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VALUE BASED PAYMENT NEWS

Boosting Payment Integrity with Pre-Payment Reviews

By Greg Dorn, President, CERIS

Tens of millions of provider claims are sent to and processed by health insurers daily, a testament to their resources and competence. However, many of those claims are either technically incorrect or inaccurate when submitted.

According to data from the White House Office of Management and Budget, nearly a quarter of Medicare fee-for-service and Medicaid claims were incorrect last year. A significant number of these inaccuracies are honest errors.

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Nevertheless, many providers face lawsuits and huge federal government fines for intentional or otherwise mistakes. The Justice Department recently reported that settlements and judgments related to false healthcare claims totaled $5 billion in the last fiscal year.

These improper charges can occur for many reasons. For example, a hospital in the Midwest recently billed an insurer more than $250,000 for services performed on a deceased patient that the regional organ procurement agency should have managed. The mix-up occurred because the hospital did not regularly treat organ donors.

The volume of inaccurate claims means that health insurers risk systematic overpayments, delayed payment, and an additional administrative burden. It can take months to rectify an incorrect claim. Numerous verification reviews and taking back overpayments create friction with provider networks. If a provider decides to appeal a payment decision, the resolution of the claims can be delayed for weeks or even months.

Despite these logistical issues, most health insurers still focus their reviews on claims that have already been paid, as opposed to reviewing them before payment. There are several reasons for continuing to do reviews after the claim is paid. The healthcare payers may have sizable bureaucracies that are resistant to change. State laws may pressure them to process and pay claims within a mandated period ranging from 15 to 45 days. Late payments are subject to additional interest payments, as well as large fines from insurance regulators if they discover late payments are commonplace.

A New Approach: Pre-payment Review

Pre-payment review is precisely what it sounds like: reviewing claims for accuracy before they are paid. Today, platforms embrace claims algorithms, data mining, machine learning, and artificial intelligence that enable them to review a large number of claims in a short period of time with a high level of accuracy. The speed of the review allows compliance with state quick payment laws.

Pre-payment reviews are extremely advantageous to healthcare payers for a number of reasons:

- Accuracy of submitted claims is increased
- The provider experience is improved. Only a single review is conducted, and requests for “bill backs” are reduced.
- Pre-payment reviews are extensively documented, making them highly defensible by insurers. Consequently, the number of appeals filed by providers and the time to adjudicate a claim is reduced.

These benefits apply to the entire spectrum of claims: commercial, Medicare and Medicaid.

The Challenges

On a large scale, switching to pre-payment claims review requires internal buy-in and support from C-suite executives, senior management and the finance team. The input of medical directors, claims, and network executives should also be sought.

Health payers must also put protocols in place to measure the cost savings and cost avoidance from switching to pre-payment claims review, and to assess the impact on current internal systems. Pre-payment claims review must also be integrated into existing internal or external payment integrity programs.

Vendors providing pre-payment reviews must demonstrate how payers can reconcile the prepayment disallowances with their short-term and long-term cost savings.

Conclusions

Despite the challenges, more health insurers should embrace pre-payment claim reviews because of the business and logistical advantages they provide:

- Improving relations with provider networks
- Reducing the time required to resolve challenged claims
- Spotting fraudulent billing patterns

Most importantly, pre-payment review will improve payment integrity while positively contributing to the insurers' bottom lines that embrace it.

Greg Dorn is the President of CERIS, a CorVel Company, and has been with CorVel since 1996. He has more than three decades of experience in the insurance sector. CERIS is a leader in both prospective and retrospective claims review and repricing. The company combines clinical expertise and cost containment solutions to ensure accuracy and transparency in healthcare payments.

