J29
SOLUTIONS

Post-Payment Claims Review: A Critical Pillar of Program Integrity

July 2025

EXECUTIVE SUMMARY

> *Improper payments—stemming from fraud, waste, abuse, or error—pose a systemic threat to the integrity, affordability, and trustworthiness of healthcare across the board.*

The financial sustainability of the U.S. healthcare system is at a critical inflection point. While Medicare's Trust Fund is projected to be depleted by 2033, **the broader issue extends beyond a single healthcare program or payor**. Improper payments—stemming from fraud, waste, abuse, or error—pose a systemic threat to the integrity, affordability, and trustworthiness of healthcare across the board.

These improper payments inflate costs, increase premiums and out-of-pocket expenses, erode public confidence in payers and government programs, and burden providers with audits, appeals, and recoupments. Most importantly, they divert resources away from patient care, innovation, and equitable access.

Post-payment claims review and medical record audits are essential safeguards in this environment. They serve as a final validation checkpoint to ensure payments are accurate, policies are applied correctly, and documentation supports the services billed. Without these mechanisms, improper payments go undetected, and systemic vulnerabilities persist.
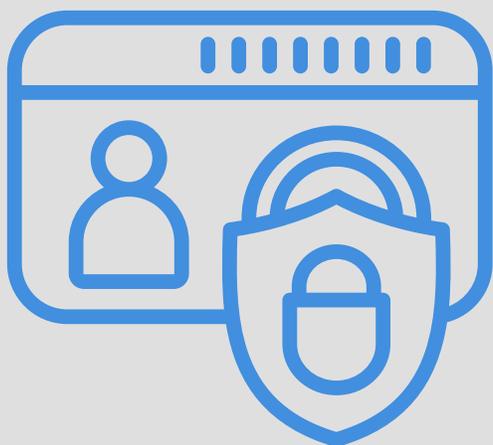
Through medical review, claims analysis activities, and various forms of data analysis, the Centers for Medicare & Medicaid Services (CMS) identified over $1.1 billion in overpayments, placed $1.3 billion in payments on hold, and denied over $106 million in potentially improper payments. These figures do not account for commercial insurance or other federal programs, suggesting the true cost is significantly higher.

J29 partners with agencies and organizations to identify improper payments, resolve systemic issues, and improve the accuracy and fairness of claims adjudication. This work not only protects public funds but also reinforces the integrity and sustainability of the entire healthcare ecosystem.

As momentum grows to implement pre-payment guardrails that prevent improper payments before they occur, post-payment review remains indispensable - enabling recovery, informing policy, and strengthens the foundation of a healthcare system that must remain resilient.

SIGNIFICANCE OF THE PROBLEM AT HAND

Embedding program integrity practices in all healthcare practices should be a continued mission for commercial, State, and Federal health programs. In Fiscal Year 2024, the Medicare Fee-for-Service (FFS) program alone reported an improper payment rate of 7.66%, amounting to $31.7 billion in erroneous payments across Part A and Part B services. Even with strong pre-payment controls and an increased program integrity focus with agencies such as CMS, improper payments persist—often due to complex policies, inconsistent documentation, and evolving clinical standards.

Recently, the Centers for Medicare & Medicaid Services (CMS) identified over $1.1 billion in overpayments through medical review activities across 1,539 Medicare providers.

Post-payment review is the last line of defense in all paying programs. It helps identify a variety of issues, such as;

- **Overpayments** due to coding errors, insufficient documentation, or lack of medical necessity
- **Underpayments** that shortchange providers and disrupt care delivery
- **Improper denials** that may stem from misapplied policy or flawed audit logic

Without effective post-payment validation, these issues go uncorrected—fueling fraud, waste, and abuse, and eroding trust in the system. Post-payment program integrity programs are critical last layers of defense, being used in conjunction with pre-payment and claims processing procedures, to ensure that the significance of the problem is identified and addressed.

HOW COULD YOU APPROACH IT?

As organizations at the commercial, State, and Federal levels start to prioritize program integrity as a consistent mission focus, there are claims analysis and medical record review strategies that should be taken on.

1. First, Understanding the Difference: Claims Analysis vs. Medical Record Review.

Medical claims analysis and medical record review are two distinct but complementary processes that play a critical role in ensuring the accuracy and integrity of healthcare payments. Medical claims analysis focuses on structured billing data—such as diagnosis codes, procedure codes, service dates, and payment amounts—to identify patterns, anomalies, or trends that may indicate improper payments. This type of analysis is typically performed using data analytics tools and is essential for flagging high-risk claims, providers, or services that warrant further investigation.

In contrast, medical record review involves a detailed clinical evaluation of the documentation that supports a claim. This includes reviewing patient charts, physician notes, test results, and other medical records to determine whether the services billed were medically necessary, appropriately coded, and compliant with payer policies. Medical record review requires licensed clinicians and certified coders who can interpret both the clinical context and the applicable coverage guidelines. It is a more manual and nuanced process, but it provides the definitive validation needed to confirm or refute the findings surfaced during claims analysis.

Both processes are essential because they serve different but interconnected purposes. Claims analysis is efficient and scalable, allowing organizations to sift through millions of claims to identify potential issues. However, it cannot determine clinical appropriateness or documentation sufficiency on its own. That's where medical record review comes in—it provides the clinical judgment and policy interpretation necessary to validate whether a claim was paid correctly. Without claims analysis, organizations may not know where to focus their review efforts; without medical record review, they cannot confirm the accuracy of those claims with confidence.

APPROACH (CONTINUED)

1. (Continued) Understanding the Difference

For organizations committed to program integrity, integrating both claims analysis and medical record review into their post-payment review strategy is non-negotiable. Together, they enable a comprehensive approach to identifying and correcting improper payments, reducing fraud and abuse, and ensuring that healthcare dollars are used appropriately. This dual-layered strategy not only protects financial resources but also supports fair provider reimbursement and safeguards patient care quality. Below, J29 outlines the difference and importance of both claims analysis and record review.

Function	Medical Claims Analysis	Medical Record Review
Data Type	Structured billing data on a particular service(s)	Unstructured clinical documentation on diagnosis, treatment plan, etc.
Performed By	Analysts, data scientists	Clinicians, medical coders, administrative support
Purpose	Detect patters and anomalies	Confirm accuracy and compliance
Strength	Scalable and efficient processing	Clinically and legally defensible, policy backed
Use Case	Targeting, risk scoring, trend analysis	Audit validation, appeals, and compliance

2. What Organizations Should Do

Organizations that are serious about protecting healthcare dollars and ensuring fair, accurate reimbursement must embed post-payment claims review and medical record validation into the core of their program integrity strategy. This is not a "nice to have"—it's a critical safeguard against the billions of dollars lost each year to improper payments.

2. (Continued) What Organizations Should Do

The first step is building a culture that prioritizes integrity, compliance, and accountability. That means leadership must champion these efforts, allocate resources, and ensure that program integrity is not siloed but integrated across departments—from finance and compliance to clinical operations and IT.

The second step is for organizations to invest in both the people and the infrastructure required to execute post-payment reviews at scale. This includes hiring or partnering with certified coders, licensed clinicians, and policy experts who understand the nuances of Medicare, Medicaid, and commercial payer rules. It also means implementing secure, interoperable systems that can ingest claims data, access medical records, and support audit workflows. Organizations should use claims analytics to identify high-risk areas and then apply clinical review to validate findings. This dual approach ensures that reviews are both targeted and defensible. Organizations must close the loop by using insights from post-payment reviews to improve pre-payment edits, provider education, and policy alignment— creating a continuous cycle of improvement.

3. J29's Approach

At J29, we don't just support post-payment review—we help organizations transform it into a strategic advantage. Our approach is built on the belief that program integrity is not just about compliance—it's about protecting patients, empowering providers, and ensuring that every healthcare dollar is spent wisely. We bring together a multidisciplinary team of board-certified physicians, registered nurses, certified coders, and healthcare policy experts who work in lockstep to deliver high-quality, clinically sound, and policy-aligned reviews. We then provide a best-in-class claims processing and record review platform wrapped in state of the art analytics powered by the latest artificial intelligence to hyper-automate our workflows. At J29, we call our process "synthetic labor." Our team doesn't just check boxes—we uncover root causes, identify systemic vulnerabilities, and provide actionable recommendations that drive real change.

We support our clients with a full suite of services, including medical record review, claims analysis, audit support, dispute resolution, quality assurance, and digital modernization.

3. (Continued) J29's Approach

Our proprietary review frameworks are designed to meet CMS standards and are backed by rigorous QA protocols that ensure consistency and accuracy. We also provide detailed reporting and insights using the appropriate technology that help clients understand not just what went wrong—but why, and how to fix it. Whether we're supporting a federal audit, a state Medicaid program, or a commercial payer, our goal is the same: to deliver clarity, confidence, and compliance.

- **Medical Record Review:** Our clinicians evaluate documentation for medical necessity, coding accuracy, and policy alignment.

- **Claims Analysis:** We identify patterns of improper payment, root causes, and opportunities for systemic improvement to ensure that duplication does not occur in the future.

- **Dispute Resolution:** We support fair and defensible outcomes through re-reviews, rationales, and corrective action plans.

- **Quality Assurance:** Our layered QA model ensures consistency, accuracy, and defensibility across all reviews and claims programs. J29 aligns itself to URAC, ISO, and CMMI standards.

- **Customer Service Availability:** *as claims are being adjudicated, improper payment decisions issues, and reviewed records and being discussed with involved parties, it is critical to have a vendor that has the ability to handle inquiries from involved parties (phone, email, chat, and web form).*

- **Reporting and Insights:** J29 delivers actionable reports that highlight vulnerabilities, trends, and recommendations for improvement.

J29 is more than a vendor—we are a proven partner with a unrelenting focus on your mission grounded in a radical hope of a better tomorrow to strengthen healthcare integrity. Medical claims analysis and record review are areas of expertise that date J29 from company inception.

IN CONCLUSION

> *Named the 2023 Small Business of the Year by the National Contracts Management Associations (NCMA) Woodlawn Chapter, J29 continues to be recognized for its services to health and human service missions at the commercial, State, and Federal levels since company inception.*

Post-payment claims review and medical record validation are not just compliance tools—they are strategic levers for strengthening healthcare integrity and protecting taxpayer dollars. As improper payments continue to threaten the sustainability of public and private healthcare programs, organizations must adopt a proactive, data-driven approach to program integrity.

At J29, we partner with agencies and payers to identify and recover improper payments, resolve systemic vulnerabilities, and improve the fairness and accuracy of claims adjudication. Our multidisciplinary team, advanced analytics, and policy-aligned frameworks ensure that every review delivers actionable insights and defensible outcomes.

We believe in a future where Medicare and other health programs remain resilient, equitable, and accountable. Through our work, we help ensure that every healthcare dollar is used as intended—to support patient care, innovation, and access.

Established in 2017 as an Economically Disadvantaged Woman-Owned Small Business (EDWOSB), and 8(a) certified company, J29 continues serve as an award-winning employee-centered healthcare management consulting company to clients at the commercial, State, and Federal levels. As needs develop, J29 will still be here to support mission involving the processing, review, and analysis of medical claims, records, dispute, and audits - every step of the way.

By prioritizing integrity, we can prevent fraud, reduce errors, and ensure that resources are allocated to those who truly need them to prevent waste through improper payments.

SOURCES
[1] 2025 Medicare Trustees Report
[2] CMS Crushing Fraud Infographic
[3] Fiscal Year 2024 Improper Payments Fact Sheet