Shoring Up Payment Integrity

Greater movement seen toward pre-pay validation as AI helps reshape provider fees and due diligence

Written By Bruce Shutan

Payment integrity is increasingly being used to help self-insured employers comply with laws and become better stewards of the benefits they offer. With more self-insured employers struggling to manage their health plans, a more proactive vs. reactive effort to rein in high-cost claims has taken shape. A recent report by PwC recommends that payment integrity shifts upstream to validate high-risk claims before payment is made rather than relying primarily on post-payment recovery.

In pushing a prepay solution for payment integrity, the approach is built around the proverb that an ounce of prevention is worth a pound of cure. Some vendors acknowledge that reference-based pricing has been perceived as a blunt instrument for pricing claims that can trigger acrimony and litigation. They also realize that tying payments to a percentage of Medicare, notorious for underpaying providers, is just a single data point, says Eric Hanna, EVP of payment integrity for Vālenz Health®.

"We can look at Medicare as a reference point. We can look at usual, customary and reasonable data sets, and we obviously have our own data through companies that we've acquired such as Healthcare Bluebook," Hanna explains, noting that all these different types of data sets can be aggregated or blended together.

Vālenz has developed a market-sensitive repricing and compliance solution using multiple data points to generate what it describes as defensible reimbursement rates. Mindful that NSA regulations created a heavy burden for TPAs and their clients, it has delivered an average 15% IDR win or withdrawal rate.

This approach allows for flexibility when shifting from a more expensive market like California to less expensive markets in Oklahoma City, Indianapolis, or other regions. "Providers either don't appeal, or if they do, we're able to resolve it fairly quickly with very little additional payment," he says.

Prepay is where rubber meets road in payment integrity, according to Hanna. While providers prefer post-pay reductions, he says plans want to prepay over having to shuttle the dollars out and wait 90 days to get them back.

"If you look at a prepay bill review vs. a post-pay recovery bill review, it could be the same provider, and the success rate of your discounts at the end of the day with the savings that you get are about 50% less on the post-pay side, and it could be the same example," he says.

In viewing payment integrity from a prospective lens, the idea is to lower claim costs before they're even incurred. The reactive side is always difficult because the focus is on reducing something that's already done, Hanna says. In other words: it's about damage control.

Then again, what constitutes payment integrity may be highly subjective. "It's a word that if you ask 10 people, you're going to get 10 different answers," he quips. "I see the same thing with [the meaning of] quality in this industry."

Angel Onuoha

NEW RULES OF ENGAGEMENT

With the recent advent of large-language AI models, Avelis Health CEO Angel Onuoha references two exciting developments on the payment-integrity side. They involve an ability to ingest summary plan documents on behalf of third-party administrators and then turn them into audit rules that can be run against the claims on both a prepayment and post-payment basis.

"This is super helpful because you actually get to see whether your claims are being paid in compliance with the contracts that you have set up," he says.

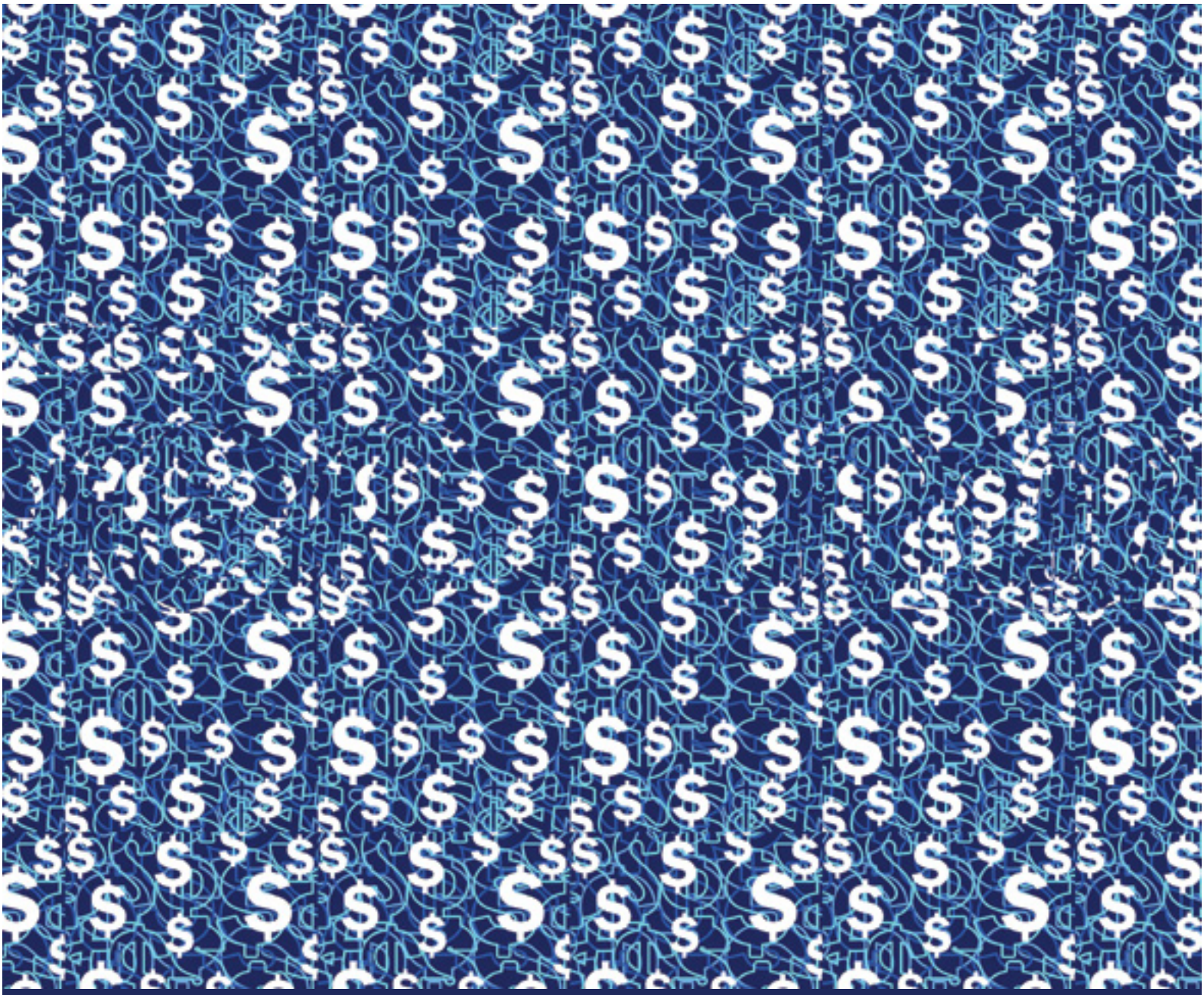
His firm has an AI call center that handles the entire recovery process for any errors that were identified through payment-integrity and audit processes, which allows for a massively scaled-up effort to chase after low-dollar requirements, especially for post-payment. Many companies will only go after claims that have a minimum of, say, $50,000 or up to $10,000 because it's difficult to recoup most of those dollars if too many errors are identified, he observes.

In focusing on post-payment reviews, Onuoha notes that payment-integrity vendors have been able to take their time through a process that doesn't require as much real-time modern technology. As such, that's where historically most of them have chosen to devote their efforts and energy. However, he has noticed the conversation moving toward prepayment because it's a lot less abrasive for providers and easier on the plan side, not having to convince providers why overpayments were found.

HORROR STORIES

Along the winding and often treacherous road to preventing self-insured employers from overpaying claims, there's no shortage of astonishing examples of just what might lurk in bill reviews.

ClaimInformatics, which uses highly sophisticated AI-supported technologies to ensure claims are adjudicated correctly, found a multitude of alarming issues surface for a university client with a Blues plan. For starters, the plan was to process claims with CPT codes that were discontinued years ago. While familiar with AMA's CPT code set requirements stipulating that claims submitted with discontinued codes face



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automatic denials rather than processing delays or conditional payments, the carrier denied the findings. It stated that the CPT was still valid, even though the CPT code was discontinued in January 2023.

As careless as that practice was, it paled in comparison to an even more egregious discovery that was made. When ClaimInformatics identified anatomically impossible claim processing errors, such as hysterectomies billed for born males with no uterus, the payer's legal counsel responded that it "do[es] not apply edits for gender specific codes. Based on legal review, gender editing would be considered discriminatory for transgender patients."

The client and broker were noticeably concerned and frustrated, recalls Stephen Carrabba, Co-Founder and CEO of ClaimInformatics, whose tool also detects ERISA and CAA violations through their contract compliance review tool. "For them not to adjudicate claims based on medical impossibilities is just a complete dereliction of duty on multiple fronts," he says. "Even if I was born a male and transition to a female, I cannot have a hysterectomy."

He has seen a troubling pattern emerge across his book of business that even when errors are clear, carriers will not own them. For the same client, the payer argued it "has been implementing multiple ICD-10 requirements over the past year to improve correct coding requirements," but declined the findings on the grounds that its technology had been subpar and was still improving. In yet another instance, the carrier conceded an error was real, then declined the finding because it had already paid itself to fix it through its own mistake and conflicted post-payment recovery program.

Stephen Carrabba

Of 107,000 claims ClaimInformatics reviewed on behalf of a captive in less than a three-month period, it denied $7.2 million at a 10.57% error rate after scrubbing claims deemed ready for payment after being repriced and adjudicated by the provider network. Carrabba says the errors were black and white.

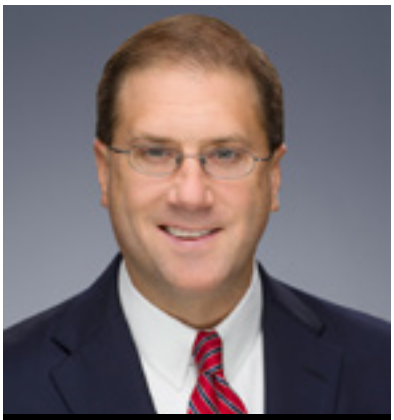
"We are not looking for medical necessity. We are not questioning the doctor. We're not doing itemized bill review," he reports. "A claim came in with the diagnosis of Type 1 and Type 2 diabetes. That is medically impossible. Period, end of story. This claim should have been denied."

Another red-flagged claim involved a physical therapist bill of $3,500 on the same day of a total knee replacement surgery, which is considered an all-inclusive procedure. "Day two? Absolutely fair game," he says, "but you cannot bill for PT on the same day of the surgery."

A MATTER OF FIDUCIARY OVERSIGHT

Carrabba explains that this is exactly why every plan needs independent monitoring on every claim, whether prepay or, at the very least, post-pay. "It is not optional; it is a fiduciary obligation," he explains. When the network is left to police its own claims, plan dollars get wasted, and no one is held accountable for how those claims are processed."

Noting that the fiduciary oversight issue is justifiably of great concern, he says independent TPAs and captives are no longer accepting the adjudication that comes out of provider networks as gospel. "They want an independent third-party review of the claims," Carrabba notes.



Chris Condeluci

Using a payment-integrity solution can actually help a group health plan sponsor satisfy fiduciary duties under ERISA, according to SIIA's Washington Counsel Chris Condeluci. However, he cautions that simply using one doesn't absolve them from a potential lawsuit claiming a breach of their fiduciary duties.

He referenced SIIA's fiduciary must-dos checklist to help plan sponsors and their service provider partners better understand all that they should do to prove steps were taken to satisfy their fiduciary duties.

Whether payment integrity is a standard operating procedure for self-insured employers depends on the TPA, their size and how their systems are set up, explains Bruce Roffé, President and CEO of HHC Group and a licensed pharmacist, who believes there will be more pre-adjudicated claims audits in the future.

"I would think that those claims are already being scrubbed before it even gets to the payer, or if it gets to the payer, then their systems are weeding out the ones that just don't make sense," he says.

Bruce Roffé

There are four areas that Roffé says the TPA or payer will focus on: overpayments; underpayments; fraud, waste, and abuse; and billing errors and coding mistakes. His firm, which tackles the latter two categories, also serves as one of five independent dispute resolution entities for the state of New York under the No Surprises Act. As part of that work, which requires a clinical review under the state's program – an effort that predates the federal effort – HHC Group determines whether claims charges are reasonable.

TPAs can sometimes absolve themselves of the responsibility of checking for claim errors simply because it requires deploying massive teams and using better technology when they're operating on tight margins, Onuoha observes.

The prevailing thinking may be that without a payment-integrity engine, there's less incentive to do that work and that their job is just to process claims. But he's well aware that employers have taken legal action against their TPA and believes the issue will intensify.

One such high-profile case involved a May 2025 decision by the U.S. Court of Appeals for the Sixth Circuit describing TPAs that control and profit from group health plan assets as fiduciaries under ERISA. Tiara Yachts Inc. had sued its TPA, Blue Cross Blue Shield of Michigan, alleging that it overpaid claims, then profited by retaining 30% of recovered funds as fees through a shared savings program.

Complicating matters is the mass adoption of AI tools on the provider side doing revenue-cycle management, Onuoha notes, likening it to "combative technology." That effort involves an attempt to find claims that were underpaid or denied and by doing any type of upcoding possible to maximize revenue. In fact, as many as 70% of health plans PwC surveyed ranked provider AI tools as one of their top three cost drivers for 2027.

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"It shouldn't really be one side vs. another side," he says. "It really should just be both sides trying to get back and forth until we reach the ultimate truth of what actually happened on that claim and make sure it's paid correctly."

PERCENTAGES VS. FLAT RATES

On another front, concern is mounting over the actual integrity of how much self-insured employers are being charged for payment-integrity services to begin with. At a time of heightened awareness of price transparency and fee disclosure, Carrabba believes self-insured customers are tired of paying vendors a percentage of savings.

"It's all kind of a fictitious number," he explains. "Is it gross? Is it net? You get into disagreements with clients. The reconciliations amass because they resubmitted and it turns out to be a disaster."

He cites a $300,000 charge for one particular payment-integrity solution, noting that irrespective of whether it's an itemized bill review or otherwise, the profit margins are egregious. In pre-payment, his firm instead charges a per-claim fee, and if the claim is resubmitted, there's no additional charge, with some clients seeing a 28:1 return on investment.

"Independent payment integrity is here, whether the industry likes it or not," Carrabba predicts. "Contracts are going to change. The tools that organizations like ours are building, coupled with great ERISA attorneys really pushing back, are forcing that change. This is what the market is now demanding from the Fortune 50 all the way down to 100-life plans."■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for nearly 40 years.