Collaboration is the key to ensuring a successful payer-provider relationship. However, effective collaboration requires mutual understanding between both parties. When payers and medical providers understand each others’ goals and compromise for the good of the patient, both parties benefit from cost savings and avoided billing disputes.

During a webinar hosted by Becker’s Hospital Review and sponsored by Optum360®, industry experts commented on the state of healthcare billing and the complexities surrounding the payer-provider relationship.

Bob Power, Optum360’s senior vice president of strategic client relationships, Mike Santoro, senior vice president of claims and appeals for UnitedHealthcare, and Jennifer Igel, vice president of San Francisco-based Dignity Health operations at Optum360, offered several insights on how to boost payer-provider collaboration to improve the billing process.

**Payer-provider friction**

One of the largest sources of tension between payers and providers revolves around clinical decision making. Physicians often grow frustrated or feel undermined when they decide to admit a patient after a face-to-face interaction, only for a payer – removed from the situation – to deny the case, claiming the admission wasn’t medically necessary or appropriate. However, what many physicians may not realize is their own clinical peers are behind those decisions to deny claims.

“Physicians don’t always realize insurance companies often employ their own physicians – it’s not just a clerk in the backend making the determination the patient didn’t need to be admitted,” said Mr. Power.

Another pain point for healthcare organizations is trying to reconcile physicians’ recommendations with the stringent protocols outlined by payers. Hospitals and health systems have to trust their physicians to make the right decisions for their patients, while also navigating the administrative aspect of the process to earn accurate compensation for care provided.

“The hospital administrators feel somewhat held hostage to the clinical decision-making by their physicians in the hospitals,” said Ms. Igel. She said hospital administrators often struggle with how to determine the appropriate level of medical necessity and care, while also following payers’ strict protocols.

Mr. Santoro said payers must realize they are not the only insurance company doing...
business with the provider. Oftentimes, providers have to navigate the rules and processes of a dozen or more different payers at once.

According to Ms. Igel, revenue cycle managers often feel like they must find their way through a maze of processes to appeal a claim decision. Every payer has their own appeals process and sometimes individual products even have their own approaches or timelines to follow. Payers and providers both devote significant amounts of staff time and money to review or appeal cases that may have occurred six months ago, creating a highly inefficient process.

Collaboration strategies

“Both [the payer and provider] must come to the table with an open mind to learn what they can do differently and how to simplify the process,” said Ms. Igel.

She recommends the healthcare organization start the collaboration process by conducting a review and analysis of some of the claims causing the most issues and rework. Once hospitals identify which types of claims account for the most denials, they can share this information with the payer and work together to find a solution.

“To be truly collaborative, [payers] have to step outside of their processes and stand in the shoes of the providers to look at it from their point of view,” said Mr. Santoro.

He believes payers must clearly inform providers what’s required and when in regards to submitting claims. A higher level of transparency within a payer’s contact center, web portals and published external policies can better articulate what’s required for a service to be payable. Payers shouldn’t tell providers how to bill, Mr. Santoro said, but they should instruct providers on how to access the payable benefit in the fewest number of steps to prevent an excessive back and forth process.

To limit disagreements over when a patient should be admitted, Mr. Power recommends holding a meeting between physicians on the payer and provider sides to establish agreed-upon admission criteria. The physicians should examine the 15 most commonly denied diagnosis-related groups and discuss appropriate admission criteria for these conditions. Agreeing upon these terms earlier “will result in fewer downgrades, less frustration for the physicians and better patient satisfaction,” Mr. Power said. This process will also reduce the cost of rework associated with appeals and denials.

Future of the payer-provider relationship

Going forward, the speakers are optimistic about the state of payer-provider relationships. “I think we’ll see better clinical alignment,” said Mr. Santoro. “Both [payers and providers] have been talking for a while now on how to eliminate all the administrative aspects preventing them from providing a better clinical outcome for the patients.”

Ms. Igel hopes to see clinicians play an active role in the decision-making processes to ensure every treatment and claim submitted to the payers is 100 percent necessary.

Mr. Power expects to see more insurers and providers jointly developing admission criteria to limit the amount of appeals occurring from denied claims. He also foresees a reduction in the amount of procedures requiring payer authorization.

“I think three to five years from now leadership on both the insurance and provider side will be sitting down as partners, trying to understand each other’s long term goals and see how they need to help each other achieve them,” said Mr. Power. “That’s where we need to be.”