Payment Integrity Programs: A National Study on the Impact of DRG Audits on Provider Sentiment and Abrasion

Conducted by Frost & Sullivan
Commissioned by Change Healthcare
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Payment Integrity Programs: A National Study on the Impact of DRG Audits on Provider Sentiment and Abrasion
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Do healthcare providers think payment integrity programs are complex, frustrating, or laborious; or do they find them to be a relatively painless process? How do payment integrity programs affect the payer-provider relationship? How can payment integrity audits be improved? And most important, can these programs become a means to improve the payer-provider relationship, or are they doomed to degrade it?

To answer these and other questions, Change Healthcare commissioned Frost & Sullivan to assess provider sentiment toward traditional and non-traditional tactics that health plans use to operate payment integrity programs. Traditional tactics include Diagnosis-Related Group (DRG) audits, post-pay review, on-site audits, and more. Non-traditional tactics focused on the pre-submission review. The goal: to better understand how, where, and why payment integrity programs cause friction with providers; and to identify tactics that can reduce provider abrasion and costs for both parties, all in the interest of helping payers improve the provider experience without adversely affecting audit results.

This national study is, to our knowledge, the first time any organization has “taken the temperature” of providers regarding their feelings about, reactions to, and impact of payment integrity programs on their business. Armed with these insights, innovative payers can start to improve the alignment of their payment integrity programs with their provider networks’ needs.
**Research Methodology**

**Data Acquisition:** Email campaign to recruit qualified respondents from list provided by Change Healthcare.

**Participants:**
- Healthcare provider organizations that have experience with payment integrity programs.
- Senior level decision-makers for health information management systems.
- Work within a formalized HIM department with managerial responsibilities for any of the following areas:
  - Health information management (HIM)
  - Patient financial services
  - Release of information (ROI)
  - Coding of health information
  - Clinical documentation improvement

**Research Notes:** Due to rounding, percentages in charts and tables may not add up to 100.
Research Sample
Respondents were highly qualified to participate in the study

Familiarity With DRG Audits
- Very Familiar, 54%
- Familiar, 46%

Activities Involved In
- Health Information Management (HIM): 97%
- Release of Information (ROI): 87%
- Coding of Health Information: 75%
- Health Information Management Clinical Documentation Improvement: 71%
- Patient Financial Services: 30%
## Research Sample

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<td>Director of HIM</td>
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<td>Director of Health Information Management</td>
<td>HIM Executive/ Patient Access Officer</td>
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- Director of HIM: 83%
- Coding Manager: 6%
- Director of Compliance: 3%
- Director of Health Information Management: 3%
- Coding Director: 2%
- Director of Health Information: 2%
- Director of HIM and Patient Access: 2%
- HIM Executive: 86%
- Coding Manager: 8%
- Compliance Officer: 3%
- HIM Executive/ Patient Access Officer: 2%
- Other: 2%
Research Sample

Region

- Midwest 19%
- Northeast 25%
- Southwest 17%
- West 11%

State

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Key Findings
Key Findings

About 1 in 4 providers have a bad experience with payment integrity audit and recovery.

50% of providers consider clinical validation audits and DRG coding very or extremely labor-intensive.

43% of providers believe pre-submission alerts can decrease administrative burden.

44% prefer pre-submission notification compared to 21% who prefer post-payment reviews.

The volume of medical requests clearly has the greatest impact on provider abrasion, with nearly half (46%) characterizing it as extremely abrasive.

50% of providers consider some audit vendors better than others—because they require fewer records and give comprehensive responses.

Overall DRG audit experience with third-party vendors is negative for 27% of organizations.

50% of providers prefer working with payers/auditors that: communicate thoroughly; provide comprehensive responses to appeals; use staff with medical records.
The Impact of Payment Integrity Programs on Provider Abrasion
More Providers Report Negative Payment Integrity Experiences

We asked providers how positive or negative their experience with commercial payers or their third-party audit vendors was during the audit and recovery process, and why.

**Negative experiences outweigh positive 27% to 22%.** Equally concerning, a mere 5% of providers rank their experiences as “extremely positive.” Half (51%) characterize their experiences as neither negative nor positive, which could be a lost opportunity for payers to stand out by better engaging their providers.

A major source of negative experiences is the providers’ perception that the audit process is biased to favor payers. Another common complaint: Providers say auditors often don’t tell them what they’re looking for. Providers want to understand the auditor’s rationale for decisions, and want decisions supported with clinical references or evidence.

Comments from providers who are satisfied with the audit process align with feedback from those who are not satisfied: **It’s all about communication.** The more frequent and transparent the communication, the more likely the provider will view the payer and auditor in a favorable light. Better communication leads to better provider experiences and lower abrasion.
Nearly 25% of Providers Want Payers to Improve the Audit Process

We asked providers which of the following statements best describes their experience with DRG audit and recovery. Nearly 1 in 4 say they viewed the process in a bad light, while only 10% had a “very positive” experience.
Most Providers Associate the Volume of Medical Record Requests With an Abrasive Experience

We asked respondents to rate their experience with four dimensions of commercial payer audits.

The volume of medical requests clearly has the greatest impact on provider abrasion, with more than 9 in 10 respondents (92%) tying it to abrasion, and nearly half (46%) characterizing it as very abrasive or extremely abrasive.

A mere 8%-16% of providers found no abrasion with practices across the board.
A Quarter of Providers Receive Over 500 Medical Requests Monthly

We asked providers what their hospital’s approximate monthly volume of medical record (MR) requests was over the past 12 months.

Two-thirds (67%) say they have to deal with up to 500 requests a month, and one quarter (24%) said they have to respond to 501 to over 2,000 requests monthly.

We also asked providers for their preferred way to deal with a payment integrity request. Perhaps unsurprisingly, nobody wants to meet with an auditor (only 2% say they preferred an onsite visit). Providers clearly welcome easier ways to provide audit information.
We asked providers what percentage of their claims are subject to payment integrity DRG audits, and how reasonable or unreasonable that volume is.

Nearly 3 in 10 respondents say they are audited for 1%-3% of all their claims. Nearly 30% report audits for 4%-10% percent of claims. And 1 in 20 say over 10% of claims are audited.

The result is a provider population that’s nearly two times (21%) more likely to say the audit volume and potential recovery are unreasonable, compared with those who say the volume is reasonable (12%).

1 in 5 Consider Audit Volume Unreasonable
For Those With Higher Claims, 1 out of 4 Consider Them Unreasonable

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The result is a provider population that’s nearly two times (21%) more likely to say the audit volume and potential recovery are unreasonable, compared with those who say the volume is reasonable (12%).
Over 50% Say Payment Integrity Audits Are Labor-Intensive

We asked how labor-intensive is it to manage payment integrity audits.

More than half of respondents say they are “extremely” or “very” intensive, and up to 95% describe them as having some intensity. Only 2%-5% define them as “not intensive.”

Labor intensity has a direct impact on administrative costs. The more a process is labor-intensive, the more costly that process becomes for an organization.
Audit Compliance Costs Exceed $500,000 for 1 out of 5 Providers

About 1 in 10 Providers Spend Over $1 Million Annually on Compliance Audits

We asked providers what their hospital’s approximate annual expense is for managing the audit process across all payers, including staff and other resources.

Ensuring payment integrity is an expensive proposition. Nearly 1 in 10 (8%) say they spend more than $1 million on payment integrity audits every year. Fully 1 in 10 (10%) spend between $500,000 and $1 million. Just under half (46%) say they spend $500,000 or less annually.

Perhaps more concerning: 4 out of 10 (37%) don’t know what payment integrity audits are costing their organization on the audit process.
Most Audits Occur After Reimbursement
More Than Three-Quarters of Payment Integrity Requests Arrive After Payment

We asked providers roughly what percentage of their audit requests from commercial payers were of the following types over the last 12 months.

Fully 3 of 4 DRG audit requests (76%) arrive after reimbursement.

Timing of DRG Audits

Prior to reimbursement: 24%
After reimbursement: 76%
Automatic DRG Down-Coding Without a Review Increases Provider Abrasion
54% of Providers Consider Technical Denials “Extremely Negative”

We asked providers how positive or negative is automatic DRG down-coding without an actual review of the medical records (also known as a “technical denial”).

Technical denials without a review are viewed negatively by 6 in 10 (59%) of providers, with a clear majority (54%) characterizing the practice as “extremely negative.”

A third (33%) of respondents do not have a strong view of the practice, and only 8% see DRG down-coding in a positive light.
42% Understand Pre-Submission Notification Can Decrease Admin Costs
But 49% Remain Unsure of Pre-Submission’s Advantages

We asked providers if receiving notifications of potential audit risk before submitting a claim, and having the opportunity to correct potential errors, would reduce their organization’s administrative burden.

Some 42% of providers believe pre-submission notification would reduce administrative costs. A large subgroup (14%) said the administrative burden would decrease dramatically.

But there’s an equally large group of providers (49%) who believe the pre-submission notification would neither decrease nor increase costs. This is an opportunity for payers to educate providers with empirical evidence that documents how pre-submission notification can decrease providers’ administrative burden and reduce abrasion.
Pre-Submission Notification vs. Post-Pay DRG Audits
Twice as Many Providers Prefer an Opportunity to Address At-Risk Claims Before Submitting a Claim to Post-Submission Audits

We asked providers if they would prefer an alert indicating a claim is at risk and offering an opportunity to address the potential error before the claim is submitted.

More than twice the number of providers (44%) say they would prefer pre-submission notification over post-pay DRG audits (21%).

Nearly a half (44%) note some preference for pre-submission, with 1 in 10 (10%) saying that they’d highly prefer the pre-submission route. Conversely, only one in five (21%) say they’d prefer post-submission notification of audits.

Surprisingly, a substantial group—some 35%—state no preference either way. This indicates payers have an opportunity to educate these providers on the cost- and time-saving benefits of a pre-submission notification approach.
Two Vendors Generate Over 75% of “Regular” or “Frequent” Audit Requests

We asked providers which third-party audit vendors used by payers regularly or frequently sends them audit requests.

Two vendors are swamping providers with two-thirds of audit requests, dwarfing the remaining three leading players. Vendor 1 was cited by nearly 80% of providers, while vendor 2 was cited by 75%.

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<td>Other vendors</td>
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Providers Prefer Engaged Payers with Fewer Record Requests
Half Have a Clear Preference for Payers Using Collaborative Techniques

We asked providers if some commercial payers or their third-party audit vendors provided a superior experience to others. We also asked what makes for a superior experience (and thus, it could be argued, reduces provider abrasion).

Half of providers have a clear preference for working with payers/auditors that:

- Communicate thoroughly during a DRG audit
- Request fewer records
- Provide comprehensive responses to appeals
- Use staff with medical degrees

Are some payers/auditors better to work with than others?

- No: 49%
- Yes: 51%

Total
About Frost & Sullivan

For over five decades, Frost & Sullivan has become world-renowned for its role in helping investors, corporate leaders, and governments navigate economic changes and identify disruptive technologies, mega-trends, new business models, and companies to action, resulting in a continuous flow of growth opportunities to drive future success.
How Change Healthcare Can Help

Change Healthcare is a leading independent healthcare technology company providing data and analytics-driven solutions and services to help improve clinical, financial, and patient engagement outcomes. We work with payers and providers who want to improve clinical decision-making, simplify billing, collection, and payment processes, and enable a better patient experience.

Visit our Website
Glossary

**Payment Integrity Program:** Processing a healthcare claim involves multiple steps and touches multiple entities before it is applied to a healthcare bill. Payment integrity involves any program that influences the delivery of an accurate bill. The process includes the submission of accurately coded claims; the correct application of member benefits and provider contracts; and a focus on reducing errors, revisions, and waste or abuse.

**Medical record request:** A medical record can be requested for many reasons. As a part of the payment integrity process, medical records are periodically requested to ensure that not only have benefits and contracts been applied correctly to the claim, but the care included in the claim is supported by the medical record. Medical records include but are not limited to a patient’s medical history, test results, office visit notes, discharge summary, and operative reports of treatments and medical services.

**Automatic down-coding/down-coding without a review:** “Automatic down-coding” or “down-coding without a review” is a payment integrity process that takes place after the provider has been adjudicated but before the claim is paid. The challenge posed by automatic down-coding is that the process does not consider the unique nuances of the healthcare encounter and there is no automated method to ensure the record matches the level of billing, without doing a medical record review.

**Post-payment DRG audit:** A Diagnosis-Related Group (DRG) audit focuses on payment of a claim related to an inpatient hospital stay. The intent of a post-payment DRG audit is to ensure that the hospital has applied appropriate care, utilization, and billing practices to code the claim correctly. The post-payment DRG audit process requires obtaining the patient’s medical record in order to review the underlying and supporting documentation. Over the last several years, the increase in the volume and complexity of the audits has added significant stress on providers, and on the payer-provider relationship.