Optum

Strategy guide

5 best practices to optimize your payment integrity program



In today's landscape, health plans face several challenges, including managing the rising cost of care and maintaining compliance with ever-changing regulations. One way you can address these challenges while remaining competitive in the market is by optimizing your payment integrity program.

In this guide, Optum experts share 5 payment integrity best practices health plans can implement to maximize payment accuracy and realize savings in line with top-performing health plans.



1 Implement a second-pass claim editor

While most health plans have a first-pass claim editor in place to help identify coding and billing errors, maintaining all of the content in these software systems can be challenging. And if your first-pass editor isn't up to date with the latest regulatory requirements, payer policies and provider contract provisions, inaccurate payments can still occur.

Adding a second-pass editor to your payment integrity program can help ensure that claims are being paid accurately. A second-pass editing system will review all claims that make it through your first-pass editor and monitor for payment leakage. Unlike first-pass editors, which often sit mid-adjudication, second-pass editors work pre-payment but can be integrated into later phases of the claim process. This enables second-pass systems to perform specific edits that require more fully adjudicated claim payment information. In addition, many second-pass editors can also generate edits that may require a medical record or additional clinical data and include dedicated staff to support provider inquires and appeals related to secondary edits.

This additional layer of review can help ensure claims are paid in compliance with the latest regulatory and plan sponsor requirements, minimizing errors, improving accuracy and preventing overpayments.



Questions to consider:

- Is your plan vulnerable to compliance risk and missed medical savings due to payment leakage?
- Would your claim editing program benefit from a second line of defense with additional specialty and custom content?

2 Improve efficiency and accuracy with automation and analytics

High-dollar claims are complex, and although they often represent the greatest opportunity to maximize medical spend savings, reviewing them for billing errors can be time-intensive. To review these claims with greater efficiency, consider using automation to reduce manual claims processing.

Automation will allow you to target high-dollar claims for review with greater accuracy, resulting in higher true positive rates and ROI. Already using automation? Add additional analytics, such as advanced algorithms, artificial intelligence and machine learning, to expand the reach and precision of your claim review program. This can help address unutilized system rules, policy enforcement and additional high-cost categories of spend, such as outpatient hospital encounters incorrectly billed as inpatient.

Together, automation and analytics can help your plan identify new sources of savings while reducing the burden on your internal resources.



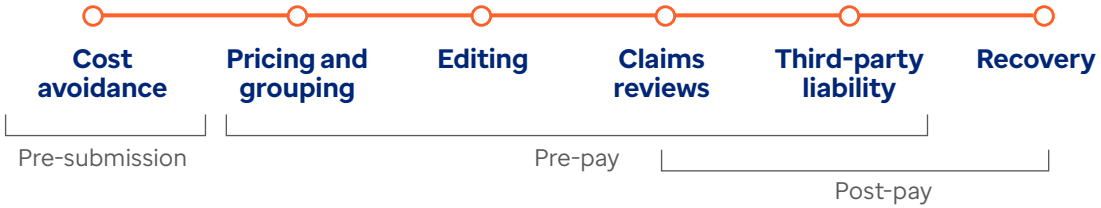
Questions to consider:

- Is your health plan easing the burden on internal staff and minimizing errors by automating claim reviews?
- Are you maximizing savings by leveraging automation and advanced analytics to target the highest-risk claims?
- Do you have both pre- and post-pay review of high-dollar facility claims to help prevent and recoup overpayments?

3 Shift claim reviews prior to payment

If your health plan is only reviewing claims for accuracy post-payment, you have a significant opportunity to improve your medical expense trend and reduce administrative burden for providers and members. Where possible, shift your claim reviews to pre-payment to improve the accuracy of your claim reimbursements, increase medical spend savings and decrease unnecessary administrative expenses.

Shifting high-dollar claim and medical record reviews to pre-pay is a great place to start. Coding and billing errors identified by these reviews can be particularly costly to recover, so detecting and preventing them pre-payment can save health plans a significant amount of time and resources.





Questions to consider:

- Does your health plan have a strong post-payment review and recovery process in place?
- Are your medical expenses increasing?
- Are your post-pay interventions causing abrasion with your providers and members?
- Is your organization ready to shift from focusing on recovery to focusing on avoidance?

4 Establish a centralized payment integrity office

A fragmented approach to payment integrity can lead to a lack of communication, misaligned incentives, duplicative efforts and missed opportunities for savings. To streamline your operations and ensure a cohesive approach to payment integrity, health plans should coordinate all strategies, vendor activities, tools, resources and expertise focused on payment integrity through one office.

With one team dedicated to payment integrity, health plans can remove siloes and foster collaboration, leading to more efficient use of resources and increased savings. Consolidating your efforts into one office can help turn payment integrity into a core, strategic function for your organization.

Payment integrity office

- Vendor management
- Innovation, research and development
- Performance management
- Operations and shared services
- Analytics lab



Questions to consider:

- Does your organization have a single owner to make critical decisions around reducing medical spend through payment integrity processes?
- Are various departments performing duplicative tasks related to payment integrity?
- Is there opportunity to align disparate tools, resources and expertise across your organization?
- Can you improve communication and data sharing amongst your internal payment integrity functions?

5 Build a program that is scalable

As your organization evolves, so should your payment integrity program. But continually adding additional point solutions to meet your immediate needs can eventually lead to fragmented approaches, complex vendor management, disparate systems and data silos. This can result in costly inefficiencies and an inconsistent provider experience.

Consider shifting away from siloed point solutions to building an integrated payment integrity program. By working with a strategic partner to manage payment integrity interventions across the claim lifecycle, you can streamline your claim payment processes and programmatically manage savings, resulting in a higher return on investment.

As your savings, provider relations and compliance needs evolve, the right partner will also offer your health plan the adaptability, customization and innovation needed to easily scale your payment integrity program.

An integrated, comprehensive PI program can lead to:

$23–$45
in savings PMPY

$12M–$26M
in annual savings
Based on a 500K health plan



Questions to consider:

- Is your current payment integrity program designed to grow with you?
- Are your current payment integrity point solutions still meeting your needs, or are their limitations preventing you from maximizing your savings?
- Do your current vendors have the right expertise to help you address new challenges or rising areas of spend?

Implementing these best practices will help you stay competitive in the market, elevating your payment integrity program to maintain compliance with evolving regulations, drive additional cost savings and relieve burden on internal resources.



Schedule an assessment to identify opportunities to optimize your payment integrity program.

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