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Sedgwick White Paper

Medical Bill Review Savings



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A best in class bill review program is more than just PPO discounts, state fee schedules, and network negotiations. The real benefit is in the way the information is processed.

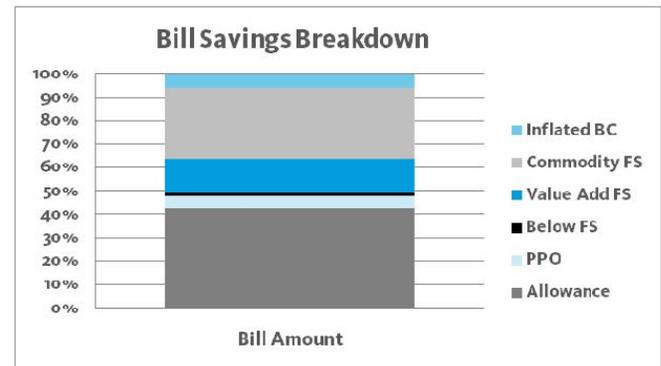
Medical bill review service providers have long held that their value can be measured in the savings achieved from billed charges as well as the average payment made per medical bill. While both of these measures may produce savings, they can be manipulated to maximize their perceived value. Often, the metrics used do not create a complete picture and do not truly reflect the impact on the cost of risk for the employer.

Sedgwick offers a different approach. When we built our bill review program, the main question we asked was, “How can we save our clients the most money and do this in the most efficient way possible?” The first step is through fee schedule reductions. Two-thirds of the fee schedule savings are straightforward. We generate the other one-third based on rules that are embedded in the system; however, a value-added approach is required to fully realize the savings generated by these rules. For example, if an assistant surgeon is treating a patient, they are paid at a reduced rate; and we maximize the value of those types of reductions by making sure we have the right people looking at the bills so that they are paid appropriately.

Our goal is to ensure accurate coding, and then we confirm that it reflects the lowest possible allowance for that code and that provider. Our primary objective is to make sure we are accessing the value-added fee schedule reductions on every bill to get the proper price for our clients.

Measuring bill review savings – an industry overview

The chart below provides a breakdown of the bill reduction measures and efforts that lead to total savings:



The average allowance for a bill is about 45% of the total charges (varies by state) and various methods are used to generate the discounts. While some require attention to detail and performance monitoring to access best in class reductions, several others are basic in nature or purely designed to inflate discount percentages with no real benefit to the payer. The categories include:

- Inflated bill charges – Companies that focus on discount percentages from billed charges can often inflate total charges by as much as 10%. This is done by including denied bills, treating reconsiderations as new bills, and establishing billed charge amounts.

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- Denied bills – Bill review providers often include full denials in savings reports (and charge a fee for the services). These bills are generally not applicable to any work-related injury, and therefore offer no reporting value and may serve to increase administrative costs. Note: Some states require employers to track and report these bills.
 - Reconsideration handling – Many bill review systems are programmed to treat a reconsideration as a new bill. In the event that the original bill was partially paid, the final allowance will reflect the appropriate amount due. However, billed charges will be duplicated resulting in an increase in the perceived discount from billed charges with no additional benefit to the payer.
 - Establishing billed charge amounts – Experience has shown that some service providers will instruct specialty program partners to bill for services at rates above the fee schedule so that they can show better discounts on the billed charges. An example of this practice can be found in the review of pharmacy bills where a pharmacy benefit manager typically bills at the state fee schedule and applies their contracted rate to show the value-added component of their offering. Any charges in excess of the state fee schedule reflect no additional value in the bill review process.
 - Commodity fee schedule reductions – As discussed above, states produce a listing of rates that workers' compensation payers are obligated to pay for each procedure code billed. These rates are effectively applied by most bill review systems and require little or no intervention to obtain. The results of these efforts should be standard across all bill review providers and the reductions are typically two-thirds of the total fee schedule reductions.
 - Value-added fee schedule reductions – State fee schedules outline specific rates for each procedure code that could be billed for medical services.
- There are also various rules, many of which are state specific, that allow bills to be reduced further. They require attention to detail and experience to maximize savings. Additionally, integrated systems that coordinate the efforts of claims examiners, nurse case managers, and bill review staff effectively reduce bills for services that were not authorized. These reductions are typically one-third of the total fee schedule reductions.
- Below fee schedule reductions – These are obtained by utilizing out of network negotiations or re-pricing partners, and a nurse's review of complex medical bills. Savings from billed charges are typically .5% to 1% across all bills.
 - PPO reductions – The key to maximizing discounts below the fee schedule is to build a network solution that is state specific, and combined with integrated specialty network programs, such as pharmacy, physical therapy, diagnostics, and durable medical equipment/ home health. Savings are typically 4% to 6% off billed charges across all bills.

IN ORDER TO ENSURE THAT ADMINISTRATIVE FEES FOR PPO NETWORK ACCESS ARE MINIMIZED, AN EFFECTIVE PARTNER WILL ENSURE THAT ALL POSSIBLE REDUCTIONS ARE TAKEN BEFORE THE APPLICATION OF PPO DISCOUNTS.

- Allowance per bill – While it is a reflection of how much is paid; this metric can also be manipulated. Many service providers bill for multiple service dates on a single bill (physical therapy providers are the best example). Bill review providers that are focused on this metric will often break these bills down into individual dates of service. This not only serves to decrease the average allowance per bill, it also generates additional service fees.

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The following chart provides realistic examples of how the gross savings and average allowance per bill could be impacted by the scenarios outlined on pages 1 and 2:

Bill review savings impact	Optimal *	Bill charge inflated **	Reduced value add bill review ***
Total bills	1,000	1,000	1,000
Total provider charges	\$775,000	\$825,000	\$775,000
Avg. provider charge per bill	\$775	\$825	\$775
Fee schedule/UCR savings	\$365,000	\$415,000	\$336,250
PPO savings	\$45,000	\$45,000	\$48,155
Out of network/negotiated savings	\$15,000	\$15,000	\$16,052
Total savings	\$425,000	\$475,000	\$400,457
Avg. savings per bill	\$425	\$475	\$400.46
Total allowance	\$350,000	\$350,000	\$374,542.68
Avg. allowance per bill	\$350	\$350	\$374.54
Gross savings %	54.8%	57.6%	51.7%

Note: The chart above assumes 70% PPO penetration and Sedgwick business mix by state. State mix and PPO penetration changes would change all metrics.

* Represents the exclusion of duplicates, proper reconsideration handling, and no manipulation of billed charges. Full fee schedule value and out of network negotiations/nurse reviews are achieved prior to bill review application.

** Represents the impact of including duplicates, improper reconsideration handling, and inflated billed charges for certain services with all discounts remaining equal.

*** Represents achieving 75% of value-added fee schedule savings with PPO and OON negotiations/nurse reviews applied. In addition to the increased allowance per bill, this also increases bill review fees by \$4.20 per bill.

What should be measured?

In order to truly measure the impact on the cost of risk for the payer, we need to measure the actual prices paid for individual services. Bill review service providers can also impact the service mix for categories like office visits

and physical therapy services. Evaluating the average cost per office visit or physical therapy treatment will help payers evaluate their service partners. Bill review provider efforts should be geared toward ensuring payments for appropriately authorized and compensable services are at the most appropriate and effective rate possible.

The application of state rules offers an opportunity for additional savings that must be measured by service mix. An effective solution will monitor and measure the actual price paid per service, or for inpatient and outpatient hospital stays, and the cost per service date including all services provided on that date. Additional metrics around service mix will help round out the analysis to ensure appropriate utilization. Comparing the payments to the utilization review results completes the process.

With Sedgwick’s integrated bill review system, we are only processing bills for the services that should be paid for the claimant. We pursue all possible reductions before we move on to nurse negotiations, network negotiations, and other discounts to make sure we reduce the administrative costs as much as possible.

Improving outcomes

An effective bill review partner understands their role in reducing each client’s cost of risk and uses all efforts to impact costs. The ability to identify the cost drivers and utilize service models that focus less on generating a discount percentage – and more on analyzing and impacting these drivers – will improve outcomes.

A model where bill review services are integrated with the claims management process provides employers with the ability to fully leverage analytical capabilities and offers them the benefits of enhanced program coordination.

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Sedgwick processes about four million bills a year and half a million claims a year, and we have one of the largest data sets in the workers' compensation industry. With our size, we can better measure performance, identify trends (adverse or positive), and create strategies to improve outcomes.

By combining traditional care management metrics with claim data, we can measure and monitor programs to help employers manage their cost of risk.

Contact us today to find out how Sedgwick's integrated bill review services can help your organization.

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