Predicting costs. Managing claims. Empowering users.

$200M; $18 PE/PM:

Why You Should Rethink Your Auto-Adjudication Strategy

Auto-Adjudication generally fails when it comes to:

Specialty Drugs

Medical Device Technologies

Multi-million Dollar Cases

A few years ago Advanced Medical Strategies (AMS) published an article covering how current auto-adjudication systems left much to be desired. Does auto-adjudication save money? Sure. It easily sorts through the low-hanging fruit, processing a large number of claims both cheaply and swiftly.

However, it generally fails when it comes to these three booming components:

1. **Specialty drugs** compose just 1.9% of total prescription volume, but account for 37% of total Rx spend — and costs continue to soar
2. **Medical Device Technologies** have a forecast compound annual growth rate (CAGR) of 5.3% for 2017-2022, yet their prices remain opaque
3. **Multi-million-dollar cases** make up roughly 2.2% of claimants but generate 23% of total stop-loss reimbursements.

The healthcare industry has seen a cataclysmic shift in the cost of care resulting from huge increases in both severity and frequency of catastrophic claims. These seismic issues cannot be adequately addressed by auto-adjudication. And as we can see from the list above, healthcare's costliest issues are rapidly expanding. While auto-adjudication does a broad spectrum of things well, to ignore its limits is to invite potential peril.

The confines of auto-adjudication are sometimes not that apparent to those who rely on it. Payers assume that since it does handle a great many claims they are saving money. Which, of course, is only partially true. They're content with saving thousands of dollars when they could be saving millions.

Have Questions? Contact Stephanie Belschner at 781.224.9711 Ext. 116 or sbelschner@mdstrat.com today to get started.

Advanced Medical Strategies
855.224.9711 | www.mdstrat.com

So, where are payers missing out? In short, system-based processing mimics a qualified claim examiner, but isn't nearly as accurate.

So, where are payers missing out? In short, system-based processing mimics a qualified claim examiner, but isn't nearly as accurate. It may spot routine flags, but when it comes to complex catastrophic claims its algorithms falter—right at the point where the most money is in play! Ironic as it may seem, ditching auto-adjudication for pricier manual claim reviews is ultimately more cost-effective in the long run.

These catastrophic healthcare claims and the processes needed to deal with them–in tandem with skyrocketing specialty drug and medical implant costs–pose other significant problems to payers:

- Noticeable increase in Revenue Code 278 billed charges and provider reluctance to supply implant invoices
- Inefficiencies within high dollar claim review process due to lack of business intelligence
- Increasing pace of FDA approvals for high dollar specialty drugs
- A lack of claim system functionality to detect the myriad of clinical complexities around drug designation and diagnosis
- An increasing need to quickly detect these claims and remove them from auto-adjudication process for detailed clinical and financial scrutiny
- Inability to efficiently identify claims needing further cost containment review with reason codes

Many payers stick to legacy platforms. They aren't looking forward. Whether that is because of prohibitive cost outlays or time restraints, payers are either unable or unwilling to make the shift from post-pay to pre-pay analyses to catch anomalies. It isn't the easiest thing to do, but it is the most rewarding. Most of the healthcare industry is lagging behind when it comes to advanced analytics. Not just data, but true business intelligence. ***Read what Healthcare IT News had to say about this in a recent article:***

"The [healthcare professionals'] answers to the following question were surprisingly unanimous: "On a scale of 1 to 10, where is healthcare on its journey to become an advanced user of data and analytics to improve care, control costs, and create operational efficiencies?" Across the board, each expert assessed healthcare's readiness at a "3" or lower."

Have Questions? Contact Stephanie Belschner at 781.224.9711 Ext. 116 or sbelschner@mdstrat.com today to get started.

Advanced Medical Strategies
855.224.9711 | www.mdstrat.com

Simply because the industry as a whole is not up to speed doesn't mean the solution, which is strategic intelligence software coupled with professional expertise, does not exist. The speed, deep insight, and transparency needed to manage the disproportionate impact of high-cost claims is available. And it is absolutely worth seeking out.

Payers should identify and invest in those specialized solutions that can meet these challenges: a) surveillance that attacks the complexities of these claims; b) the ability to realize a minimum of 3:1 ROI on claims payment integrity; c) provide fraud waste and abuse teams the resources needed to evaluate egregious claims; d) short implementation and minimal IT resources. In a perfect world, claims should be reviewed holistically, taking into consideration clinical, financial, and even political ramifications that affect outcomes. Payers must take special note of how potential systems are deployed for their own benefit.

For example, system architecture must be in place to create maximum efficiencies and return on investment for catastrophic claims, in general, and specialty drug and medical-surgical implant devices, in particular, with respect to:

- Payment Integrity
- Large Case Management (LCM)
- FWA & SIU (Fraud, Waste and Abuse; Special Investigation Units)
- Utilization Reviewers
- Cost Plus Repricing

Let's address these things one-by-one to see where auto-adjudication systems fall short—or even address significant costly issues—and why manual claims reviews and comprehensive tech-enabled healthcare solutions are the better option.

The questions you should be asking in reference to auto-adjudication and the following subjects:

Payment Integrity: *Does the software have the capacity to analyze complex high dollar claims for medical appropriateness, standard of care treatments and costs? Does it have additional applications for Reference Based Pricing? Is actual drug/implant pricing vetted for accuracy? Is implant pricing even included?*

You should be asking questions in reference to auto-adjudication and the following subjects:

Payment Integrity

LCM

FWA & SIU

Utilization Management

Cost Plus Repricing

LCM: I*s your LCM negotiation team equipped with both clinical and cost data in order to be effective in patient and financial advocacy?*

FWA & SIU: *Do these units have the data analytics available to detect fraud & abuse quickly and accurately?*

Utilization Management: *Can your system identify when your claims submissions deviate from utilization approvals & recommendations—not just approved days of confinement but level and type of care?*

Cost Plus Repricing: *When auto-adjudication automatically routes OON claims to a wrap network, do you know how much you are losing by not using a direct negotiation?*
*(***HINT***: You're foregoing deeper discounts by automatically having it do this.)*

A well-taught claims examiner would likely spot anomalies that many auto-adjudication setups are simply not programmed to handle. Payers are finally coming around to this reality. That's a good first step. But it shouldn't end there.

A tool like this which could apply highly advanced analytic surveillance rules to accurately process complex medical and pharma data would save hundreds of millions of dollars.

What the industry needs is an intelligence system that goes deeper. A financial and clinical surveillance platform designed to not only detect claims that should be removed from auto adjudication, but also to do so with near real-time response rates pre-pay/post adjudication with minimal IT requirements via a cloud-based solution (without the need for PHI). A tool like this which could apply highly advanced analytic surveillance rules to accurately process complex medical and pharma data would save hundreds of millions of dollars—not to mention untold hours of manpower which could be refocused on other critical tasks.

This artificially intelligent, predictive modeling IT solution is not just futuristic fantasy. For more than two years, AMS has been working on software that they believe will become this next generation surveillance tool, titled Predict FACS (Fiscal and Clinical Surveillance).

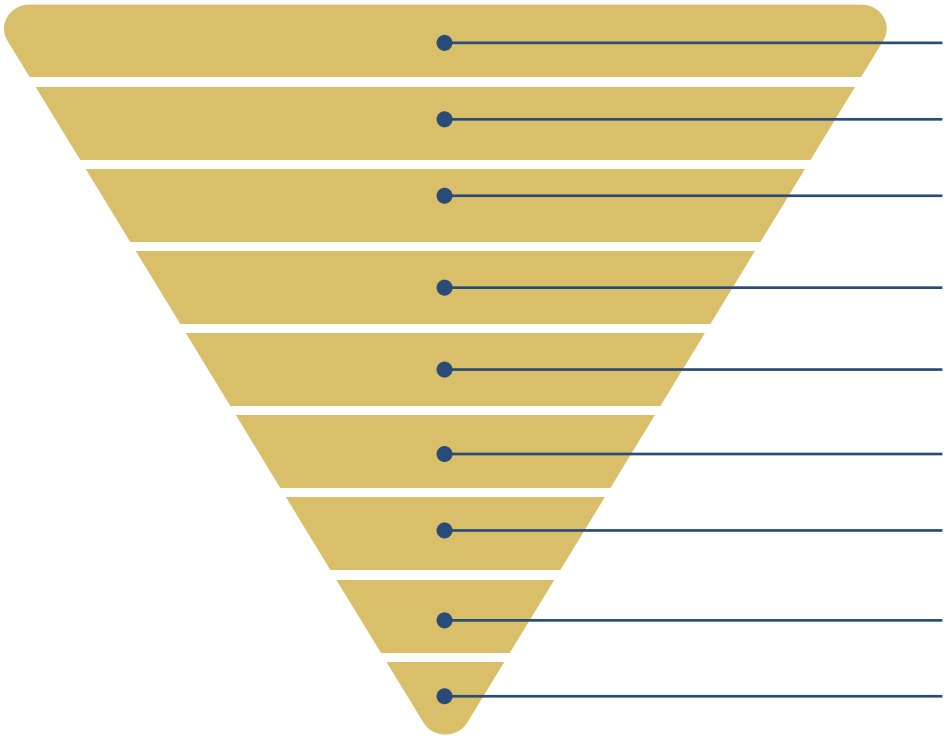
AMS established a set of rules for problem claims, then ran those medical and pharmaceutical related rules on one million members' allowed claim history. **NOTE:** *These claims had already been paid.*

Have Questions? Contact Stephanie Belschner at 781.224.9711 Ext. 116 or sbelschner@mdstrat.com today to get started.

Advanced Medical Strategies
855.224.9711 | www.mdstrat.com

Here are the astonishing results:

Members:	Total Allowed Charges:	Year:	Data Type:	Total Claims:
1M	$5.25B	2017	In Network Commercial	23M



Orphan Drug Designation:
$121,370,519

Not FDA Approved/Notable Off-label:
$57,382,066

Off-label Use:
$35,215,044

Breast Reconstruct:
$2,779,373

RF Ablation (SS):
$2,738,630

Transplant:
$1,308,943

INO:
$66,583

Radiation MM:
$35,621

IPS Pyloric:
$4,582

Questionable Claims:	$220M
PM/PM:	$18.41
Claims Identified:	53K (.2%)
Members Flagged:	**9750**

That's over $200M in questionable claims.
It comes to $18.00 PM/PM.

While the cynical crowd may have previously doubted that "the juice is worth the squeeze" for the highest dollar 1% of claims, looking at the allowed charges associated with the .2% of flagged claims is enough to make them believers. The numbers are staggering and even before this .2% validation, should be cause for concern. And while these organizations may have pre-certification, case management and LCM teams in place, the vast complexity of clinical uses and emerging high cost claims are prone to cause even these well-versed teams to make errors. There are stop gaps, but there is more to be done by utilizing a software which is continually up-to-date on clinical uses and costs, and much more to be gained financially through partnership with AMS.

Predict FACS is on-going to optimize I/O. Meanwhile, as AMS keeps refining it, the industry would do well to re-think their auto-adjudication protocols—especially regarding complex catastrophic claims, specialty drugs, and medical implants.

Have Questions? Contact Stephanie Belschner at 781.224.9711 Ext. 116 or sbelschner@mdstrat.com today to get started.

Advanced Medical Strategies
855.224.9711 | www.mdstrat.com