

# **Investor & Analyst Presentation**

## **2<sup>nd</sup> June 2011**

Market Dynamics: Sandy Rasmussen, SVP Finance & Operations

Acquisition Financials: Craig Preston, CFO

Craneware InSight Overview: Joe Ferro, EVP Craneware InSight

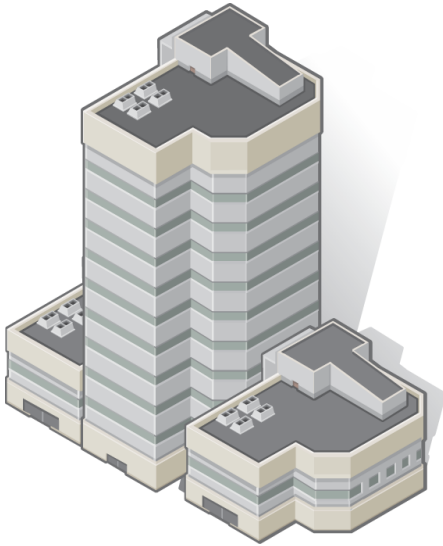
RAC Programme: Karen Bowden, SVP Craneware InSight

# **United States Healthcare Provider Market Dynamics**

**Sandy Rasmussen**

Senior Vice President Finance & Operations

## ▶ Emerging Opportunities and Challenges for Healthcare Providers



State Budget Shortfalls

ICD-10

Recovery Audit Contractors

Reform through Legislation

Healthcare Exchanges

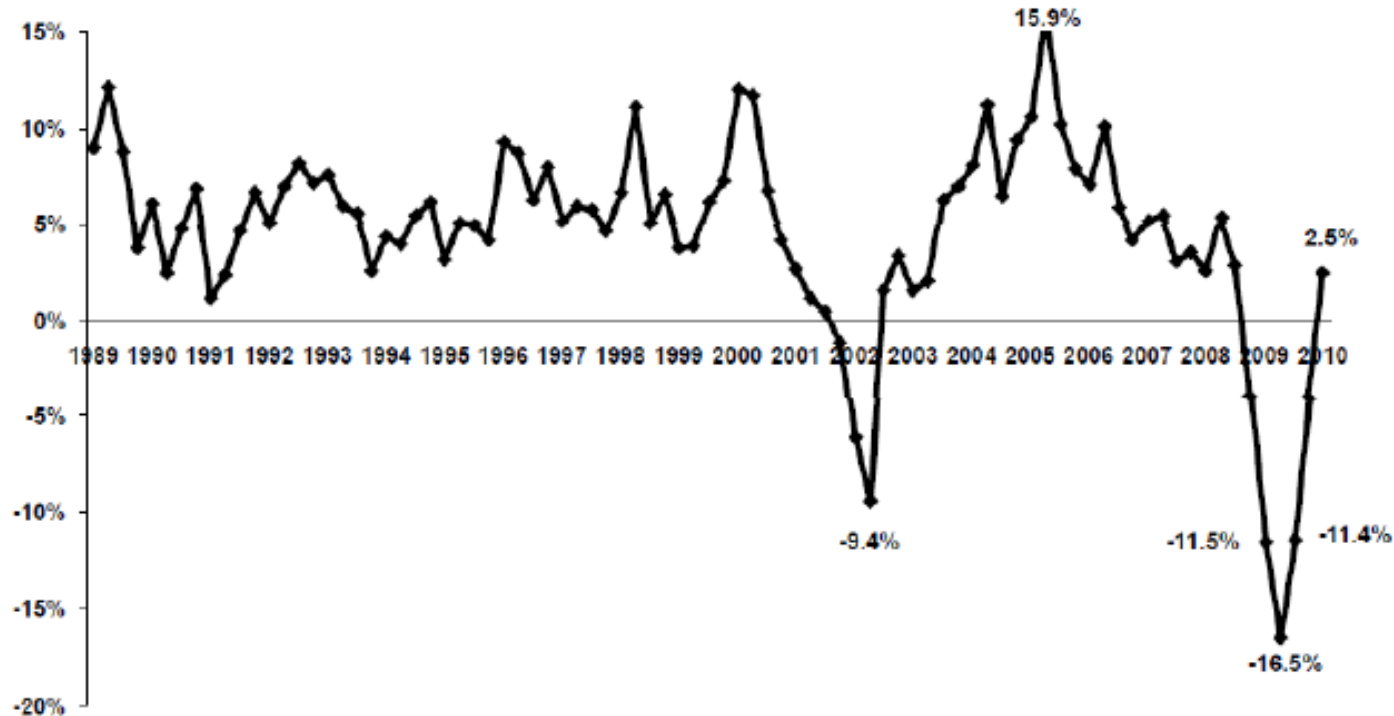
Market Consolidation

Managing cost per unit

Trends

## State Tax Revenue Fell Dramatically

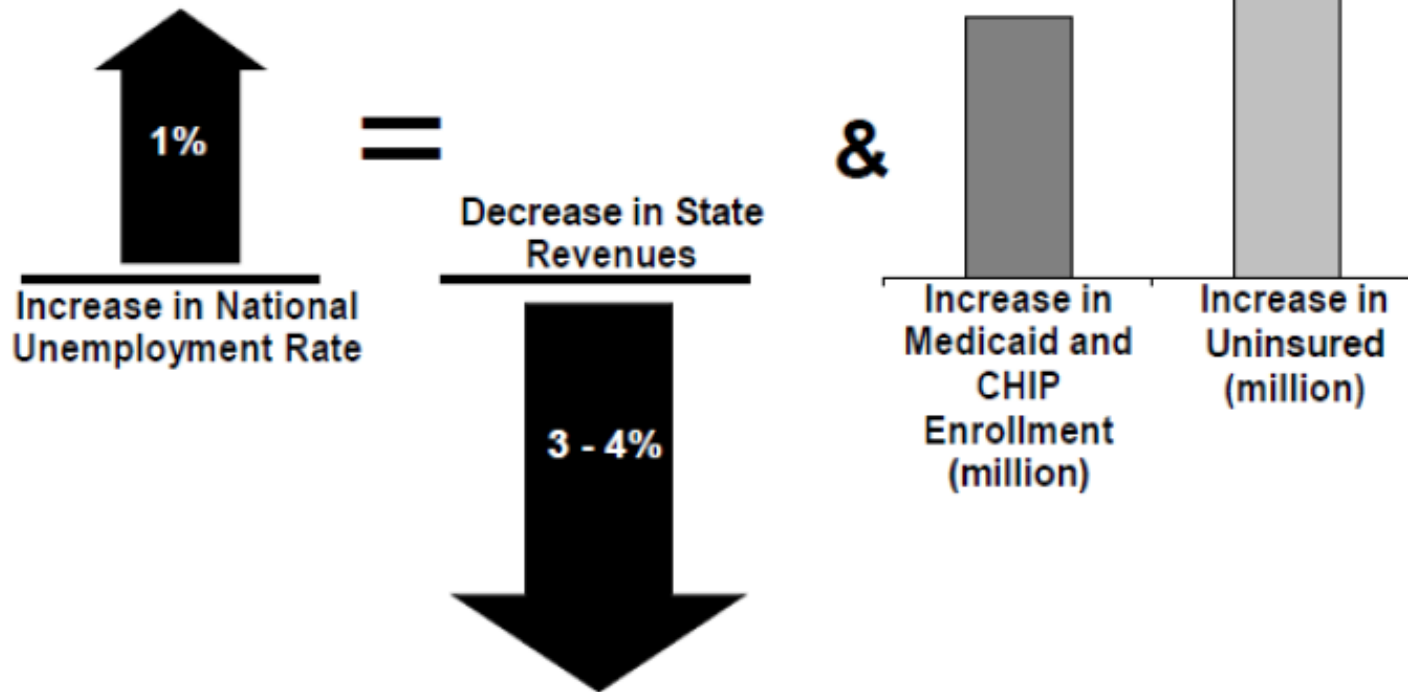
### State Tax Revenue, 1999 – 2010



SOURCE: Percent change in quarterly state tax revenue. US Census Bureau.

Trends

## Unemployment Exacerbates the Budget Problem



Source: Kaiser Commission on Medicaid and the Uninsured

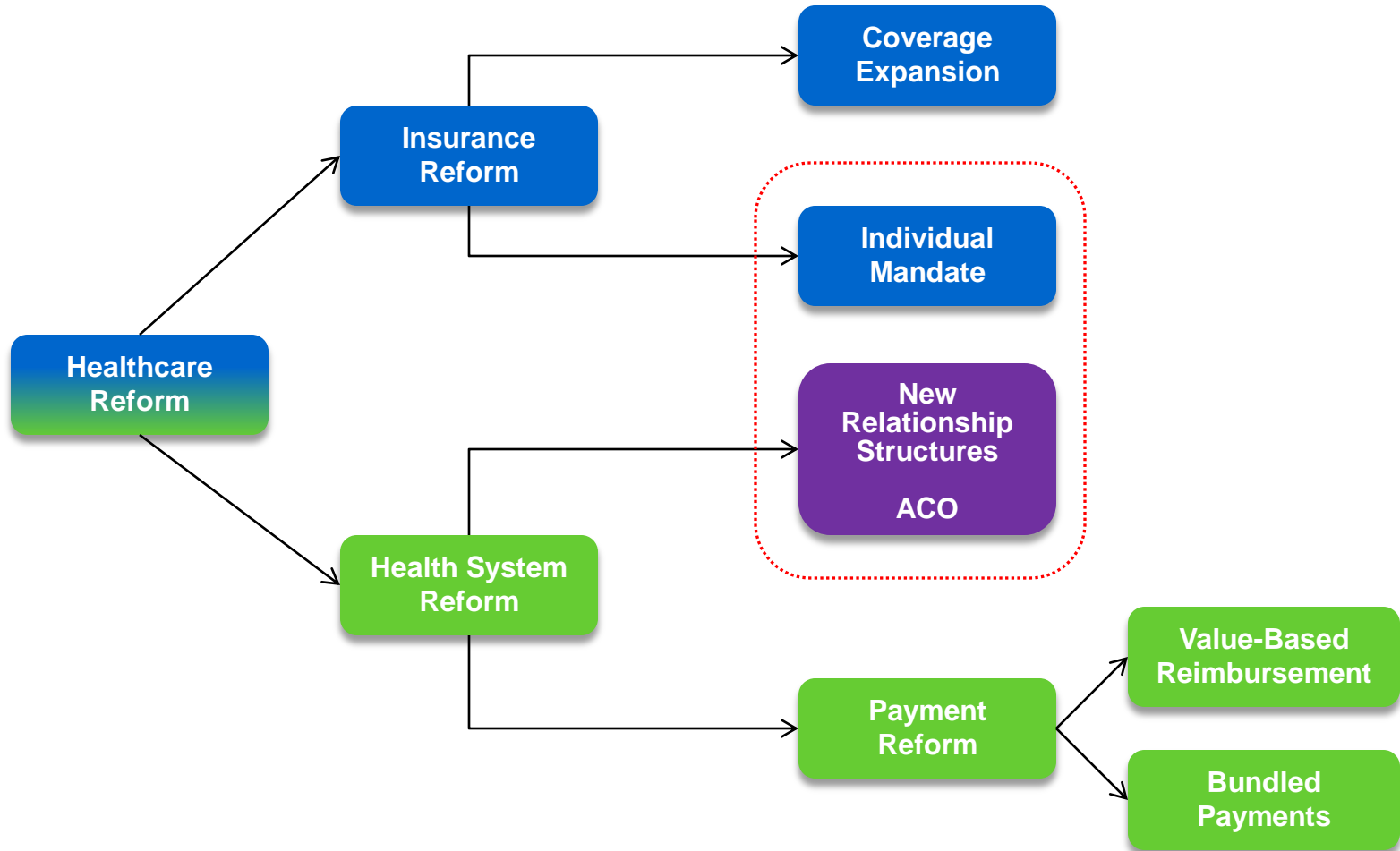
## Trends

### 2012 Budget Cut Severity and Impact: % of Medicaid Budget



Source: Health Management Academy analysis

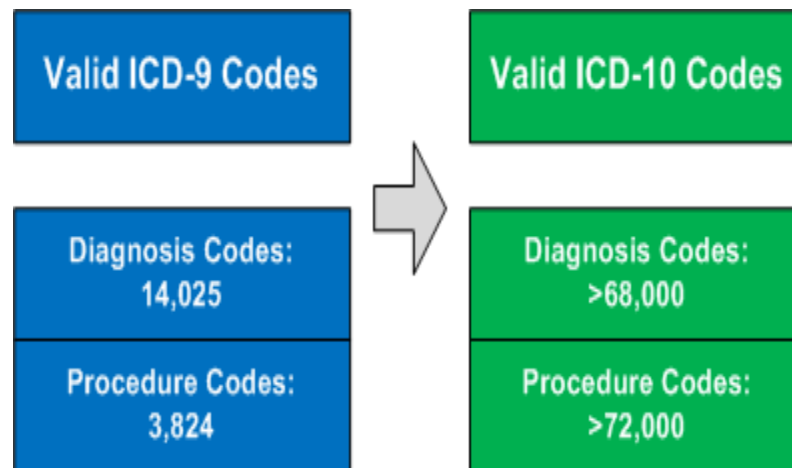
## US Healthcare Reform



## ▶ ICD-10 and 5010

**5010** – Transaction format. Allows for the additional field length and addition of non-numeric characters to support ICD-10

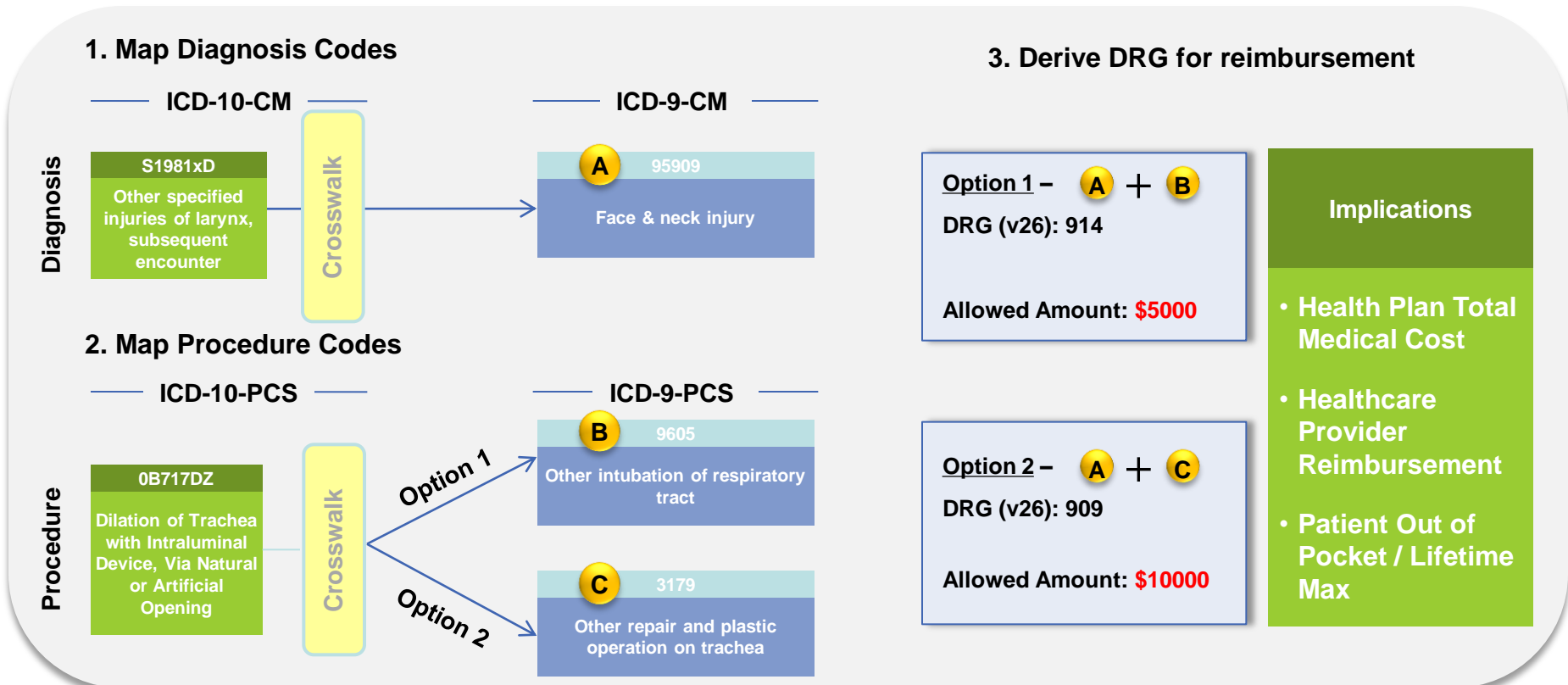
**ICD-10** – New, more detailed diagnosis and procedure code sets and logic. Goal is to improve patient care, enhance claims processing, and improve data collection



## Under or Overpayment

### Interim Period Crosswalk vs Accepting ICD-10 and ICD-9

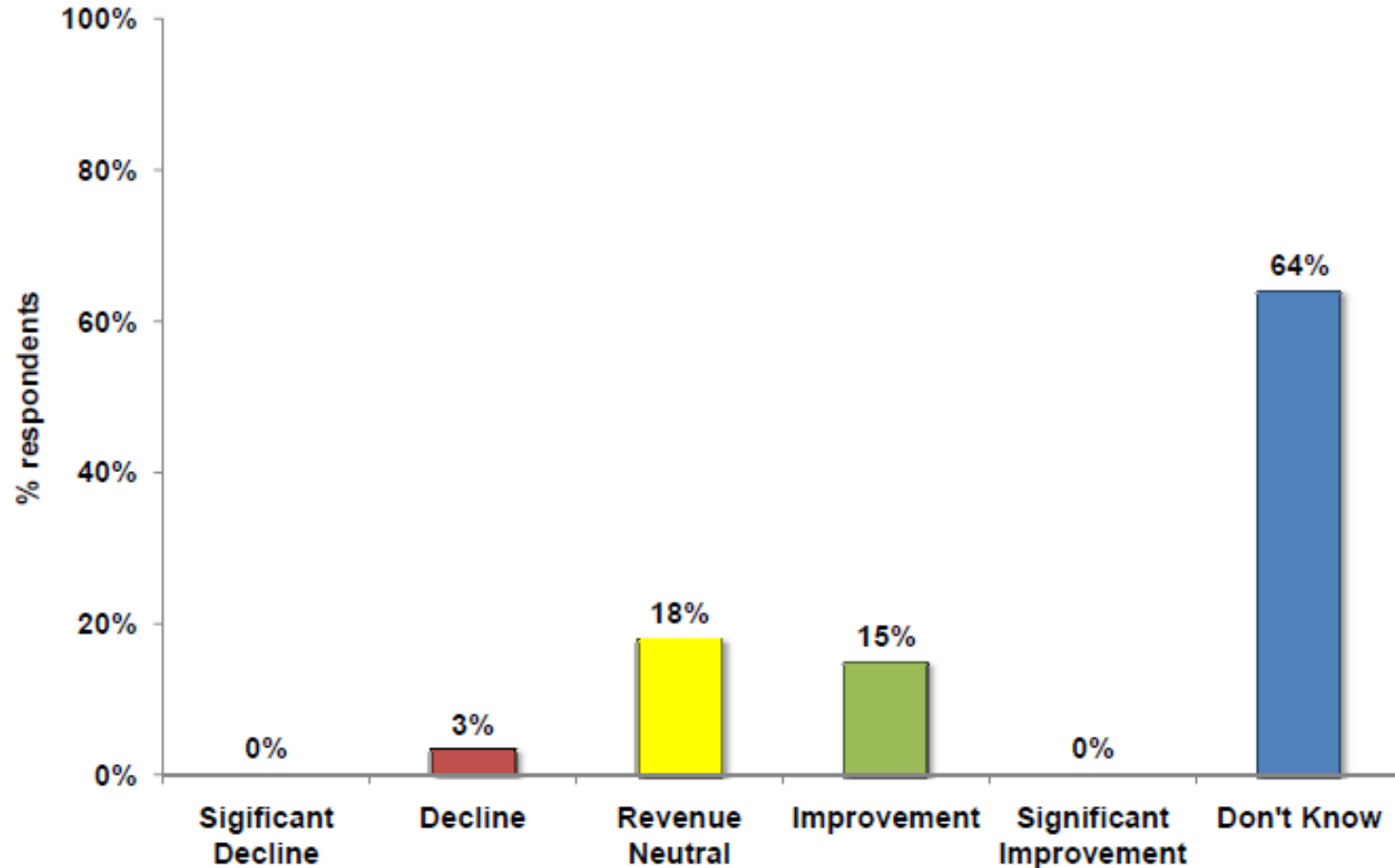
Cross-walks between ICD-10 and ICD-9, a central tenant of an 'insulate' strategy, can have a **material impact on reimbursement**. Decisions are required about mapping options



There is no industry standard to apply, and COTS cross-walk solutions still require > 75,000 hour of validation, and COTS claim engines are embedding cross-walks that will also require validation

# Revenue Impact To Be Determined

Expected Impact on Revenue



The Academy



## Risks for Healthcare Providers

- Interim resource drain
- Loss of productivity
- Under and overpayment by payers during transition period
- Increase in A/R days
- Increase in denials

## How is this different from prior history?

- Unprecedented increase in populations covered by government sponsored healthcare & tax burden
- Potential conversion of existing payments to Medicare level for exchanges
- Availability of clinical data for analysis
- Clear evidence and acceptance that variation in care exists and creates significant waste
- Consumer share of the cost much greater
- Recovery Audit Contractors have unprecedented funding and authority to deny claims



## How are Healthcare Providers responding to reform?

- Managing their budgets tightly – ROI is an absolute requirement. Capital constraints will continue
- Increased attention to business performance
- Looking to transform operations to create sustainable cost reductions (not just to balance this years budget)
- Experimenting with ACO and VBP models
- Emphasis on relationship between clinical & financial operations
- Looking for partners (but carefully)

## Likely Outcome

- Some permanent increase in market consolidation
- ICD-10 will pass like Y2K
- Economic recovery will resolve part of Medicaid cuts – but not in short term
- Very large health systems will have 20% of their business in some form of risk arrangement
- Fee for service will remain the predominant form of measure of the services/cost of care delivered
- Some portion of payments will be tied to outcomes

## Overall Thoughts

- Much is being discussed about the infrastructure and business partnerships needed to support capitation and bundled payment
- Not much is being discussed about emerging risks associated with managing the financial transactions
- Healthcare Providers expect to live in world where capitation, bundled payment and fee for service coexist
- Most risks Healthcare Providers face today will continue

## Risk Continues Under Health Reform

- Pricing, charge capture and compliance risks continue as Healthcare Providers must still translate care delivered into a measure of cost that will ultimately drive price negotiation and profitability analysis
- Denial risk grows as:
  1. RAC's focus on Fee For Service
  2. ACO's incented to exclude non-medically necessary services from capitated risk pools
- New Risks will emerge

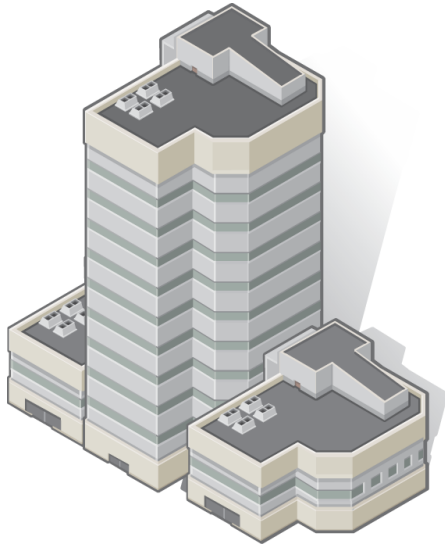
## Advice to Healthcare Providers

- Don't take your eye off the ball
- Revenue cycle risks as you know them today will continue in the foreseeable future with a new layer of risk to be managed as you assume many of the administrative, data analysis and risk management roles of a third party payer

## How Does Craneware Support Health Reform?

- Partnering with IDN's to identify new control risks, create visibility into expanded areas of the revenue cycle, and adapt/embed our tools into changing business processes
- Assist hospitals in engaging physicians as stakeholders
- Prepare IDN's for standardization of CDM
- Engage clients as problem solvers in partnership with GPO partners
- Emphasize sustainability and integrity of the business process through technology
- Help maximize and track ROI to invest in patient care

## ▶ Emerging Opportunities and Challenges for Healthcare Providers



Unprecedented?	Maybe
Unsustainable?	Likely
Cyclical?	Somewhat
Predictable?	On some levels

# Appendices



## Key Elements of the ACO Model

- Organized group of physicians (with or without hospital)
- Legal entity with approach to sharing risk/savings
- Ability to distribute payments
- Payment predicated upon hitting targets for quality and care coordination
- Standardized clinical reporting across participants
- Clinical re-engineering



## The Accountable Care Organization Solution

- Doesn't replace employer sponsored healthcare
- Pushes health plan function down to the Healthcare Provider
- Claims as basis for distribution of funds unless Healthcare Provider owns 100% of pieces like Kaiser
- Even under capitation the government will want to know its cost per unit of care delivered
- Healthcare Providers expect to be less than 15% of their total revenue stream for the next 5-10 years

## **Structural Barriers to ACO's**

- Must be physician driven
- Physician ownership of hospitals banned
- Regulatory limitations on Healthcare Providers assuming insurance risk
- Regulatory limitations to incenting physicians to refer patients within the defined ACO
- Cost to put legal structure in place and more importantly processes that demonstrate that it meets requirements with regard to clinical outcomes

## Practical barriers to ACO's

- Significance of actuarial risk beyond Healthcare Providers' control especially for smaller populations
- Changing the way all patients are managed when that means less revenue for the majority
- Political uncertainty
- Healthcare Provider ability to define and maintain payment mechanisms for participants they don't own

# Financials of the Acquisition

**Craig Preston**

Chief Financial Officer






## Acquisition Overview

- **Headline Consideration – \$15 Million**
  - \$9 million Cash
  - \$6 million New Craneware Equity
  
- **Contingent Consideration – Up to \$4.5 million**
  - Based on financial performance 1 July 2011 to 30 June 2012
  - 60/40 Cash to Equity ratio (as for initial consideration)
  - Payable August 2012
  
- **Rationale for acquisition**
  - Met all three of our acquisition criteria:
    - Customer Base (c.250 software customers, c.10% overlap with Craneware)
    - Products (5 complementary products)
    - Domain expertise
  
- **Valuation**
  - Based on forecast results to 30 June 2012
    - No 'Earnout' 10x EBITDA\*
    - Full 'Earnout' c.7x EBITDA\*








\* *Adjusted Earnings Before Interest, Tax, Depreciation and Amortisation*

## Status of Acquisition/Integration

### Consideration

-  Deal completed 17 February 2011
-  \$9 million cash paid (from \$31.2m (H1:2011) cash reserves)
-  641,917 new shares
  -  24,186 outstanding to be issued (3 minority shareholders)
  -  Total Issued Share Capital (once completed) – 26,816,867

### Integration

-  Working Capital/Completion Balance Sheet – Finalised
  -  No impact on headline consideration
-  90 day Integration Plan – Complete, includes:
  -  Sales teams cross trained, management aligned
  -  Marketing: common branding and messaging – “Craneware InSight”
  -  Contracting: established foundation for new customers on Annuity SaaS model
-  Intangible Valuation exercise – underway

## Changes to Financial Reporting

### PROFIT & LOSS

- Include InSight Financial Results
  - FY11 c. 4 months results consolidated – EBITDA neutral
  - FY12&13 ~1-2 % EBITDA margin reduction
  
- Revenue
  - Now 3 elements contributing to future visibility
    - Annuity SaaS (long term contracts)
    - Renewals
    - Monthly payments
  
- Adjusted EBITDA/EPS
  - Adjusted for:
    - Transaction related costs
    - Acquisition related Intangible asset amortisation
    - Fair Value adjustments to Contingent Consideration (future years)

## Changes to Financial Reporting

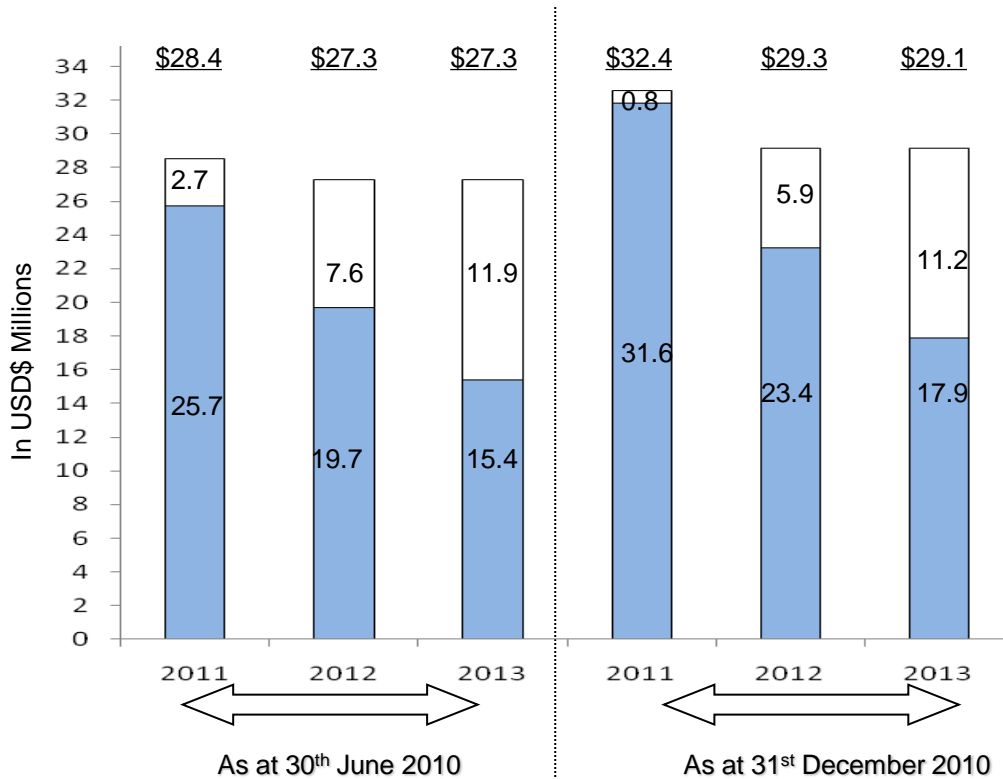
### BALANCE SHEET

- Consideration
  - Cash \$9 million reduction
  - Increase shares in issue – 641,917 acquisition related
  
- Claimtrust – Net Assets Acquired
  - ~\$1.8m
  - Subject to FV exercise
  
- Goodwill
  - Include FV of contingent consideration
  - Separately identify Intangible assets

# Changes to Financial Reporting

## Key Performance Indicators

- Future Revenue Under Contract



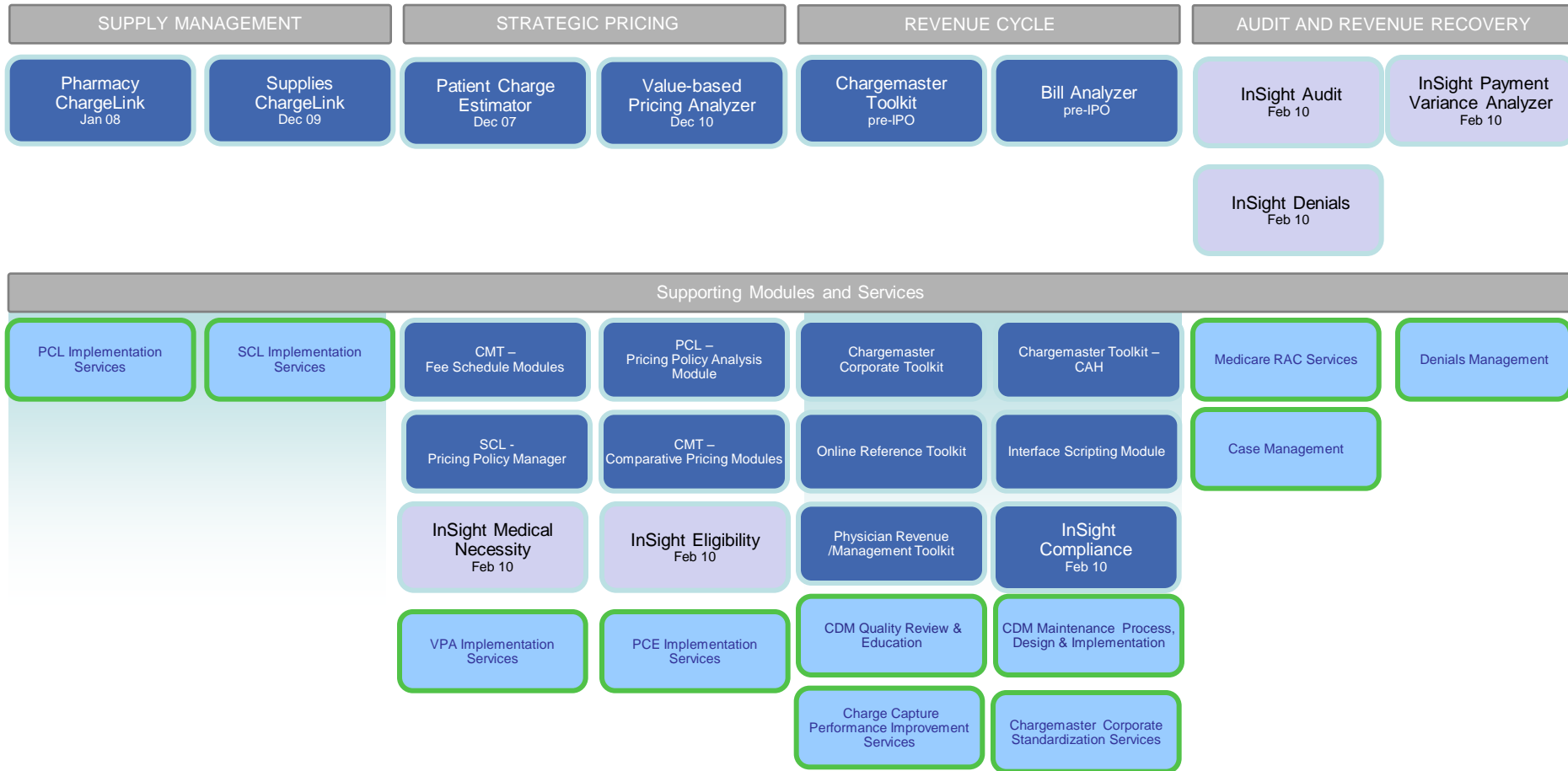
- Introduce '3rd' Category – Monthly Income

## Changes to Financial Reporting

### Product Attachment Rate

- Core Products
  - 6 Craneware
  - 3 of 5 InSight Products defined as 'Core': included in PA calculation
  - 2 (Medical Necessity & Compliance): to be sold as modules therefore not included in PA calculation
  
- Blended Product Attachment Rate
  - Craneware H1:2011: 1.7 products out of 6 products
  - InSight: c.60% of customer base with Core products
  - Blended Product Attachment rate 1.5 out of 9 products
    - Reflects increased market opportunity

# Craneware 'Core' Products



**Questions?**

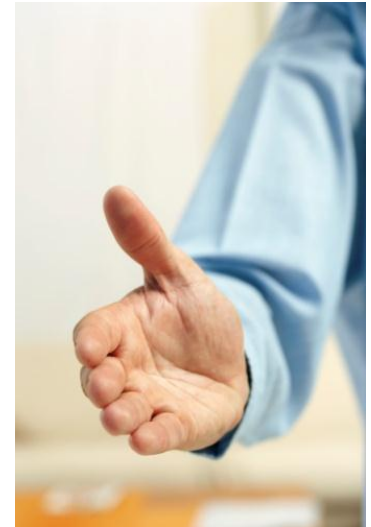
# **Craneware InSight Corporate Overview**

**Joe Ferro**

Executive Vice President, Craneware InSight

## ▶ Introduction: Craneware InSight

- ClaimTrust acquired by Craneware in Feb 2011, renamed Craneware InSight
- Founded in 1998 as a seamless front-to-back software for Medicare clinical services, now offers a full suite of Revenue Cycle Solutions
- Installations in 250 Hospitals in all 50 states, only 10% overlap with Craneware clients
- Offices in Nashville, TN and Boston, MA





# Market & Product Overview

## Business Opportunity: Revenue Integrity

- The Market - The Time is Now
  - Hospitals Margins are under pressure with reduced reimbursement from government and commercial payers
  - The Financial crisis has eliminated investment income putting pressure on hospitals to look for other sources of cash
  - Billing rules complexity continue to increase
    - 5010 & ICD-10
  
- Craneware InSight – The Right Stuff
  - Combined Product Set has the best/most effective coverage
  - Experienced, highly effective staff, unique in the industry

## Our Focus Makes the Difference

- We are Specialists who focus on hospital revenue generation
  
- Increase Cash
  - Most Effective Revenue Cycle Improvement
    - Clinical editing to the Payer-plan Level for Hospital's payers
    - Find missing codes
    - Workflow across departments
    - Denials root cause analysis
  - Save Time
    - Reduced re-work
    - Reduced Denials
    - Real-time claim correction revalidation
  - User Friendly/Flexible
  - All Payers
  
- Generalists can't match this!

## InSight Product Delivery

- Fully-Hosted Solution - SaaS
- Browser-Based, Secure and HIPAA Compliant
- Statement on Auditing Standards No. 70: Service Organizations – SAS 70
- FIPS 140-2 Encrypting methodology compliant data center (U.S. Federal Government security requirement)

# ▶ Craneware InSight Product Overview

All products are web-based



## Audit & Revenue Recovery

- InSight Audit
  - Audit tracking, reporting, and workflow system
- InSight Denials
  - Denials Management System
- InSight Payment Variance Analyzer
  - Contract Management System



## Strategic Pricing – Patient Access Support Modules



- InSight Medical Necessity
  - Medical Necessity and Authorization Pre-Screening System
- InSight Eligibility
  - Eligibility Verification







# Audit & Revenue Recovery

## InSight Denials

### **The Problem**

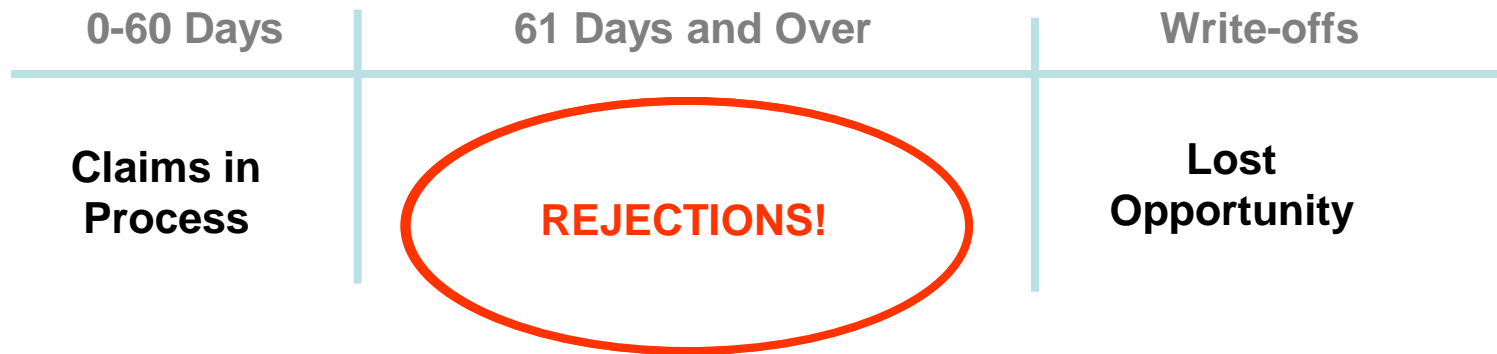
-  The typical U.S. hospital loses 7%-10% of its revenue to denied claims that could have successfully been corrected and resubmitted.<sup>1</sup>
-  A denial is a payers response to request for payment, there are thousands of denial reasons

### **The Solution – InSight Denials**

-  Capture, qualify and measure denials
-  Manage denial follow-up
-  Prevent denials before they occur
-  Reporting tools to manage and track performance

*1. HFMA Payment & Reimbursement Forum, Best Practices for a Denials Prevention Program, (June 2008)*

## Hospitals Lose Significant Revenue Due to Denied Claims



### Current Remittance Advice Processing Doesn't Tell the Story

- Accounts are worked one by one in alphabetical order
- Trends can not be established
- Rejection data is never aggregated

### Good Receivables Are Written-off Because :

- Rejections are inappropriately written off (as contractual adjustments)
- The real issue isn't understood
- Rejections age beyond appeal due to lack of follow up or focus

## Typical Rejection Processing

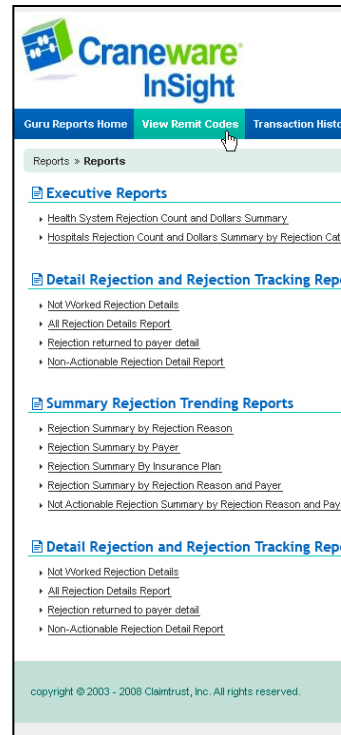
- Issues arise in managing rejections because of:
  - Delay in response by other departments
  - Lack of good communication tools and use of a “common language”
  - Poor tracking tools to identify which claims have been corrected and which have not
  - Missed appeal file limits
  - Limited knowledge of how to “fix the problem”
  - No aggregated, detail data that show trends

## **Craneware's Denial Management Strategy**

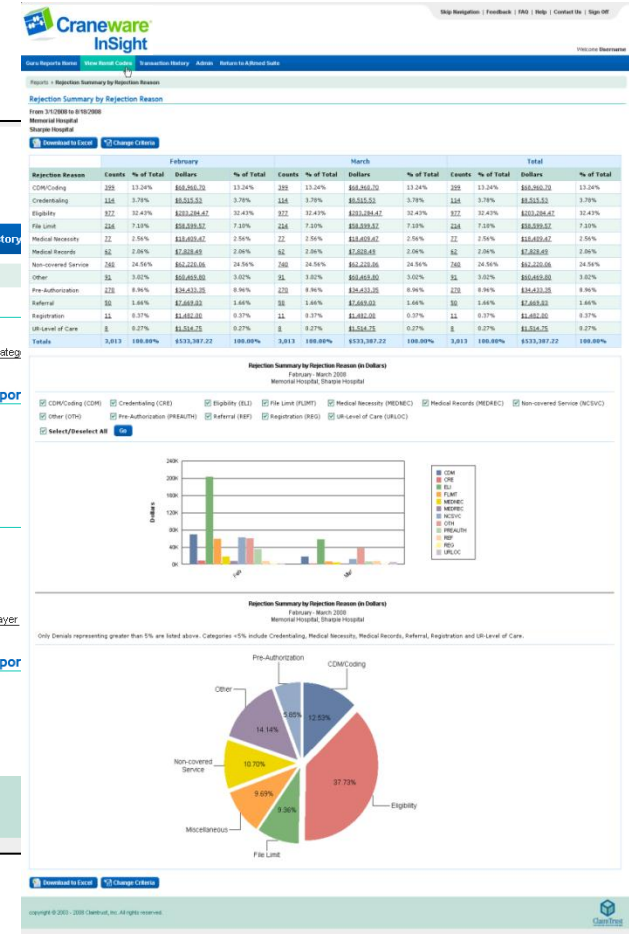
- 1. Collect and aggregate rejection data**
  
- 2. Prevent recurrence of rejections**
  - Trend significant issues by payer and reason
  - Perform root cause analysis
  - Develop corrective action plan
  - Monitor
  
- 3. Correct rejected claims**
  - Identify owner
  - Distribute rejected claims to owners
  - Embed knowledge into system
  - Track and report on un-worked
  - Track worked not closed

# Craneware's InSight Denials Reports

- Dashboard of Key Performance Indicators
  - % Rejected Claims
  - Top 3 Claim Error and Rejection by Reason
  - Error volume by Payer and Reason
- Summary and Trending Reports
  - Error Type
  - Payer
  - CPT
- Root Cause Analysis Reports
- Workflow tracking and productivity reports
- On click drill down to details
- Graphical and Tabular Displays
- Download to Excel



The screenshot shows the Craneware InSight web application interface. At the top, there is a navigation bar with links for 'Guru Reports Home', 'View Remit Codes', and 'Transaction History'. Below this, a sidebar menu lists various report categories: 'Executive Reports' (including Health System Rejection Count and Dollars Summary, and Hospitals Rejection Count and Dollars Summary by Rejection Category), 'Detail Rejection and Rejection Tracking Report' (including Not Worked Rejection Details, All Rejection Details Report, Rejection returned to payer detail, and Non-Actionable Rejection Detail Report), and 'Summary Rejection Trending Reports' (including Rejection Summary by Rejection Reason, Rejection Summary by Payer, Rejection Summary By Insurance Plan, Rejection Summary by Rejection Reason and Payer, and Not Actionable Rejection Summary by Rejection Reason and Payer). A footer note states 'copyright © 2003 - 2008 Claimtrust, Inc. All rights reserved.'

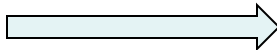


The screenshot displays a detailed denial report from Craneware InSight. The report is titled 'Rejection Summary by Rejection Reason' for the period 'From 3/1/2008 to 3/15/2008' at 'Memorial Hospital, Chicago Hospital'. It features a table with columns for 'Rejection Reason', 'Counts', '% of Total', and 'Dollars' for both February and March. Below the table, there are two charts: a bar chart showing 'Rejection Summary by Rejection Reason (in Dollars)' for February and March 2008, and a pie chart showing 'Rejection Summary by Rejection Reason (in Dollars)' for the same period. The pie chart highlights 'Eligibility' as the largest category at 37.73%, followed by 'Non-covered Service' at 10.70% and 'File Limit' at 9.36%. A legend for the pie chart includes categories like 'CDM Coding', 'Other (OTH)', 'Pre-authorization (PREAUTH)', 'Referral (REF)', 'Registration (REG)', and 'UR-Level of Care (URLOC)'. The bottom of the page includes a footer with 'copyright © 2003 - 2008 Claimtrust, Inc. All rights reserved.'

## ▶ Example Customer Results

Fiscal Year	Gross Patient Services Revenue	Denial Write-offs	%GPSR
FY 2003	1.6 Billion	12.2 Million	.77%
FY 2004	1.7 Billion	7.7 Million	.45%
FY 2005	1.8 Billion	6.1 Million	.34%
FY 2006	1.9 Billion	5.6 Million	.29%
FY 2007	2.0 Billion	4.7 Million	.23%

## Improved Efficiency and Better Cash Flow

FY 2003: 12-15% Rejection Rate  FY 2007: 5-7% Rejection Rate

## Success Stories



- Multi-million dollar recoveries once data aggregated
  
- Sustainable reduction in rejections
  - Less rework
  - Faster cash
  
- Customer feedback

*“At St. Elizabeth’s Medical Center alone, we have seen well over 60% reduction in write offs and I credit the InSight Denials Workflow as the tool that has enabled us to achieve that success.”*



Katherine Fehser  
VP of Patient Access Service

## InSight Audit

### The Problem

-  A variety of Audits are increasing financial risk and creating administrative burden
-  The biggest threat is Medicare's Recovery Audit Contractors (RACs), with \$1.3 billion in overpayments retroactively collected from hospitals so far

### The Solution – InSight Audit

-  Covers all audits – RAC, MAC, MIC, ZPIC, CERT, OIG, and even commercial payer audits
-  Track and manage every aspect of every audit case

## InSight Payment Variance Analyzer

- The Problem
  - Incorrect payments cause lost revenue that is nearly impossible to track and resolve
  
- The Solution – InSight Payment Variance Analyzer
  - We model the contracts
  - Identifies any payment at variance to payer contracts
  - We enable you to recover revenue that you are contractually entitled to



# Strategic Pricing

Patient Access Support Modules

## InSight Medical Necessity

- The Problem – Medical Necessity and Prior Authorization Denials
  - Did not validate Medical Necessity and/or get Prior Authorization
  - Poor or insufficient data on payer policies and guidelines
  - Never gave patient an Advanced Beneficiary Notice (ABN) or Notices of non-coverage (NONCs)
  
- The Solution – InSight Medical Necessity
  - Customized with hospital's payers, not limited to Medicare
  - Validates Medical Necessity and flags when prior authorization needed
  - Use anywhere - Registration, Admissions, Order Entry, Medical Records and External Physical Practices
  - Up-to-date payer policies and guidelines available to review. Rules are built into the system and updated weekly
  - Automatically create ABNs and NONCs

## InSight Eligibility

- The Problem – Eligibility Denials
  - Incorrect payer is often billed because existing procedures and tools meant to verify eligibility are slow and cumbersome, using up time and resources that hospital staff do not have.
  - Non-adoption of other eligibility solutions (phone call to payer, payer websites, or POS machines) result in lost or delayed payment
  
- The Solution – InSight Eligibility
  - Verify Eligibility instantly when you need it – at Scheduling, while the patient is with you at Registration, or at any point in the revenue cycle.
  - Eligibility response displays everything staff needs to know about patient’s coverage (e.g., copays, limitations, out-of-pocket amounts, primary and co-insurance amounts, dependent information)
  - Prevent payer denials and billing rework on the front-end
  - Also available integrated with InSight Medical Necessity

**Questions?**

# Recovery Audit Contractors (RACs)

**Karen Bowden**

Senior Vice President, Craneware InSight

## Background

- Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress directed DHHS to conduct a 3 year demonstration using Recovery Audit Contractors (RACs) to detect and correct improper payments
  
- Improper payments:
  - Services that don't meet medical necessity
  - Coding errors
  - Failure to submit requested documentation

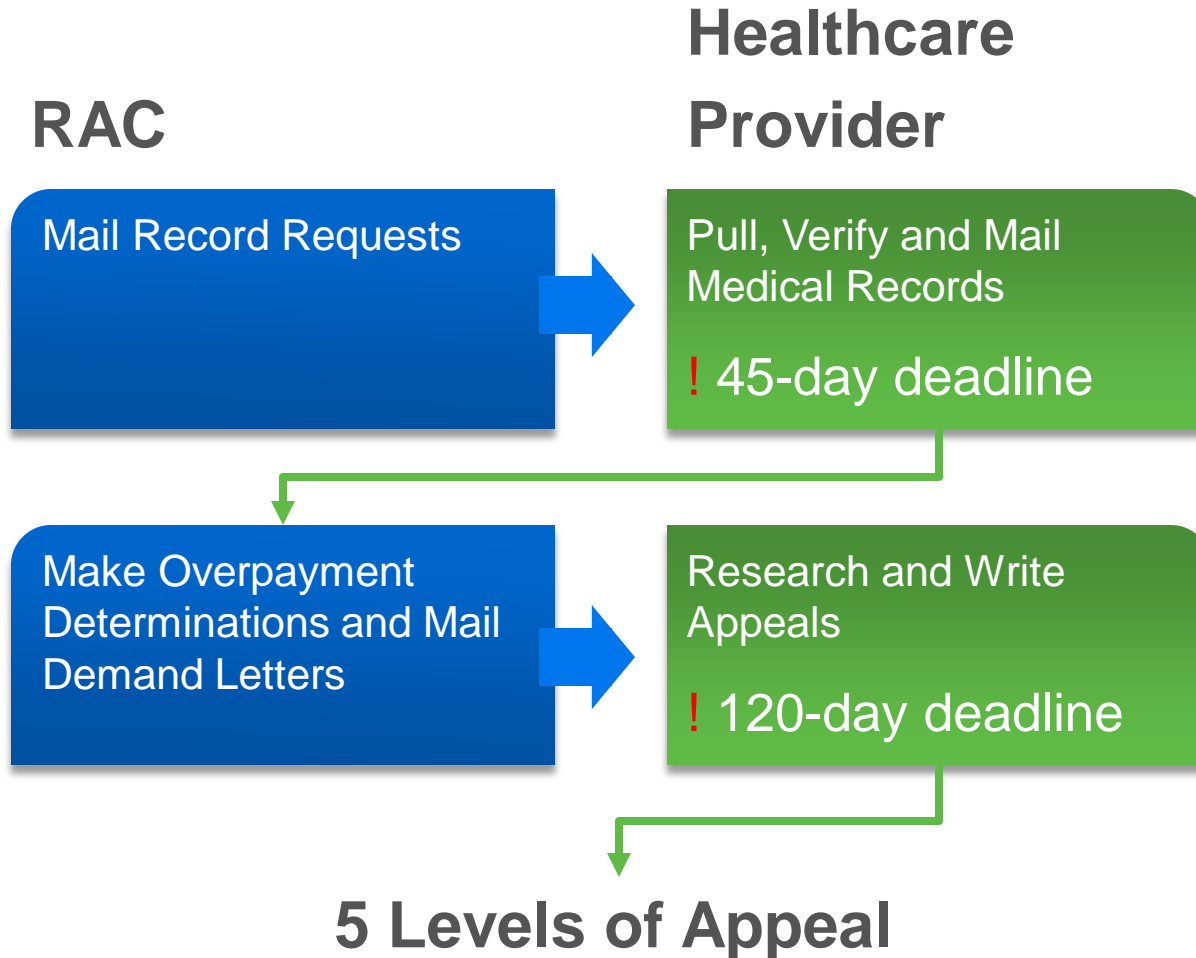
## RAC Demonstration Project

- Five states were selected for the Demonstration pilot (California, Florida, New York, Massachusetts, South Carolina). The pilot ran for 3 years (2004 – 2007)
- Center for Medicare and Medicaid Services (CMS) awarded contracts to 3 companies who were paid a contingency fee (averaging about 30%) for finding Medicare overpayments in a 4 year look back period

## **Demonstration Process**

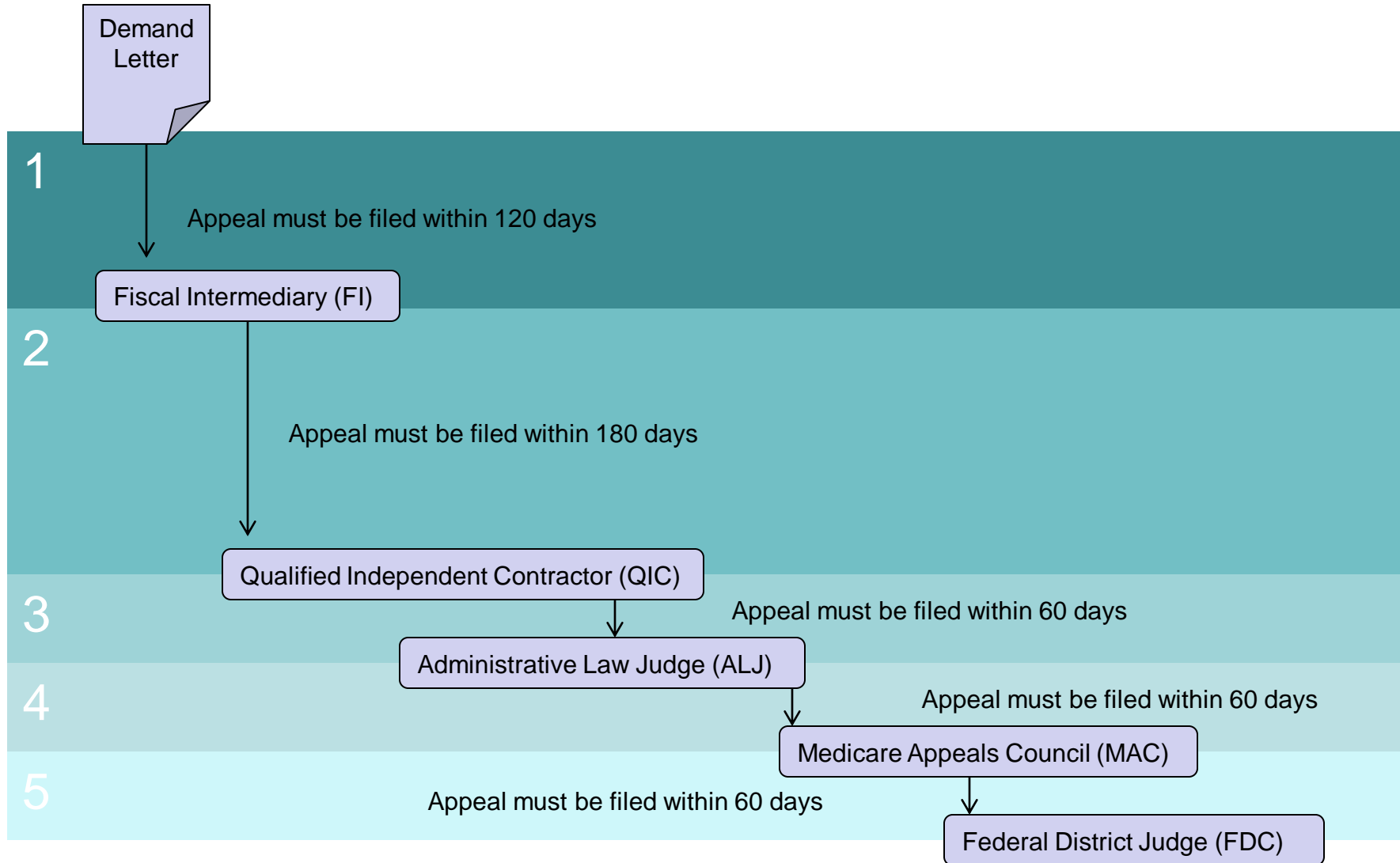
- RACs requested an unlimited number of records from healthcare providers in CA, NY and FL. Record requests were limited to one round of 100 records per healthcare providers in MA and SC
- The volume of chart requests and denials overwhelmed healthcare providers
- Healthcare providers were not adequately staffed or prepared to respond in a timely manner to the 5 step Medicare appeal process
- Payment was immediately recouped from current payments upon RAC denial

## ➤ RAC Review Process



<sup>1</sup> National averages as reported by the American Hospital Association, AHA RACTrac Nationwide Results, <http://www.aha.org/aha/content/2011/pdf/Q4ractracresults.pdf> (Feb 24, 2011)

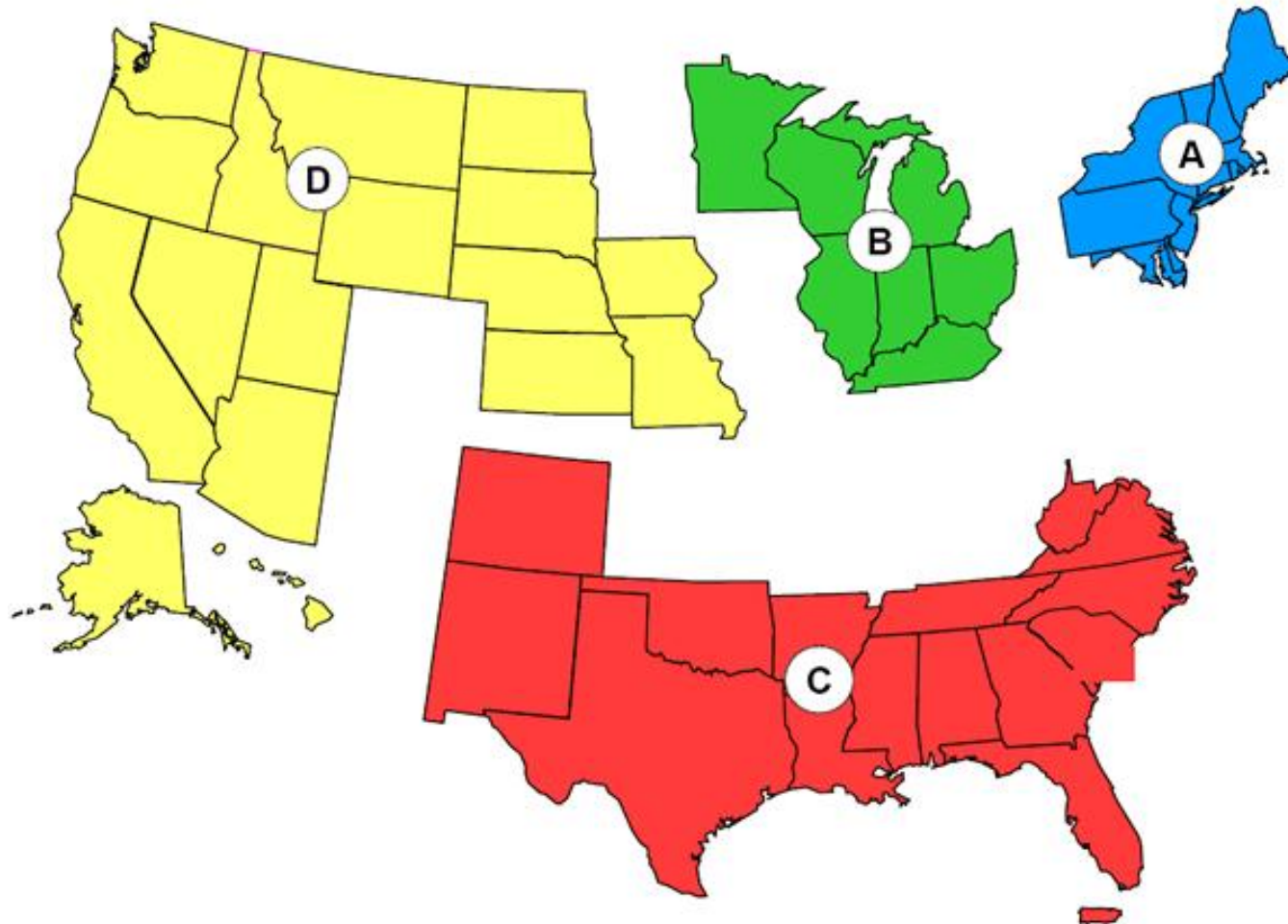
# RAC Appeal Process



## **Demonstration Project Led to Full Roll Out of RAC**

- Centers for Medicare and Medicaid Services deemed RAC a success > \$1 billion in payment errors, \$983 million in overpayments was recovered
- The U.S. Congress authorized the permanent RAC program in 2006 and regulated that it be rolled out nationwide by January 1, 2010. President Obama reconfirmed the RAC roll-out in the Patient Protection and Affordable Care Act
- The country has been divided into 4 RAC regions.

## ▶ RAC Regions



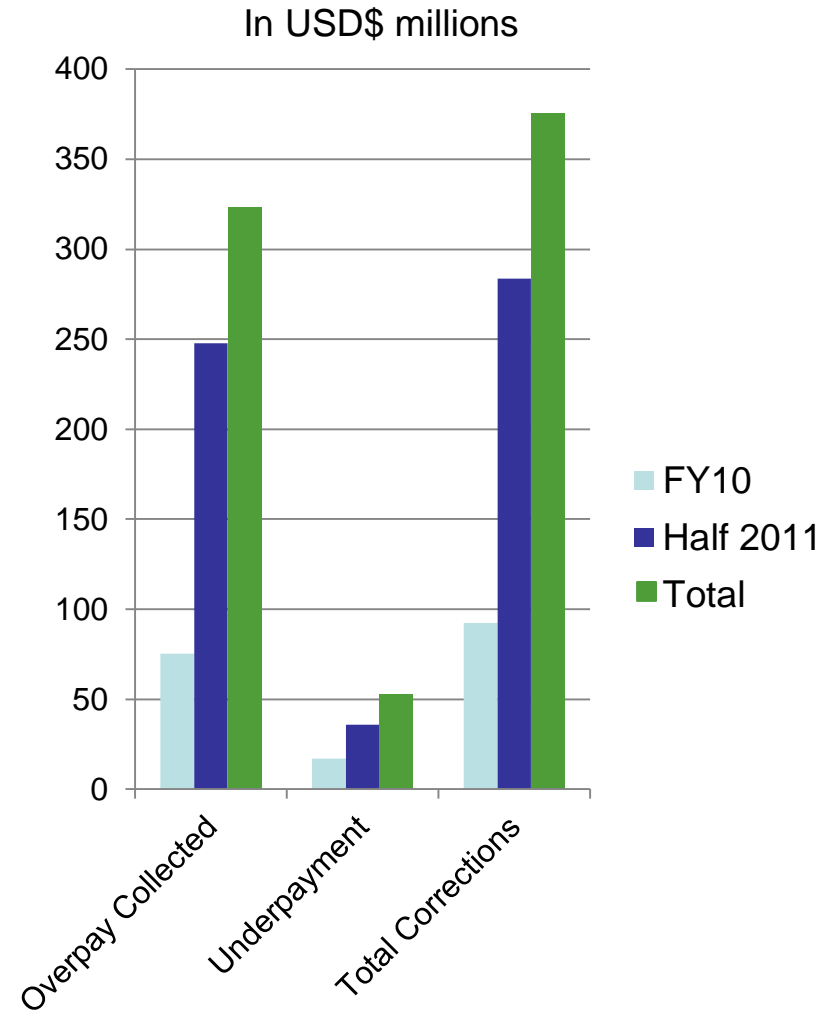
## ▶ The Permanent RAC Program

Program Rules	Demonstration	Permanent Program
Look Back Period	4 years	3 years
Audit Focus	Any reason	Must show “just cause” and gain CMS approval
Record Limit	Unlimited per 45 days	1% Medicare claims; maximum 500 records per 45 days
RAC Payment	30% of overpayment even if overturned on appeal	12.5% overpayment and underpayment but must survive appeal
Provider Payment	Recouped upon RAC denial	Recouped if not appealed within 30 days at level 1 or 60 days at level 2.
Rebilling options	Inpatient denials could be re-billed as outpatient from any date	Inpatient denials can be re-billed as ancillary services only and only within 1 year of the original payment

## Permanent RAC Status

	<b>FY10</b> (Year to 30 September 2010*)	<b>FY11 Half Year</b> (to 31 March 2011)	<b>Total</b>
Overpayment Collected in millions	\$75.4	\$247.8	\$323.2
Underpayment Identified in millions	\$16.9	\$35.7	\$52.6
Total Corrections in millions	\$92.3	\$283.5	\$375.8

\* FY10 only includes 9 months of RAC program



## ▶ Top Issues/Challenges for Healthcare Providers in the RAC Permanent Program

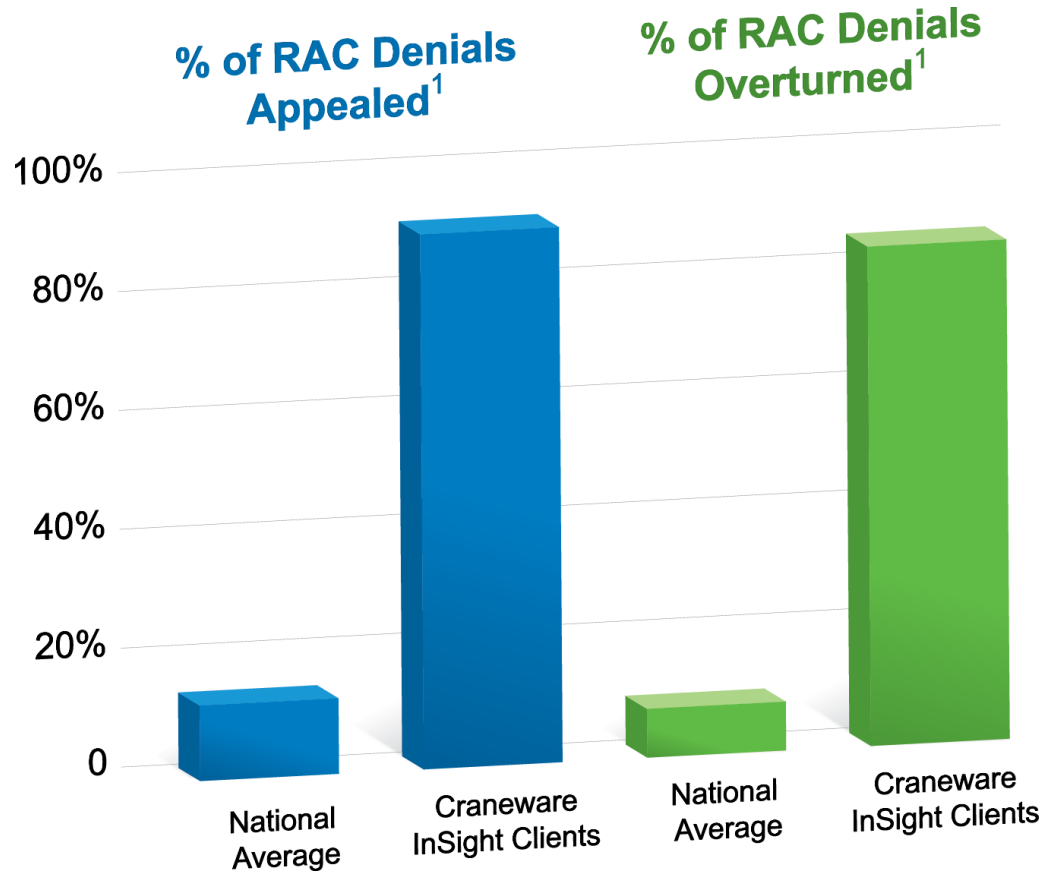
- Reporting (financial exposure, denials, appeal success)
- Tracking correspondence and staying on top of expected response times
- Lack of Available Skilled Appeal Resources
  - Know-how to make arguments
  - Possess excellent writing skills
- Costs of Administration of the Program
  - The literature reports an average hospital's cost to appeal is \$2,000 per record

## ▶ Craneware InSight RAC Appeal Experience in the Demonstration Program

- Craneware InSight worked with 8 Massachusetts hospitals in 2007 in the RAC Demonstration Program
  - A total of 800 records were requested
  - 385 denials ( 48%)
  - Craneware InSight appealed 347 denials (90%). Nationally only 12.7% of RAC denials were appealed\*
  - Craneware InSight won 323 appeals (93% success rate). Nationally 65% of appeals were won\*
  - Craneware InSight's appeal work returned \$8.1 million to its clients

*\*The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration  
June 2010, CMS*

## ▶ Comparing Results



<sup>1</sup>The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, June 2010, CMS

## ▶ Lessons Learned from Demonstration Project = Business Opportunity for Craneware InSight

- Facilities must have an automated tracking and reporting tool
  - We developed software system InSight RAC
    - Developed with consultants based on our experience
    - Knowledgebase is loaded with data from our experience
  - Quickly expanded system capability beyond RAC to other payer audits
  
- Facilities will likely need help writing appeals and managing the RAC process
  - We know how to overturn denials by winning appeals
  - Appeals can be done from a central location
  - Precedent setting, reasoned responses linked to Medicare regulation

## InSight Audit – Module Overview

- Organizes, manages and reports on all audit requests, responses and appeal activities for all payers and audit types
- Stores relevant information and document the steps taken to appeal denials
- Quickly identifies and trends areas of exposure



## InSight Audit – Feature Overview

- Patient Record – Track all data associated with audits and appeals
  - Complete Document Repository
  
- Workflow – Manage record requests and appeals across multiple departments and locations
  - Knowledgebase – letter templates, winning arguments from real experience
  - Proactive Deadline Warnings
  - Efficient and tracked interdepartmental communication
  
- Reports – Identify areas of risk, etc.
  - Dollars at risk, deadline reporting, win/loss reports, trending, volume by DRG and CPT

## InSight Audit Competitors

Competitor	Software	Appeals
Healthport	Yes	No
Med Assets	Yes	No
McKesson	Yes	No
Greater NY Hospital Association	Yes	No
Compliance 360	Yes	No
Advisory Board	Yes	No
Homegrown Systems	Yes	No

## **Craneware InSight Audit Differentiators**

- **Audit Tool**
  - Handles multiple audit types
  - Built with input from users
  - Ability to quickly adapt to changes identified by consultants
  - Tool houses our “intelligence”
    - Ever growing library of reference documents
    - ALJ responses
- **Extremely successful appeal experience in the RAC Demonstration Program**
- **Feedback to clients**

**Questions?**



# GLOSSARY

**ABN** - Advanced Beneficiary Notice is a report given to Medicare beneficiaries to let the patient know Medicare is not likely to pay for certain services. The notice must be given to the patient before services are performed if the healthcare provider is to bill for this service.

**ACO** – Accountable Care Organisation is a type of payment and delivery reform model that starts to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. [Kaiser Permanente](#) and [HealthCare Partners Medical Group](#) are two examples of established ACOs.

**Capitation** - Under a capitation system, healthcare service providers are paid a set amount for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time.

**CERT** – Comprehensive Error Rate Testing program was designed to be a measurement of improper payments. The program calculates the Medicare Fee-For-Service error rates for all Medicare Administrative Contractors (MACs). MACs are the new claims processing entities created under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA; Public Law 108-173).

**CMS** - Centers for Medicare & Medicaid Services (CMS), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the [United States Department of Health and Human Services](#) (DHHS) that administers the [Medicare](#) program and works in partnership with state governments to administer [Medicaid](#), the [State Children's Health Insurance Program](#) (SCHIP), and [health insurance](#) portability standards.

**Commercial Payer** – See Third Party Payer

**CPT** - Current Procedural Terminology (CPT) code set is maintained by the [American Medical Association](#) through the CPT Editorial Panel<sup>[1]</sup>. The CPT code set accurately describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

**Denial** – A notice from a third party payer of non-payment for a line item or entire claim of a medical bill.

**FIPS 140-2** The [National Institute of Standards and Technology](#) (NIST) issues the 140 Publication Series to coordinate the requirements and standards for cryptographic modules which include both hardware and software components for use by departments and agencies of the [United States](#) federal government.

**Healthcare Provider** is typically used to refer to a hospital but can refer to any individual or institution that provides preventive, curative, promotional or rehabilitative [health care](#) services in a systematic way to individuals, families or communities.

**HIPAA** - Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191) [HIPAA] was enacted by the [U.S. Congress](#) in 1996. HIPAA protects [health insurance](#) coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of [electronic data interchange](#) in the U.S. health care system.

**HITECH** - Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the [American Recovery and Reinvestment Act of 2009](#), addresses the privacy and security concerns associated with the electronic transmission of health information.



# GLOSSARY

**ICD** – The International Statistical Classification of Diseases and Related Health Problems (ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease as well as procedural based medicine. The International Classification of Diseases is published by the [World Health Organization \(WHO\)](#) and used worldwide for morbidity and mortality statistics, reimbursement systems and automated decision support in medicine. The ICD is revised periodically and is currently in its tenth edition. The [ICD-10](#), as it is therefore known, was developed in 1992 to track mortality statistics.

**IDN** - An Integrated Delivery Network (IDN) is a network of Hospitals and providers working together to offer a continuum of care to a specific market or geographic area.

**MACs** are the new claims processing entities created under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA; Public Law 108-173).

**Medicare** is a [social insurance](#) program administered by the [United States government](#), providing [health insurance](#) coverage to people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria.

**Medicaid** is the [United States health](#) program for people and families with low incomes and resources. It is a [means-tested](#) program that is jointly funded by the state and federal governments, and is managed by the states.

**MIC** – Medicaid Integrity Contractor similar to RACS but focused on MEDICARE claims with state dependent differences to the length of look back, number of days to appeal, number of medical records that can be reviewed and the dollars MICs recover aren't tied to their compensation, although they will be eligible for bonuses based on how “effective and efficient” they are.

**OIG** – Office of the Inspector General is an office that is part of [Cabinet departments](#) and [independent agencies](#) of the [United States federal government](#) as well as some state and local governments. Each office includes an [Inspector General](#) and employees charged with identifying, [auditing](#), and investigating fraud, waste, abuse, and mismanagement within the parent agency.

**QIC** – Quality Improvement Committee – See RAC

**RAC** - Recovery Audit Contractor, or RAC, program was created through the [Medicare Modernization Act of 2003](#) (MMA) to identify and recover improper [Medicare](#) payments paid to healthcare providers under [Fee-For-Service Medicare plans](#) (FFS plans). The [United States Department of Health and Human Services](#) (DHHS) is required by law to make the program permanent for all states by January 1, 2010 under section 302 of the [Tax Relief and Health Care Act of 2006](#)

**Self Pay** – The component of a medical bill paid by the patient.

**Third Party Payer** - an organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services. Where this organisation is a for profit non- public funded company it may be called a Commercial Payer.

**ZPIC**- Zone Program Integrity Contractors are similar to RAC's with the emphasis on non-hospital providers.