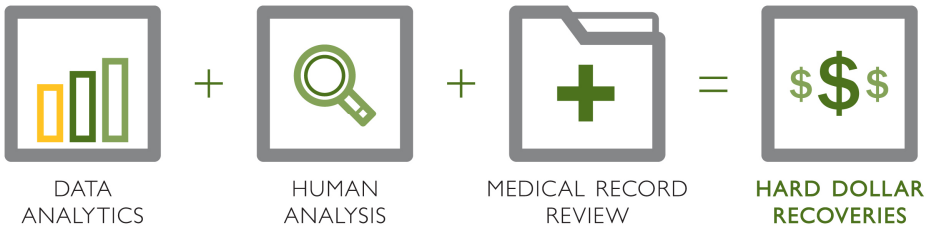
INPATIENT DIAGNOSIS RELATED GROUP (DRG)

SERVICE OVERVIEW

VARIS' 16-year audit history has familiarized us with all of the DRG variations, such as MS-DRG, APR-DRG, CMS-DRG, AP-DRG, and TRICARE-DRG. The exceptional knowledge and expertise of VARIS' certified coding and clinical professionals coupled with our advanced methodology, analytics and technology is evidenced in finding overpayment errors in 75% of the DRGs. As an innovator in DRG reviews, VARIS' Team has identified over One Billion dollars in overpayments, resulting in hard dollars back to the health plan's bottom line.

TAP_{Rx} REVIEW PROCESS

VARIS' proprietary tri-level, risk analysis and stratification process (TAP_{Rx} Review) provides the most thorough recovery audit reviews in the industry. 100% of the health plan's inpatient DRG claims data is reviewed at some level during our process, *resulting in up to 3% return on your total paid DRG claims dollars.*



DRG COMPLEX MEDICAL RECORD REVIEW

The detailed complex chart review commences with a meticulous comparison of the elements from the medical record with the claims and provider data. The documentation contained in the medical record must support every individual diagnosis and procedure code submitted on the claim in accordance with ICD-10-CM/ICD-9-CM Manuals, approved coding guidelines and *AHA Coding Clinic* interpretations. The instructive manuals, guidelines and interpretations utilized are date-specific and applied based on date of service. The Coding Validation Specialist (CVS) will validate that all the medical documentation present substantiates that correct codes were billed to the health plan.

SERVICE TYPES

Inpatient DRG reviews can be conducted in a pre-pay, post-pay, or onsite environment, all yielding recoveries.

For more information, please contact VARIS:

(916) 294-0860 or info@varis1.com

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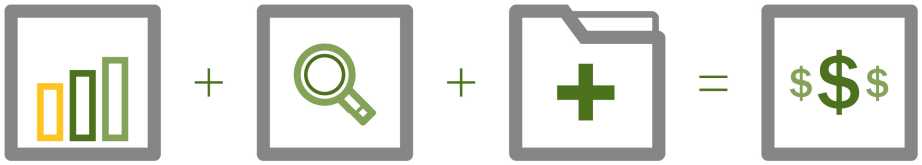
OUTPATIENT / AMBULATORY PAYMENT CLASSIFICATION (APC)

SERVICE OVERVIEW

Outpatient services represent a fast growing segment in healthcare expenses today. Due to the high volume of outpatient claims, there is a great potential to recover significant dollars in overpayments. The Ambulatory Payment Classification (APC) prospective payment system is a system designed to define and explain the amount and type of resources used during a single outpatient visit.

TAP_{Rx} REVIEW PROCESS

VARIS' proprietary tri-level, risk analysis and stratification process (TAP_{Rx} Review) provides the most thorough recovery audit reviews in the industry. 100% of the health plan's outpatient/APC claims data is reviewed at some level during our process, *resulting in up to 3% hard dollar recoveries back to the bottom line.*



APC COMPLEX MEDICAL RECORD REVIEW

VARIS' Coding Validation Specialists (CVS) are experienced in measuring the validity of assigned CPT codes and HCPCS Level II in the outpatient setting. The CVS reviewers are expertly trained and certified at a mastery level by AHIMA and/or AAPC, and validate payment information against the medical record documentation to ensure charges were billed according to national coding standards and client regulations and policies, and AMA CPT Assistant interpretations and other appropriate reference documentation. Records received are comprehensively reviewed and validated by our health information management professionals.

SERVICE TYPES

Outpatient/APC reviews can be conducted in a pre-pay, post-pay, or onsite environment, all yielding recoveries.

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CLINICAL VALIDATION

SERVICE OVERVIEW

Clinical validation is an additional process that may be performed along with DRG validation to ensure accuracy of payments. Clinical validation involves a clinical review of the cases to see whether or not the patient truly possesses the conditions that were documented in the medical record. Diagnoses documented in the patient's medical records must be substantiated by clinical criteria generally accepted by the medical community. This may result in claims denial when the clinical indicators in the record do not support the reported diagnoses and procedures.

Clinical validation is performed by a clinician (RN/MD).

CLINICAL VALIDATION REVIEW

The Clinical Validation Team at VARIS applies extensive knowledge of clinical criteria and guidelines when reviewing MS-DRG, AP-DRG, and APR-DRG data.

VARIS maintains current knowledge of the clinical guidelines and updates the criteria as needed. At VARIS, a physician makes the final determination as to when the criteria are not met.

Specialized in providing recovery audit and clinical validation services to clients ranging in member size, from 2,000 members to over 15+ million members, including one of the nation's largest payers, we have experience in analyzing billions of dollars of healthcare claims to identify more than a billion dollars in overpayments.

SERVICE TYPES

Clinical Validation can be performed in either a pre-pay or post-pay environment, yielding recoveries.

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READMISSIONS

Readmissions: What is it?

As defined by Centers for Medicare and Medicaid Services (CMS), “a hospital readmission to an acute care hospital within 30 days of discharge from the same acute care hospital or health system.”

Goal of Readmissions Program: What is it?

The goal of VARIS’ readmissions program is to assist health plans in recovering dollars spent unnecessarily by identifying potentially preventable readmissions within a 30-day time period.

VARIS’ Post-Pay Readmission Review Services.

As an adjunct to our DRG review program for Medicare Advantage health plans, VARIS will apply CMS requirements and guidance to acute care facilities that are paid based on Medicare Severity Diagnosis Related Group (MS-DRG) payment methodology.

Utilizing VARIS’ proprietary TAP_{Rx} Review process which encompasses data analytics/Artificial Intelligence (AI), human analysis and complex medical record review allows VARIS to select and review those claims with the highest probability of overpayment.

All readmissions reviews are conducted by an experienced team of Registered Nurses and physicians. We do not conduct any offshore or nearshore activities and do not contract out.

About VARIS

VARIS provides inpatient and outpatient overpayment identification services to health plans of all size and scope throughout the United States and Puerto Rico. Specializing in pre-pay, post-pay and onsite audits, allows for health plans to maximize hard dollar recoveries.

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EMERGENCY DEPARTMENT (ED) LEVELING

SERVICE OVERVIEW

The leveling of Emergency Room services (ED Leveling), is a payment strategy that reimburses providers and facilities based on the diagnosis' complexity and severity.

Facility coding guidelines are inherently different from professional coding guidelines. **Facility coding** reflects the volume and intensity of resources utilized by the facility to provide patient care. Whereas **professional codes** are determined based on the complexity and intensity of provider performed work and include the expertise expended by each provider.

Health plans nationwide have seen san increase in the number of Emergency Room claims as well as an increase in the level of the CPT codes reported. Many health plans have developed program integrity strategies including policies that will provide appropriate levels of reimbursement for services that may indicate lower levels of complexity or severity rendered in the emergency room. Typically, the health plan policies define payment criteria for the Emergency Room service(s) to be used in making payment decisions and administering benefits.

VARIS ED LEVELING SERVICES

When no payment criteria have been established by a health plan, VARIS offers a proprietary ED Leveling System that was developed utilizing CMS' 11 general principles. This system was created by VARIS' specialized team of Emergency Department coding professionals with an average of 25 years of experience. VARIS' proprietary system is exemplary at identifying the intensity of facility resources to the levels of effort represented by the codes used, thereby accurately coding the E/M CPT Codes, based upon medical record documentation.

VARIS' ED Leveling System will ensure that your health plan payment criteria for ED services are met, thus allowing your plan make the best payment decisions.

ED FACILITY GUIDELINES: WHAT ARE THEY?

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to report ED facility resources using CPT® E/M service codes. CMS provided guidelines in the 2008 Outpatient Prospective Payment System Final Rule.

ED PROVIDER GUIDELINES: WHAT ARE THEY?

At the direction of the health plan, VARIS will use the CMS 1995/1997 Documentation Guidelines for E&M Services as published by CMS to determine if the medical records support the provider billing. VARIS provides ED Facility and Professional compliance review.

SERVICE TYPES

ED Leveling reviews can be conducted in a pre-pay or post-pay environment, all yielding recoveries.

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