AUDIT SUCCESS STORIES

Successful Claims Audits Empowered by Data and Analytics

Rising healthcare costs are taking their toll on employers' profitability. Conducting healthcare claims audits can help control costs and improve the quality of claims administration. Comprehensive healthcare data and analytics not only detect errors, but also reveal the underlying cause and identify opportunities for improvement.

At Truven Health Analytics™, our commitment to providing employers with audit solutions has paid big dividends. Here are five examples showcasing our clients' successes. (NOTE: Client names are removed for privacy purposes.)

CLIENT A: Significant Medical Claims Recovery Without Costly Legal Action

Business Challenge:
Client A acquired a company that had not audited its administrator for many years. Because our client had severed its service agreement with the claims administrator prior to the audit and had limited experience with claims audit recovery negotiations, their negotiating position was weak.

Course of Action:
- Truven Health reviewed 100 percent of the claims and identified $1.7 million in potentially recoverable exceptions due to undocumented deviations from the Summary Plan Description (SPD)
- When the claims administrator disputed results, we worked with Client A to define a negotiating strategy and joined them for a face-to-face meeting to support negotiation discussions with the administrator
- Client A was willing to pursue legal action, so Truven Health wrote an emphatic letter with key findings and expectations for the client to send to the administrator

Results:
Without having to proceed with legal action, thus avoiding legal fees and staff distraction, Client A received a significant recovery from the claims administrator with stipulation that the exact amount remain confidential. Furthermore, Client A is establishing annual audits of current plans and implementation audits for new vendors.

CLIENT B: Medical Claims Audit Results in More Than $4 Million in Savings

Business Challenge:
Out of concern that the three carriers they used to administer the same benefit plan design were paying medical claims differently, Client B requested a review to assess performance and test compliance.

Course of Action:
- Truven Health analyzed 100 percent of the claims — including covered and noncovered benefit payments and coverage limits (copays and deductibles) — to determine if they were being paid according to the SPD and industry standards
- We worked with Client B to negotiate stronger contract terms and additional performance guarantees to hold carriers more accountable for errors and overpayments. We also worked with the carriers to identify corrective actions to avoid future noncompliance.

Results:
Our analysis identified more than $4 million in savings due to errors and noncompliance with the benefit plan design.

CLIENT C: Medical Claims Audit Produces $240,000 in Savings and Reduces Employee Complaints

Business Challenge:
After receiving multiple complaints from employees experiencing healthcare claims errors and customer service issues, Client C needed to determine if its plan administrator had sufficient audit and quality assurance programs in place.

Course of Action:
- Truven Health analyzed 100 percent of the claims for a 2-year period to determine if claims were being paid according to the SPD and industry standards
- We also performed an onsite analysis to validate the findings and assess internal controls at the administrator's site
- We worked with Client C to recover overpayments from the administrator and worked with the administrator to identify corrective actions to improve service quality and the overpayments recovery process

Results:
While the administrator had a plan to recover overpayments, recoveries were not being posted to Client C's account and credits were not reflected on the billing statements. Claims errors and overpayments accounted for 1.8 percent of paid claims, or $240,000.

CLIENT D: Pharmacy Audit Uncovers Contract Loopholes Costing the Client $1.5 Million

Business Challenge:
Client D wanted to evaluate the performance of its current Pharmacy Benefits Manager (PBM) before deciding whether to enter into a long-term renewal.

Course of Action:
- Truven Health performed an audit on 100 percent of pharmacy claims, evaluating PBM compliance with Client D's benefit plan designs and contracted pricing, discounts, and rebates
- We found that the PBM was not in compliance with the plan design and pricing/discount parameters of the contract, and the impact of these errors was $1.5 million in additional cost to Client D
- The contract (the PBM's standard template) permitted the PBM to offset these errors with overpayments on rebates

Results:
Client D realized that contracting with the PBM's standard agreement put them at a significant disadvantage. We recommended contract language changes that allow Client D to collect on improperly paid claims in the future. Client D leveraged the knowledge and insight from our findings to conduct a formal procurement for a new PBM.

CLIENT E: Audit Leads to Improved Quality Assurance

Business Challenge:
As part of a required audit of medical and prescription drug plans every 3 years, Client E — a state government client — needed to review health plan administration contract compliance and internal controls.

Course of Action:
- Truven Health performed a comprehensive audit of the medical plan administrator and PBM that included:
  - A claims audit (paid and denied), business process review, and financial reconciliation
  - An operational audit to evaluate the control environment and assess the risk of fraud or error, the adequacy of internal control policies, and the potential of irregularities
  - A contract compliance audit to determine if the administrator was paying claims according to the administrative agreement
- Multiple instances of noncompliance with the SPD were found, annual maximums were not being administered properly, and an Other Party Liability process did not adhere to NAIC (National Association of Insurance Commissioners) rules, resulting in excessive and erroneous payments

Results:
Truven Health worked with Client E and plan administrators to correct problems and establish performance standards and quality assurance measures for contract renewal.

FOR MORE INFORMATION

Send an email to **employer@truvenhealth.com**, call **+1.866.263.1958**, or visit us online at **truvenhealth.com/employer**

TRUVEN HEALTH ANALYTICS™

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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