Tips for Payer Reviews

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Insurance plans are scrutinizing claims more than ever before. Common questions from our clients are: What does this mean? What should I do? Should I be worried?

Generally, there are three types of payer reviews: prepayment, postpayment, and probe. The first step is to figure out what type of review it is. What you do and how you handle the review is dependent on that information.

Should you be concerned? Always. Payer reviews need to be taken seriously and addressed properly. The level of concern is different for each one.

Prepayment Reviews

Level of concern: Low

Prepayment reviews occur when your practice's claim data are analyzed by the payer and a provider has been identified as an outlier. For example, Dr. Jones is billing more level 4s than other providers of the same specialty in your area.

Practices are notified by letter stating which provider and which codes will require a review prior to adjudication of the claim, with the date the prepayment review takes effect. Claims for the provider with codes under review require that the medical record be included at the time of initial claim submission. Failure to submit the medical records will result in a claim denial and further delay in payment.

Payers review the medical record and either adjudicate the claim (if they agree with the coding) or deny (if they disagree with the coding). Often, a practice will receive detailed letters as to why the reviewer did not agree with the coding. Resources for education may be included.

The payer will take the practice off prepayment review when the payer has received a specific volume of claims with a specific threshold of accuracy. For example, hypothetically, a practice may be required to submit 500 claims with an accuracy threshold of 95%.

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What should I do?

1. Work with your billing team to make sure the initial claims are being submitted with medical records. Make sure they have the criteria of which claims require medical records. It won't be 100% of your visits.
2. Ask the reviewer what threshold and volume of claims are required to satisfy prepayment review. Call the number on the prepayment review letter, not the regular claims representative number. Most likely, the claims representative will not know that your practice is on prepayment review.
3. Compare your data with other urgent cares. If your billing team doesn't have this data, consider reaching out to a consultant.
4. Look at your results and identify claims to appeal or areas for improvement. Be objective. The insurance plan will not always be right, and neither will your practice. Choose the claims to appeal wisely. If it is a gray issue where you can see the payer's point, it may be a better idea to submit a lower-level code for payment.
5. Be proactive. Take the results, after your medical team reviews, and educate providers on how they might improve their documentation to properly reflect the level of care delivered.

   If you have been on a prepayment review for months, reach out to the payer to see what can be done. The practice may need to change their behavior to see better

results. This doesn't necessarily mean lowering your levels; rather, you may need to improve your provider documentation.

Postpayment Review

Level of concern: Moderate

Postpayment reviews are routine actions by a payer. Medicare or Medicaid managed care products are required to do a review of claims for the Centers for Medicare & Medicaid Services or your state Medicaid program to verify the payer is adjudicating the claims correctly.

Dates of service will fall in the prior year or even earlier. The payer may ask for monies back if they conclude the coding was incorrect. For government payers, the amount may be extrapolated to your entire volume of claims for that payer, resulting in large refund requests.

Postpayment reviews come in the form of a letter with a listing of claims for which the practice must submit records. Pay attention to the deadline in the letter. Failure to provide documentation will result in the payer requesting their payment back.

A payer may give you only one appeal opportunity, so it's better not to squander that with having to prove your practice performed the service. Rather, you want to use the appeal to defend your coding.

What should I do?

1. Pull the records and submit by the payer's deadline. Include all supporting documentation (ie, laboratory results or radiology reports).
2. Be patient. It may be longer than 6 months before you hear the results of the review.
3. Review every claim that the payer counted as an error. If the number of claims is high, consider using an external auditor with experience in urgent care to perform this review.
4. Involve your medical team. The current Evaluation and Management (E/M) guidelines were written for medical providers and can be subjective. For example, take the element Risk of Complications and/or Morbidity or Mortality of Patient Management. The American Medical Association offers little guidance beyond a few examples in their medical decision-making matrix. However, these are not meant to be absolutes. Ultimately, the management risk is what is understood by providers of your same specialty. The individual that reviewed the claims for the payer may have no experience with urgent care. This is where the medical team can assist with identifying the visits to appeal and the rationale for your appeal.
5. Pay attention to the appeal deadline. If you need more time, call and request an extension from the special investigator listed on the letter.
6. Negotiate. Your practice may have to send some amount back to the payer. However, usually the payer will ask for the full payment back. If the payer has agreed that your practice was entitled to payment yet at a lower level and you agree, offer to send back the difference only.
7. Use this as an opportunity to improve your documentation and educate your providers.

"Don't panic, but take these reviews seriously. Be organized and perform your own review focused on defending your coding...and creating a learning opportunity for provider documentation and coding/billing processes going forward."

Probe Review

Level of concern: High

Probe reviews happen when a payer notices an unusual pattern in your claims data. The letter you receive will look similar to a postpayment review letter. The dates of service will be current, however. The letter may even say it is a probe review. Usually, these are provider-, not practice-specific.

What should I do?

1. Pull the records and get them to the payer by the deadline in the letter.
2. Don't wait for the payer to send you the results. That could be months. Have a coding/billing expert review the sample of claims requested to identify any red flags.
3. Research and, if needed, correct any mistakes that your expert identifies on a go-forward basis. Claims that have already been billed should be addressed with the special investigator at the insurance plan after the results are received.

Bottomline: Don't panic, but take these reviews seriously. Be organized and perform your own review focused on defending your coding, where applicable, and creating a learning opportunity for provider documentation and coding/billing processes going forward. Be prepared to respectfully advocate for your practice. ■