Prepay Clinical Reviews

Get A’s to your FAQs About HMS’s Innovative Tool to Fight Fraud, Waste, and Abuse

Q: What types of errors does the HMS prepay clinical solution find?
A: Diagnosis Related Group (DRG) coding validation, reimbursement methodology, covered vs. non-covered services, readmissions, level of care, and others.

Q: We outsource clinical complex and automated reviews on a postpay basis. What is the incremental savings/value from moving the review process from post-pay to prepay?
A: With the prepay solution, payers are capturing 100% of review findings because they will be paying the claim accurately in the first place, rather than recovering on the findings retrospectively. There can be significant financial upside since not all postpay findings are recovered. The solution also reduces provider abrasion.

Q: What non-financial benefits does the solution provide?
A: Prepay Clinical Reviews avoid provider limitations on postpay audits, deliver Medical Loss Ratio protection, reduce provider abrasion, and increase provider cooperation.

Q: How do you target claims for medical record review?
A: HMS employs the proprietary highly successful claims targeting approach utilized in our longstanding retrospective work. Our success is due in large part to our advanced logic, which targets the best possible claims for review. Selected claims are run through our refined clinical logic so that only the appropriate claims go to record request. This process results in a high rate of findings, while minimizing provider abrasion that would otherwise result from requesting records inappropriately.

Q: What are the qualifications of the personnel reviewing medical records?
A: Our physicians, nurse reviewers, and certified coders have the highest findings rating in the industry, as proven by exceptional quality scores from Centers for Medicare and Medicaid Services.

Q: How does this solution comply with prompt pay laws?
A: Prompt pay laws vary by state, and typically range from 30-45 days. The claim adjudication instructions are delivered within hours of receiving files from the client. With a complex review, prompt pay laws are paused or extended (depending on the state statue) when a medical record or other documentation is requested. Once we notify the provider that a claim is being reviewed, prompt pay timing is placed on hold for the review process to complete. As a result, the HMS prepay clinical process is completed within the strictest prompt pay law requirements.

Q: Is this solution available as a standalone product?
A: Yes, we offer this solution both as a standalone service as well as an integrated part of our fraud, waste, and abuse solution.
Q: How does this solution integrate with existing prepay fraud, waste, and abuse solutions?
A: The prepay clinical complex review solution can be fully integrated into the fraud, waste, and abuse solution, and can be turned on as soon as rules and customization for prepay clinical has been completed.

Q: What data do we need to provide HMS?
A: HMS requires claims, membership, and provider data. Claims data is post-adjudication, pre-check write, and is typically provided daily; provider/member data is provided on a regular basis (monthly or bi-monthly), depending on the client.

Q: What information will I receive about the reasons for pended/denied claims?
A: Clients receive notification via an automated return file when a claim has been selected for review.

Q: How do I know the status of the claims?
A: All clients will receive an automated return file, which will provide the final status of the claim for automated and after the medical record has been reviewed for complex reviews. Clients can also use our portal to get claim status updates in real time.

Q: How do you charge for this service?
A: HMS’s prepay clinical solution is offered on a contingency fee basis, calculated against findings.

Q: How many members/claims do I need in order to get maximum value from this solution?
A: Payers with inpatient claims (Medicaid) or DRG claims (Medicare/Commercial) covering at least 35,000 members will benefit from this solution.

HMS powers healthcare with integrity through payment integrity, eligibility, and coordination of benefits solutions. HMS’s clients include health and human services programs in more than 45 states; commercial payers, including group health plans, Medicare Advantage plans, and more than 160 Medicaid managed care plans; employers; the Centers for Medicare and Medicaid Services; and Veterans Administration facilities. As a result of the company’s services, clients recover billions of dollars every year and save billions more through the prevention of erroneous payments.

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