

3Pillar Develops Business Rules Engine to Improve In-Home Health Care Offerings, Accelerate Throughput of Eligibility Approvals and Insurance Claims

AT A GLANCE:

Industry: Healthcare

Challenge: A traditional home health TPA sought to automate their authorization and claims adjudication process, driving efficiencies and increasing accuracy in their revenue cycle management operations.

Offering: Application Modernization

Highlights:

- Decreased claims revenue cycle time from 6 weeks to 2 weeks
- Increased auto-adjudication of claims by 67 percent and improved claims processing accuracy to 97 percent
- Reduced time to onboard and credential new providers by 60 percent, and doubled claims processing capacity with existing staff
- Enabled payer to ramp up from processing a few thousands claims per day to 75K+ claims per day as customer base scaled

A leading provider of value-based home health TPA solutions has been helping patients get the healthcare they need in the privacy of their own homes for more

than 25 years. The company serves as a bridge between healthcare providers and payers to ensure that authorization for care is processed quickly and accurately before care is provided, and that the post-care claims adjudication process between payers and providers flows smoothly. Their range of solutions is designed to reduce the total cost of care by reducing hospital readmissions and providing personalized, whole-person care.

CHALLENGE:

Manual Approvals and Claims Bottlenecks Led to a Lengthy Revenue Processing Cycle

As the organization grew in size, scope, and number of providers, their systems and processes struggled to keep up with the influx of authorizations and claims they needed to review and approve or reroute daily. A few thousand authorization and claims requests came in each night when we first began working together. The company's team manually reviewed and approved the majority of these authorizations and claims, or sent them back to providers with requests for additional detail if not enough information was provided to determine eligibility or payment approval.



generated approvals for incoming authorizations submitted electronically that met all the necessary payer parameters. The BRMS determined if the provider was in-network, if the requested service was covered, and if authorization was automatically available.

We worked closely with the company's claims processing department to understand how the rules definitions needed to work. As part of this exercise, we also ensured the rules could be easily maintained separately from the rules engine's code base. This was a key feature for the company, as it was necessary for them to account for changes in the business environment like bringing aboard new providers and entering new markets, or industry-specific shifts like responding to regulatory changes.

Once the BRMS was up and running, our work wasn't fully done. The BRMS helped the company account for 67% of claims that could be successfully authorized automatically, but what about the 33% of claims that couldn't be automatically adjudicated?

This reliance on manual review of authorizations and claims negatively impacted the company's cost of operations and ability to scale by onboarding new customers. It also stunted their overall revenue growth due to the increased employee headcount necessary any time they brought on new customers.

SOLUTION:

3Pillar Developed a Rules Engine to Automatically Generate Authorizations, Followed by a Routing System for Claims Adjudication

3Pillar began by developing a business rules management system (BRMS) that automatically

Those claims were entered back into a queue for manual review in a process that, at the time, lacked logic around which reviewers received which claims. Each claim simply went into the queue and was then handled by the next available team member in the order it entered the queue. While this process made sense on its face, it didn't take into account that certain reviewers were better equipped to review and approve claims based on a patient's diagnosis, coverage, and requested care.

We used our knowledge of how claims were routed to different digital care centers for review to establish a skill-based queue management application that dramatically streamlined and accelerated the review process. This application was developed using

the jBPM workflow engine, a Java-based workflow engine that can execute complex business processes described in BPMN 2.0.

OUTCOME:

A Powerful System That Provides Real-Time Authorization Data, Plus a Sophisticated Queue Management Application for Further Remediation

The success metrics of our work together were striking. Just a few of the tangible highlights of our work together include:

- We helped the healthcare company cut their claim payment time by nearly 70%, decreasing the average payment time from 6 weeks to 2 weeks
- Auto-adjudication of claims increased by 67% thanks to the BRMS we built
- Claims processing accuracy was increased significantly, from 50-60% to 97%

The company also saw a lift in several key business outcomes. We helped them double the claims



processing capacity of their existing staff, which not only drove significant cost savings but also meant they no longer had to hire new employees alongside every new provider they added. Providers benefited from this increased efficiency as well, as the time it took to onboard new providers was slashed by 60%.

All in all, the work 3Pillar did with this healthcare company is a prime example of how technology can be used to provide both a superior customer experience while also driving real business results.

“

We got better results than we expected. Not only did 3Pillar reduce our claims processing time, they increases our auto-adjudication rate to 97%!”

– COO of a leading provider of home health benefits management services

3Pillar Global is here to help you build strategy, shift your cultural mindset, and build modern data products for an evolving market.

Contact us today to speak with a 3Pillar expert.
www.3pillarglobal.com