Out-of-State Medicaid Billing Services

Addressing the biggest reasons for unpaid claims

Out-of-State (OOS) Medicaid accounts often go uncollected by hospitals – resulting in valuable loss of revenue.

Through more than two decades of focused OOS collections service to hospitals nationwide, we have developed proven processes to prevent the top two issues that lead to unpaid Medicaid claims: missing provider enrollment information and missing or late authorization for a stay or service.

Provider Enrollment Information

CHALLENGE:

Hospital Board of Director and Managing Employees' information is now a required element of the Provider Enrollment (PE) process for 48 of the 50 state Medicaid programs. Omitting this information is a top reason for non-paid claim closures.

SOLUTION:

Our team is familiar with the data that is common to every Medicaid provider application and we work with clients to develop an individualized, flexible strategy to obtain the sensitive stakeholder information.

Once we gather the required data, it resides in our data repository system for all future provider applications. Designed to tailor to each state's application, our system pulls the needed information and populates it, saving staff time and reducing errors.

RESULTS:

A large multi-hospital health system in the Southeast was having issues with rejected PE applications. Its biggest challenge was missing Board Member signatures.

By providing detailed reports that identify the growing loss of revenue due to missing information, educating on Medicaid Payor requirements and outlining the high security practices followed by our team, we were able to obtain the necessary Board signatures.

Medicaid Authorization

CHALLENGE:

Another leading reason for Medicaid claim denials is either not getting Medicaid authorization for the patient's stay/service, or not getting it in a timely manner.

SOLUTION:

Our proprietary Eligibility Verification (EV) service completes eligibility verification upfront for clients, providing the most accurate information about the patient's eligibility, authorization requirements and payor timely filing deadlines.

RESULTS:

A Southeast regional medical center averaged 130-140 days to pay when they turned to our team's expertise. With the support of our eligibility verification tool and the information it provided, the client saw fewer denials and appeals and their average days to pay dropped dramatically to just 42 days.

Centauri Health Solutions is a healthcare technology and services company – powered by analytics. Our workflow platform integrates cross-functional support across all our products and services. Centauri helps hospitals and health plans to manage their variable revenue linked to population health, quality and eligibility factors for more than 25 million lives.

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