

Risk, Responsibility and Revenue

Managed Care Service Providers Reform Health Care Through Cost Containment, Fraud Detection and Better Billing

By Carol Berry, President, PCG Software



The staff at most payer organizations may not have taken the Hippocratic oath, but they do have a fiduciary responsibility. For the good of patients, physicians, health plans and the greater communities they serve, payers must make a concerted effort to spend health care dollars wisely. Given the complexities of health care finance, compounded by constant regulatory and policy change, some tasks that should be basic tend to get lost in the shuffle.

To ensure that premium dollars are well spent, a revenue integrity initiative should cover three primary areas at a minimum. Primarily, payers should have the ability to audit large volumes of claims data for improper coding and accurate reimbursement. Secondly, payers should have the organizational intelligence necessary to identify and protect against intentional fraud and abuse. Thirdly, payers should be equipped with tools to better educate providers in an effort to prevent future errors in both claims submission and overall billing practices.

Unfortunately, it's been largely impractical to pursue these revenue integrity measures thoroughly until recently. But with the latest health care information technologies, California payers have begun to take on these responsibilities and more.

COST CONTAINMENT INFORMATION IS NEGOTIATING POWER

In recent years, physicians have come to expect clear, objective justification to accompany denials or rejections of their charges, and rightfully so. For fairness and consistency, some payers are augmenting their claims adjudication systems with new solutions that flag unclean claims and identify coding errors.

Organizations like ProMed HCA, a company that provides managed care services to independent practice associations and medical groups, did just that in 2005. In addition to saving money and introducing a powerful negotiating tool, the software helps both ProMed and its providers save time and effort. Rather than debating reimbursement rates endlessly,

ProMed can now edit and audit claims quickly and show providers clean, authoritative data to support its findings.

The Virtual Examiner application from Malibu-based PCG Software provides a single source of information for reimbursement rates, coding rules, insurance regulations and abusive billing pattern profiling.

Whether they're under fee for service, subcapitation or fixed monthly contracts, all physicians want to know what they're earning in comparison to the Medicare rate. This need to evaluate compensation is just one way ProMed uses PCG's software when working with IPA physicians. Ongoing use of the software has produced multiple benefits for the organization, including education to providers on correct billing procedures, a vital negotiation tool and improved claims processing.

TAKING A BITE OUT OF HEALTH CARE CRIME

Fraud and abuse have become big business in California. According to the *New York Times*, 12 different Blue Cross and Blue Shield plans collaborated with federal authorities in 2005 to stop a scam that drew thousands of patients from 47 states to California for unnecessary procedures. This web of outpatient clinics had attempted to bill more than \$1.3 billion in fraudulent claims, a revenue figure that would put this enterprise just barely out of reach of the *Fortune* 1,000 ranking of America's largest corporations.

In another case of fraudulent billing, the *Orange County Register* reported on the case of one Arizona couple that both allegedly underwent endoscopies at a clinic in Buena Park on a Saturday, colonoscopies the next day and surgery for sweaty palms the following Saturday.

The National Health Care Anti-Fraud Association conservatively estimates that fraud consumes at least 3% of total health care expenditures. Some sources report a rate of 10% or about \$200 billion annually. From the mafia in New Jersey to Russian and Eurasian mob groups in California, even infamous organized

crime syndicates are in on the action.

Of course, abuse is rarely perpetrated on such a grand scale — or at such great risk to patients. But small-scale fraud adds up over time. Most organizations are unaware that the majority of payers' claims adjudication systems are merely automation tools intended to expedite claims processing. They're effective as far as they go, but they lack the intelligence to detect systematic fraud.

The new generation of revenue integrity technologies can help organizations at financial risk by analyzing hundreds of thousands of claims at a time and searching the data for certain outliers and patterns of abuse. Among the top categories of abuse payers need to protect against or be aware of are "spiking," "churning" and "trending."

Generally, doctors submit a consistent volume of claims each month. But most adjudication software applications do not monitor volumes by group and provider over time. With a tool like Virtual Examiner, investigators will see a provider whose volume "spikes" all of sudden by hundreds of claims.

Intentional fraud will often require churning: filing claims for an impossible number of encounters or services provided in a given time frame. Revenue integrity technologies can target potential outliers, such as four urinalyses on one office visit or claims representing 48 total hours of psychiatric care in one day.

The various levels of E&M billing should follow a predictable bell curve for most physicians. Software can easily review trending data by group or provider, compare codes against comparable providers or CMS standards, and identify those billing disproportionately at the highest level. In some cases, it may be justified. In other cases, payers will want to see the relevant medical records and documentation.

Increasingly, revenue integrity technologies are crucial tools for providers as well as payers. Errors are one thing, but providers who are dedicated to become better billers realize that a higher percentage of clean claims heading out

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the door can equate to quicker reimbursement in the long run. These technologies allow payers to equip their providers with remittance advice and reimbursement recommendations to assist in scrubbing future claims. This means that payers can now help to update their providers' billing systems so future claims will not be returned unpaid.



Cost containment and sophisticated fraud detection capabilities are well within reach for payers these days. The technology can review huge hundreds of thousands of claims per hour, evaluating them against tens of millions of edits.

Actually, it's a part of their charter that all delegated-risk programs that reimburse claims using federal or state dollars are required to maintain fraud and abuse prevention initiatives. Having this kind technology not only makes payers compliant; it makes prevention effective.

Increasingly, the results are being used as a tool for investigators to protect premium dollars and to strengthen payer-physician relationships. In California, as elsewhere, any measure that promotes revenue integrity is welcome news.

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Graybill Medical Group Honored with Best Practice Award

Use of Information Technology Enables Practice to Enhance Operations and Quality of Patient Care

Graybill Medical Group today announced it was named a winner in the second annual NextGen Best Practice Award competition. The award — given by NextGen Healthcare, a leading provider of fully integrated healthcare information systems — honors clients who have demonstrated exemplary use of the NextGen ambulatory solutions suite. Graybill Medical Group won the “mid-sized practice” category, which focused on medical practices with more than 11 but less than 50 physicians on staff.



Leslie Chapman, Finance Director

Graybill fully implemented NextGen's image control system (ICS), electronic medical records (EMR) and enterprise practice management (EPM) systems in October 2004.

Since that time, it has experienced many operational benefits including increased staff efficiency and a reduction of office expenses. The technology has also benefited the practice's patients by enhancing the quality of care. For example, the reduction in medication errors due to illegible handwriting is a result of utilizing the fax management tool for prescribing. Other benefits related to patient care include:

- Enhanced ability to report, measure and schedule patients for key clinical parameters such as childhood immunizations, breast cancer screening, management of asthma, cholesterol management and diabetes.
- The ability to access information from any

George Rodriguez, Graybill Medical Director



Mariann Gesino – Business Office Manager, Leslie Chapman, Finance Director and Carol Sweda – Front Office Manager

site or remote location allows for immediate patient response and treatment.

“This year we are celebrating 75 years of service to the Escondido community, and this award helps represent the ongoing commitment to our patients we have established,” said George Rodriguez M.D., Medical Director. “We are very pleased with the benefits we have experienced as a result of the technology and are eager to see our success continue as we expand to utilize the full functionality of the NextGen suite of products.”

NextGen Best Practice Award applications were judged by NextGen Healthcare staff and third-party consultants, and then voted on by clients to determine the winners in their respective size classes (small, medium and large). Award recipients were recognized last month during a ceremony at the NextGen Healthcare Users' Group Meeting at Disney's Coronado Springs Resort in Orlando.

Established in 1932, Graybill Medical Group is the largest primary care medical group in San Diego's North County and provides care to over 150,000 patients yearly. The group's 40+ physicians and practitioners have offices in Escondido, Fallbrook and San Marcos. A top 10 percentile-rated group in patient satisfaction, Graybill implemented its Premier Patient Scheduling system, which greatly enhances the patient being seen on a timely scheduled basis by their primary care physician. Graybill was the first to implement a fully integrated electronic medical record and practice management system in San Diego. For more information, visit www.graybill.org. ■