Tips and Techniques for Designing an Ideal Claims Preparation Process

1. **Include Key Stakeholders** – Ensure representation from all parts of the process, including at least 1-2 clinics (e.g., receptionist, MA/CNA, LPN) and anyone who interacts with a patient chart.
2. **Plan a Structured Session** – Schedule an initial two-hour session. Use large easel board paper taped to the wall to map out the process visually.
3. **Define Scope and Boundaries** – Clearly establish where the claims preparation process begins (e.g., the first point of patient contact in the clinic) and where it ends (e.g., when patient information is sent to coders).
4. **Focus on the Ideal Future State** – Design the optimal process (future state) rather than simply documenting the current one. Gather input from as many involved team members as possible.
5. **Clarify Mapping Session Goals:**
    - **Standardize & Improve** – Develop a consistent, standardized process to ensure all necessary information is accurately and promptly completed before reaching coders.
    - **Define Standard Work** – Clearly document what tasks are performed, where, by whom, and how.
    - **Establish Metrics** – Identify key performance indicators (KPIs), such as the turnaround time (TAT) for getting patient files to coders.
6. **Use Visual Mapping Tools** – Utilize yellow Post-it Notes to outline each process step (e.g., patient registration/sign-in). Additional details for each step should be added using green or blue Post-it Notes.
7. **Detail Each Process Step** – Once all primary steps are identified, expand on them with additional necessary details.
8. **Define Key Metrics** – Determine performance indicators for critical process steps, such as coding quality, accuracy, and turnaround time. Consider implementing a random monthly chart review.
9. **Establish Standard Work Requirements** – Define what is expected at each process step (e.g., clinic staff responsibilities when a patient signs in), ensuring clarity on what, who, where, when, and how tasks should be completed.

Improvement Goals

- **Enhance Timeliness & Accuracy** – Optimize the claims submission process on the clinic side.

- **Reduce Days in Accounts Receivable (AR)** – Decrease overall AR days to align with top performers.
- **Improve Clinic Performance** – Minimize AR days for underperforming clinics by moving them closer to top performers (benchmark required, need to obtain average # of days in AR by clinic)
- **Minimize Open Charts** – Track and report chart completion rates across clinics and providers.
- **Improve Charge Capture Accuracy** – Ensure all services are accurately documented at patient checkout, with clinic staff focusing on charge capture rather than coding accuracy (coders are uniquely qualified to verify accuracy, not clinic staff).
- **Strengthen Denials Monitoring** – Implement better tracking and feedback loops to provide coders with useful insights from denial patterns.
- **Implement QA Checks** – Conduct a monthly quality review of 10 random charts per coder, calculating completeness and accuracy (% C/A) for inclusion in dashboards.