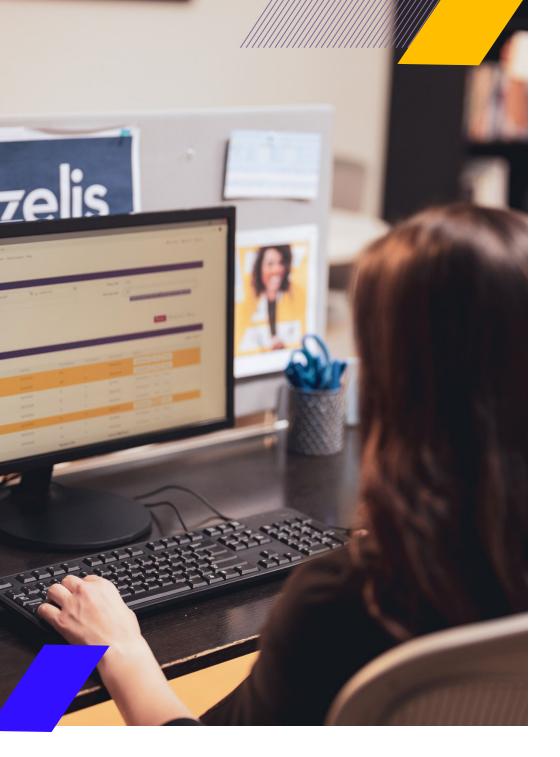# Top 6 Challenges to Improving Payment Accuracy

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Introduction

Waste in the healthcare industry adds up. It accounts for approximately 25% of all healthcare spending. A significant chunk of that waste is attributed to administrative burden and overpayments. All healthcare stakeholders have a role to play in curbing this waste. One of the most powerful tools that payers can use is payment integrity.

Payment integrity programs tackle waste by identifying inaccurate coding and billing that ultimately lead to inaccurate payments. Managing these inaccuracies helps keep the rising cost of healthcare manageable while reducing provider abrasion.

Health plans face six prevailing challenges to their payment integrity efforts:

- Cost of payment corrections or inaccurate claims
- Compliance challenges
- Inefficient processes
- Highly complex claims
- Expertise and staffing
- Provider abrasion

With the help of a payment integrity partner, health plans can address and overcome these challenges by streamlining processes, improving accuracy in coding and billing, and maintaining improved relationships with providers. This partnership enables health plans to focus on their core mission of delivering quality healthcare while managing costs and maintaining compliance with industry regulations. Such collaboration is essential in transforming challenges into opportunities for improvement and efficiency in the healthcare system.

The cost of correction

The cost of errors quickly mounts. In 2023, Medicaid had an improper payment rate of 8.58%, a total of $50.3 billion. Chasing down those errors comes at a price.

"There are many costs associated with ensuring that payments are accurate," says Timothy Garrett, MD, chief medical officer at Zelis. "For providers, the financial burden includes the administrative overhead required to manage and contest claims, often involving dedicating staff and time. Payers must invest in claim processing systems and employ teams of auditors and claims reviewers who meticulously verify the accuracy of claims."

Payers are required to identify the billing issues that lead to overpayments, which often requires additional coding or clinical expertise for the payer to hire and maintain. That doesn't include the additional costs required to chase down unrecovered payments, which fuels their rising costs.

Payment integrity can reduce the need for these costly corrections. "It's not about denying payment to providers," Jon Grandstaff, general manager and senior vice president of payment integrity at Zelis, observes. "It's about paying the appropriate amount every single time."

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A payment integrity partner significantly reduces the need for postpayment corrections by ensuring reimbursement accuracy upfront. Utilizing a team of expert coders and clinicians, supported by advanced technology, a partner like Zelis is able to review and verify claims in a prepay environment. This meticulous approach prevents costly "pay and chase" scenarios, streamlines payment processes and upholds financial stability by catching discrepancies before payments are issued.

AI can sift through mountains of medical records and documentation to identify potential errors and trends. Once human experts know where to look, they can apply their expertise to the complexity of claims and make the right decisions. This combination of technology and human expertise drives review efficiency, reduces turnaround times and empowers expert reviews with all the supporting and ancillary information to allow them to make the most appropriate decisions.

"We augment our decisions with the deep expertise, credentials and years of experience our professionals bring, ensuring accuracy in every case," Grandstaff adds.

Complexity of regulatory compliance

Payers are subject to maintaining compliance across many facets of the business, specifically around prompt payment on tight timelines.

"Payers must not only adhere to external regulatory guidelines but also manage unique contracts for each provider and facility they work with," notes Garrett.

Payers must navigate the claims process efficiently and accurately, but shifting regulatory requirements and increasing high-cost claims complicate payment integrity.

High-cost claims require payers to delve into proper clinical documentation and billing accuracy, which is no easy task as high-cost claims tend to be incredibly complex. Overbilling, discrepancies and other errors that slip through the cracks have a significant financial impact.

The time-consuming process of claims review challenges payers to meet their regulatory obligations, but the right partner offers the technology and people necessary to manage compliance.

"When you have a partner who has teams of people, that's what their full-time job is -- keeping up with regulations," says Grandstaff.

Those teams of people do not stand alone. They have access to technology that powers prepay and postpay claims reviews, both important elements of payment integrity. Prepay reviews catch errors before payers reimburse claims. This process is an opportunity for payers to build stronger relationships with providers through education, reducing abrasion in the future.

The complexities of claims management and gathering all necessary documentation mean prepay reviews aren't always possible. A claims-review partner may need to dig deeper to confirm potential issues via postpay reviews. However, their team's experience and technology ensure payers still meet the turnaround times regulatory compliance demands.

Inefficiency and inconsistency

While attempting to ensure payment accuracy, payers will encounter inconsistent billing practices, difficulties gathering the necessary documentation and provider appeals.

While digital transformation has driven significant healthcare improvements, manual processes continue to persist in many areas. And in the world of digital transformation, interoperability presents a challenge.

These process-related issues can make payment integrity resource-intensive and, as a result, drive up costs. Issues like staffing shortages and cybersecurity threats compound the increase in costs. The tangle of process-related issues, unsurprisingly, leads to higher costs.

In 2023, medical spending on claim status inquiries hit $12.5 billion, up 71%, according to the 2023 Council for Affordable Quality Healthcare "CAQH Index Report." Increased volume and workforce issues were two of the culprits behind that increase.

Technology continues to be a critical element of the solution. The right technology can streamline processes to drive great efficiency and lower costs. "Using automation and artificial intelligence is important to help decrease the number of manual steps," says Grandstaff.

A strategic partner can tailor its AI capabilities to fit the specific needs of a payer. If a payer is concerned about inconsistent billing practices in a specific area, such as high-cost drugs, a strategic partner's AI-driven algorithm can find outliers and help human experts know where to look.

Increasing complex claims

Maintaining payment integrity for high-cost, complex claims is a challenge. These claims require more payer resources to review and ensure accuracy before reimbursement. And the number of these claims is growing. For example, the share of higher intensity level 4 outpatient office evaluation and management claims was 19% in 2004. Over the years, those claims have become more common, hitting 37% in 2021, according to the Peterson-KFF Health System Tracker.

Tackling that complexity requires a two-pronged approach. A payment integrity partner will have both the human intelligence and technology ready to help payers work through those high-cost, complex claims, ensuring accuracy and identifying savings opportunities.

A strategic partner can customize advanced technology to service the specific needs of a payer, but technology alone isn't enough. Expert coders and clinicians provide the human intelligence essential to understanding the nuances of complex claims and achieving payment accuracy.

"Some decisions require medical records and can only be made by trained individuals reviewing those records," Garrett explains.

Mounting high-cost, complex claims are taking more of payers' time and resources, but they cannot forget about the more basic claims. "It's important to take care of those less complex ones as well because if you completely ignore that, then there could be lots of overpayment hidden in there," says Garrett.

A strategic partner can give payers the scale and support they need to achieve payment integrity across the entire range of claim intensities.

Staffing and expertise shortage

The healthcare staffing crisis is ongoing, laid bare and exacerbated by the COVID pandemic. While provider shortages garner a lot of attention, payers also feel the pinch. Payers need experts to manage the increasing influx of high-cost, complex claims. But hiring and retaining those experts is easier said than done.

While internal talent is a valuable resource, many payers need help. A payment integrity partner can offer a robust team of expert coders and clinicians supported by the latest technology. That external team can seamlessly integrate into a payer's workflows, augmenting internal teams' capabilities.

With the right combination of external support, payers can scale and ensure payment accuracy even as claim volume and complexity increase.

Impact of provider abrasion

Payers and providers must work together to ensure patients receive care and providers are reimbursed for that care. But that relationship can quickly become contentious. Providers can view the claims-management process as convoluted, opaque and directly contradictory to their ability to provide care.

Yet payers and providers do have a common goal: to deliver timely and appropriate care. Provider abrasion, the name for that tension between payers and providers, can make it difficult to see that shared aim.

Provider abrasion can be costly for payers. A deteriorating relationship between payers and providers can make it more difficult to obtain important documentation and records required for the claims review process. In turn, that makes it more difficult for payers to reimburse claims on time and accurately. Provider appeals add another layer of complexity that requires payer time and resources. In some instances, that relationship can reach a breaking point. A provider may decide to no longer work with a payer.

That's why building positive relationships with providers is invaluable for payers. When people on a payment integrity team can easily communicate with billing departments, payers and providers can establish relationships that are collaborative, not combative.

Provider abrasion can be a tough cycle to break. How can payers build those collaborative relationships? Education and transparency are vital to strong payer-provider partnerships.

"Helping providers comprehend the application of regulations, guidelines and code descriptions to their claims is crucial," says Garrett.

Payer requests for documentation and claims decisions can seem hard to understand without that information. A strategic payment integrity partner has expert team members who can demystify the process and educate providers.

"We aim to offer clarity on the rationale behind decisions and the status of claims," Grandstaff states. "Our goal is to ensure transparency and information provision."

Choosing a payment integrity partner

Payers have an important, and challenging, role to play in the healthcare industry. They connect their members to vital healthcare services and reimburse providers for those services. While they have a shared mission and responsibility, payer needs differ vastly. Payers serve different markets, requiring varying claims management and payment integrity approaches.

The right payment integrity partner recognizes the unique needs of individual payers and works to meet them instead of offering a one-size-fits-all solution. That kind of customizable service is delivered not via just the right technology or the right people but both. A superior partner uses AI to strengthen the human capabilities that remain essential to claims management and payment accuracy.

While payers have unique needs, they operate in a shared industry. Understanding how their peers manage overpayments and address payment integrity can be useful, but there isn't a significant source of public data to tap. A payment integrity partner with broad experience across different markets can offer that.

"Partners can assist in benchmarking, offering insights into the performance of your payer organization relative to similar entities," Garrett emphasizes.

Addressing the six challenges to payment accuracy is crucial for reducing healthcare waste, ensuring regulatory compliance and optimizing claims processing. Payers can significantly improve payment accuracy through collaboration with strategic partners and the effective use of technology and expert analysis. This multifaceted approach not only curtails healthcare costs but also elevates care quality, highlighting the essential role of payment integrity in improving the healthcare system.

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About Zelis

Zelis is modernizing the healthcare financial experience by providing a connected platform that bridges the gaps and aligns interests across payers, providers and healthcare consumers. This platform serves more than 750 payers, including the top five national health plans, BCBS insurers, regional health plans, third party administrators and self-insured employers, and millions of healthcare providers and consumers. Zelis sees across the system to identify, optimize and solve problems holistically with technology built by healthcare experts -- driving real, measurable results for clients. Learn more at **zelis.com**.

Zelis exclusively employs closed-source AI platforms to enrich its product suite, ensuring adherence to legal, ethical and industry-leading standards and practices. All outcomes undergo rigorous and continuous scrutiny by Zelis personnel to uphold and ensure the highest levels of quality and reliability in the AI community.

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