TRUVEN
HEALTH ANALYTICS™

The Difference Between 99% and 100% Claims Accuracy Could Cost You Millions

Claims Audit Solutions

BENEFITS

- Improve payment accuracy and plan compliance
- Evaluate the effectiveness of your administrator's controls
- Ensure your administrator set up your plans correctly
- Objectively assess whether performance guarantees have been met
- Uncover the root cause of waste
- Identify future cost-savings opportunities

FEATURES

- Flexible approach tailored to your specific audit needs
- Proprietary software re-adjudicates 100% of claims against your SPDs and industry standards
- Unparalleled fraud and waste algorithms and predictive modeling
- Annual audit or event-driven options

The United States wastes $275 billion annually on healthcare spending through administrative inefficiencies, fraud, and abuse — that's nearly $9,000 per second. Furthermore, forces outside our control, such as "pay-or-play" provisions of the Patient Protection and Affordable Care Act and the "Cadillac tax," have dictated that employers accelerate efforts toward reducing healthcare cost trends.

Yet employee health benefits remain one of the least-monitored corporate expenses. Most organizations rely on third-party administrators to manage the healthcare claims payment process, and claims auditing is often low on the long list of competing priorities — even though identifying errors can result in significant savings opportunities.

It's Time to Maximize Performance by Exercising Control

By exercising control of the claims auditing process, you can be confident you're maximizing the financial performance of your healthcare benefit. In doing so, you'll be improving the bottom line and raising the bar for performance from your third-party administrators.

How can you exercise that control? Whether you're implementing a new vendor or plan design, or conducting an annual review, Truven Health Analytics℠ can help. Our proven claims auditing solutions help ensure claims are paid accurately — and in compliance with your plan design.

Truven Health is a recognized leader in claims analysis and audit services, and our experts have performed claim reviews that include all of the major national insurance carriers and many of the nation's most widely used third-party administrators. We've been auditing healthcare claims for more than 20 years; and we provide the flexibility, independence, and expertise to help proactively identify and resolve potential benefit interpretation and setup issues specific to your organization. **The result for our clients: Millions of dollars in cost-savings.**

" *It was unlike any other audit in terms of revealing significant issues that we really need to revisit and get on the same page with our TPAs.* "

— Truven Health Claims Audit Customer

A Flexible Approach to Claims Auditing

We understand that organizations have different objectives when it comes to claims auditing. That's why we offer a suite of flexible solutions that can be tailored to fit your objectives. In addition, we offer a consultative approach that helps you interpret the results, makes recommendations, and coaches you on how to best work with your administrator to make corrections and improvements.

Our team of experts, proven methodologies, and cutting-edge technology can be applied to:

- Retrospective audits
- Event-driven audits
- Continuous monitoring
- Fraud, waste, and abuse analytics

Benefit plan audits performed by Truven Health typically find anywhere from **5 to 8 percent of claims are paid incorrectly** because of issues ranging from coding errors to lack of quality control to fraud and abuse to administrator system setup issues.

A Solution to Fit Your Needs:	
Your Objective	**Our Approach**
Improve payment accuracy and plan design compliance	• 100-Percent Audit • Continuous Monitoring • Pre- or Post-Implementation Audit
Evaluate the effectiveness of your administrator's controls	• 100-Percent Audit • Stratified Random Sample Audit
Ensure administrator sets up plans correctly before the plan year begins	• Pre-Implementation Audit
Objectively assess whether performance guarantees have been met	• Stratified Random Sample Audit
Uncover the Root Cause of Waste	• Fraud, Waste, and Abuse Analytics • Continuous Monitoring • 100-Percent Audit
Identify future cost-saving opportunities	• 100-Percent Audit • Continuous Monitoring • Fraud, Waste, and Abuse Analytics • Pre- or Post-Implementation Audit

Retrospective Audits

There are two generally accepted approaches for auditing medical claims: 100-percent claims audits and stratified random sample audits. Based on your objectives, Truven Health can fully support either method.

100-Percent Claims Audits

Our 100-percent claims audit re-adjudicates all claims for compliance with your plan designs, as well as eligibility, compliance with an administrator's policies and procedures, and industry best practices. This 100-percent claims audit approach identifies hard-to-discover, systemic processing errors and potential overpayment recoveries.

The 100-percent claims audit focuses on the following key areas:

Exception Category	Description	Analytics
Plan Design	Assess whether administrator accurately interpreted and administered benefits according to plan design features and benefit exclusions. Confirm that appropriate reviews were performed to determine medical necessity, appropriateness of treatment, and compliance with care management programs.	▪ Deductibles/Copayments/ Coinsurance ▪ Benefit Limits/Maximums ▪ Benefit Exclusions ▪ Large Dollar Claims ▪ Emergency Care ▪ Case Management and Utilization Review
Eligibility	Compare claims against eligibility/ enrollment data to identify claims paid for ineligible members, and to assess procedures for updating eligibility files and procedures for testing retroactive eligibility changes.	▪ Claims Paid Before/ After Member Enrolled in Benefits ▪ Timely Maintenance of Eligibility
Other-Party Liability	Determine the parameters used by the administrator to flag claims for investigation and/or the pursuit of recovery associated with potential third-party liability.	▪ Regular Coordination of Benefits (COB) ▪ Medicare COB/End-Stage Renal Disease (ESRD) ▪ Subrogation ▪ Work-Related Injuries or Illness; Workers' Compensation
System Edits and Controls	Evaluate the effectiveness of administrator's claims system edits and controls.	▪ Provider Discounts ▪ Duplicate Payments ▪ Upcoding/Unbundling Customization vs. Correct Coding Initiative Edits ▪ Payer-Specific Edits and Standard Operating Procedures
Fraud and Abuse	Test to detect patterns of potential fraud and abuse by either the provider or member.	Examples: ▪ Ambulance Rides to Nowhere ▪ Upcoding of Services

Stratified Random Sample Audits

This random-sample approach is an end-to-end claims processing audit used to measure an administrator's claims processing accuracy and timeliness against performance guarantees, industry practices, and marketplace standards.

Event-Driven Audits

If you're changing claims administrators or making adjustments to your plan designs, it's critical to test the accuracy and readiness of your administrator before your go-live date or shortly thereafter.

Pre-Implementation Audit

To ensure your administrator is ready to process your benefits, we take a number of critical pre-implementation steps, including:

- Testing your administrator's interpretation of your benefits against your Summary Plan Description provisions
- Providing an action plan and timeline for resolving any issues
- Serving as the liaison between you and your administrator to clarify plan design discrepancies and direct corrections, as needed

Post-Implementation Audit

As beneficial as pre-implementation audits can be, they do have limitations. They are performed in a claims-system test environment and the scope of what is reviewed is restricted by the number and thoroughness of the scenarios presented. That's why we often recommend that a 100-percent, post-implementation audit be performed 90 days following the effective date of a material change. Our experience has found this to be an even more rigorous and complete approach to testing benefits interpretation and setup.

Continuous Monitoring

Our continuous monitoring solution provides early detection of unusual utilization patterns and potential issues, as well as assessing compliance with plan design. By assessing 100 percent of claims on an ongoing basis, we can proactively identify and correct errors — and minimize wasteful spending.

Throughout the calendar year, we apply proprietary analysis and business rules that are generated from your plan design documents and industry standards. Quarterly reports are provided in an easy-to-read format with findings, analysis, and a list of areas for further investigation.

Fraud, Waste, and Abuse Algorithms

Truven Health also offers the most advanced predictive models and algorithms to identify and reduce claims fraud, waste, and abuse. Our proven detection methods and powerful analytics help you stay on top of ever-emerging and cleverly concealed schemes.

Our proprietary algorithms and models are not only wide-reaching and current, they also have embedded clinical intelligence and flexibility for tailoring to specific characteristics. Each algorithm contains the rules, clinical constructs, and statistical processes best suited to your plans.

In addition, each of our detection algorithms is assigned to one of four categories of vulnerability: Recoverable, Billing Error, Long-Term Savings Opportunity, or Interesting Observations. These categories make it easy to guide recommendations for further action in the most cost-effective manner.

The Truven Health Difference

Leading-Edge Data Management Solutions

Healthcare data is "big data" — huge amounts of data, from disparate data sets, that is difficult to handle and even more difficult to analyze. Fortunately, as a data-management market leader, we've been working with big data both successfully and efficiently for more than 30 years. We are one of the most experienced providers in warehousing, mining, managing, integrating, and analyzing unparalleled amounts of healthcare-specific data; and we already have the proven methodologies and analytics to address our clients' smallest and largest challenges.

Claims Auditing Experience

The Truven Health audit solutions team includes highly accomplished professionals who have practical, hands-on experience in the fields of claims administration, network management, medical management, pharmacy benefits, and benefits consulting — gained from working at major corporations, national health insurance companies, and consulting firms. Our team has handled just about every possible benefit plan scenario.

Driving Real Value

Our suite of audit solutions, fraud algorithms, and predictive models has helped our clients identify hundreds of millions of dollars in potential overpayments and long-term savings.

Our results often speak for themselves:
- One customer's 100-percent claims audit identified more than $7 million in possible erroneous payments by their third-party administrator.
- For another client, we discovered more than $4 million in savings due to errors and noncompliance with benefit plan design.

With money-saving opportunities like these, it is important for you to ensure the accountability and compliance of your vendors and to have the tools and knowledge to collect monetary recoveries. With more than 20 years of claims auditing experience, we're here to help.

GET CONNECTED

Email **employer@truvenhealth.com**,
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visit **truvenhealth.com/employer**

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ABOUT TRUVEN HEALTH ANALYTICS

Truven Health Analytics delivers unbiased information, analytic tools, benchmarks, and services to the healthcare industry. Hospitals, government agencies, employers, health plans, clinicians, pharmaceutical, and medical device companies have relied on us for more than 30 years. We combine our deep clinical, financial, and healthcare management expertise with innovative technology platforms and information assets to make healthcare better by collaborating with our customers to uncover and realize opportunities for improving quality, efficiency, and outcomes. With more than 2,000 employees globally, we have major offices in Ann Arbor, Mich.; Chicago; and Denver. Advantage Suite, Micromedex, ActionOI, MarketScan, and 100 Top Hospitals are registered trademarks or trademarks of Truven Health Analytics.

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