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How to complete clinical reviews within prompt pay guidelines

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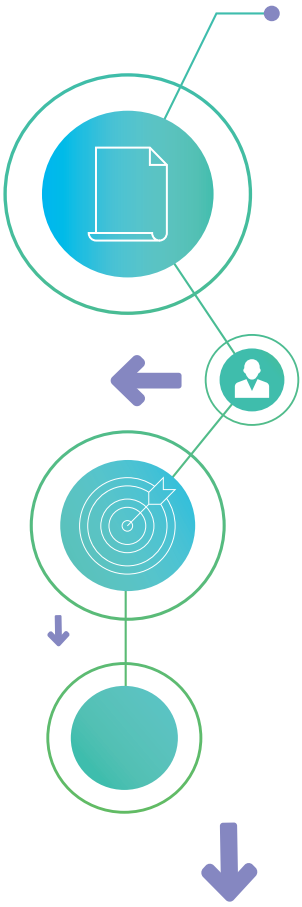

Most questions we receive regarding pre-pay clinical claim review involve prompt pay. They tend to come down to, "How can I complete a clinical claim review within prompt pay guidelines?"

So let's first address prompt pay guidelines. Prompt pay guidelines are based on specific requirements of the program and/or a contract between the plan and the provider. The Centers for Medicaid and Medicare Services and most contracts do allow for additional timing when a claim requires review of documentation for a payment determination.

Plans are likely managing to multiple, different guidelines. We understand the complexities associated to the process. Incorporating a pre-pay clinical claim review to this process can seem complicated. Especially, when you consider the elements to audit: You're selecting claims, requesting documentation, reviewing documentation, and applying claim dispositions – all within a timeframe to ensure compliancy with those applicable guidelines.

But it's not as difficult as you may think.

Let's begin by walking through an example of a claims cycle and how the most standard clinical claim review process fits within that cycle. The clock starts when the claim is received. Once the claim is in a post-adjudication, pre-check-write status, the claim-targeting technology is executed. Upon completion of the targeting technology, the claim is either approved for payment or selected for a clinical claim review.

If the claim is approved for payment, this indicates there is not a probability of a finding. So the claim is released for payment, all within the prompt-pay guidelines. For those claims selected for a clinical claim review, the most standard process is for the claim to be pended – and running parallel to this activity, a request for additional documentation is submitted to the provider.

These activities occur within prompt pay guidelines. At this point in time, the clock stops until the additional documentation is received.

Upon receipt of the additional documentation, the clock resets and the review is completed by a clinician or a coder, with a final recommendation of "pay," "deny," or "adjust" made. The review period and the final recommendation being applied to that claim all occur within prompt pay guidelines.

Now there are variances to the process. You may be a payer which requires the claim to deny for additional documentation versus a pended claim. Or you may have a guideline that requires the clock to restart versus reset. All of these factors can be customized specific to your prompt pay requirements.

So the message is you can complete a clinical claim review in a prospective environment and remain compliant with prompt pay guidelines.