MERITAIN® HEALTH

An Aetna Company

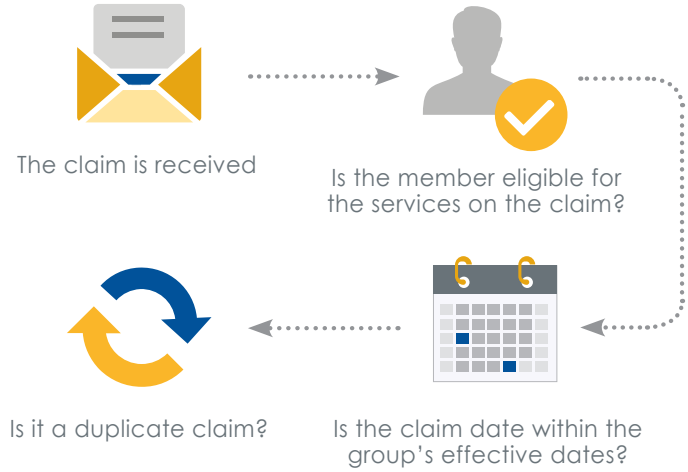
Life Cycle of A Claim

Information about our claims processing

At Meritain Health®, we are committed to working with our clients and producers to achieve the best level of cost savings through multiple approaches to claims management. The following is an outline of the steps taken to ensure each claim is appropriately reviewed and priced.

Claims flow

Upon receipt of a claim, Meritain Health starts tracking the progress of the claim to ensure timely handling. The initial claims review determines if any denials should be applied.



Meritain Health—in partnership with our trusted vendor—systematically evaluates and edits eligible claims based on our established rules. These rules produce savings of approximately four to five percent of overall claims costs.

Pricing

If we reprice a claim, we adjudicate that claim per the plan document. Meritain Health sends claims that do not have attached repricing to the appropriate network(s) for repricing. The claim is sent through the plan sponsor's selected in-network or out-of-network hierarchy until repricing is received. Meritain Health then adjudicates these claims per plan guidelines.

Claims editing

Meritain Health is continually reviewing our business processes to keep current with the marketplace. We are actively engaged in a project to upgrade our existing claims editing software, specifically to remain in compliance with ICD-10. We also make certain that our rule sets are up to date with industry standards, and continue to reflect our clients' needs. In addition, we will be implementing a rules engine component that will provide deeper support for the changing complexity of self-funded plans.

Our claims edits incorporate various industry standard reporting criteria, which include, but are not limited to:

- American Medical Association (AMA) (i.e., HCPCS Level I CPT coding and modifier logic).
- Centers for Medicare and Medicaid Services (CMS) (i.e., NCCI).
- HCPCS code-to-code logic.
- HCPCS-to-diagnosis code logic.
- Medicare Processing logic.
- Federal Register.
- National Center for Health Statistics (NCHS)/World Health Organization (WHO [ICD-9/ICD-10]).
- Food and Drug Administration (FDA).

Today, Meritain Health applies claims editing rules to all the professional claims we receive. Depending on the contractual terms of the network, in-network claims over $15,000*, as well as out-of-network claims over $15,000 are subject to an additional line-by-line review to capture additional edits, or savings recommendations.

We continually review our claims editing rules to ensure we are aligned with changing industry standards. We make necessary enhancements such as quarterly coding updates and rule changes. We manage the claims editing process within a 24- to 48-hour time frame from receipt of a claim.

Once Meritain Health has applied the claims editing rules, our processes determine if additional cost management strategies should be considered.

**Depends on the contractual terms of the network*

Cost management strategies

Meritain Health's Cost Management Solutions

Our cost management solutions allow Meritain Health to provide our clients access to the best cost management programs available. We have a strategic cost management strategy for most claims situations, including in-network, out-of-network, high-dollar, complex, pharmacy, fraud, waste, abuse and dialysis claims.

In addition, we provide proactive review that helps our clients address claims issues and take control of benefits spending. In this way, we are able to offer savings other Third Party Administrators (TPAs) cannot.

A few facts about Meritain Health's Cost Management Solutions:

- ☑ Savings are captured on 86 percent of out-of-network claims, with average discounts of 55 percent.
- ☑ Our clients saved over $411 million on out-of-network claims in 2019—almost a 15 percent increase from 2018.

Meritain Health applies specific cost management strategies in the claims process. This helps us ensure we obtain the most cost-effective pricing on behalf of our clients.

- We provide additional review and cost reductions on in-network claims $15,000* and above.
- We route in-network claims below $15,000* to a claims examiner for processing in accordance with the plan's network-contracted rate.
- Out-of-network claims below $15,000 are routed to PBS for additional savings/negotiations through an automated process.

**Depends on the contractual terms of the network*

*In-network process for claims over $15,000**

Our staff reviews the various services and charges reported by a network provider, and with the edit information, we will review the following:

- Services reported for accuracy of HCPCS codes, modifiers, units and related charges
- High-dollar drug review will be evaluated for overall impact and potential relief on a long-term basis

As needed, we contact billing offices to address in-network costs. We cannot—for the purposes of reducing charges—negotiate these charges; however, the team can contact providers/facilities regarding high-dollar claims to afford additional financial relief. They can also have reported charges/services corrected to reduce costs.

As needed, if discrepancies are found in reported services and charges, and we escalate such charges for a reported-services-and-charges audit process on a prepayment basis.

If additional cost savings cannot be achieved within the time constraints necessary for claims payment, the charges can be addressed through an on-site, post-payment, reported-services-and-charges audit process.

Out-of-network process for claims at $15,000 and above

For claims with charges of $15,000 or more, Meritain Health's Cost Management Solution removes ineligible charges, per the edits or plan design provided, and the claim is managed through a standing out-of-network contract, or handled as a negotiation.

We then negotiate these claims using benchmarks for pricing that may include, but are not limited to:

- Usual and Customary (UCR/U&C/R&C).
- Facility Charge Review (FCR).
- Medicare.
- Average Wholesale Price (AWP).
- Average Sales Price (ASP).
- Historically relevant negotiation amounts for a specific provider.

Out-of-network process for claims below $15,000

Meritain Health's Cost Management Solution sends claims with charges below $15,000 through various steps to attain the greatest potential savings. This can include the application of an established, PBS negotiated contracted rate; a negotiated rate from one of a series of vendor options; the application of a calculated reasonable rate; or a calculated Usual and Customary Rate (UCR/U&C/R&C), based on the services and claims type involved.

Additionally, we review clinical states that demand extended treatment designs and work towards securing long-term agreements.

If necessary, we work with various internal processes to escalate a claim to a full audit if the facility is not agreeable to a negotiation that is reasonable.

Final review

High-dollar claims

By utilizing Meritain Health's Cost Management Solution, clients have the advantage of the pre-pay claims review process for large claims. One hundred percent of claims with paid amounts of $15,000 or greater are automatically selected for this review prior to being released for payment. The pre-pay claims reviews are conducted by a dedicated high-dollar audit team for processing accuracy. This ensures that proper code editing, discounts and additional cost management review and recommendations are applied correctly.

Less than $15,000 paid

Once a claim is ready to be paid, it becomes eligible for audit, based on its paid amount. We select claims below a paid amount of $15,000 for audit by a random two-percent, system-generated process. Once the claim is audited and determined to be eligible for payment, we release the claim to the payment cycle. Claims not selected for audit continue through to the appropriate payment cycle.

$10,000 in denied charges

Additionally, 100 percent of denied claims with a billed amount of over $10,000 are automatically pulled for audit review to validate the denial.

If you have any questions about Meritain Health's claims processing procedures, please contact your Meritain Health representative.

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