



Post-Payment Services

DRG Audit Services

Hospital Bill Audit Services

Contract Compliance Audit Services



Viant Post-Payment Services Overview

COMPANY OVERVIEW

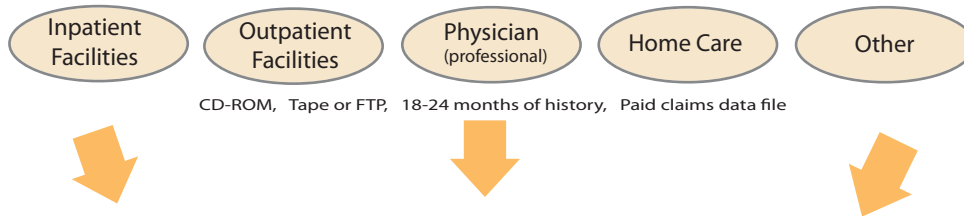
Viant is one of the largest national providers of cost management solutions to the healthcare industry, offering a broad array of solutions that reduce medical claim costs and ensure accurate claim payment, both pre-payment and post-payment. Founded in 1990, we serve government payers, third-party administrators, Taft-Hartley sponsored plans and other leading national and regional health plans. Viant employs more than 1,200 people and generated well over \$3.6 billion in savings for its clients in 2008.

POST-PAYMENT CAPABILITIES

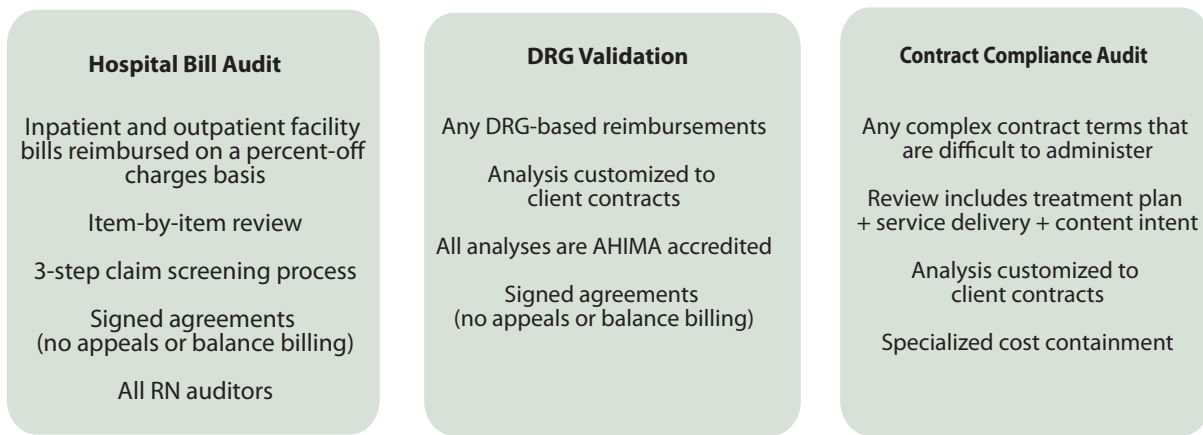
Viant's Post-Payment audit and review services identify and recover meaningful savings from previously resolved claims. Reviews are performed by a team of highly skilled professionals including field nurse auditors, pharmacists, DRG coding analysts and contract compliance specialists, resulting in identification and recovery of overpayments back to the client.

Viant Post-Payment Bill Management

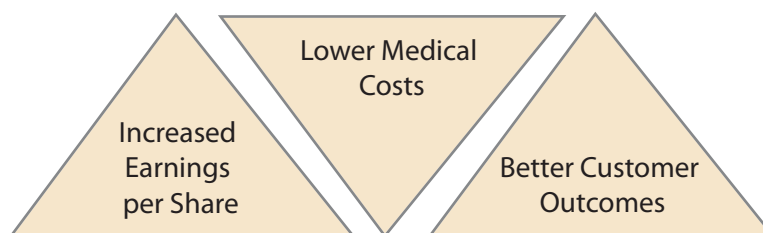
Bill Types



Viant Cost Management Services



The Result



Diagnosis Related Group (DRG) Audit Services

One area of possible cost exposure for payers is that of inaccurate DRG assignments and reimbursement, which can impact a payer's bottom line.

Value Points

- Effective post-payment cost control for large facility bills
- High success rate and high average dollar savings per successful claim
- No minimum claim size threshold
- Signed agreement with provider on each claim, minimizing provider appeals and back-end "noise"
- Customized and targeted reviews based on the DRG-related terms of clients' contracts
- Identification and review of readmissions, transfers and duplicate paid claims for appropriate reimbursement
- A "must" if reimbursement terms with providers are based on a DRG assignment
- Recovery of overpayments is an add-on service available to DRG clients

Viant DRG analysts ensure that all key components that affect the DRG assignment and associated reimbursement are documented and reported accurately within the medical record, and comply with required American Hospital Association Coding Clinic Guidelines and the ICD 9 CM Official Coding Conventions.

How It Works

DRG claims are first screened for codes, or combinations of codes, with potential for savings. Next, Viant DRG analysts ensure that the diagnosis and procedure codes are accurate and valid based on medical record documentation. If the analyst identifies a coding error, then a revised DRG is assigned by Viant and submitted to the provider for approval. If the submitted documentation supports the original DRG, the client receives a final disposition indicating the original DRG assigned by the provider is accurate.

For clients with Medicare plans, or commercial contracts that support it, Viant's DRG analysts can also refer cases to our Inappropriate Admission Review (IAR) team if they identify a potential medical necessity or coverage issue during their coding review. Both the IAR team and the DRG audit team work closely together to ensure that the proper audit with all appropriate documentation and clinical rationale are identified and realized on behalf of the client.

DRG Case Study

Client Profile

Large national health plan with diversified healthcare products including commercial, Medicare Advantage and consumer-driven plans covering more than 12 million members.

Situation

In 2007, this payer determined that the DRG reimbursement structure of its facility contracts exposed it to significant costs on claims that were overpaid; competing priorities prevented the company from using its existing audit resources to address the issue.

Solution

The payer contracted with Viant to perform DRG audits on 20,904 claims for facilities across the United States in 2008. Viant identified errors on 2,189 claims with an average savings of \$4,400 per claim. Viant continues to work with the payer to verify that the ICD-9 and procedure codes billed are consistent with the medical record and the appropriate DRG reimbursement has been applied.

Results

2007	
Claims	17,432
Billed Charges	\$232.3 million
Savings	\$10.9 million
2008	
Claims	20,904
Billed Charges	\$187 million
Savings	\$9.6 million

Hospital Bill Audit Services

Value Points

- Effective post-payment cost control for large facility bills
- High success rate and high average dollar savings per successful claim
- Signed agreement with provider on each claim, minimizing appeals and back-end “noise”
- Ability to audit hospital bills before or after the claim is paid
- Scalable, reviewing more than \$1 billion in claims annually
- Recovery of overpayments is an add-on service available to HBA clients

As payers look deeper for opportunities to manage their medical costs, another area yielding savings is the actual comparison of the medical record to the hospital bill, in those cases where reimbursement has occurred on a percent-off charges basis. In many instances, this comparison reveals such billing errors as services not delivered, multiple billing for the same item, unbundling of charges, mathematical errors and data entry errors.

Hospital Bill Audit (HBA) is a post-payment service that can audit medical claims before or after they are paid. The analysis compares physician orders to billed charges. All hospital bill auditors have acute-care nursing experience and are successful on 80+% of cases.

How It Works

Claims with a high probability of error are identified based on claim-specific criteria and historical audit results and then forwarded to a Viant nurse-auditor. The auditor performs a thorough line-by-line review of the entire hospital bill to ensure reimbursement is based on actual services rendered to the patient. Most audits are conducted on-site at the hospital. However, off-site desk audits may be performed at the request of the hospital. Upon completion, the audit results and revised charges are confirmed with a signed agreement from the hospital representative.

HBA Case Study

Client Profile

Large national health carrier with diversified products including group, Medicare and consumer-driven plans totaling more than 17 million members, and a Viant customer since 2000.

Situation

In 2007, the payer became concerned about the increased cost exposure it was seeing relative to hospital charges that could not be substantiated by the medical record. The client looked to Viant's hospital bill audit expertise to help augment its own audit resources to address this growing volume of overpaid claims.

Solution

The payer contracted with Viant to perform HBA Services on 1,556 claims for facilities across the United States in 2008. Viant identified 1,253 claims containing charges unsupported by the medical documentation or charges for goods and services unrelated to the patients' care. Viant achieved an average of \$3,200 savings per claim by identifying these errors.

Results

2007	
Claims	1,461
Billed Charges	\$104 million
Savings	\$3.2 million
2008	
Claims	1,556
Billed Charges	\$162.2 million
Savings	\$4.1 million

Contract Compliance Audit Services

Value Points

- Specialized cost containment for unregulated high-cost specialty services with high potential for savings
- Productive post-payment tool for controlling home infusion/DME costs, which are typically under-scrutinized
- Additional filter to maximize post-payment savings recovery in addition to traditional Hospital Bill Audit or DRG Audit Services
- All CCA reviews are customized specific to the client's contract or policies and reimbursement methodology
- CCA results can be used to improve and strengthen future specialty contracts and policies with providers

In their efforts to stem escalating health care costs, payers often overlook the billing and reimbursement errors due to misapplied or misinterpreted contract or other payment terms for various ancillary services. These errors can often be significant and require the specific contract audit expertise to understand the root cause of the problem and then recommend a solution. Contract Compliance Audit Services (CCA) is an intensive audit review service that looks at several areas of specialized care and treatments administered in both the physician and outpatient care setting in which complex contract terms may result in a high potential for billing errors, including:

- High-cost specialty injectable medications (RXI) including
 - Physician- and oncologist-administered injectables
 - Home infusion therapy
 - Renal dialysis claims
- Inappropriate hospital admission review
- Implant and contract exclusions
- Durable medical equipment

How It Works

Claims associated with complex contract terms that present administrative challenges are first screened using a combination of clinical expertise, contractual review and historical experience to identify areas of potential overpayment. Treatment plans and physician orders obtained from the provider by Viant are then validated against what was billed on the claim and the reimbursement terms outlined in the provider contract. In cases where overpayments are identified, providers are made aware of Viant's findings, and given an appropriate amount of time to submit the additional documentation necessary to support their original billing. After that timeframe, the overpayment recovery process begins.

Viant's CCA Services address a large number of medical services, typically unregulated in today's healthcare environment. They include:

RxI Services

Healthcare payers now can control the rising costs associated with reimbursement of prescription injectable medications in physician and other outpatient settings through Viant's unique RxI Services, a series of pharmacy cost-management services designed to support many of the nation's leading health plans. RxI Services helps manage high-cost injectable and specialty pharmaceuticals in care settings such as oncology, physician, home infusion and renal dialysis through validation of the clinical, contractual and financial components of a claim. RxI Services consists of experienced pharmacists, nurses and contract audit professionals who understand the complexities of claims systems, reimbursement methodologies and clinical service issues.

Physician- and Oncologist-Administered Injectables

Since 1999, Viant's RxI Services has reviewed more than \$2 billion in specialty physician and oncology claims to identify and validate actual physician orders and units of medication when indicated. This validation process allows Viant auditors to perform exact pharmaceutical calculations, reconcile correct product and package size and verify correct units of high-cost drugs billed. Once correct orders and units are validated, accurate pricing of claims to any variety of applicable fee schedules or reimbursement methodologies can be accomplished.

Home Infusion Therapy

As the emphasis to move patients from the inpatient setting to the home to receive a variety of therapies at a lower cost, home infusion therapy providers emerged and annual growth of this industry was exponential and continues to grow each year. The complexity of the high-tech services and drugs administered in the home setting has also contributed to billing and reimbursement challenges between home infusion providers and payers. Viant recognized the high incidence of billing and reimbursement errors and developed the most comprehensive post-payment audit and recovery program in the industry, allowing payers to regulate the reimbursement of these complex reimbursement agreements.

Renal Dialysis Claims

Viant has identified a significant need to audit and recover overpayments specific to the renal dialysis industry. High-cost hemodialysis and peritoneal dialysis services become routine patient care, however, the variables in dosing and utilization of the high-cost drugs associated with these services lead to complexity in billing with a high potential for drug unit billing errors and over utilization of medication. Viant utilizes pharmacist and contract compliance auditors to carefully analyze previously paid claim files to identify those cases which have a high potential for drug unit billing errors. Viant also analyzes patient history, billing and utilization trends to clinical protocols, validation of hematocrit and lab values supporting high dose cases when necessary, frequency of hemodialysis treatments and billing of associated lab services.

Inappropriate Admission Review

Inappropriate Admission Review (IAR) of inpatient clinical criteria provides an effective screening mechanism to identify specific claims with a high potential for overpayment based on the level of care, severity of illness and intensity of service provided. Viant's Certified InterQual instructors, Certified Case Managers and Utilization Review professionals review medical record documentation on select claims and document unsupported admissions for recovery of overpayments. IAR cases undergo a unique data mining routine that looks for potential inappropriate admissions, as well as potentially non-covered services that may be medically unnecessary.

Implant and Contract Exclusions

Viant has developed a niche post-payment audit service specifically targeting high-cost, high-impact cases where reimbursement methodology within contractual agreements is difficult to administer and monitor. Viant has a dedicated staff of highly skilled healthcare professionals familiar with these products and services, as well as expertise analyzing and auditing carve-outs and exclusions submitted on claims for reimbursement. This specialized audit service provides payers with the ability to review previously paid claims, analyze and identify payment errors and successfully recover overpayments from the facility.

Durable Medical Equipment

Viant has created a unique post-payment audit and recovery service specific to analyzing the high volume of low-dollar durable medical equipment (DME) claims billed on a daily basis to healthcare providers. Traditionally, regulation of the billing of these low-dollar claims has been limited due to the high volume of cases involved and the lack of documentation often associated with billing for these services. Viant leverages DME industry expertise to analyze and identify cases where inappropriate or unnecessary DME billings occur or where unbundling of services, excessive units or incorrect coding occurs. Viant is also able to aggregate historical claims by patient and provider to regulate rental to purchase price limits within contract reimbursement provisions.

Overpayment Recovery Services

Overpayment Recovery Services helps Viant's customers realize the true value of medical cost savings identified through our Post-Payment Services by the actual recovery of claims overpayments. Viant's Overpayment Recovery has the refund recovery preparation and collections expertise to consistently recoup claim overpayments with low provider appeals. Viant also has the ability to utilize established payer offset processes.

CCA Case Study - Rxl

Client Profile

A large national insurance company with significant operations in most states.

Situation

Since 2001, this client has been utilizing several of Viant's Post-Payment Services. Viant identified a significant issue with dialysis payments in general and a very serious problem with one provider in particular. The magnitude of the overpayment situation was very high considering that renal providers typically bill at approximately 10 times cost.

Solution

In late 2006, the client determined that Viant was best suited to address this global problem because of the significant experience Viant possessed in the renal arena and our ability to negotiate directly and successfully with difficult renal providers. The client began sending Viant all of its renal claims for review on a quarterly basis, resulting in a tremendous amount of success in identifying and collecting overpayments. In addition, Viant has been directly involved in collection negotiations and contracting with several large providers. During the last two years, the recovery rate has totaled several million dollars using Viant's Rxl Services.

Results

2007	
Claims	3,670
Billed Charges	\$10.2 million
Savings	\$3.5 million
2008	
Claims	6,436
Billed Charges	\$8.95 million
Savings	\$5.1 million



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