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Value-Based Payment NEWS

How Pre-Payment and Other Reviews Can Dramatically Reduce Healthcare Costs

By Mark Johnson

A recent study in the publication *JAMA Network* contained data demonstrating the perils health plans and self-funded employer groups encounter when trying to keep costs under control.

The study included interviews with dozens of executives with physician organizations. The consensus was clear: Nearly 84% of the primary care physicians who work with these organizations were compensated primarily based on volume of services they provided. Patient outcomes were mostly a secondary consideration regarding pay. While a majority of these doctors did receive some compensation based on the quality of care they delivered, less than 10% of their pay was based on such incentives.

In other words, healthcare in the U.S. is being driven primarily by volumes of patients seen and the bills they generate. While efforts to transform volume to value have received significant news coverage over the years, they had effects only around the edges of healthcare spending.

That means if costs are going to be properly controlled over the long-term, most of the work will have to take place on the payer's end. That's made more challenging by the fact most payments are made retrospectively – after care is delivered. To keep those numbers under control, payers and self-funded employer groups are going to have to take a much closer look at the way patient encounters are coded and billed.

One option is undertaking pre-payment reviews – scrutinizing coding and billing before payment is made to the provider. These reviews provide numerous advantages over post-payment reviews, as they can help avoid contentious payment drawbacks from providers. Such reviews can also provide a clear pattern of how a provider bills and how that may be addressed, allowing for more efficacious management of future claims submissions.

The Centers for Medicare & Medicaid Services began pre-payment reviews as a demonstration project nearly a decade ago. It has become a handy tool for Medicare recovery audit contractors (RACs). Such reviews are triggered when a claims comparison or analysis of utilization practices by providers uncovers some potential outlier behavior; through complaints from beneficiaries or competing provider organizations; or if the provider is under investigation by the Government Accountability Office or U.S. Department of Justice. Although RAC pre-payment reviews are considered especially draconian within the provider community, they are effective.

Partly as a result of the success of the CMS' demonstration project, some form of pre-payment review is now conducted by most major commercial payers. Some companies, such as CERiS, can save money on 97% of the claims it processes. In work with one national payer, CERiS is saving $9,000 on average for each claim. Appeals by providers undergoing this pre-payment review stand at just 3%, far lower than the industry average of 10%.

And the average turnaround time to complete a pre-payment review is just four days – a necessity where many states impose financial penalties if a claim is not paid within 45 days or less. CERiS is regularly exceeding payers' performance guarantees while also driving significant savings.

Along with pre-payment review, there are many other CERiS tools payers can use to keep close tabs on provider expenditures and charges. Here are other analyses that may be performed on claims to keep tighter control over costs:

DRG Validation and Review

Along with straight overcharges that may be discovered through clinical review, a DRG validation and review may also uncover incorrect uses of both diagnoses and procedure codes. If they don't reflect the official documentation in the medical record, DRGs can be assigned inaccurately, leading to higher costs. DRG review may be used both in pre-payment and post-payment analyses.

continued on page 2

How Pre-Payment and Other Reviews Can Dramatically Reduce Healthcare Costs continued

Surgical Implants

Surgical implants are another red flag. Some implants – particularly for spinal procedures – run well into the six figures. Moreover, payers and employer groups are billed for device "bundles" – oftentimes screws or other specialized fasteners – that contain more devices than were actually implanted in a single procedure. That can drive the implant costs tens of thousands of dollars higher than necessary. A fixed payment for a surgery and post-surgical care – a bundled payment – can counter such activities.

However, most providers will only go along with such restrictions in the case of a major accountable care organization (ACO), or other value-based payment initiative. Surgical implant reviews by CERiS are conducted by identifying and providing the manufacturer's implant cost through its proprietary repository of national implant invoice data. CERiS will use that data not only to weed out bundling practices, but also to set recommended payment to the provider.

Special Services

The abundance of specialty medical services in the United States is one of the reasons why it is often considered the best place in the world to obtain healthcare. But with this plethora of services can come abuses such as overcharges. CERiS can conduct reviews in the areas of specialty care where overcharging has become an issue in some quarters, like hospice. They can include hospital emergency room visits – which can lead to charges of thousands of dollars for a visit that lasts just a few minutes

Hospice care has become another area of concern. Little more than a novelty a decade ago, hospice care has become a huge business in recent years, dominated by some multibillion dollar firms. As a result, some patients are in hospice even though they may not be terminally ill – and that is even before overcharges or miscoding can occur. A 2019 report by the Office of the Inspector General for the U.S. Department of Health and Human Services concluded that more than 80% of hospice centers providing treatment to Medicare patients had at least one deficiency. Such issues can lead to incorrect coding and billing for services. If a single patient is in hospice care for six months or more, the potential overcharges can be huge. Many payers are now offering the hospice benefit to their members with little or no review expertise to validate the hospice charges. CERIS now offers this review to the market.

With the cost of delivering healthcare twice as much in the U.S. than in the rest of the industrialized world, such reviews are absolutely necessary. Although they will not solve rising healthcare costs single handedly, they can make a significant difference for a single payer or a self-funded employer group.

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