FRAUD PREVENTION SERVICES

Eliminate Fraud, Improve Your Health Plan's Performance

Federal Medicare and State Medicaid programs are vulnerable to Fraud, Waste, and Abuse, and the cases are well-documented. To ensure that dishonest individuals and companies cannot take advantage of your organization, Health Plans must continually monitor payment activities and close medical loopholes. Fraud, Waste, and Abuse in the Medicare and Medicaid program is estimated to be over $30 billion annually, and CGS has developed the expertise, business processes, and solutions necessary to detect and prevent improper billing practices.

Our proven Medicaid Medical Review (MR) process allows us to detect and prevent improper billing practices and provide an effective and efficient solution to reducing and preventing these payments. Our MR process uses state-of-the- art tools that enable statisticians and data analysts to quickly identify and monitor payments patterns, and our skilled nursing staff reviews pre and post payment history to ensure it is medically necessary.

Methodologies for Detection and Prevention

CGS's Medical Review process is comprised of detection and prevention methodologies:

DETECTION METHODOLOGIES

- Strategy for data analysis
- Probing data of upcoding practices (billing for higher cost equipment than was actually provided)
- Probing data of unbundling practices (billing for the component parts instead of the entire unit)
- Determining if equipment has medical benefit to the beneficiary
- Reviewing for reimbursement patterns that are excessive compared to other payers

PREVENTION METHODOLOGIES

- Coverage Determinations (CDs) that clarify policy
- Claims edits to correct improper billing practices
- Prior authorizations for specific durable medical equipment(DME)
- Supplier education and training to facilitate accurate billing practices
- Progressive Corrective Action (PCA) plans for suppliers who continue to bill incorrectly

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Medical Review Strategy Solutions

PROVIDE A QUALIFIED TEAM OF EXPERTS

The MR process begins with the development of a comprehensive strategy to identify improper billing providers. The strategy is led by a Medical Director (MD) and developed and implemented by a team of Registered Nurses (RN), Licensed Practical Nurses (LPN), and Statisticians. This team uses data analysis techniques to identify and validate strategies for the next 12 months, and includes a formal review after six months to ensure process effectiveness. The MR strategy focuses on reducing the claims payment error rate; identifying erroneously paid claims; identifying providers who are potentially fraudulently billing; and identifying gaps in the medical policies which create billing errors. The MR team meets weekly to review status on data analysis, probe reviews, and other post-payment reviews to set, adjust, or change priorities as necessary.

IDENTIFICATION OF PERFORMANCE ISSUES

Data analysis identifies providers who have unusually high billing for any code compared to their peer providers. RNs and LPNs request the providers provide supporting claims documentation and conduct a review as part of an initial PCA measure. These post-payment probe reviews ensure the provider has adequate documentation to support the claim. The formal documentation review ensures the equipment is: covered under a benefit category; not statutorily excluded; medically necessary; coded correctly; and supplied to the beneficiary. Claims where the supporting documentation does not meet the eligibility requirements are denied or down-coded to a lesser paid code and the recoupment of the overpayment is initiated.

MEDICAL POLICY DEVELOPMENT

Medical policy plays a critical role in the education of the provider community by giving guidance on the requirements. It is essential that medical policies are reviewed to support proper billing patterns. The MR staff uses data analysis to identify HCPCS codes with high denial or appeal overturns rates to determine if a policy needs further revisions.

IDENTIFY AND REFER OVERPAYMENTS

Overpayments are identified and calculated for claims that do not have the necessary documentation to support the payment. In situations where the denial or downcoded rate is excessive, coordination with the client is required to initiate pre-payment edits for the provider. Claim pre-payment reviews are part of the provider PCA process to ensure the provider has submitted correct documentation prior to payment. Pre-payment edits can be placed on all claims submitted by a provider or for problem-specific codes.

TAILORED PROVIDER EDUCATION

Customized outreach and education ensures that providers have a clear understanding of the medical policy. Specific providers who repeatedly have a high denials or downcoded rates are provided the education and training to ensure they understand the medical policy and appropriate billing practices. This education includes detailed letters, references to site-hosted webinars, or one-on-one education preformed by the MR team. Ongoing monitoring of the provider continues until it is no longer warranted, but when improper billing continues, the provider is identified and referred to the health plan's fraud and abuse contact. The content of the education programs is easily hosted on existing websites or provided through a web portal to ensure providers obtain frequent, timely, and cost-effective training.

Benefits

Our MR process reduces claims payment errors and supports claims error rate reduction efforts to enable a quicker realization of cost savings for the health plan. The reduction in errors are the result of effective data analysis, focused pre- and post-payment reviews, identified overpayments, strengthened Coverage Determinations, and focused provider education. The results of an effective MR strategy lead to an immediate cost savings on claims paid in error, as well as an increase in public trust. Additionally, providers want to submit claims correctly to avoid delays in payment. Our MR process increases the efficiency of the claims payment process by reducing the number of improper claims, ultimately increasing provider satisfaction.

Conclusion

Ensuring that claims are processed and paid correctly is an ongoing challenge for health plans and requires an effective detection and prevention program to identify and deter fraud, waste, and abuse. Managed Care Organizations (MCO) need an effective integrity program to keep costs low while battling rising fraud and abuse activities. Medicaid is the largest healthcare provider in the nation, and MCOs must ensure claims are paid correctly to mitigate risk and control costs. At CGS, our track record of having the lowest claims payment error rate in Medicare speaks to our ability to develop business process solutions to detect and prevent improper payments patterns and deliver measurable results to our customers. We have the tools, technical resources, personnel, and business processes to help you develop and implement a strategy to reduce improper payments, prevent fraud, waste, and abuse, and generate significant cost savings.

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