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Two Dozen Reasons Why Claim Payment Error Occurs

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Pioneering Specialists in Group Health Care

Post-Payment Administration for Over 20 Years

- First with 100% claim audits
- Introduced the use of claim audits for recovery
- Originated linking of enrollment reconciliation with claim audits
- Started dependent audits 15 years ago
- Revolutionized data intake with payer-defined downloads – always successful
- Unblemished track record – no HIPAA violations or employee issues

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Attendee Survey Responses

- Do you know any payer that pays claims correctly 100% of the time?
  - Unanimous “No”

- For a “typical” self-funded plan. What is the most common source of payment error?
  - Enrollees 20%
  - Providers 20%
  - Plan 0
  - Administrator 20%
  - All of the Above 40%

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Attendee Survey Responses

- How have levels of payment error changed over time?
  - Increased 40%
  - Decreased 40%
  - Same 20%
- Have the reasons for claim payment error changed?
  - Yes 80%
  - No 20%
- What is the likely impact of health reform on claim payment error?
  - Increase 40%
  - Decrease 60%

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Presentation Overview

Why can't claim payment errors be prevented or stopped?

Every group health payer has the goal of paying every claim correctly the first time.

No payer meets that goal.

Today we examine 24 questions that must be answered "yes" for correct claim payment, and the consequences of each "no."

NOTE: Not clinical care errors but errors associated with plan administration and payment processes.

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The Claim Payment "Gauntlet"

Stage	Step	Questions
Pre-Payment	Person Enrolls	1 - 2
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Pre-Payment: Person Enrolls

Questions	Consequence of "No"
1. Did the person completely and accurately fill out the enrollment application?	Stage set for payment errors. •Most common source of error. •Most overlooked cause. •Providers and payers take NO responsibility. •Updates and corrections NOT applied retroactively. •Plan must address.
2. Did the person report changes and updates in a timely manner?	

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Pre-Payment: Person Presents for Care

Questions	Consequence of "No"
3. Did the person report the correct source of health coverage?	Chain of Eligibility-Enrollment-Entitlement Once broken by person (through ignorance or intent) must be repaired by others or error ensues.
4. Is the person still eligible for that coverage?	
5. Has the person met all the entitlement requirements for coverage?	

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Pre-Payment: Provider Renders Service

Questions	Consequence of "No"
6. Is this a covered service?	Provider priorities ≠ Plan priorities Provider focused on best care for patient (and avoiding lawsuits). Providers will assume "Yes" and let payer deal with "No".
7. Have all required authorizations been received?	
8. Are all benefit limits and exclusions known?	

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Payment: Provider Bills Payer

Questions	Consequence of "No"
9. Are the diagnostic and procedure codes accurate, complete and appropriate?	Provider economic incentives ≠ Plan economic incentives Providers maximize income. Provider honesty required to avoid error.
10. Have all provider contractual relations been reported?	
11. When multiple payers are billed is only one billed as primary?	

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Payment: Payer Adjudicates Claim

Questions	Consequence of "No"
12. Are eligibility, enrollment and entitlement all confirmed?	Payer processes that rely solely on prior steps have more error.
13. Are all plan exclusions and limits enforced?	Payers must reduce prior error and not introduce new error.
14. Are all provider discounts and fee limits assessed?	Payer policies can and do differ from self-funded plan policies.

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Post-Payment: Payers Coordinate Benefits

Questions	Consequence of "No"
15. Are sources of other coverage identified and updated?	Coordination-of-Benefits (COB) Very "hit or miss"
16. Are other payers contacted to verify primary and secondary status?	Relies on what is known with limited investigation.
17. Are both duplicate payments and double payments identified?	Duplicate payments are different from double payments.

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Post-Payment: Medicare Status Reviews

Questions	Consequence of "No"
18. Are ALL types of Medicare eligible (aged, disabled, ESRD) identified?	Medicare is NOT limited to retirees. It impacts ALL plan error rates.
19. Are Medicare facts questioned as part of claim payment?	Medicare is one-sided, admittedly biased, and often incorrect.
20. Are procedures for Medicare collection in place and in use?	Without collection procedures, any review is simply there to comply with Medicare regulations, not to prevent against error.

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Post-Payment: Case Reviews

Questions	Consequence of "No"
21. Are all subrogation cases identified and pursued?	Any gaps in case reviews are linked to claim errors. •Payment errors associated with past claims for known cases (collection) •Payment errors associated with future claims for known cases (correction) •Payment errors associated with new claims for new cases (detection)
22. Are divorce decrees documented and enforced?	
23. Are stop-loss provisions verified and enforced?	
24. Are procedures for large case and/or claim review monitored and enforced?	

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Two Dozen Reasons
Why Claim Payment Error Occurs

Payment errors can be minimized but not eliminated.

Don’t wonder whether your self-funded plan has error.

Error detection, correction and prevention is on-going.

Audits help but are not enough without ...

Routine Performance Monitoring

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Past Webinars Available for Download

Recordings of past webinars are available through **Si's Library** (www.healthdecisions.com/library) including:

- April, 2011 - How Does Your Plan Compare?
- March, 2011 - How Medicare Can Help Employer Health Plans
- February, 2011 - Administrative Fee Inflation: Causes and Consequences
- January, 2011 - Planning for 2011
- November, 2010 - Provider Score Card: 5 Common Sense Tests to Foster Competition
- October, 2010 - Post Payment Administration: The Missing Link in Health Plan Management and Cost Control
- September, 2010 - Complete Enrollment: The Source of Cost Control

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For More Information

Contact

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We offer no-cost consultations

to answer questions and discuss options.