Roughly one in three California residents—approximately 12 million people—are enrolled in Medi-Cal, the state’s publicly funded Medicaid program. To put this in perspective, California has 12 percent of the U.S. population, and yet accounts for 17 percent of the nation’s Medicaid enrollment. And the enrollment is growing—with 2.7 million people added since federal healthcare reform was enacted.

Given the large percentage of revenue that Medi-Cal claims constitute for California hospitals, efficient and accurate Medi-Cal claims processing is a high priority for healthcare providers. But in reality, many providers find that Medi-Cal claims can be difficult to manage.

The root causes of denials and rejections are often difficult to pinpoint. Is there a claim error or is it an enrollment issue? Was a claim edit missing or is an edit override the real culprit?

A survey of California hospitals commissioned by RelayHealth Financial found that frequent Medi-Cal code updates and a lack of transparency into the system were cited as major challenges to efficient claims processing. Medi-Cal requires extensive documentation, and if any part is
Ensuring claim edits are up to date,
One central California hospital
Payer requirements change frequently.
Appropriately for enrolled services.
Once that’s done, ensure claims are coded
to occur. Avoid this by enrolling with
Many providers not enrolled for all of them,
There are a variety of claim types, and with
Rejection by Medi-Cal.
An outpatient claim, resulting in a claim
Enrolled as an inpatient provider submits
That claim type. For example, a provider
Who is not enrolled to submit
Medi-Cal rejects any claim submitted by
If they do, start using the
Vendor’s notification systems to quickly identify claims that will be rejected due
to enrollment and/or coding errors. Your
Claims management system should include
Edits to capture errors and provide early notification of enrollment issues.
When a notification is triggered, you have
The opportunity to change the code or enroll
For the service type before re-submitting
One last note: On the patient enrollment side, responsibility for securing Medi-Cal coverage for patients now falls on the provider. There are time limits for application filing, so pay attention to deadlines to avoid rejections.

2. Create a forms library to expedite enrollment
Central to a streamlined enrollment process is the creation of an online enrollment forms library. This can be challenging in the case of California, because there are many payers under the Medi-Cal umbrella.
An enrollment forms library should contain every form required by the state of California, and should be easily accessed by everyone in the billing department. It’s important to include forms for all payers that process Medi-Cal claims.
Likewise, it’s important to create an index of Medi-Cal related plans and their required forms, because the plans’ names don’t always reference Medi-Cal specifically. As part of this, document and include specific instructions for completing each form.

Here’s another area where your vendor might be able to help. Ask your clearinghouse if they maintain a comprehensive enrollment forms library for customers, and start using it if they do. Even if they don’t have a customer forms library as part of their offering, they still might maintain their own internal library of forms. See if they’ll make those forms available to you.

Ready access to all enrollment forms and their instructions is one of the simplest and easiest ways to help ensure claims acceptance and reduce administrative costs. As is often the case with instructions, the devil is in the details. Some errors and rejections can be traced to something as trivial as the wrong color ink—so make sure the library is comprehensive.

3. Keep claim edits current and refine edit override management
The management of claim edits poses two distinct challenges. By ensuring the accuracy and timeliness of edits, you may increase the number of clean claims you submit and worry less about them being denied or rejected later. Two governance practices that can improve submission of all claims (not just Medi-Cal) are:

- Ensuring claim edits are up to date,
and that new edits are in the system in a timely manner
  - Payer requirements change frequently.
  Medi-Cal is no exception. This complicates the claim submission process. But you can reduce the potential for rejections by using a claims management solution that automatically checks for updated payer requirements on a daily basis, updates the system with new edits prior to effective date and then implements the corresponding edits on their effective date.
  - One central California hospital dramatically reduced the amount of manual work required to keep ahead of Medi-Cal’s exhaustive list of special codes and modifiers by setting up automated sub-routines in its claims management system. These

The five steps to improved Medi-Cal claims processing are:

1. Maintain accurate enrollment status to help eliminate errors and rejections
2. Create a forms library to expedite enrollment
3. Keep claim edits current and refine edit override management
4. Use analytics to reveal and target processes that need improvement
5. Work vendor relationships to help reduce work, save time, and lower administrative costs

Let’s examine each of these five points and see how they can apply to your organization.

1. Maintain accurate enrollment status to help eliminate errors and rejections
Medi-Cal rejects any claim submitted by a provider who is not enrolled to submit that claim type. For example, a provider enrolled as an inpatient provider submits an outpatient claim, resulting in a claim rejection by Medi-Cal.

There are a variety of claim types, and with many providers not enrolled for all of them, it’s common for enrollment error rejections to occur. Avoid this by enrolling with Medi-Cal to submit all relevant claim types. Once that’s done, ensure claims are coded appropriately for enrolled services.

Determine how many rejections are due to these errors and why. The solution might be as simple as training staff on the various enrollment types and/or providing more training on coding claims with the right claim type before submitting.

Also, your claims management vendor might be able to help. Ask them if they have systems in place to catch coding errors before claims are submitted to Medi-Cal. If they do, start using the vendor’s notification systems to quickly identify claims that will be rejected due to enrollment and/or coding errors. Your claims management system should include edits to capture errors and provide early notification of enrollment issues.

When a notification is triggered, you have the opportunity to change the code or enroll for the service type before re-submitting the claim.

One last note: On the patient enrollment side, responsibility for securing Medi-Cal coverage for patients now falls on the provider. There are time limits for application filing, so pay attention to deadlines to avoid rejections.
sub-routines not only helped lower the hospital’s denial rates, but also improved biller efficiency.  
- While technology can slash the amount of manual work required to satisfy Medi-Cal requirements, a billing department shouldn’t rely solely on technology alone to keep edits current. Institute a governance process to help ensure that all edits and changes are tracked and complied with in a timely manner.

Evaluate override protocols to disregard an edit holding up a claim  
- Even when edits are kept current, claims can be rejected due to undisciplined use of override protocols. Tight management of edit overrides can help expedite the claims process. Overrides are required in some cases, but they become problematic when overused.  
- You can avoid rejection issues by enforcing a policy that outlines who can override an edit and under what circumstances. Additionally, inform your claims management vendor of all exceptions the hospital has with payers, and set up a process for conveying new exceptions. Also, make someone responsible for reviewing all edits that come from the claims management vendor, to ensure no conflicts.  
- Finally, establish periodic reviews of all overrides. Occasionally, billing staff will override an edit in error and cause claims to be rejected. Implementing frequent reviews will help ensure overrides are used only when necessary and appropriate, and that your claims management vendor is instructed to make corrections in the case of longstanding overrides. As part of this, confirm that your clearinghouse is aware of exceptions you have with payers.

4. Use analytics to reveal and target processes that need improvement  
One of the most effective and, surprisingly, least-used tools for reducing delays, denials, and rejections is hiding in plain sight. It’s analytics. Hospitals can gain a wealth of knowledge about payer billing cycles by collecting and performing robust analysis on Medi-Cal claims data. They can discover the source of claim errors, identify reasons for denials, and then address the root causes.

But you can’t fix what you don’t see. Using analytics reporting to see what processes are causing delays and rejections helps hospitals zero in on the improvements that can have the greatest impact. Comparing that information with data to benchmark with peers of the same size, region and/or services and best performers can be used to help set realistic goals and improve crucial metrics.

Of course, the vast amounts of data now flowing through hospital revenue cycle systems can make this task seem daunting if not impossible. The right analytics tools, however, can make short work of this challenge, and reveal the patterns that are contributing to negative financial impact. Once these patterns are exposed, hospitals can work to resolve these financial management issues that were, until then, invisible.

For example, one Florida hospital used analytics to identify and examine high denial trends. They discovered a specific procedure that was being rejected at an extremely high rate. The analytics tool helped them learn the root cause was a long-standing hospital protocol that, it turned out, conflicted with the payer’s authorization guidelines. The hospital had 17 related denials in the previous 90 days. After using analytics to expose the cause, they had just one denial in the nine months following.

5. Work vendor relationships to help reduce work, save time, and lower administrative costs  
One improvement strategy that’s often overlooked is to make better use of revenue cycle software vendor relationships. Software vendors that also manage the clearinghouse function have to maintain stronger relationships with payers. They can, therefore, also serve as advocates for providers. These vendors can be a source of insight and information about payers that can be used to improve processing speed, accuracy, and efficiency.

Be proactive in communicating with vendors. For example, call your vendor when processing efficiency is compromised in any way. If an exception to a new payer edit creates the need for workarounds and staff attention, ask them if they can ask the payer for a systemic solution, or if they can help you come up with another solution.

When claim denials and rejections arise, it’s easy to point the finger at Medi-Cal and say it’s a complicated system. Yes, Medi-Cal is complex. But reducing denials and rejections doesn’t have to be. As this paper documents, some simple processes and tools can mitigate these risks and, better still, can be applied in many Medicaid-related situations beyond California.

Use an analytics-driven claims and remittance management solution with robust editing designed to reduce payment obstacles and optimize staff productivity through exception-based, just-in-time workflow in a single web based system. Coupled with improved processes for enrollment-status accuracy, analytics to target and fix root causes, and capitalizing on vendor relationships, your hospital can greatly reduce the probability of Medi-Cal claim rejections and improve overall revenue cycle health to boot.

So what are you waiting for? Let’s get started!
RelayHealth Financial Solutions

RelayHealth® Financial’s revenue cycle and analytics solutions give hospitals the tools they need to efficiently manage the entire financial cycle. The RelayHealth Financial platform processes 2.3 billion financial transactions annually and connects thousands of payers and providers—providing deep transactional data analysis. Cost-effective SaaS deployment means easy implementation, lower overhead and reduced capital investment—so users can quickly realize the benefits of the solutions.

RelayAssurance™ Plus provides complete transparency into the lifecycle of claims. It helps manage all claims, including Medi-Cal, Medicare, Workers Comp and Property & Casualty, in a single web-based system. With connections to 2,200 health plans, comprehensive and current edits, and user-friendly workflow, it helps users efficiently manage the claims and remittance process to help keep cash flowing.

RelayHealth Financial’s auditing function oversees provider data as it moves through the clearinghouse to the payer, and back to the provider. Additionally, our dedicated payer analyst team constantly searches for changes in payer business rules and helps ensure that edits are created and in place before the effective date.

Advanced analytics give hospital leaders insight into a huge range of data—helping to enable smart decisions in key areas such as ICD-10 impact, billing efficiencies, reimbursements, payer relations, charge monitoring, and clinical services.

The result of all of the above capabilities:
Successful processing of Medi-Cal claims.