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Are there gaps in your approach to claims accuracy?

Claim review best practices

A guide for health plans

The importance of strategic inpatient and outpatient claim accuracy modeling

Health plans know that the stakes for reviewing inpatient and outpatient claims are high. The complexity of bills and changing CMS rules increase the likelihood of both human and system billing errors. A comprehensive claim review strategy allows plans to increase payment accuracy across the claim payment process and stop repeat claim errors.

An all-in claim review approach works with providers along the claim lifecycle – from pre-submission to post-payment – to reduce vulnerabilities, lower medical spend and increase satisfaction.

What should be included in an all-in review approach?

Targeting inpatient and outpatient claims for review should include all types of reimbursement, for example:

- DRG
- Percentage of billed charges
- Per diems
- Hybrid combination
- Carve-outs
- Ancillary services
- Custom outpatient groupers

Focusing on only one or two reimbursement models can result in large payment accuracy gaps that increase a health plan's vulnerability.

Focusing on coding changes in both inpatient and outpatient procedures results in eliminating tens of thousands of overpaid dollars in both facility and professional settings. In these complex, higher-cost services, even small coding changes that are unaddressed can contribute to significant misspent dollars and recurring errors.

Provider collaboration is an integral part of an inpatient and outpatient claim strategy. With contractual limits on audits, plans need to target the claims most likely to have errors in the post-payment environment. Minimizing false positives by scoring claims accurately based on their likelihood of errors further reduces abrasion. Collaborating and educating providers pre-payment and pre-submission on appropriate billing practices decreases provider pushback.

How can health plans implement an all-encompassing claim review approach?

1 Consider the whole patient visit to a facility

The cost of a hospital stay or an outpatient procedure goes well beyond the primary facility charges. A member's claim history should be considered when reviewing facility claims. Accordingly, a health plan is in a good position if it can access overpayment detection analytics that cover not just the hospital stay but other services attributed to the hospital stay:

- Specialist follow-ups
- Pharmacy visits
- Durable medical equipment charges
- Diagnostic tests

All these services may stem from an inpatient claim. By taking a holistic claims review approach, a health plan captures data on peripheral outpatient claims that are related to an inpatient stay and can use professional claims to validate and corroborate the services billed on an inpatient claim.

2 Review claims in pre-payment and post-payment cycles

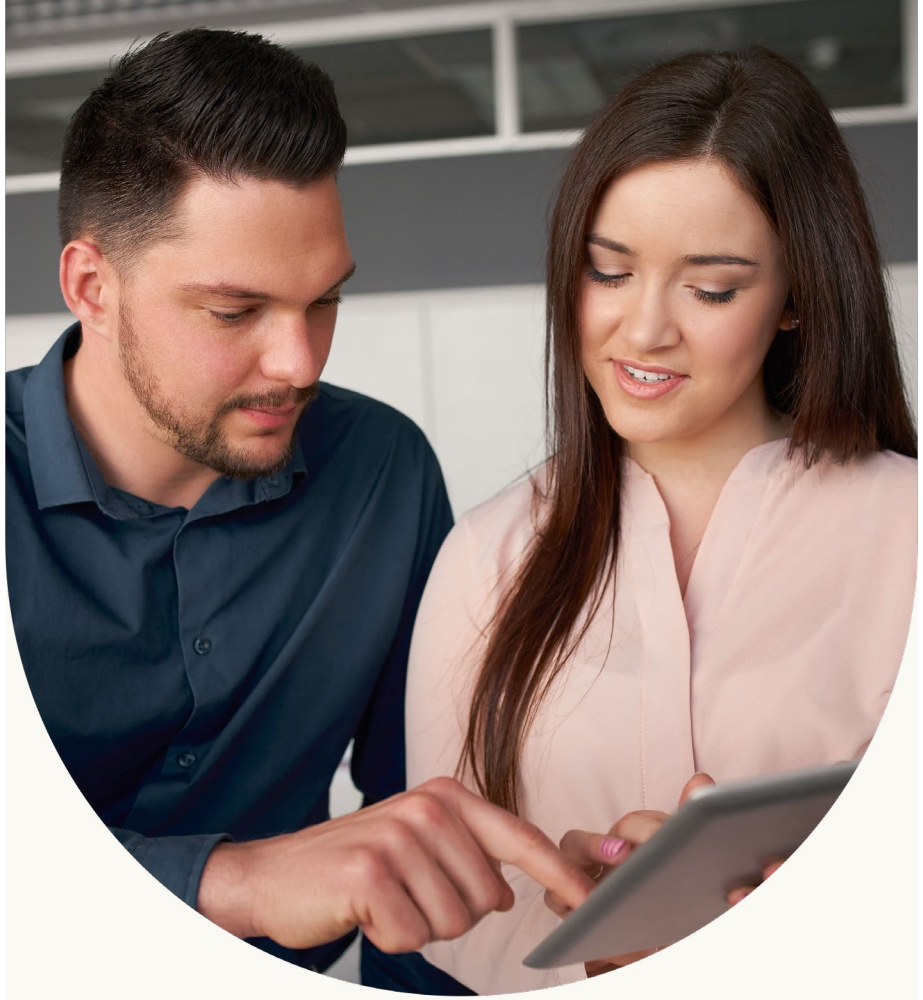
Reviewing claims both pre- and post-payment enables health plans to educate and collaborate with providers at the most appropriate stage in the claim lifecycle. Daily predictive scoring can help target claims for review by quickly and accurately identifying potential errors, flagging providers and validating charges. By using multiple points of intervention, health plans can optimize both their savings and accuracy across channels.

3 Incorporate pre-payment high-dollar inpatient facility claim review (typically claims over $25K)

A pre-payment approach to high-dollar claims ensures a deeper dive into these cases early in the process. High-dollar claims should be tied to a clean claim philosophy during the initial adjudication process so providers are engaged quickly. The best high-dollar reviews use automation to normalize charge descriptions and then apply rules to determine if charges have a high probability of being inaccurate before engaging with the provider.

4 Review member claim histories

By looking at a member's full claim history, a health plan can determine if a member's facility stay issues are chronic or acute. This can make a big difference in coding the severity of DRG.



Example impact: Member history data

If a diagnosis shows up in a member's history that hasn't been cited in past claims, a plan can set a more accurate DRG.

If professional claims history supports a chronic condition diagnosis, then the DRG can be adjusted accordingly.

5 Monitor results quarterly

Quarterly monitoring can create a process to determine where adjustments are needed in the claim lifecycle. By regularly evaluating the performance of a rule or DRG, health plans can determine which rules to turn on or off based on the true positive results. Continuously monitoring and adjusting rules creates an ongoing integration of new rule logic, retires outdated concepts and deploys new rules – all with no interruption to production. Continuous monitoring reduces provider abrasion and results in a consistent true positive rate.

6 Utilize advanced clinical input

By using internal or external clinical experts, a health plan can review decision-making and improve provider relations. These clinical experts can help develop new and refine existing clinical audit approaches, respond to escalated clinically related reconsiderations, disputes or appeals, and engage with providers in peer-to-peer and provider education situations. By helping to shape the detection analysis, clinical experts can further assist in developing clinical policies for auditors to follow to improve detection and true positive rates.

7 Foster transparancy with providers

Being fully transparent with providers regarding potential problems and remediation methodologies allows health plans to address problematic billing trends and create billing efficiencies. Offering on-site provider reviews builds rapport with the provider that can help a health plan determine how errors are occurring. On-site reviews alleviate provider burdens, encourage collaboration and focus on education. By working transparently and face to face with providers, a health plan can improve the process and reduce future errors or inaccurate charges.

Example impact: Code monitoring

One rule looks for DRGs with only one complication/comorbidity (CC) or major complications and comorbidities (MCC), with the assumption that if there is only one, a chart can be reviewed and possibly rule out that one CC or MCC. This would result in downcoding and lower reimbursement. This allows plans to quickly adjust logic specific to each DRG within the rule or remove DRGs that are not performing well (based on various factors) to increase true positive rates.

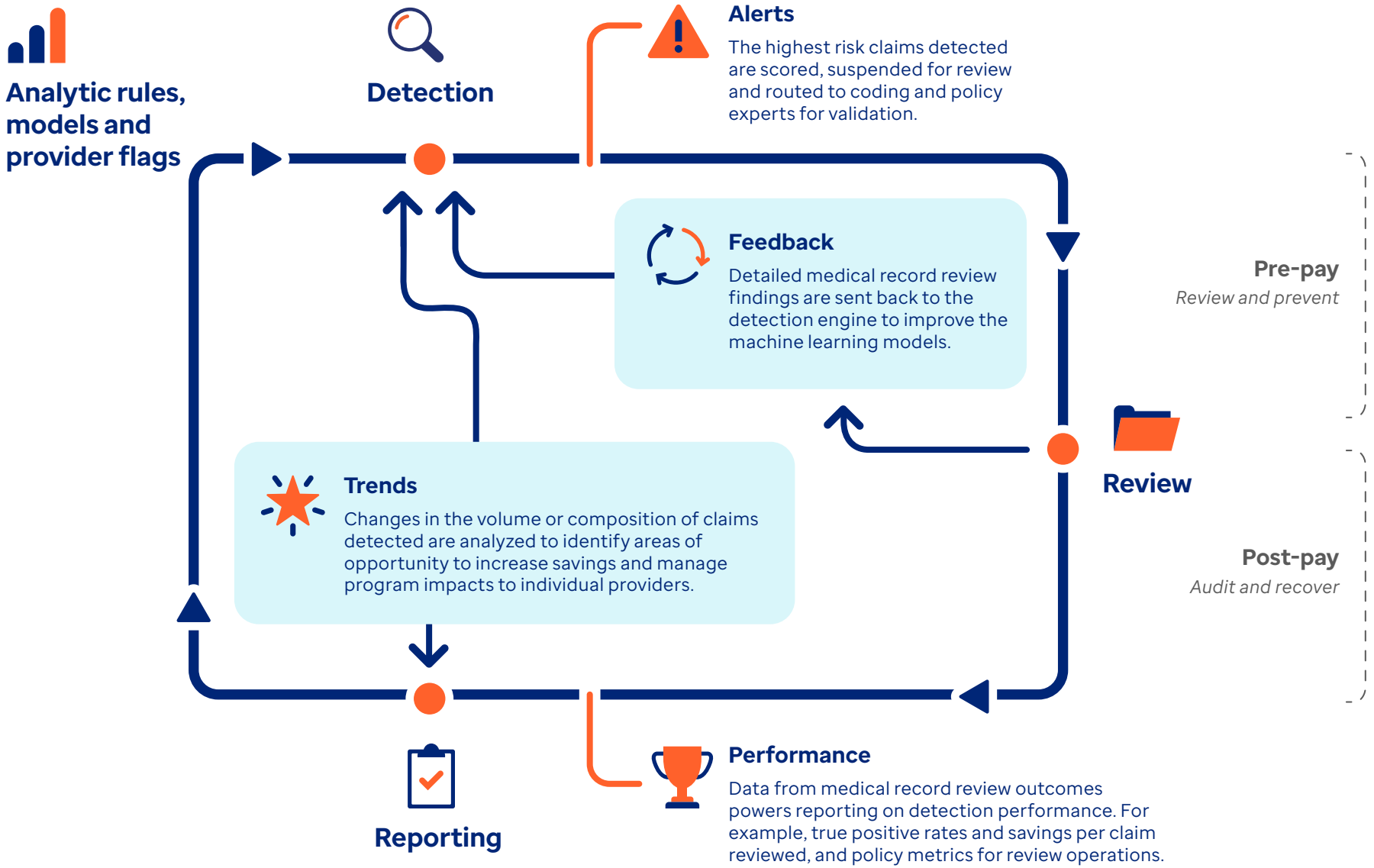
8 Utilize machine learning and other advanced analytical capabilities

There are many machine learning capabilities in the market that can quantify the risk of overpayment for all claims and offer detection that cover inpatient, outpatient and professional claims. Working internally or with vendors, health plans should focus on analytic detection expertise that supports all aspects of reimbursement methods across these services.

9 Tailor approach to meet your spend goals

Accurate and high-quality claim reviews can boost a plan's competitive advantage in the marketplace. But each plan has different medical cost-savings objectives and tolerances, so they should seek a solution that pairs expertise, tools and analytics in a way that helps them strike the right balance between savings and claim volume in a sustainable, manageable way.

Machine learning in payment integrity



About Optum

Optum offers customized, full-service claim reviews that work across the claim lifecycle to catch claim errors and inaccuracies. We continuously improve claim payment integrity data to improve our models.

Our approach goes beyond data analytics to change behavior and maximize savings. We realize that plans are striving to move from post-payment reviews to pre-payment reviews and from pre-payment reviews to prevention, and we help them get to the root cause of payment issues while minimizing provider abrasion. Because of our proven track record and face-to-face approach, providers and facilities trust Optum. We are immersed in a provider's reimbursement environment and can easily identify vulnerabilities.

Visit **optum.com/pi** to learn more about how Optum can help you unlock medical cost savings.

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