Pre-payment Review Solution

Complement recovery efforts with front-end prevention

Stop improper Medicaid claims before they are paid with proven predictive analytics and an early detection system from Optum.

Optum

States seek a more efficient approach to avoid inappropriate payments

The goal for every Medicaid professional is to see that the right people get the care they need, and providers are paid promptly and accurately for their services. But fraud, waste and abuse persist in the billing and payment systems, and most states rely solely on post-payment efforts to detect and recover overpayments – a time- and resource-consuming process. In addition, states must balance pre-payment reviews and investigations with timely payment requirements – each of which is vital to the success of the Medicaid program. With fewer resources, Medicaid staff must focus their work on the strategies that will deliver the best return.

Pre-payment Review Solution prevents improper payments

Detecting and preventing improper payments is a complex challenge requiring continual innovation. The Optum Pre-payment Review Solution combines time-tested predictive analytics, a flexible case management system to manage the overall pre-payment claims workflow, and a reporting engine to track performance and savings. Our solution will meet federal requirements for securing enhanced funding while also providing measurable results.

Predict Medicaid fraud and abuse risk early and accurately

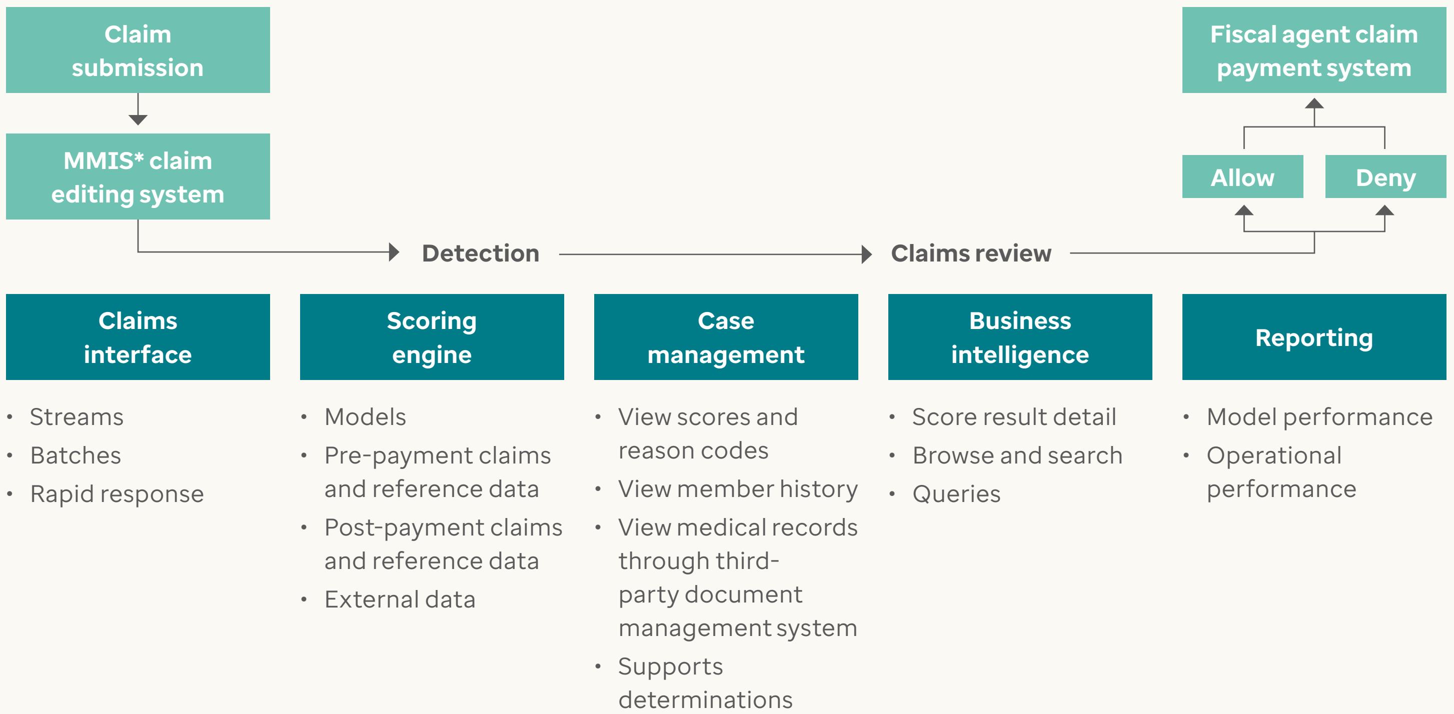
With the Pre-payment Review Solution, your state will see significant benefits:

- **Determine risk earlier – before payment:** Informed by over 10 years of evaluating millions of health care claims pre-payment, our highly accurate analytics and detection methodologies identify errors and potential fraud, waste and abuse upfront to minimize pay-and-chase later.
- **Review 100% of incoming claims efficiently:** We provide comprehensive and nondisruptive scoring of all incoming claims, increasing the probability of catching erroneous submissions while supporting prompt payment of claims.
- **Prioritize claim review and investigation effectively:** Accurate risk scoring identifies only those claims most likely to be erroneous and provides analytical support to help the reviewer make a quick and appropriate decision about how to address each claim or the identified billing issue.
- **Reduce provider abrasion:** Pre-payment review allows states to focus on opportunities to correct and educate providers early, instead of recover and/or prosecute long after payment has been made. This shift to proactive outreach reduces the need for a potentially disruptive and contentious recovery effort later, helping to improve provider relationships and maintain the Medicaid network.
- **Improve overall program integrity operations:** Pre-payment predictive analytics will detect errors not found in post-payment processes and post-payment insight can further improve the accuracy of pre-payment models. By incorporating the valuable insight between pre-payment predictive analytics and post-payment processes, agencies can improve the accuracy of identification, acquire additional audit case support, identify system vulnerabilities, pinpoint inaccurate front-end system edits and identify ineffective policy rules. When pre- and post-payment intelligence are shared, agencies create a continuous cycle of improvement that can transform overall operations for increased return.

Continuous cycle of improvement to transform program integrity operations

Analytical insight can be fed back into the post-payment review process, providing case support for existing investigations or identifying new opportunities to revisit potential fraud not previously identified.

Optum Pre-payment Review Solution



A pre-payment solution that integrates seamlessly with your MMIS claims flow

With no disruption to your claims-review process to jeopardize meeting prompt-payment guidelines, our solution rapidly applies analytics and insights to score 100% of incoming claims for fraud and improper payment risk.

Efficient detection using highly accurate predictive methodologies

The Optum Pre-payment Review Solution detection engine reviews post-adjudicated claims in the context of claims history to determine whether they should be paid or reviewed. The solution scores claims using a wide array of analytics, including models, rules, soft rules and exception analytics to inform its recommended action, then rapidly returns this recommendation to the MMIS. These analytics are highly customizable to state policies and adaptable to new results as they emerge, for continuously improved detection and minimized false positives.

Case management system swiftly prioritizes claims for review

To support the review function, the Optum Pre-payment Review Solution includes a robust yet nimble case management system that captures all suspended claim data, the decision-making rationale for each claim, outgoing recommendations to the MMIS and analytical performance improvement feedback. It also provides access to stored documents, including medical records, and connects seamlessly to the solution's business intelligence system to support reviewer investigations of each claim. Experienced Optum review personnel are available to support states in this process.

* Medicaid Management Information Systems.

Highly detailed scoring results and flexible analysis capabilities

The Optum Pre-payment Review Solution contains a business intelligence component that provides in-depth analytical results and facilitates a variety of user investigations. With a reports library, scored claims results and a variety of reference data, this component supports reviewers' exploration of scored claims results to monitor progress, identify trends and help support actions on complex billing issues. It also contains helpful pre-built queries for analyzing key provider or beneficiary patterns in order to identify provider education opportunities or inform post-payment review decisions. Quickly analyze claim lines of greatest interest for review, and clearly view an individual scored claim line, its key attributes and the reasons it was identified as suspect.

Total Claim View

Claim ID: * [ ] Finish

Model Risk Score: 943

SCORE REASON	DESCRIPTION	CONTRIBUTION
1:	Suspicion of Upcoding	62.17%
2:	Unusual Use of Modifiers	15.03%
3:	Near Duplicate Claims	9%

Recipient / Provider

RECIP ID	DOB	GNDR	AGE	CITY	STATE	CLAIM ID	Ln Num	Cpt Ctgry Num	MINUTES	PROV ID	PROV NM	Procedure Code	PROV CITY	Bill Amt	Pd Amt
00000000000	01/01/2099		0	City	ST			58	40	00000000	Prov Name	99215	City		

Diagnosis / Procedure

Dx1	Dx2	Dx3	Dx4	Srvc Frm Dt (H)	Srvc To Dt (H)	Srvc Frm Dt (L)	Srvc To Dt (L)	Px1	Px2	Px3
								25		

Model Risk Score Details

Reason 1: Suspicion of Upcoding
Contribution: 62.17%

1: CODE SET billing level higher than 84% of peers
2: Code set: 99211,99212,99213,99214,99215
3: Code level billed: 5
4: Levels in code set: 5
5: Provider billing at level 5: 96% of lines
6: Peer avg billing at level 5: 12% of lines
7: Provider billing: 0%, 0%, 1%, 3%, 96%
8: Peer avg billing: 3%, 2%, 28%, 55%, 12%
9: Providers in peer group: 172
10: Peers billing in code set: 133
11: Service lines billed in code set: 114
12: Provider specialty: Pediatrics

Reason 2: Unusual Use of Modifiers
Contribution: 15.03%

1: Scored Modifier: 25
2: Modifier descr: Significant, Separately Identifiable Evaluation and
3: Procedure billed: 99215
4: Procedure description: Office/outpatient visit
5: Provider frequency of modifier for procedure: 88%
6: Peer median frequency of modifier for procedure: 5%
7: Peers billing modifier with procedure: 24
8: Provider lines with modifier and procedure: 97
9: Provider Specialty: Pediatrics

Reason 3: Near Duplicate Claims
Contribution: 9%

1: Matching claim: TCN line
2: Same TCN as billed service: Yes
3: Matching claim provider:
4: Same provider as billed service: Yes
5: Days between claims: 0
6: Billed procedure: 99215
7: Billed procedure description: Office/outpatient visit
8: Matching claim procedure:
9: Matching claim procedure description:
10: Matching diagnoses: 1 of 1 billed
11: Provider Specialty: Pediatrics

Screenshot is for illustrative purposes only.

Significant savings and detection opportunities

Optum pre-payment predictive analytics saved health plans more than $120 million in 2012, while also helping to correct payment system vulnerabilities and providing support for law enforcement.

Comprehensive results reporting

Because states need to effectively measure the results of all program integrity activities, the Optum reporting system provides complete transparency on how savings are being realized, from remediation of improper claims, changes in provider billing practices, or cost avoidance due to program or policy changes. This system also contains a variety of metrics to improve the efficiency of operations and to assess opportunities to expand program integrity efforts. Users can view these results at the program, service category, specialty, provider or transaction level to effectively measure the state's return on investment.

Proactively protect state dollars to keep the focus on quality care

By applying accurate predictive models and an efficient workflow system, the Optum Pre-payment Review Solution helps states prevent fraud, waste and abuse pre- and post-payment, while improving overall Medicaid operations. With streamlined processes and transparent results, our solution saves states money, so that critical Medicaid dollars go toward quality care for those who need it most.

Learn more about how Optum can help improve your state's program integrity operations:

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