



Zelis Expert Claims Review[®]

Managing Increasing
Complexity in
Healthcare Billing





Introduction

Complex and high-cost claims are increasing in volume, with serious financial implications for payers, providers, and members.

Variation in billing practices, particularly the accuracy and complexity of submitted claims, directly affects the review and payment process, as inaccuracies or high-complexity claims require more extensive scrutiny and can delay reimbursement. The prevailing trend toward billing at higher complexity levels likewise increases administrative burden on payers to ensure claims are properly supported by documentation and aligned with contractual agreements, impacting the speed and efficiency of payment.

Payers are obligated to comply with regulations that impose specific time constraints for processing and paying claims, often mandating tight turnaround times and raising the risk of penalties for delays. These time-bound mandates ensure payers expedite reimbursements to healthcare providers and maintain regulatory compliance.

Zelis Expert Claims Review can address the increase in complex and high-cost claims by carefully evaluating the appropriateness, medical necessity, and accuracy of the billed services. The process can identify discrepancies, overbilling, and unjustified coding levels, ensuring that charges align with actual service delivery. It can also establish benchmarks for medical services to keep billing practices consistent and fair.

By choosing a strategic partner that leverages artificial and human intelligence, health plans and third-party administrators (TPAs) can fortify their payment integrity and generate savings more efficiently and effectively, benefiting providers and members.



The Billing And Claims Landscape

The healthcare billing and claims landscape has evolved into a more complex system characterized by increased regulatory demands, a shift toward higher-complexity claim submissions, and a greater need for advanced technology and analytics to ensure accuracy and compliance in reimbursements.

State and federal regulations and individual contractual agreements dictate the timelines for healthcare payers to process claims, with prompt payment laws typically setting a window of 30 to 45 days for electronic claim reimbursements. [The Employee Retirement Income Security Act \(ERISA\)](#) guides self-insured plans without fixed time frames. At the same time, Medicare and Medicaid enforce a 30-day deadline for clean claims, and the Affordable Care Act and No Surprises Act further influence these timelines, particularly with new reporting requirements and protections. Non-compliance with these timeframes can lead to financial penalties and additional costs for payers.

Due to the shifting landscape of medical claim intensity levels, high-cost and complex claims have escalated as a significant challenge for payers. According to [an analysis by the Peterson Center on Healthcare and Kaiser Family Foundation](#), data indicates that moderate claims have decreased from 60% in 2004 to 45% in 2021. In contrast, higher intensity level 4 claims have surged from 19% to 37% in the same period.

Additionally, new high-cost centers continue to emerge, such as in the dialysis space. Researchers from the University of Southern California have found dialysis costs for patients with end-stage kidney disease (ESKD) in the individual market [have soared to three times the amount that Medicare pays](#). Specifically, on average, individual market plans spend \$10,149 per month on outpatient dialysis for each ESKD patient, which is over 300% higher than what Medicare reimburses for the same service. Patients with ESKD also incur monthly healthcare costs 33 times higher than individuals without ESKD.

Variations in billing practices have become a significant pain point. According to the American Medical Association, provider billing practices negatively impact claims review and payment due to [coding issues such as unbundling, upcoding, and incorrect use of modifiers](#). Unbundling involves using separate codes for a procedure that should have a single comprehensive code, leading to increased claims. Upcoding is reporting a higher-level service than what was performed, often resulting in excessive billing. Failing to adhere to national correct coding methodologies can result in inappropriate payments, while incorrect reporting of time-based services like infusions and injections, as well as misusing unlisted codes without proper documentation, can lead to further errors and delays in the claims process.

The healthcare industry is also witnessing a [shift in reimbursement models](#) from percentage-of-charge contracts to locked reimbursement models such as fee schedules, diagnosis-related group (DRG) reimbursement, ambulatory payment classification (APC), and enhanced

ambulatory patient groups (EAPG). In traditional percentage-of-charge models, healthcare providers bill a percentage of their set charges. These charges can increase dramatically year over year, leading to increased costs for insurers. Conversely, locked reimbursement models like DRG, APC, and EAPG aim to standardize payments based on specific medical services provided or patient diagnoses, making costs more predictable for insurance companies.

Despite rapid digital transformation over the past few years, manual processes and lack of interoperability in claims review and payment are leading to increased administrative costs for payers and providers. The [2022 CAQH Index](#) indicates that despite advances in automation, which have improved efficiency and reduced costs, the healthcare system still spent \$60 billion on administrative transactions, with potential savings of nearly \$25 billion achievable through full automation.

Addressing these challenges across the billing and claims landscape requires a combination of technology adoption, process improvements, and effective communication between all stakeholders.

Diagnosis-Related Group (DRG) reimbursement is a system for classifying hospital cases into groups with similar clinical characteristics and expected costs, allowing for a fixed payment rate for inpatient care.

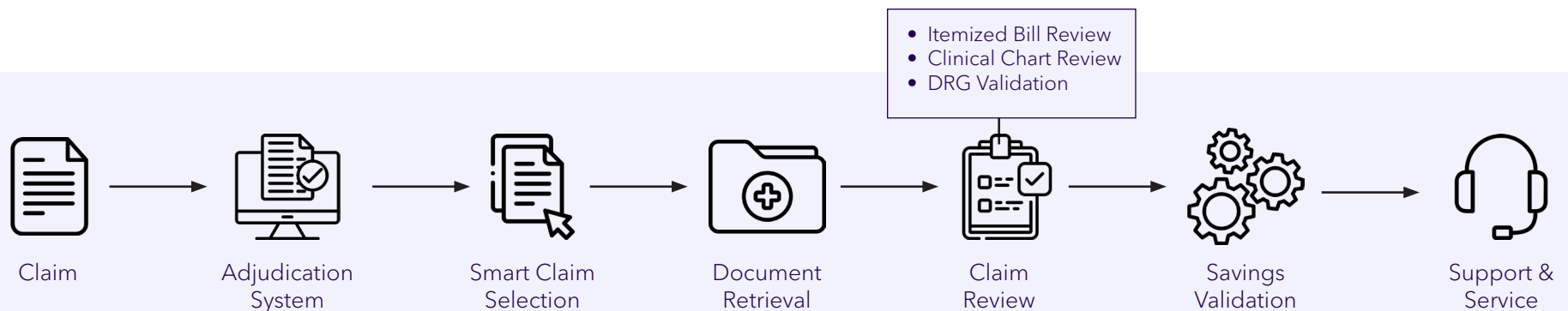
Ambulatory Payment Classification (APC) is a classification system used by Medicare for outpatient services. APC groups procedures and services that are similar both clinically and in terms of the resources they require, with set payment rates for each group.

Enhanced Ambulatory Patient Groups (EAPG) is a payment methodology that categorizes outpatient services to determine payment. EAPGs are designed to explain the amount and type of resources used in an outpatient visit and often reflect the complexity and severity of the patient's condition.

How Automation Optimizes Claims Review

A streamlined claims review workflow integrates human expertise with advanced technology to meet strict turnaround times and identify savings. This process includes the initial evaluation of the claim, efficient adjudication, intelligent selection of claims for further review, swift retrieval of necessary documents, thorough claim examination, validation of identified savings, and comprehensive support and service.

The collaboration between technology and human reviewers enhances efficiency, speeds up the decision-making process, and ensures accuracy in identifying potential savings.



“Ensuring claims are paid correctly the first time and reducing costs are hallmarks of an effective claims review program,” says Brian Rubio, Vice President of Product at Zelis. “Fast turnaround time is crucial to meeting prompt payment requirements. Claims may undergo initial reviews by the client and can take 10 to 14 days before reaching us. Automation enables claims to be intelligently routed to the right expert claims reviewer who must also have actionable intelligence at their fingertips.”

Automation is key to savings, reducing the manual processes contributing to outsize healthcare spending.

“Utilizing technology to correctly process claims from the outset can significantly reduce the 15 to 20% of healthcare costs attributed to administrative tasks such as managing medical records, addressing denials, and repricing,” Rubio explains. “This efficiency not only results in cost savings for providers and payers but also conserves resources for Medicare and Medicaid that allow for extending more benefits to more people. And members benefit by ensuring they face accurate deductibles and co-insurance amounts, reflecting the true cost of services.”

While the benefits of effective claims review are clear, payers of various sizes are limited in their ability to take on this work themselves. In an economic environment defined by a limited skilled workforce and a demand to reduce costs, payers can achieve new levels of efficiency and effectiveness by tapping into external resources combining both artificial and human intelligence, the latter proving invaluable to understanding the complexities of claims reviews.

Components of Effective Expert Claims Review

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“At the end of the day, you always need an expert looking at it just because of those nuances,” notes Emily Ehle, PharmD, Vice President of Operations for Expert Claims Review at Zelis. “While technology plays a significant role, the human expertise of coders and clinicians is essential for a final review to guarantee the accuracy of every claim. Some payers have tried a variation of it, but they often can’t achieve the same level of aptitude, efficiency, and savings compared to a company with the right combination of people, process, and technology.”

Human intelligence applied to claims review ensures provider satisfaction, meets high quality standards, generates client savings, and drives innovation, given the complexity of medical billing and the necessity of continuous education and adaptation.

“Prioritizing strong, transparent relationships with providers leads to both savings and increasing levels of trust between payers and providers,” Ehle emphasizes. “Educating billing departments is essential due to the intricate nature of medical billing, especially with complex cases and the growing prevalence of high-cost drugs. The ability to communicate person-to-person backed by data cannot be overstated.”

In the context of Expert Claims Review, payers gain efficiency by engaging external expertise that blends human and artificial intelligence, with human insight being critical for grasping claims complexities and ensuring accuracy.





WHERE HUMAN INTELLIGENCE MATTERS

Itemized bill review is a process that involves a detailed examination of itemized medical bills by certified coders to identify billing and coding discrepancies. The review ensures the correct application of charges according to industry-standard guidelines and seeks to correct errors such as duplicate charges, inconsistent billing, or medically unlikely services. Additionally, the review process addresses unbundling issues, where services that should be billed together are inappropriately separated, and professional charges that may not be reimbursable.

Clinical chart review is a detailed evaluation of medical records by clinicians, focusing on the accuracy of billed charges. It involves analyzing complex claims to confirm the clinical accuracy and necessity of the care provided, the appropriate length of hospital stay, the correct use of specialty medications, and the medical necessity of experimental treatments and implants.

DRG validation is the process of carefully examining all aspects that influence the payment level for a hospital stay to ensure the accuracy of the DRG code assigned. The goal is to confirm that the medical record supports the DRG billed and adheres to the official coding rules, ensuring accurate reimbursement. If errors are found, recommendations for DRG reassignment are made, which can affect the payment and savings realized.

Dialysis review is a specialized process where medical billing experts scrutinize dialysis-related charges for accuracy and compliance with medical billing standards. The objective is to verify that each claim is accurately represented and billed per accepted medical billing practices and rectify discrepancies like overcharges, undercharges, or misclassified services. This ensures that only legitimate, medically justified dialysis claims are submitted for reimbursement.

Pre- to post-pay claims review is a streamlined approach that integrates the handling of claims before and after payment. This innovative method differs from the common practice of managing these stages as distinct silos. A coherent and consistent process is ensured by maintaining a single department to oversee the entire lifecycle of a claim, from pre-pay review to post-pay handling. If timing issues arise with a claim in the pre-pay stage where a review cannot be completed in the designated turnaround time, our process will allow for a seamless transition to post-pay review by the same team, ensuring the claim is paid accurately. This continuity eliminates discrepancies that typically occur between pre-pay and post-pay reviews, and minimizes complications with healthcare providers and enhances efficiency for clients.

Choosing The Right Strategic Partner

Zelis Expert Claims Review not only identifies inaccuracies and unnecessary billing but also promotes fair and consistent billing practices across the board. As healthcare billing practices evolve and regulatory demands tighten, payers must pivot towards more sophisticated solutions. An adept partner offers advanced technology to facilitate intelligent claim routing and data analysis while retaining human expertise to navigate the nuances of complex claims. This combination is essential for achieving high standards of accuracy and ensuring that reimbursement aligns with the services rendered.

Selecting the right strategic claims review partner is crucial in addressing the complex challenges of today's healthcare billing and claims landscape. Accurate and efficient claims review is paramount to financial stability and regulatory compliance with complex and high-cost claims rising. A strategic partner that utilizes a blend of artificial and human intelligence can significantly streamline the review process, ensuring that claims are correctly paid in the initial pass, minimizing costly rework and ensuring compliance with strict regulatory timelines.



About Zelis

Zelis is modernizing the healthcare financial experience by providing a connected platform that bridges the gaps and aligns interests across payers, providers, and healthcare consumers. This platform serves more than 700 payers, including the top-5 national health plans, BCBS insurers, regional health plans, TPAs and self-insured employers, and millions of healthcare providers and consumers. Zelis sees across the system to identify, optimize, and solve problems holistically with technology built by healthcare experts – driving real, measurable results for clients.

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