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WHITE PAPER

Data Management for Smarter Payments and FWA Prevention

Foreword

A Data-Driven Imperative for Payer Success

Today's healthcare landscape is defined by complexity and constant change. As value-based care gains momentum, and fraud schemes become increasingly sophisticated, payers are under pressure to improve outcomes while simultaneously reducing administrative waste. Success in this environment requires more than process improvement, it demands precision. And precision begins with data management.

At the intersection of strategy and technology lies strong data management, the cornerstone of advanced analytics and a critical enabler of payment integrity (PI). Without a solid data foundation, analytics tools are underpowered, insights are delayed, and fraud can go undetected.

The key to modern data management is the ability to:

- Collect, cleanse, integrate, store, and govern data across multiple systems and silos.
- Create structured, accurate, timely, and accessible data to support advanced analysis.
- Utilize the data to reduce administrative waste and prevent fraud, waste, and abuse (FWA) before payments are made.
- Avoid the pitfalls of fragmented, outdated, or inconsistently formatted data, which can derail analytics, miss savings opportunities, increase audit fatigue, and obscure fraud risks.

Analytics, in turn, rely on this managed data to:

- Detect patterns, flag anomalies, and drive high-impact decisions.
- Serve as a source of truth that enables real-time analysis, risk scoring, and cross-system insights.
- Increase audit and payment precision, reduce false positives, and surface fraud indicators earlier in the claims cycle.

For payers ready to move from reactive claim correction to proactive payment accuracy, data management is not just an operational necessity, it's a strategic asset. When leveraged effectively, data management becomes the launchpad for advanced analytics, transforming the way payers approach fraud prevention, audit efficiency, and payment integrity.

This article focuses on advancing data management, utilizing data management for precision payment and fraud detection, and operationalizing data management for long- term success.

Section I: Advanced Data Management for Payer Success

The next generation of payment integrity is built on a foundation of data management infrastructure that goes beyond simple collection, storage, and reporting. To enable powerful analytics, payers must focus on the following capabilities:

- **Centralized and Interoperable Systems**: Effective payment accuracy depends on seamless integration across claims systems, clinical documentation, provider networks, and member data. These unified systems eliminate silos and ensure that all departments work from a single source of truth, enabling more coordinated and accurate decision-making.
- **Structured and Normalized Data:** Structured data supports scalable analytics, while unstructured data, from clinical notes to scanned attachments, must be standardized to be usable. Normalization of this data then transforms disparate inputs into actionable insights, enabling algorithms to detect FWA across multiple formats and sources.
- **Real-Time Access:** Timely data availability supports dynamic decision-making, early intervention, and audit prioritization. With real-time feeds, payers can shift from retrospective reviews to proactive identification of high-risk claims prepayment.
- **Audit Cycle Optimization:** Integrated strategies increase audit potential and throughput without sacrificing accuracy. By embedding data-driven intelligence into workflows, payers can streamline audit selection, shorten resolution times, and minimize provider abrasion.

With a solid data management foundation, payers can shift from lagging indicators to real-time, predictive insights, positioning themselves for greater savings, better compliance, and improved member and provider experiences.

Section II: The Path to Payment Precision

Precision in payment integrity is no longer a luxury, it's a strategic imperative. Analytics are the engine that drive this precision, enabling timely, targeted, and accurate interventions that reduce leakage and build trust across the provider ecosystem. To unlock the full potential of analytics, payers can adopt capabilities like those listed below that will elevate precision and intervention earlier in the claim lifecycle:

- **Data Focused on Early Detection:** Pattern detection and data anomaly flagging allow plans to quickly determine claims associated with inappropriate billing behaviors before payment is issued. This proactive approach prevents revenue loss by identifying errors and discrepancies before they are embedded in downstream processes. It also empowers payers to prioritize resources and focus on where financial risk is highest.
- **Predictive Scoring Models:** High-risk claims and providers can be identified prepay using predictive algorithms trained on historical fraud and error data. These models can continuously learn and adapt, improving accuracy over time and minimizing false positives. By anticipating problematic claims, payers can reduce reliance on post-payment recovery efforts.
- **Enhanced Content Libraries:** Upcoding, unbundling, and medically unnecessary procedures can be detected more easily by continuously updating clinical and coding libraries. These libraries need to evolve alongside regulatory changes and billing behaviors to ensure alignment with industry standards and to maximize impact. Automation driven by content intelligence allows for scalable prepayment review without overwhelming staff.

- **Intelligent Claim Prioritization:** Advanced analytics assigns risk scores to claims, allowing for targeted audits and faster adjudication. Prioritizing high-risk claims streamlines investigator workflows and boosts overall operational efficiency. This focused approach leads to higher recovery rates with less provider abrasion.
- **Fewer Post-Pay Clawbacks:** Prepayment scoring and audit accuracy reduce downstream provider disputes and administrative rework. Preventing overpayments at the source builds stronger provider relationships and enhances member satisfaction. It also lowers the cost of reprocessing claims.

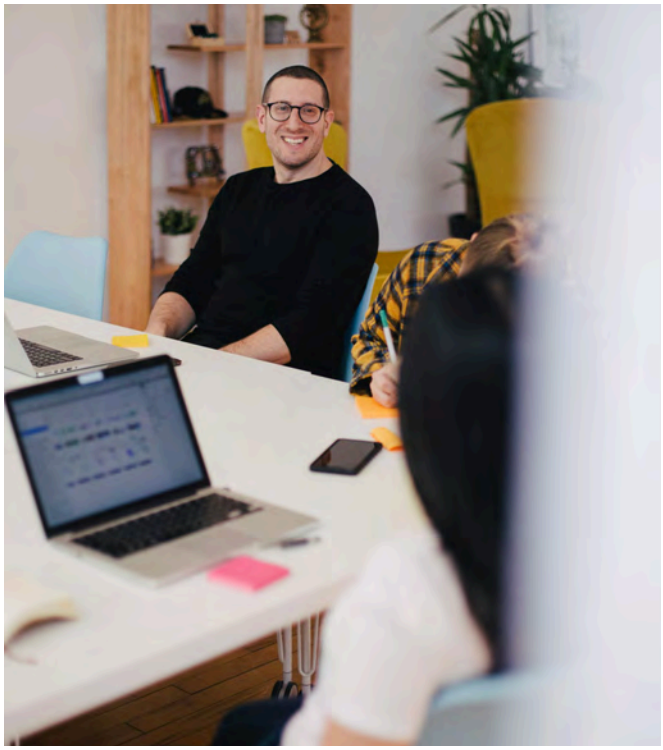
When executed effectively, these analytics-driven strategies create a payment environment that is not only accurate and efficient, but also proactive, transforming payment integrity into a forward-looking capability rather than a retrospective correction process.

Section III: Turning the Tables on Fraud

As fraud schemes become more agile, coordinated, and difficult to detect, payers must adopt equally agile and sophisticated countermeasures. Modern fraud prevention demands a layered, data management approach that proactively surfaces suspicious activity and empowers rapid intervention, well before payment is rendered. The following tactics are a few methods to enhance fraud detection:

- **Cross-Silo Data Integration:** Combining data from claims, clinical documentation, pharmacy, behavioral health, and provider credentialing exposes patterns that would otherwise remain hidden. Integration helps reveal complex schemes involving provider collusion, identity manipulation, or service overutilization. By breaking down silos, payers gain the visibility required to understand not just individual claim behavior but systemic vulnerabilities.
- **Behavioral Profiling:** Advanced analytics can develop behavioral baselines for both providers and members, flagging outliers based on utilization, diagnosis combinations, and treatment patterns. This approach catches subtle changes in behavior that rule-based engines might miss, such as a gradual shift in billing volume or location-based anomalies. Profiling helps identify both emerging threats and long-term patterns indicative of organized fraud.
- **Claim Pattern Analysis:** Algorithms analyze large volumes of historical data to identify unusual billing trends, irregularities, and service delivery inconsistencies. Machine learning enables dynamic pattern recognition that evolves as fraud tactics change, making detection more resilient over time. These insights allow payers to build more intelligent rulesets and target investigation resources more effectively.
- **Clinical Data Overlays:** Pairing claims with electronic health records (EHRs), medical notes, and treatment histories ensures billed services align with the clinical narrative. Overlaying these data points can validate the legitimacy of high-dollar or high-frequency services and expose phantom billing or exaggerated care. This deeper clinical alignment moves fraud detection from guesswork to clinical verification.

Together, these advanced data management techniques shift fraud prevention from a reactive process to a proactive defense strategy, enabling payers to identify, investigate, and intervene before fraudulent payments are made. As fraud continues to become more coordinated, payers must match their sophistication with integrated analytics, cross-functional intelligence, and adaptive models that continuously evolve. This transformation is only possible with high-quality, well-managed data at the core.



Section IV: Operationalizing Data Management

Data management and analytics must influence precision payment and FWA detection to be successful. To truly enhance the process, payers must move from insights to action, embedding intelligence into everyday operations and aligning teams across functions.

The following areas of focus can help operationalize data management to function effectively within existing workflows:

- **Audit and Payment Workflow Integration:** Embedding analytics directly into claims adjudication and audit workflows ensures timely, evidence-based decisions. Real-time integration allows for dynamic routing of claims, instant flagging of risk indicators, and rapid deployment of targeted audits.
- **Cross-Functional Collaboration:** Aligning clinical, coding, compliance, and payment integrity teams around shared data sources and performance metrics is critical. This collaboration creates a unified view of risk, ensures consistency in decision-making, and eliminates redundant or conflicting efforts. When teams operate from a common data foundation, it fosters trust and accelerates outcomes across the claim lifecycle.
- **Continuous Feedback Loops:** Using audit results and payment outcomes to refine predictive models and scoring algorithms improves performance over time. These closed-loop systems help reduce false positives, optimize audit targets, and evolve detection strategies as billing patterns shift.
- **Culture of Data-Driven Execution:** Building a culture that trusts, understands, and incorporates data management at every level is essential to long-term success. Training, governance, and transparency empower staff to use analytics confidently. A data literate organization can scale insights into action faster and more effectively than one that utilizes data in a retrospective manner.

Incorporating analytics into operational workflows isn't a one-time project, it's a continuous, strategic effort that maximizes the ROI of data management investments. When analytics are part of daily execution, not just standard reporting, payers gain agility, resilience, and better outcomes. Ultimately, the value of data management is only realized when it drives smarter actions, reduces waste, and delivers measurable impact across teams.

Conclusion

Payers that rely on fragmented data management and disjointed detection methods are increasingly vulnerable to rising costs and payment errors. The demand for earlier detection, higher audit precision, and better provider experiences requires a new approach. Payers that elevate their data management practices today will lead the future of payment integrity tomorrow.

The CERIS Advantage:

- Independent Partner: Not owned by a payer and focuses solely on payer success.
- Embedded Analytics: Integrated tools that support both prepayment and post-payment strategies.
- Full Alignment with Payer Goals: No conflicts of interest, only results-driven partnerships.
- Proven Results: Demonstrated savings, fewer disputes, better provider collaboration.
- Data as a Strategic Asset: Transforms payer data management into a powerful engine for payment integrity, compliance, and reduced total cost of care.

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