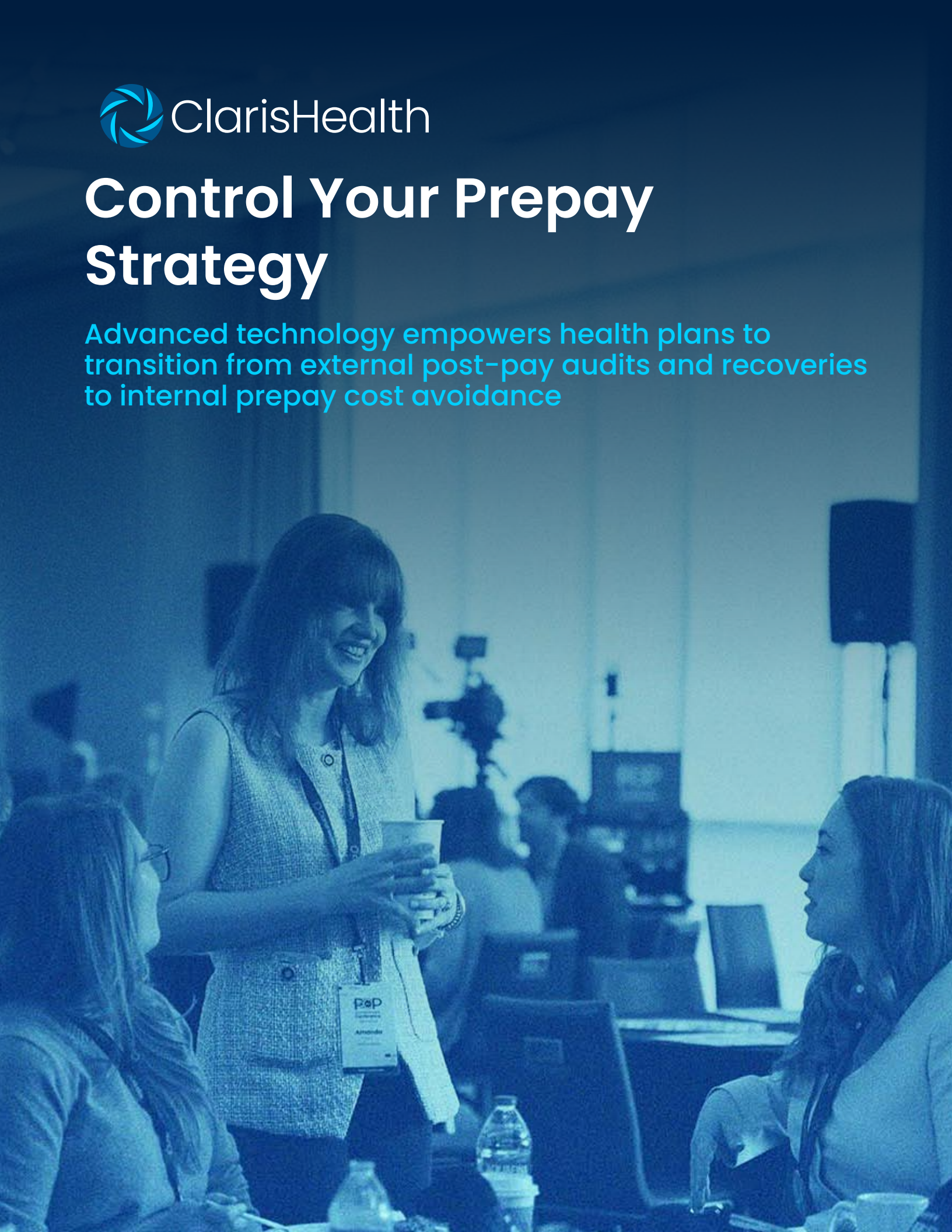
ClarisHealth

# Control Your Prepay Strategy

## Advanced technology empowers health plans to transition from external post-pay audits and recoveries to internal prepay cost avoidance



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# Introduction

About one-quarter of total healthcare spending in the U.S. is waste, with a price tag ranging from $760 billion to $935 billion, according to the widely cited JAMA review.[1] Of that number, administrative complexity alone accounts for 30% of excess spending,[2] which includes billing and coding waste. While the entire healthcare industry has work to do to combat that waste, health plans are doing their part by putting increasing focus on paying claims correctly the first time.

Prospective claims validation offers many benefits over the traditional "pay and chase" approach, which increases administrative costs – both for payers and providers – and provider abrasion.[3]

Industry research[4] found a non-trivial share of providers (8%) reporting more than $1M per year in admin costs tied to post-payment audits; another 10% spend $500k–$1M. Moreover, nearly half of respondents preferred prepay processes in which payers alert providers of potential errors before the claim is submitted for payment, citing how it can help them reduce their organization's administrative burden and associated costs.

The benefits to payers of shifting to prevention versus chasing recoveries are equally significant. Reducing administrative churn – duplicate records requests, appeals, vendor handoffs – directly improves ROI and provider relationships.

But technical, clinical and administrative barriers stymie widespread adoption. Claims adjudication systems – well-suited to payment policy checks – simply can't handle the complexity. Primary editors provide another line of defense, but the configuration timelines can add up to months, which creates more openings for leakage. And adding more outsourced vendors isn't a long-term solution.

**Industry survey finds**

8% of providers report more than

**$1 MILLION**

per year in admin costs tied to post-payment audits

**Nearly half of respondents** prefer prepay processes where payers alert providers of potential errors before the claim is submitted

**Health plan payment integrity leaders want to control their own prepay strategy, which prompts three questions:**

1. How can we review a **high volume of claims quickly and accurately** enough to prevent the provider abrasion that characterizes post-pay audits?
2. How can we **easily apply successful post-pay concepts** to prospective claims validation?
3. How do we **measure the ROI of "soft" value** like avoidance?

Fully eliminating retrospective payment audits isn't a realistic goal. But using advanced technology to move more payment integrity efforts to internal prospective claims validation will allow for maximizing avoidance and recoveries at the most optimized cost while improving provider relationships.

According to Tom Noack, SVP of product strategy for ClarisHealth and a long-time payment integrity leader at a top payer, "Our goal is always to pay the claim right the first time. Moving 70% of edits prepay reduces provider abrasion, cuts re-work, and drives real savings we often can't capture post-pay."

In this paper we discuss the challenges that have traditionally plagued health plans on their prepay goals and how technology that provides a 360-degree view of payment integrity efforts empowers health plans to progress to a more sophisticated operation with an optimized mix of prepay avoidance and post-pay recovery.

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# Challenges to Executing on Prepay Goals

Health plans want to prevent as many improper payments as possible and do so with their own internal resources. The benefits of the strategy speak for themselves:

**Realize cost savings.**
Internal prepay claims validation simply costs less than vendor post-pay efforts – 3x cheaper by some estimates.[5] The overpayment recovery success rate averages less than 70%, and the cost of recovery is at least $50 per claim.

**Minimize provider abrasion.**
Quickly and skillfully validating claims before payment offers opportunities to engage with providers and prevent painful clawbacks. Paying claims correctly the first time makes sense for providers and payers alike.

With these advantages, health plan leaders are increasingly focusing their efforts on prospective payment accuracy efforts to mitigate margin pressures. Our own research reveals greater than 60% of payment integrity savings are now prepay.[6]

But, of course, if transitioning more claims validation upstream were simple, every health plan would be primarily cost avoiding. There are four major challenges that prevent payers from making progress on their prepay goals.

## Siloed internal departments

When health plans designate separate departments responsible for specific elements of payment integrity, silos naturally emerge. They have different goals and use different systems and may even be incentivized to compete against each other. But now, these silos are generally recognized as detrimental to knowledge sharing, efficiency and innovation. Every payment integrity function – including the SIU – has a hand in prepay success and proceeding otherwise is counterproductive.

## Provider abrasion risk

While a successful prepay strategy stands to improve valuable provider relationships, a disjointed approach promises to accomplish the opposite, perhaps even more damaging than standard post-pay recovery efforts. With as few as 15 days to make a pay/deny decision and only the simple edits available in claims adjudication systems, a sophisticated prepay strategy remains out of reach for many payers. They simply don't have the time to apply manual or otherwise disjointed coordination of benefits, complex coding and clinical expertise to claims on a prepay basis.

## Limited technology and resources

Advanced analytics, machine learning and other more modern applications of artificial intelligence have emerged to take on increasingly complex claims scenarios. At the same time, seamless technology integrations can make it easier for health plans to take advantage of the best the industry has to offer. But the outdated systems in place at most payers make it next to impossible to properly leverage their troves of data for timely error detection or integrate detection results from modern solutions into auditor workflows.

Research conducted by ClarisHealth shows greater than 60% of payment integrity savings are now prepay

## Over-reliance on vendors

For most health plans, their prepay strategy relies on third-party services vendors; according to recent statistics, 90% of health plans use more than three vendors, and 40% use more than five.[7] These partners can be an excellent way to augment limited health plan resources including staff, expertise and technology.

But leaving payment integrity efforts solely in the hands of vendors can lead to gaps that keep PI programs from moving forward:

- **Lack of integration.** Vendor efforts are often siloed in their own systems. And, just like internal department silos, there is little ability to connect the efforts of prepay and post-pay vendors, much less ingest the useful analytics they offer. This issue leads to missed opportunities.

- **Lack of visibility.** Because of the lack of integration, health plans often struggle to gain real insights into which vendors are the most successful and how to quantify their efforts. Which vendors provide the most value to a health plan by pass order, line of business, specialty and more? What vendor concepts yield the fastest, most accurate results, both prepay and post-pay? Most health plans must guess at these comparisons, which limits their ability to optimize supplier relationships and prevents them from progressing on internalization strategies.

And the high contingency fees associated with this approach are the source of some of the highest administrative costs in the health plan.

Kimberly Fadden, SVP of client management for ClarisHealth, explains, "Every health plan is doing $50-$100 million in post-pay data mining and paying 12-16% in contingency fees. Most of that can be insourced and pushed prepay with a self-serve secondary edit solution. With everything happening around MLR, insourcing is the key to reducing administrative costs."

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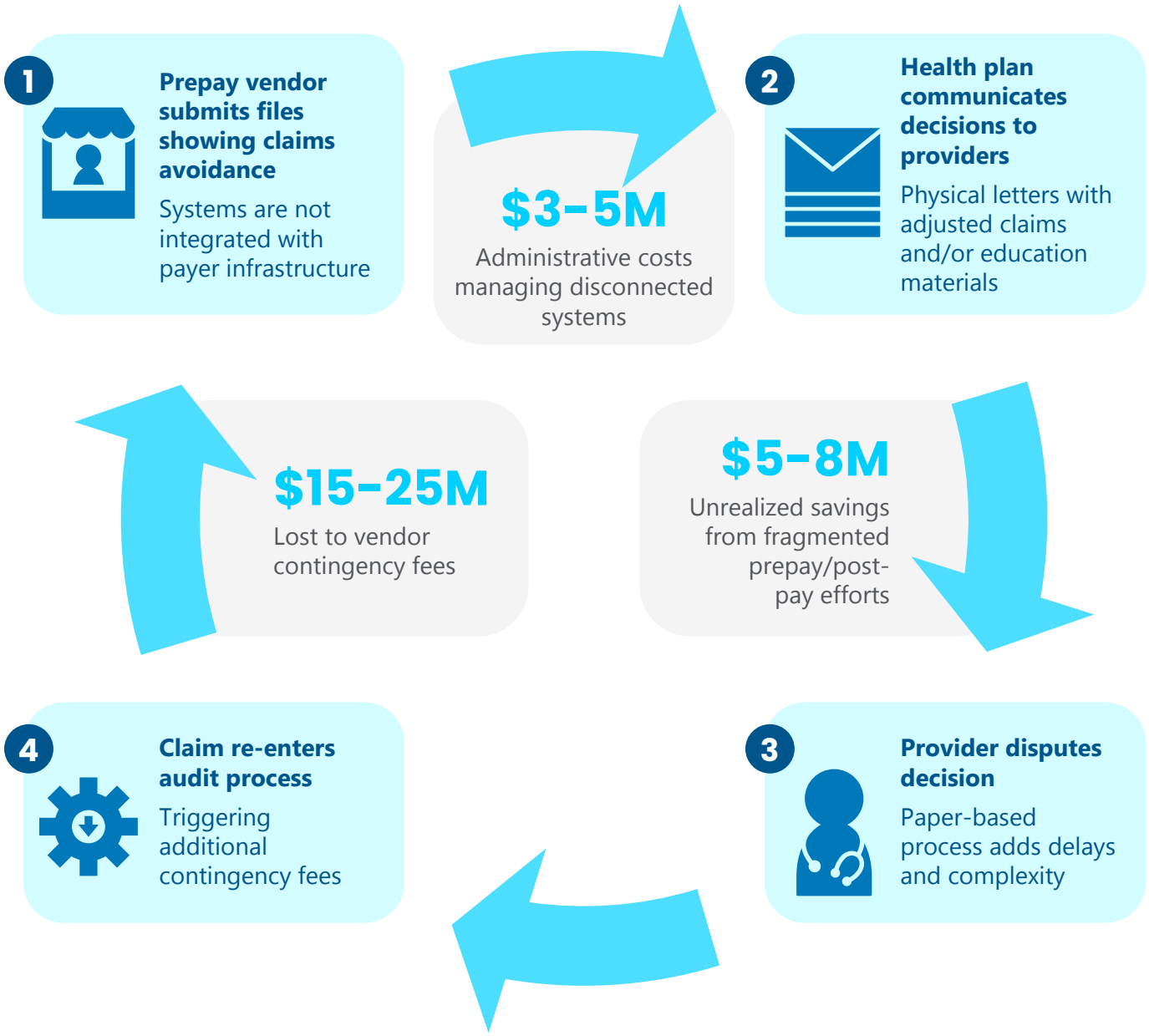
## An Inefficient Prepay Process Costs $23-38M

Because of technology, staff and expertise constraints, many health plans are stuck in a manual prospective claims validation cycle that limits their ability to take control of the process and shift more efforts internal. This inefficiency comes at a cost, calculated for a typical health plan processing 10 million claims annually:



# When the Primary Editor Isn't Enough

Every U.S. health plan relies on a primary claims editor. These primary editors do an essential job: they check every claim for basic coding errors, coverage rules, and common industry edits. For example, National Correct Coding Initiative (NCCI) bundling logic, duplicate-claim edits, and age/gender conflicts.

However, primary editors leave significant gaps that routinely allow overpayments to slip through.

According to Noack, "A standard primary editor is really designed for operational efficiency — making sure claims pass basic compliance checks and can be auto-adjudicated quickly. It's not engineered to go deeper into nuanced clinical policy or revenue-integrity patterns where most overpayment risk hides."

A primary editor's purpose is to automate clean-claim adjudication; it is not a comprehensive payment-integrity platform. Without a purpose-built secondary-edit capability that brings advanced coding, clinical, and revenue-integrity logic upstream, health plans risk leaving 1–3% of medical spend unprotected from overpayment. Several factors explain the limited coverage.

## Narrow edit scope and static rule sets

Primary editors focus on a fixed library of standardized edits such as NCCI bundling and some duplicate/frequency checks. They rarely include the specialty-specific, locally customized secondary edits that catch improper units, inappropriate modifiers, DRG shifts, or service-to-diagnosis inconsistencies. In addition, the frequency of updates may not be able to keep up with regulatory coding and billing guidelines.

Fadden has years of experience with these systems from a product development perspective and notes their lack of responsiveness. "Primary editors need constant updates for CMS, AMA, state-specific rules, and more," she says. "Maintenance is a big lift."

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Hank Turner, VP of client engagement for ClarisHealth, recalls this limitation from his years managing vendor contracts for strategic programs at a large regional payer. "We were always saying, 'Why do we need a secondary claims editor? We just need our primary editor to work better and faster.' But their turnaround for new edits took forever and a day."

## "Clean-claim" bias and the rebill loophole

Primary editors are designed to accept a claim as soon as it meets minimum data-cleanliness rules. When a provider resubmits a corrected claim, the primary editor often again allows it through at the full allowed amount — even if the original overbilling pattern persists.

"You get this vicious cycle of deny-rebill-deny," Noack cautions. "Primary editing just re-adjudicates; it doesn't recognize that it's the same improper billing pattern showing up again."

## Insufficient clinical-policy and revenue-integrity logic

High-risk categories such as medical-necessity for high-cost imaging or specialty drugs, maximum units of service, inconsistent outpatient psych services, bilateral-procedure modifiers, and Z-code misuse typically fall outside the reach of the primary editor.

"A lot of edits require a clinical orientation—understanding what it really means to bill for the same surgery on two different sides of the body, for instance," Turner explains. "That nuance is critical."

## Lack of configurable controls and audit trail

Vendor-run secondary-edit engines usually offer granular inclusion/exclusion logic and transparent adjustment workflows. Conversely, core claims editors are often "black-box," offering limited visibility for PI teams to tune rules by line of business or to avoid duplicate contingency fees on repeat denials.

But in an industry characterized by change, understanding methodologies is imperative to being able to process claims as accurately as possible.

"Early primary editor systems especially were black boxes. You couldn't see why a rule fired," says Fadden. "Today, payers and providers both expect more transparency."

### What Claims Editors Can Control – and What They Can't

*Payment Integrity provides a critical checks-and-balances system*

| Category | Examples | % of Medical Spend Impact | Typical PI Tools / Controls |
|---|---|---|---|
| Uncontrollable: Billing Errors (Provider-driven)<br><br>Incorrect or inappropriate claim submission by providers (intentional or unintentional) | • Upcoding (higher level service billed)<br>• Unbundling (separate billing for bundled services)<br>• Duplicate claims<br>• Non-covered/experimental services<br>• Missing documentation for medical necessity | 7%–12% error rates in Medicare/ Medicaid<br><br>3% – 5% of total claims cost (Commercial) | Prepay claims edits<br>Clinical coding audits<br>Natural Language Processing (NLP) for documentation review<br>Fraud, Waste & Abuse detection models<br>Provider education & feedback loops |
| Controllable: Operational Inefficiencies (Payer-driven)<br><br>Overpayments caused by internal payer system, process, or configuration errors | • Misapplied provider contract rates<br>• Incorrect Coordination of Benefits (COB)<br>• System rule configuration gaps<br>• Missed prepay edits (caught only post-pay)<br>• Insufficient clinical review capacity | 1% – 2% of total claims cost (avoidable leakage) | Automated contract validation<br>COB automation & eligibility verification<br>AI-based payment policy checks<br>System configuration audits<br>Centralized PI dashboards & reconciliation |

# Elements of a Successful Prepay Strategy

The goal for every future-looking health plan is to transition payment integrity efforts from predominantly outsourced post-pay, to a healthy mix of prepay and post-pay led by both internal and external resources. How to get there is the question.

For health plans just starting out with this realignment, we put forward five recommendations. However, payment integrity operations vary greatly in sophistication, so each health plan will pursue a slightly different path from current state to full transformation.

## Adopt advanced technology

Strategic directors of payment integrity understand the potential of digital transformation: a greater focus on prepay functions yields a better balance between internal and external functions and improves recovery returns. Breaking down data silos to centralize efforts is the first phase, and adopting advanced technology is key to this goal.

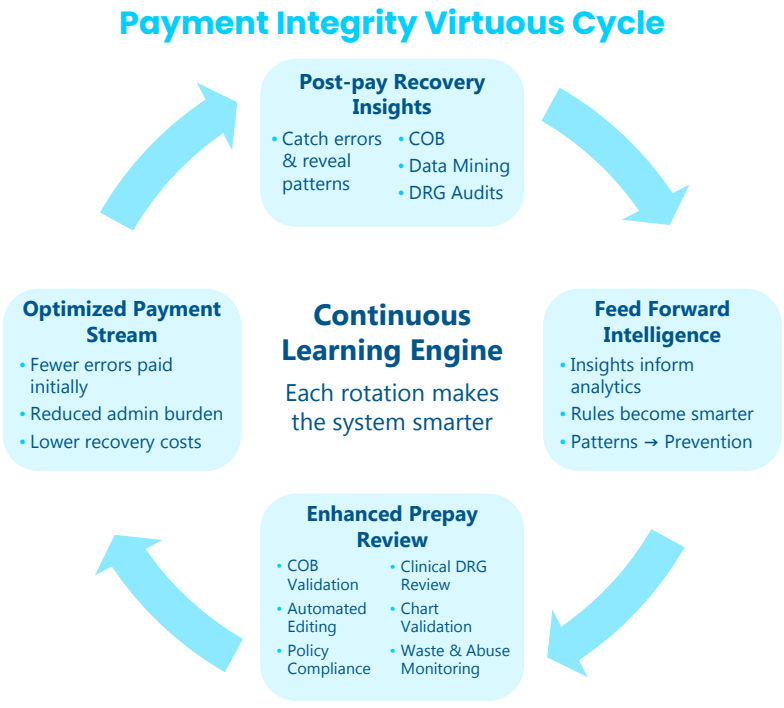
Instead of the multiple technology and manual systems and processes that historically characterize health plan operations, unite disparate internal payment integrity departments and vendor information under a single technology platform. Especially if that technology supports APIs for real-time data feeds from service vendors, industry databases, provider EHRs and best-of-breed applications, it stands to streamline payment integrity operations and support health plans in owning their prepay strategies.

## Optimize post-pay recovery efforts

While a health plan's goal is to ultimately reduce the overall retrospective effort in favor of primarily prospective claims validation, successful post-pay recovery is the foundation. In fact, the predictive analytics that form the foundation of prepay concepts – and even more advanced AI-driven error detection solutions – often rely on compiling historical results to improve precision.

PI programs should start by ensuring they have all areas of payment integrity covered – coordination of benefits, data mining, medical record review, contract compliance, and fraud and abuse detection – and coordinating these efforts between internal and vendor resources.

This effort should help in the effort to evaluate provider claim submissions for trends to identify those providers that could benefit from additional support. Work to engage these providers with education and motivation to improve billing practices and submit clean claims that ensure prompt payment.



## Gain visibility on vendor successes

Because most health plan prepay strategies begin with outsourcing to third-party payment integrity services partners, the most successful prospective claims validation concepts may be siloed within those vendors. But the best partnerships are rooted in transparency. Maximizing the mutual value of the payer-vendor relationships starts with increasing visibility on the assignments, efforts and results.

Integrative technology streamlines the vendor effort needed to receive claim files, submit audits, and get real-time feedback on denials. Health plans can strategically stack and segment high-performing vendors and mutually develop goals with vendors and track performance real-time. Over time, this data also provides insights into which activities are best suited to internalization.

## Aggregate analytics from multiple sources

Once health plans have optimized post-pay recovery efforts and gained visibility on vendor prepay contributions, a baseline library of concepts to launch an internal prepay strategy should emerge. Some algorithms and data sets that support retrospective issues may be insufficient for prospective intervention, so thoughtfully adjust as needed to accommodate thresholds better suited to the prepay environment.

Payment integrity technology vendors may also be a source of prepay analytics. Combined with concepts developed by internal data science resources and those internalized from third-party suppliers, health plans can develop a robust concepts repository.

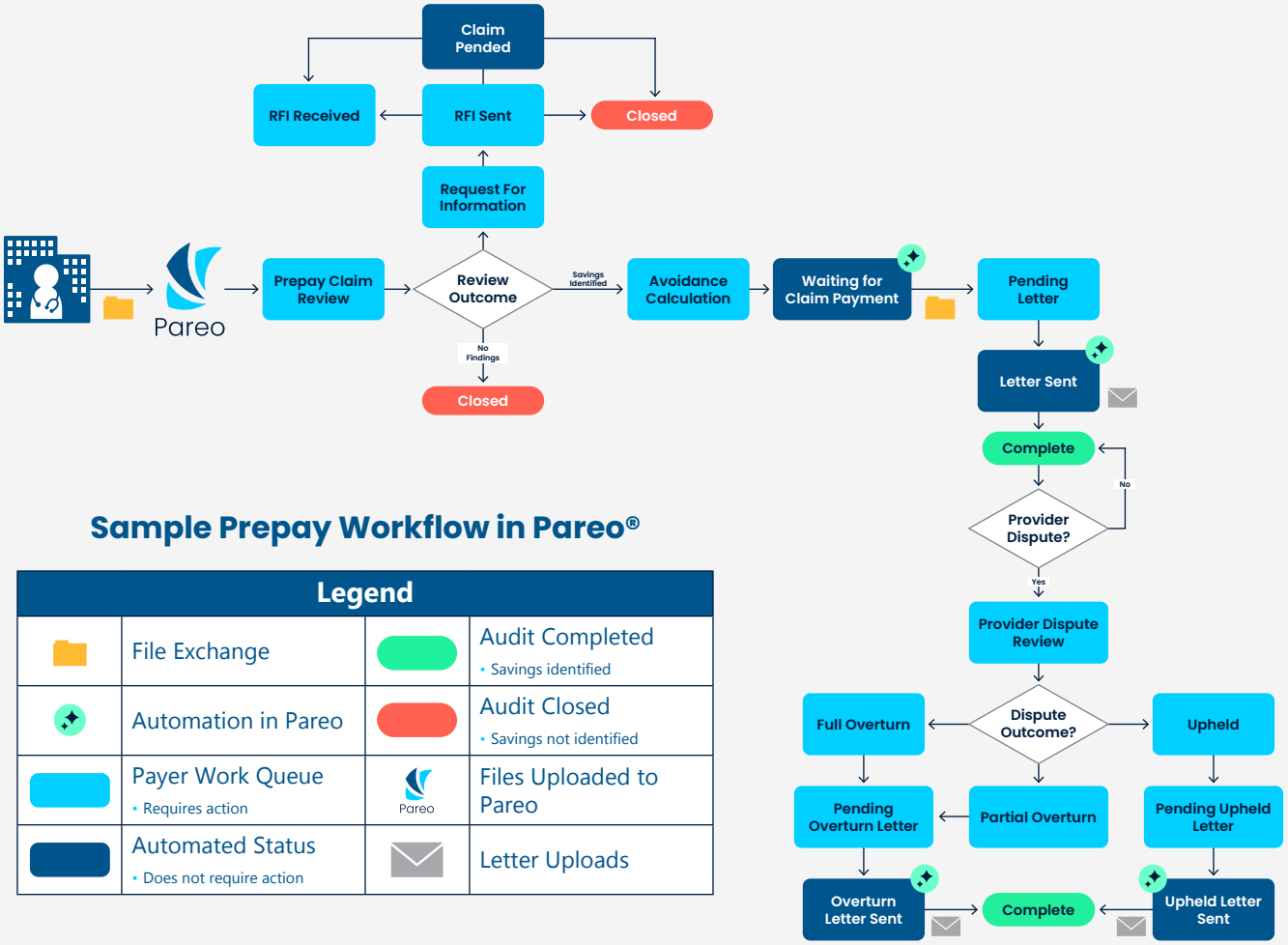
## Configure workflows to maximize internal resources

At this point, payment integrity leaders should be in a better position to assign internal resources to managing more prepayment audits. These prepay workflows will likely look different from post-pay recovery workflows, particularly in terms of timelines and provider engagement.

While retrospective payment solutions may allow ample time for plan staff to review and validate findings, prepay operates on a much shorter timeline. Health plans must manage the accuracy of prospective findings and should hold their team to an appeals uphold rate of 90 percent or greater. Automate as much as possible to reduce the risk of having to pay without review.

Additionally, as complexity increases, so should team coordination. Retrospective recovery efforts will continue and may be better at spotting long-term trends. Real-time collaborative technology enables prepay operations to ingest post-pay intelligence to educate providers accordingly and adjust prospective validation processes to ingest post-pay intelligence to educate providers accordingly and adjust prospective validation processes to rapidly prevent future payment errors.

Finally, ensure the prepay program lives up to its promise of engaging providers and reducing abrasion. Proactively communicate with providers to get their buy-in on new policies. Consider implementing a web-based provider communication tool that integrates with the prepay workflow to deliver explanations of payments and denials and supports provider inquiries and appeals. Combined with dashboards that display billing patterns and other relevant analytics, this framework opens new avenues for extending the provider relationship.




### Sample Prepay Workflow in Pareo®

| Legend | | | |
|---|---|---|---|
| | File Exchange | | Audit Completed<br>• Savings identified |
| | Automation in Pareo | | Audit Closed<br>• Savings not identified |
| | Payer Work Queue<br>• Requires action | Pareo | Files Uploaded to Pareo |
| | Automated Status<br>• Does not require action | | Letter Uploads |

## Expert Insights: Building Blocks for a Self-Serve Prepay Program

Insourcing prepay audit programs hinges less on adding more staff and more on having the right mix of technology, data discipline, and streamlined processes. These foundational elements help PI leaders accelerate adoption of self-serve secondary edits while reducing provider abrasion and re-work. Kimberly Fadden and Hank Turner weigh in with their expert insights.

### Technology that works with—not against—claims operations

- Ability to suspend claims post-adjudication and release them within required prompt-pay timelines
- Integrated workflow plus a rules-based engine that a business analyst (not IT) can configure
- "Test-and-learn" environment to model the impact of new edits before they go live

**Turner:**

*"You can't just drop an edit in and hope it works; you need the right test environment and cross-functional expertise."*

**Fadden:**

*"You want a tool that's easy to build, easy to maintain, fully transparent, and fully sourced to industry standards like AMA, ICD, HCPCS."*

### Data discipline and visibility

**Turner:**

*"Speed to market is the main advantage. A modern secondary editing tool should allow you to spot behavior and respond in days, not months."*

- PI-savvy analyst(s) who understands claims data flows and edit logic
- Reporting that shows ROI by edit (e.g., dollars saved, re-work avoided) and highlights gaps or low-value effort

**Fadden:**

*"You should be able to measure direct claim-payment reduction. For example, one client projected $75 million in cost reduction with self-serve secondary edits."*

## Provider-friendly processes

- Clear criteria to separate rebillable vs. solid edits to minimize abrasion
- Defined SLAs to keep suspended claims within regulatory payment windows
- Feedback loops such as provider scorecards to improve coding upstream

**Turner:**

*"PI has to stay closely tied to provider contracting teams. Some edits are straightforward like duplicates; others get complex depending on modifiers, procedures, and contract carve-outs."*

## Aligned people and governance

**Turner:**

*"A health plan that can stand by its own edits is in a stronger, more defensible position with state regulators."*

**Fadden:**

*"Open-source, fully-sourced edits mean providers can see exactly why something paid or didn't—critical for compliance and provider relations."*

- Core PI staff trained to manage edits and workflows end-to-end
- Leadership focused on continuous optimization: refining rules, reviewing provider trends, and measuring the reduction in re-work percentage and write-off rates.

# Most Common Prepay Audits Performed by Payers

Most payers prioritize coding accuracy, medical necessity, duplicate/frequency controls, and high-cost service reviews.[8] Mature prepay programs often shift more clinical audits—like DRG validation and high-cost drug reviews—upstream to prepay to reduce costly post-pay recoveries and improve provider relations.

## Coding & Billing Accuracy Audits

Focus on whether the claim is billed with the correct diagnosis, procedure, and modifiers:[9]

- **Upcoding/Downcoding audits** – e.g., validating DRG assignments, sepsis vs. infection, or high-level E/M codes
- **Modifier misuse** – e.g., 25, 59, or bilateral modifiers applied inappropriately
- **Bundled service compliance** – ensuring services that should be bundled (like anesthesia with a surgical procedure) aren't unbundled
- **Global period audits** – checking for services inappropriately billed during a postoperative period

## Medical Necessity & Clinical Policy Audits

Evaluate whether the service provided meets the payer's medical necessity criteria, particularly for claim types with historically high improper payment rates:[10]

- **High-cost imaging & diagnostic testing** – MRI, CT, PET scans
- **Inpatient vs. outpatient setting validation** – e.g., two-midnight rule, elective vs. emergent admissions
- **Specialty drug administration** – confirming approved diagnosis, dosing, or route of administration
- **Behavioral health & therapy visits** – validating documentation supports frequency and intensity

## High-Dollar & High-Risk Service Audits

Target claims with significant financial or regulatory risk:

- **Transplants, cardiac devices, and orthopedic implants** – ensuring correct billing and documentation
- **Sepsis and severe DRG shifts** – identifying diagnoses that drive higher reimbursement but may lack clinical evidence
- **Inpatient readmission reviews** – within 30-day windows
- **Outlier or excessive charges** – flagging claims with unusually high allowed amounts

## Consistency & Data Validation Audits

Identify claims that don't align across coding, provider, or member data:

- **Diagnosis-to-procedure consistency** – e.g., male patient billed for obstetric procedure
- **Specialty-to-service mismatch** – service billed inconsistent with provider specialty or taxonomy
- **Age/gender conflicts** – such as pediatric codes on adult patients
- **Discharge status validation** – ensuring status codes align with length of stay and downstream billing

## Duplicate & Frequency Audits

Catch repeated or excessive billing for the same service:

- **Exact/near-duplicate claims** – identical claim lines submitted multiple times
- **Frequency limits** – e.g., labs billed more often than policy allows; infusion units exceeding approved limits
- **Maximum units per day/week/month** – especially for injectables, dialysis, or therapy

## Provider & Member Eligibility/ Coordination Audits

Address errors not tied directly to coding but to payment eligibility:

- **COB (Coordination of Benefits)** – ensuring primary payer liability is correct
- **Member eligibility at date of service** – avoiding payment for inactive coverage
- **Provider credentialing or contract status** – confirming provider is eligible for reimbursement

# Case Study: A TPA's One-Year Proof-of-Concept with Self-Serve Secondary Edits in Pareo®

*6% savings - nearly $40M in recoveries - uncovered with a single integrated prepay workflow*

## Background and Goal

A leading third-party administrator (TPA) serving Medicaid and commercial health plans wanted to expand its prepay payment-integrity capabilities while keeping control over which solutions it offered to clients. Historically, each client chooses its own secondary-edits vendor—typically on a contingency fees model—forcing the TPA to support multiple vendor integrations and absorb those fees in some cases.

To improve both margin and user experience, the TPA piloted a self-serve secondary-edits solution fully integrated within Pareo®. Leadership viewed this approach as a way to:

- Shift more payment-integrity activity upstream into prepay
- Avoid paying duplicative contingency fees to outside vendors
- Provide a single, consistent secondary-edits workflow for all clients
- Create a new revenue-generating service line for certain customer segments

## Scope of the Proof-of-Concept

### Client

Metropolitan area Medicaid MCO

### Timeframe:

One paid year of claims (July 2024 – July 2025)

### Total Paid Spend Analyzed

$3.3 billion

### Scope After Exclusions/ Logic Alignment

$2.7 billion in eligible dollars processed through the secondary-edits engine inside Pareo

## Approach

Using the self-serve editor integrated within Pareo, jointly-defined adjustment logic and exclusions were applied, then the resulting edits were categorized into three groups:

1. ICD / "Clean-Claim" Edits: Mainly diagnosis-code-driven issues that often trigger provider rebill with no change to reimbursement amount
2. Revenue Edits: Non-ICD issues (e.g., duplicates, max units, specialty-consistency) plus a few ICD-based edits that typically result in true payment reduction with little or no appeal/rebill potential
3. Other Specialty Edits: Bundled-service and medical-necessity logic

To prevent the common "deny-rebill-deny" cycle seen with some traditional vendors, Pareo is designed to run each claim through the prepay editor only once at initial payment. This approach reduces provider abrasion and eliminates the risk of layered contingency fees.

## Results

Across the full year of paid claims:

- Total Edits Identified: ≈ 551,000
- Gross Savings Opportunity: ≈ $162 million (≈ 6% of total claim spend)
- Revenue-Edit Savings: ≈ $40 million (1.48% of spend), representing reductions that typically result in a payment decrease or provider write-off with minimal appeals
- When focusing only on the most conservative revenue-edit subset across all service years, results held steady at ≈ 1.49% of spend, or about $25–26 million in concrete savings.

"The diagnosis-code consistency edits, max-unit checks on drugs, outpatient-psych taxonomy errors — those aren't in the primary editor at all," said Noack, who validated the POC data. "Without a secondary-edit layer, you're not even reviewing those claims."

### Top Revenue-Edit Categories

- Z-codes
- Bilateral-service edits with modifiers
- Outpatient psych-service consistency
- Incorrect specialty taxonomy on outpatient services
- Maximum-unit drug edits
- Discharge-code discrepancies

**551,000**
**Total Edits Identified**

**$162 million**
**Gross Savings Opportunity**

**$40 million**
**Revenue-Edit Savings**

## Key Business Takeaways

### Material Financial Impact

A single-year pilot covering one Medicaid plan surfaced 6% savings potential overall and nearly $40 million in hard-dollar recoverable savings, validating the business case for further prepay adoption.

### Margin Improvement vs. Post-Pay Vendors

By internalizing edits that previously would have gone to an outside vendor on contingency, the TPA can avoid repeated contingency charges—sometimes assessed multiple times on the same claim line under traditional vendor models.

### Operational Efficiency & Provider Experience

Running edits once per claim at initial payment avoids repetitive denials and rebills, lessening provider abrasion and staff workload.

### Platform Advantage

Integrating edits directly in Pareo creates a single, scalable workflow for all current and future client plans. Eliminates the need to maintain multiple client-specific vendor solutions.

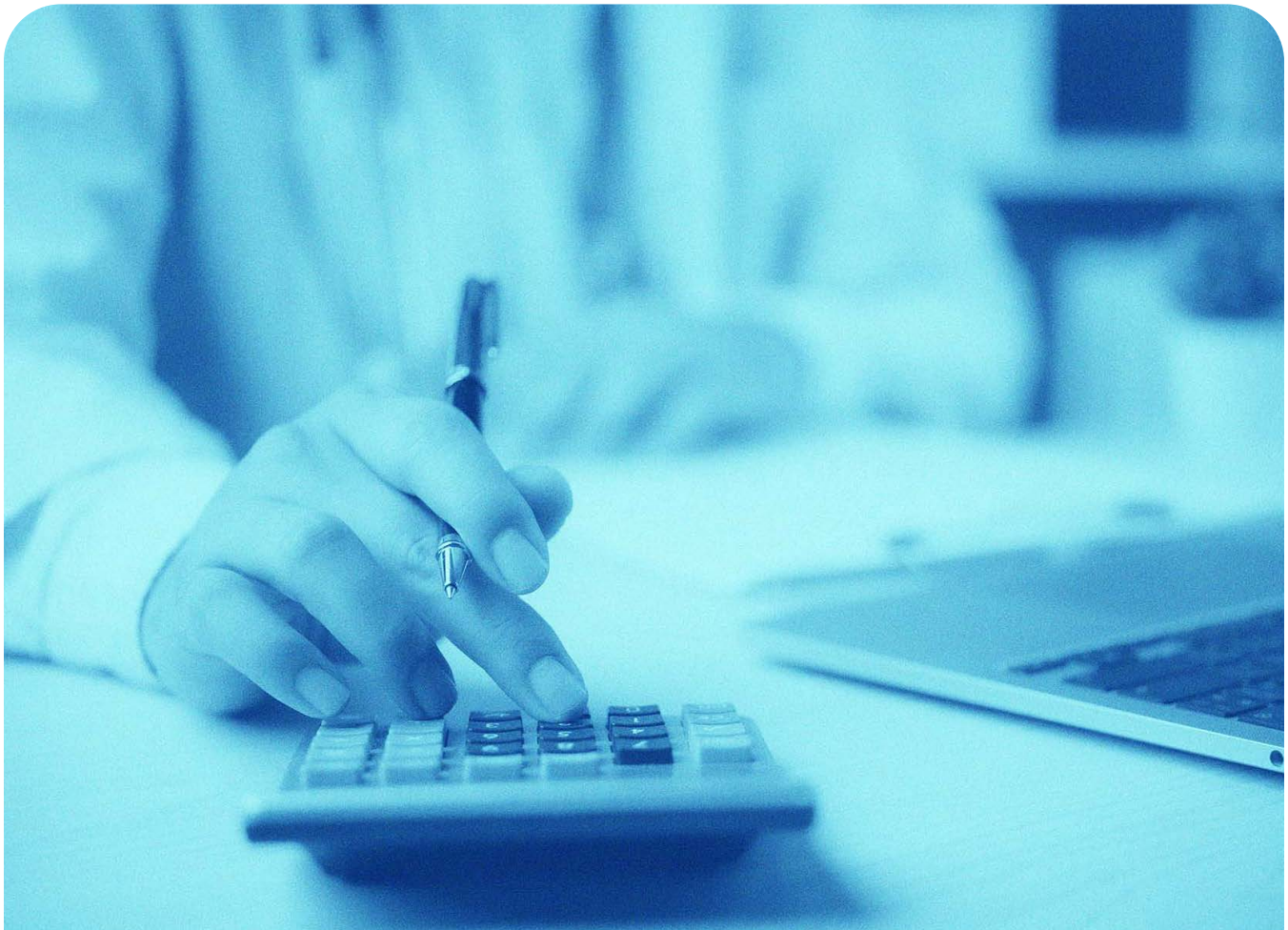
"With a platform like Pareo you can expand beyond secondary edits to prepay, pend, even subrogation," says Fadden. "It's an end-to-end solution you can leverage across the payment integrity continuum."

> *We all want to see the shift from post-pay to prepay. Most vendors approach this solution with a contingency fee model. The white box solution is more appealing to us versus black box because we have more investment capability to impact savings and make changes on the fly. It's not just another way for a vendor to charge us.*

Managing Director, Payment Integrity Services

## Proof of Concept at a Glance

| Client | Medicaid MCO in a major metropolitan area |
|---|---|
| Claims Period Analyzed | Jul 2024 – Jul 2025 (1 paid year) |
| Total Paid Spend Reviewed | $3.3 B → $2.7 B in eligible scope after exclusions → $1.74 B conservative subset |
| Total Edits Identified | ≈ 551,000 claim-line edits |
| Gross Savings Opportunity | ≈ $162 M (6% of total spend) |
| Revenue-Edit "Hard-Dollar" Savings | ≈ $40 M (1.48% of spend) |
| Conservative Revenue-Edit Subset | ≈ $25–26 M (1.49% of spend) |
| Top Revenue-Edit Categories | Z-codes • Bilateral-service w/ modifiers • Outpatient psych-service consistency • Incorrect specialty taxonomy • Max-unit drug edits • Certain discharge-code edits |



# Pareo Empowers Health Plans to Control Prepay Cost Avoidance

The secondary-edit capabilities integrated into Pareo give payment integrity teams full self-service control inside the same workflow platform where the entire PI operation resides, reducing the need for costly, contingency-based vendor models. By embedding the rules engine directly in the claims workflow, PI leaders can design, test, and deploy new edits in-house without IT coding, measure their impact in a silent-mode environment before activation, and align edits to business priorities in near-real time.

As Noack says, "Pareo empowers payment integrity leaders to self-serve within their own workflow at a flat non-contingent cost. All while testing and learning in a 'silent' environment before any claim is stopped. That's a huge value driver for both payers and providers."

The result: faster optimization, lower administrative costs, and a better experience for all stakeholders.

> *Pareo empowers payment integrity leaders to self-serve within their own workflow at a flat non-contingent cost. All while testing and learning in a 'silent' environment before any claim is stopped. That's a huge value driver for both payers and providers.*
>
> Tom Noack, SVP of Product Strategy, ClarisHealth

## Key Differentiators: Greater Control and Value

| | Pareo | Legacy Vendors | Point Solutions |
|---|---|---|---|
| **Business Model** | Fixed-fee platform | High contingency fees | Mixed pricing models |
| **Analytics Access** | Full transparency | Black box | Limited transparency |
| **Customization** | Self-service | Vendor-controlled | Limited flexibility |
| **Workflow Integration** | Complete PI platform | Siloed approach | Disconnected tools |
| **Path to Insourcing** | Clear transition plan | Vendor dependency | Partial capabilities |

## Capabilities

Pareo equips payment integrity leaders to move the most lucrative concepts to a prospective environment with limited vendor reliance because all the data necessary to make these strategic decisions is housed in a single platform.

### Integrate Pre- and Post-Pay with Best Practice Workflows

Audit validation workflows are configured for prepay, including ability to query down to the claim level and manage to the concept level. Tight integration to post-pay enables comprehensive audit management. Connect internal post-pay (both complex and non-complex), internal prepay (both complex and non-complex), and vendors (both prepay and post-pay).

### Integrate Systems

Flexible integrations with the claim system adhere to stringent SLA performance, maintain common audit and analytic experiences, and streamline disparate data sources.

### Inject Plan Owned Analytics

Build new edits, including the ability to use reference data in stored tables across a library of edits. Create logic testing cases for all edits. Customize Pareo's baseline library of 3500+ successful prepay analytics (augmented monthly) to enhance internal analytics.

### Extend Post-Pay Concepts to Prepay

Easily transition post-pay analytics to the prepay environment. Leverage integrated confidence reporting to continuously reduce pay-and-chase volumes. This transition can cover both complex (requiring medical record review) and non-complex (data mining) audits.

### Test Provider Impact

Model the financial and provider impact of new edits before activating them with test-and-learn "silent mode". Capture all claims with denials and re-coding to flow through Pareo with advanced reporting on each edit, client and provider impacts.

### Manage Internal Auditor

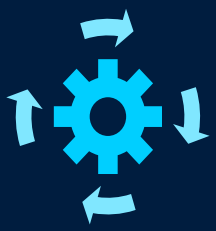
Workflow and UI to manage inventory and manual review of prepay results to support edits requiring repricing; review library or custom edits; drive edits to manual review or no-touch denial; assign and manage prepay data mining inventory.

### Prove ROI

Track estimated avoidance and compare to actual payments when processed. Reporting shows analytics retrospective accuracy (false positive rate) and how retrospective-to-prospective analytics reduce leakage post-pay.

## Advantages

Pareo spans retrospective to prospective, outsourced to insourced for a 360-degree approach to payment integrity. It is the industry's only health plan-controlled solution that empowers leaders to shape their own strategy and have the advantage of the best technology and best analytics – without over-relying on services vendors.



**Embedded in existing workflow**

Eliminates multi-solution processes and keeps data, rules, and reporting in one place.

**Non-contingent cost model**

Predictable membership- or flat-fee pricing replaces high vendor contingency rates.

**Self-service rule creation**

Empowers PI business analysts to configure edits without IT coding support.

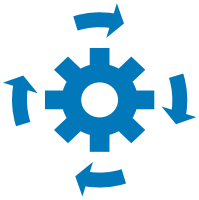
**End-to-end visibility**

Data flows seamlessly through audit workflow and reporting for faster optimization.

With Pareo, health plans can cover all lines of business, prepay and post-pay, with solutions in place to continuously evaluate and move post-pay identifications internal and ultimately to avoidance. As a result, health plans can expect to realize substantial ROI:

**30% reduction in payment integrity costs**

**15–25% savings on vendor fees**



**20–30% efficiency improvement**

The future of payment integrity isn't about choosing between prepay and post-pay, or internal and external resources. It's about having the flexibility and control to optimize both.

Pareo puts that control in your hands, enabling you to shift high-value work upstream, reduce dependency on costly contingency-based vendors, and build a sustainable, scalable payment integrity operation.

**Ready to see how Pareo can transform your program? Contact us today to schedule a demonstration.**

*The closer we can get to intervention at the provider level, the better off we're going to be. We're looking for low-cost options to change behavior, and to utilize the technology that the suppliers we've decided to partner with have. But we want to get to the point where we can use technology to learn from what's happening in post-pay, create our own prepay edits and save even more money.*

Kimberly Jones-Schneider, Director of Payment Integrity Operations & Recoveries, Blue Cross Blue Shield of Michigan

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