Commentary

Cut Health-care Abuse by Stepping Up Review of Paid Claims, Pharmacy Data

By William L. Hurlock

The Patient Protection and Affordable Care Act provides for a significant increase in funding, $250 million, to identify and address abusive practices in the administration of the nation's health-care programs.

In enacting the PPACA, Congress strengthened many statutes and regulations to try to identify and curtail wasteful practices.

But the effort cannot stop there. Periodic reviews of group health and pharmacy benefit programs are needed.

The legislation, which became law on March 23, 2010, mandates new and strict penalties for health-care providers who submit false data in seeking payment. In addition, Congress enhanced the penalties for submission of false claims for payment or obstruction of an investigation relating to Medicare, Medicaid and the Children's Health Insurance Program. Moreover, the PPACA provides for a 60-day period in which a health-care provider must report, refund and explain certain overpayments it has wrongfully received.

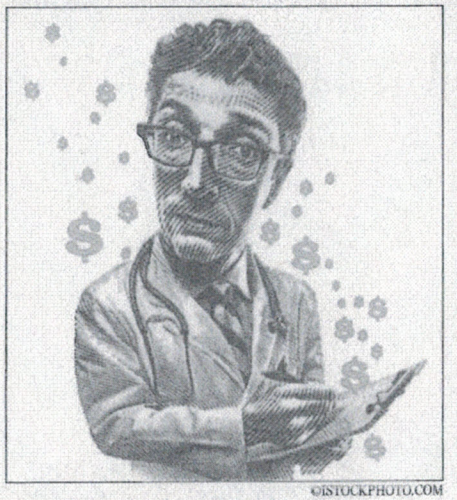
The statute requires that physician ownership in certain health-care facilities be disclosed and it strengthens and establishes reporting requirements of ownership interests in nursing home and long-term care facilities.

Transparency in the administration of pharmacy benefit managers' programs is mandated. The amount of generic drugs dispensed and the amount of drugs dispensed from retail as compared with mail-order pharmacies must be disclosed. The rebates afforded a program must also be reported to plan administrators.

The Centers for Medicare and Medicaid Services recently projected that Americans spend about $2.26 *trillion* a year for health care, according to the Federal Bureau of Investigation *Financial Crimes Report to the Public — Fiscal Year 2008*, the most recent version available as of this writing. By 2016, CMS estimates this amount will increase to more than $4.14 *trillion* per year.

This figure accounts for 19.6 percent of the total gross domestic product in the United States. The need for the changes Congress mandated becomes apparent as one becomes aware that abusive practices account for a significant portion of this spending. Indeed, the FBI report estimates that wasteful practices cost *both public and private health-care programs* about 3 percent to 10 percent of the total money spent on health care in this country.

Assuming these figures are correct, the cost of such practices will rise from $67 billion-$224 billion to $124 billion-$414 billion *per* year.



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The effort to curtail wasteful practices can't stop with the Patient Protection and Affordable Care Act.

While there is no consensus on a definition of wasteful or abusive practices, they may include, but are not limited to, charging for health-care services or prescriptions that were not provided, overcharging or double-billing for health-care services or prescriptions, and providing treatment or prescriptions that were incorrectly coded or documented.

All increase the health-care cost for every segment of the economy and place an enormous strain on overtaxed resources.

While such practices can be difficult to detect, steps can be taken to discover and stop them. Every year, private employers, trade unions, insurance carriers, managed care organizations and governmental entities spend *trillions* to administer health-care programs. These programs often contain a group health and pharmaceutical component. The group health component consists of claims for medical services. The pharmacy component concerns prescriptions.

A review of the paid health-care claims and paid prescription drug data can assist in the detection of wasteful practices. For instance, an analysis can detect instances where a health-care provider may have billed the plan twice for the same medical procedure.

A review may uncover whether a health-care provider billed for services that were never rendered or were medically unnecessary. Instances of upcoding and unbundling can also be discovered.

A review of a plan's prescription program may uncover instances where prescriptions may have been filled with invalid or incomplete physician prescriber information, often resulting in abuses.

Such practices as "shorting" — filling prescriptions with less medication than the amount charged — can be identified. These reviews can also detect whether a program is receiving the rebates it is entitled under its contracts.

The cost associated with health-care waste and abuse is alarming. The projections reveal a disturbing pattern. In this current economic climate, plans are forced to cover more with a great deal less. Periodic reviews of paid health-care claims and paid prescription data may be an effective tool in detecting and addressing these practices. ■

The author is a partner in Seiger Gfeller Laurie in New York and Princeton. The opinions expressed in this article are solely those of the author and may not be attributed to his firm.