Playing the “Payer Game” Overcoming the Odds to Win

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As Vice President of Revenue Integrity Solutions for MRO, Crump oversees revenue integrity service line. She has over 25 years as an experienced healthcare leader with extensive knowledge of provider compliance and revenue cycle operations. She has a passion for improving healthcare and reducing administrative burdens, especially across revenue cycle functions and payer denials.

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Objectives

- Discuss rules of the Payer game
- Identify pitfalls that can prevent payment
- Identify a strategy for success

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The Rules

Basic

- Submit a claim and get paid

Variations

- Submit an appropriately coded claim and get denied
- Provide documentation for coded claim, get paid
- Submit claim, get denied, provide documentation…get partially paid, continue to appeal to the next level
- Get paid fully for the previous denial but now the payer is denying something else on that same claim
- Payment does not align with contract amount, reach out to the payer and speak to multiple representatives

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"Winning" Takes Teamwork

PHYSICIANS AND NURSING STAFF- I.E., CLINICAL CRITERIA AND DOCUMENTATION

ANCILLARY DEPARTMENTS- I.E., DOCUMENTATION

LEGAL-I.E., COMPLIANCE/ CONTRACT MANAGEMENT

CDI- I.E., PROVIDER EDUCATION, QUERYING OPPORTUNITIES (INCOMPLETE DOCUMENTATION, RISK AREAS)

CODING- I.E., REVIEWING EDITS AT TIME OF CODING AND BEING COGNOSCENTE OF POTENTIAL RISK AREAS OR TARGETING, QUERYING AS APPROPRIATE

BILLING/FINANCE- I.E., SCRUBBER EDITS, POTENTIAL PAYER NUANCES, CHARGE MASTER, COMMUNICATION WITH HIM

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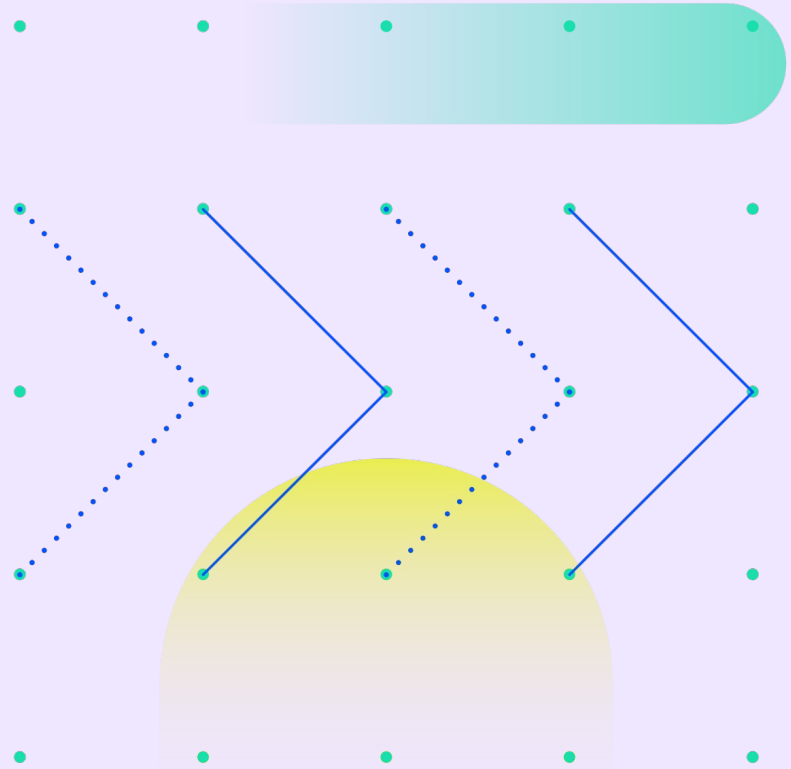
Billing and Coding



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Claims submissions . . .

- What can be built into the claim scrubber?

- Coding edits- Coders should be mindful for triggers that may need a second look i.e., only one MCC/CC on the claim, or an unspecified principal dx.

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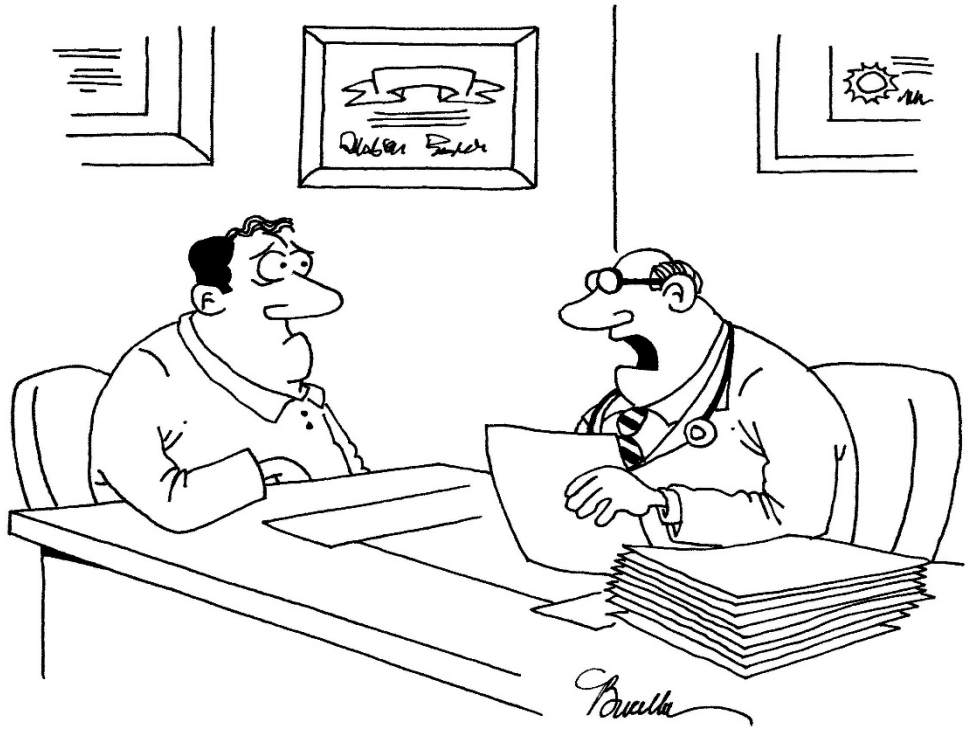
Claims submissions . . .

- Payer specific criteria can become a “foul” in the game One commercial payer may require modifier 59 over X modifiers for outpatient claims (or LT/RT vs 50). Maybe they prefer HCPCS codes over CPT. In these cases, the coding may be accurate, but the “risk” is really about payer preference. This is a definite “challenge” in the game!



“Laughter is the best medicine, but your insurance only covers chuckles, snickers and giggles.”

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Claims submissions and finding “penalty” flags . . .

Example 1- Outpatient claim billed with surgical path is w/o surgical REV code

Example 2- Outpatient claim with billed radiologic guidance biopsy code missing the surgical bx code

Example 3- Inpatient claim billed with surgical REV code w/o a PCS code

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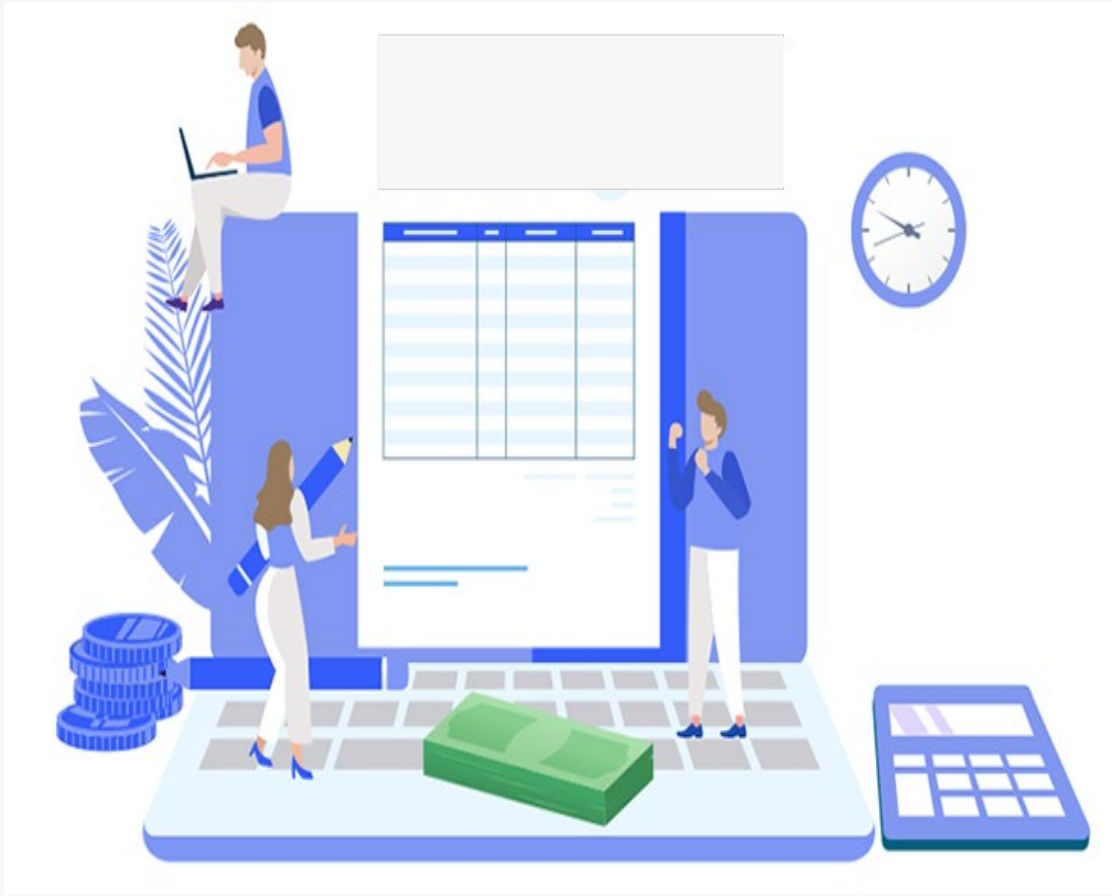
Payer policies . . .



Payer policy vs. facility contract?

Who manages this and how is it communicated?

Unlike CMS, COMM payers often do not have scheduled timelines for updates to their payer policies. This proves to be a challenge in the "payer game".

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Internal Resources . . .

Coding Accuracy/QA results- What coder specific education needs are there?

Who triages your facility audits/ denials and decides where they should be routed to?

Understanding “which” payment methodology

Denials- What are your highest volume of denials based on the denial category (i.e., is it medical necessity or coding or other). Evaluate that more granularly within the specific category for the specific denial reason (i.e., insufficient or ambiguous documentation). Consider the denials with the highest financial impact. You cannot solve everything. However, strategically utilizing the data from your current denial's can be useful to identify future risk and ideally prevent future denials

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Use your external resources. CMS has valuable reports that can be utilized (i.e., CERT) https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

Table L4: Top 20 Service-Specific Overpayment Rates: Part A Hospital IPPS

Part A Inpatient Hospital PPS Services (DRG)	Claims Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	2,923	$1,830,461	$47,210,817	$1,154,625,072	4.0%	3.2% - 4.7%
Major Hip And Knee Joint Replacement Or Reattachment Of Lower Extremity W/O MCC (470)	585	$3,700,075	$7,534,754	$528,805,646	47.8%	43.1% - 52.5%
Percutaneous Intracardiac Procedures W/O MCC (274)	459	$4,625,630	$11,128,489	$511,070,034	42.2%	37.4% - 47.0%
Endovascular Cardiac Valve Replacement & Supplement Procedures W/O MCC (267)	457	$2,405,576	$18,894,500	$201,463,359	12.9%	9.8% - 16.0%
Psychoses (885)	344	$323,407	$4,054,467	$179,313,067	7.7%	3.4% - 12.1%
Combined Anterior/Posterior Spinal Fusion W/O CC/MCC (455)	96	$918,061	$3,691,299	$170,447,055	25.4%	13.3% - 37.5%
Spinal Fusion Except Cervical W/O MCC (460)	76	$336,344	$2,103,445	$143,169,201	16.2%	7.6% - 24.7%
Endovascular Cardiac Valve Replacement & Supplement Procedures W MCC (266)	284	$1,498,014	$15,429,424	$112,416,408	9.7%	6.3% - 13.1%

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Medicare FFS Supplemental Improper Payment Data

Table 13: Top Root Causes for Endovascular Cardiac Valve Replacement & Supplement Procedures (266, 267)

Root Cause Description	Error Category	Sample Claim Count
Preoperative surgeon's office notes - Missing	Insufficient Documentation	86
Documentation to support medical necessity for the procedure – Missing*	Insufficient Documentation	37
Discharge status incorrectly coded*	Incorrect Coding	36
NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation	13
Incorrect secondary diagnosis code- DRG change*	Incorrect Coding	5
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

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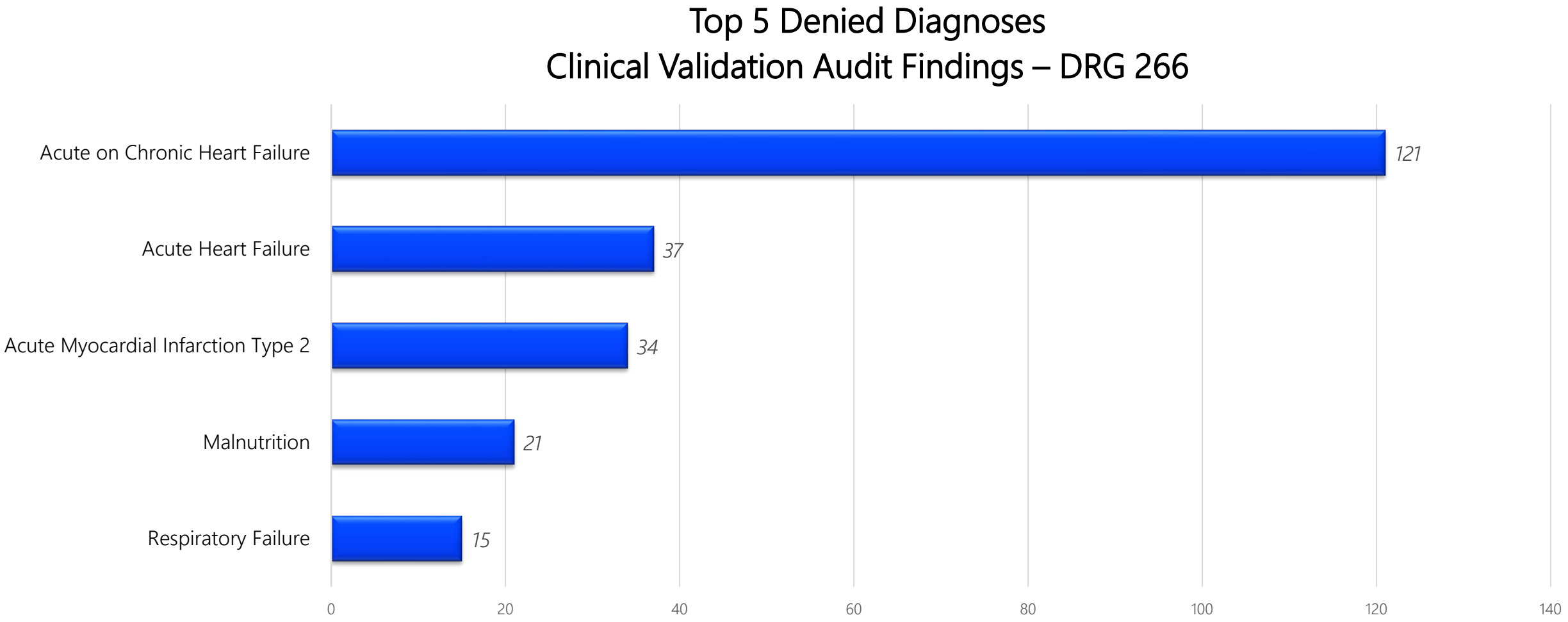
Example: External Clinical Validation Audit Findings for DRG 266 with MCC ENDOVASCULAR CARDIAC VALVE REPLACEMENT AND SUPPLEMENT PROCEDURES WITH MCC



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Key Audit Findings

Heart Failure in Transcatheter Aortic Valve Replacements (TAVRs)

Conflicting/ambiguous documentation of the “currentness” of the acute portion of the heart failure

- **Presented in a prior encounter with acute on chronic valvular heart failure**
- **Acute on chronic carried forward/ambiguous whether it is current to this elective TAVR encounter**
  - Corrective actions on TAVR Audit Findings
- **Provider education**
- **clinical validation queries**
- **coder education**

Given all these pieces, this area is easily targeted by payers through data: DRG 266, admit type elective, only MCC is acute or acute on chronic heart failure

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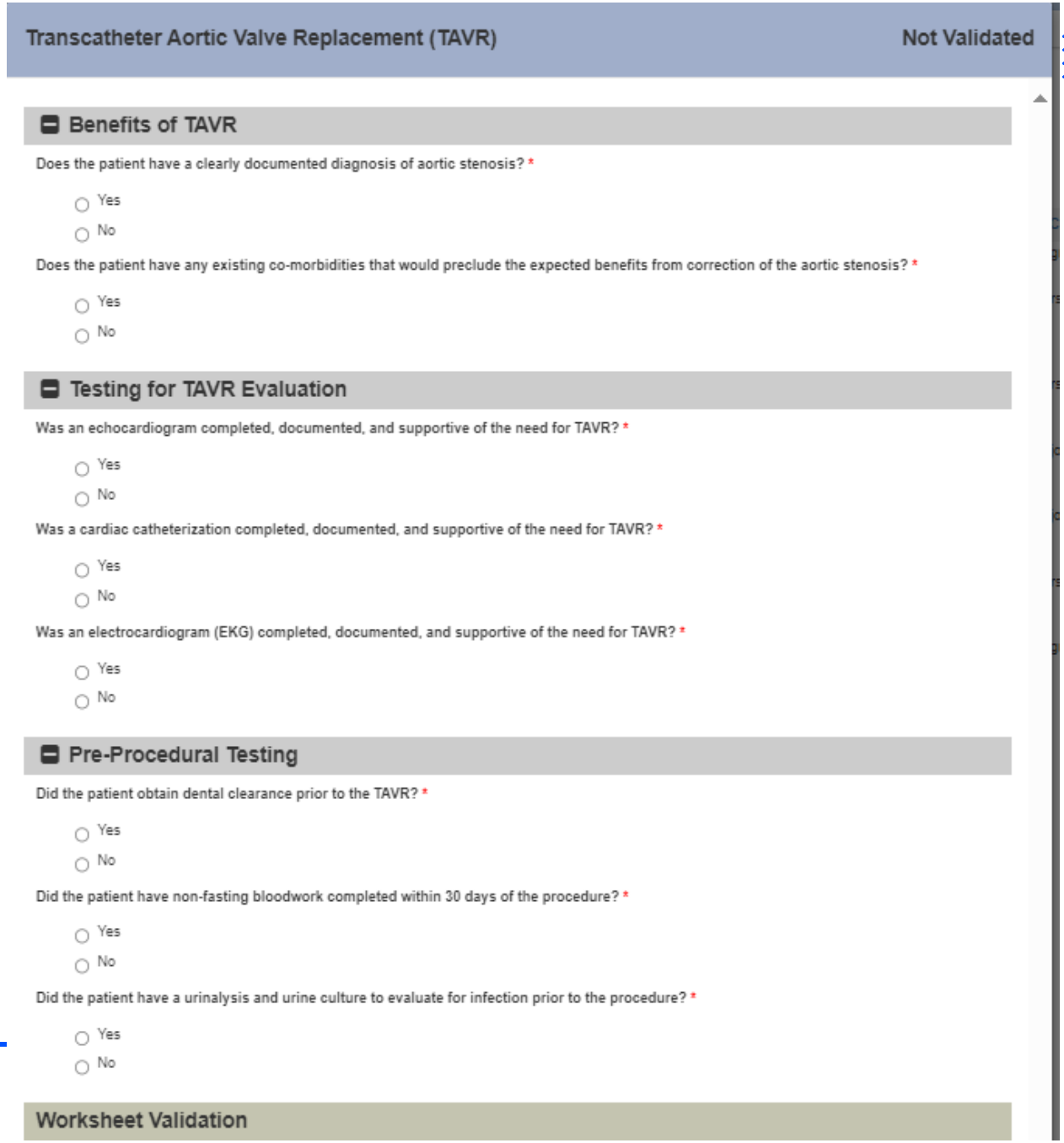
Create tools such as checklists for reviews i.e., looking for support for NCD, LCDS (or other clinical criteria)

Templates- for writing appeals



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Missing Documentation: Does the existing documentation not support what was coded or is the documentation missing all together?

https://www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf

Table 2: Top Root Causes for Hospital Outpatient

Root Cause Description	Error Category	Sample Claim Count
Documentation to support medical necessity - Missing	Insufficient Documentation	57
Order - Missing	Insufficient Documentation	39
Provider's intent to order (for certain services) - Missing	Insufficient Documentation	38
Order - Inadequate	Insufficient Documentation	26
Documentation for the associated diagnostic lab test(s) - Inadequate	Insufficient Documentation	20
Documentation for the billed date of service- Missing	Insufficient Documentation	19
Service code billed is changed to the service provided and/or ordered*	Incorrect Coding	17
Attestation for unsigned documentation - Missing	Insufficient Documentation	16
NCD requirement(s), other documentation required for payment - Missing	Insufficient Documentation	16
Physical/Occupational/Speech Therapy - Certification/Recertification - Missing	Insufficient Documentation	15
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

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The Administrative burden “pitfall” meeting all the deadlines . . .

Timely claim filing (coding the claim, insurance coverage issues)

Timely submission for record requests

Timely Appeals (who reviews, writes and sends it, who tracks it, who follows up)

Timely re-billing when appropriate, posting to the account etc.

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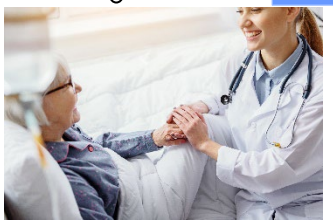
The Payer Games

A journey to a TAVR (transcatheter aortic valve replacement) and a provider's journey to receive payment.

Start - Patient is unwell



Patient referred to cardiologist who recommends a TAVR

Scheduling the TAVR procedure

Surgeon on vacay
Miss a turn

OR Block open
Move Ahead 1

Pre-registration complete

MD Notes complete for Prior Auth
Move up 1

Eligibility and Prior Auth

Back 3 Spaces
Insurer changes & delays

Procedure Rescheduled
Lose a turn

TAVR completed
Patient is feeling better

Coding: Choose a code?

Charge Posting

Skip One Turn
Charge entry delay

Time to Charge

Query hold
Lose a turn

Billing

Claim Submitted

Oh No!
Claim Rejected! Back to Billing Cleanup claim and resubmit

Corrected Claim Submitted

252/16/197 CARC
Submit records

Post Pay ADR

TAVR Internal Audit
Rebill

Claim Paid

Wait for claim payment

DENIAL / APPEAL MISS A TURN

Submit Medical Records

Missed sending in MD notes
Miss a turn

Appeals Management

Appeal Won

Wrap up- Revenue cycle is complex and no game at all!

- Payer complexity can impact patients and providers ability to get paid
- Understanding the rules and pitfalls is critical to your success
- Pairing technology with a collaborative team approach will reduce redundancies, inefficiencies and can guarantee your ascendancy in the “payer game”

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Questions?

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