Reducing provider abrasion associated with payment integrity

Payment integrity (PI) interventions have long been a point of abrasion for providers, as many consider PI to be a major driver of costly and time-consuming administrative rework. And the current climate is only amplifying the problem.

Many providers see claim denials shifting back to pre-pandemic levels, with health plans offering less flexibility as they shift the focus back to payment accuracy. With that shift comes increased administrative costs for everyone. Rework or appeals cost providers an average of $79* per denied claim and health plans an average of $62 per denied claim.[1]

In addition to increasing administrative burden, this rise in claim denials is also delaying payments, resulting in cash flow impacts for many providers.

But what's really driving the increase in provider abrasion? And what can health plans do to alleviate provider pain points while maintaining payment accuracy? We surveyed 150 providers and health plans across the U.S. to find out.

The top points of abrasion

For providers

1. Claim denials
2. Lack of communication and transparency
3. Delayed responses

For health plans

1. Lack of data and dashboards
2. Provider demographics
3. "Unclean" claims or lack of information

The cost of claim denials

$79
average administrative costs associated with rework and appeals of denied claims for providers[1]

$62
average administrative costs associated with rework and appeals of denied claims for health plans[1]

$0.67
average cost to submit an accurate claim electronically[2]

*Excludes write-offs and bad debt related to claim denials.

Both the health plans and providers we surveyed feel the friction between them is likely at an all-time high. Communication challenges are one of the top drivers of abrasion on both sides. Communication was described as transactional by many and isn't happening early enough in the claim workflow to effectively mitigate denials.

> **"I would say 90% of the time I [talk to] payers, it's due to account escalations or contractual disagreements."**
> – Chief revenue cycle officer, Health system

In addition, denials driven by incorrect coding and a lack of appropriate or accurate supporting documentation are a major pain point for both groups. Providers expressed their frustration at trying to navigate the ever-changing rules and policies set forth by health plans. Meanwhile, health plans felt the lack of accurate data available from providers was only compounding coding issues.

Both providers and health plans also expressed that the coordination and resources needed to manage medical record requests adds unnecessary complexity to the payment lifecycle. Providers are unsure exactly what a health plan needs to adjudicate and process a payment. Health plans find it challenging to request and retrieve records in a way that enables timely adjudication.

In this guide, our experts further explore the top causes of provider abrasion and share the best practices your plan can implement to reduce abrasion without sacrificing payment accuracy.

Shift communication earlier in the claim lifecycle

Health plans and providers agree — ineffective communication is one of the top barriers to solving for abrasion. But both groups also acknowledge that it's the most solvable of the abrasion pain points.[1] So where's the disconnect?

Communication between health plans and providers is often transactional and occurs after a claim has already been denied. Forward-thinking health plans need to establish open channels of communication earlier in the claim workflow and provide more transparency and clarity into what is expected of providers.

Real-time messaging and alerts that integrate with provider practice management systems are an efficient and effective way to help providers avoid errors and denials. By providing clear, concise instructions to address actionable errors or information gaps at the point of claim coding and billing, health plans can enable providers to submit accurate, complete claims the first time. And by reducing unnecessary claim denials, health plans will also reduce the associated abrasion.

Health plans and providers agree that one of the top barriers to solving abrasion is **ineffective communication.**

Enhance your provider education program

When it comes to understanding health plan coding reimbursement policies, providers were clear — to avoid claim denials they need additional training and education. Over half of providers cited incorrect coding as the top reason their claims were denied.[1] And although many plans noted that current policies are easily accessible online, 2 in 5 providers still felt they would benefit from additional education or training on claim coding requirements.[1]

Provider education programs have proven to be an effective tool in combating low-dollar, high-volume billing errors. In our experience, over 80% of providers demonstrate positive behavioral change when participating in a targeted education program.[3]

2 in 5

providers want additional education or training on health plan claim requirements[1]

The most effective tools use advanced analytics to identify outlier billing patterns and then deliver provider-specific coding insights and education on health plan reimbursement policies. Insights are most impactful when delivered via multiple communication channels but should not be disruptive to provider workflows.

By providing additional insight into coding inaccuracies, you can encourage providers to self-correct claims before submission. This enables health plans and providers alike to avoid the unnecessary administrative rework, costs and abrasion that result from repeated claim coding errors.

Reduce the administrative burden through technology

The administrative process of submitting data and documentation to accompany claims can be a burden for providers. Take medical record requests, for example — many providers are still processing these manually, and some still fax supporting documentation to health plans. This isn't just time-consuming and abrasive, but providers also feel that it contributes significantly to clinician burnout.[4]

Enabling technology can reduce the burden on both sides by automating or digitizing administrative tasks. At minimum, health plans should offer an easy way for providers to submit digital medical records or additional information via a portal.

Better yet, health plans and providers should pursue partnerships with electronic medical record (EMR) vendors or medical record clearinghouses to facilitate more efficient request and retrieval processes. Enabling plans to directly access records, where appropriate, without having to engage a provider for requests will expedite adjudication and allow providers to focus on patient care or more follow up on complicated claims.

Make relationship management more personal

We already know that providers and health plans want regular and open communication, but for the providers we surveyed, health plans often feel inaccessible.[1] Without a dedicated point of contact, providers described the process of trying to resolve denied claims as opaque and inefficient.

To establish a strong culture of collaboration, leading health plans leverage dedicated provider advocacy teams. Provider advocates are equipped with the claim-level detail needed to help providers remediate their core operations. In addition, advocates share data on payment trends, patterns and outliers to help the provider and the health plan identify opportunities for improved operational effectiveness and efficiency. By creating an open line of direct communication between the provider and the plan, advocates promote a culture of trust and accountability while improving claim accuracy.

1 in 3

providers feel having access to a dedicated health plan liaison would positively impact abrasion

Optum can support your payment integrity evolution

Optum is an information and technology-enabled health services business platform serving the broad health care marketplace, including care providers, health plans, life sciences companies and consumers. We have been the leader in payment integrity innovation, helping state Medicare and Medicaid programs and commercial health plans adopt forward-thinking strategies for more than 20 years. And we help our clients routinely identify opportunities to achieve industry-leading medical cost savings while minimizing the abrasion caused by payment integrity interventions.

1. Optum Payer-Provider Abrasion Study 2023.
2. CAQH U.S. Healthcare Efficiency Index. June 8, 2023.
3. Data from Optum book of business. 2023.
4. Gartner. Top 4 ways healthcare payers can reduce provider burnout by improving payment integrity. September 16, 2021.

Learn more about how we can help optimize your payment integrity program and minimize provider abrasion.
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