BLOG | HEALTHCARE

5 Ways Payers can Reduce Physician Abrasion

by Mary Kane

Improving the physician and member experiences are critical undertakings for health insurance payers.

Healthcare is at an inflection point — again. While there continues to be movement within the industry from M&A activity and integration of payers and providers, the volatility is far less than in recent years. Relationships have more-or-less settled (to the extent that they are ever settled), and now we're seeing disruption at a far more micro-level: physician abrasion. It is a disruption that is eroding the overall healthcare experience not only for the over 1 million professionally active physicians but also for the 293 million Americans who have healthcare insurance.

Physician abrasion occurs when the payer-provider dynamic becomes strained. While a primary goal of each is to provide high-quality health care at an affordable price, there are competing business considerations that are also at play. As a result, payer decisions regarding common pain points such as claims reimbursement, pre-authorization approvals and customer support, impact physicians and others providing healthcare services across the care continuum. All, of course, also impact the member (patient), causing more churn with physicians and the systems, clinics and hospitals they practice in. The consequence is an unsatisfactory experience for both physicians and patients.

As abrasion increases, both the physician and their patients (members) may reevaluate and even seek coverage with an alternate payer, impacting the bottom line for payers and physicians across the healthcare system, an undesirable effect for both. But all is not lost. There are several important ways that a health insurance payer can minimize physician abrasion, thereby improving the quality of care and member and physician satisfaction, while also boosting patient/member loyalties and payer and physician profitably. In short, payers can reimagine their organizations to be more nimble and flexible in a way that will improve the physician and member experience and decrease physician abrasion.

1. Improve the Communication around the Claims Adjudication Process

Outside of cryptic codes that a provider or member receives "explaining" a claim's denial, the claims adjudication process requires clear and succinct communication to the healthcare delivery system, the physicians and support staff. Clear communication will help manage physician, staff, and member expectations. There are several important ways that this can be accomplished by a healthcare payer.

Provide clear, written guidelines for physicians that detail your processes and data requirements. The guidelines should have specific criteria explaining how, when and where you will publish and update them. The more specific your requirements, the more likely accurate claims information will be provided, increasing the chance for a streamlined flow-through of approvals at the onset and decreasing the need for costly manual review.

Revisit the communication guidelines often and refine your processes and requirements. If possible, seek provider input, as you will also be demonstrating a willingness to partner in solving problems, which will go a long way towards easing abrasion.

If you change your processes, communicate those revisions with your physicians and those staff members that support the claims process for the provider. This will help to better manage their expectations and allow them to adjust their decision-making, if necessary.

2. Provide Transparency into Denials

Health care systems, physicians and those who work in claims want — rather, *need* — to get paid. Promptly. And when a claim is denied, they all need to understand the reasons, allowing them to either correct what may have been a clerical error (coding, for instance), or respond to a payer's denial of reimbursement for a certain type of claim.

According to a recent report by the Kaiser Family Foundation, up to **17% of claims are initially denied by payers**. Knowing that up to 50% of claims are resubmitted by physicians, and up to 76% of those claims are ultimately paid, developing a streamlined methodology to evaluate initial and resubmitted claims could improve the physician experience while potentially decreasing costs.

To address a denial, a physician, an office staff member or other resources assigned to address claims issues may call the payer, a time-consuming process that impacts profitability and office efficiency. Providing clear guidelines to healthcare systems outlining the process for resubmission for the previous denial will ensure a smooth process for the physicians and staff involved in the resubmission process.

3. Accelerate Payments

Physicians depend on timely payments to manage their practices. Anything that you can do to expedite the payment process will go a long way in elevating the physician experience.

If delays are the result of incomplete medical requests, communicate those errors promptly to the physician/clinic or hospital staff within billing, thus allowing the right resources the ability to correct the mistakes and avoid any payment delays.

4. Automate Data Exchange

Many processes require the manual submission of data, a huge time burden on physicians and their office staff. Requests for prior authorization is but one example of this.

Additionally, in many circumstances, the data collection process is uneven without a set of clearly established guidelines. Where possible, payers should adopt features that are time-savers like auto-population of data or eliminating the need to re-enter the same data multiple times. This will not only save time but reduce errors. When it is known that some data must be manually submitted, set clear guidelines for how to accomplish this task.

5. Reassess Denial Reversals

Denials are often appealed, triggering a manual review by the payer. Ultimately, many are later paid, a relief for the physician but one that carries with it steep time and resource costs. To minimize these effects, look at the data. Payers should review payment denials that are later reversed, identifying and addressing any patterns that emerge. The process should be reviewed regularly, and payers should be flexible in modifying their guidelines accordingly.

Finding a path forward for payers and physicians can be tricky. While the goal is to decrease physician abrasion, walking in the shoes of the support/office staff and understanding their pain points will directly support physicians and their practices. These five areas of focus could minimize physician abrasion and improve the patient experience, a necessary pursuit as competition intensifies across all phases of the healthcare continuum. By providing clear and open communication that clarifies processes and decision-making, the payer will go a long way toward developing stronger and more durable payer-physician relationships, as well as enhancing the healthcare experience for members/patients.

Physician abrasion leads to a variety of unsatisfactory healthcare experiences. Northridge offers **healthcare solutions** for minimizing physician abrasion and improving the overall physician and patient experience. **Contact us** to learn more.

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