Full Cycle Payment Integrity Drivers
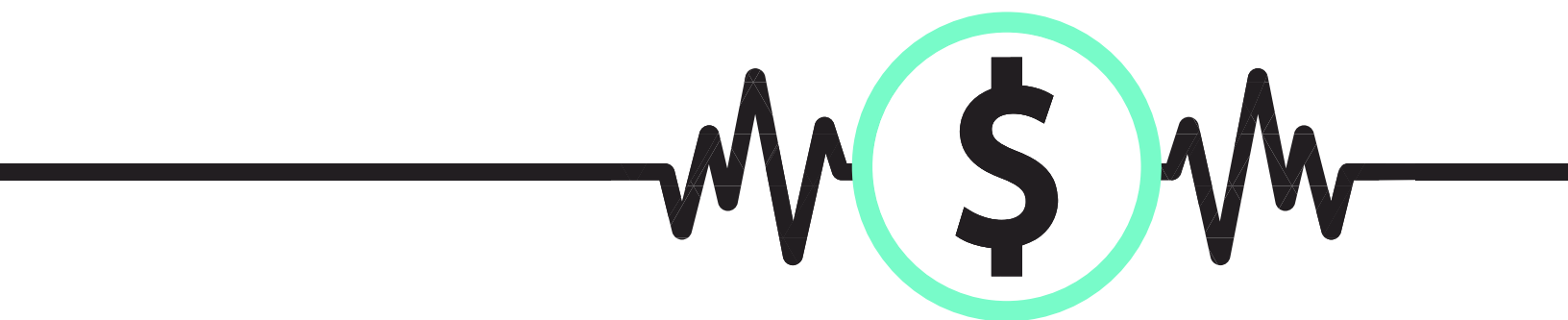
Deeper Dive into The Pulse of Payment Integrity

Foreword

US Healthcare is a highly complex ecosystem with challenges that must be met. A Full Cycle Payment Integrity program is a comprehensive approach to managing and monitoring healthcare payments. This type of program provides a complete review of payment from start (provider billing) to finish (provider payment). It includes a range of activities and technologies, including data analysis, detection and prevention, policy development and enforcement, and provider engagement and education.

By implementing Full Cycle Payment Integrity, healthcare organizations can expand transparency, accountability, and accuracy in the payment processes.

Payment pressure points excerpt from The Pulse on Payment Integrity:

The 5 key factors of a Full Cycle Payment Integrity program include:

1   Prepay solutions identify the detection of errors early in the process, control costs, improve compliance, reduce admin burdens, and improve patient experience.

2   Post Pay solutions increase savings using additional data and provide information that supports the ongoing analysis of root causes and recovery.

3   Data analysis from various sources such as claims, electronic health records, and other payment data, identifies trends, patterns, and anomalies.

4   Policy development and enforcement promote accuracy, efficiency, and transparency in the payment process.

5   Provider engagement, outreach, and education in the payment process ensure all stakeholders are informed and educated about policies and procedures.

Foreword continued

End to end claim receipt, processing, adjudication and payment can be complicated and include multiple technology applications, edits, rules, and databases.

End-to-end payment integrity is designed to strengthen payment accuracy at every touchpoint along the claim lifecycle.

Preventing, Editing, Repricing, Assessing, Recovering, and Analyzing along the claim payment process drives the greatest results.

This deeper dive article looks further into the development and benefits of a Full Cycle Payment Integrity program initially outlined in our Pulse on Payment Integrity white paper. We hope our in-depth analyses continue to provide tools to help you enhance payment integrity success.

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A Deeper Dive into Full Cycle Payment Integrity

Full Cycle Payment Integrity refers to the process of ensuring accurate and appropriate payment for healthcare services from provider bill submission to claims adjudication and payment.
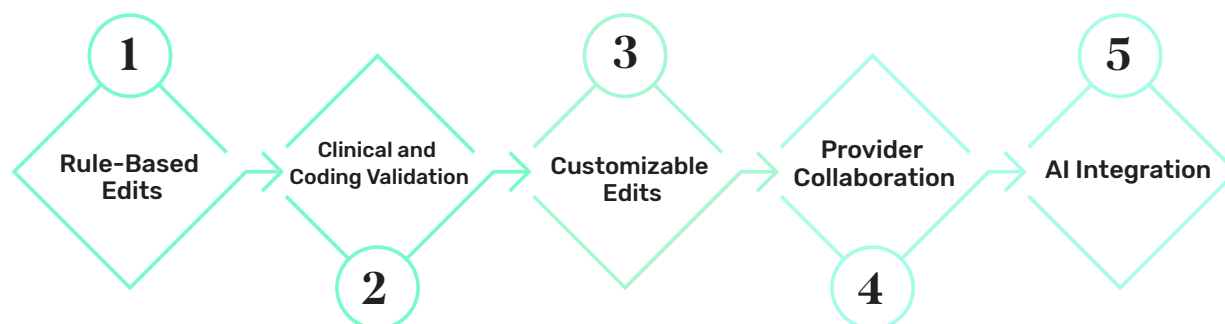
The main challenges in Full Cycle Payment Integrity can vary depending on the specific healthcare system and context. Below we dive deeper into key drivers of a successful program that can be implemented along the stages of the claim process. Integrating all of these drivers into payment integrity governance can accelerate success.

Prepay

Prepay solutions are the first stop in the cycle. They enhance payment integrity by proactively identifying errors and inconsistencies before claims are processed.

Full Cycle Payment Integrity starts with identifying issues in claims before they are processed for payment. Below are 5 key strategies that can be incorporated into prepay:

1 Rule-Based Edits → **2** Clinical and Coding Validation → **3** Customizable Edits → **4** Provider Collaboration → **5** AI Integration

1 Rule-Based Edits: Solutions should offer automated application of predefined rules and edits on claims data to identify common errors and inconsistencies. These edits can check for correct coding, appropriate modifier usage, coverage verification, and compliance with bundling and unbundling rules.

2 Clinical and Coding Validation: Solutions should incorporate all industry-standard coding guidelines governing CPT codes, HCPCS codes, and ICD codes; and validate claims against guidelines to ensure accurate coding and billing. Clinical validation provides a deeper analysis that combines coding, documentation, and clinical chart reviews to reveal higher-value errors.

3 Customizable Edits: Technology solutions allow payers to customize and define specific edits based on their policies, reimbursement rules, and regulatory requirements. This ensures that claims are compliant with payer-specific guidelines.

4 Provider Collaboration: Offering educational resources and training programs to providers improves their understanding of payment integrity requirements. Solutions should be developed that address provider coding questions, clarify documentation requirements, and resolve potential issues before billing submission.

5 AI Integration: AI solutions automatically review claims, apply coding guidelines, and detect potential errors or anomalies to reduce the burden on manual reviewers and enhance accuracy. Prepay should incorporate the integration of AI automation to improve efficiency and effectiveness.

The evolution of prepay practices has been influenced by several factors including rising cost of care, advancements in analytics, regulatory reforms like surprise billing, focus on value-based care, increased capabilities, technology solutions fostering data sharing and collaboration with providers, and AI. Prepay is the primary building block of Full Cycle Payment Integrity.
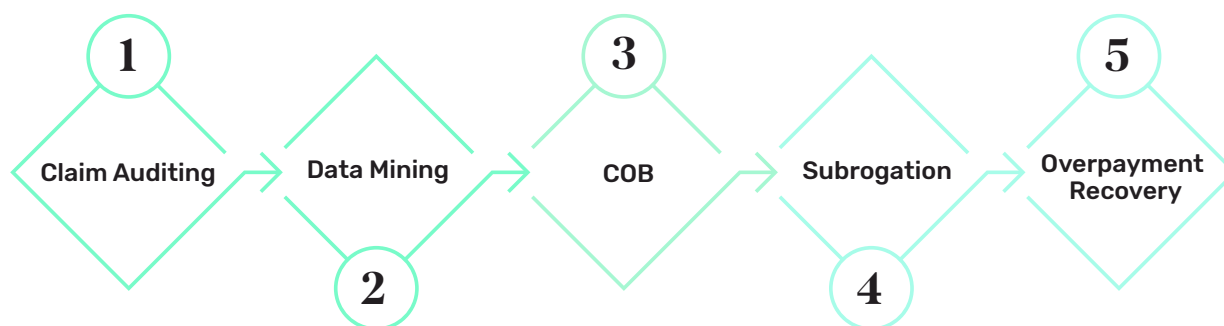
Post Pay

Strong, well-rounded payment integrity offerings combine post pay solutions with prepay solutions to optimize accurate reimbursement at different stages of the reimbursement process.

With prepay methods in place to prevent errors, post pay methods complement efforts by identifying and addressing errors retrospectively. With a retrospective lens, several additional data points can be garnered. Payers can leverage complete claims data, and a more comprehensive dataset allows a more thorough review and analysis of claims.

There are many ways to improve accuracy after claims have been paid and 5 of the key foundational areas that reinforce Full Cycle Payment Integrity include the following:
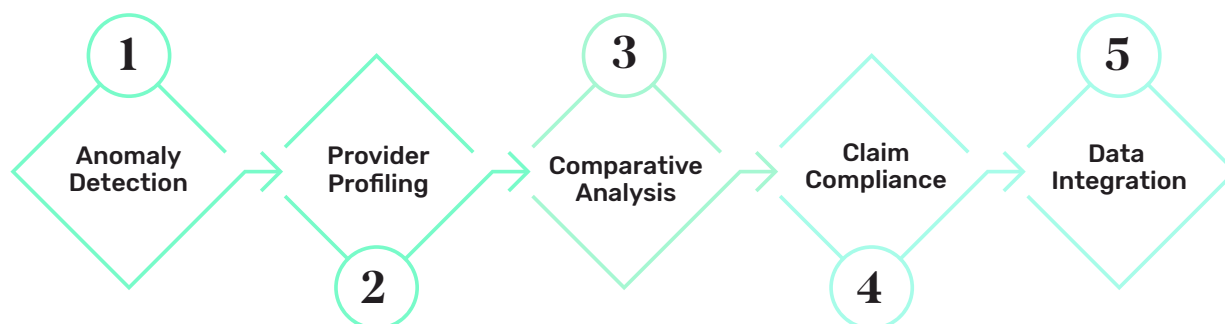
1   **3**   **5**

Claim Auditing   Data Mining   COB   Subrogation   Overpayment Recovery

2   **4**

1   **Claim Auditing:** Validation solutions should occur in both prepay and post pay. Post pay solutions retrospectively assess accuracy and compliance with a detailed examination of paid claims data, documentation, and supporting information that can further identify errors.

2   **Data Mining:** Data mining analyzes large volumes of claims data to identify patterns, trends, and anomalies. Data mining workflows should be continuously assessed and optimized. This may involve refining the error detection techniques or implementing preventive measures to minimize future errors.

3   **Coordination of Benefits (COB):** COB ensures multiple coverage for the same individual do not collectively pay more than the total allowable expenses for the healthcare services rendered. COB prevents overpayment and duplication of benefits.

4   **Subrogation:** Subrogation requires reimbursement from responsible third parties in cases of personal injury or liability claims. It allows the payer to recover funds, reduce financial burden, and maintain payment integrity.

5   **Overpayment Recovery:** Once payment errors or overpayments are identified through post-payment methods, the process of recouping the overpaid amounts from the provider is important and should be consistent.

By retrospectively reviewing data trends, implementing automation where possible, establishing clear metrics and protocols, using feedback mechanisms, and collaborating with providers, payers can continuously improve their post pay strategy and ensure the most accurate payments in the changing healthcare environment. Data gathered in post pay is an important part of the feedback loop that can be applied in the prepay stage as well. It is important to continually enhance prepay solutions based on post pay data to stop as many errors as possible upstream in the cycle.

Analysis

Data analysis from various sources, such as claims, medical records, and payment data, can be applied in several ways to enhance Full Cycle Payment Integrity. Below are 5 key applications for analysis:

```
  1                    3                    5
Anomaly    Provider   Comparative  Claim       Data
Detection  Profiling  Analysis     Compliance  Integration
           2                    4
```

1. **Anomaly Detection:** Advanced analytics like AI, machine learning, and predictive modeling highlight anomalies indicative of waste. By applying findings from these data protocols, payers can proactively flag suspicious billing patterns for further investigation. Payers can also identify emerging risks by addressing potential errors.

2. **Provider Billing Patterns:** Data analysis can be used to create provider billing patterns based on various metrics such as billing patterns, coding accuracy, utilization rates, and outlier identification. By comparing providers against benchmarks and norms, payers can identify providers who deviate from established patterns. This allows targeted education, audits, and interventions to improve payment integrity.

3. **Comparative Analysis:** Comparative analysis involves comparing claims and payment patterns across regions, or time periods. This type of analysis can uncover variations, outliers, or discrepancies that support the identification of billing errors, inconsistencies, or unusual utilization.

4. **Claims Compliance:** Data analysis can verify the accuracy and compliance of claims with coding guidelines, medical policies, and reimbursement rules. By assessing claims against established criteria, payers can identify errors, missing information, and inappropriate coding, allowing for appropriate payment adjustments and improved compliance. Claim compliance analysis can also identify specific types of claims prone to errors and implement targeted interventions, such as provider education, system enhancements, or process improvements to reduce errors.

5. **Data Integration:** Integrating data from multiple sources, such as claims, EHRs, and external databases enables cross-referencing and validation. For example, payer data can be compared against provider-submitted data or external databases to identify discrepancies or inconsistencies in billing or patient information.

By leveraging multiple data analysis techniques, payers can gain valuable insights into claims, payment patterns, and provider behavior, enabling them to make informed decisions. Using focused analyses as part of Full Cycle Payment Integrity determines where enhancements to existing prepay or post pay solutions can be made. These strategies support the optimization of resources, error prevention strategies, and payment policy updates.

Policy

Policy development plays a critical role in Full Cycle Payment Integrity by establishing guidelines, rules, and standards that promote accuracy, efficiency, and transparency in the payment process.

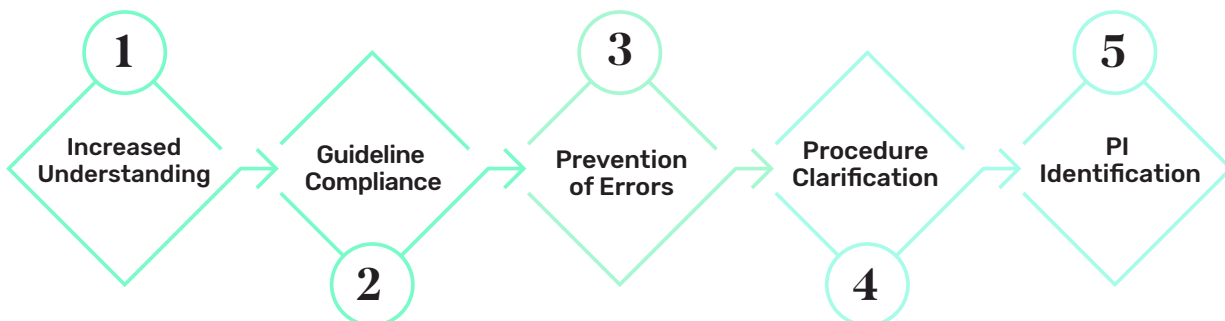5 key aspects of policy development that support the improvement of payment integrity include the following:

1 — Payment Guidelines
2 — Reimbursement Rules
3 — Compliance
4 — Quality Improvement
5 — Policy Updates
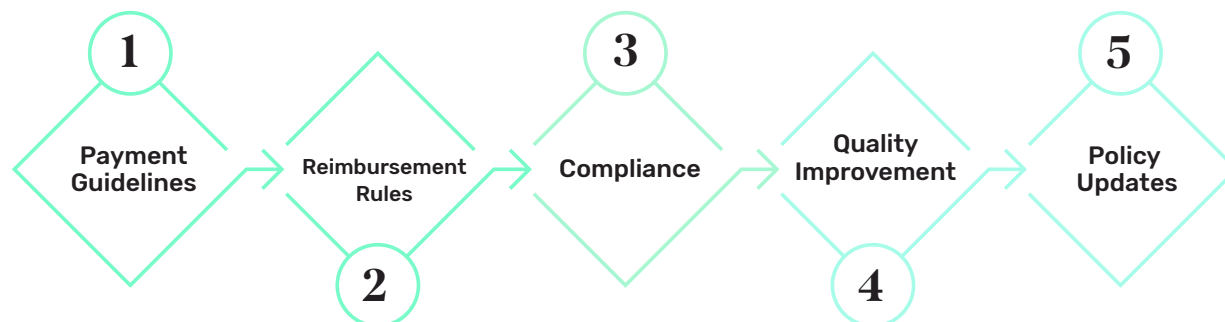
1 Payment Guidelines: Policy development defines payment guidelines and coding standards that govern the submission, processing, and reimbursement of healthcare claims. These guidelines outline the appropriate use of codes, documentation requirements, medical necessity criteria, and other factors that impact payment accuracy. Clear and well-defined payment policies help ensure consistent and accurate payments, reducing waste and errors .

2 Reimbursement Rules: Policies establish reimbursement rules and rates that dictate the payment amounts for different healthcare services and procedures. These rules outline how payers determine the appropriate reimbursement based on factors such as the type of service, geographic location, and payer-specific guidelines. By setting fair and transparent reimbursement rules, policy development supports accurate and consistent payment determinations.

3 Compliance: Policy development establishes compliance requirements that providers must adhere to for accurate and timely reimbursement. These requirements may include documentation standards, coding guidelines, claims submission deadlines, and other compliance-related provisions. Enforcing compliance ensures that claims meet necessary criteria for payment.

4 Quality Improvement: Policy development supports quality improvement in payment integrity. For instance, policies may require the use of evidence-based practices, quality reporting, and performance measures to promote appropriate and effective healthcare services. By incentivizing quality care and aligning payment with value, policies encourage accurate payment for high-quality services, reducing waste and errors.

5 Policy Updates: Payment integrity policies should be regularly reviewed, updated, and adapted to address changing healthcare regulations, industry practices, and emerging challenges. Policy development facilitates the ongoing adjustment of guidelines, rules, and compliance to ensure they are relevant, effective, and aligned with evolving payment integrity.

Policy development is an integral part of Full Cycle Payment Integrity because it provides a framework for an accurate, efficient, and transparent claim process. It establishes guidelines, standards, and rules that foster accuracy and promote the appropriate use of healthcare resources - ultimately resulting in more effective payment integrity practices.

Education

Provider engagement, outreach, and education are crucial components in supporting payment integrity. Below are 5 ways education within Full Cycle Payment Integrity contributes to accurate and compliant payment processes:

```
  (1)                    (3)                    (5)
Increased     Guideline     Prevention    Procedure       PI
Understanding Compliance    of Errors     Clarification  Identification
          (2)                    (4)
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1 Increased Understanding: Provider engagement, outreach, and education increase awareness and understanding of payment policies, coding guidelines, documentation requirements, and other payment integrity-related processes. Keeping providers well-informed makes them better equipped to submit accurate claims.

2 Guideline Compliance: Effective engagement and education provide guidance on proper billing and coding practices. By educating providers about changing coding guidelines and documentation requirements, payers can improve compliance and reduce inappropriate upcoding or down coding and billing inconsistencies.

3 Error Prevention: Engaging with providers helps prevent unintentional errors in billing submission. Providers can stay informed about changes in reimbursement policies, coverage determinations, and documentation requirements which reduce the likelihood of errors.

4 Procedure Clarification: Provider outreach initiatives offer a platform for clarifying payment policies, procedures, and coverage guidelines. Regular communication and dialogue give providers an avenue to seek clarifications on any ambiguous aspects of the processes - resulting in adherence to policies. Clear guidance and procedures minimize confusion, errors, and payment integrity concerns.

5 Payment Integrity Identification: Active provider engagement encourages providers to be vigilant and proactive in identifying potential payment integrity issues within their own practices. Providers who are well-informed about payer policies are more likely to recognize errors or compliance violations. By reporting issues to payers, providers contribute to overall payment integrity efforts.

This important step in Full Cycle Payment Integrity fosters a culture of transparency, trust, and accountability in the payment process. Improved provider understanding and adherence to policies and procedures minimize errors and enhance the overall accuracy and integrity of the payment system.

Summary

To remain competitive, payers must continually find new savings opportunities at every turn and continue to drive better member health outcomes. It is essential to incorporate payment integrity governance that supports the continued maturity of strategies to uncover all opportunities. A comprehensive model can help health plans increase saving on their total medical expense annually through payment integrity functions.

What CERIS has learned through our transformational Full Cycle Payment Integrity partnerships is that the rising cost of care cannot be attributed to one variable. Cost drivers are often a combination of things that can differ from health plan to health plan. As a transformational partner, CERIS assesses the current state, reveals opportunities, supports opportunities with solutions, and accelerates success by partnering with our clients and integrating solutions across the claim life cycle.

CERIS has partnered with payers across the nation to support their payment integrity programs and help them advance where they are in their journey.

Visit CERIS.com to Learn More!