



## CLAIMS COST CONTAINMENT

Medical plans and claims administrators have become more aggressive in attempting to control and manage claim costs. This section addresses some of the measures that can be taken to ensure that only reasonable and appropriate expenses are paid. Cost containment functions may be handled by the claims administrator, outsourced to a vendor or may involve the purchase of a software program. The various components of a cost containment program are addressed in this topic.

### **Hospital Cost Containment**

A variety of programs are available to help a claims administrator contain hospital costs.

#### Utilization Review

Components of a utilization review program relating to hospital charges usually consist of the following:

Pre-certification Requirements - Many medical plans contain a provision that requires the claimant contact a toll free phone number upon learning of the need for a hospital admission or within a specified period following an emergency admission. Failure to comply with the pre-certification requirement may result in a penalty (e.g., a flat dollar amount or eligible expenses are paid at a lower coinsurance rate). The purpose of a pre-certification requirement is to review the proposed confinement for appropriateness, medical necessity and to identify case management opportunities as soon as possible.

Concurrent Review and Discharge Planning - This process begins after the claimant's stay has been pre-certified. It may be conducted on-site at the hospital or by telephone. Additional information is obtained to ensure the continued hospital stay remains medically necessary and to coordinate the hospital discharge.

Retrospective Review - This is the process of obtaining information from providers and facilities in cases where the care has already been rendered.

The Examiner should be familiar with the utilization requirements (if any) that are applicable to a claim. Utilization review may be performed by the claims administrator or may be outsourced to a vendor specializing in this service. Typically, a nurse reviewer applies criteria based on guidelines from sources such as the Milliman USA Health Care Management Guidelines, Interqual, Medicare, etc. Generally, a confinement that meets the established criteria for coverage is approved and those not meeting the criteria are referred to a physician for further review.



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If a claim is subject to utilization requirements, the Examiner should:

- Ensure the days of inpatient confinement match the days authorized during the pre-certification process.
- If the medical plan requires outpatient hospital authorization for outpatient surgery or diagnostic/therapeutic procedures, the Examiner should ensure that the call for authorization was made and the service approved.

Utilization review decisions should be documented by the claims administrator either on-line or attached to the hard copy claim to provide an audit trail. Some claim systems are programmed to integrate the utilization review decision with the claims system and will flag the Examiner when a service is not authorized or the dates approved do not match the claim.

A denial for administrative reasons can be made by the Examiner. For example, a penalty for failure to comply with a utilization review requirement may be applied. However, the claimant should receive a written explanation on the explanation of benefits as to why benefits were reduced. The decision may be reconsidered if additional information is received.

A decision to deny benefits for medical services because they are not medically necessary should be made by a physician. A denial under these circumstances should include an explanation of the criteria and guidelines used and the claimant and provider should be advised of the appeal process.

### PPO Claim Issues

The Examiner should ensure any applicable discounts are correctly applied to in-network claims. Processing PPO claims with discounts can raise the following claim processing issues.

Processing Ineligible Expenses - Unless the PPO discount is based on a DRG, case rate, or per diem, ineligible expenses (e.g., private room difference, personal comfort items) should be identified and considered as ineligible. The discount should also be adjusted and applied only to eligible charges.

Audits on In-Network Claims - Unless the claim is adjudicated exclusively based on a DRG, case rate, or per diem the bill can still be a good candidate for an audit. Any audit reductions are deducted from the billed charges and the bill is repriced.

### Hospital Bill Audits & Negotiations

Hospital billing is a complex and error prone process.



Types of billing errors can include:

- duplicate charges,
- charges for supplies, medications, tests, or services that were not ordered or received,
- unbundled charges,
- charges for services that should be included in the room charge,
- charges for services that the patient refused,
- data entry, coding or keying errors, and
- line items that do not meet criteria for appropriateness or exceed usual and customary guidelines.

If a summary UB-92/UB-04 hospital bill is received and the charges are \$10,000.00 or greater, it is recommended that an itemized hospital bill be requested. Hospital bill audits and negotiations realize the greatest savings if they are performed on a timely basis and before the bill is paid. A claims administrator may offer these services or the audit can be outsourced to a vendor. Most vendors work on a contingency basis with the audit fee based on a percentage of savings. Typically, the itemized bill is screened by a professional who determines if the bill is a good candidate for audit or negotiation.

The various cost containment options include:

Hospital Bill Audits - These types of audits have been largely replaced by negotiations and charge line audits but can still be valuable in certain cases. A hospital bill audit involves comparing the charges on the itemized bill line by line to the information contained in the medical record to uncover overcharges and errors. Hospital bill audits are typically outsourced to vendors specializing in this service. The bill is first pre-screened to assess if it is a good audit candidate. If an audit is indicated, the claims administrator will usually process for payment eligible room and board and 80% of the ancillary charges. The 20% balance of the ancillary charges are pended for the hospital bill audit results and this should be clearly indicated on the explanation of benefits form. Any discrepancies are identified and submitted to the hospital for rebuttal. The process continues until the disputed charges are either verified or removed from the bill. When the audit is complete, the Examiner should deduct the amount of any overcharges from the pending expense and process any additional payment due, ensuring that the claimant is advised he or she is not liable for any non-covered charges.

Bill Negotiations - Negotiations are generally performed on out-of-network claims. Generally, a flat percentage (e.g., 5%, 10%, etc.) reduction is applied to the total bill, often in exchange for prompt payment. The provider agrees to accept the payment as payment in full and not balance bill the claimant. The terms of any negotiated discount should be documented in



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writing. The Examiner should appropriately code the explanation of benefits form to ensure that the claimant is aware that he or she is not liable for reduction to the bill due to any negotiated discount. This service can be outsourced to vendors or assigned to a designated individual within the claims department. The key is to have a screening mechanism in place (often in the mail room) to identify large hospital claims as soon as they are received.

Line Item Audits - This is the newest hospital cost containment tool and is offered by a number of vendors. The process can encompass:

- Usual and Customary Charge Review - line items on the bill are reviewed for usual and customary versus a database based on the revenue code and geographical area of the provider.
- Technical Audit - line items that do not meet clinical and billing appropriateness guidelines are identified.

Claims administrators have routinely applied reasonable and customary guidelines to services billed by other than a facility. This type of audit extends the reasonable and customary check to hospital charges and is typically performed by vendors who have developed an extensive database against which to compare line charges. It is important that the vendor obtain written agreement from the provider that the patient will not be balance billed for any reductions made to the bill as a result of this type of audit. The Examiner should also include a message on the explanation of benefits advising the claimant that he or she is not liable for any reasonable and customary reductions due to this type of review.

DRG Audits - The purpose of DRGs is to provide a basis on which to monitor quality of care and length of stay in a hospital setting. Medicare employs DRGs to determine the Medicare approved amount for an inpatient confinement and DRGs may be the basis for discounts applicable to in-network claims. A DRG charge for a particular hospital bill may appear unfair or unlikely when compared to the total hospital charge for the services performed. The following is a brief overview of how hospitals determine charges under a DRG system.

Under the DRG system of billing, the hospital confinement is classified by diagnosis and the fee for the confinement is calculated based on the diagnosis. All diagnoses in the International Classification of Disease (ICD-9-CM) are classified into major diagnostic categories based on organ systems. They are further broken down into groupings which are "medically meaningful". This means that all patients with the same DRG classification will generally be medically treated in the same way. Therefore, statistically, these DRGs are expected to result in roughly the same utilization of hospital resources and all hospital confinements within the same DRG are roughly equal.

The hospital assigns a DRG to a hospital confinement based on the following:



- principal diagnoses for the confinement,
- up to four complicating diagnoses,
- treatment procedures performed,
- age,
- sex, and
- discharge status.

Special adjustments may be made to the DRG amount based upon either excessive days of confinement or excessive costs and other factors.

Vendors offer DRG validation audits to ensure that hospitals are using the appropriate DRG code that drives the level of reimbursement. The process involves an in-depth review of the claimant's medical records to validate the correct diagnosis and procedures were used to establish the DRG for the claim being billed. Vendors offering this service utilize software to determine DRG abuse and maintain a database to monitor a hospital's coding patterns. If it is determined that an incorrect DRG was utilized, the hospital should issue a corrected bill.

To determine a DRG payment, a DRG payment calculator and instructions are available on the following Web site. Click on the applicable calculator for the fiscal year and specific dates for the rates that you are searching for. Once the DRG calculator is opened, insert the requested information into the yellow fields (these are the only fields you can manipulate). The calculator will display the payment details to explain the formulas used to arrive at the DRG payment amount.

<http://www.tricare.mil/drgrates/>

**Prompt Pay Discount** - To facilitate payment, many hospitals now offer a prompt pay discount if the hospital bill is paid within a given date from the initial billing. Normally, this is 20-30 days from the billing date. The average discount ranges between 3% - 5% of the total billed charges. Hospitals expect this payment to be made in lieu of an audit or any other discount. The offer of a discount is usually stamped on the hospital bill. The Examiner should always take advantage of this discount if there are no other discounts available and the review of the hospital bill does not warrant an audit. If the prompt pay discount is taken, the discounted amount should be entered on a separate line with a code that will print an appropriate message on the explanation of benefits statement to notify the claimant that the prompt pay discount is not his or her responsibility.

### **National PPO Networks**

Vendors offering national PPO networks can be utilized to receive a discount on claims for services rendered outside the PPO geographical area or received from a provider that does



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not participate in the group's contracted PPO. Claims from in-network providers with a low percentage of savings, i.e., less than 5%, may also be referred to these vendors for additional savings. When processing claims with such a discount, although the group's PPO network has not been utilized, the provider may require the PPO level of benefits be paid. The explanation of benefits statement should advise the member that the amount of the discount is not their responsibility.

### **Case Management**

Identification of claims for case management services can come from many sources. Claims can be identified through system edits, by diagnosis, high dollar claim reports, pre-certification processes, provider referrals and by Examiners. Claims referred for case management are reviewed by medical staff who assess if the claimant is likely to benefit from case management services. Participation in a case management program is voluntary and a claimant can decline case management services.

Case managers are generally nurses. The nurse works with the claimant, family and physician. A case manager can identify any unmet needs, help coordinate care and services, assist with health education and identify available resources.

### **Code Auditing Software**

A claims administrator should have automated edits integrated into its claim system to identify improper or questionable coding. Many administrators purchase the McKesson claims adjudication code audit solutions ClaimCheck® and CodeReview®. These are comprehensive code auditing solutions that assist payers with proper physician reimbursement, automatically evaluating claims via sophisticated clinical logic before reimbursement. All claims are reviewed for unbundled, upcoded and fragmented provider billing. ClaimCheck recommends correct procedure coding and multiple surgery percentages. The software also recognizes potential cosmetic procedures, gender and age discrepancies, obsolete codes and possible duplicates. Additional information on this software is available on the Internet at:

[http://www.mckesson.com/en\\_us/McKesson.com/](http://www.mckesson.com/en_us/McKesson.com/)

Another option for administrators without unbundling software is to access the Centers for Medicare and Medicaid Services (CMS) data. The NCCI is software consisting of automated edits used to identify questionable claims and adjust payments to reflect what would have been paid if the claim had been filed correctly.

The NCCI includes three types of edits as follows:



- comprehensive/component edits - these edits identify code pairs that should not be billed together because one service inherently includes the other
- mutually exclusive edits - these edits identify code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day
- unit-of-service edits - these edits determine the maximum allowed number of services for each HCPCS code

The NCCI edits are posted on the following Web site and are updated quarterly.

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp>

### **Usual, Customary & Reasonable (UCR) Software**

Medical plans typically allow benefits for usual and customary or reasonable and customary fees. This is usually defined as a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. UCR edits are applied to non-network claims and network providers are paid in accordance with the terms of their individual contracts. A claims administrator must have a consistent approach to determine the prevailing fee amount. In most cases, the fee is determined through use of a surgical statistical profile of physician's charges. This type of profile may be purchased from an outside vendor or developed internally.

Historically, many claims administrators utilized the Ingenix MDR and PHCS databases for UCR determinations. Ingenix is a wholly subsidiary of United Health Care (UHC). Recent lawsuits and settlements involving UHC, Aetna, Wellpoint and CIGNA have affected how claims administrators will administer UCR in the future. The basis for the lawsuits was that insurance companies used skewed Ingenix data to set reimbursement rates for out-of-network care and use of the flawed data resulted in physician underpayments and forced claimants to pay an excessive portion of the charge. As part of the settlements, major insurers have committed nearly \$100 million to help establish a new independent database governed by a non-profit group. Some insurers also agreed to share claims and billing data with the new database. Insurers who have not participated in legal settlements can use the new database but are not required to do so.

Work has begun on the new database which will be called FAIR (Fair and Independent Research). The FAIR database will be marketed and administered by the nonprofit group FAIR Health, Inc. A network of researchers based at universities in upstate New York will create the product. Researchers plan to start work in January 2010 and release the first



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version of the database six months later. Once developed, the new database is meant to be used industry-wide and a simplified version will be available to the public via a Web site. It is anticipated the Web site will be up and running in the fall of 2010. Patients and physicians will be able to check the prevailing rate for a given service in a given geographical area.

Claims administrators can expect the following:

- providers will find it easier to challenge a UCR payment reduction,
- more class action suits on behalf of physicians and claimants,
- payers will increase efforts to negotiate reimbursement prospectively with out-of-network providers,
- plan language will be utilized in the future to clarify liability for non-network provider charges (e.g., 125% of the Medicare fee schedule), and
- increased steerage to network providers.

**Vendor Information**

The following chart provides contact information for various vendors specializing in cost containment services including case management, transplant negotiations, neonatal case management, transplant networks, shock loss assessment, peer review and subrogation recovery.

The numbers across the top of the chart correspond to the following services offered by the vendors:

- 1 - Out of Area PPO Network
- 2 - Bill Negotiation
- 3 - Hospital Bill Audits
- 4 - Case Management
- 5 - Transplant Negotiation
- 6 - Neonatal Case Management
- 7 - Line Item Repricing - Inpatient and Outpatient
- 8 - DRG Analysis
- 9 - Transplant Network
- 10 - Shock Loss Assessment
- 11 - Peer Review
- 12 - Subrogation Recovery
- 13 - Specialty Injectable Medication Audits

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VENDOR	1	2	3	4	5	6	7	8	9	10	11	12	13
A&G Financial Services 5048 Tennyson Parkway, Suite 200 Plano, TX 75024 972-312-8589 <a href="http://www.agfinancial.com/">www.agfinancial.com/</a>	X	X											
A & S Financial Services 3230 West Commercial Blvd., Ste. 350 Fort Lauderdale, FL 33309 800-633-9355 <a href="http://www.asfin.com">www.asfin.com</a>	X	X											
American Health Holding, Inc. 100 W. Old Wilson Bridge Road Third Floor Worthington, OH 43085 866-614-4244 <a href="http://www.americanhealthholding.com/">www.americanhealthholding.com/</a>		X	X	X		X	X				X		
Assist Group 300 Union Boulevard, Suite 515 Lakewood, CO 80228 877-631-9080 <a href="http://www.assistgroup.com">www.assistgroup.com</a>		X				X							
Beech Street Corporation 25500 Commercentre Drive Lake Forest, CA 92630-8855 949-672-1000 <a href="http://www.beechstreet.com">www.beechstreet.com</a>	X	X			X				X				
Coalition America, Inc. Two Concourse Parkway, Suite 300 Atlanta, GA 30328 404-459-7201 <a href="http://www.coalitionamerica.com">www.coalitionamerica.com</a>	X	X			X		X	X					
CorVel Corporation Multiple Locations 888-7-Corvel <a href="http://www.corvel.com">www.corvel.com</a>	X	X	X	X									
Global Claim Service 2319 South Foothill Drive, Suite 200 Salt Lake City, UT 84109 801-994-7777 <a href="http://www.globalclaim.com">www.globalclaim.com</a>		X					X						



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VENDOR	1	2	3	4	5	6	7	8	9	10	11	12	13
Health Systems International 5975 Castle Creek Parkway Suite 100 Indianapolis, IN 46250 800-962-6831 <a href="http://www.us-hsi.com">www.us-hsi.com</a>	X	X		X			X						
H.H.C. Group Health Care Consultants 438 North Frederick Avenue Gaithersburg, MD 20877-2432 301-963-0762 <a href="http://www.hhcgroup.com">www.hhcgroup.com</a>	X	X	X	X	X		X	X	X		X		
Hines and Associates 115 East Highland Avenue Elgin, IL 60120 800-735-1200 <a href="http://www.hinesassoc.com">www.hinesassoc.com</a>				X		X				X			
Interlink Health Services 4660 Northeast Belknap Court, Suite 209 Hillsboro, OR 97124 800-599-9119 <a href="http://www.interlinkhealth.com">www.interlinkhealth.com</a>									X				
Kotowski, Nullmeyer and Associates 14368 Manchester Road, Suite 200 Manchester, MO 63011 636-779-2226 <a href="http://www.ihmcares.com">www.ihmcares.com</a>				X									
Medical Impressions, LLC 150 N. Sunny Slope Road, Ste. 370 Brookfield, WI 53005 262-796-8007 <a href="http://www.medimpressions.com">www.medimpressions.com</a>											X		
Medical Review Institute of America 2875 South Decker Lake Drive, Suite 550 Salt Lake City, UT 84119 800-654-2422 <a href="http://www.mrioa.com">www.mrioa.com</a>							X				X		
Meridian Resource Company 20725 Watertown Road Waukesha, WI 53186 800-319-2453 <a href="http://www.meridianresource.com">www.meridianresource.com</a>	X	X	X					X				X	

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VENDOR	1	2	3	4	5	6	7	8	9	10	11	12	13
Moody Review, Inc. 2525 South Shore Boulevard, Suite 102 League City, TX 77573-6506 800-293-1397 <a href="http://www.moodyreview.com">www.moodyreview.com</a>		X					X						
MultiPlan, LLC 115 Fifth Avenue New York, NY 10003 212-780-2000 <a href="http://www.multiplan.com">www.multiplan.com</a>	X	X							X				
OptumHealth 6300 Olson Memorial Highway Golden Valley, MN 55427 800-847-2050 <a href="http://www.myoptumhealthcomplexmedical.com">www.myoptumhealthcomplexmedical.com</a>				X					X		X		
PMCS 17200 N. Perimeter Drive, First Floor Scottsdale, AZ 85255 877-768-1968 <a href="http://www.pmcsaz.com">www.pmcsaz.com</a>	X	X							X				
Premium Healthcare Services One Selleck Street, 5 <sup>th</sup> Floor Norwalk, CT 06855 203-852-8500 <a href="http://www.premiumhealthcareservices.com">www.premiumhealthcareservices.com</a>			X	X				X			X		
ProPeer Resources 1065 N Highway 89, Suite 202 North Salt Lake City, UT 84054 800-292-3051 <a href="http://www.propeer.com">www.propeer.com</a>		X	X								X		
SHPS/Carewise Health 11405 Bluegrass Parkway Louisville, KY 40299 888-421-7477 <a href="http://www.shps.net">www.shps.net</a>		X	X	X		X		X					
Viant 535 East Diehl Road Naperville, IL 60563 800-820-5824 <a href="http://www.viant.com">www.viant.com</a>	X	X	X				X	X	X				X



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Trilogy does not endorse or specifically recommend the services of any of the vendors referenced in this topic. The references are provided only as a resource to assist claims administrators with researching various cost containment methods.