

**INGENIX<sup>®</sup>**

## Six Best Practices for Claims Editing



## Six Best Practices for Claims Editing

Controlling health care costs, keeping employers and providers satisfied, and maintaining optimum profit margins. Payers must continually balance these competing objectives, and that means processing claims as efficiently and accurately as possible. As health care costs continue to soar while profits stagnate, much of the blame can be traced to faulty claims processing.

Ineffective claims editing leads to a cascade of expensive problems, including high error rates, inaccurate and inconsistent assessment of claims, penalties for regulatory noncompliance, unnecessary overhead, and fraud and litigation costs. Moreover, the ability to attract and retain participating providers depends in large part on the payer's ability to process and settle claims quickly and accurately.

Ingenix is committed to lowering costs and strengthening the fabric of relationships between payers, providers, consumers and employers. Central to the Ingenix philosophy is the ability to fight billing errors, abuse and fraud through efficient and accurate claims processing. To help payers optimize profits—while avoiding claims disputes, litigation and deteriorating provider relationships—Ingenix has defined the following six best practices for claims editing.

### 1. Use the rules in effect on the date of service

#### The challenge

Billing codes and coding rules are in constant flux due to constant changes in the regulatory climate, Medicare requirements, commercial editing rules and in coding systems—with updates often occurring on a monthly basis. It is important to edit claims based on the rules and codes that were in effect when the provider actually rendered the service.

Failing to edit claims using date-appropriate rules inevitably leads to a higher rate of provider appeals. As a result, payers face the increased administrative costs of responding to appeals, potential litigation over reimbursement disputes and deteriorating relationships as providers struggle to understand claims denials and wait longer to get paid for their services.

#### The solution

To avoid these problems, payers need to use date-appropriate rules and codes in order to edit and pay claims accurately and consistently the first time. In fact, Medicare requires date-sensitive claims auditing. Ideally, claims editing software has the ability to automatically apply rules and edits based on the date service was rendered—giving payers the flexibility to respond immediately to rule and data changes without losing the ability to accurately edit claims for services performed while an earlier set of rules was in effect.

If the claims-editing software does not provide this capability automatically, the only option is to manually check edit results against the rules in force on a particular date. These manual checks can significantly increase claims-processing expenses and error rates, but may be necessary to satisfy Medicare requirements as well as commercial contracts based on the Medicare model.

Improper coding relationships that may be date-sensitive include:

- Unbundling
- Incidental services
- Mutually exclusive services
- New patient visit auditing
- Diagnosis to procedure appropriateness
- Surgical assistant appropriateness
- Maximum frequency per-day editing
- Place of service editing
- Procedure/diagnosis/modifier validations
- Multiple procedure reductions

### 2. Source edits at the code relationship level

#### The challenge

When edits to a claim result in reductions or denials, providers will want to know the reason for the edits. And as health care consumers bear an increasing share of the cost, they will want to understand the reasons as well. Failing to provide that information puts the payer at risk for costly appeals and even lawsuits. In recent years, legal challenges

have forced various health plans to reopen claims appeals, pay physicians for previously denied claims, and update their systems to provide transparency regarding rule sources and appeals procedures.

Beyond the threat of lawsuits, it is simply good business practice to provide transparency into edit sources—keeping consumers and plan members satisfied that they are being treated fairly.

#### The solution

In the past, claims processing vendors competed on proprietary edits based on their interpretations of coding and billing regulations. But with the growing demand for standards and accountability, today's best practice is to base edits on industry-recognized third-party sources, and to clearly document the sources and explain edits in language that providers and patients can understand.

Ideally, edits should be sourced and explained at the level of code-to-code relationships. Sourced edits should be based on AMA CPT guidelines, CMS guidelines, Correct Coding Initiatives, commercial and Medicare code sets, medical societies and other widely accepted third-party sources. As coding guidelines change over time, sourced edits should be kept up to date. Finally, all sourced edits should be accompanied by disclosure statements. Thorough, plain-language documentation helps providers and members understand the reasons behind the determination, thus reducing inquiries and disputes.

### 3. Provide full disclosure and transparency

#### The challenge

Some health insurance companies may find themselves burdened with an unfortunate history of regulatory noncompliance, coupled with a lack of transparency and disclosure in claims processing. In recent years, providers and health plan members have been pushing back, seeking the information they need to understand benefits and, if appropriate, to appeal claims reductions and denials.

Sometimes it takes a lawsuit to get payers to understand the

importance of transparency. In November, 2006, Blue Cross and Blue Shield affiliate Highmark settled a class-action suit originally brought by an elderly couple who were denied benefits with only a numeric rejection code on the EOB to explain the decision. As an attorney for the class members explained, printing a number on an EOB is “a far cry from telling someone what they need to know” to appeal a denial. In settling the case, Highmark agreed to reopen the appeals process for potentially thousands of previously denied claims, as well as to update its claims processing technology to provide clear descriptions and sources for more than 400 codes used on its EOB.<sup>1</sup>

The Highmark case is an important precedent illustrating the need for full disclosure and transparency in claims processing. It is not just a matter of avoiding lawsuits, but also keeping providers and members satisfied by giving them the information they need to understand the decisions made regarding health care provision and reimbursement.

Transparency is becoming even more important as health plans evolve to become more consumer-driven, pushing more of the risk away from health plans and onto lay members. This trend will increase the pressure for laws and regulations mandating completeness and clarity in the information provided to patients via web portals and EOBs.

#### The solution

When claims are denied, providers and members need to know the reasons why and, if they disagree, what they can do to appeal the denial. All of this information should be provided in language that anyone can understand. To cite one common example, when a procedure code for an individual lab test is denied because the test is part of a lab panel, the consumer needs to understand why the individual test and the full panel cannot both be billed together.

Ideally, the claims editing system has the ability to make edit messaging, rule sources and disclosure statements available to providers and consumers, promoting full understanding to minimize the impact of potential inquiries and appeals. In addition to citing the sources for all edits, as discussed in the previous section, this means enabling full visibility into the system's rule logic.

This logic should always be based on the health plan's specific payment policies, which in turn should draw upon nationally recognized and accepted sources—including AMA CPT guidelines, specialty society recommendations, the National Correct Coding Initiative and current medical practice standards. And it should be tied to complete, accurate disclosure statements—drafted in plain language—that can automatically be provided by the system for use in EOBs and inquiry responses, as well as the plan's help desk and web portal.

## 4. Improve workflow efficiency by integrating rules engine capabilities

### The challenge

Most payers are still using the core adjudication systems they purchased more than a decade ago—systems that are tuned to address the lines of business they served at that time. Now, with a continuing trend toward mergers and acquisitions, along with an ever-tighter competitive landscape, payers are finding they must be creative in their new product offerings and contracting in order to win new business. To support these new offerings, core adjudication and operational systems need to provide new levels of automation and workflow integration.

### The solution

In a survey of health plans, Gartner found an average auto-adjudication rate of 71.8 percent.<sup>4</sup> Similarly, a Forrester Research survey calculated the average auto-adjudication rate at about 70 percent.<sup>5</sup> Both studies found a wide range of variability, and the figures do not necessarily capture the specificity of editing rules used in auto-adjudicated claims, or the number of claims that have to be adjusted later. In other words, if the payer loosens the rules in order to achieve a higher auto-adjudication rate, or if more claims come back for adjustment due to a rigid set of rules that fail to take into account plan-specific benefits, then the benefits of a high auto-adjudication rate quickly evaporate.

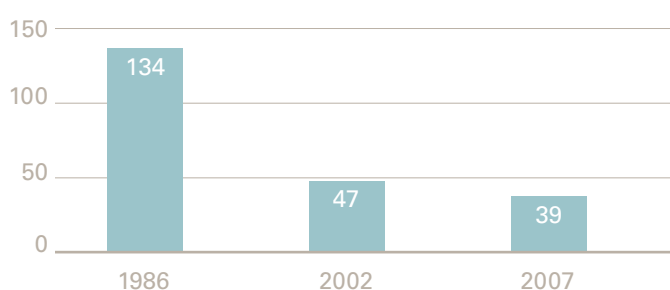
Ingenix believes the goal should be to achieve a 90 percent or better auto-adjudication rate, with the calculated rate based solely on claims that are processed correctly the first time. To achieve this goal, the claims editing solution should employ rules engine technology that incorporates a comprehensive set of commercial and Medicare edits and rule logic to minimize the manual work involved in adjudicating straightforward claims.

In addition, the ideal claims editing system should provide the flexibility to serve as an adjunct to the core adjudication system—automating the new payment policies that are driven by the launch of new products and contracts. Similar

### Mergers: Revolutionizing the Payer Landscape

The American Medical Association documented more than 400 mergers in the health insurance market over a 12-year period ending in 2005.<sup>2</sup> The rampant consolidation of Blue Cross plans exemplifies the trend—from 134 plans in 1986 to only 47 by 2002.<sup>3</sup> A check of the Blue Cross Blue Shield Association website reveals that the number has dwindled even further, to just 39 plans in 2007.

### Mergers in the Health Insurance Market



to a developer's toolkit, the system should ideally enable the payer to create new rules as needed, without relying on the vendor to provide these mission-critical logical statements. By applying sophisticated rules engine technology that automates both routine and custom edits, payers should be able to maximize their auto-adjudication rates across all their product lines and contracts—without significantly increasing appeals, adjustments or unnecessary payments.

## 5. Use the right rules for facility claims editing

### The challenge

In the U.S., less than 25 percent of the population incur a health care expense in an inpatient or outpatient facility setting over the course of a year. At the same time, facility services account for more than 40 percent of the overall health care spending.<sup>6</sup> Based on these figures, facility claims represent a particularly important area of focus for achieving potential health care savings.

It is important to understand that facility claims editing is driven by different claim forms, contracts and coding rules than physician/professional services editing. But while professional claims and facility claims are very different, some health plans have chosen to audit facility claims using professional edits.

A payer that uses professional edits to edit facility claims will almost certainly encounter a range of problems, including rules that conflict with provider contracts, reprocessing of claims, a high provider appeal rate, and possibly even a loss of providers from the network due to deteriorating relationships.

### The solution

The ideal solution includes the comprehensive set of rules for both commercial and Medicare facility claims editing, incorporating true facility edits. The solution should automatically review and edit inpatient and outpatient facility claims for errors, omissions and questionable coding relationships by testing the data against an expansive

knowledgebase containing millions of government and industry rules that cover health care claims.

The solution should also automatically detect coding errors related to DRG and modifier appropriateness, mutually exclusive and incidental procedures, duplicate claims, revenue code and HCPCS relationships, implantable device processing and more. Medical necessity edits should also be available to help payers detect procedures billed without supporting diagnoses or considered not medically necessary based on National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

At the same time, the ideal solution should allow the health plan to configure the software's logic to create and customize rules and reimbursement policies for facility claims processing. It should also give payers the ability to customize the sequence in which rules are applied and to define the level of automation for denials, profiling and claims requiring additional review. These capabilities are well beyond the standard physician/professional edit packages that many payers are using today.

By using a comprehensive facility-specific claims editing solution, payers can streamline the claims processing workflow; catch errors, omissions and questionable coding relationships; and improve payment integrity to maximize potential savings.

## 6. Customize rules to suit individual plans and lines of business

### The challenge

One size certainly does not fit all when it comes to claims editing. Each health plan has its own specific way of doing business, complete with different provider contracts, member benefits and business-specific payment policies. It only makes sense then that a health plan's claims editing solution should be customizable to reflect facility-, physician-, employer- and benefit plan-specific reimbursement policies. At the same time, the system should provide the configuration capabilities needed to manage these agreements, as well as to respond in a timely manner to regulatory changes.

### The solution

Most solution vendors offer the ability to turn edits on or off and to create new code-to-code relationships—with no ability to differentiate across lines of business or across provider or employer contracts. If payment policies differ, a health plan may be forced to pay on claims that they otherwise would not, or to set aside claims for manual review.

An ideal solution enables health plans to align their rule sets to their specific line of business, including PPOs, HMOs, consumer-driven plans, provider networks and employer groups. It allows payers to customize the software's editing logic to support user-defined rules and reimbursement policies—while enabling users to create new rule logic and new edits, as well as to turn codes, modifiers and edits on or off as necessary to meet business needs. And it allows users to define the sequence in which rules are applied, as well as to define the level of automation for denials, monitoring and claims requiring additional review.

Of course, the ideal solution also offers the ability to test-drive any customized changes before moving the new rules and edits to the production environment.

### Why Ingenix

Best practices are, as the name implies, a collection of policies and procedures for obtaining the best results. In an effort to maximize claims-processing efficiency, too many payers today overlook one or more of the best practices described in this white paper—to the long-term detriment of their business. But for companies looking to adhere to best practices without sacrificing efficiency, one solution vendor stands out: Ingenix.

Using Ingenix' Claims Edit System®, health plans can:

- Audit claims to assess whether they are being submitted appropriately the first time, and to pay claims consistently and accurately.
- Understand and explain the rationale behind claims edits and why a particular claim was denied.
- Improve transparency and communications with providers and consumers alike to reduce the risk of legal penalties tied to inappropriate denial of submitted claims.
- Increase workflow efficiency and accelerate reimbursement through process integration, including auto-adjudication of claims.
- Edit facility claims according to facility-specific rules.
- Create customized rules to match specific lines of business.

More than 165 payers currently use Ingenix' Claims Edit System to streamline claims processing workflows, reduce reimbursement errors and secure payment integrity—while improving provider and member loyalty.

### Learn more

For a demonstration of Ingenix' Claims Edit System, contact Ingenix today:

- Tel: (800) 765-6713
- E-mail: [engage@ingenix.com](mailto:engage@ingenix.com)
- Web: [www.ingenix.com](http://www.ingenix.com)

### Ingenix consulting

Ingenix offers consulting to help customers build reimbursement policies, research regulation guidelines and customize claims editing systems. With our consulting services, our customers are able to fully understand how Ingenix solutions impact their business optimization initiatives.



For Information: 800.765.6696 | [insight@ingenix.com](mailto:insight@ingenix.com)  
Ingenix, Inc. | 12125 Technology Dr. | Eden Prairie, MN 55344  
[www.ingenix.com](http://www.ingenix.com)

<sup>1</sup>Source: Olga Pierce, "Analysis: Claim Denials Made Clearer," United Press International, November 6, 2006.

<sup>2</sup>"Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2005 Update," American Medical Association, 2006.

<sup>3</sup>Jane-Ellen Robinet, "UPMC Health Plan Ponders Consolidation," Pittsburgh BusinessTimes, January 11, 2002.

<sup>4</sup>Robert H. Booz, "Health Insurers Measure Metrics to Gauge Their Performance," Gartner, Inc., October 24, 2005.

<sup>5</sup>Eric G. Brown, "The Forrester Wave™: Healthcare Claims Platforms, Q1 2005," Forrester Research, Inc., March 24, 2005.

<sup>6</sup>David Kashihara and Kelly Carper, "National Health Care Expenses in the U.S. Community Population, 2002," Medical Expenditure Panel Survey Statistical Brief #61, December 2004.

**Ingenix | Intelligence for Health Care | [www.ingenix.com](http://www.ingenix.com)**

From North America, call: 800-765-6034 • Outside of North America: +1-801-982-3588  
[ingenuity@ingenix.com](mailto:ingenuity@ingenix.com) • For a list of Ingenix global office locations, please refer to our web site.

Corporate Headquarters | 12125 Technology Drive, Eden Prairie, MN 55344

Ingenix and the Ingenix logo are registered trademarks of Ingenix, Inc. All other brand or product names are trademarks or registered marks of their respective owners. Because we are continuously improving our products and services, Ingenix reserves the right to change specifications without prior notice. Ingenix is an equal opportunity employer.

07-11027B 05/07 Original © 2006 Ingenix. All Rights Reserved