How to Survive a Payer Review

Benjamin Barlow, MD; Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC

One of the biggest challenges facing urgent care operators is increased scrutiny in the form of payer reviews. More clients than ever are facing these administrative and financial burdens. Compounding the issue is that urgent care clinicians often struggle to understand coding guidelines and how to document in a way that shows their medical decision making, which is vital in care and in payer reviews.

Prepayment Reviews

Nationally, we are seeing prepayment reviews on current claims. Prepayment reviews occur when a practice's claims data is analyzed by the payer, resulting in a specific provider being identified as an outlier. For example, Dr. Jones is billing more level 4s than other providers of the same specialty in her area.

Practices are notified which provider and codes will require a review prior to adjudication of the claim by letter, indicating the date the prepayment review takes effect. Claims for the provider whose codes are under review require 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.

Many of these prepayment reviews are unofficial. This means there is no specific threshold of accuracy to reach before being removed from prepayment review (eg, 500 claims with an accuracy of 95%). Thus, the removal from prepayment review is subjective to the reviewer. Payers routinely requesting medical records are UnitedHealthcare, Elevance (formerly Anthem), Wellmark (via Optum), Blue Cross California, MDWise, CareSource, and Medical Groups in California. Providers in California, Indiana, and Illinois have been affected particularly hard.

Benjamin Barlow, MD is Chief Medical Officer for Experity
Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC is Manager of RCM Compliance at Experity.

Postpayment Reviews

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 (CMS) 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 determine 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.

These reviews are outsourced to cost recovery companies like Cotiviti or MCMC. Clients have reported that Cotiviti is specifically targeting urgent cares. This is due to the increased volume during the public health emergency when urgent cares were often the only practices willing to see COVID-19 patients. Often, they question services performed in drive-up clinics.

It is important to review these claims line by line and address their rationale for not allowing the claim. Our team at Experity has reported the following errors:

- Utilizing the 1995 guidelines for claims submitted in 2021 and after. The reviewer incorrectly stated that the only change was to the time requirements.
- Incorrectly counting data reviewed by excluding in-house labs or send-out labs.
- Downplaying the seriousness of COVID-19 in prior years. According to the National Center for Health Statistics, COVID-19 was the 3rd leading cause of death in 2020 and 2021.[1]
- Misinterpreting the CMS guidance on use of CPT 99211 for specimen collection.

Keep in mind when a request is made for repayment of previous reimbursement, it can become a matter of negotiating. Payers will ask for a refund of the full amount of the claim instead of the difference between what was coded and what they think it should have been. In the case of extrapolation, this can result in refund requests in

the 6-figure range. When requesting a redetermination, it can be helpful to make a counteroffer based on your review of their findings.

Medical Decision Making

Current coding guidelines focus heavily on the provider's medical decision making. This makes it more important than ever for documentation to reflect the full scope of the problems the provider is evaluating at the visit.

Providers are taught in medical training to form a list of diseases, a differential diagnosis, based on the patient's history, past medical history, and exam. That differential diagnosis is then refined with testing and the most probable diagnosis is then selected as the patient's final diagnosis. If a provider only documents their final diagnosis, it is impossible for auditors to know what the provider was thinking and what problems they addressed. This is why it is a best practice for providers to clearly document the decision-making process they went through during the patient's evaluation. This process is not only critical for coding compliance and accuracy but aligns with excellent patient care. Clinicians learn how to from a differential diagnosis early in their training because if a clinician is not thinking about it, they may miss it.

Organizations wishing to improve should organize and document a standard process of providing specific recommendations and education to the clinicians providing the care. Have a coding champion that interacts with the providers and helps them improve based on the feedback from your center's billing team is critical for improvement.

Often clinicians don't know what they don't know regarding coding guidelines. Education and helping them understand current guidelines will improve the whole team's ability to code claims accurately and streamline the flow of claims. Implementing this education and review process will drastically decrease the chance of prepayment reviews. If an organization does receive a prepayment review and they don't make changes, the review may be extended, causing more payment delays. Always appeal the claims that you believe are correct but also focus on improving your organization's documentation through an organized training program.

Reference

1. Centers for Disease Control and Prevention website. National Center for Health Statistics COVID-19 Death Rate and Resources. https://www.cdc.gov/nchs/nvss/covid-19.htm Accessed December 21, 2023.