

Finding new opportunities to improve payment integrity with inpatient claim review

By Cheri Moehring and Michael Jablon

The administrative burden of research and recovery for improper healthcare claim payments is an industry-wide problem for all payers. Inpatient care is one of the most expensive types of healthcare services, where errors may have a significant financial impact including delayed payments, increased provider abrasion, and lower member satisfaction.

According to the Centers for Medicare & Medicaid Services (CMS), improper payment rates are on the rise from pre-pandemic levels in 2019, with Medicare fee-for-service alone spending a staggering \$31.2 billion in fiscal year 2022 on improper payments. This amount includes a large portion from inpatient facility claims, whose complexity often leads

payers to bypass inpatient claim editing, resulting in millions of dollars in preventable overpayments for just a single organization.

In addition, recent research from the Office of the Inspector General (OIG) indicates that inpatient claims are a significant portion of spend, costs are increasing, and that inpatient claim spend is growing faster than general healthcare spend—with increasing billing at the highest severity levels. Between 2019 and 2022, there was a 17.5% increase in hospital expenses according to the American Hospital Association, with increased billing at the highest levels of care. According to recent Cotiviti data, the outsized growth in average inpatient claim spend extends from Medicare (8%) into commercial (15%), and Medicaid (30%).

A comprehensive and tailored payment integrity program that monitors inpatient claim spend can protect member benefits and help ensure accuracy to reduce the financial and administrative burden of improper payments. Let's examine the benefits of not only improving the efficiency of existing postpay inpatient review programs (including diagnosis-related groups), but also implementing prepay review to improve value.

Improving payment accuracy with efficient postpay review

Retrospective interventions based on the member's medical record remain a valuable component of a health plan's payment integrity program but have significant room for improvement. The efficiency of a postpay

program requires precision to reduce the impact on providers. Here are a few steps that plans can take.

First, identify claims with the highest probability of an incorrect payment where the complexity of the review requires a medical record to confirm the error. Second, when possible, leverage outpatient and professional claims data in lieu of a full medical record to validate the accuracy of the inpatient DRG assignment. Clinical review of multiple claims, across multiple providers and at various points in the patient's continuum of care, can enable payment accuracy determinations for the inpatient claim without the requirement of a medical record. This eases the potential of provider abrasion and allows for review even when a provider limits chart requests.

Finally, ensure you have a comprehensive program that incorporates all three facets of validation, including:

- Documentation: Does the medical record contain the necessary information?
- Coding: Does the diagnosis code on the claim match the diagnosis in the medical record
- Clinical: Is the diagnosis on the claim supported by the clinical information within the medical record?

Applying prepayment integrity

The value of prepay DRG review

Of course, payers and providers prefer to avoid retrospective review whenever possible by paying claims accurately the first time, reducing administrative costs and burdens. But when it comes to inpatient DRG claims, most plans have relied exclusively on postpay claim review to catch inaccuracies. In postpay, payers are typically able to recoup only a portion (about 70%) of the identified overpaid amount at an additional recovery expense. These costs make it prohibitive for payers to recover smaller overpayments, reducing the value captured (Figure 1).

Prepay claim review eliminates the headache of a pay-and-chase approach, where the plan pays the claim, identifies an overpayment during an audit, and the plan is tasked with adjusting the claim and preparing an offset or pursuing recovery. In Cotiviti's experience, the time to recoup value from postpayment identification can exceed 90 days. Accurately paying the claim at the start of the process can reduce administrative costs for payers and providers.

Cotiviti's own approach to prepay DRG review focuses on claims where scoring algorithms indicate the probability of an error is greater than 50%. By applying this

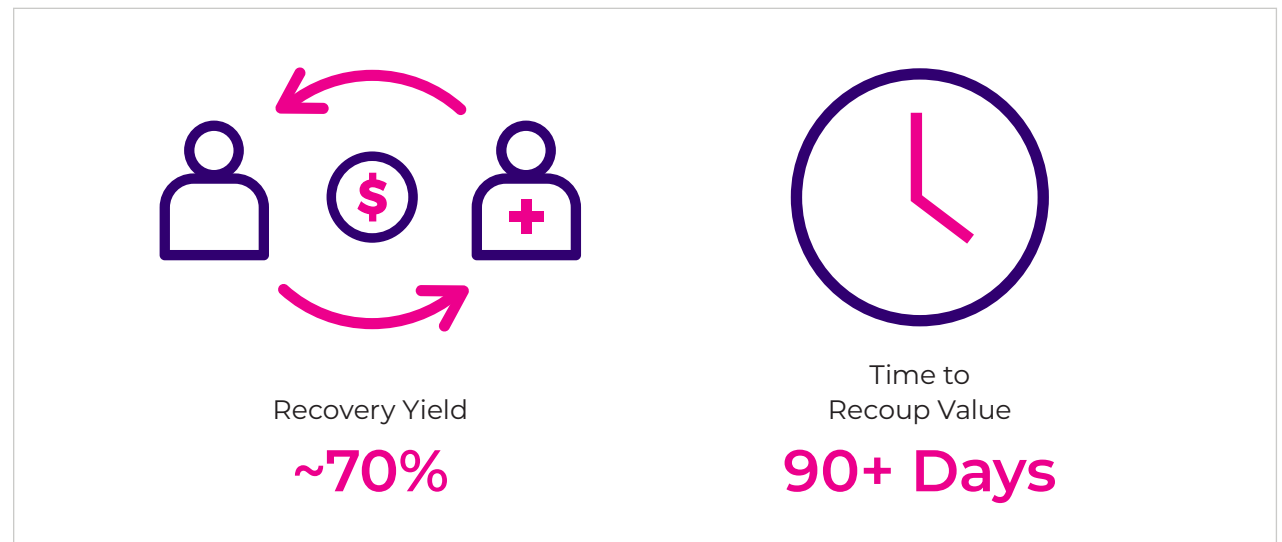


Figure 1. Challenges in optimizing value with retrospective DRG review.

probability factor, the volume of medical records requested from a provider is reduced prior to receiving payment.

Prepayment review also opens the opportunity to audit non-contracted providers who are often excluded from post payment review. By catching errors prior to payment, a plan avoids the challenge of not being able to offset overpayments from a non-participating provider, resulting in a higher rate of compliance submitting medical records.

Innovations in inpatient payment policies to reduce chart review needs

Inpatient payment integrity isn't limited to reviewing DRG claims. By introducing new and expanded inpatient payment policy content to existing automated prepay final filter review practices, health plans can utilize full member contextual processing, looking across professional, outpatient, and inpatient claims. This can be achieved by adding inpatient claims data to a file ingestion using a plan's existing layout, which also contains outpatient claims, providing a longitudinal view of a member's claims for the most accurate results.

Inpatient claims inclusion increases savings to health plans by looking at an untapped area of prepayment spend. This increases yield compared to recovery and

its associated administrative costs. It also reduces provider abrasion by identifying correct coding issues up front across all claim values and allowing errors to be identified and corrected to expedite payments to providers.

Best practices when implementing inpatient payment integrity

Consider provider differences

When implementing or optimizing an inpatient payment integrity program, plans should keep in mind that inpatient claims editing might involve different personas and needs than with their outpatient review. For example, hospitals and inpatient facilities may have a more sophisticated revenue cycle department. Plans should emphasize early communication and awareness when new policies are being implemented in order to spell out what the inpatient provider should expect.

Take a unified approach

Plans should consider the overall value of their payment integrity program versus working in prepayment and postpayment integrity siloes. For example, siloed postpay departments may feel that they will be penalized with reduced value when certain policies are enabled prepayment.

To mitigate these worries, communicate any changes in policy across payment integrity teams and forecast any impact that may occur. Cotiviti's own experience shows that prospective inpatient editing creates a relatively small impact on postpay findings of approximately 8%, attributed to claims findings that were excluded or bypassed in prospective claims editing. This allows an opportunity for health plans to review and make sure that these exclusions and bypasses are still appropriate when enabling inpatient policy.

Seize new opportunities to improve payment accuracy

Inpatient claim review increases savings to health plans by looking at an untapped area of prepayment integrity. This increases value and reduces provider abrasion by identifying coding issues across all claim types, rather than limiting prepay review to outpatient and professional claims as health plans have traditionally done. Errors may then be identified and corrected to expedite payment to providers versus a full claim denial. Cotiviti's own results demonstrate approximately 20% in additional value can be captured when both pre and postpay auditing are performed compared to postpayment alone.

Health plans should look at the bigger picture by applying correct coding and protecting the member's plan benefits at all levels of payment integrity. By deploying prepay inpatient claim review alongside retrospective chart auditing and postpay data mining, payers will have a more comprehensive payment integrity program that improves value, reduces provider abrasion, and enhances member satisfaction.

Want to see prepay DRG review in action? Read Cotiviti's case study, **Unlocking hidden value: Discover the impact of prospective DRG validation**, and learn how one regional plan identified \$4 million in inappropriately coded claims before payment using this approach.

[Read the case study](#)

If you would like to dive deeper into Cotiviti's payment integrity solutions, set up a time to talk with one of our experts.

[Start the conversation with Cotiviti](#)

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Cheri oversees the operation and strategic direction of Cotiviti's prospective and retrospective Clinical Chart Validation solutions. As a tenured member of this business unit, Cheri leads a team of clinical and coding professionals, product specialists, and medical directors and brings valuable hands-on, day-to-day experience with Cotiviti's portfolio of clients. Before joining Cotiviti, Cheri spent more than 20 years working with health plans, health systems, employers, and government agencies to improve their payment integrity, contract and policy compliance, talent acquisition, and care management practices.



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Michael focuses on building capabilities within Cotiviti's prospective payment integrity solutions, understanding the changing dynamics of prospective claims editing and applying solutions that ensure accuracy in the complex interchange between healthcare providers and client payers. His responsibilities include performing industry research, understanding market trends impact on clients, leading product discovery, data analysis, business case development, managing the prospective product roadmap, defining technology solutions, and leading implementation of capabilities.

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