

How to Select a Good Claims Clearinghouse

How does one distinguish a good clearinghouse from a bad one? The answer is not always simple. But here are some important things to look for:

– **Payer List:** First and foremost, make sure that the insurances you bill on a regular basis are on their payer list. This list is most often available online at their website.

– **Nationwide:** Many clearinghouses are regional. Steer towards ones that operate nationally.

– **Claim Software:** Let them know what medical billing software you have and ask if they have people using it successfully on their system. This part can make a tremendous difference to avoid what billers know as clearinghouse hell. Clearinghouse hell is when you call your clearinghouse about a claim error and they tell you that 'you absolutely have a billing software problem.' Then you call your claim software provider and they assure you that the problem lies with the clearinghouse. This circle of discussion can go on for days and weeks and can make you insane when all you want is the darn claim to go through, but no one will take responsibility to get to the

bottom of it. Avoid clearinghouse hell when at all possible.

– **Easy-out Contract:** Most of the better claims processors today offer a month to month subscription.

– **Support:** Try contacting their support before you sign up.

– **Error Reports & Control Panel:** Most clearinghouses will offer you a quick tour of their control panel, (the location online where you'll be managing your medical claims). What you want to see here is easy navigation within the management area, and claim errors and rejections to be reported in clear, concise language, not merely as numbers which can be very confusing.

Advanced Revenue Cycle Management Features: Over and above just processing medical claims, the best clearinghouse providers offer many highly desirable advanced features such as: Eligibility Verification, Sent File Status, Claim Status Reports, Rejection Analysis, Paper Claims (created for you and mailed when necessary), Secondary Claims Processing, Electronic Remittance Advice (ERA), Patient Statement Services (you no longer have to mail out all those patient statements each month), Payment Processing, and finally, Transaction Summaries of all your clearinghouse activity. These advanced features make a good clearinghouse worth its weight in gold.

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