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No Where to Go But Down, Insurers Must Understand High-Dollar Facility Claims
The Assist Group White Paper
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The Problem

Pinched by Medicare and Medicaid reimbursement decreases, facilities around the county may be looking for ways to subsidize revenue. Given the lack of standardized pricing for medical care, facilities are charging whatever they deem fit for services. Who pays the difference between what is fair and what is inappropriate? Insurance payers: health plans, TPA's and reinsurers.

As a payer you have surely seen the news about varying hospital charges. The Readers Digest *Special Report: Why a Hospital Bill Costs What It Costs* quoted an Archives of Internal Medicine study that "the median charge for acute appendicitis admissions at 289 medical centers and hospitals throughout California, for example, ranged from $1,529 to almost $183,000."(rd.com) Certainly, the variance in technology and staffing costs from one hospital to another cannot justify this disparity.

With the national expenditure on healthcare reaching $2.7 trillion in 2011, costs should have nowhere to go but down. Unfortunately, the opposite is happening. Over the last decade, the number of $1 million claims has increased from 1 per 1 million lives covered to 30 per 1 million lives covered. As the number of catastrophic claims increases, the chance for inappropriate billing escalates as well.

Although each claim can contain a multitude of potential errors/disputable charges, certain medical categories stand out as common assailants: neonatology, oncology, pharmaceuticals, implants, transplants, cardiology, ICU/CCU and orthopedics.

Experimental or investigational pharmaceuticals can lead to large, improper claim charges. For instance, the inappropriate or extended use of Inhaled Nitric Oxide (iNO) is generally billed at over $5,000/day, frequently resulting in hundreds of thousands of dollars in claim liability and multi-million dollar underlying claims.

Additionally, surgical implants are another area in which hospitals are showing egregious mark-ups. One hospital has been documented to mark-up implants more than 1000%.

Unfortunately, when it comes to reviewing a facility claim for inappropriate charges, it sometimes feels like the movie *Catch Me If You Can*. It takes a thorough, proven process with a competent, alert and knowledgeable team to "catch" the errors and make the appropriate adjustments. Some of the more common reasons claims get reduced are:

- Level of care
- Experimental and investigational procedures/pharmaceuticals
- Unbundling
- Upcoding
- Billing errors
- Never events
- Hospital acquired conditions

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Inevitably, some claims contain "creative" charges. Below are some examples of actual charges discovered in facility bills The Assist Group has reviewed:

Charge Description	Amount
No Technical Description	$ 230,185
Incomplete Circumcision 1	$ 1,888
Odor Eliminator	$ 30
Camera Quick Snap Flash	$ 46
Boston Butt Cream	$ 82
Mary's Magic	$ 200
Brain	$ 546
Panda Activation Programs	$ 3,302
Meat Tenderizer Solution	$ 53

Industry

The Affordable Care Act was designed to reduce medical costs and is relying on reimbursement cuts and electronic medical records to find those. For the past two years, medical costs have been increasing at a faster rate than that of 4 years ago, and the "policies and procedures" that are yet to be written and implemented will probably not have an impact on stemming increasing costs in the near future. The message is "don't wait" – get a handle on what's happening with your high dollar claims now.

Solution

Although health care payers may have in-house claim reviewers, payment timing and insufficient processes allow inappropriate charges to fall through the cracks and inflate into billions of dollars annually. Retrospective audits, which review claims after payment, are not sufficient and essentially leave organizations chasing the providers for refunds. A prospective solution is needed.

The Forensic Review (FR) provides the detailed, prospective claim-examination that yields the highest savings. The FR serves a very different purpose than a traditional medical record review Audit. State and federal law define a "clean claim" as being a claim that lacks defects or improprieties, contains all of the information required to process the claim and does not require further investigation or development of facts prior to determining payment liability. During the Forensic Review process, clinicians and coding experts conduct an in-depth review of the billing material (the UB-04 claim form and the Itemized Detail) to identify potential defects or improprieties and determine whether additional information

(medical records) and/or explanations are necessary to consider any portion of the claim on its merits.

Any charges flagged on clean claim grounds during the Forensic Review process are listed as clean claim exceptions on the Forensic Review Report and payers are only required to reimburse facilities for the clean portion of a claim.

The Forensic Review analyzes the facility's underlying billing methodology to assure our clients only tender payment for properly billed charges and examines whether:

- the underlying bill has unbundled routine supplies and/or services from underlying room or procedure charges (i.e. potential double billing);
- billed daily room charge accurately reflects the patient's underlying acuity level;
- the facility is billing for "experimental/investigational" drugs and/or devices that are outside of the scope of the plan's benefit package;
- any portion of the claim is attributable to a preventable Hospital Acquired Condition or Never Event; and
- billed charges bear the requisite "reasonable and consistent" relationship to the facility's underlying costs.

Once the underlying clean claim payment is tendered to the facility, the claim resolution and appeals team works to engage the facility in a dialog to address the nature of the clean claim issues and obtain the information necessary to resolve these issues.

Conversely, "Audit" has become a term of art in the healthcare industry that refers to a post-payment medical record review that seeks to confirm that each billed supply or service is accurately reflected in the medical record. In fact, many facilities have developed "Audit policies" that preclude the issues raised during our prepayment clean claim review from being addressed during an Audit by requiring the claim to be paid prior to conducting an Audit. These policies further limit the scope of an Audit to the verification that billed supplies or services are reflected in the medical record by prohibiting payers from questioning a facility's billing methodology during an Audit. While a traditional Audit continues to offer payers an opportunity to validate the accuracy of paid claims, the Forensic Review process helps payers assure that they are only reimbursing facilities for properly billed charges.

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Conventional Audit vs. Forensic Review℠

Conventional Audit	Forensic Review
Retrospective	Prospective
• Claim Reviewed for coding compliance	• Claim reviewed for coding compliance • Billed charges vs. care provided • Billed charges vs. plan benefits • Algorithms and logic applied by clinicians • Discount Negotiation Experts
• Automated claim review • Non-clinical reviewers	• Hands-on clinical and financial review • Physician and nurse specialists • Resolution by legal and financial experts • Provider appeals experts • Coding Experts
• Exceptions typically include: • Upcoding • Unbundling • Billing Errors	• Exceptions may include: • Experimental/Off label drugs • Never Events • Hospital acquired conditions • Level of care

Typically, traditional bill audits (including DRG) produce a 1%-3% savings. The Forensic Review (more specifically the prospective clean claim forensic review) produces 15-22% of savings AFTER any contractual discount and 96% of the savings we find are upheld due to the rigor and transparency of our findings.

Conclusion

Costs are rising and to protect bottom lines and flourish in this struggling economy, insurance payers must make sure not to pay the difference between what is fair and what is inappropriate on facility claims. Prospective claim review leads to higher savings than a traditional audit.

The Assist Group's proprietary Forensic Review is the industry-leading, prospective solution. While other companies offer a broad range of solutions, The Assist Group only focuses on high-dollar claims. Utilizing an extensive database, proprietary technology, and experience to review and resolve high dollar claims, the company uses hands on clinical and resolution teams to ensure the most thorough and detailed clinical review is performed and maximized savings for clients are realized.

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1. Hiss, Kimberly. "Special Report: Why a Hospital Bill Costs What It Costs." *Readers Digest Magazine*. September 2012. http://www.rd.com/health/healthcare/special-report-why-a-hospital-bill-costs-what-it-costs/

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