the cypress solution

February 10, 2010

ARGUS Claim Review:
A powerful system to guard against errors and fraudulent billing

At Cypress Benefit Administrators, we are continually on the lookout for ways to save our clients money on their medical expenses. As a part of this effort, we've instituted ***the most all-encompassing fraud protection and cost containment system available: ARGUS Claim Review.*** *Many of our clients have experienced the* ***significant savings*** *generated by ARGUS.*

Following is just one example:

CASE #105:
Small dollar amounts add up to significant savings over time.

Some administrators tout their efforts to save clients money on their claim review efforts. But, it is easy for any administrator to boast about that large claim where they saved the client thousands or even tens of thousands of dollars. The fact is, the larger the bill, the larger the savings will probably be.

But what about the smaller charges – the ones under $5,000 or even $1,000? While most administrators will not waste their time on small savings, ARGUS wholeheartedly believes in the "nickel and dime" theory. That is, small incorrect charges also add up over time to become huge savings to employer health plans. Whether it is a trend of smaller charges or isolated charges here and there, **ARGUS understands that ignoring those incorrect charges would be wrong and would cost our clients in the long run.**

Some examples of smaller charges that might not be considered important enough for most administrators to consider are:

- A heart institute billed the following CPT codes: *33960 - Prolonged extracorporeal circulation for cardiopulmonary insufficiency, initial 24 hours; and 33961 - Prolonged extracorporeal circulation for cardiopulmonary insufficiency, each additional 24 hours.* These codes were listed separately in addition to a code for a primary procedure on the same date of service. Obviously, there can't be 48 hours worth of treatment on one day. CPT 33961 was denied and was not questioned by the provider. Total savings to the client: $1,357.00

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- A facility attempted to bill $742.50 on a UB92 for the professional services of a Certified Registered Nurse Anesthetist (CRNA). It is inappropriate, per Centers for Medicare and Medicaid Services (CMS) guidelines, to bill for professional services on a UB92. Additionally, we received a separate bill from an MD anesthesiologist, which together tells us that both charges should be reduced by 50%.

  Standard claim editing software does not review facility charges for issues like this. It is only through individual scrutiny of billing and itemizations that a charge like this would be caught. The CRNA charge on the facility bill was reduced by 50% for a total savings to the client of $371.25.

Individually, these savings amount may not seem like much. However, multiply these amounts by 5, 50, or 100 claims, and these amounts add up to **significant savings** for our clients.