



**Appeals Management in the
Revenue Recovery Process**

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❖ OVERVIEW

- **Challenge**

Claims payment audit and recovery processes are common to many managed healthcare organizations. This process seeks to identify over/under payments on claims followed by an effective course of collection on overpayments and resolution of underpayments¹. The “rubber meets the road” when parties disagree that in fact a payment error has occurred. When the affected party is a provider, the response mechanism takes the form of an appeal. As appeals can substantially increase both the cost and timeline of the recovery process, efforts to avoid them rewards the recovery organization.

- **Solution**

Significant efforts must be expended to ensure the accuracy of reported overpayments. In addition, the identification and reporting process needs to be supported by a reliable and robust electronic communication framework that allows sharing of the rationale for the overpayment and related support documentation with all stakeholders to the process, thereby creating the essential component to an efficient an audit and recovery process: Transparency. By implementing a robust documentation and communication solution, evidence supporting reported over/under paid claims is readily available for retrieval and review by all stakeholders. This can significantly reduce the need to refer claims back to the auditing / reporting party for clarification and additional information, yielding a more efficient process.

- **Benefits**

A reduction in the number of appeals translates to lower expenditures for the audit and recovery operation, an improved workflow process and enhanced providers relations.

One component of a successful revenue recovery operation involves a “contract compliance” audit. This involves a careful re-assessment of claims for payment integrity in accordance with the terms of the provider agreement. Whether a health plan is using an internal vs. business process outsourcing (BPO) option or manual vs. electronic methodology, one thing is certain: providers are intent on stemming revenue leakage and are aggressively responding to reported overpayments through the appeals process. It is therefore imperative that every effort is made to incorporate transparency into the process of communicating the contract compliance findings to providers.

Managing the appeals process requires a well designed process including

- a clear *understanding* of the business rules of the contract on the part of the health plan and the provider;
- effective *validation* of reported overpayments;
- *transparency* of the overpayment reporting process; and,
- an effective *response mechanism* to provider appeals.

There are many parties involved in a contract compliance reporting and response cycle including the health plan, internal/external claim auditing vendor, recovery personnel, network management, provider relations and the provider.

¹ Audits are performed both pre and post-pay. This paper deals with post-pay audits.

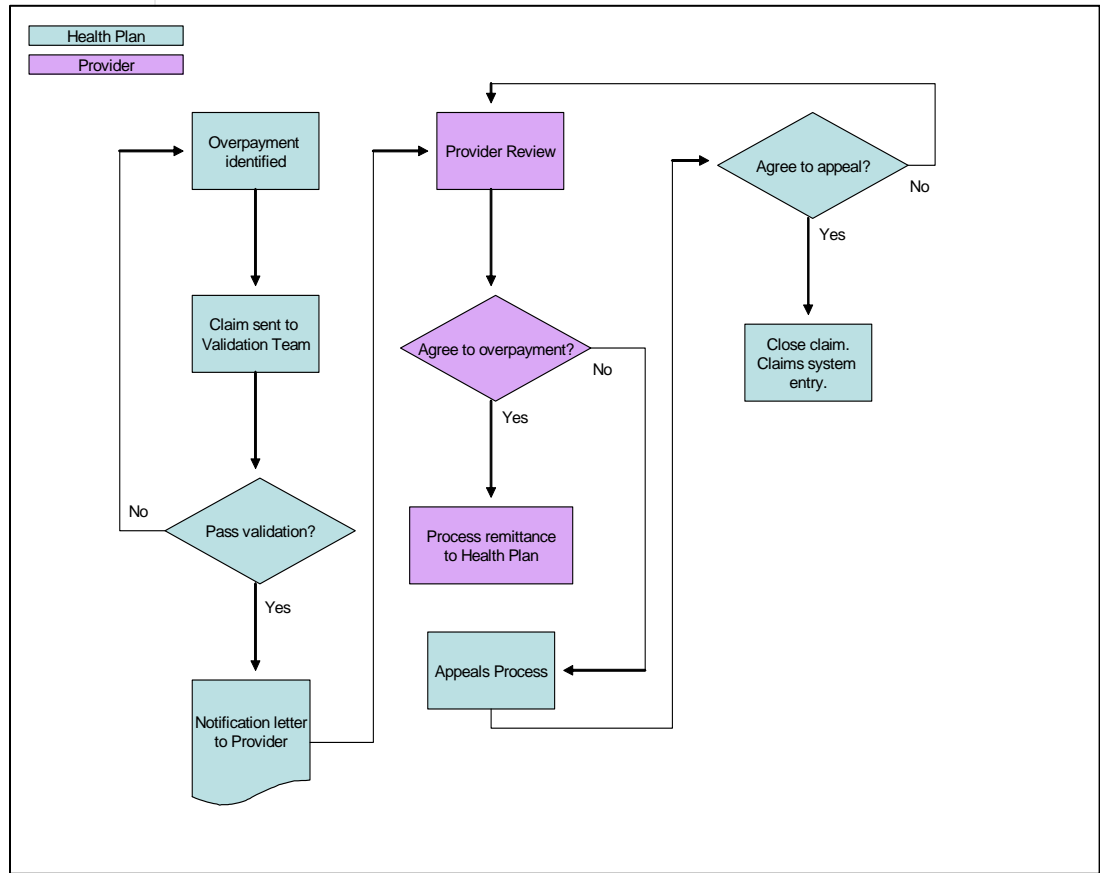
	<p>It is therefore important that the process is designed to provide all necessary information that each of these stakeholders might require to evaluate the accuracy of a reported over/under payment, the supporting contractual language and the validity of an appeal. Clearly, any solution to this challenge requires a rather robust technology.</p> <p>An effective revenue recovery operation will seek to maintain the lowest possible number of claims overturned on appeals for two reasons. Every successful appeal:</p> <ul style="list-style-type: none"> ➤ represents wasted resources expended on that particular claim, while <p>undermining a provider relationship that colleagues in the payer organization consistently work very hard to create, maintain and improve.</p> <p style="text-align: center;">❖ A clear understanding of the business rules of the contract</p> <ul style="list-style-type: none"> • Contract Intent Appeals management actually begins <u>before the signing of the contract</u>, with the health plan and providers' agreement on contract <i>intent</i>. In the absence of agreement on what the words in the contract <i>mean</i>, there are certain to be disagreements on appropriate payment levels later. Within many contracts, clarity of intent is blurred through careless word structure resulting in ambiguous and contradictory language. This often leads to unnecessary expense to both parties (as well as compromised relations) as each struggles to clarify <i>intent</i> at a point when perhaps large dollars are in play. • Contract Summary If the health plan's contract management system can generate a "contract summary", this can be a very useful tool to define <i>intent</i>. A "contract summary" can best be explained as a <i>quantification and qualification of the contract payment terms</i>. In other words, "this service, defined by this code (or group of codes) pays this amount in this manner (e.g. case rate, per diem, per visit, per unit, percent of charges, etc.); that service, defined by that code (or group of codes) pays that amount in that manner; this service, defined by this code (or group of codes) never pays; that service, defined by that code (or group of codes) always pays, etc.". Contracts sometimes quantify <i>when</i> a code pays by using dollar triggers (i.e. pay high cost prosthetics at 50% of allowable charges <i>if</i> charges exceed \$1400). The contract summary must have the ability to reflect all of these realities, replacing verbiage with payment terms defined in a clear, concise manner which any reasonable person can understand. Such a document can function as a highly effective authority when utilized in the contracting process. To more effectively manage the appeals process, stakeholders must understand the intent of the contract at the onset of contract term. <p>Often overpayments are erroneously reported due to a rate table change or an amendment that was not accounted for. Health plans and their vendors need to exercise caution in this regard. A good rule of thumb is that if a pattern of over/under payments emerges in the audit process, it is likely that either:</p> <ol style="list-style-type: none"> 1) a revised contract, amendment, addendum or rate table has not been properly accounted for, or; 2) a rule has been loaded to the health plan's repricing solution improperly.
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<ul style="list-style-type: none"> • Contract Summary (cont.) • Use Correct Information • Consistency of decision making • Consistency of the process & data 	<p>Diligence in discounting the one possibility, confirming the other and taking immediate corrective action is an essential and responsible exercise towards minimizing appeals at a later point in audit and recovery process.</p> <p style="text-align: center;">❖ Effective validation of reported overpayments</p> <p>Claims auditing is a rather complex process which requires that an analyst fully understand the intent of the contract as well as the adjudication mechanism that led to the overpayment (which cannot always be determined). Due to the sometimes subjective nature of contractual payment terms, some interpretations are lost in translation (see Contract Summary above). It is therefore important that the contract compliance process include a pre-reporting validation of over/under payments to ensure consistency of the decision making process.</p> <p>Some health plans adhere to a 100% validation process. While this may be perceived as time consuming and expensive, the investment is rewarded by a greater accuracy of reported over/under payments and the avoidance of wasted resources on the part of all stakeholders.</p> <p>Validation also serves as a quality assurance mechanism that will ensure maintenance of high standards for accuracy amongst the audit and recovery staff. Analysts failing to meet minimum standards should be identified and removed from the contract compliance process, as their contributions <i>will</i> actually prove to be counter-productive.</p> <p>Validation serves to ensure quality of the reporting data. In effective contract compliance operations, the communication and resolution of over/under paid claims is largely electronic and a single record may contain as many as 100 fields. As such, data and file formats must be strictly defined and maintained for efficient processing. Data errors, omissions and corruption need to be identified and corrected as early in the process as possible and returned to the reporting party for correction and re-submission, as all future remediation efforts depend on the reliability of this data.</p>
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❖ **Transparency in the overpayment reporting and appeals process**

- **Transparency**

Transparency in the over/under payment reporting process is critical to effective appeals management. Stakeholders benefit substantially by understanding exactly *why* the claim was determined as over/under paid based on the applicable contract language and having access to all reasonable data as may be required for a party to respond to the issue. This includes salient provider billing data, plan payment data, an explanation as to how correct payment was calculated per the terms of the agreement and the actual contract language pertaining to the issue.



- **Transparency(cont)**

In the simplified scenario reflected in the flow chart above, the claim is reviewed by:

- Health plan audit team
- Health plan validation team
- Provider denial management team (perhaps multiple times by different personnel)
- Health plan recovery team
- Health plan appeal response team

Maintaining efficiency throughout this progression of events requires a carefully designed, well organized and *transparent* process.

Transparency refers to providing clear and concise information regarding an over/under paid claim. Communications includes all information pertinent to the mis-payment including, but not limited to:

- An electronic file of all claims data that stakeholders may require to process the claim through the resolution process and *back into the plan's claim system*.
- A clearly written Provider Notification Letter which includes all the information necessary for the provider to fully understand the over/under payment issue and easily conduct their own review to support or refute a payment error.
- An *Explanation* supporting the rationale that the claim has been over/under paid that can be understood by any reasonable party to the process. (The Explanation is represented as a field in the electronic file and populates to the Provider Notification Letter electronically. See examples below.)
- Supplying *all supporting documentation* that a reasonable person would require in order to evaluate and respond to the over/under payment determination. This includes:
 - a. Contract identification (number / effective dates / product type / name)
 - b. Specific contract language pertaining to the particular claim / over/under payment
 - c. Clear explanation of how the claim was repriced by the audit team.

(Whatever contract compliance technology is employed by the health plan, it should have the ability to record "a" through "c" above, which can then be made available electronically to all stakeholders.)

- **Transparency(cont)**

How is a valid overpayment *Explanation* structured?

Here are a few examples of effective *explanations*. Note the specificity of the language.

Original claim allowed \$2122.35 minus patient responsibility; should have allowed \$1026.92 minus patient responsibility. Per the contract CPT Code 86850 is subject to CPT CAP on Exhibit 3456 pays \$16.50; CPT Code 86900 is subject to CPT CAP on Exhibit 3456 pays \$5.00; CPT Code 86901 is subject to CPT CAP on Exhibit 3456 pays \$8.70; CPT Code 86920 is subject to CPT CAP on Exhibit 3456 pays \$49.04; Revenue Code 460 pays (\$200.00) per visit (1); Revenue Code 940 pays (\$75.00) per visit (1); Revenue Codes 250/270/390/391 pay 50% of charges (\$1345.35) for \$672.68.

Original claim paid \$990.61 minus patient responsibility; should have paid \$1391.96 minus patient responsibility. Per the contract DRG 391 pays a Case Rate of \$1391.96.

Original claim allowed \$3387.60 minus patient responsibility; should have allowed \$645.74 minus patient responsibility. Per the contract Lab services pay per unit according to the fee schedule for \$39.69; CPT Code 95811 pays \$600.00 Per Visit (1); Revenue Code 250 pays 50% of billed charges (\$12.10) for \$6.05.

Diagnostic services were performed on the day prior to an inpatient admission (claim # 123456789) and had related diagnosis codes. Per contract these services are not separately reimbursed but are included in the inpatient admission payment.

❖ **SUMMARY**

Health plan's claim audit operations serve to ensure payment integrity. Provider's response may be to minimize this "leakage" from their organizations and aggressively pursue a "denial management" strategy. The result can be significant numbers of provider appeals, which increases the cost of revenue recovery operations and potentially puts provider relations at risk.

Failure to effectively communicate *why* a claim has been determined as over/under paid substantially increases the probability of an appeal. A well designed recovery operation includes a highly trained staff supported by current technology; a comprehensive over/under payment data set which serves to fully inform stakeholders of the relevant issues pertaining to each mis-payment; continuous quality improvement to the process; and, controls to ensure the health plan's determination and information is accurate.

- **About Chart-Tech**

Since 1981 Chart-Tech has provided cost containment and revenue enhancement solutions to healthcare. Hundreds of clients across the U.S. have benefited from the expertise and technology the company provides.
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