AArete
Payment Intelligence®

THE HIDDEN COSTS

How Fragmented Payment Solutions Undermine Efficiency and Long-Term Success

© AArete, LLC | ALL RIGHTS RESERVED

Table of Contents

Overview 2

The Major Role Payment Policies & Related Edits Play in Payment Accuracy 3

Diving into Details: Accurate Contract Configuration 5

8 Focus Areas for Provider Data Management that Impact Payment Accuracy 7

Breaking Down Benefits to Improve Payment Accuracy 9

The Impact of Prior Authorizations on Claims Payment Accuracy 11

Summary 12

About AArete & Contacts 13

Overview

Payers have a fiduciary responsibility to pay claims accurately. The process of adjudication requires streamlined communication and processing across multiple payer departments, interfaced systems and add-ons, workflows, and external vendors, which opens up the doors for processing inefficiencies and risk exposure to payment errors, including misplaced payment responsibility on members and providers. AArete's highly customized plan-specific solution helps payers transform their end-to-end claims process by focusing on the identification and resolution of known payer challenges resulting in higher rates of claims being paid accurately the first time. We help transform our clients from Payment Integrity into Payment Intelligence®.

Payment Intelligence® take a holistic approach to unveil opportune areas for significant cost savings through optimizing processes, people, technology and organizational culture to increase profitability and enable increased focus on quality of care.

This e-book navigates select Payment Intelligence® areas of expertise and serves as a guide on how to approach these complex subjects.

Explore how Payment Intelligence® can help your organization by clicking below:

LEARN MORE

The Major Role Payment Policies & Related Edits Play in Payment Accuracy

A health plan's payment policies provide the billing and payment requirements for services and procedures (including unit limitations). These policies are based upon industry guidelines and standards such as CMS, state regulatory agencies, NCCI, CPT Assistant, HCPCS Manual, ICD Guidelines and various specialty publications, as well as specific health plan policies. Such policies can be superseded by federal/state regulations, as well as the terms of provider contracts. To ensure reimbursement, it is the responsibility of providers to bill claims in accordance with the health plan's payment policies. In turn, the payers have the responsibility – to their individual members and employer groups (who pay the premiums, deductibles, and co-pays), as well as to the taxpayers for government-funded plans – to pay claims right and in accordance with their published policies and regulatory guidelines.

Payment policies play a vital role in improving payment accuracy – but only if the plan adheres to those policies. The process around creation, implementation, maintenance, communication, and enforcement are all important to ensure that the policies remain purposeful, relevant, and adhered to by providers, both in and out of network. Maintaining a comprehensive set of administrative, clinical, and reimbursement policies is essential for health plans to process claims efficiently, apply the appropriate benefits, and reduce unnecessary costs. While policy maintenance will always have an important place in healthcare, it is especially relevant in the healthcare system of today that employs a variety of reimbursement models, on the spectrum from fee-for-service to value-based care to full capitation models, which all rely on the complete, accurate and timely transmission of 1) claims data for payment and 2) encounter data to report health care information used to calculate risk.

But where should health plans look to ensure their policies are effective, comprehensive, and up-to-date and to determine the need for new policy creation or for the implementation of policy changes to ensure compliance with the standards? Managed Medicare and Managed Medicaid plans should look to the guidance published by CMS.gov as a starting point. Commercial and Exchange plans should also pay close attention to the policies implemented by CMS as they are often a precursor of where the industry standards are headed. For example, Medicare's three-day (or one-day) payment window policy, which dictates when pre-admission charges should be bundled with inpatient claims, has been widely adopted as a standard billing and reimbursement policy across various lines of business. Even commercial plans recognize the intent of these policies and can implement similar ones to achieve comparable results. Other reputable organizations to which health plans can look for guidance on policy creation and maintenance include the National Uniform Billing Committee, The American Medical Association, and coding guidelines developed by national societies to name a few.

Once your organization has set up a comprehensive database of policies derived from the guidance from reputable industry standards, what can go wrong from here? First, many payers have issues keeping up with the continuously updated billing and coding standards, which cause policies to quickly become outdated without the appropriate maintenance. Furthermore, many health plans have issues operationalizing their policies due to system limitations, workflow issues and manual process requirements, change management concerns, lack of resource requirements, and the potential for provider pushback, to name a few. These issues result in a lack of coordination between the policies and the edits used to deny claims, thus resulting in erroneous claims payments.

Consistency in application can also be a problem when there is a disconnect between the corporate payment policy and the local-level application of that policy. Varying degrees of adherence and enforcement of corporate policies across markets within the same health plan cause confusion that leads not only to missed opportunities for cost-savings but can also cause provider abrasion, compliance issues, and potential legal exposure if policies are applied inconsistently and/or inappropriately.

The common errors that impact the enforcement of payment policies and the resulting claims payment accuracy can be grouped into five categories:

POOR COMMUNICATION OF POLICIES

Provider access to and communication of payment policies is critical to assure providers understand the billing requirements that are essential to the payment integrity process.

OUTDATED POLICIES

Keeping up with continuous updates across various industry sources that result in additions, deletions, and/or minor tweaks to coding requirements and policy guidance is vital to ensuring best practices in payment accuracy are being followed.

MISSING OR MIS-CONFIGURED EDITS

Cross-alignment between payment policies and edits is vital to employing best practices in payment accuracy. When a health plan's claims processing system has misinformed logic tied to an edit, the integrity of claim payments is impacted. Amongst others, edit logic issues may include incorrect or incomplete lists of CPT/HCPCS codes, inaccurate edit assignments based on the line of business, improper application between facility vs. professional edits, inaccurate unit limitations, improper configuration of edits based on provider contract exceptions, and programmable edits that are missing, customized off or otherwise not configured.

BROKEN MANUAL PROCESSES

Certain payment policies are more complex in nature, creating difficulties in the configuration of the claims adjudication system and resulting in the deployment of manual processes which are susceptible to human error. In addition to clerical errors, inadequate workflows and/or lack of training are the usual culprits when it comes to inaccuracies in this category.

PROVIDER ABRASION CONCERNS

Inconsistent or incorrect policy application sometimes results from payer concerns about the potential for provider abrasion. Health plans are very careful to manage their provider relationships, especially when certain market dynamics exist that give providers additional leverage. In these instances, it is critical for payers (including those in the provider contracting department) to understand any risks of non-compliance, as well as to be educated on the overall market acceptance of the related edit (i.e., are denials under this edit consistent with denials performed by other payers in the market?).

It's imperative health plans create and maintain a comprehensive database of policies reflecting the best practices in the industry. That information should be cross-walked to company policies, which should then be compared to existing edits, to ensure alignment and consistency. By operationalizing and enforcing both new and existing policies through the implementation of edits using software, manual workarounds, and third-party vendor solutions, payers can reduce those complexities that are likely causing limitations within existing systems and workflows.

Diving into Details: Accurate Contract Configuration

A successful health plan offers the highest quality of healthcare to its members while operating efficiently with a strong network of healthcare providers at market-negotiated rates.

While the process to finalize a contract can sometimes take months, once signed, the importance of keeping both parties (the payer and the provider) happy in their relationship lies in symmetrical interpretation and execution of the agreed-upon pricing (e.g., rates, groupers, fee schedules) and payment terms that include lesser of language, payment hierarchy, outlier provisions, unlisted services, and other carve-outs. If the terms are not straightforward enough to be passed on and interpreted identically across departments in either organization with easy efficient processing, the relationship will surely suffer.

While it sounds very simple, incorrectly interpreted or inaccurately configured contracts are a key driver of the costs to adjudicate claims, which are amplified by claims payment inaccuracies and process inefficiencies caused by appeals and grievances, post-pay adjustments, pend volumes, and manual processing and/or pricing. The ability to accurately configure provider contracts and efficiently adjudicate claims can be enhanced by following a few key recommendations focused on understanding the configuration process and the limitations of the adjudication system, including the need for customizations and workarounds.

NEGOTIATE CONTRACTS THAT CAN BE CONFIGURED

Most standard negotiations result in reimbursements set at a "simple" fixed percentage of a defined rate that may be based upon provider's billed charges, Medicaid rates, Medicare rates, or the payer's custom fee schedule. In some of the more complex cases, custom terms and provider-specific rate cards are negotiated, resulting in highly complex contract carve-outs, including contract terms that are so complex they cannot be configured in the payer's adjudication system, resulting in pended claims and manual adjudication processes. As a result, complex contract terms can be more costly to the payer (and much simpler) than the alternative standard percentage-based rate. Health plan contract negotiators should be well-versed in how contracts are configured in the adjudication system and the related system limitations, including the related costs to manually process claims.

NEGOTIATE CONTRACTS THAT ARE EASY TO CONFIGURE

While some contracts are able to be configured, they sometimes require significant hours from the configuration department to load correctly. Contracts with multiple custom carve-outs, modifier-based rate adjustments, time- or age-based adjustments, or sequence-based rates typically require customizations or workarounds (beyond simple configuration), as well as the involvement of the plan's IT team to accurately execute. Other contracts have terms that require the health plan to update the rates on an annual basis, which is costly to administer, especially when the rate revisions are delayed, causing claims submitted at the beginning of each contract year to fall victim to manual pricing errors. Health plan contract negotiators should understand the costs associated with creating IT customizations and workarounds, as well as the costs associated with manually-priced claims (including an understanding of the potential for manual volumes associated with each contract).

NEGOTIATE AMENDMENTS THAT ARE TRANSPARENT IN COMPARISON TO THE BASE CONTRACT AND PRIOR AMENDMENTS

Many factors can lead a payer and provider to renegotiate a contract or to add an amendment to adjust select terms. For every amendment, it is important that the document clearly articulates which reimbursement terms are changing and which are not changing in comparison to the most recent agreement. When the complexity of an amendment doesn't mirror the base contract's level of complexity (low to high, high to low), it can often lead to gaps in configuration, and ultimately to inaccurate claim payments. Avoiding transparency issues is generally as easy as running the amendment by the configuration team for consistency and transparency review prior to signature.

MAINTAIN A CLEAN CONTRACT MANAGEMENT SYSTEM

Depending on the age of a health plan and the span of products it offers, a base contract with a provider can evolve to tens if not hundreds of documents across decades. Saving, storing, and maintaining an accurate and searchable repository of contracts, amendments, W-9s, and other related documents become increasingly difficult. Adding in the impact of department turnover, cross-departmental collaboration, and technologies that change and evolve every few years, makes contract management increasingly difficult. Plans with proper organization of contracts and amendments typically have higher accuracy in adjudication.

REQUIRE FREQUENT AUDITS AND SAMPLING OF CLAIMS (INCLUDING A FEEDBACK LOOP) ACROSS THE CONTRACTING, CONFIGURATION, AND CLAIMS TEAMS

As contracts grow increasingly complex with arrangements focused on value and quality, constant communication and feedback between the contracting, configuration and claims teams increases in importance. Health plans should ensure that audit and feedback loops exist between the departments to confirm contracts continue to be negotiated with terms that can be configured, as well as configured and processed as per the negotiated terms.

Ensuring contract terms are properly configured, claims are paid accurately, and operational processes are efficient and effective is the foundation of the claims process. Identifying configuration gaps, inaccurate claim payments, and process improvement recommendations are the building blocks. Enabling health plans to operationalize changes, whether it's related to system set-ups, provider communications, or process improvements is the finished product. Allowing claims paid under provider contracts to be cleanly auto-adjudicated with as little manual intervention possible is key in keeping operational costs low. Both the contracting department and configuration department play key roles in ensuring that contracts are negotiated in a manner that can be configured and maintained easily, with minimal intervention, configuration, and other work around requirements.

> *Allowing claims paid under provider contracts to be cleanly auto-adjudicated with as little manual intervention possible is key in keeping operational costs low.*

CLICK TO LEARN MORE

8 Focus Areas for Provider Data Management that Impact Payment Accuracy

Managing a network of healthcare providers presents many challenges. Given the wide variety of data collected, maintained, and distributed by network management teams, maintaining a network's provider data can become a nightmare when not managed effectively. Even small gaps and inefficiencies in data management can cause major issues across the health plan, especially when not quickly addressed.

Errors in provider data account for the top reasons' claims are pended or processed incorrectly, leading to frequent reprocessing and even potential fines, often attracting unwanted attention from providers, members, and regulators. This can be frustrating, given the widely accepted belief that quality provider data is difficult to collect, validate, and update within reasonable turnaround times. Many plans are forced to rely directly on providers to submit rosters of data, which are often not the group's top priority to maintain or distribute. Even when relying on delegated groups and IPAs, it can be challenging to receive accurate data at the required frequency from providers.

Below are identified areas of PDM pain points and the ongoing and evolving challenges they face:

1. MEMBER ABRASION

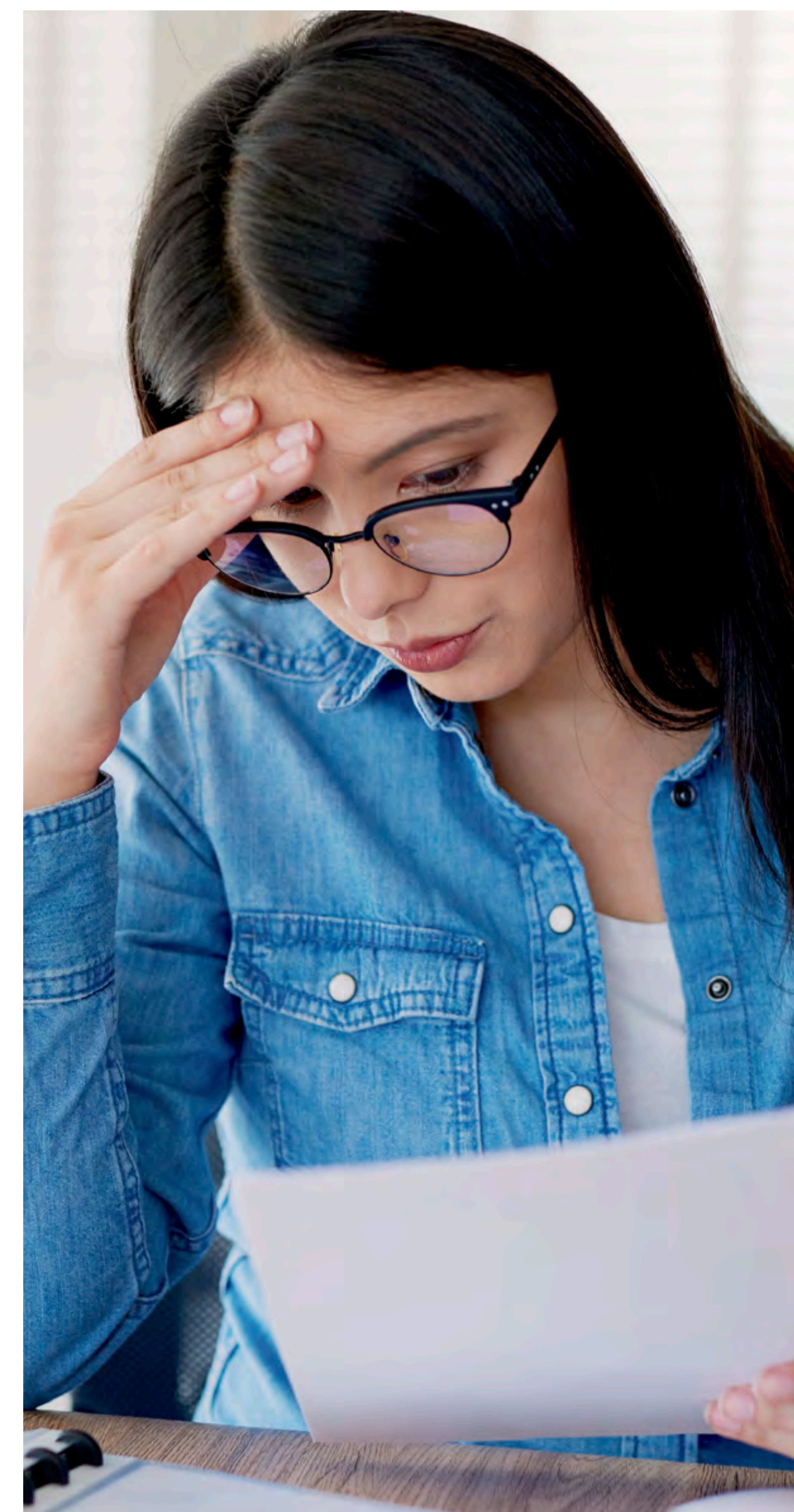
As with all areas of payer operations, the primary objective is to ensure adequate care is being provided to members. Members need access to an accurate list of in-network specialists. They must feel confident that they are assigned to an appropriate primary care physician. They need to access and understand provider directories to locate urgent care facilities and clinics for rapid-response treatment. Any gap in provider data that leads to a member having even a slightly difficult experience locating or receiving healthcare must be treated as a critical risk to payers, even if it is as "simple" as incorrect provider demographic information such as suite or telephone number. If these gaps are not remediated, the impact on members can quickly snowball to become catastrophic.

2. PROVIDER ABRASION

Keeping providers happy is a critical goal of health plans. When providers join a payer's network, they expect their information and data to be managed with the utmost care. Every physician, facility, pharmacy, and lab must be accounted for in a payer's system. Any inaccuracy may lead to issues including incorrect claims payment, authorization issues, PCP assignment issues, publishing incorrect data in a provider directory, the list goes on. If a provider feels their data is not being collected, stored, and updated in an accurate and timely fashion, that provider becomes a risk. In their view, these errors are not just inconsiderate to them as providers but are also dangerous to members. Whether choosing to act on their own behalf or in defense of their patients, providers will not hesitate to raise concerns if they feel a health plan is not maintaining their data at a high standard. In these instances, they will not hesitate to amend or terminate their contracts, alert regulators, or take legal action.

3. STATE/REGULATOR ABRASION

Maintaining a good relationship with regulators is crucial to any payer looking to maintain or expand their current book of business. Generally, this relationship is managed by specific teams that are responsible for producing reports, sharing information, and providing updates to specific regulators. However, this department is not usually responsible for the maintenance of accurate data, as they rely on a PDM team. Due to the demanding nature of many regulators, other teams typically don't have the time or resources to



validate the accuracy of the data they use to respond to regulators' demands. They run the risk of being caught off guard when regulators bring up issues that have been escalated to them from members and providers. It may not be immediately obvious from where these issues stem and performing root cause analysis is often time-consuming and expensive. In order to keep regulators happy, it is critical for all teams to have a high degree of confidence in the provider data that they use.

4. CMS ABRASION

Everyone fears a CMS audit. Similar to state and local regulators, CMS and the federal government have a say in how provider data should be maintained. In fact, it is common for federal, state, and local requirements to be in conflict with each other, which creates challenges for the PDM team that is trying to manage a large network. In any case, PDM teams must have documented policies and procedures that comply with all levels of government oversight, while simultaneously meeting contractual obligations, provider requests, and internal corporate goals. Once these are established, payers need to face the challenging task to develop processes, metrics and quality checks that accurately measure the PDM team's performance on meeting these requirements.

5. NETWORK ADEQUACY AND ACCURACY

Finding out that your network has gaps can be scary. Any issues in network can escalate from any of the previously mentioned groups, and any suspected issues in your underlying data must be promptly remediated. However, before those issues can be resolved, fingers will be pointed, and blame assigned. More often than not, the PDM team is an easy target because they manage the overall provider data, and as a result they are accountable for any and all gaps in accuracy, regardless of providers and other departments that share in the responsibility to exercise checks and balances leading up to the current issue at hand.

6. UNDERUTILIZING TECHNOLOGY

We read about new technology all the time. Apple, Google, 5G, Tesla, block chain, Bitcoin, ChatGPT/generative AI. It's a lot to keep track of. Unsurprisingly, it can be difficult to tell where a healthcare payer fits into this new world of technology. Provider data management is not often the target of new and exciting innovation, with entrepreneurs preferring to focus on shiny, marketable areas that will be more visible to patients, providers, and regulators. It can be difficult to find support, funding, or even interest in upgrading the technology used for PDM, despite its critical role in the success of the health plan's operations.

7. MISSED NETWORK OPPORTUNITIES

Even if things are going well (which in PDM is often defined as "no major catastrophes yet today"), mismanaged data inhibits payers from realizing a number of opportunities. Truly accurate and complete provider data can tell a lot of stories to other departments. Where are our contracting opportunities? How can we foster better relationships between patients and providers? Are we utilizing our entire network to maximize its impact on our members? Even if a health plan has decent data, it's critical to understand how to extract, cleanse, and interpret provider data that answers these questions. Sadly, these types of initiatives are often forgone to make time for dealing with day-to-day maintenance and issue remediation. When this happens, opportunities (and money) are left on the table.

8. INEFFICIENT USE OF RESOURCES

Due to everything discussed so far, it is easy for payers to fall into a similar pattern when dealing with provider data. It is easy for the department to become reactive, focused on daily issues resolution and the prioritization of escalated items in order to narrowly avoid ruining a relationship with a member or provider. This leads to a high demand for skilled, manual data entry resources who can react quickly to the changing demands of the network. Not only can this lead to an inefficient use of time and resources, but it also puts payers at risk of becoming reliant on a group of employees performing reactive, manual tasks to avoid disaster. It's an odd feeling to simultaneously worry about having too many resources devoted to manual data entry, but also worry about what would happen if even a few of the experts leave the company.

These focus areas often require difficult conversations with providers, members, and regulators. These challenges range from quick fixes to complex overhauls of provider data management, including but not limited to:

- Roster and PDM accuracy audits
- Claims data mining and analytics
- Customer Relationship Management (CRM) optimization and turnaround time reduction
- Add/Term/Change process optimization and documentation
- Advanced Master Data Management (MDM) solutions to ensure consistency and accuracy across multiple systems
- Contract/Amendment implementation tracking, quality checks, and key performance indicators (KPIs)
- Incorporating third-party sources into the data validation process, including CAQH, NPPES, state files, and Google Maps API
- Reports, dashboards, and other tools that track discrepancies and changes to provider data over time
- In depth analytics on a number of challenging data elements, including phone numbers, address, ADA accessibility, BH expertise, taxonomies, provider specialties, new patient acceptance, etc.

Provider Data Management is a multi-faceted focus area requiring intensive, cooperative tech stacks and intentional data design frameworks. With strong dependencies demanding intelligent digital and data solutions, the key to simplifying the complexity is by ensuring that the digital and technology framework supports the organization's specific, targeted needs and is sustainable for profitable business growth.

Breaking Down Benefits to Improve Payment Accuracy

Benefits are often ignored when it comes to focusing on impactful initiatives to improve payment accuracy. Although benefits are an important component of delivering accurate coverage to health plan members, often other initiatives receive more attention given the immediacy of cost savings. However, healthcare payers should take a closer look at how benefits shape provider actions and can affect exposure to wasteful or inappropriate provision of services and supplies.

Top reasons benefits should be a focus, enabling healthcare payers to further improve payment accuracy include:

HEIGHTENED REGULATORY COMPLIANCE

Benefits managers are commonly nested under the compliance department. The driving force behind payers' benefits review comes from regulatory and contractual requirements to provide certain services or risk. The reviews are often driven by:

1. Penalties from the governing body that sets the rules, whether that be CMS or State regulatory agencies,
2. Contractual terms
3. Dissatisfaction of employer groups or individual enrollees.

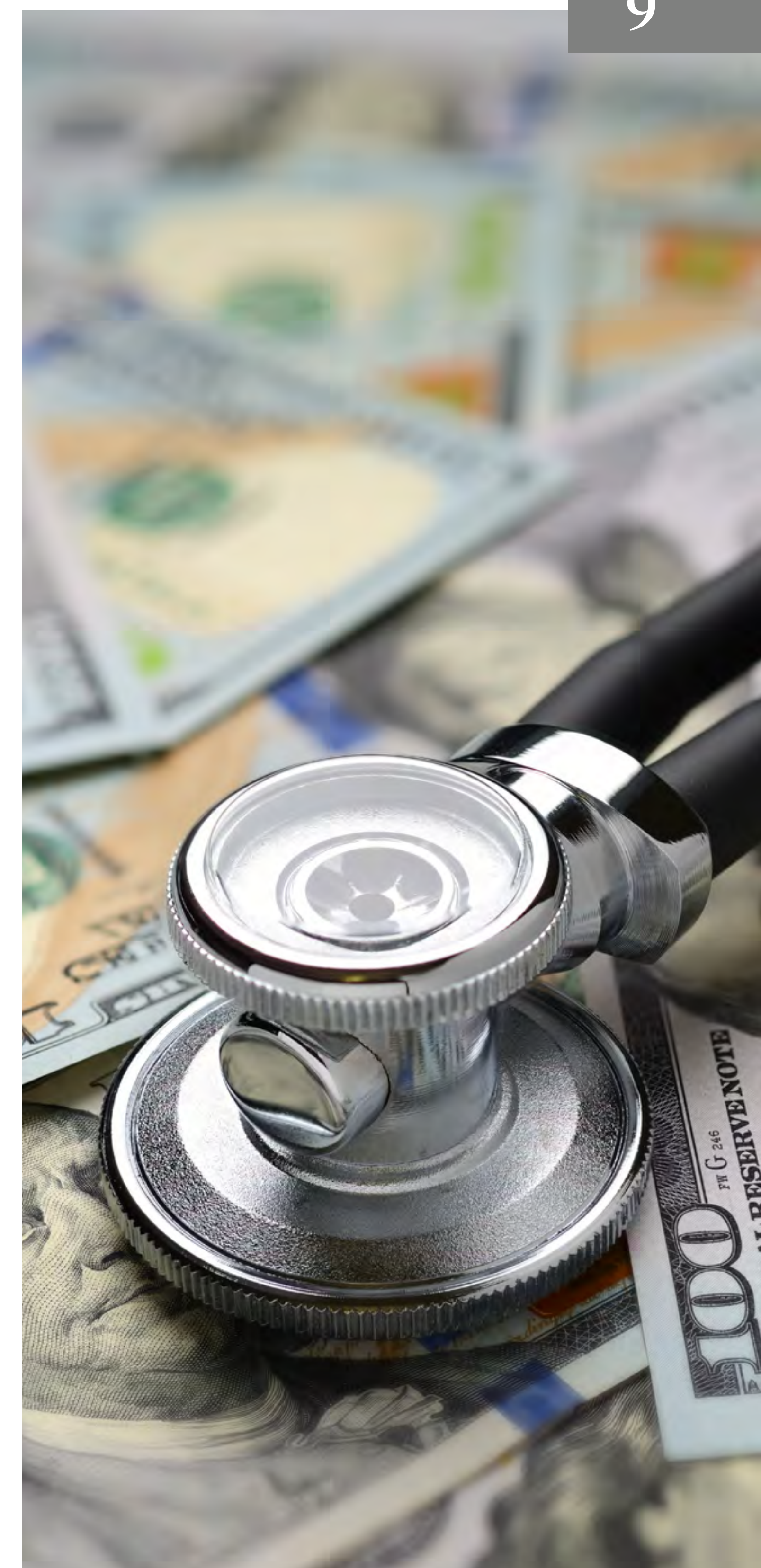
Having a solid reputation for improving member outcomes ensures customer satisfaction and goes a long way in growing membership, while consistently delivering on essential health benefits to cover a given standard of care that gives regulators peace of mind.

UNNECESSARY SERVICE UTILIZATION

Published benefits give members and providers guidelines on appropriateness of care. Maintaining a website or application of health plan coverages and communicating updates with providers signals that the payer understands the effectiveness of certain procedures and prompts providers to deliver cost-effective high-quality treatments. When providers and members understand covered benefits and service limits, attempts to utilize non-covered services plummets. Once benefits and their associated limits have been established and communicated to providers and members, the utilization of those benefits should be quantified and tracked. As the saying goes, "you can't manage what you don't measure." Measurement opens up the floodgates for assessment of performance from a quality and cost-effectiveness standpoint. If a specific benefit limit is constantly being hit or challenged in appeals, then the payer is in a position to evaluate limits in comparison to those set by other payers in the market, consider whether it is a specific population of members that requires additional care, or investigate if it is an instance of fraud, waste, or abuse. As a result, the outcome results in a reduction of excessive or unwarranted services, while ensuring a more fiscally responsible use of funds for their intended purposes.

COVERED SERVICES REIMBURSEMENT AND PRIOR AUTHORIZATION LIMITS

Configuration of benefits and their limitations are critical to achieving payment accuracy. Configuration involves setting up the adjudication system to pay only for services covered by the plan design and properly authorized in accordance with medical management requirements which includes tracking of maximum units accumulated over time. This requires that benefit accumulators be set up to properly deny claims in excess of covered or authorized limits. This also requires proper interface with medical management's prior authorization systems.



Prior authorizations should be strategically set up to reduce waste/abuse and minimize the financial operational burden on the health plan, while still ensuring that member safety requirements are met. To improve utilization and compliance, as well as to minimize payments for wasteful and abusive claims, prior authorization requirements need to be properly communicated and easily accessible to providers and members.

SERVICES PER MEMBER

A sick member is an expensive member, so payers typically do everything in their power to enable members to seek preventative treatment which sustains optimal health. However, there are a multitude of factors that can cause providers to overtreat patients, especially if there is a fee-for-service agreement in place. Including appropriate levels of treatment or steps in the treatment process within benefits will guide providers to consider the appropriateness and cost of care before ordering additional tests or performing a procedure. That same guidance can also be used to incentivize treatments for those who may be receiving a lower standard of care, thus creating a healthier member in the long-term. This dual effect cuts costs in the short-term and lowers risk in the long run, a two for one!

ADMINISTRATIVE BURDENS ON HIGHLY-SKILLED RESOURCES

Physician and nurse wages associated with managing benefits and associated authorizations are some of the costliest. Their clinical expertise and specialized skillset is needed to assess medical necessity of a given treatment or procedure. With an increased focus on maintaining and communicating benefits to members and providers, a payer can reduce its reliance on high-cost clinical services with proper leveraging of benefits frameworks.

While benefits are only one contributing factor to payment accuracy, a health plan should further analyze subsets within benefits to discover cost savings opportunities that also optimize quality of care. The granularity of benefits may seem daunting, but by deploying digital and data solutions such as the use of artificial intelligence (AI), predictive analytics, and the build out of data visualizations and user-friendly dashboards, health plans can simplify processes and analyses to prevent further cost hemorrhaging. These integrated solutions are designed to empower meaningful business decisions yielding measurable results, opening up the door to analyzing areas of the business that are often neglected.

The Impact of Prior Authorizations on Claims Payment Accuracy

The purpose of a prior authorizations (PA) is to aid health plans in the management of care to their members, ensuring patient safety and validating the medical necessity of services, while also overseeing the cost of care. Having an efficient and accurate process to manage PAs can impact multiple aspects of a health plan's business including enhanced member care, utilization management, provider relations, and claim payment accuracy.

Providers often find the PA process to be tedious and time consuming due to the lack of information and transparency into a payer's PA requirements. As each payer has different PA guidelines, if not clearly documented and communicated, providers tend to cover their risks by over-submitting PA requests, which leads to additional administrative burden for both sides and can ultimately impact a member's care.

There are both process and configuration opportunities on which health plans can focus to further improve the PA experience, manage utilization, and control costs.

One of the most important aspects of an effective PA process is to actively manage and regularly review PA guidelines to stay up to date on regulatory requirements and best practices within the market. It is important to share updates with external parties like providers and members; however, it is equally important to share changes with internal parties that facilitate the interface of the PA and claims adjudication systems in order to ensure payments are made only for properly authorized services and only up to the authorized service limitations.

PAYING FOR CLAIMS WITH NO AUTHORIZATION ON FILE

A common disconnect occurs when the claims system is not set up to automatically interface with the PA system and its requirements, leading to claims being paid improperly without having an active or matching PA on file. A similar issue occurs when a claim is flagged for manual PA review by a claims examiner, who manually overrides the system to pay for an unauthorized claim in error. This is typically a result of unclear documentation in the department's policies and procedures and/or vague training.

PAYING FOR CLAIMS WHEN AUTHORIZATION IS FOR AN UNRELATED SERVICE

An improper interface between the PA and claims systems can lead to claims being paid based on a PA on file that is not related to the actual services rendered, such as paying for a service or procedure that has been up-coded to a higher level of service, is a higher-cost code that is in the same range/family of codes or is otherwise different from the one that was authorized. Without a proper automated interface or well-documented manual processes to guide claims examiners, discrepancies in the services actually rendered can lead to improper payments.

PAYING FOR CLAIMS THAT EXCEED THE AUTHORIZED UNIT QUANTITY (ACCUMULATOR ISSUES)

Matching the PA to the correct claim is crucial; however, maintaining and managing to the number of units approved and allowed per a health plan's policies is equally important to ensure payment accuracy. If a member is authorized for a certain number of units for a particular product or service, but the units accrued are not being tracked or are not being properly accumulated over time, then it is possible to pay for units in excess of the authorized service limit.

Claims systems often have difficulty tracking the accumulation of services, especially across multiple claims. Systems are often able to compare the units on a single claim to the authorized amount, but unable to accumulate the units on multiple claims submitted over time. As a result of non-functioning auto-accumulators or non-diligent claims examiners, overpayments can occur.

Health plans can strengthen the PA process by focusing on these key actions:

- Comprehensive assessment of the current state comparing PA requirements to regulatory/policy requirements, best practices, and system set-ups
- Cost-benefit analyses resulting in recommendations to remove/add procedures from/to the PA grid based upon utilization, optimization, and member safety
- In-depth claims analysis identifying inaccurate claim payments and configuration set-up opportunities
- Technology improvements such as PA lookup tools

Often times, the dedicated subject matter expertise and market intelligence required to deploy these solutions is greater than the resources at hand. Partnering with a subject matter expert armed with proven digital and data capabilities will play a large role in the impact prior authorization practices have on claims payment accuracy.

Summary

Accurate payment processing is essential for health plans, yet the industry's common approach of repeatedly "finding and fixing" issues can become a costly and reactive cycle.

AArete has worked with **over 70 health plans** to integrate plan-specific policies, contractual obligations, and regulatory requirements into a more proactive decision-making process.

Payment Intelligence® addresses the root causes, taking a holistic approach to helping health plans adhere to regulatory requirements while saving valuable time, reducing costs, strengthening provider relations, and improving payment accuracy, member satisfaction, and operational efficiency.

Thank you for taking the time to read *The Hidden Costs* e-book. We hope the insights shared here resonate with your experiences and concerns.

CALCULATE YOUR SAVINGS OPPORTUNITY!
Provide a few pieces of information and see the estimated impact on your claims payment process.

GET STARTED!

Up to 5%*

First-Year Medical Claims Savings above and beyond savings identified by other vendors or internal processes

Up to 18%*

Annual Reductions in Administrative Costs by systematically eliminating inaccuracies and driving productivity improvements in the claims payment lifecycle

*Typical client savings

Humanizing Data for Purposeful Change® | AArete.com

AArete is a global management and technology consulting firm dedicated to driving profitability, digital transformation, and strategic change. Our data-driven solutions, powered by market intelligence, deliver purposeful change and guaranteed results. We humanize data, turning numbers into actionable insights to help clients make better decisions. With a focus on optimizing profits quickly, we foster change with confidence, empathy, and purpose.

Contacts

Maria Turner
Managing Director
MTurner@AArete.com | 312.731.6173

The AArete Difference

MARKET INTELLIGENCE

DATA-DRIVEN STRATEGIES

WE IMPLEMENT

GUARANTEED RESULTS

ATTRIBUTING AUTHOR CREDITS:

(Sorted by last name)

Nick Bohacek, Patrick Glennon, Renee Knott-Freeman, Erica Nelson, Brian Poulter, Jeff Schacht, Adam Schulz, Maria Turner

© AArete, LLC. All rights reserved. This eBook and its contents are the intellectual property of AArete® and may not be reproduced, distributed, or used by any other parties without prior written consent.