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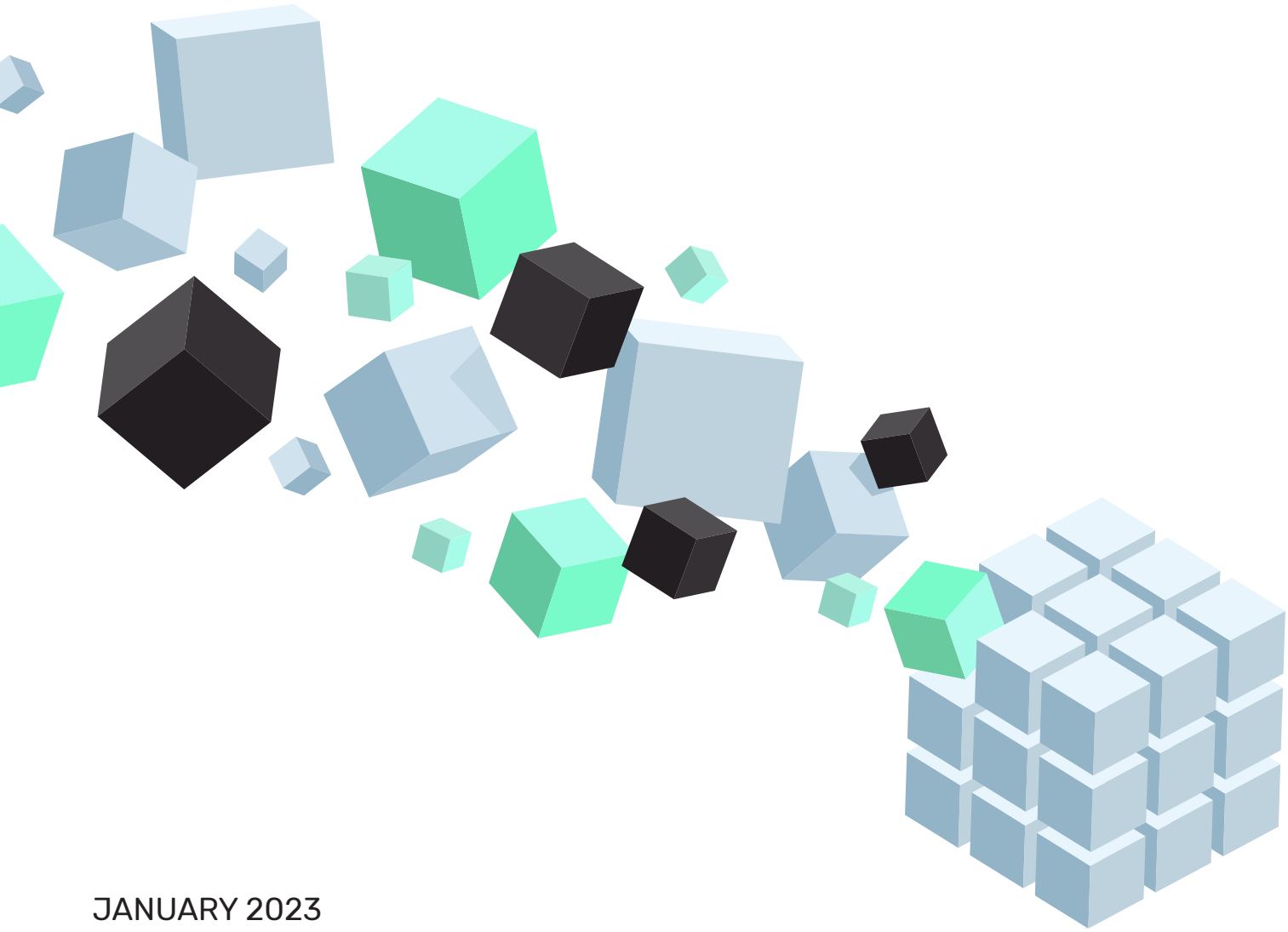
Solving the Rubik's Cube of DRG and Clinical Validation

Long-standing challenges with solutions that continue to advance.



JANUARY 2023

Foreword

As we look to the coming year in healthcare, it will definitely be interesting. Payers, providers, and employers we have spoken to have a lot on their mind - lowering the total cost of care, staffing challenges, regulatory changes, high inflation, economic pressure, political conflict, rapidly changing tech, public health, supply chain disruptions, employee wellbeing, healthcare affordability, uncertainty, increasing competition – and the list goes on.

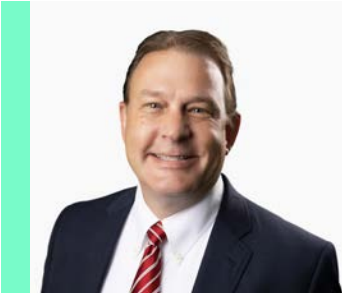
For CERIS, this means we must share the new capabilities we diligently advanced in 2022 to help our clients continue to build on existing payment optimization solutions in a simplified manner. As the healthcare ecosystem was drastically changing and codes and technology continued to advance, we set our sights on new ways to deliver more effective solutions that strengthened provider relations and focused on everyone working together for the greater good.

One of our big investments in 2022 was in DRG Audits, specifically regarding clinical and coding expertise. As we advanced our capabilities in this core product offering, we recognized this was an iconic solution that has been around since the 90s – which reminded us of the Rubik's Cube – another, slightly more famous 90s icon. Maybe solving DRG Validation is not as fun as solving the Rubik's Cube, but solutions for both continue to evolve into better, faster methods.

The white paper that follows takes a very complex challenge (DRG and Clinical Coding Validation) and illustrates how we can use algorithms, models, automation, clinical experts, and outside-the-box thinking to advance payment optimization and better serve the changing market needs. Just like super cubers continue to figure out how to expedite and simplify solving the Rubik's Cube every year (4.86 seconds in 2022), CERIS will continue to ideate and improve solutions in DRG Validation and payment integrity in total.

We hope you enjoy the white paper!

Greg Dorn
President



Mark Johnson
SVP, Product Management

DRG and Clinical Validation – Multi-Layered Solutions

The Rubik's Cube is known as a **configuration challenge**, To solve a Rubik's cube you need to manipulate the cube without messing up other tiles. Each algorithm contains 4 to 20 steps to solve just one tile - it's a **multi-layered solution**. The whole problem is only solved when you solve every sub-problem, and solutions to each sub-problem may look quite different. It takes each unique algorithm to solve the whole problem, and you can't dismiss any part of the solution.

DRG and Clinical Validation seem to also fit that category of challenge. The process can be seen as a **configuration challenge that needs a multi-layered solution**.

Some of the foundational layers that need to be solved include:

- Selecting the right claims for review
- Confirming diagnostic, procedural, and coding information
- Partnering with already fatigued provider staff
- Managing rapidly changing payment policy and regulation
- Determining where in the claims workflow to validate

Like the Rubik's Cube that requires you to solve one layer at a time without disrupting other layers, a successful DRG validation process starts by first solving how to identify which claims should be audited. With a limited number of audits allowed, you need to choose wisely, and each audit issue may be unique. At the same time, you need to be sure you are not disrupting the relationship between the payer and provider in the process.

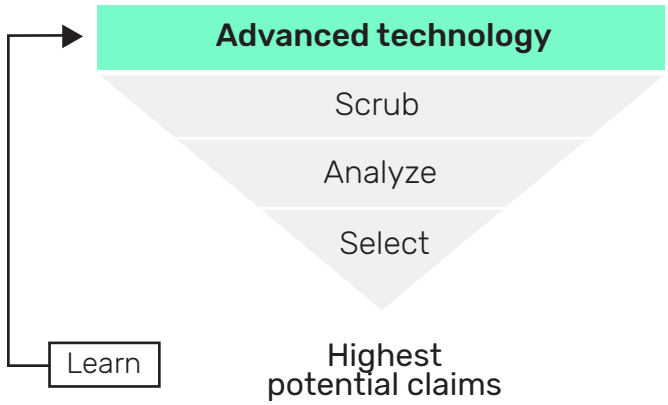
Every layer of the solution has to work in unison in a multi-layered challenge like DRG and Clinical Validation – Or even solving a Rubik's Cube

Solving Each Complex Layer

Everyone in the healthcare industry understands how DRG and Clinical Validation can reduce risk, defend claims, and ensure code accuracy. As we look to 2023, the industry is ready to maximize success, remove obstacles and improve provider relations for a complete solution. Below are the foundational aspects our experts see driving the industry to a faster, more efficient, more successful approach.

1. Unscrambling claims selection

We can now rely on tech such as AI, natural language processing and machine learning to continually get smarter about which claims are most applicable for audit and most likely to yield results. In today's validation process, payers need to be able to rapidly assess the full universe of claims and identify the optimal subset for audits to maximize savings and minimize provider abrasion.



Solving Each Complex Layer

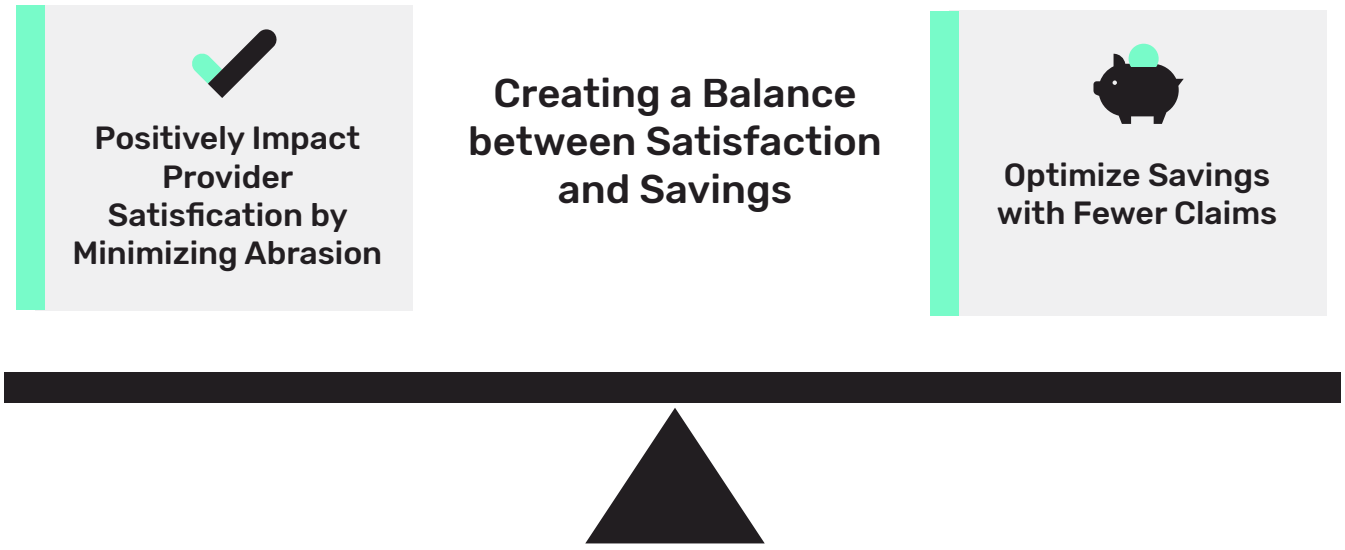
Just like elite speed cubers rely on robotics to help them understand the patterns of a Rubik's Cube, payers need technology to assist in solving for the best claim selection. Technology can analyze millions of claims and know which to choose based on pattern recognition. When a machine sees a pattern it recognizes, it performs the corresponding algorithm, and brings the challenge one step closer to a solution.

As claims data and audit results continue to be filtered through technology solutions like machine learning, the results will continue to improve. The advances in technology allow payers to start with a full universe of claims not just a selection of those with "high likelihood" codes, adjust claim audit volume based on internal and external parameters, and accurately assess projected cost savings before audits even occur.

2. Unscrambling confirmation, matching, and validating

Advanced automation can assist in confirming diagnostic and procedural information. With records stored electronically, matching discharge status coded on a claim to attending provider descriptions and medical record information can be systematically processed to some degree. By normalizing structured and unstructured data, we can further unify disparate information. It is also important to ensure the right data elements are being mapped into the audit process workflow.

Unifying data that can be housed in multiple systems is an important part of the process. Similar to the very best speed cubers using what they call the look-ahead, or the ability to plan for future algorithms in a fraction of a second, automation can put data together and allow auditors to quickly spot where errors may be.



Solving Each Complex Layer

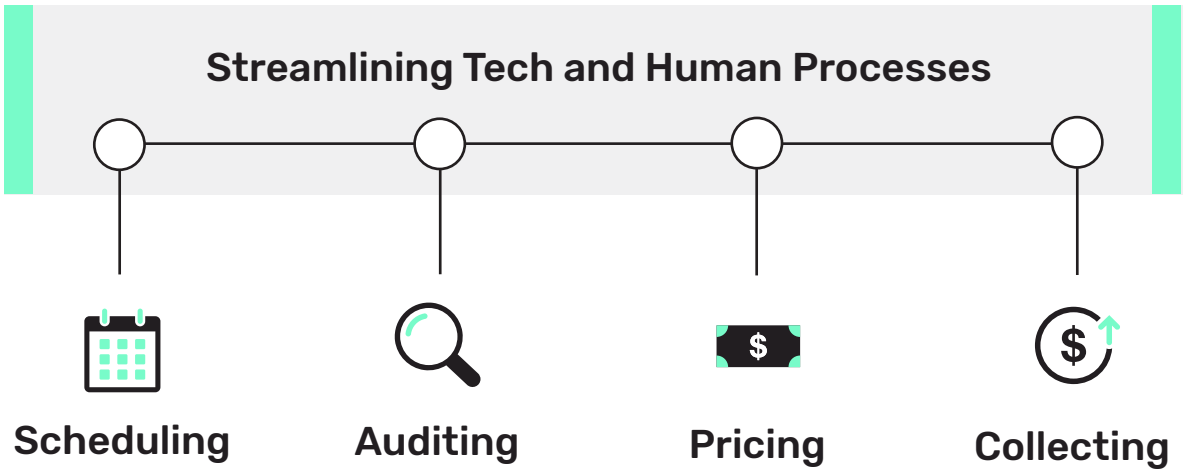
3. Unscrambling the human layer

Third, in addition to using the great advances in tech that can simplify the process, human experts still need to be in the loop to validate complex audits, reduce provider abrasion, and work with providers to understand areas for improvement.

There is no standard for how a hospital receives and processes requests for medical records. Within that process there is also staff turnover, multiple points of entry for requests, and ongoing process changes that can delay and create frustration for everyone.

Whether audits are completed onsite or offsite, the human relationship between the auditor and the staff at the provider organization is a key tipping point in overall success. Additionally, humans with clinical expertise can instill trust in findings.

An accurate payment benefits everyone in the healthcare system, so the human connection can help drive that common bond. The Rubik's Cube has over 43 quintillion combinations, and yet it is solvable in 20 moves. So, regardless of the number of ways to access, validate and audit claims, the auditor and the provider staff must work together to solve the problem.



4. Unscrambling payment policy, and regulation

Another layer payers must have in place for successful solutions is integrating official policies, guidelines, and regulations into the workflow, so they don't derail perfectly planned audit execution. Many hospitals also develop internal guidelines defining those diagnoses most vulnerable to denials.

It is important for people in the process to have experience with all payment methodologies: DRG, AP-DRG, APR-DRG, MS-DRG, APC, APG and understand base rate calculations at a statewide level, hospital-specific level, and peer-group level.

Solving Each Complex Layer

Experts must stay on the pulse of changing rules. Here is just one example of an upcoming changing payment policy that can impact how a claim is coded and paid:

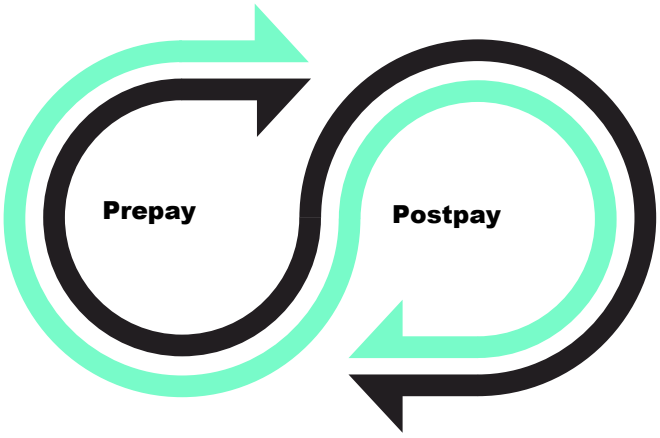
> **Example of changing payment regulation**
>
> CMS modified its methodology for determining FY 2023 Medicare Severity-Diagnosis Related Groups (MS-DRG) relative weights by calculating two sets of weights — one including COVID-19 claims and one excluding COVID-19 claims — and averaging the two sets of weights to determine the final weight values. CMS just finalized the proposal in late 2022 to limit the reductions to 10% for MS-DRG relative weight decreases each year to mitigate financial impacts resulting from significant fluctuations in the relative weights.

5. Unscrambling prepay / postpay

Prepay reviews can eliminate the burden of accessing and retrieving medical records and detect potential errors in the patient record or coding. It can also reduce provider friction by paying claims accurately upfront and using fewer resources in the validation process. While prepay solutions do a great job of capturing overpayments, they don't catch everything, and real dollars may be left behind. Payers may also be missing an opportunity to apply DRG reviews prepay on medical claim inventory leveraging existing prepay medical record requests.

Postpay validation continues to add incremental value as not all DRG reimbursed claims can conceivably be stopped for prepay review. Postpay solutions allow certified coding professionals to conduct postpay audits onsite or remotely.

Prepay and postpay edits and audits are both important program integrity strategies, often making the biggest impact when used together. It is a circular process of defining and moving edits up front to capture the majority of errors before payment - saving everyone in the ecosystem time and money.



Conclusion – Continuous Ideation

Every year, someone solves the Rubik's Cube faster than the year before, and we wonder how. Similarly, perhaps there are methods yet to be developed that will assist heathcare stakeholders in performing DRG Clinical and Coding Validation reviews more efficiently ensuring accurate payments for services rendered.

In summary:

- Identification analytics in advanced tech create less audits with increased savings.
- Automation allows all claim analysis, and the ability to target reviews based on specific criteria.
- The human element continues to build important relationships to advance accurate payments.
- Changing regulations and payment policies are always a known unknown.
- There is a place for both prepay and postpay solutions.

> The CERIS team sees year over year improvement across all clients in our process, and that success is contributed to our partnership approach and promise to never stop looking ahead and working towards perfecting our solution.

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