

Claiming Responsibility



With new revenue integrity technologies, health plans and payers are more effectively controlling costs and identifying fraud.

By Michael Lubao

Just like their healthcare provider colleagues, health plans and payers have a fiduciary responsibility to spend hard earned premium dollars both fairly and wisely. A vigorous approach to maintaining revenue integrity is, of course, good business. But it's also supposed to benefit patients and healthcare professionals. Given that annual healthcare expenditures are approaching \$2 trillion, the stakes are enormous and, from the perspective of the individual, these high costs leave absolutely no room for inaccuracy. When undetected, most errors and fraud count against someone's annual deductible or lifetime limit on benefits. Dollars squandered today can mean financial risk tomorrow.

To further illustrate what is at stake, the FBI estimates that healthcare fraud losses within the government (commercial sector excluded) total more than \$100 billion annually. If those lost funds could be recovered and re-used, we could insure every American citizen currently without healthcare coverage, as well as our population of undocumented workers. The measures that at-risk entities take to bolster revenue integrity vary widely by size, organization type and state regulations. But one aspect is the same everywhere: The complexities of healthcare finance, frequent regulatory change and continuous coding updates present formidable challenges.

Revenue integrity comprises three basic elements: First, payers increasingly need the capability to efficiently audit large volumes of claims data to verify for proper coding and accurate reimbursement. Next, payers must maintain the ability to protect against intentional fraud and abuse, as required by law in some states. And third, payers can make a valuable contribution to the healthcare community by educating providers in such a way that they can avoid claims submission mistakes and elevate their billing practices.

Until recently, however, it's been difficult to adequately address revenue integrity. "With an increasingly high number of changes in coding, coverage and payer guidelines, keeping on top of accurate claims adjudication without automated auditing software can be challenging," says

Tracy Harswick, CPC, director of claims and decision support for Memorial Integrated Healthcare in Hollywood, Florida. "It's time consuming for hospitals and medical system staffs."

As they managed claims for nearly 35,000 covered lives, such was the dilemma for Harswick's nine-person department within Memorial Healthcare System (MHS). Fortunately, new analytical information technologies are helping organizations like MHS to take on these responsibilities, in addition to others.

Controlling Costs

As MHS had been doing, many organizations continue to perform code auditing using manual processes. When auditing is paper based, it's a cumbersome, slow process with limited reach in terms of the volume of claims reviewed as well as rules and edits applied. MHS has augmented its claims adjudication system with a new, electronic process for flagging unclean claims and identifying coding errors. "There was no easy way for specialists to uncover duplicate files, gauge eligibility, or quickly review claims histories," says Harswick. "And using paper, there's no way to track accidentally overpaid bills or duplicate bills, which come directly from profits. So we took a proactive approach to ensure that physicians were being reimbursed fairly and to open the door for cost savings."

MHS began using Virtual Examiner, a product from Malibu, Calif.-based PCG Software that helps payer organizations identify and understand coding errors with intelligence built on tens of millions of reimbursement, coding and regulatory edits. Most claims adjudication systems focus on automation and expedited claims processing, however, this particular solution monitors internal claims processes to target unclean claims and conserve premium dollars. "During evaluation, the vendor ran a test for us," says Harswick. "Their system evaluated thousands of lines of MHS's claims data from the previous two years, and it demonstrated a significant financial difference compared to our existing methods."

Spiking, Churning and Trending

The second component of revenue integrity calls for measures that protect against fraud, which has become a big business in recent years. In 2005, a group of providers in three south Florida counties submitted \$2.5 billion in fraudulent HIV/AIDS-related Medicare claims. That's compared to less than \$1 billion in legitimate claims for the rest of the U.S. combined. That may be an extreme example, but a conservative estimate by the National Health Care Anti-fraud Association places fraud at a minimum of 3 percent of total commercial and Medicare and Medicaid healthcare expenditures. Other sources report rates as high as 14 percent.

Revenue integrity technologies, such as the solution we've deployed, are currently being utilized to help payer organizations and administrators analyze hundreds of thousands of claims at a time, searching the data for certain outliers and patterns of abuse. Examples of patterns these systems search for include indicators such as "spiking," "churning" and "trending." Because providers typically generate consistent volumes of claims, software can monitor practices or providers over time. Sudden "spikes" may require further investigation, which is especially critical in the age of electronically submitted claims.

An example of spiking occurred when one of our customers used our revenue integrity software's fraud module to review spikes in the volume of their claims and discovered 13,000 fraudulent claims electronically submitted by a durable medical equipment supplier. Although payments were made, the organization has taken steps to recover lost funds. Had an examiner received 13,000 claims in paper form, this would have immediately triggered an audit and ultimately stopped, but since the claims were submitted directly into the claims system via an electronic data interchange, they were automatically adjudicated and paid.

Evaluation and management coding for office and hospital visits will usually fall within a normal bell-curve distribution for most practices. Software should be utilized to compare the billing provider's code submission against comparable specialty and/or CMS benchmarks to reveal billings skewed toward the highest levels. This consistent safeguarding practice should help to identify churning indicators. Aggregating claims data and identifying those providers who always bill the same level of code is not only an important quality review, but also a financial responsibility of the payer.

Trending comes in many forms and an adequate revenue integrity software solution should incorporate extensive flagging and reporting capabilities in order to detect them. There are only so many hours in a day; fraudulent claims may indicate trending from an impossible number of encounters or services provided in one day, week or month. Billing 20 level-five office visits in a day, for example, should be identified as inaccurate or fraudulent claims.

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In another example, we found a Chicago-area physician pilfering our tax dollars by billing over 900 visits per day to the Illinois Medicaid program. Today, this physician is no longer practicing medicine.

Provider Education

Revenue integrity tools have a third function; offering constructive feedback to providers. With intelligent technology, at-risk organizations can share clean, demonstrative data that helps providers understand errors. Software packages like the one we've implemented let payers equip their providers with remittance advice and reimbursement recommendations to assist in scrubbing future claims. With education on correct billing procedures, payers are helping to update their providers' billing systems so future claims will not be returned unpaid. At the same time, the information can improve provider relations by minimizing the friction and effort associated with deliberations regarding reimbursement rates.

Increasingly essential for providers as well as payers, revenue integrity technologies benefit those dedicated to improving their billing operation. These forward-thinking organizations realize that a higher percentage of clean claims will ultimately lead to improved cash flow. Claims auditing tools are well within the reach of any type of payer organization. Installation and integration with existing systems should be possible in a matter of hours or days and with little, if any, disruption or downtime. Furthermore, users in the claims department should not have to change their data input procedures and customization should not represent a hindrance to carrying out a timely implementation.

The AMA and CMS are working diligently to create concrete payment guidelines and codes, therefore, it is important that claims auditing software not be programmed to ignore these rules. Doing so could place the provider or group at risk for collusion. The software selected should also be powerful enough to review hundreds of thousands of claims per hour, even as it evaluates them against tens of millions of Medicare, CCI and other edits. Finally, the solution should not cost more than it saves. Many vendors rent software at exorbitant prices to the extent that actual recoveries never exceed the yearly rental fees.

For good business and healthy communities, plans and payers are increasingly adopting the revenue integrity model. Protecting premium dollars, detecting fraud, implementing recovery programs and strengthening payer-physician relationships are all key parts of the solution.



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