Ensure Claims Are Paid Accurately — and in Compliance With Plan Design — With Our Proven Auditing Solutions

- Uncover the root causes of waste
- Identify cost-savings opportunities
- Evaluate the effectiveness of your administrator’s controls
- Ensure your administrator sets up plans correctly before the plan year begins
- Objectively assess whether performance guarantees have been met
The U.S. wastes $275 billion annually on healthcare spending through administrative inefficiencies, fraud, and abuse. That's nearly $9,000 per second. Plus, provisions of the Patient Protection and Affordable Care Act and the Cadillac tax have dictated that public employee plan sponsors accelerate efforts toward reducing healthcare cost trends. Yet public employee health benefits remain one of the least monitored government 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. However, by exercising control of the claims auditing process with help from Truven Health Analytics,™ an IBM® Company, you can be confident you’re maximizing the financial performance of your healthcare plan.

Whether you’re implementing a new vendor or plan design, or conducting an annual review, Truven Health can help you improve the bottom line and raise the bar for performance from your third-party administrators.

**Need to Reduce Costs?**  
Start by Leveraging the Proven Claims Auditing Solutions of Truven Health

Truven Health is a recognized leader in claims analysis and audit services, and our experts have performed claims 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.*

**Real Client Results**

| **$7M** | Amount one customer’s 100-percent claims audit identified in possible erroneous payments by their third-party administrator |
| **$4M** | Amount of savings discovered for one customer due to errors and noncompliance with benefit plan design |

Benefit plan audits performed by Truven Health typically find that 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 Flexible Approach

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

A Solution to Fit Your Needs:

<table>
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<tr>
<th>Your Objective</th>
<th>Our Approach</th>
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| 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: stratified random sample audits and 100-percent of claims audits. Based on your objectives, Truven Health can fully support either method.

100-Percent of Claims Audits

Our 100-percent of claims audit readjudicates 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 of claims audit approach identifies hard-to-discover, systemic processing errors and potential overpayment recoveries.

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.

### 100-Percent of Claims Audit: Key Areas of Focus

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<th>Exception Category</th>
<th>Description</th>
<th>Analytics</th>
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| **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, Utilization Review, and Disease Management |
| **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. | - Member Eligible and Enrolled on Date of Service |
| **Other-Party Liability** | Determine the parameters used by the administrator to flag claims for investigation and/or the pursuit of recovery dollars 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. | - Ambulance Rides With No Medical Services  
- Upcoding of Services  
- New Patient Codes  
- Excessive Use of Supplies |

“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 third-party administrators.”

— Truven Health Claims Audit Customer
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.

Get Exactly What Your Organization Needs
- Flexible approach tailored to your specific audit needs
- Proprietary software readjudicates 100 percent of claims against your Summary Plan Descriptions and industry standards
- Unparalleled fraud and waste algorithms and predictive modeling
- Retrospective, event-driven, or continuous monitoring audit options
Leading-Edge Data Management Solutions

Healthcare data is Big Data — huge amounts of data, from disparate datasets, that are difficult to handle and even more difficult to analyze. Fortunately, as a data management market leader, we’ve been working with Big Data 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 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. With money-saving opportunities like these on the table, it’s important for you to ensure the accountability and compliance of your vendors, and to have the tools and knowledge to collect monetary recoveries.

Fraud, Waste, and Abuse Algorithms

Truven Health also offers the most advanced analytics 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
- Interesting observations

These categories make it easy to guide recommendations for further action in the most cost-effective manner.
Truven Health Analytics, an IBM Company

Truven Health Analytics, an IBM Company, delivers the answers that clients need to improve healthcare quality and access while reducing costs. We provide market-leading performance improvement solutions built on data integrity, advanced analytics, and domain expertise. For more than 40 years, our insights and solutions have been providing hospitals and clinicians, employers and health plans, state and federal government agencies, life sciences companies, and policymakers the facts they need to make confident decisions that directly affect the health and well-being of people and organizations in the U.S. and around the world.

Truven Health Analytics owns some of the most trusted brands in healthcare, such as MarketScan®, 100 Top Hospitals®, Advantage Suite®, Micromedex® Simplex®, ActionOIL® and JWA. Truven Health has its principal offices in Ann Arbor, Mich.; Chicago, Ill.; and Denver, Colo. For more information, please visit truvenhealth.com.

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