

How a “smart prepay” approach to payment integrity delivers a cleaner claim stream and better provider experience

By Matthew Hawley, EVP, Payment Integrity

While payers have generally improved their claim payment integrity programs and systems in recent years, adjudicating claims appropriately the first time while minimizing the need to pursue overpayment recovery remains one of their greatest challenges.

Beyond the pressures of rising inflation, payment integrity costs have continued to be compounded by several short-term and long-term developments, including relaxation of edits during the COVID-19 pandemic, the explosive growth in telehealth and behavioral health since

2020, and sharp increases in specialty drug spending. According to the Centers for Medicare & Medicaid Services (CMS), the estimated improper Medicare fee-for-service payment rate for FY 2022 was a staggering 7.46%, approaching \$31.5 billion in inappropriate payments for one government program alone. For the entire healthcare industry, annual estimates of waste reach as high as \$935 billion, according to the most recently available studies.

Many plans have made a valiant effort to transition payment integrity

programs from postpay recovery to prepay prevention, but continue to be challenged by significant hurdles. Some plans consider prepayment integrity to be a panacea and apply too much too soon, which causes significant abrasion with high-value providers, while others transition so slowly that the return takes too long to materialize. Payers also often struggle to use sufficient insights or benchmarks from their markets or postpayment integrity efforts when considering prepay strategies.

While many players in the payment integrity space have looked to solve systemic errors, waste, and abuse with software that enables health plans to manage their prepay claim editing of professional and outpatient facility claims, this approach only tackles one aspect of the payer's entire claim stream and the payment integrity continuum. It also often prevents health plans from editing more complex claim types (e.g., inpatient, behavioral, and specialty pharmacy). Furthermore, a software-only approach can hinder plans from achieving true integration between claim editing and the other vital payment integrity programs focused on coordination of benefits issues, diagnosis-related group (DRG) errors, and waste and abuse prevention. Finally, it requires that plans take on the significant burden of maintaining and updating their payment integrity system.

On the other hand, a "smart prepay" approach, wherein a payer adopts an outsourced, holistic prepay claim review process that is accompanied and informed by a postpay safety net, delivers better savings and accuracy all along the claim stream. Comprising both analytic software technology and expert services, such an approach alleviates the technical burdens of maintaining payment integrity systems while delivering comprehensive review support

including clinical specialties, coordination of benefits, and contract and investigative reviewers who know what to look for in claims data. Furthermore, the backing of clinical expertise gained from nationwide experience offers an extra layer of confidence that payment policies are well-researched and defensible.

A "smart prepay" approach comprising holistic prepay claim review that is accompanied and informed by a postpay safety net delivers better savings and accuracy all along the claim stream.

Software-only solutions: Value versus total cost of ownership

One choice commonly facing health plans is whether to deploy a subscription-based, prepayment software solution from a vendor, managed in part or in whole by the plan. These vendors focus solely on prepay claim editing software, offering what appears to be a nimble and easy-to-implement approach. On the surface, this can look like an attractive, cost-effective option, one that appears to enable payers to retain greater control over how their claim edits are implemented.

However, plans must dig deeper than just the subscription fee to find the value the software delivers relative to the total cost of ownership. Areas of cost and value to consider include:

- **Payment policy content updates:** Keeping payment policy up to date with bodies such as the American Medical Association (AMA), CMS, Medicaid agencies, and other organizations is job one of any prepay review system. With a software-only solution, content is generally released along with software updates on a quarterly basis or perhaps even less frequently. The health plan clinical team managing the software must then review all new and deleted codes (e.g., HCPCS, CPT, diagnoses) multiple times a year for impact to their organization's specific policies.

Delays in content deployment can cause compliance issues and associated monetary or provider abrasion costs related to under- or over-editing.

- **Medicaid compliance:** Software-only vendors may deliver editing content only based on general Medicaid guidelines, leaving plans to configure their own system or pay the vendor for state-specific Medicaid customization to stay in compliance.
- **Configuration flexibility:** A software-only solution requires significant health plan resources to learn how to navigate claim editing software as well as administer configuration changes, which can be particularly challenging across multiple platforms and lines of business.
- **Technology maintenance:** When deploying a software-only approach, changes may often require extensive internal resources and project plans to install, test, and deploy, rather than being handled entirely on the vendor side.
- **Defensibility and support of edits:** While all vendors have intellectual property that informs their payment rules and edits, health plans need them to provide the sourced rationale behind this content for internal support teams and via provider portals. Most software-only vendors

provide this, but it requires plans to be ready to support inquiries at scale with ample clinical coding support resources.

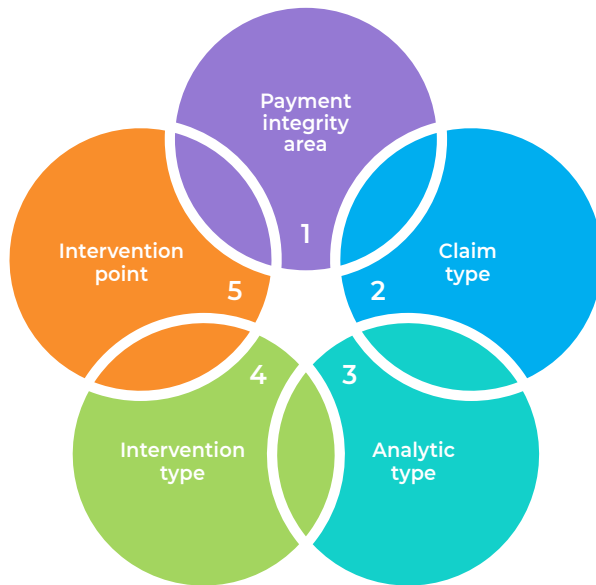
- **Reporting and data insights:** A high-value payment integrity solution should support health plans with analytic and clinical resources to deliver a regular cadence of benchmark-driven insights to plan leadership. Software-only solutions provide only data from within the organization's four walls and misses opportunities for industry benchmarking.
- **Payment integrity coverage:** Health plans are used to performing automated editing on professional and outpatient facility claims that are in violation of very clear coding guidelines. Software-only solutions on the market today typically stop there and cannot address the complexities of preventing improprieties within coordination of benefits and inpatient claims, or those found within larger patterns of waste and abuse.
- **A closed-loop feedback system:** Prepay claim editing software lacks a closed-loop feedback system where insights garnered from postpay programs feed into new prepay policy. Plans running their own software in a vacuum run the risk of continuing to let the same errors slip

through their prepay systems time and again, increasing abrasive overpayment recovery and decreasing savings.

- **Strategic partnership:** A software-only provider generally lacks the ability to provide strategic guidance to the health plan around industry trends, benchmarking, and ongoing opportunities to achieve new value.

Other factors to consider include software licensing fees, the staff needed to enable clinical coding research, interoperability with other software systems, and general market acceptance of the software vendor's payment content.

A high-value payment integrity solution supports health plans with analytic and clinical resources to deliver benchmark-driven insights.



Full-scale service solutions: Aligning with the five dimensions of payment integrity

Health plans looking for a smarter approach to prepayment integrity must look beyond low-cost subscription fee-based editing software to an end-to-end payment integrity approach that comprises technology, analytics, and human expertise for optimal savings and minimal resource burden. To do this, plans need to consider five crucial dimensions of a comprehensive payment integrity program.

1 Payment integrity area

While payment integrity has numerous facets, it can be broken down into three major pillars:

- **Ensuring claim accuracy:** Questions answered within this payment integrity pillar, the largest of all, include, “Is the claim coded correctly? Were services billed in accordance with provider contracts and industry and payer guidelines? Does the medical chart substantiate the services billed on the claim?” This comprises solutions that correct inappropriate claim coding while validating other suspect claims against medical records, contract terms, and other data.
- **Determining responsibility:** Solutions in this pillar analyze contracts, eligibility files, third-party benefits agreements, and other data sources to determine whether a payer is the primary or secondary payer of the claim—or not responsible at all.
- **Detecting patterns:** This area of payment integrity is critical to understanding if there exists larger patterns of waste, abuse, or fraud that claim-by-claim review solutions are not designed to detect. Software-only solutions may provide data that requires plan analysis to turn into actionable knowledge, requiring advanced analytics and investigative expertise.

While a software-only solution can assist with some aspects of claim accuracy, it doesn’t deliver the robust human expertise that a full-scale service solution offers, which is required for more complex claim accuracy issues as well as to determine payment responsibility and detect fraud, waste, and abuse (FWA).

2 Claim type

To minimize leakage, all major claim types should be processed by payment integrity systems, including professional, outpatient facility, inpatient, and drug claims. Most software-only solutions generally focus on professional and outpatient claims. Inpatient claims are often bypassed because they are significantly more complex due to the various models for how they are reimbursed, including percentage of charge, per diem, case rate, or DRG. These require expert review by qualified nurse coders who understand the nuances of inpatient claims and may need to inspect medical records.

3 Analytic type

Payment policy rules or algorithms, which compare claims to a client’s national guideline-driven payment policies, are the bread and butter of payment integrity systems. However, other analytic types are also critical across both prepay and postpay programs:

- **Provider-based algorithms:** These algorithms take a provider-specific look at claims to determine accuracy. Such algorithms are critical to detecting and investigating patterns of FWA, and generally require analyzing data across multiple payers to determine inappropriate patterns.
- **Member-based algorithms:** These are algorithms that take a member-specific look at claims to determine accuracy. Such algorithms are critical to coordination of benefits as well as detecting and investigating FWA.
- **Claim-based prediction:** This approach involves leveraging artificial intelligence and machine learning used to predict the highest likelihood of claim inappropriateness. This is critical to payment integrity efforts that involve significant time and expense such as retrieving medical records for clinical chart review.

The development and use of analytics cannot operate in a vacuum and must consider the payment integrity job at hand, the claim type involved, and the type of intervention needed—all curated by clinical experts.

4 Intervention type

Software systems are very good at performing prepay claim reviews in an automated way,

looking at procedure and diagnosis codes and code pairs on the to-be-adjudicated and associated historical claims to determine correctness relative to the plan's payment policy. While this automated claim intervention takes care of a large portion of errors and waste, there are many other payment integrity interventions required to catch more nuanced improprieties and abuse that automation cannot, including:

- **Human review of claims:** Many claim situations like COB issues, modifier misuse, or outlier providers are too complex for automated rules and must be reviewed by a human with a special skillset and clinical or claim knowledge base.
- **Medical record review:** Many inpatient and some professional and outpatient claim scenarios requiring human review can't be decided without using medical records to validate an improper claim or pattern of claim FWA. DRG claims are a good example of this.
- **Medical record retrieval:** Retrieving a member's medical record for a specific review is an important step in the process, which often requires manual intervention. Artificial intelligence is critical in medical record selection as it's highly impractical to request a record to substantiate every claim.

- **FWA review:** A reviewer with special investigative skills and techniques is required to validate larger patterns of potential FWA. Pattern-flagging analytics and special workflows are required for this type of review.
- **Appeal support:** Health plans are familiar with handling provider inquiries, reconsiderations, and appeals. Adding more payment integrity often requires deploying more clinical coders to support provider appeals on claim decision recommendations applied by the plan.
- **Contract review and other system lookups:** A reviewer often needs eligibility as well as access and knowledge of provider contract and other non-claim client systems to determine claim responsibility or accuracy. One example occurs when looking for providers excluded from specific policies.
- **Direct outreach:** When system lookups alone are not enough, human reviewers may need to call providers or members to help with a claim responsibility or accuracy determination.

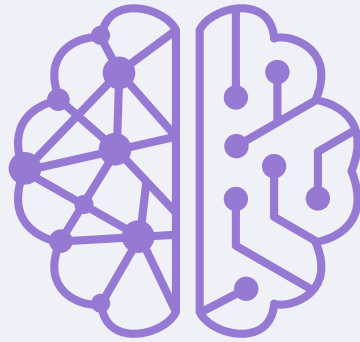
5 Intervention point

The final dimension of payment integrity concerns whether a particular intervention happens before or after the point of final

claim payment. Software-only solutions are built for efficient claim editing of basic claims at the prepayment intervention point, but as mentioned, numerous scenarios often prevent inappropriate claims from being caught by prepay filters:

- **Payment methodologies:** APGs, EAPGs, and more are routinely bypassed or excluded in prepay editing.
- **Sequencing and repricing:** Inpatient duplicates, missing data, and more may not be known until after claims have been paid.
- **Provider exclusions:** Providers may be excluded for specific concepts, CPT codes, rules, and more.
- **Pharmacy billing on medical benefit:** Many costly examples such as duplicates may not be uncovered until after payment.
- **Type of service limitations:** Valuable findings can be excluded due to limitations on prior-authorized services.
- **Pre and postpay misalignment:** Lack of coordination between systems can enable inappropriate claims to slip through prepay filters, requiring a postpay safety net.

In addition to providing a safety net to prepay, postpay interventions can be critical to making prepay analytics and interventions



Artificial intelligence and machine learning in payment integrity

More vendors are leveraging artificial intelligence and machine learning capabilities embedded within their payment integrity solutions. At its core, machine learning enables automated systems to improve human behavior through detecting patterns for prediction or decision guidance. Analytical model building provides deeper insights through the ability to quickly connect information from disparate datasets, flagging patterns that could otherwise be missed.

In payment integrity, there are a growing number of use cases for machine learning. For example, in clinical chart review, a vendor may use it to isolate charts for claims with the highest probability of overpayment. Given the high cost and

burden of medical record retrieval, this can be an extremely valuable tool as it helps to minimize the likelihood of chasing after charts that generate no value to a health plan's program while also reducing provider abrasion. In the realm of FWA prevention, machine learning is a valuable mechanism for detecting suspicious patterns that warrant further investigation.

While these technologies are certainly valuable and will continue to grow in importance in healthcare, plans must remember that they are not an immediate panacea for payment integrity. For example, deploying these technologies effectively requires them to "train" on vast amounts of data before they begin to produce effective, accurate results. Health plans also need to gain buy-in from providers before using these tools in payment integrity, as they will still need reassurance that payment decisions are being made based on documented payment policy and clinical guidelines. Artificial intelligence and machine learning are valuable tools in a plan's payment integrity portfolio, but only when backed by significant clinical and analytical expertise.

smarter with a feedback loop. For example, a genetic testing provider whose billing practices avoid claim editing rules might be confirmed for abusive billing patterns with postpay analytics and investigation. In addition to provider education, closing the loop would require a fast update to the prepay analytics to monitor the provider's claims for prepay review, which would allow for those inappropriate claims to be denied going forward.

Continuing the postpay to prepay shift

Payers want and need to continue shifting as much as possible away from postpay to prepay, but health plans and vendors must fully consider the interplay of all five payment integrity dimensions before deploying a software-only solution to meet this goal. A full-scale solutions vendor working successfully within all five dimensions can manage prepay claim editing alongside claim pattern review, FWA management, coordination of benefits, and more—while efficiently synchronizing with postpayment integrity interventions where they are needed. This approach delivers comprehensive, aggregated insights into the health of a plan's payment integrity programs, enabling the plan to more rapidly identify deficiencies and

deploy solutions to fix those deficiencies. It's not about maximizing prepay efforts, but rather making the plan's prepay approach smarter for a cleaner claim payment stream.

Are you ready to unlock value, increase efficiency, and improve performance across the payment cycle with one partner? Cotiviti's shared savings model means that we partner with you all the way to deliver the most value. Read our Payment Accuracy solutions brochure to learn how Cotiviti enables health plans to achieve the highest levels of payment integrity by determining responsibility, ensuring accuracy, and detecting patterns across the claim payment continuum.

[Read the brochure](#)

If you're ready for a deeper dive, set up time to speak with one of our experts by requesting a conversation with our experts.

[Start the conversation with Cotiviti](#)

About the author



Matthew Hawley
EVP, Payment Integrity, Cotiviti

As executive vice president of payment integrity operations, Matthew is responsible for the success of Cotiviti's prospective payment solutions and content development team. Since joining Cotiviti in 2004, he has held roles with responsibility for implementation teams, software development, clinical claim validation, and retrospective claims accuracy. Prior to Cotiviti, Matthew was a senior manager of healthcare at Accenture, where he consulted and defined solutions for Blue Plans and other large national payers with their business challenges as they sought to improve care and reduce administrative costs.

Unlock unique value with our solutions

Payment Accuracy

Risk Adjustment

Quality and Stars

Network and Clinical Analytics

Consumer Engagement

[Learn more](#)

COTIVITI

cotiviti.com

