

Fraud Detection and Recovery Services



Optum™ Fraud Detection and Recovery Services help health plans meet their goals of paying claims accurately, resolving claims that are paid inaccurately, and finding ways to prevent future claim errors. As a flexible partner with a full spectrum of services and software, we can help enhance your existing initiatives or provide full-service business process outsourcing.

Protecting your resources is essential to achieving payment accuracy

Health plans often lack the staff or resources to effectively manage fraud, waste, and abuse activities, which are time consuming and cumbersome but essential to avoiding an estimated 7–10 percent in annual operating losses.

OptumInsight™ offers a full range of software, services, and expertise to help health plans improve their fraud, waste, and abuse initiatives, whether that means bolstering an internal special investigations unit (SIU) or outsourcing the activities altogether. Our solutions can help your organization:

- Enhance existing efforts
- Resolve or recover inappropriately paid claims
- Prevent incorrect claims payment

Integrated analytics approach

We provide multifaceted detection capabilities, including rules, flags, predictive modeling, and social network analysis. OptumInsight utilizes vast commercial data to develop new ways to prevent and control inappropriate claims payment.

Broad spectrum of offerings

Our unique services are flexible and scalable. The Optum Fraud and Abuse Detection System, a web-based retrospective case management tool, can be customized to fit your business needs. Whether you want to augment your existing activities with our sanctions verification and compliance service or outsource all your detection, investigation, and resolution activities, we can shape our services accordingly.

- Detection methods applied to 1 million claims a day
- \$500 million saved or recovered on an annual basis
- The largest SIU in the country
- Flexible, scalable approach including retrospective case management tool

Custom advisory services

Our dedicated clinical, policy, program design, and financial teams can provide advisory services through their broad and deep understanding of health plan business and operations. This expertise can help you reduce medical spend and other administrative costs.

Provider verification

Our Provider Verification Service validates the legitimacy of new non-contracted providers who submit claims for payment. To help you pay only those claims from legitimate providers, the verification process focuses specifically on the analysis of the provider's license status, tax identification numbers (TIN), billing, and site of service information. Any provider information anomalies are reported as data integrity changes and may result in a pre-payment flag/review being placed on the provider's claims to prevent payment.

A full spectrum of solutions

OptumInsight offers a broad range of products and services to help health plans detect and rectify recurring payment errors. Leverage the expertise of our 450 anti-fraud, waste, and abuse professionals and advanced analytics to fit your organization's needs.

Uncover fraud, waste and abuse for improved payment accuracy.

CALL: 800.765.6807

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Offering	Description	Partnering with OptumInsight for one or all of our fraud components can help:
Retrospective Investigations and Recovery Solutions	Full service offering to detect overpayment opportunities, create a case for investigation, and pursue recovery through a rigorous analysis of historical claims data.	<ul style="list-style-type: none"> • Reduce medical costs • Meet SIU compliance regulations • Decrease overpayments of inappropriate, incorrect, and fraudulent health care claims • Reduce investigative, legal, administrative, and recovery costs • Focus resources on claims most likely to be problematic • Industry-leading analytic and predictive scoring methodologies applied to data to identify aberrant claims
Retrospective Detection and Investigation	Identify and validate overpayment opportunities through analytics and retrospective case investigation.	
Retrospective Detection Only	Detection through data analytics and algorithms and billing patterns. Investigate overpayment opportunities through data mining queries, analytics, and retrospective case management to develop cases with high potential for recovery.	
Fraud and Abuse Detection System	Full solution suite comprised of complementary tools related to provider, member and claim data. Application for retrospective case management.	
Prospective Investigations	Apply predictive scoring model for detection and investigation of overpayment before payment but after service. Post investigation, client receives response advising whether to pay or deny.	
Prospective Detection Only	Apply OptumInsight analytics to data for payers who want to utilize their own investigation. Allows for combination of more complex behavior patterns.	
Provider Verification	Analyze provider claims data to identify unverifiable physicians or providers to help pay only claims from legitimate providers.	
Compliance	Database of compliance regulations as they apply to special investigations units' Medicaid activity; includes Medicaid product information. In addition, we can assist with fraud plan creation, state regulatory audits, or CMS audits.	



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