



WHITE PAPER

Payment Integrity Trends: What's A Code Worth

A White Paper by Equian

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To install or not install a pre-payment code edit, that is the question. Not all standard coding rules and edits are created equal in terms of value to a payer. Equian's physician leadership, combined with a solid understanding of the future of integrated payment integrity, is a market game changer.

PART 1: THE CHALLENGES OF INSTALLING CODE EDITS

The core principle of Payment Integrity is to efficiently and transparently pay health insurance claims using pre-payment, post-payment, and analytic tools that ensure accuracy and eliminate incorrect, unwarranted payments. An optimal payment integrity model also ensures an organizational focus on paying providers promptly, while optimizing the edit logic.

Over the past twenty years the primary focus of code auditing has been specific to the editing of professional claims and in more recent years the outpatient claims environments. Professional rule and editing logic has been created primarily through coding guidance provided by the American Medical Association CPT (Current Procedural Terminology) and the Centers for Medicare and Medicaid Services' National Correct Coding Initiative (NCCI); for outpatient claim editing the most meaningful source of information has been derived from the National Correct Coding Initiative. Inpatient claims evaluations, generally accomplished through post-payment review until the more recent CMS Diagnosis Related Group (DRG) pre-payment demonstration activities, is typically focused on medical necessity and other high-yield triggers (such as short stay DRGs); often times these reviews are resource intensive. Inpatient reimbursements based on DRGs are common, and other inpatient reimbursement methodologies may include per diem reimbursements or less commonly payment based on usual and customary charges. While DRG payment methodologies may eliminate some of the need for "automated" claim auditing (specific to inlier payments), the details behind the claim, and total billed charges under any revenue code, are a prime potential area for building automated rules. Outpatient claims are often bundled by logic such as the NCCI edits for outpatient services, especially with regard to Medicare and Medicaid claims. In contrast the billed charges and units of service reported on inpatient claims, generated through the CDM (charge description master), 'hide' the CPT codes that generate a portion of the reported charges, charges that have the potential to represent unbundled services. This unbundling of services can only be addressed by requesting a detailed bill with the proper components: CPT codes (when applicable - not all inpatient services are represented by or linked to a CPT code), date of service, time stamps, charge code, department code, etc. Once these data elements

are received, the unbundling of services and charges can be seen and the impact on payment integrity properly assessed.

The processes that should be in place to optimize an end-to-end Payment Integrity solution includes point of health care service tools (provider space) as well as comprehensive tools integrated into pre-payment and post-payment processes (payer space). Understanding the components and limitations of each environment are essential to achieving success:

Point of Service payment integrity tools:

- Limited provider tools in today's environment
- Primarily based on NCCI procedure to procedure and medically unlikely edits
- Medical Necessity (NCDs/LCDs)
- Payor specific payment integrity tools are limited and when available are often underutilized

Analytics allow users to dig deeply into the data to identify aberrance.

Pre-Payment aspects to payment integrity:

- Benefit and administrative logic
- Standard rules and edits (e.g., NCCI PTP and MUE)
- Commercial auditing logic
- Packaging Rules
- Medical Necessity
- Medical Policy 'px:dx'
- Business Intelligence (actionable data)

Post-Payment payment integrity functionality

- Contract compliance
- Administrative rules
- Standard rules and edits
- Medical Necessity (Admissions, high-dollar procedures)
- Data mining
- Aberrancy detection

Claim editing can be used to intervene effectively within the various stages of the claims process. The first step in the process occurs pre-payment in both the provider and subsequently the payer setting, when a claim initially arrives at a payer organization. In this stage, some code auditing, aberrance rules, and predictive analytics can be used to intervene when a claim is identified as either incorrectly reported or in some form aberrant and worthy of additional analysis and review. The post payment phase is the last phase where gaps and inappropriate patterns of claims payments become recognizable, and where additional payment recoupment efforts can be made.

Appropriately integrated edit and audit logic in all areas of payment integrity has proven over time to have a substantive impact on the final payments made for healthcare services. The question is which processes – standard audits, propriety rule sets, numerical edits, and other methods – should be deployed.

PART 2: DETERMINING THE RIGHT EDITING PROCESSES TO DEPLOY

Ideally, one would think just turning on all edits available in a payer's claim processing system would be the best way to ensure optimal payment integrity results. However, there are things to consider which include your health plan goals and objectives, available resources, and the challenges of change in operational workflows.

Resources - Before deploying a code auditing rule in any claims payment system, each available rule has to be installed, configured and tested. Because of the demands on IT and business staff, and the complexity of integrating code edits into operational workflows, payers may only be able to integrate a portion of the available rules and edits depending on the technology platform and the availability of operational resources. Business intelligence and predictive modeling/scoring tools are generally insufficient to deny claims without human validation; so as these methods are deployed, a drop in the auto-adjudication rate can occur requiring a more sophisticated claims adjudication workforce to review claims for coding and billing accuracy. Additionally, as patterns and issues regarding improper billing are identified, focused investigative resources are also required.

Operational Workflows – Improper billing, 'aggressive' or abusive coding, and schemes involving true fraud are prevalent in the health care space; additionally, sophisticated and emerging patterns and new data sets continue to make fraud and abuse detection complex; as such, the historical models of payment integrity are no longer sufficient. Payers are continually working to shift the focus for aberrancy detection and identification to the pre-payment environment in an effort to eliminate the long-standing pay and chase model. Integration of data sets from variant sources (e.g., licensing agencies, registries, and claims data from multiple payers) is also limited in many organizations, impacting the ability to create a 'holistic' model for payment integrity.

In the claim payment process, it's crucial to look as far upstream as possible for actions that can bring a return on investment to an organization. It is in pre-payment space where many experts see the greatest potential for improving Payment Integrity, though payers'

adoption of advanced technologies such as mathematically-based scoring models remains a challenge. Moving strong controls several steps upstream to a pre-payment position is highly desirable; however many payer organizations do not have the infrastructure required to make that advanced Payment Integrity a reality.

To shift additional Payment Integrity activities to the pre-payment space requires a two-pronged approach; the successful implementation of automated aberrancy detection systems and as well as the integration of a comprehensive post-payment assessment process. Remember that mathematical models, while unbiased, can fail to recognize large patterns of inconsistency (i.e., if all providers report a service incorrectly, the incorrect reporting appears 'normal'). A perfect example of this conundrum is evidenced by the most recent Office of the Inspector General report showing that 26% of E&M claims were billed at levels higher than warranted. Post-payment review is necessary and should be deployed to determine additional payment discrepancies, the reasons for those discrepancies, and financial impact to the payer. It is also important to remember that individual claims with true irregularities may not score at a pre-determined threshold sufficient enough to warrant use of resources to review the claims in the pre-payment space, which is another area of opportunity for post-payment review. Once an analysis is done, pre-payment logic can be developed to shore up the gaps in claims processing based on priority – hence creating an end-to-end solution for payment integrity. Ultimately, deploying code auditing controls in the pre-payment position of the payment integrity model is the most effective configuration for payers, improving payment accuracy and limiting unnecessary recoupment efforts.

PART 3: POST PAYMENT INSIGHT & ANALYSIS

While challenges exist with pre-payment scoring programs and systems, advanced models for detection of improper billing is emerging in the market as an integral component of a successful auditing program. There are a multitude of analytic models involved in payment integrity today which include:

- Predictive modeling
- Regression analysis (Linear and non-linear)
- Benford's Law (digit frequency)
- Kolmogorov-Smirnov (data set variations, no assumptions)
- Cost Distribution Models (provider, recipient, encounter)
- Outlier models ('canned' vs. full claim distribution models)
- Targeted queries
- Scoring of claims
- FICO
- Neural Models



Many companies can offer components of Payment Integrity, few have what can be considered a total Payment Integrity solution.

Refinement is sometimes necessary to move financial and marketing industry models into the healthcare data sector. It is also important to remember that “aberrancy” does not always mean improper reporting or delivery of healthcare services. A service that is rarely reported may in fact be entirely suitable for reimbursement depending upon the clinical picture. Each model will have certain strengths and weaknesses, and it is important for any payer to understand the limitations of the technology deployed in a pre-payment or post-payment environment.

A post-payment queue of work can be created to assist payers in identifying abnormalities AND in the creation of new rules and edits; the identification of true positives, false positives, and just as important the false negatives not captured by existing technology can be used to refine the outputs of the tools.

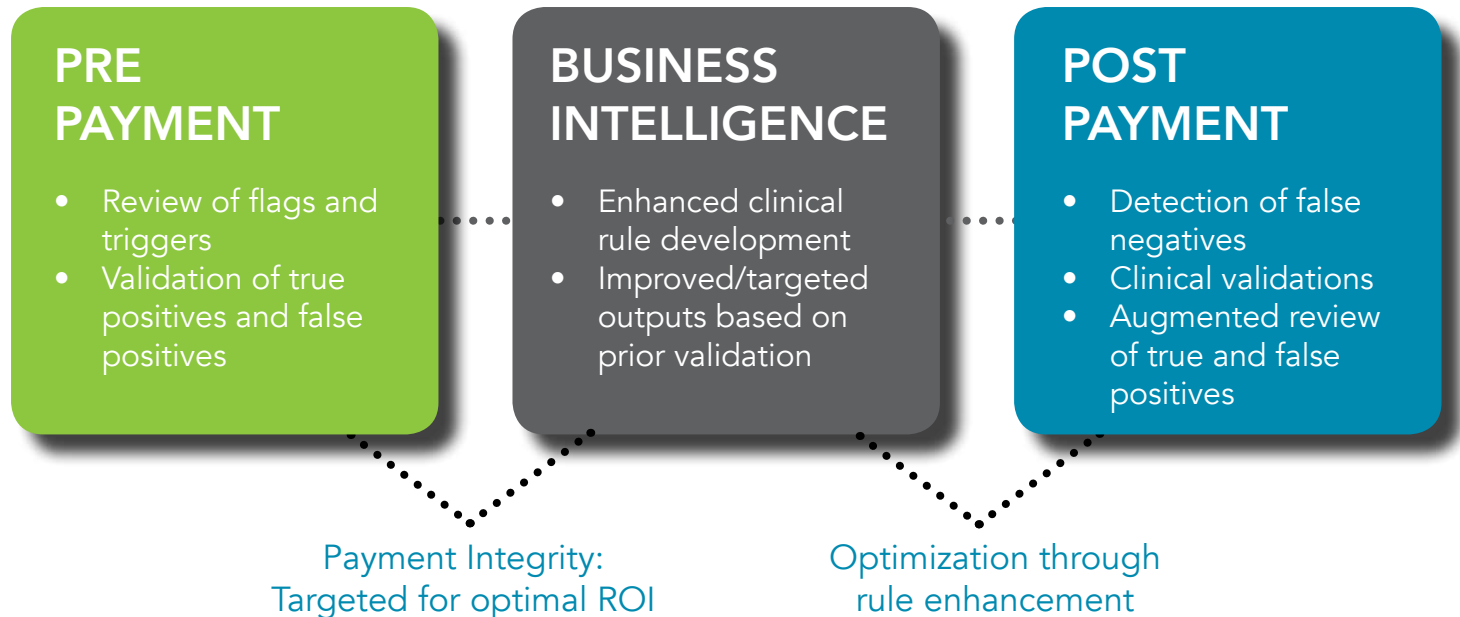
PART 4: PAYMENT INTEGRITY: THE OPTIMIZED SOLUTION

For Payment Integrity to succeed, executives must carefully leverage resources and decide which aspects of the model to outsource. Equally important is incorporating operational efficiencies. The first step is assessing a payer’s payment integrity workflow and technology. The resource equation and the information technology environments must be optimized. It is not just a matter of turning on rules or edits in the pre-payment cycle, or improving existing workflows—optimization requires both pre and post-payment expertise. Payment Integrity solutions must advance efforts to reduce fraud, waste, and abuse, without drastically disrupting business functions.

While many companies can offer components of Payment Integrity, few have what can be considered a total Payment Integrity solution. Payers should seek vendors offering a solution that easily grows and changes as their Payment Integrity program matures and evolves. The industry leaders in payment integrity will be the organizations that incorporate a continuous cycle of business insight and analytics to improve both pre-payment accuracy and post-payment capture of improper claims payments.

See an illustration of the optimized cycle on the next page.

OPTIMIZED CYCLE:



The future state of Payment Integrity will incorporate processes historically lacking in many payer programs – including comprehensive provider and recipient profiling, social network analysis, mathematically-based aberrancy detection, advanced predictive modeling, cost distribution models, and other key elements that are part and parcel to the future of payment integrity.

Finally, ensuring a transparent approach and providing accessible provider education is increasingly important. Payers understand how significant the provider networks are to their business model, and comprehensive provider education solutions are lacking as are transparency solutions. Information must be readily accessible and web-based, and focused seminars as well as 1:1 provider outreach should occur in some situations. A dynamic shift that is needed for the future is one that integrates a partnership approach in lieu of more punitive approaches to payment integrity.

Equian offers solutions that augment and enhance a payer's payment integrity performance. Our understanding of pre-payment processing rules and post payment analytics, combined with Equian expertise in the application of proper coding methodologies, identification of abnormal and inappropriate payment, and the future state of payment integrity make Equian a favorable choice for any partner wishing to achieve optimal payment integrity.

// Pre-Payment // Post-Payment // Data Analytics

Our nation's most pressing challenge is the rising cost and affordability of healthcare. At Equian, our efforts are dedicated to this challenge. We provide solutions for carriers and payors to ensure each healthcare interaction is paid accurately at the lowest possible cost.

Equian is a healthcare information services company focused on lowering the cost of care. To learn more about our company, our services, and our commitment to improving healthcare, visit our website at equian.com or call (800) 962-6831.



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