Analysis of Medical Claims and Billing System in New Mexico

Findings from Focus Groups of Claims Professionals and Clinicians

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Study Overview

- This report and the findings are produced by The University of New Mexico Center for Social Policy
- Commissioned by the Legislative Council Service
- The views expressed in this report are those of the authors and do not necessarily represent those of the Center for Social Policy, the University of New Mexico, collaborating organizations, or funders.

The Center for Social Policy

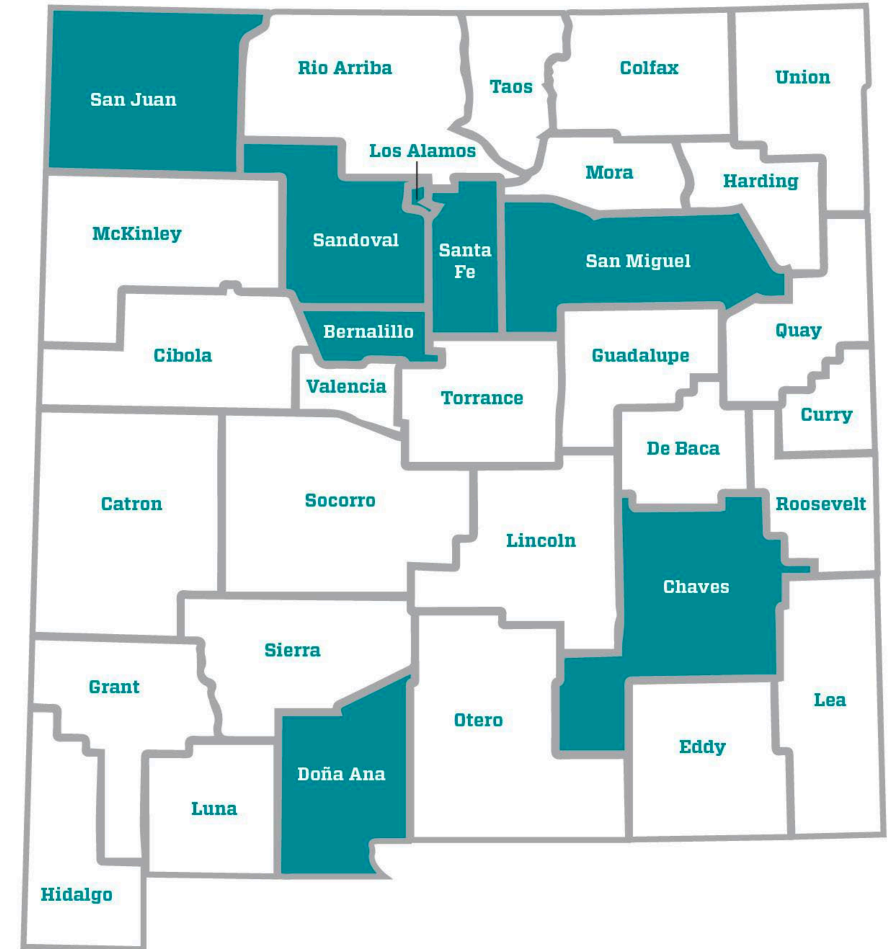
- The University of New Mexico Center for Social Policy specializes health and social policy work, especially in the state of New Mexico
- Our work bridges applied and academic research, with a mission to improve social policy outcomes, especially for more marginalized, overburdened, and underserved communities
- The study was conducted by Dr. Melanie Sonntag and Dr. Gabriel Sanchez

Research Aim

- How much time is needed and spent in each respective step during the billing, coding, and claims process?
- How much staffing, and infrastructure currently exists within different health facilities and how much is needed to effectively manage patient loads?
- What differences do staff and clinicians observe in terms of billing, coding, and claims by different insurance companies, plans, and types?
- What impact do the current billing, coding, and claims systems have on patient care and clinician well-being?

Data Collection Process

- Qualitative focus groups and interviews with 31 people working in eight counties
- Clinicians, Billing and Claims Professionals, Administrative/Leadership



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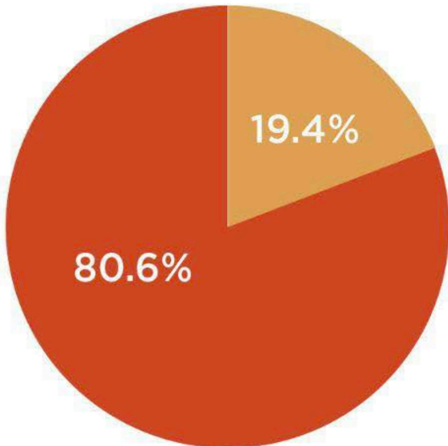
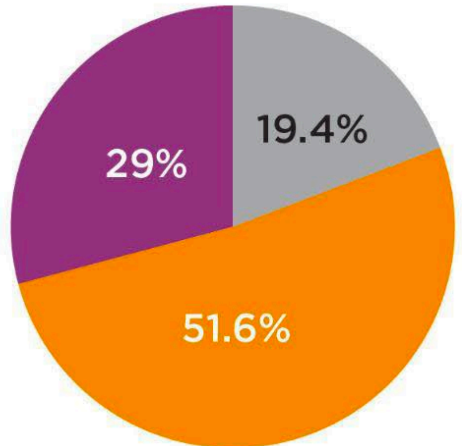
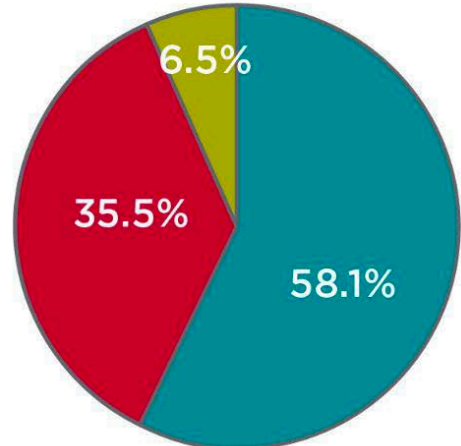
Participant Demographics

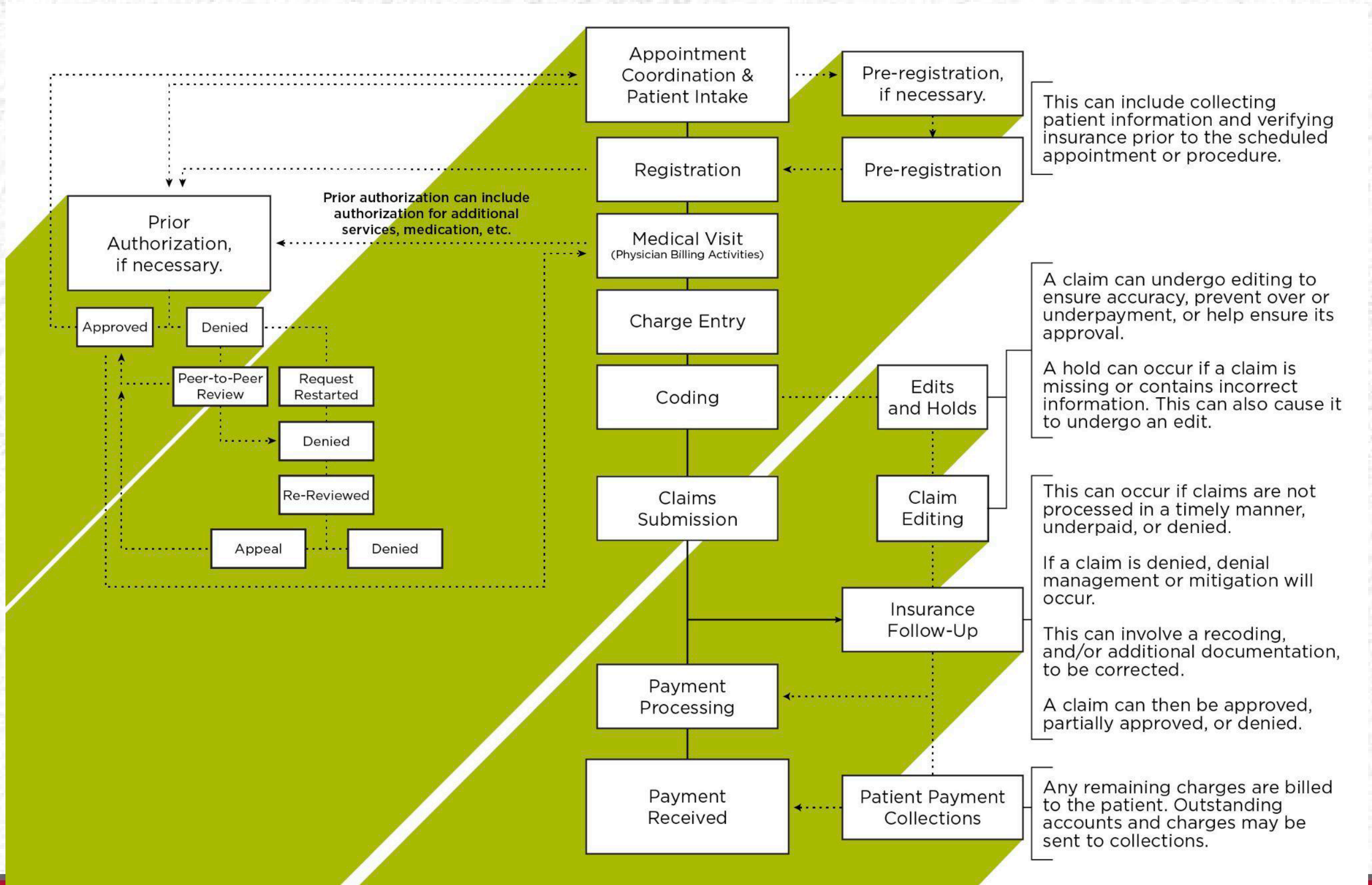






Participant Overview

- 77.4% of participants interacted with billing on a daily-basis
- 65.5% of participants worked in hospitals
- 80.6% of participants worked in health care for 10+ years



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(1) How much time is needed and spent in each respective step during the billing, coding, and claims processes?

1. There are time consuming processes at each point of patient encounters (before, during, after)
2. Frequently changing rules and updates create delays and take more time

(1) How much time is needed and spent in each respective step during the billing, coding, and claims processes?

- 3-4 hours a week is spent on billing and insurance related tasks for clinicians, although it is likely more
- A lot of time is spent on prior authorization, especially by nurses
- Some said they spend at least 2 hours a day on prior authorization alone; one noted as much as four hours a day for four days straight
- A lot of time is spent on the phone
- It can take between 7-14 business days but can take a lot longer
- Takes longer for highly specialized and costly care

(1) How much time is needed and spent in each respective step during the billing, coding, and claims processes?

- 15-20 minutes with patient, another 10-15 minute for documentation
- Others said they use non-clinical hours for any BIR tasks but that this is unsustainable
- Bureaucracy has increased over the past decades and differ by insurance of patient. CMS has self-attestation requirement and multiple medically unrelated questions providers need to fill out
- Navigating patient in- and out-of-network is also time consuming for clinicians

(1) How much time is needed and spent in each respective step during the billing, coding, and claims processes?

- Denials (even from previously accepted claims) that date back 9-12 months also take a lot of time away from patient care; Some dealing with denials as far back as 2 years
- The process of rectifying denials is time consuming and mentally taxing on clinicians
- Denials and rejections happen a lot. Some went as far to say that it feels as if insurance companies default to denials
  - *"So much time is spent on arguing back and forth [with the insurance companies.] Patients are just trying to get care."*
  - Some insurance companies are using AI-solutions to automatically deny claims based on medication that was prescribed
- There is a lot of variation on how denials and rejections need to be addressed by insurance companies. Some are more streamlined than others (i.e., web portal vs. having to talk to someone on the phone)

(1) How much time is needed and spent in each respective step during the billing, coding, and claims processes?

- There are constant changes around the BIR process, such as the updates in ICD, HCPCS, CPT, and formulary
- A lot of the esp. billing and coding professionals we spoke to noted that this entire process is really not straight forward:
  - *"Billing is not black and white. If you're coding according to the book, it won't work."*
  - *"If you follow the book, no one gets paid."*
- Formulary changes impact patient care and are time consuming

(2) How much staffing, and infrastructure currently exist within different health facilities and how much is needed to effectively manage patient loads?

- Almost all claims and billing professionals we spoke to felt their facility did not have enough staff or infrastructure to process the current claims load
- High turnover in the profession exacerbates this problem
- Facility-specific solutions:
  - Outsourcing
    - *“We don’t care [if you guys get reimbursed.] We get paid regardless.”*
  - Artificial Intelligence (AI)

(3) What differences do staff and clinicians observe in terms of billing, coding, and claims by different insurance companies, plans, and types?

- There was overall frustration with insurance companies. The many processes and rules in place prevent or obstruct patient care
- The *“medical side has to adhere by a lot of rules that the insurance companies don’t”*
- *“[I]nsurance companies are dictating all of the billing. It’s not coming from doctors or clinics.”*
- Issues with Medicaid reimbursements came up a lot. And CMS requirements that seemed medically unnecessary and burdensome (self-attestation requirement, questionnaire of patients that includes questions on they type of housing they live in, treatment plan)

(4) What impact do the current billing, coding, and claims systems have on patient care and clinician well-being?

- Patient impact on health and finances
  - *“Clinical decision making is driven by insurance formulary, not individualized patient care. I always jokingly tell residents: "In medical school, we learn evidence-based medicine. In residency, we learn systems- and insurance-based medicine and often, those are two very different things.”*
  - Unpaid medical debt gets sent to collections or is absorbed by the health facility, impacting both patients and health facility
- Health facility impact
  - When facilities are not reimbursed by insurance companies (or insufficiently so), they are expected to cover the remainder of the cost → This is especially challenging for rural facilities and smaller facilities that have little to no wiggle room in their budget
  - BIR tasks have a huge cost on health facilities, leading some to move to private practice and no longer accept insurance
- Clinician well-being
  - *“If [my hospital] got bought out by private equity, I’d leave”*

(5) Rural Areas of the State Face More Challenges

- Challenge 1:
  - In and out of network challenges
- Challenge 2:
  - BIR issues contribute to challenges rural facilities are already facing: *“Rural medicine is different – it is different in terms of billing, staffing, recruiting… Working in [name of larger city in NM] was easy. Here [citing their rural town] – not so much”*

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Big takeaways

- Clinicians are spending a large amount of time on billing and insurance related tasks that are interfering with time spent with patients.
- Insurance-level decisions interfere with evidence-based care, consequently impacting the quality of care that patients can receive
- The administrative complexity of the current system adversely impacts patient care and clinician well-being (e.g., prior authorization)
- These issues are exacerbated for rural health facilities, that are already struggling to keep their doors open.