Newgen Healthcare Claims Repair Platform

Overview

The US Healthcare market is undergoing rapid changes. The emergence of new, consumer driven health plans, ever rising regulatory mandates, and elaborate risk-sharing agreements between payers and providers have led to a highly complex and labor intensive claims process. With healthcare payers losing an average of $3.2 billion every year from inefficient manual processes, current claim processing approaches are clearly unsustainable for long-term growth and profitability.

Organizations need to innovate across their core operational frameworks to create efficient and cost-effective customer service. They will have to fortify their central processing systems while adjudicating policy claims utilizing 'out of the box' automation based on industry best practices. The system also needs to provide transparent and unambiguous electronic information to members and providers to enable collaborative transactions with all stakeholders. These transactions need to be fast, as any time delay in claims disbursements can lead to high "Penalty Payouts".

Auto adjudication has, to a great extent, simplified the process for payers and enabled faster resolutions. However, there are still a magnitude of cases that fall beyond the gambit of the business rules driving the claims engine. Organizations need a smart claims repair solution that addresses those claims that cannot be handled through auto adjudication and "error out" from one of the multiple systems that touch a claim during the adjudication process.

Key Industry Drivers

The Healthcare industry endures constant pressure to move from error-prone manual processes to more structured, streamlined and automated processes. Some key factors that push Healthcare Payers to automate the Claims Process include:

- **Process Complexity –** The document intensive nature of the process and multi-level manual interventions has led to a high "Claim Rejection Rate" and loss of claims applications across the industry. Payer organizations have felt the need to streamline the processing of different Claims Applications to ensure process visibility and control.
- **Rising Customer Expectations –** Consumer driven healthcare plans have led to increased consumer involvement across the claims management process.

Payers need to ensure faster and more accurate processing of claims applications and streamlined customer communications at every stage of the process. They need a comprehensive information management system that provides adjudicators with easy access to critical information and enables timely follow-up for missing documents that are mandatory for processing the Claims Application.

- **Risk and Compliance –** The industry has seen a rapid rise in the regulatory mandates that govern key processes. Payers need to ensure process standardization to manage compliance with HIPPA and other state specific regulations. The ultimate goal is a process automation framework that enables rule based claims screening as per the existing regulatory guidelines, along with the flexibility to keep pace with ever changing mandates.
- **Growth and Profitability –** Increased market competition has put considerable performance pressure on Payers to reduce the turn-around-time for processing claim applications, while drastically lowering their operational costs. They are increasingly looking for a system with low TCO (total cost of ownership) that helps them manage swift process changes to cater to new product launches and set the pace for competition.
- **Resource and Infrastructure Optimization –** The claims management process is highly labor intensive and traverses many existing systems and applications within the enterprise. Payers need a solution that integrates easily with different databases, networks, and functional applications, which would greatly reduce the cost of creating any additional infrastructure. It should also be able to provide greater control and visibility over rejection handling processes thereby eliminating the need to rely on multiple disjointed reports.

Newgen Solution

Newgen's Claims Repair solution brings intelligence and flexibility into the rule based auto adjudication framework to create an agile platform that optimizes complex claims processing, drives down costs, responds rapidly to new benefit plans, provider contracting models and the latest regulatory mandates. It combines business configurable process automation with claims processing best-practice templates across the adjudication process.

Newgen's Claims Repair process product suite includes:

OmniFlow™ – OmniFlow is a platform independent and flexible process automation solution that enables process optimization by prioritizing work items based on business rules and industry best practices, ensuring case specific SLA adherence. It is designed to simplify the creation, deployment, modification and management of business processes with seamless integration capabilities, allowing it to be introduced into any IT infrastructure.

OmniDocs™ – OmniDocs is an enterprise document management (EDM) platform that enables collaborative & integrated creation, capture, organization, archival and retrieval of large volumes of documents associated with the claims management process. It works as a Knowledge Management System for the operational documents, allowing seamless access to critical information to enable faster and efficient decision making.

OmniBAM – Newgen's Business Activity Monitor is designed for real-time monitoring of processes through dashboards, alerts and notifications. It provides a quick snapshot of process performance by consolidating the inventory of approved and pending claims. The BAM framework gives business project analysts the ability to create and generate track & trending reports on the fly.

Key Features

- Mass auto uploading of claims from system and creating individual cases in OmniFlow
- Auto assignment of work to the users based on their skill set (Claim Type, Error Type, and State etc.)
- Auto sorting of work based on pre-defined parameters (Company Received Date, Paper/EDI Claim etc.)
- Escalation and re-routing in case of misrouting or assistance required from managers or other departments
- Auto Letter generation based on Line of Business in case of claim denial
- Unified desktop for users to access information from multiple systems
- Electronic document storage of letters & paper claims
- Compliance and productivity reports
- End to End process visibility allowing Healthcare Payers to drive business as per SLAs
- Electronic Archival of applications and related documents with extensive search capability for instant access

Newgen's claims repair solution provides payers with a perfect combination of enhanced business agility, enterprise wide process standardization, and improved resource productivity. It empowers payers with sophisticated tools to improve their first-pass rates and process TATs for all claim types, while reducing their operational and IT expenses dramatically.

It offers rules-driven automation to optimize the handling of claim exceptions. Based on work type and user skills, the solution prioritizes claim exceptions, and automatically routes the right task and documents to the appropriate staff, while seamlessly integrating with adjudication systems. Any additional information is automatically updated in the case file upon receipt, and automatic update-alerts are sent to claims staff.

Key Benefits

Auto Case Creation: Auto Upload of information from feed files and case creation based on work types

Automated Claims Exception Processing – Reduces processing time and mitigates risk associated with manual claims exception handling

Integrated Platform – Real time information extraction from the 'Core System' has reduced the time spent on tracking providers, members and claims

Auto Letter Generation – Auto Letter generation saves valuable time that was previously invested in generating letters manually

Compliance Adherence – Configuration of multiple reports enables management to keep visibility on the status of each claim throughout the "Claims Lifecycle", thus ensuring adherence to compliance

Productivity Improvement – Automates business platform reduces handoffs and eliminates instances of errors/rework

Resource Optimization – Improved efficiency and increased productivity of staff has led to the handling of a greater number of claims, without increased head count

Proactive Error Identification – Enables the identification of "Possible Errors" for cases submitted by Provider based on past history. This enables Providers to ensure processing of cases effectively in a single attempt

Streamline Operational Efficiency – Consolidates all channels used to receive rejections into a unified high performance channel, which is a single-pass process to validate, acknowledge, and route data

·Increased Business Agility and Responsiveness: Provides management with visibility and control over the volume of claims getting rejected from the adjudication system. Enables immediate, actionable decisions for mission critical processes, thereby improving efficiency and shortening cycle time started versus current.

About Newgen

Newgen is the leading provider of a unified digital transformation platform with native process automation, content services, and communication management capabilities. Globally, successful enterprises rely on Newgen's industry-recognized low code application platform to develop and deploy complex, content-driven, and customer-engaging business applications on the cloud. From onboarding to service requests, lending to underwriting, and for many more use cases across industries. Newgen unlocks simple with speed and agility.

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