Healthcare Claim Audits

Why 100 Percent Claims Audits Outperform Random Sample Audits Every Time

A White Paper By TFG Partners

TFG PARTNERS

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Introduction

Regardless of what happens to healthcare reform, employers will continue to worry about the spiraling cost of the healthcare benefits they offer to their employees, dependents and often their retirees. Almost all large U.S. employers are self-insured, so the burden of rising health benefit expenses is directly carried by each employer. As a result, self-insured firms, and particularly their human resource executives and CFOs, are acutely aware of how these rising costs negatively impact their bottom lines.

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Employers increasingly try to rein in these rapidly rising costs. New consumer-driven plans encourage employees to be partners in their coverage to promote cost control. Others offer incentives for wellness initiatives to decrease plan utilization. When it comes to directly reducing claims costs, human resource executives are also becoming increasingly pro-active in searching for improvements in their plan administration. Many have begun to reduce plan overpayments through Dependent Eligibility Verification audits, and better coordination with CMS to optimize disability and Medicare benefits.

Even so, most companies today overlook a highly effective method of cost control: the claims audit. Minimizing claim errors is important for any self-insured firm, but large organizations in particular can capture savings far in excess of their audit expenses as accuracy and efficiency improve. In 2010, average healthcare claim expenses had reached $10,188 per employee (Source?). As an illustration, a Fortune 500 company with 10,000 employees and a retiree plan will likely experience total claims costs well in excess of $100 million dollars per year. Of that amount, overpayments represent hundreds of thousands and sometimes even millions of dollars. On a national level, even a half percent reduction in overpayments would save large employers over $25 billion.[1]

But there is a catch: the selection of the type of audit will determine the extent that a company can identify and recover overpayments. This white paper examines the implications of the two approaches to auditing claims data and helps determine what methodology one should select if you not only want to precisely know how your vendor is doing but also truly want to save the company money.

The objective of this study is to compare the exception errors, overpayments, recoveries and process improvements of the 100 percent audit versus the sample audit methodology. To perform the comparison, the authors run four consecutive quarterly 100 percent audits and compare the results against the best results selected from 100 random sample audits in order to weigh the relative effectiveness of the two audit methodologies. The two different audit methods will be compared based on the quantity and value of the claim exceptions identified as well as the types of errors and the relative success in determining overpayments and recovering refunds. The quarterly audits will also permit us to consider the data over time in order to map process improvements. The results on effective cost control are surprising.

Audit Approaches

Traditionally, companies and their benefit consultants have used random sample audits to meet their fiduciary duties, and maintain compliance with ERISA and Sarbanes-Oxley which require self-insured employers to assess the accuracy of the claim adjudication and billing process for medical expenditures. This method of randomly sampling claims for audit purposes has been widely used because it is relatively easy to complete on a regular basis. The third party administrators appreciate that this method does not require much on-site review time and it requires only minimal follow up work from them. Importantly, these audits also produce statistically accepted and valid results regarding claims error levels, so they meet the standards of the regulatory agencies and can confirm the compliance of an employer's plan and its administration to ERISA and Sarbanes-Oxley.

More recently, though, advances in modern information and audit technologies have made it possible to screen every claim for processing and adjudication errors, allowing auditing firms to audit 100 percent of a plan's claims, without requiring a lot of additional effort from the auditors or clients. The result is an audit that delivers not only more precise information, but actionable data that can be used for recoveries and process improvements.

The most effective health plan audits go beyond simply confirming regulatory compliance, and allow the employers to use the audit information to pin-point losses related to overpayments and to prevent future claims exceptions. By identifying the root cause of errors, such an audit program also becomes an important element in an ongoing cycle of process improvement, ensuring future efficiencies. Finally, the detailed audit results enhance the capability of employers to realize savings by recovering overpaid claims where appropriate.

Effective health plan audit programs help employers and their plan administrators strive to achieve a zero defect level. Integrated into a firm's Six Sigma initiatives, effective health plan audits are a key component of the continuous improvement cycle of DMAIC (Define, Measure, Analyze, Improve and Control). An effective audit is the measurement tool not only to establish the baseline for a plan administrator's efficiency but also to track the plan's improvement.

Methodology

In order to compare the two audit approaches, four separate 100 percent audits were performed. Each audit covered a quarter's worth of claims data from a large self-insured employer. The data tapes, provided by the third party administrator, covered the 12 month period from July 2007 to June 2008. The 100 percent audits were conducted following the 100 percent audit protocol of TFG Partners (TFGP). The tapes consisted of 2.2 million processed claims and a paid amount of $369.6 million covering the medical expenses for an average of 93,000 members who sought medical care each quarter.

The TFG Partners' protocol consists of a six-step process for the 100 percent claims approach that has been developed and refined for over 20 years:

1. Discover. TFGP collects data from the plan administrator on every single paid claim for a specific period.

2. Customize. TFGP tailors its system to each client's unique plan offerings by inputting the information from their specific Summary Plan Descriptions. This information is input into TFGP's proprietary adjudication engine in order to prepare a program tailored to the needs and services of each client.

3. Validate. Once the data is loaded, TFGP electronically checks each and every claim line using several hundred potential exception algorithms by leveraging the unique client plan requirements as well as the insights from hundreds of audits over the last twenty years and then categorizes the exception results.

4. Analyze. The categories are manually double checked for false positives and the auditor selects a sample from the identified exceptions for on-site review with the administrator.

5. Audit. Using a formal audit process, all claims are reviewed, the errors are identified and agreed upon with the plan administrators on-site and TFGP prepares a formal audit report.

6. Plan. TFGP continues to work with the third party administrator to plan remedial action and preventative measures as well as tracking refunds and recoveries on an ongoing basis.[2]

In contrast, the random sample approach selected an identical sample size of 400 claims from the same company's 2.2 million processed claims. For the purposes of this study, some of the most advanced sample selection and stratification methods were used and the selection of the sample was repeated 100 times and checked against the claim errors identified in the 100 percent audit. The most robust of these samples – the sample that identified the most errors – was the one used for comparison purposes in this study. (For more details see Appendix I)

Study Results

Of the total 1,602 sample claims that were reviewed on-site, the auditors and the third party administrator confirmed that 945 or 59% of the reviewed claims were processed in error. The random sample of claims identified 171 exception errors or 11% out of a total sample of 1,602. Although the higher exception rate is expected with a focused audit, it is important to note that the focused audit with the higher hit rate was able to identify a total of 33.5 of the total of 41.8 different types of exception errors on-site (See table 12). In testing how well random sampling was able to identify different exception errors, we found that the random audit only identified 13.5 exception error types or only about 40 percent of the 100 percent audit results. Consequently, with a random audit, one will likely miss more error types and it would be very difficult to request impact analysis on exception error categories that have not even been identified, missing a significant improvement opportunity.

The random sample was weaker when it came to projecting accurate estimates for overpayments. The random sample could closely project claim accuracy in the aggregate, it projected a total number of 21,947 exceptions, compared to 22,498 exceptions that were identified in the 100% audit, or only a 2.4% difference. As such, overall accuracy would have been projected to be 99.00 percent using the sample method while the 100 percent audit would have identified a 98.98 percent accuracy. However, although the overall percentages are close, we did observe a significant difference in error rates per strata results from sample audit to sample audit.

When it comes to comparing financial accuracy, the random sample was significantly less helpful. For example, the random sample in Q2 overestimated overpayments by 30.8% compared to the 100 percent audits while in Q3 it swung to underestimating the overpayments by 9.5%.

Table 1: Comparison of total number of exceptions errors and overpayments identified through 100% audits compared to stratified randomized sampling.

	Exceptions			*Overpayments ($-millions)*		
Audit	**100%**	**Random**	**% Diff.**	**100%**	**Random**	**% Diff.**
Q1	6,876	6,667	-3.0%	$2.666	$3.243	21.7%
Q2	6,379	6,264	-1.8%	$2.356	$3.082	30.8%
Q3	4,457	4,267	-4.3%	$1.973	$1.786	-9.5%
Q4	4,786	4,749	-0.8%	$1.888	$2.169	14.9%
Total	22,498*	21,947	-2.4%	$8.883	$10.280	15.7%

Overpayments

Where the study revealed the greatest differences was in the area specific detection of overpayments, which is key as this drives improvements and refunds and thus cost savings opportunities from an audit. The 100 percent onsite audits revealed that the 945 confirmed exceptions produced $591,680 in actual agreed overpayments. Ultimately these identified overpayments generated refunds in the amount of $418,555 or an over 70 percent refund percentage. As such, the focused audit was able to capture almost 4 times as many recoveries from the onsite audit. However, these insights are tied back to the full claims universe to identify additional overpayments, often in cases where claims are directly related to the same member (e.g. COB overpayments) or where the on-site review confirmed error in a small subset of a much larger pool of exception errors in the same category (e.g. miscalculated co-pays).

The 100 percent audit further identified a value of overpayments exceptions of $9,494,000 versus a value of $10,280,00 the sample based methodology.

Table 2: Comparison of total number of agreed overpayments and refunds collected through 100% audits compared to stratified randomized sampling.

	Agreed Overpayments			*Refunds*		
Audit	**100%**	**Random**	**% Diff.**	**100%**	**Random**	**% Diff.**
Q1	$139,382	$60,286	-57%	$84,871	$17,245	-80%
Q2	$93,733	$41,070	-56%	$54,727	$13,127	-76%
Q3	$205,687	$39,506	-81%	$153,329	$26,783	-83%
Q4	$151,311	$67,667	-55%	$125,628	$54,482	-57%
Tot.	$590,115	$208,528	-65%	$418,555	$111,637	-73%

As part of the 100 percent audit protocols of TFG Partners, recovery efforts succeeded in collecting not only $418,555 in refunds from on-site claims but an additional $1,129,510 of refunds from related claims resulting in over $1.5 million dollars in total refunds. This is money that was refunded directly to the client without effecting employees and that would likely not have been recovered had the client relied on only the random sample audits.

The 171 exception errors confirmed in the random sample process identified only $208,528 in overpayments, of which $111,637 were refunded. As the random sample methodology does not capture precise information that can drive refunds from related claims, clients would have to start up a subsequent impact analysis and recovery or would not be able to collect the additional refunds. Although impact analysis can be done, they are usually only used in major error categories, as there are no requirements for this extra effort as long as ASO financial accuracy goals are met.

Importantly, the quarter-over-quarter improvement in the claims process that resulted from the ongoing discovery of root errors resulted in fewer overpayments over time. This is the key to long term cost savings. Many firms will choose not to pursue recovery attempts for all overpayments because of the impact those efforts would have on their employees. But the 100 percent of claims audits allows for a larger pool of errors to review and learn from. As demonstrated by the quarterly audit results above, overpayments were reduced 32% from Q1 to Q4. The audits uncovered errors and root causes early in the year that were addressed and resulted in fewer overpayments as the year progressed. Table I of Appendix III highlights this improvement.

Table 3: Key Audit Outcome Measures for 100 Percent Audits

Key Audit Outcome Measures	**Q1**	**Q2**	**Q3**	**Q4**	**4 Audits**
Financial Accuracy	96.5%	97.3%	97.5%	97.7%	**97.3%**
Overall Claim Accuracy	98.4%	98.6%	98.9%	99.0%	**98.7%**
Exceptions	8,552	7,564	5,997	5,863	27,976
Potential Overpayments ($-millions)	$3.098	$2.563	$2.315	$2.109	$10.086
Recovered Refunds ($-millions)	$0.489	$0.322	$0.451	$0.313	**$1.574**

Table 3 provides an overview of the key audit outcome measures established by the four 100% audits. The table illustrates the actual bottom line difference between a compliant plan administration process that meets regulatory standards and a plan administration process that provides genuine efficiencies and cost management. Despite achieving an overall claim accuracy of 98.7% the claim payments still resulted in over $10 million in overpayments.

Discussion

The difference between these two methodologies is striking, and is of particular interest to companies looking to reduce health care costs over the long term.

The random sampling procedure does produce statistically valid estimates of exception errors, and in doing so it satisfies the compliance requirements for monitoring health care plans. However, it does not provide much utility beyond that. The audits conducted using the random sampling methodology missed over 80% of exception errors, which translates into significant financial exposure. What's more, random sampling produces poor financial projections – in the case of these four audits it overestimated overpayments by 15.7%, making it difficult for the client to make accurate financial impact projections. Furthermore, the random sample audits capture such a small portion of the claims errors that they limit organizations the opportunity to determine root causes let alone establish processes to eliminate those errors.

TFG Partners' six step protocol for 100 percent of claims audits addresses these issues and produces real results. In the case of this study, it yielded a 59% exception hit rate and did away with the problem of misestimated overpayments. Even more important, the 100 percent of claims audits significantly reduce error rates over time by identifying root causes early. With TFG Partners' guidance, quarterly audits can be used not only to initiate recovery efforts in a timely fashion, but also to implement corrective action and process improvements to reduce the recurrence of the errors identified by the audits.

Conclusion

Random sample audits underperform 100 percent of claims audits on virtually every metric. Random samples do little beyond satisfying the legal requirements of compliance audits. Random samples do not provide accurate projections of financial performance and they are demonstrably inferior in identifying the number and types of claim errors, overpayments and recoveries from on-site sample claims.

Because of these limitations, random sample audits of health care claims are not useful in designing process improvements. In contrast, 100 percent audits allow health plan auditors

to discover more overpayments, make better projections and achieve more recoveries. Most importantly, the auditors can better understand the processing errors and inefficiencies their clients are experiencing and can work with them to address those issues moving forward, capturing permanent savings that can be in the seven figures for many large employers.

For self-insured employers, health care audits can mean more than achieving regulatory compliance – they can also be a significant component of an organization's Six Sigma strategy of defining, measuring, analyzing, improving and controlling health care plan efficiencies. 100 percent of claims audits are the key measurement tool for process improvement and are necessary to pursue a zero defect rate in processing.

References:

1. CMS – Sponsors of Health Care Costs: Private Business, Households and Governments, 1987 – 2009

2. For more information about TFG Partners see http://www.tfgpartners.com