Best Practices in Claims Management

Use of treatment guidelines and clinical logic for preauthorization and claims adjudication

The need for standards in claims processing

Indian health insurance companies or TPAs generally hire medical professionals ranging from pharmacy graduates to alternative systems doctors to MBBS doctors for process claims. These medical professionals use their training and experience to verify a healthcare claim and to determine if the procedures, diagnostics, consumables being billed are warranted and if the costs are reasonable. The claim processors may have limited clinical experience, may not be current with new developments and may not be familiar with certain procedures. This results in variations for how a similar claim is processed within a single TPA and also from one TPA to another. It can often lead to leakage or abuse to go unnoticed and unwarranted payments. Sometimes the incentive structure is designed to encourage a processor to get through as many claims as possible thus reducing the time they can spend on a specific claim. The significant variation of care across provider further compounds the problem. Due to all these factors, it is felt that claim processing is discretionary or arbitrary. This leads to provider – payor disputes, abuse or overpayments and leakage. In other countries, a common solution to these problems is usually some set of protocols or guidelines adopted by the industry. **These guidelines are widely accepted by all stakeholders and they assist in claims settlements. Without widely accepted and evidence based guidelines which detail what is 'medically appropriate or justified' or what is 'reasonable and customary' for a particular medical or surgical intervention, conflict is inevitable**.

The two main initiatives in the last few years on developing standard treatment guidelines or clinical protocols by WHO/ AFMC STGs (2008), FICCI STGs released in 2009 and FICCI current initiative to develop guidelines for a wider set of conditions started in 2011, have limitations in terms of conditions covered and have been written with minimum standards of care or from the public health system infrastructure perspective. They do not truly fulfill the needs of the insurance industry as the content is not specifically designed for preauthorization and claims adjudication. The health insurers and TPAs require guidelines that help to define the medical complexity of a particular case, provide appropriateness and reasonability checks for diagnostics, treatment and associated consumables and indicative length of stay.

In some countries such guidelines are developed by independent organizations and are regularly updated. The mostly commonly used product in the USA for prior authorization and claim settlement are the Milliman Care Guidelines. These guidelines are well accepted since they are not the opinion of any one person or a small group but entirely based on current evidence, which is directly quoted in the guidelines. Thus these are viewed as benchmarks and thus become a widely accepted basis for prior authorization and claims resolution. For example when a pre-auth request is made by a hospital, the insurance company and the provider refer to the guidelines to predict the length of stay and likely interventions for a particular diagnosis. It is commonly accepted that to be effective a guideline should only focus on the clinical aspect. They do not provide the cost of investigations or surgical charges or consumables that may be required. The cost is determined by provider and insurer negotiations which include factors such as patient volumes, speed of payment etc etc. Thus the providers and payors rely on the guidelines to determine clinical appropriateness and rely on agreed tariffs or package rates to take care of the cost issues.

Claim processing guidelines

Milliman recognized that India needed similar systems to bring about some form of standardization and three years ago they set out to create a complete suite of solutions specifically for India. Thus the solutions developed for India represents the best practice recommendations from Indian publications based on practice patterns, infrastructure, equipment physician training, culture and costs prevalent here.

The claim processing guidelines were launched in 2009 under the brand name of 'ClaimsRef' and they cover 200 common in-patient interventions. They aim to enhance productivity and optimize cost savings by:

- Improving efficiency, uniformity and accuracy in claims processing
- Promoting standard practices across different TPA / insurer sites and personnel
- Ensuring early identification of 'incomplete claims' and 'inaccurate charges'
- Supporting information based negotiation with providers

Milliman has conducted formal external review of these guidelines with practicing experts from both the health providers and health insurance field to ensure they are comprehensive and accurate. Numerous sample trials with retrospective audits with different health insurance companies and TPA's have also been held. It has been found that almost all common causes of admission are covered by the 200 conditions in ClaimsRef. Further, **the various retrospective audits have confirmed that the use of claims processing guidelines accurately identify variations in medical claims and about 2-5% of these savings can lead to definite cost savings.** The design of ClaimsRef helps with two critical steps, the prior authorization and final claim settlement.

In health insurance, the preauthorization is an important step. When a hospital sends an admission note to a TPA for preauthorization, the authorization personnel refer to ClaimsRef for that particular intervention and match the details on the authorization note to validate appropriateness for admission and to determine the severity of condition. Severity determination is rather important as it defines the likely investigations and length of stay and consumables that may be used during the hospitalization. Once severity is determined the ClaimsRef indicates the likely length of stay. Claims processors can then look up the rates for the specific facility type and location in the TPAs database and estimate the likely cost of procedure / hospitalization episode. The whole process takes a few additional minutes but what gets authorized is based on clinical logic, in line with expected practice patterns and standardized. If a TPA has pre-negotiated package rates, then they can just use those.

When settling a claim, the Milliman guidelines enable a claim processor to accurately determine the severity of a patient's condition and identify if the length of stay, investigations, consumables and treatment are in proportion to the condition. They also list special checks to identify patterns of inappropriate billing or industry accepted non chargeable items. In addition to standardizing and accelerating claim processing, the ClaimsRef also reduces errors and omissions, thus enabling a TPA or an insurance company to process more claims with existing manpower. ClaimsRef guidelines also have additional details which can be useful for a claims team e.g. brief description of surgery, anesthesia choices, additional investigations that may be needed with specific indicators, impact of common co-morbidities or risk factors that could lead to extended hospital stay etc. Possible clinical reasoning for additional investigations and longer hospitalization are also available. This enables a claim processor to rule out common reasons for variance before calling the hospital. **The guidelines ensure that the claim settlement process is driven by clinical logic.**

Integration of claim processing guidelines into a claims management platform

Most existing health insurance claims systems focus on data and workflow management. The primary goal is to achieve process efficiency. They offer work flow management module for work distribution and routing or in-built escalation. They integrate simple rules engine to configure products and automate various validation checks on policy, claimant, benefits and provider. Usually a product configurator is included so the rules engine can also be used to define product benefits and exclusions. This makes it possible to apply checks and edits that increase efficiency and help process claims faster. The ability to efficiently link policy benefits, enrollment and underwriting information, previous claims, prior authorization and any subsequent enhancements to the current claim, is deemed as mandatory. Some basic checks, i.e. matching of ICD code to gender and age validations, having a basic length of stay reference or integrating drug databases are also a common feature, as are links to contracted tariff lists and prior payments to a specific hospital for a specific ICD codes. However vendors of claims system have rarely attempted to build clinical intelligence into the system. Clinical logic in the forms of rules that can be integrated into claims systems are now available to complement the knowledge and experience of doctors who process claims in real time. Some claim system vendors and insurers are already adopting and using such clinical logic in India.

Milliman provides the claim processing guidelines in a rules format that can be easily integrated into a claims system. This significantly automates the "clinical checking" of a claim. Some insurers and their IT vendors are adopting this route. This makes the use of the guidelines an inherent part of the claims workflow and increases their effectiveness. The integration is relatively simple as data sets, master tables and rules are provided to the IT team, with instructions for integration.

The rules identify key variations based on the data entered into a claims management platform. The data input is compared against the clinical logic and rules, if any variation is identified then an alert is generated. The key variations that the clinical logic is able to identify include, but are not limited to:

- ICD CPT mismatch (indications not met for the surgery)
- Length of stay mismatch
- Duration of ICU mismatch
- Delay in surgery flag
- Excessive physician visit flag
- Unwarranted specialist visit flag
- Unwarranted assistant surgeon fee flag
- Procedure not indicated for the age group / gender
- Excessive investigations flag
- Unwarranted investigation flag
- Excessive consumables flag
- Unwarranted consumables flag
- Excessive drug use flag
- Unwarranted drug use flag
- Drug charged above marked price flag
- Unwarranted pre hospitalization or post hospitalization expense
- Non chargeable consumable flag

The generation of these alerts ensures that these variations are noted by the claims processor. For example, upon receipt of the hospital claims at discharge, a very junior claim processor enters data from the hospital invoice into their claims management system. The system runs the Claimsref clinical logic rules and compares the data entered with the expected investigations, length of stay and consumables etc for that specified procedure. If the hospital has excessive units of a particular billed item, those entries are flagged as variation for a senior claim processor (usually a doctor) to consider. The flags alert the claims doctor to review the clinical reasoning for these variations in discharge summary or to seek details from the provider.

With additional integration, the claims IT system can retrieve the cost of expected services from the negotiated rates database. If the invoice costs are within the expected cost range, it automatically clears the invoice for payment. If any variance is noted it flags them. This ensures that complete and appropriate claims get processed immediately allowing the doctors, who are an expensive resource, to focus on the 'incomplete or potentially inappropriate claims'. However, the generation of these rules based alerts is dependent on accurate data entry and the additional data entry will have some implications on productivity.

An effective way to manage productivity implications (additional data entry) is to recognize and focus on its maximum value and specific business need. The clinical logic rules can be activated or inactivated for different scenarios. These options may be desired for different claims type, claims value, products, staff experience, provider etc. A robust claims IT system would provide the claims manager at the insurer or TPA to create such rules and then activate or deactivate them based on business needs at a specific time.

Conclusion

Indian health insurance industry is at a critical stage of development. While it is growing rapidly, the associated processes of underwriting and claims processing are yet to be standardized. Milliman has developed guidelines specifically for the Indian health insurance industry which combine published clinical evidence with expert opinion of doctors. These guidelines can be integrated into claims systems to ensure standardized information based claims adjudication and enhanced cost savings. The next generation of claims systems will incorporate more intelligence to ensure quality and standardization in claim processing.

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About Milliman

Milliman serves the full spectrum of business, financial and government organizations. Founded in 1947, the company has 52 offices worldwide. Milliman currently employs more than 2,000 people, including a professional staff of more than 900 qualified consultants and actuaries. The firm has consulting practices in employee benefits, healthcare, life insurance / financial services, and property and casualty insurance. The Indian subsidiary, based in Gurgaon, has a staff of over 80 actuaries, clinicians, IT and other professional and provides a wide range of services and products customized for the Indian health insurance market. Milliman is also developing India specific clinical protocols for healthcare providers and underwriting guidelines for health insurers. The clinical team based at Gurgaon conducts rigorous research of Indian published evidence and practice patterns. The evidence supported tools developed for healthcare providers is the basis of 'ClaimsRef'. Milliman India has extracted evidence based on Indian research publications which detail the expected best practices for management of medical and surgical conditions.