CHANGE HEALTHCARE

Insight. Innovation. Transformation.

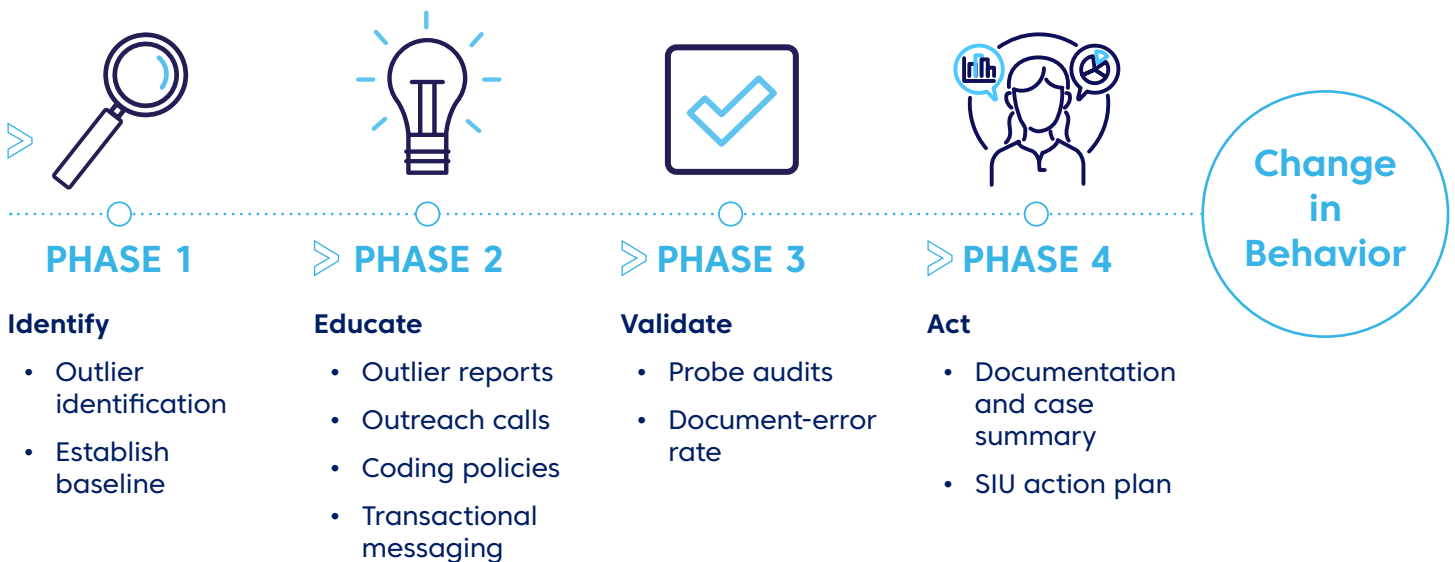# Help Increase Savings and Provider Engagement

Spot outliers and improve provider behavior with advanced AI and peer analysis

Tackling improper payments on low-dollar, high-volume claims is often a daunting task for payers. It requires significant resources, access to sophisticated data, and high levels of expertise. Even then, the return can be marginal and disruptive to provider relationships. Historically, the cost of pursuing this type of overpayment has been cost-prohibitive. Coding Advisor changes that.

Experience and Footprint

- 10 years and 2.5M providers' data analyzed
- 29 payer customers
- More than 190K current outliers
- Provider engagement in all 50 states
- Includes more than 45M covered lives
- Extensive collaboration with regulatory agencies, provider associations, and large provider groups

The software uses a proven, four-phase process for changing behavior and improving coding practices:

PHASE 1

Identify
- Outlier identification
- Establish baseline

PHASE 2

Educate
- Outlier reports
- Outreach calls
- Coding policies
- Transactional messaging

PHASE 3

Validate
- Probe audits
- Document-error rate

PHASE 4

Act
- Documentation and case summary
- SIU action plan

Change in Behavior

Our approach to communicating and editing uses AI and behavioral science to cadence messages in a way that doesn't disrupt workflow. Rather, Coding Advisor gives providers the office documentation and information they need to change patterns.

Accuracy Leads to Savings, Thanks to Analytics

Coding Advisor uses analytics and a sequenced process to address losses to more than 32,000 commonly up-coded, low-dollar, high-volume CPT codes across 20 modules, with new modules released quarterly. Data analytics, benchmark-provider billing behavior, and the payer's coding-reimbursement policies are used to educate outlier providers. It's a process designed to drive positive change and, as a result, more accurate billing practices.

Combining Master-Level Coders with a Collaborative Provider Engagement

Coding Advisor works to compare your claims to the billions of claims we process each year. Our master-level medical coders deliver targeted provider messaging on potentially erroneous billing — whether accidental or intentional — to educate providers in a collaborative, nonconfrontational way. It's all part of a process that encourages self-correction of claims and ultimately results in long-term behavior change.

The Coding Advisor Call Center reaches out to educate and discuss outlier results to help providers understand how and why they are different from their peers. This additional interaction with 85% of outliers ensures resolution and satisfactory behavior adjustment:

- Less than 1% provider escalation
- 9.6% avg. decrease in cost of outlier E/M claims
- 20.6% avg. decrease in outlier billings
- 81.8% outlier providers exhibiting better accuracy
- $3.5 Average Annual Savings PMPY

What Makes Coding Advisor Work?

- Coding Advisor brings to the market a unique approach to addressing high-volume, low-dollar professional claims, which until recently have been too cost-prohibitive to tackle.
- Corrects behavior for outlier providers using a focused, educational approach.
- Highly collaborative approach (not edit or audit) mitigates provider abrasion.
- Multiple methods of engagement for maximum impact.
- Evaluates providers on 32,000 CPT codes in 20 modules with continued concept growth.

- Part of a cohesive payment-accuracy suite of solutions.
- Simple implementation of the program is a light lift for our clients.

Not Just Another Alert

Coding Advisor isn't just another stopgap. It's a provider system and educational process designed to change behavior collaboratively.

Stop alienating providers and start saving on high-volume, low-cost claims. Contact our Sales team to learn more about how Coding Advisor can help you reduce provider abrasion while increasing savings.