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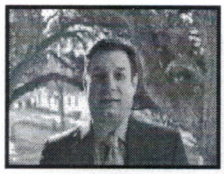
How Group Health Paid Claims and Pharmacy Benefit Data Can Address Wasteful and Abusive Healthcare Practices



MUELLER LAW

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The Patient Protection and Affordable Care Act ("PPACA") provided a significant increase in funding – approximately $250 million - to identify and address wasteful and abusive practices in the nation's healthcare programs. When enacting the PPACA, Congress strengthened certain statutes and regulations in an effort to identify and eventually curtail practices that impact quality of care and contribute to an overall increase in healthcare costs. A review of healthcare paid claims and paid prescription data can be an effective remedy in stopping wasteful and abusive practices. These issues are of great concern to those administering and funding healthcare programs.

The PPACA mandates new and strict penalties for healthcare providers who submit false data in seeking payment. In addition, Congress enhanced the penalties for the submission of false claims for payment or obstructing an investigation relating to certain Government-funded healthcare programs such as Medicare, Medicaid and the Children's Health Insurance Program. Most importantly, the PPACA imposes an affirmative obligation on healthcare providers to report overpayments received. Specifically, healthcare providers have a sixty day time period in which they must report, refund and explain certain overpayments they have wrongfully received.

In enacting this legislation, Congress mandated disclosure of physician ownership in certain healthcare facilities. The Act also requires the reporting of ownership interests in nursing home and long-term care facilities.

The PPACA mandates transparency in the administration of pharmacy benefit managers' ("PBM") programs. For the first time, PBMs must report the amount of generic and brand drugs dispensed from retail and mail order pharmacies. Moreover, any rebates afforded a program must be identified and reported to plan administrators.

The Magnitude of Healthcare Spending in the United States

The Centers for Medicare and Medicaid Services ("CMS") recently reported that healthcare spending in the United States grew 3.7 percent in 2012, to a total of $2.8 *trillion* or $8,915 per person, per year. Healthcare related spending now accounts for 17.2 percent of the United States' Gross Domestic Product. CMS projects that the average annual projected growth of healthcare related expenses will rise 6.2 percent per year from 2015 through 2022. CMS *National Health Expenditures Projections 2012-2022* available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/ NationalHealthAccountsHistorical.html. This increase is largely attributed to the continued implementation of the PPACA's coverage expansions.

The Federal Bureau of Investigation estimates that wasteful and abusive practices cost *both public and private healthcare programs* between three to ten percent of the total monies spent

on healthcare in the United States. (Federal Bureau of Investigation *Financial Crimes Report to the Public - Fiscal Years 2010-2011* available at http://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011 (most recent version available as of this writing)). Assuming these figures are correct, the cost of these wasteful and abusive practices will rise from approximately $67 - $224 billion to $124 - $414 billion *per year*. Given these increases, the need for the changes that Congress implemented in the PPACA becomes readily apparent. Quite simply the wasteful and abusive practices that account for a significant portion of the total amounts must be addressed.

While there is no consensus on a precise definition of what exactly constitutes wasteful or abusive practices, it is generally understood that these practices run the gamut and include: charging for healthcare services or prescriptions that were never provided; overcharging or double-billing for healthcare services or prescriptions; rendering inappropriate or unnecessary care or medicines; and providing treatment or prescriptions incorrectly coded or documented. These practices not only hurt patients, but cost insurance and self-funded plans enormous amounts of money. These practices significantly increase the cost of healthcare for every segment of the economy and place an enormous strain on already overtaxed resources.

While often difficult to detect, steps can be taken to discover and end these harmful practices. Every year, governmental entities, trade unions, private employers, insurance carriers and managed care organizations spend *trillions* to administer healthcare programs. These programs often contain a group health and pharmaceutical component. The group health plan covers the costs for medical services and the pharmacy benefit plan covers prescriptions drugs.

A review of the paid healthcare claims and paid pharmacy benefit data can detect wasteful and abusive practices. Current Procedural Terminology ("CPT") codes are developed by the American Medical Association, and are assigned to every task and service a medical practitioner may provide to a patient including medical, surgical and diagnostic services. CPT codes are uniformly utilized by all healthcare payers, and assist in determining the amount of reimbursement that a provider receives. ICD classifications refer to the International Statistical Classification of Diseases. These classifications pertain to the underlying symptoms and causes of disease or death. The FBI specifically references the use of data mining to combat waste and abuse practices. (Federal Bureau of Investigation *Financial Crimes Report to the Public - Fiscal Years 2010-2011*). It is surprising that these reviews have not become more prevalent.

A Review of Group Health Data

Specifically, an analysis of the paid claims data can uncover instances where a healthcare provider may have engaged in double billing – billing the plan twice for the same medical procedure. A review may uncover whether a healthcare provider billed for services that were never rendered or were medically unnecessary. Instances of upcoding and unbundling can also be discovered.

Upcoding occurs when a health care provider uses a CPT code to bill a payer (private or Government-funded program) for providing a higher service than the healthcare provider performed. A classic example is where a healthcare provider conducts a routine office visit, but bills using a CPT code for a more complex follow-up visit. This can be problematic for a number of reasons. In addition to the extra cost, this conduct puts false information on a patient's medical records, and can impact a patient's ability to obtain insurance.

Unbundling occurs when a healthcare provider breaks out a treatment or test that is to be billed together. An example is where a healthcare provider orders a metabolic panel for a blood test. The panel is to be billed together under one CPT code. A typical laboratory test panel consists of screening for the following: calcium, carbon dioxide, chloride, creatinine, glucose, potassium, urea nitrogen and sodium. However, to increase revenue by billing for each test separately, a healthcare provider need only remove one test – sodium from the panel. By removing this one test a healthcare provider can bill for *each test separately* resulting in an overcharge of more than double than what should be paid.

A Review of Pharmacy Benefit Data

On the pharmacy benefit side, a review of the prescription drug data can uncover many improper practices. It can be determined whether the program is receiving the rebates it is entitled under a plan's contracts. Rebates from drug manufacturers are usually based on a plan's prescription spend, but are sometimes withheld entirely, or lower than what they should be.

Reviews can identify where a prescription plan administrator may have engaged in "switching." As particular drugs go off patent, PBMs induce clients to approve switches from the drugs going off patent to other expensive brand name drugs remaining on patent. The switch costs the plans and patients substantial money as it ensures that patients remain on expensive brand drugs even after less expensive generic alternatives become available.

Pharmacy benefit reviews will uncover instances of "shorting." Shorting occurs where prescriptions are not completely filled, but the plan and patient were charged for a full prescription. As many patients order prescriptions for lengthy periods of time – 90 days and longer - this practice can result in large overcharges as one often does not necessarily count the pills they receive and the improper practice can continue for years. .

A review of a plan's prescription program may uncover instances where prescriptions were filled with invalid or incomplete physician prescriber information, often resulting in abuses. This is important because many contracts call for the pharmacy benefit manager or pharmacist to conduct a drug utilization review ("DUR"). A DUR consists of a PBM or pharmacist calling a prescriber to verify the prescription and to ensure that there are no contraindications with other medications a patient may be taking. Obviously it is impossible to undertake this review if the PBM or pharmacist issues a prescription with an invalid prescriber number - as one has no way of contacting the healthcare provider who authorized the prescription in the first place.

Conclusion

All of these practices can be uncovered by a review of the paid claims data. In addition, those few entities capable of marrying both the health and pharmacy paid claims data review can uncover a great deal more information. Trends become readily apparent as the diagnoses, treatments and prescriptions can be reviewed together as a whole. For instance, one could review whether a prescription was issued properly given the diagnosis code contained in the group health paid claims data.

The cost associated with healthcare waste and abuse is alarming. The projections outlined above reveal a troubling pattern. In this current economic climate plans are forced to cover more with much less. Periodic reviews of the group health and prescription data serve as an effective tool in detecting and addressing these wasteful and abusive practices.

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