Provider

integrated health care

RelayHealth | Financial

Revenue Cycle Management

RelayAssurance Status Amplifier™
Enable Action on Claims Earlier in the Process

Data indicates that the average time to receive a remittance is approximately 26 days.* In other words, the ability to take action on claims that are pended or denied is significantly delayed. Further, your staff will likely spend hours on the phone searching for pended or denied claims to try to alleviate the wait time and keep your cash flowing.

This scenario highlights five areas of inefficiency found in most providers' back-office:

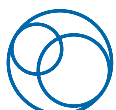
- Denials are worked late in the billing process, or not at all
- Staff performing tasks that add no value to the process
- Staff working the wrong accounts at the wrong time
- Staff performing tasks that are above, or below, their competence level

Reducing the negative financial and operational impact of these inefficiencies begins with obtaining complete information about the status of a claim earlier in the process without costly efforts such as phone calls or manual web research.

RelayAssurance Status Amplifier connects directly to payer portals to gather proprietary payer payment and denial

Key Functionality:

- Connects directly to payer portals
- Access to status as early as one day post submission
- Provides the most comprehensive status information available



BUSINESS
CARE
CONNECTIVITY

* RelayHealth, 2014.
** CAQH Index, 2014.
*** Ovation Revenue Cycle Services Case Study, 2013.

Status Amplifier Helps:

- Reduce phone calls to payers
- Enable earlier action on pended or denied claims
- Speed payment

277 / 835 EDI Response	Status Amplifier Response
16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**REJ:** Itemized bill required. Resubmit with itemized bill.
96: Non-covered charges. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	**SF:** This Claim is being denied because our records indicate you have primary medical insurance with another company (other than Medicare).
95: Plan procedures not followed.	**1005:** These benefits were reduced due to failure to obtain pre-certification approval as outlined in the plan.
16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**E5904:** Final Benefit determination cannot be made until we receive specific requested medical information.

figure 1
Status Amplifier responses, when compared with 277 / 835 responses, offer more actionable information to help resolve claim issues faster and earlier.

information as soon as one-day post submission. Incremental to, or in place of, EDI claim status transactions (276/277), Status Amplifier retrieves the most comprehensive claim status information available from the payer (figure 1). It goes beyond providing a status and presents detailed reasons for why a claim may be pended or denied, or may indicate the claim is progressing as it should without further action.

The additional information helps staff to:

- Apply time and expertise only to claims that need attention
- Take appropriate action earlier based on more complete explanations of issues

Status Amplifier can help you to respond to growing demands on your team by driving exception-based workflow to make the most of your resources while speeding the payment of claims.

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RHF-RASA-PB-0316

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