Payer Case Study

Claims Management: Automated Claims Detection Systems

The Challenge

The client had invested significant time and money in Fraud, Waste and Abuse (FWA) detection and control within its claims management system. As part of this investment, the system was designed to receive large volumes of claim data from multiple health plans.

However, the system's limitations forced the client's data analysts to manually process certain types of claims from certain health plans. This process was time-consuming and prone to errors, eventually disrupting the client's productivity and bottom line.

Our Approach

We developed an automated claims detection system. To do this, an emids team—featuring members with experience in claims management, FWA processes and automation—established multiple scrum teams with weekly grooming sessions (driven by system analysts) to ensure a faster turnaround time for new, automated features within the claims detection system. These teams delivered elaborate application support documentation with the release of each new automated feature.

Over the years, emids continued its association with the client by taking full ownership of the support, maintenance and enhancements of the application, leveraging the in-depth expertise gained from the initial creation of the automated system.

Value Addition for the Customer

- Established higher overall coding standards through the use of tools like Fortify Scan and ANTS Profiler
- Automated a major regression suite, saving 18 to 20 hours of QA testing time

Payer Capability
Claims Management

Customer Profile
An information technology health services arm of a large health carrier, with services aimed at enabling population health management and assisting in revenue cycle management

Services and Solutions Rendered
End-to-end development, enhancement and continued support of an automated claims detection system