

CLIENT ADVISORY

Selecting the Right Audit Service, Strategy and Partner - A Brief Guide

Millions of consumer dollars are wasted each year due to erroneous health care claims as a result of faulty IT systems, human error or premium benefit rules. In AmWINS' own state of North Carolina, the State Auditor's Office identified that a lack of proper oversight by the State Health Plan for medical claims likely led to nearly \$49 million in potential overpayments.

While 80 percent of health care spending is in the area of medical services, some experts attribute a significant part of that to inaccurate medical claims. In addition, claims trends over the last decade have brought about new issues. While some are related to trends in the actual delivery of health care, many are a result of errors made in the claims process.

Auditors have found that 3 to 5 percent of pharmacy benefit manager claims are processed incorrectly. The implementation of a strong auditing process can detect reporting errors and irregularities and ultimately stop overspending to cover exaggerated health care benefits. A thorough pharmacy audit program will identify the plausible issue, support the refund negotiation process, and assist in preventing future mistakes.

With the recent discovery of potential overpayments by the NC State Health Plan, now is a good time for every benefits professional to evaluate their partnership with an experienced medical and pharmaceutical auditing firm. A strong relationship between a benefits professional and an auditing firm demonstrates leadership and focus on controlling costs – a strongly-valued consideration as CEOs and CFOs attempt to manage tight budgets in today's economic downturn. The key to success is to make the right decisions when selecting the partner and audit service that can ensure an effective audit.

Step One: Choosing the Right Audit Service

The first step is to identify a high-quality audit service. The more elements examined during the review, the more thorough the audit will be. Any audit will check for straightforward issues, such as claims basis, eligibility for payment and payment in excess of allowable charges. The better audit services go above and beyond these parameters.

For example, an audit for a medical benefits program will likely check for duplicate billings. Better services take a sophisticated approach, reviewing the data against a number of criteria. It may begin by looking for mechanical duplicates (claims for one patient seeing the same doctor on the same date for the same procedure). This can happen when a medical group submits a bill one month, does not receive payment and resubmits a new bill the next month. It can also occur when a medical practice mistakenly submits bills in both the individual doctor's name and in the practice's name.

Other errors that may be uncovered during a well-done audit are clinical duplicates (claims entered several times for a specific procedure that is typically only done once over a certain time span) and procedural duplicates (claims where a doctor has billed under multiple codes for specific parts of a procedure rather than using a single code that covers the entire procedure).

Good audits also check for single-event, once-in-a-lifetime procedures done multiple times on the same patient (a tonsillectomy or hysterectomy, for instance), double billing for procedures that are bilateral and should be billed under a single code (for example, renal artery angiography on both kidneys) and mutually exclusive coding, such as gender mismatches (prostate surgery on a female).

Assistant surgeon overcharges are also a key area for audits. Since few procedures require two surgeons, any doctor assisting in the operating room should bill at no more than 20 percent of the surgeon's rate. This is a claims error quagmire because until the main surgeon bills, the assistant surgeon cannot determine his or her rate. Thus, the billing staff often makes the error of sending through full charges for both doctors. A similar area of concern is billing for services rendered by physician assistants and nurse practitioners. While a valuable addition to medical care, services from

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these professionals should be billed at a lower rate than those provided by a full-fledged doctor. A thorough audit will check for these coding errors.

While both medical and pharmaceutical audits have the same goal – identifying mismatches between payments and allowable claims – pharmaceutical audit tools have their own unique attributes. Pharmacy benefit managers establish and regularly revise Maximum Allowable Cost (MAC) prices to indicate what they will pay pharmacies for a given drug. The MAC is proprietary rather than industry-wide, which makes it very difficult to audit payments against a standard of reasonableness. However, a thorough audit can determine whether a pharmacy benefit manager is at least conforming to its own MAC guidelines consistently.

Other elements that a pharmaceutical audit should check for include reasonableness and compliance with contract terms such as pricing, dispensing and administrative fees, and eligibility requirements. Pharmaceutical audits typically find dollar-amount errors on a claim by claim basis that are smaller than those discovered in medical audits. However, due to the rapidly increasing volume of prescriptions, the errors can add up quickly to large sums of money.

For example, one pharmaceutical audit uncovered a specialty-drug company that was charging a 700 percent markup for dispensing fees even when issuing regular drugs, like Motrin. Another discovered that a poorly designed technology system was failing to require patient co-pays, resulting in the plan overpaying an average of 50 percent for prescriptions. Small on an individual basis, these problems added up to substantial costs across the covered population.

For the best audit results, demand a sophisticated service that offers the capability of checking multiple elements for error.

Step Two: Choosing the Right Strategy

The next step is to compare the approach of different audit services and to determine the most effective strategy for your organization's goals.

One of the decisions to make is between a full review versus a sample audit. While some firms that conduct sample audits claim a 95 percent confidence rate, the results may not be as thorough as a full review. If only 5 percent of claims have errors, a small sample size may miss problems entirely – envision examining a sample of 5,000 bills out of a million claims for disparities and the difficulty of finding errors.

Additionally, if the goal is to receive reimbursement for overcharges, presenting documentation for each error will be much more compelling than trying to collect on the basis of an extrapolated sample. Also, with the power of today's computing muscle compared to yesteryear's painful hands-on audit analyses, it makes little sense to under-invest in the number of claims examined once the decision has been made to go forward with an audit.

The second important decision is how frequently to audit. Historically, the standard has been once every three years, typically in sync with contract renewal times, so that information may be used in negotiating new terms. However, some pharmacy benefit management companies are establishing new ground rules, insisting on a "look-back" limit of two years, or 18 months, or even less. It may be prudent for more frequent audits, particularly if the first audit uncovers pervasive practices that are likely to yield reimbursements.

One reasonable strategy is to conduct one thorough, baseline audit to assess the conduct of the benefits administrator under contract, and then decide on the frequency for future audits based on the severity and number of issues identified.

Finally, and perhaps most importantly, there is the difference between an audit that simply reviews the medical order and eligibility for payment and one that elevates the review to determine which items are medically necessary and allowable under the contract. An audit is strengthened when it adds a clinical dimension to the review, requiring the audit to be backed by clinical expertise including on-staff medical and pharmaceutical doctors.

As an example, pharmacy benefit managers typically pay claims as written, not necessarily according to the terms of the summary plan design. They may even say, "We do not argue with doctors; we dispense as requested." This is in contrast with medical benefits processors who frequently require prior authorization for whole categories of procedures – delivery of chemotherapy, for example – and routinely refuse to pay claims for treatment they determine has moved from sound medical science into theoretical experimentation. A pharmaceutical audit with a well-developed clinical component can render judgments about such factors as reasonable dosage, standard-of-care drug selection,

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and other utilization criteria. Similarly, a medical audit that questions how often a diagnostic test or an expensive scan should be performed can help identify areas where reasonable limits are being exceeded.

The most effective audit strategy will be grounded in the most thorough approach: a 100 percent review, with a frequency dictated by the level of issues discovered and a clinical rigor that goes beyond accepting whatever doctors order.

Step Three: Choosing the Right Partner

Just as a benefits professional takes care in selecting a third party administrator, the same level of scrutiny should be involved in selecting a technically competent audit firm. The firm should have a well-established track record of conducting medical and pharmaceutical audits; additionally, the firm should have a solid background in medical and pharmaceutical billing issues, as well as expertise in identifying errors based on experience from past audits. Clinical expertise, as demonstrated by having the firm's own medical and pharmaceutical staff involved in audits, is a plus.

Most important, however, is to evaluate the firm's offering of solution-oriented service. Is the goal simply to "run the numbers" and deliver a report? Or does the audit firm intend to be a full partner, identifying errors, working to obtain repayment, and making recommendations for implementing new processes or standards to reduce ongoing problems?

Think of it as the ability of the audit firm to deliver service that spans the past, present and future. An effective partner will help a benefits professional recoup payment for past errors, make the best use of audit data for current negotiations on contract renewals, and set up a system to decrease the likelihood of future errors.

What to Expect

The right audit strategy can be a powerful tool for benefits professionals who want to become more proactive about managing limited health care dollars. The plusses of a good audit go beyond reining in costs, however. Additional benefits include: meeting the requirements of ERISA and Medicare Part D for verified audits, recognizing when it is necessary to shop for a new, more competitive and rigorous benefits administration contractor – and using information uncovered in the audit to drive the best bargain; managing utilization of medical and pharmaceutical benefits in a way that balances the health care needs of employees with a standard of reasonable treatment; and demonstrating cost-saving expertise to the corporate leaders who already have their hands full in a stumbling economy.

With rising costs and shrinking coverage everywhere, there are few opportunities for those in the health care arena to be heroes. Choosing a sophisticated auditing tool and the right partner can ensure the gets the best value from their carriers.