WHITE PAPER

The Hidden Complexity of Accident Claims Management

Why it might not make sense to “bring it in-house”

Ensuring proper management of accident claims is a highly complex process that requires a great deal of attention.

This White Paper reveals the many hidden complexities and why it is crucial to have expert, often outsourced, management of these claims.
Why it Might Not Make Sense to Work Accident Claims In-House

Overview

Accident claims management is complex. Patient accounts resulting from motor vehicle accident and/or workers’ compensation injuries are largely paper-based and difficult to resolve. Throughout MRA’s 15 year history, we have refined and tweaked our model to ensure hospitals obtain optimal revenue from these complex claims.

The skill set required to properly manage these claims is broad. A legal understanding of the state and federal laws is certainly a must. Registration teams must be trained to educate patients and collect necessary information up front, and back end billing teams need solid investigative expertise to reach patients missed upfront, convincing them to share needed information. Also, billing teams must be knowledgeable as to correct billing and follow up procedures with several unrelated (non-Health) payers – remember, this is a paper-based billing process!

The following sections explain how to properly manage accident claims, and why many successful health systems have chosen to outsource these claims.

Patient Communication

Most accident claims lack necessary information after registration is completed. Thus, the first step in ensuring proper management of these claims is to reach out to the patient and walk them through the coordination of benefits available in order to elicit correct insurance information. Typically 25 - 35% of these patients will file a claim against an “at-fault” party. This legal pursuit is always done “post care”, so patients will not be able to provide this critical information at the time of registration or treatment. Thus, an effective outreach program is a must on these claims.

An effective team of outbound and inbound patient advocates is needed to walk patients through the complex world of accident claims management. The entire goal of this team should be to elicit needed attorney and/or insurance information, which takes time and is harder than it sounds. A typical call center does not have the accident claim volume to merit hiring professional patient advocates to manage every call. In addition to dedicated phone expertise, an effective mail campaign and web presence is also critical to success. An outbound letter campaign should be well-coordinated with the call center, and the website should be easy for patients to access and provide needed information. At the end of the day, a multi-prong patient engagement strategy is critical to ensure the correct insurance information is captured to ensure optimal reimbursement.
Insurance Verification

Once all relevant insurance information has been obtained, all coverage(s) must be verified. Electronic eligibility for Auto and Work Comp policies is nonexistent – meaning each potential coverage must be verified manually. Accident claim specialists must contact each identified Auto and Work Comp carrier to ensure both coverage and also availability for No Fault, Liability, and/or Work Comp benefits. Following confirmation of coverage, each patient must be re-contacted to manually open a claim with the adjuster. Additionally, health coverage eligibility must be re-verified, with appropriate timely filing alerts set so that health billing deadlines are not missed while pursuing higher reimbursement rates from non-health payers.

MSP regulations require that both No Fault (MedPay / PIP) and Liability dollars be billed and fully exhausted prior to submission to Medicare (and Medicaid, as well, most of the time). Increasingly, commercial plans are adopting these “payer of last resort” rules, implying that it is more important than ever to pursue No Fault insurance before submitting a commercial claim.

Follow-Up

Once an accident claim is billed, most claims require significant follow-up to successfully resolve. Calls must be made to ensure claims are received. Medical records (for all work comp claims, and most personal injury claims) must be obtained from Medical Records and delivered to the payers, based upon each payer’s differing requirements. And multiple calls are often required to ensure accurate payment is completed.

Billing

Accident claim billing remains almost 100% manual, with no scheduling, no pre-registration, and no electronic transactions for (i) eligibility, (ii) claim submission, (iii) claim status, or (iv) remittance. All claims billed to an auto payer and almost all workers’ comp carriers are 100% manual and paper based. These claims require a great deal of follow up to simply ensure they are received, much less paid, translating to multiple billing cycles per claim. For workers’ comp, a line-level code review should be performed prior to bill submission. This review is performed at the payer level, as different payers have different billing rules that apply only to them. Not performing this review results in unnecessary denials and increased aging. For liability accounts, each claim must be verified with the patient’s attorney (or the adjuster, if the patient is not represented) and then a lien must be filed or letter of protection secured, resulting in additional costs for both the lien filing and certified mail requirements to put all parties on notice.
non-contracted PPOs. Similarly, all workers’ comp payments should be reviewed (at the line item level) to ensure payment was made correctly in accordance with the specific State fee schedule or UCR rate. Particular attention should be made to work comp re-pricing firms. They should be countered with “negotiation from strength” using knowledge from a firm that negotiates with re-pricers nationally to obtain the highest reimbursement rates.

Payments from liability settlements are either “paid in full” or are considered “reduction requests”. For all “reduction requests”, negotiations should be led by an attorney that negotiates these requests for a living to ensure optimal reimbursement.

**Volume**

Accident claim volume typically represents only 3% of claims, yet significantly more in terms of net revenue. For a $2BB GPR health system, there are often 4,000-5,000 accident claims annually. Given the labor intensive nature of these claims, and the lack of dedicated resources focused on them, many of these claims are incorrectly processed as Health claims or sent straight to Self Pay. For hospitals that do not dedicate appropriate resources to these claims, revenue is lost, patients are dissatisfied, and compliance risk is increased.

**About AcciClaim**

AcciClaim™ optimizes reimbursement from accident claims. Our proprietary technology and dedicated team of accident claims specialists generates higher revenues, increased patient satisfaction and 100% billing compliance from your most complex claims, all while significantly reducing pain and complexity for the hospital billing office.

**About MRA**

Medical Reimbursements of America (MRA) optimizes reimbursement rates for hospitals and health systems nationwide. Founded in 1999, we are exclusively focused on helping providers receive optimal value for the services they deliver.
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