



Flawed Medical Claims Handling Undermines Program Integrity

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EXECUTIVE SUMMARY

Every year, lack of prioritization of program integrity practices needed within the medical claims' process leads to increases in fraud, waste, and abuse that has totaled over \$200 billion in recent years across Federal, State, and Commercial healthcare plans [1].

The much needed focus on program integrity typically combines technology, people, processes, and corporate cultures to ensure that healthcare providers receive honest reimbursement for services rendered, while all protecting stakeholders in the healthcare ecosystem—beneficiaries, providers, and payors.

Efficient claims processing is crucial for the financial health of healthcare stakeholders and for ensuring timely payment for services rendered, among numerous other benefits. Current healthcare claims handling faces significant program integrity issues due to the complexity and volume of claims. Fraud, waste, and abuse issues divert resources from essential healthcare services, leading to increased costs and inefficiencies that harm the quality of care and appropriate reimbursements.

Fraudulent activities include billing for services not provided, upcoding, double billing, kickbacks, medical identity theft, and duplicate claims. These inflate healthcare costs and undermine trust in the system. **Waste** involves the overutilization or misuse of services, often due to poor oversight or inefficient processes, such as excessive tests or treatments that do not improve patient outcomes. **Abuse**, highlighted during the COVID-19 pandemic, involves practices inconsistent with sound medical or business practices, leading to unnecessary costs and improper revenue generation.

Efforts to address these issues include enhanced data analytics, better distribution of labor, cultural buy-in, stricter compliance, and increased transparency in progress made on combatting fraud, waste, and abuse. However, the scale of the problem requires constant improvements in claims processing workflows to maintain accuracy and integrity as 'bad actors' continue to exploit weaknesses. Addressing these challenges is vital for maintaining healthcare financial health and ensuring resources are used appropriately.

By prioritizing program integrity, quality of care can increase, providers are reimbursed properly, premiums stabilized, and dollars recouped efficiently.

SIGNIFICANCE OF THE PROBLEM AT HAND

The healthcare industry in the United States (U.S.) is one that recently accounted for nearly 18% of Gross Domestic Product (GDP), with an average rise of nearly 6.0% per calendar year expected over the next seven (7) years into 2032. [2].



With a rise of annual healthcare spend in the U.S., claims processes that incorporate multiple 'good' to 'best' program integrity practices will still have a varying improper payment starting at 6% and upwards.

For claims handling processes that do not incorporate compliant or policy-driven program integrity solutions in any capacity, the improper payment percentage in those processes will continue growing starting at 10% and quickly going upwards. The importance of program integrity to prioritize the mission surrounding fraud, waste, and abuse in healthcare, with a yearly healthcare spend of \$5 trillion, is now needed more than ever. The claims adjudication process is one that cost health systems, hospitals, and post-acute care providers more than \$25 billion in claims adjudication in recent years. [3]

With dollars growing between healthcare spend, improper payment, and claims adjudication costs, J29 has worked with various clients at the commercial, State, and Federal levels to make sure they are leading the initiative to prioritize program integrity in the way that we process, review, or analyze medical claims, records, disputes, audits, and codes.

WHERE DO WE START?

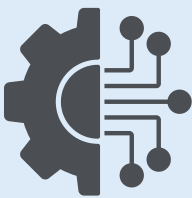
The first step in a solution starts with the culture of the organization, agency, or stakeholder. Now, more than ever, effective leadership can lead the prioritization and importance of program integrity within various corporate processes related to the flow cycle of a medical claim – with benefits ranging from labor costs, employee morale buy-in, financial prioritization for improper payment prevention, and lowering of vendor or internal spend due to program integrity battles.



Effective Provider Credentialing, Enrollment Verification, and Future Auditing

Providers that are enrolled, or have been previously enrolled into a plan should be properly credentialed and cross-referenced against various State and Federal exclusion lists along with provider registry databases. A majority of provider credentialing issues stem from the lack of self-reporting that should be done by providers.

The J29 team has observed that most provider credentialing changes occur approximately every 11-14 months. Leveraging various technology connections between internal and external systems to ensure that data is properly ingested, cross-referenced, and providers needing to be re-credentialed are flagged is a step in the right direction. Regular updates and audits can also ensure that such provider information remains accurate, non-excluded, and reliable for the payors and beneficiaries.

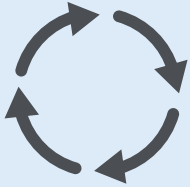


Implementation of Compliant and Certified Claims Processing Technologies

Now, more than ever, it is critical to maintain reasonable proper staffing levels through the claims processing lifecycle to ensure that human intervention is there as needed. From front-end claims filtering to proper auto-denial inputs, the technologies that teams are leveraging should be constantly updated with front-end edit policies and codes that governmental agencies make readily available. J29 is proud to be a leading front-end edit policy, procedural, and consulting party to clients today.

Adjudication should utilize advanced technology and automated workflows to streamline claims processing, ensuring compliance and reducing errors while infusing some of J29's strongest subject matter experts into the process.

SOLUTION (CONTINUED)



Infusing of Payment and Coding Policies through Lifecycles

Commercial, State, and Federal agencies invest billions of dollars in ensuring that collaboration and research goes into medical coding and payment policies before they are issued. Companies that are passionate about program integrity cannot say they prioritize such a mission, but not incorporate the appropriate policies and guidelines that are there to help them auto-adjudicate.

It is imperative to leverage policy and compliance expertise into the program integrity medical claims practices. Organizations should regularly update policies to reflect changes in regulations and industry standards.



Leveraging Proper Prior Authorization with a Process Improvement Mission

During a time of such emphasis on technology being infused into the prior authorization space, companies should properly mix subject matter experts with technology tools that they are using. Nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process. [4] Labor, system connections, escalation procedures, and technology solutions can help ensure that claims that were pre-approved for medical necessity are not then being adjudicated extensively.

With CMS' Final Rule (CMS-0057-F) insinuating plans leverage prior authorization automation by 2026, it is imperative now more than ever to reconstruct processes to have future streamlining.

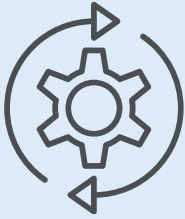


Pre-Payment Auditing and Processing Capabilities

The J29 team has seen that operational processes and costs are streamlined more efficiently when pre-payment claims processes are properly configured and implemented versus the historical notion to address program integrity issues at the post-payment stage.

Companies should implement pre-payment review processes, medical coding detections, medical necessity, and guardrails to identify and correct errors before claims are paid. Analytics tools can be utilized to flag high-risk claims for more accurate and efficient reviews.

SOLUTION (CONTINUED)



Incorporating Risk-Based Approaches, Leveraging Automation Tools

Incorporating risk-based approaches in medical claims program integrity involves identifying and prioritizing potential fraud, waste, and abuse risks to ensure that resources are effectively allocated to mitigate critical threats.

Where are the risks for program integrity exposure in your process? Leveraging automation tools can support this process by providing real-time data analysis, detecting anomalies, and reducing errors that come with being too manually reliant.



Data Sharing, Analysis, and Auditing on Findings

In all phases of the medical claims' lifecycle, data analytics can be leveraged to lower the occurrence of program integrity concerns – fraud, waste, and abuse. The creation of interactive business intelligence dashboards help show bottlenecks, aged claims, and tools such as proper Application Programming Interface (API) data mappings to highlight outliers in chargers should be taken advantage of.

Claims auditing tools can also be used to enable thorough reviews leveraging program integrity methods for high-risk areas impacting claims payment and processing accuracy.



Enhanced Fraud Detection & Proper Payment Analysis

It is important to incorporate both human knowledge and technology in a well-balanced structure within program integrity environments, thus empowering fraud protection. Where reasonable and when data-backed, consider implementing machine learning and Artificial Intelligence (AI) to enhance fraud detection and prevent improper payments. Staying ahead of how 'bad actors' take advantage of program integrity vulnerabilities is an important recurring step to make sure subject matter experts are involved in such assessments.



Staffing Training and Cultural Buy-in on Program Integrity

Program integrity starts with leadership buy-in at the top and should become infused into the culture of an organization or team. From there, recurring staffing training on compliance and ethical practices to reduce errors and misconduct should be conducted.

IN CONCLUSION

Named the 2023 Small Business of the Year by a National Contracts Management Associations (NCMA) Regional Chapter, J29 continues to be recognized for its services to health and human service missions at the commercial, State, and Federal levels since company inception.

Today, J29 has provided successful support, management, and process re-designs to clients that have been in need of incorporating more clinical, policy, compliance, and technology-driven program integrity solutions. Important to today's healthcare ecosystem, technology solutions should be leveraged and implemented in environments that are applicable and have a use-case that is understood by the appropriate subject matter expertise.

Equally important and fundamental to the creation of J29, was giving back and supporting people in the community. Making company culture the main priority ensures employees' satisfaction and retention. We believe in empowering employees to support the missions that we serve.

When you invest in your people, and focus on creating a healthy work life balance, then your employees will take care of your customers and make sure they are happy.



Established in 2017 as an Economically Disadvantaged Woman-Owned Small Business (EDWOSB), and 8(a) certified company, J29 continues serve as an award-winning employee-centered healthcare management consulting company to clients at the commercial, State, and Federal levels.

As commercial, State, and Federal agencies are being tasked now, more than ever, to identify program integrity gaps or vulnerabilities, it is imperative that the medical claims lifecycle is taken seriously. By prioritizing integrity, we can prevent fraud, reduce errors, and ensure that resources are allocated to those who truly need them to prevent waste through improper payments.

SOURCES

- [1] [Medicare and Medicaid: Additional Actions Needed to Enhance Program Integrity and Save Billions](#)
- [2] [NHE Fact Sheet](#)
- [3] [Hospitals, Providers Spent \\$25B on Battles Over Claims, Report Finds](#)
- [4] [Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims](#)