Medicaid Provider Claim Review

To report a more complete picture of member health status to state Medicaid agencies, it's important to review claims against medical charts for suspected but unreported diagnosis codes.

For Medicaid managed care organizations (MCOs) performing risk adjustment, it can be difficult and time-consuming to search for and identify documentation to support unreported diagnosis codes in medical charts.

Many state Medicaid programs only accept a diagnosis code that has been billed on a claim or encounter to support Medicaid managed care risk adjustment. However, when a Medicaid MCO identifies unreported diagnosis codes for its members, there may be no readily available alternate submission method to report supplemental diagnosis codes. In most cases, these supplemental diagnosis codes must be submitted via the claims reporting system and move through the encounter data system of the managed care organization.

How can you report a more complete picture of member health status?

For Optum risk adjustment program clients, there is an add-on service[2] that can help report a more complete picture of member health status. The Optum® Medicaid Provider Claim Review coordinates reviews with providers of unreported diagnosis codes directly related to a member's visit found in the member's medical charts.

35%–40% of claims returned with approval of one or more unreported diagnosis codes identified by Optum prospective programs

40%–45% of claims returned with approval of one or more unreported diagnosis codes identified by Optum retrospective programs

85%
Total successfully released[1]

1. Percentage reflects combined approval totals for prospective and retrospective programs. Your results may vary.
2. Add-on service for Optum clients with chart review or in-office assessment. Service is limited to professional services only.

Optum

The Optum team manages the entire claim review process to help lessen the provider's administrative burden. Here's what we can do:

- Compare coding results to the historical submitted claims
- Determine if any suspected risk-adjusted diagnosis code(s) is unreported from the member visit
- Create a pseudo corrected claim on Form CMS 1500 that includes unreported diagnosis code(s), member and provider details
- Send pseudo claims to providers for their review and validation, which are made available in a digital workspace
- Work with providers who do not return claims within the set time limit
- Coordinate with health plans to create an escalation plan to engage providers not participating in the claim review
- Track provider claim validation status
- Submit the approved diagnosis codes to the health plan
- Generate program performance reporting

Provider Claim Review process for Medicaid managed care

Step 1 Unreported risk-adjusted diagnosis codes are identified from Optum programs.

Step 2 Pseudo claims are created to include unreported diagnosis codes.

Step 3 Optum coordinates delivery of pseudo corrected claim form(s) and receiving validation or rejection from providers in a digital workspace.

Step 4 Pseudo, corrected claim forms are processed and approved results are sent to the client in an outbound file.*

* 837P (future state)

Enabling meaningful efficiencies

Enhance provider engagement through dedicated outreach team with experience in 21-plus markets

Increase risk capture by leveraging Optum analytics using applicable state risk models, to identify all supported diagnosis codes not reported in the claim submitted originally

Optimize complete and accurate reporting by working with providers to review and validate diagnosis codes

Prioritize all approved diagnosis codes

Improve targeting through provider response-rate tracking

Remove administrative burden of resubmitting a corrected claim by creating the pseudo corrected claim on behalf of providers

Reduce administrative costs and standardized use of electronic transactions

Want to know how to generate a more complete, accurate picture of Medicaid members?

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