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Points of Light

Points of Light 2024 Case Study 9

Reducing Administrative Burden by Resolving Overpayment Claims via a Third-Party Partner

May 2024

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Reducing Administrative Burden by Resolving Overpayment Claims via a Third-Party Partner

Executive Summary

The payer and provider organizations in this collaboration were struggling with a high volume of correspondence regarding potential overpayment claims, creating an administrative and time burden for both organizations. To resolve this issue, they partnered with TREND Health Partners to review potential overpayments and facilitate communication between the organizations. Outcomes include a reduced administrative burden for the organizations and improved financial performance for the health plan.

The Collaborators

Healthcare Organization 9

Anonymous
Location: AZ, CA, CO, NE, NV, and WY
Sizing: 31 acute care facilities

Payer Organization 9

Anonymous
Location: Nationwide
Sizing: 31.2 million members

TREND HEALTH PARTNERS

Headquarters: MD
Segment: Payment integrity

Points of Friction—Challenges to Be Solved

- **Volume of potential overpayment claims was causing administrative burden for payer and provider organizations and impacting their regulatory compliance:** Both payer and provider organizations share the burden of ensuring that their claims adjudication adheres to contract stipulations. To this end, payer organizations conduct regular audits to identify overpayments made to provider partners. They then must notify provider partners of those overpayments and reconcile the discrepancies by requesting refunds or adjusting future payments. Likewise, provider organizations are required to review their accounts for any credit balances, report those to the payer, and refund overpayments to the payer or patient. Both entities must maintain clear documentation of all transactions to demonstrate compliance in case of an audit. In this collaboration, contractual limitations kept Payer Organization 9 from being able to automatically recoup overpayments made to Healthcare Organization 9. To reconcile the overpayments, the two met for multiple hours each month to manually review each claim, placing a significant time and resource burden on both parties. Organizing and prioritizing the overpayments also proved challenging as potential overpayments were identified by both internal means and through work by third-party overpayment-recovery firms. The collaborators' objective was to increase the timeliness of recovery as well as the overall volume of overpayments recovered.

Action Plan—How the Collaborators Worked Together to Reduce Friction

- **Payer Organization 9 and Healthcare Organization 9 engaged a third party to review their data and help resolve overpayments in a timely manner:** Payer Organization 9 and Healthcare Organization 9 engaged TREND Health Partners to participate as a neutral third party in facilitating and mediating case review. TREND undertook a considerable amount of prework to reduce debate between the two parties during their recurring meetings. Payer Organization 9 provided TREND with an initial list of potential overpayments, and the vendor completed a comprehensive review of each of these claims. For the review, they leveraged various resources from Healthcare Organization 9, including the organization's patient accounting system, UB-04 forms, explanation of benefits documentation, and charge information. This manual review process has been crucial in verifying the legitimacy of the overpayment claims and ensuring the accuracy of the EOBs. TREND's team tackles coordination of benefits issues by searching payer eligibility systems, calling insurers, and collecting supporting documentation to enable Healthcare Organization 9 to accurately bill the correct primary insurance. Additionally, TREND locates primary EOBs that are missing from Payer Organization 9's records and forwards them to the payer's coordination of benefits department. Using their proprietary software, TRENDConnect, TREND facilitates electronic communication for overpayment request validations, allowing for paper-free approvals and real-time updates. Claims deemed incorrect or requiring further information from the payer organization are sent back weekly for resolution or closure of the request.
- **On a monthly basis, Payer Organization 9 pulled aged overpayments within TREND's scope of work:** TREND would then work those overpayments and provide the payer with weekly updates on which claims had been agreed or disagreed with and which claims had been approved by the provider organization to receive offset/recovery payment.
- **Healthcare Organization 9 reviewed all information on overpayment determinations that TREND loaded into their software:** This included information on claims analysis, an EOB view, charge reviews, and coordination of benefits/eligibility research. This allowed Healthcare Organization 9 to come to a final determination on a claim.

- **Payer Organization 9 routinely held monthly calls with Healthcare Organization 9 to review the lists of previously identified overpayments:** Healthcare Organization 9 also worked with TREND's team to preview lists of claims before the monthly calls. Through these efforts, the number of claims able to be addressed on the monthly calls increased by 500%.
- **Payer Organization 9 negotiated contingency fee arrangements with overpayment recovery vendors:** This enabled them to identify overpayments on the payer organization's side and route those to TREND for review. TREND then sent these to Healthcare Organization 9 for final review.

Points of Light—Outcomes Achieved through Collaboration

Reduced administrative abrasion in the claims-resolution process for the payer and provider organizations

Resolved 298 accounts of potential overpayment: In some cases where the payer organization felt they had overpaid Healthcare Organization 9, TREND determined that the provider hadn't been overpaid, resulting in $1.7 million in savings for the provider.

2,000 finalized overpayments (worth $7.7 million in cost savings) since project inception

Lessons Learned—What Best Practices Can Other Organizations Replicate?

- **Mutual trust across all stakeholders is imperative for success:** In order to achieve timely credit balance resolution, all stakeholders needed to develop a trusting partnership. Trust was earned by having a mutual third party at the table (TREND) who was a subject matter expert and was transparent in their communication with the payer and provider organizations.
- **Ensure everyone at the table is operating from the same set of data:** The TREND solution gives all stakeholders access to the same data. This reduces friction and ensures there is no misalignment as to what is being discussed.
- **Be flexible and think outside the box:** For example, the payer's COB expert was spontaneously brought in to educate both TREND and Healthcare Organization 9. The improved understanding helped create a more seamless process.
- **Maintain consistent, open lines of communication:** The collaborators in this case study held biweekly meetings to ensure close tracking of the claims. Having hard conversations in an amicable way helped the partnership be successful in meeting shared goals.

What's Next?—Vision for the Future

- **Expand to additional payer-provider relationships:** TREND aims to continue to identify and alleviate friction points in payer-provider interactions by offering cross-function technology and processes that improve claims resolution. Additionally, Healthcare Organization 9 would like to scale this process to other payer partners they work with.