Hospital Claim Payments – Due Diligence for Payers

Written by Jakki Lynch

Hospital claims are typically the largest and most challenging risk for health plans and payers. Although clinical outcomes may be favorable, inappropriate billing practices and errors, significant inflation of charge and non-covered services may not be identified, resulting in excessive claim payments. Negotiated contract terms should be applied to correctly billed charges and using discounts alone is not an effective strategy to mitigate risk. Ensuring claim payment integrity either prospectively or retrospectively is a necessity which can be challenging due to the complexity and high level of detail inherent in hospital claims.

Recent healthcare reform changes resulting in unlimited benefits increase the risk threshold from hospital claims. According to a 2011 report by the consulting firm Milliman, the average cost of health care for American families doubled from 2002 through 2011. Costs will continue to escalate, adding increased risks to payers and their insureds.

In a recent Time Magazine article, journalist and author Steven Brill presented his very timely and provocative 11-page cover story, Bitter Pill. In his article, Steven Brill gives numerous examples of hospital charges:

"What are the reasons, good or bad, that cancer means a half-million- or million-dollar tab? Why should a trip to the emergency room for chest pains that turn out to be indigestion bring a bill that can exceed the cost of a semester of

college? What makes a single dose of even the most wonderful wonder drug cost thousands of dollars? Why does simple lab work done during a few days in a hospital cost more than a car? And what is so different about the medical ecosystem that causes technology advances to drive bills up instead of down? When we debate health care policy in America, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: Why exactly are the bills so high?"

This is a key point because if the chargemaster rates are significantly inflated, payers, even with the most leverage due to volume, are negotiating contractual discounts from potentially inflated chargemaster rates. The inflation of charge cannot be ignored as this can be as important as the accurate billing for the services received. Both impact the cost significantly. Hospitals should receive a reasonable margin over the cost of their services and payers should understand and monitor charge levels as well as billing practices.

What can be done to address these issues? By dissecting the medical bills, Brill says we can understand how and why we are potentially overspending and where the dollars are going.

Key considerations for payers include the following:

Hospital charges – the financial significance

According to the Centers for Medicare and Medicaid Services, hospitals are the largest segment of U.S. health expenditures at 31%. Payments to U.S. hospitals are expected to increase over 76% from $794 billion in 2010 to $1.4 trillion dollars annually in 2020.

Industry guidelines for hospital claims

Hospitals submit claims using the UB-04 form which contains a summary of charges in categories and record formats defined by the National Uniform Billing Committee (NUBC). The NUBC was established to develop a single billing form and standard data set that could be used nationwide by institutional providers and payers for handling health care claims. The NUBC was formed by the American Hospital Association (AHA) in 1975 and it includes the participation of all the major national provider and payer organizations.

The UB-04 form is summary data only. Hospital claims are typically paid based on the two or three page UB-04 form only. The itemized detail of charges comprising the summary data is generally not requested or reviewed by payers. However, this is a critical piece. Often a series of errors can be uncovered by going beyond the summary data and doing a "deep dive" for details.

In addition to the NUBC Guidelines, payers may also have their own supplemental guidelines for hospital claim payments including claim review policies, provider manuals, the definitions of covered and non-covered services and payment policies for distinct medical services.

Claim Reviews and Due Diligence

An effective review of facility claims requires a flexible yet thorough process including coding and regulatory compliance as well as clinical expertise. Payers typically do not have these skill sets available as internal staff resources nor do they have the ability to devote the time necessary for an in-depth review. The payer's provider agreements should also be considered to ensure that payment guidelines are specified and payment integrity practices confirm the right to review claims based on industry standard and plan specific references. The selection of claims for review should be based on recognition of the amount of the requested contracted payable and the financial risk. In and out of network claims should be considered for review prior to payment based on the pre-audit payable amount of $150,000 or more.

The following case studies demonstrate the importance and financial significance of performing facility claim reviews:

Case Study – Claim Review #1

- Prospective Payment Review
- Payable Charges without Review: $2,005,998
- Payable Charges After Review: $1,611,191
- Claim Review Savings: $394,807 – 19.7%

Claims were incurred for twin preterm babies with 4 month inpatient NICU stays. The health plan received the medical records prior to claim payments. The specialty clinical and coding compliance teams identified significant room and board acuity adjustments based on the NUBC Guidelines. The billed room charges were not consistently supported by documented nursing resources received by the babies. The claim payments were prospectively adjusted to address the overstatement of patient acuity and related daily room and board charges for selected dates of service. The facility agreed with the recommended payment adjustments.

Case Study – Claim Review #2

- Retrospective Payment Review
- Payable Charges Without Review: $2,366,414
- Payable Charges After Review: $1,039,742
- Claim Review Savings: $1,326,672 – 56.1%

An adult was admitted to the ICU for transplant evaluation and surgery. Pharmacy charges comprised 54% of the claim. The claim review team clinicians evaluated the reasonableness of units charged for a pulmonary vasodilator which was administered throughout the stay. Based on the prescribed dosage and a daily assessment of medication administration, the clinicians identified a billing error of $1.3 million which the facility agreed to refund since the claim had already been paid by the health plan. The refund was obtained even though the payer waived the right to audit as a condition for a 50% discount under the terms of the single case agreement.

Case Study – Claim Review #3

- Prospective Payment Review
- Payable Charges Without Review: $135,159
- Payable Charges After Review: $95,042
- Claim Review Savings: $40,117 - 29.7%

An adult with a genetic metabolic disorder received outpatient specialty drug infusions. The payer had access to a 50% contractual discount. The unit price of the drug was evaluated based on estimated facility cost and margin benchmarking. The pre review contracted amount payable resulted in a markup of approximately 422% over the facility's cost. A case specific carve out rate was negotiated for this patient based on a reasonable margin for the facility as well as recognition of ongoing health plan exposure for the treatment. Annual claim savings from the review were approximately $321,000. Although the payer had a significant contractual discount, it did not reasonably address the high charge level for this specialty drug.

These case studies demonstrate that an effective claim review process needs to be thorough, supported by experts with a broad range of subject matter and clinical expertise with the results communicated effectively and professionally to providers. The reviews should be based on a claim specific risk management perspective rather than a standardized formula

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based approach. References to support claim review adjustments should be transparent and based on accepted industry standards.

Resources for Hospital Claims Due Diligence

Some companies may utilize a partner to implement effective claim reviews with optimal financial outcomes. Successful resolution of the review findings with a facility is an important detail to highlight as this process requires a special skill set to address the discoveries as well as time to come to an agreement. It is important that during this course, payers hold firm as successful settlements are about patience and persistence for a positive mutual outcome. ■

Jakki Lynch BSN, RN, CCM, CMAS is Vice President, Clinical Director, Critical Response Team, PULSE + Plus™, the medical management program for PartnerRe Health. Jakki developed PULSE + Plus™ - a unique program to assist health plans with the complex tools and expert resources needed. The PULSE + Plus™ resources are customized for each payer's needs to achieve significant savings with no impact on provider relationships, patient balance billing or additional staffing requirements. The PULSE + Plus™ team has significant experience supporting health plans providing collaborative and consultative solutions.