CRACKING THE CODES

Payment-integrity services evolve as tool to help self-insured health plans weed out fraud, waste and abuse

Written By Bruce Shutan

It's almost hard to fathom that an estimated 25% of $4.1 trillion in U.S. health care spending has been traced to fraud, waste and abuse. In some cases, overcharging for medical services represent egregious attempts to capitalize on a woeful lack of transparency and misaligned incentives that the Consolidated Appropriations Act (CAA) seeks to correct. Other instances involve revenue-cycle management at its most creative or honest medical-coding errors.

In response to all these activities, self-insured employers, along with their brokers, third-party administrators and other partners, have turned to so-called payment-integrity (PI) solutions designed to end substantial leakages in such transactions and ensure that health care claims are correctly paid.

Although industry observers say the approach has been around for years, it appears to be gaining traction as a complement to claims adjudication with the help of


Cherise Skeba

powerful new technologies that are helping pass along savings to health plan members and raise the bar on talent management. Another driving factor is the growing emphasis on prepayment rather than post-payment review to head off questionable billing practices in the first place.

PI actually dates back at least 50 years with what is known today as editing systems, says Cherise Skeba, SVP of analytics and client services at MultiPlan, which offers these services through a company it acquired and acts as the wrap network that self-insured employers use for their out-of-network providers. In recent years, she has seen the emergence of multiple stacked solutions.

Semantics have certainly changed as the industry evolved. Until about five or 10 years ago, for instance, PI was described for the longest time as simply fraud, waste and abuse, observes Brian Atkinson, chief operating officer of Imagine360, another player in this space.

PI started to become more sophisticated during those years when edits would be built into systems to prevent specific issues from recuring, recalls Mary Catherine Person, president of Blue General Partners, LLC, who was running a large TPA at the time.


Brian Atkinson

Clinical editing software then got faster at flagging questionable charges, which she says is why it made more sense to buy some of those products "because you couldn't stay ahead of some of the bad actors out there."

Just as the U.S. Department of Labor years ago cracked down on fiduciary breaches involving 401(k) plan administration, the CAA has extended that enforcement to health and welfare plans. And with this game-changing legislation comes deeper obligations alongside greater opportunities, PI being one of them, notes Stephen Carrabba, co-founder and president of ClaimInformatics, which provides PI services.

"There's no such thing as propriety anymore," he says. "There's no such thing as confidentiality anymore. All billed amounts need to be disclosed. The CAA represents a pivotal moment to bring transparency to U.S. health care in a way that that never has been seen before."

In the face of greater federal government oversight, the marketplace is changing in a way that emphasizes operational efficiency over labor-intensive scrubbing of claims.

PI is shifting from the pay-and-chase model of paying full bill charges and then reviewing those claims on the back end, notes Katy Brant, president of 6 Degrees Health, which focuses on high-dollar inpatient "clean" claim PI reviews. That result was always a long tail of negotiating with providers and clawing back overpayments. Nowadays, she says the industry has wised up to front-loading such efforts to save both time and money.

It also is trickling down market. "Payment integrity has evolved as a separate function in large health plans where the emphasis is on identifying improper payments," explains Raghav Pawar, co-founder of CoverSelf, estimating savings for this service to be in the 2% to 8% range.

Scanning billing errors from a clinical lens prior to payment offers the highest level of savings within the PI spectrum, according to Brant. Whereas PI solutions such as DRG validation, hospital bill audit and data mining can produce savings in the single-digit range, she says a clean claim review can be as high as 10% to 20%.

Having worked as a neonatal intensive care unit nurse for about seven years, she's able to leverage her background. "Nurses understand what should be included in an ICU room and board vs. a med-surg setting," she explains, "or what should be included in a ventilator vs. setting up a CPAP machine. And so, it's that type of detail that we get into in the review that made it imperative that we had nurses performing it."

Another important component is supporting reviews through provider disputes or appeals after having long been blocked by audit language. Providers have become adept at controlling their exposure with audits, Brant notes. "The hospitals know that as long as they have good documentation they will pass an audit and their claims will be payable," she explains. "But that doesn't mean that they don't have creative billing practices which generate errors on claims. It just means that they're protected against a certain type of review."


Katy Brant

This is where PI solutions seek to demonstrate that sometimes the emperor has no clothes. One issue that has long been ignored is whether providers correctly bill for their services, opines Keith McNeil, a partner with Arrow Benefits Group, a division of Patriot Growth Insurance Services, who recommends PI to his employer clients. "Unfortunately, there are efforts in the medical community to enhance revenue by playing games with the billing," he says.

And this is where the business of health care violates the sanctity of doctor-patient relations, bringing to mind the need for integrity in payments. "Providers are hiring revenue cycle experts to come in and help monetize their billing practices," Atkinson reports. "It's almost like an arms race. You have people on front end who are helping provider offices bill creatively so that they get paid more money without doing more work."

But employers are battling back with PI partners whose sole responsibility is to weed out malfeasance. An ongoing challenge for employers is tracking all the CPT code sets and reimbursement policies that are constantly changing, according to Pawar.

Take testing and procedures related to COVID-19, which he notes, initially weren't covered during the early days of the pandemic. "Everybody had to ensure that all the reimbursement policies were actually up and running," he recalls, adding that the PI vertical brings a laser focus to this area.

Nearly every claim adjudication system has the ability to create built-in PI rules, Skeba notes. But since there are thousands of rules that have become an industry standard, she says it's difficult for claims adjudicators to keep up with all this information. That's why more claims processing houses have purchased an outside vendor system to be their editor.

HIGH TECH TO HIGH TOUCH

As the industry becomes increasingly sophisticated, highly advanced and nimble technology continue to shape the PI space. CoverSelf's domain-specific PI platform, for instance, was built in the cloud. That makes it much quicker to implement, as well as easier to use and more adaptable, than legacy systems.

"If you have to launch any product nowadays in a particular cloud, it takes only 10 to 15 minutes," Pawar observes. "How can you respond fast if your technology is very old?"


Raghav Pawar

CoverSelf is one of a handful of recent market entrants that bring newer, more user-friendly PI services downstream to health plans as well as upstream to providers. The startup's open and transparent design allows anyone access to the technology, representing a significant leap forward in health care PI architecture.

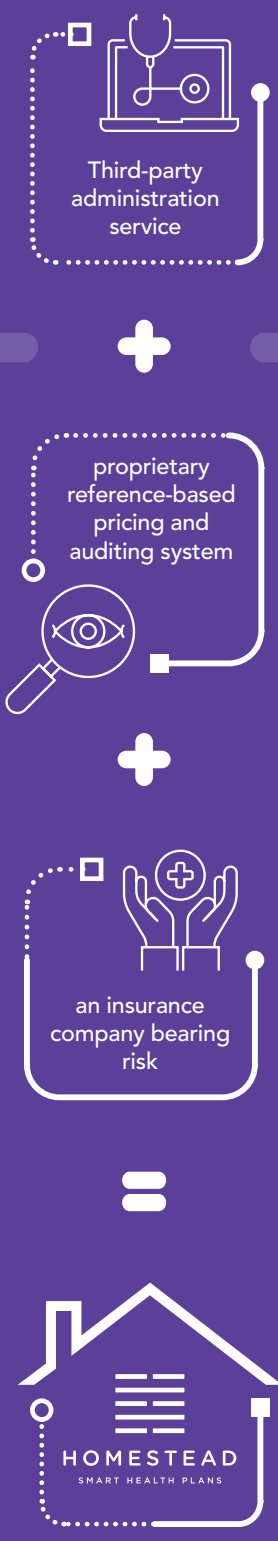
HOMESTEAD
SMART HEALTH PLANS

info@homesteadplans.com • homesteadplans.com

INTEGRATION. TRANSPARENCY. PARTNERSHIP. MEMBER EXPERIENCE.

Everything but the kitchen sink.

We know the current health benefits system is broken. At Homestead Smart Health Plans, we don't just spend time talking about the problem—we deliver the products and services that fix it, **all under one roof.**



Don't settle for a traditional health benefits plan

What are you waiting for?

Other advantages include better security and privacy safeguards, as well as an ability to launch a solution anywhere without having to move servers.

Since claims are processed in silos, ClaimInformatics built sophisticated algorithms that identify billing improprieties and analyze questionable claims in a holistic manner. "We take all those pieces of the disparate puzzle, if you will, and put them back together," Carrabba explains.

Stephen Carrabba

One client's health plan member who required an amputation shows how those puzzle pieces just didn't fit during a PI investigation. While the physician billed for a big-toe amputation, which was the procedure that was actually done, the radiologist billed for a right foot X-ray and then the hospital billed for a right leg amputation.

Given the enormous volume of medical claims, Skeba says PI is ripe to benefit from machine learning and artificial intelligence. But technology can only go so far. "We still need human expertise," she observes. "You need physicians. You need nurses. You need medical coders who are really smart at looking at an abnormal situation and researching in a very efficient manner."

While PI players easily can develop their own proprietary edits, Atkinson says most of the abuse is still of a brute-force nature that requires an expert coder or health care professional to review and identify the real error. "They can skirt around the algorithms," he adds.

Mary Catherine Person

One example that he just learned about involved double billing the payer at $35,000 for removing a kidney. The facility charged an additional $9,000 for the use of a mobile unit. "But because we got the ID and were able to look at the supplies, they in essence were getting rid of the kidneys twice," he says.

PI firms will no doubt make their mark by hiring the best and brightest coders, though they appear to be in short supply on the provider and payer side. There are plenty of bad coders handling medical claims, Person points out.

People who code claims represent some of the lowest-paid employees in the health care chain, and often may have the least amount of experience. Given this phenomenon, she believes PI must be a high priority "just because there's so much bad billing out there, whether it's meant to be or not meant to be. You have to do something to manage it."

QUESTIONABLE CLAIMS

Over the past 15 years, some of the most questionable claims Brant has seen involve the operating room. For example, scalpels, sutures, gloves and gowns are typically billed on top of the base OR charge, which can range from $25,000 to $50,000.

"Anything that's required to open and close a patient should necessarily be included in the base charge for the surgery," she says. "It's kind of the equivalent of if you went to a restaurant and ordered a cheeseburger, and there's a charge on your bill for a cheeseburger, and then there's a charge for cheese and a hamburger patty, lettuce and tomatoes."

Another example would be very ill patients who have been weaned from a ventilator to CPAP within 24 hours, but charged a full day for both pieces of equipment on the same date of service.

"Well, they can't be applied to the patient at the same time," she says. "On top of that, they're billing for 24 hours of oxygen, which is an integral component of both modalities. You can't actually run those machines without oxygen. So what it amounts to is 72 hours of respiratory support being billed on a single date of service."

Keith McNeil

A single claim that is run through PI can produce dramatic savings. Skeba says it's not uncommon for, say, a $1 million claim to be cut in half following an investigation. Scores of both intentional and unintentional errors came to light during the pandemic. For example, she noticed that a number of laboratories ran large panels of expensive respiratory, genetic and infectious disease testing from COVID-19 screenings.

What made those charges difficult to find was that the labs would bill the government for the COVID test and then bill the patient's insurance company for everything else that they were doing. Skeba also referenced an oncology physician in Florida whose buoyant telemedicine activity generated 15 to 35 hours of daily billing, seven days a week for an 18-month stretch.

Some TPAs are assessing fees that should never be billed, according to Carrabba. His firm worked with a client with 3,700-plus in-network claims that were repriced to land an out-of-network negotiation fee. The ancillary fees were north of $45 per member per month on top of the cost to administer the plan, which was outlined in the agreement.

In another case he encountered, a male in Arizona in his early 30s was billed for three circumcisions in a matter of two and a half weeks. "We find constant abuses," Carrabba reports, noting that modifiers are appended to specific claims that will allow for additional reimbursement. Two men who his firm encountered were actually indicted on fraud charges by the U.S. Department of Justice last December.

Predicting that PI will become an essential service for self-insured health plans, Pawar believes that educating the marketplace will be the key to arriving at that point in time. "Unless we educate employers and brokers about the importance of payment integrity, I think it will be very tough to reduce health care costs in the self-insured market," he says. ■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for more than 30 years.