White Paper

OPTUM™

Facility editing: Enhance payment integrity while building strong provider relationships

Five steps toward effective facility editing

It is a real challenge to edit facility claims, given the overall complexity of the UB-92 and UB-04 claim forms, the variety of contractual methods used to pay for facility services, and the likelihood that many claims will not contain CPT® codes— the primary focus of editing systems.

As payers evaluate their options for editing facility claims, they need to recognize that simply repurposing a professional services editing system designed to edit 1500 claims is not likely to provide the optimum return on investment—or to retain providers as satisfied members of the network. Instead, payers need to develop a comprehensive strategy designed around the specific requirements for a productive and accurate facility editing system, and then plan to implement that system in a way that accelerates time-to-value for payer, provider and member alike.

Editing systems for hospitals and other large facilities must take the unique structure of UB claim forms into account. In addition to claim-level information such as patient demographics, provider information and diagnoses, UB forms contain service-specific detail with item revenue codes that generically describe the types of services used (for example, operating room, emergency room, or central supply), units and dates of service, and billed charges. CPT® codes may also be included to characterize more specifically the service that was provided, but these are not required for most non-Medicare claims.

As an industry leader in the emerging field of facility editing, Optum™ knows the road to success well. Following the five steps outlined in this white paper will help payers set the stage for an effective facility editing process that improves accuracy and efficiency, reduces fraud and abuse, and maintains strong provider relationships

Step 1: Impact analysis

Facility editing is driven by different needs, claim forms, contracts, and coding rules than physician/professional services editing. Payers who use professional services editing systems to edit facility claims will almost certainly run into trouble over editing rules that conflict with provider contracts, re-editing of claims pushed back from providers, negotiations with provider appeals groups, and possibly even loss of providers from the network due to deteriorating relationships.

Evaluating solution options

When assessing options for facility editing—whether claims are edited in-house or using a third-party vendor—payers need to be sure they are looking at solutions actually built around facility rules, not just a revised version of physician/ professional services rules. When it comes to coordinating patient care, contracting with payers, coding procedures and services, submitting claims forms, and handling appeals and paying claims, there are many differences between the hospital environment and the typical physician's office. These differences have far-reaching implications for the claims editing system, which must correctly model the complex and sophisticated logic of each health care environment in order to accurately identify appropriate DRGs for admission, utilization of modifiers in the outpatient setting, appropriateness of units of service, and a multitude of other billing scenarios.

CPT is a registered trademark of the American Medical Association.

The differences between the 1500 and UB claim forms alone dictate a separate set of facility editing rules to gauge the accuracy of claims submitted from the hospital environment. Add the different contracting processes and even the different policies and procedures specific to individual facilities, and it is easy to see why a one-size-fits-all approach based on physician/provider coding rules will cause problems when used for editing facility-specific claims. Because the rules are inappropriate, claims will not edit properly.

Testing solutions against historical data

The impact analysis should provide an objective assessment of the results that can be expected with the proposed facility editing solution. Payers should collect a subset of historical claims data—at least six months' worth, and preferably as much as a year—that can be run against the proposed facility editing application and database. Based on actual health plan data, the solution vendor should be able to provide a report broken out by edit type, and explain how the system will impact the payer's business.

Analyzing potential savings

A thorough impact analysis will evaluate real savings based on actual dollar amounts for each edit flag, as well as potential savings based on further edits that could be allowed by the provisions of specific provider contracts. The vendor may also be able to show how different rules configurations can be used to provide further savings. Understanding these potential savings can be particularly useful when it comes to planning a phased implementation of facility edits based on an analysis of costs, risks, and benefits.

The analysis should provide a reasonably accurate picture of the types of facility edits that are available and their financial impact. When weighing multiple solutions, this information can provide a solid basis for comparison to help select the best vendor to meet payer-specific needs

Step 2: Provider notification and education

In addition to helping predict efficiency gains, payment integrity and other benefits of a proposed solution, the impact analysis provides a better understanding of claims data and how it relates to existing provider contracts. In particular, it can show what types of facility edits would be triggered, which can help the payer evaluate how implementing the solution might affect provider relationships.

Increasing transparency

Transparency is a key to attracting and retaining providers within the health plan's network. Providers need to know the rules they should follow in order to submit clean claims and avoid expensive appeals. At the same time, payers need to avoid implementing rules that could put them in conflict with providers and potentially drive them away from the network. These basic requirements become even more important when implementing a new system that could lead to incorrect assumptions and expectations on both sides.

While there are basic, widely accepted edits that reflect CPT® and ICD-9-CM coding guidelines, there are fewer industry standards for facility edits. Once a payer enters this realm, it is a good idea to document the facility edits that will be applied to claims and to provide this information for the benefit of providers and members who may have questions. For example, the payer's website could have a searchable page that explains which edits will be applied to procedures billed on a facility claim.

Keeping providers informed

The lesson, in a nutshell, is that both the payer and its providers need to be absolutely clear about all the changes involved when moving to a facility editing system. The impact analysis in Step 1 provides insight into what these changes are and how they will affect the business. The next step is to communicate with providers, letting them know what changes to expect and how to address any concerns they may have. This communication needs to happen up front—before implementing the new facility editing system—and on an ongoing basis, as new questions arise and claims processing policies evolve.

Payers will want to take a proactive approach—notifying providers of upcoming changes—as well as having available one or more people who know the contracts and coding systems inside-out and can answer questions at any time. Ideally, the solution vendor should also thoroughly educate the claims processing staff in advance of implementation. When both payer and provider understand the changes that are coming, as well as why and how, both sides can benefit from fewer claims disputes and denials, lower claims processing costs, better provider and patient relationships, and an optimum return on the cost of providing care.

Step 3: Policy analysis and contract review

Ahead of implementation, and as part of the provider notification and education process, it is important to review medical and payment policies. The ability to edit claims for potential savings depends on the correct understanding of these policies so they can be configured in the system.

Understanding policies and how they affect editing practices

For example, if a policy calls for a flat case rate for all emergency room visits—say, $150 for any ER visit regardless of the service provided—there is no point in editing UB claims with regard to specific services. The reimbursement will be the same, whether or not the claim is edited. Likewise, a policy may call for the bundling of multiple procedures into a single case rate—for example, specifying a flat case rate when cardiac catheterization, PTCA, and open coronary artery bypass procedures are all performed during the same patient admission.

Conversely, a policy may be based on a reimbursement methodology that ties reimbursement to the codes on individual lines on the claim. For example, the contract may use a fee schedule that specifies a $42 payment for each biopsy of the upper arm (CPT 24065). Or a contract may use an APC-based payment methodology—the prospective payment model currently used by Centers for Medicare & Medicaid Services—that ties reimbursement to specific CPT® codes. Under these types of contracts, editing claims enables the payer to identify and deny individual lines on outpatient claims that are logically inconsistent, medically unnecessary, improperly unbundled, or contrary to medical policy.

Editing claims unnecessarily, as in the first example, wastes resources. But failing to edit claims of the second type— where the edits can make a difference—means unnecessary reimbursements and a higher overall cost of health care. To make matters worse, leaving these claims unedited means there is no way to identify potential savings that could help attract and retain customers while making a long-term difference in the bottom line.

Determining policies and negotiating contracts that are consistent with facility editing rules

When adopting facility editing, it is important to understand all of your medical and payment policies as well as the contracting process, individual contracts, and the extent to which reimbursement is associated with specific codes. Otherwise, it is difficult to understand all of the ramifications of the impact analysis in Step 1, or to derive full benefit from editing claims once the new system has been implemented. In particular, payers need to evaluate the extent to which the contracting process is consistent with established coding guidelines as well as with the rules embedded in the proposed facility editing solution.

All contracts and policies should be reviewed and renegotiated, if necessary, to accommodate the new facility rules, should be assessed to determine whether it can be customized and configured to handle the rules specified in each contract, and providers should be engaged in the notification and education process described in Step 2. At a minimum, most payers will want to require providers to submit appropriate CPT-4 codes on facility outpatient claims. Contractually requiring CPT-4 codes supports facility editing and eliminates the possibility that providers will circumvent facility edits by removing CPT-4 codes from their bills. As an additional benefit, requiring CPT-4 codes provides the health plan with more accurate information about members and the services they receive.

Step 4: Phased implementation

The impact analysis, provider notification and education, and contract reviews set the stage for the actual implementation of the new facility editing solution. For an orderly and successful transition, Optum recommends implementing the solution in multiple phases. In other words, payers should not turn on all editing flags at once, but rather phase them in logically based on payment methodologies.

Planning for an orderly phase-in

A successful phase-in process might include these steps:

- **Assign implementation team.** The team might include an executive sponsor as well as stakeholders in the areas of payment policies, provider contracting, customer service, and technical resources. The legal department is also typically involved prior to vendor selection to make sure the solution meets transparency and disclosure requirements.
- **Hold kickoff meeting.** The goal of the meeting and follow-up activities is to define the different payment methodologies and their specific claims processing and editing needs. A project lead should also be assigned to work with the vendor’s implementation lead.

- **Define edit configurations.** Each facility will have similar contracts, but with variations that require different edit configurations. These should be broken out to determine which facilities to include in the initial phase-in.
- **Determine custom edits.** Following the policy analysis, custom edits should be designed and configured within the system to take advantage of additional cost savings.
- **Work with vendor to create implementation plan.** The plan should cover all configuration and development activities required for the solution to automatically enforce the identified flags and edits. It may also specify changes that need to take place in the existing claims processing system and procedures.
- **Work with vendor to specify the interface.** If the interface is not already built, or does not meet specific needs, the payer will want to verify that the design is customized to integrate with the workflow and maximize claims processing efficiency. A little time spent here could save a lot of time in the long run.
- **Test and implement facility edits on a phased basis.** After gaining experience using facility edits customized for the least-complex facility contracts, the payer can make necessary adjustments to provide a more solid footing for more complex implementations. A phased implementation—moving from well-established coding guidelines to contract-specific edits, and from simpler to more complex and high-volume payment methodologies—is the best way to prepare claims processors, keep providers satisfied, and tailor the facility editing solution appropriately to contracts and workflows.

Understanding when procedures and services can be coded and billed separately

Although CMS rules generally regard medical services as an integral component of corresponding procedures, some procedures and services remain logically separate. For example, when a patient goes to the ER with a laceration, the ER physician will first evaluate the patient and determine an appropriate course of treatment. In this situation, it is reasonable to pay separately for both the patient evaluation and the actual suturing of the wound. However, facility editing rules generally assume that physician services should be bundled into therapeutic procedures when they are present on the bill. To avoid inappropriate bundling—which would result in a line-item denial applied to the evaluation and management (E&M) service—the hospital can append a "–25" modifier to the E&M code, indicating that the medical service is separate and distinct from the procedure itself. With a valid code that includes the "–25" modifier, CMS will pay for both the E&M code and the procedure code. If the provider contract includes a similar provision, the "–25" modifier will likewise turn off an edit that would deny reimbursement for the E&M service. The ideal facility editing solution provides the flexibility to handle this type of contract provision so that reimbursements are appropriate regardless of whether a medical service is performed as part of a procedure or whether the two are performed and billed separately.

Step 5: Monitoring and continuous improvement

Editing facility claims is never a static process. There is always room for reevaluation and improvement as contracts and coding rules change, and as best practices evolve. The solution should have the flexibility to change and grow as the payer monitors results and discovers better ways to process claims.

Testing the solution in the pre-live environment

After implementation, but before going live, the payer should run tests using historical claims data. Any issues that arise with editing workflows or with specific edits should go back to the implementation team for review and revision. Any issues with the function or usability of the facility editing solution itself should go back to the vendor in the form of defect reports and change requests. The technical team should be closely involved in the process of tracking these issues, reporting them to the vendor, and verifying that fixes are performed in a timely manner. This is important not only for the payer's own operations, but also to help the vendor continuously improve the product.

Monitoring and improving claims processing in the live environment

After the solution goes live, the payer should monitor results to adjust edits and processes as necessary. The goal should always be to reimburse the claim appropriately and maintain a satisfied provider network. All available tools should be used to monitor these areas and identify any problems that could be affecting metrics. For example, if there is a dashboard for tracking auto adjudication rates and the financial accuracy of claims payments, it should be used to evaluate how the new system is performing and whether there could be areas of improvement. An inordinate number of provider appeals may indicate a misconfiguration in the system. And claims processors can provide feedback on workflow efficiency, determine new custom rules to be built, as well as catch edits that are not being applied as expected.

Up-front planning: The key to success

Payers have been editing professional services claims for more than 20 years. It is a well-established process, based on familiar claim forms and coding rules as well as on contracts that tend to be very similar from provider to provider.

Facility editing is a newer, more complex and highly variable process. Using a variation of physician/provider coding rules to perform facility edits is an expensive mistake—virtually a guarantee that coding errors will be missed and claims paid inappropriately. Systems designed specifically for facility editing can help catch these errors more effectively. But implementing a new facility editing package entails its own risks, including unprepared claims processors, inaccurate edits, alienated providers, and more.

When deploying a new facility editing solution, the key to success is to spend the time and effort up front to:

- Analyze needs, verifying that the proposed solution meets those needs and will provide the desired benefits
- Notify and educate providers regarding the changes they can expect to see
- Review provider contracts, negotiating changes as necessary and checking that the solution is configured appropriately

- Phase in facility-specific edits in a planned fashion, over time, beginning with the most straightforward edits and simplest claims
- Monitor results and continuously adjust edits as necessary to maximize claims processing efficiency and payment integrity

Following these planning and implementation steps will enhance the business value of the chosen facility editing solution, while keeping providers satisfied that claims are always processed as accurately and efficiently as possible.

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