PAYMENT INTEGRITY

SUCCESS STORY

TRUVEN HEALTH ANALYTICS™

Truven Health Payment Integrity Vulnerability Assessment Identifies **More Than $40 Million in Potential Fraud, Waste, and Abuse Overpayments**

OVERVIEW

Large national employer with approximately 70,000 employees and members

- Evaluated 36 months of claims
  - 2 medical administrators
  - 1 dental administrator
  - 1 pharmacy benefit manager
- Identified more than $40 million of potential overpayments
- Recommended $3 million in recoveries and $15 million in potential future savings

Truven Health Analytics™ consulted for this large national employer with approximately 70,000 employees and members. The organization was concerned about potential fraud — both provider and employee — and the associated ethical issues. Truven Health completed a vulnerability assessment on three years' worth of data from multiple administrators. Our vulnerability assessment uses thousands of algorithms and edits to identify fraud, waste, abuse, problematic billing and incorrect payments, and search for member and/or provider fraud.

The company felt confident it had fraud, waste, and abuse under control. However, our assessment identified more than $40 million of potential overpayments, in addition to finding vulnerabilities in their processes, procedures, and in the administrators' systems that could be fixed to help mitigate some additional vulnerabilities. From that $40 million in overpayments, we developed a conservative recommendation to pursue recovery of $3 million and avoid future costs of an additional $15 million.

Issue #1: Member Vulnerability – Drug Seekers

Key Findings:

- More than $445,000 for 55 members with 10+ prescribers for Schedule II Controlled Substances (e.g., Vicodin®, oxycodone)
- 15 of the 55 members identified were employees
- For the top 5 members, 3 were spouses and 2 were employees
- Profile for the top offender (a spouse):
  - 165 different prescribers for Schedule II drugs
  - 134 different dispensing pharmacies
  - Prescribed oxycodone
  - No diagnosis supporting this utilization
- Member 2 had 159 claims, 38 prescribers, and 25 dispensing pharmacies

The first issue our assessment uncovered was that this company had a small, but expensive, population of what we call "drug seekers." These are individuals who have seen more than 10 different prescribers for Schedule II drugs. We identified $445,000 of claims paid for these members for Schedule II drugs.

This particular member went to more than 130 dispensing pharmacies.

We found one member, who was a spouse of an employee, had gone, over the course of the 3 years, to 165 different prescribers primarily for OxyContin® and Vicodin and other painkillers. A patient with a chronic pain condition may visit several prescribers and one or two dispensing pharmacies, but a key flag of potentially fraudulent or abusive drug utilization is filling scripts at multiple pharmacies in multiple cities. This particular member went to more than 130 dispensing pharmacies. Additionally, there was no medical diagnosis to support the use of these drugs. And with that many drugs being dispensed, it's likely this member was selling, as well as using, the drugs.

Altogether, our assessment identified more than 55 members who fit this pattern. The top offenders, whether employees or spouses, were seeing up to 40 different prescribers and using up to 30 different dispensing pharmacies. Action needs to be taken to ensure the health of the population as well as prevent this kind of behavior.

Issue #2: Controlled Substances, No Prior Medical Visit

Key Findings:

- $1.25 million in potential overpayment amounts
- OxyContin and drugs for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) comprise the majority of the findings
  - ADHD drugs are the fastest-growing abused Schedule II drug
- More than 300 members with potential overpayments of $1,000 or more for Schedule II drugs without medical care

The second issue our assessment revealed was that members were receiving Schedule II controlled substances without seeing physicians for proper care. These members primarily fell into two categories: those taking pain medications, like OxyContin, and those taking the drugs dispensed to ADHD patients.

It's important to note that abuse of ADHD drugs is on the rise among teens and college students across the country. According to NBC's Dateline, it's popular for ADHD drugs to be used as a study medication in college. We found more than $1.25 million in overpayments for drugs being dispensed without medical supervision.

Category	Members
Child or Other Dependant	227
Employee	78
Spouse/Partner	33
Total	338

Issue #3: Provider Vulnerability

Provider Vulnerability – John Doe, MD, PC, Internal Medicine Physician

Key Findings:

- Client paid more than $360,000 for just over 100 members
- Identified on numerous algorithms — $166,000 identified in potential overpayments
- 88 percent of his patients had Chronic Airway Obstruction diagnoses
- 91 percent of his patients had an Abnormal Respiratory diagnosis
- Half of his 9,000 claims had modifier 25 or 59

During our assessment, we uncovered an internist who received almost half of his total payments for services that appeared to be abusive or unwarranted and unnecessary care. Out of his payments totaling $360,000 for roughly 100 different patients, we found $166,000 in potential overpayments. What made this particular doctor stand out to us was the fact that 91 percent of his patients had a respiratory diagnosis — and he was not a respiratory specialist.

Additionally, 88 percent of these same patients carried a secondary diagnosis for chronic airway obstruction. We believe these diagnoses were added to the claims to support the high level of diagnostic testing that Dr. Doe was prescribing for these patients.

Here is the breakdown on his suspicious claims:

- 80 percent of all claims were for diagnostic testing
  - 99 percent of the patients received diagnostic testing
  - An average of 70 diagnostic tests per patient
- More than 99 percent of overpayments were for excessive diagnostics
  - The modifier usage on the diagnostic tests were likely coded to get the tests paid
  - Most patients had the same tests (>8) each visit
- Local hospital (Hospital ABC below) saw 75 percent of Dr. Doe's patients; yet only 6 of them had a respiratory diagnosis

This particular physician was also using what's called "a claim modifier" to drive reimbursement. Many times, repetitive tests will get rejected unless the provider uses modifier 25 or 59 on the claim to help get them paid. This technique avoids some standard edits that administrators have in their systems to prevent this kind of billing abuse.

Not only had 75 percent of Dr. Doe's patients been seen at this hospital, but 55 percent of them had been seen in an emergency room setting.

Provider Vulnerability – Hospital ABC

Key Findings:

- 75 percent of Dr. Doe's patients were treated at Hospital ABC
- 55 percent of Dr. Doe's patients had ER visits
- Only 6 of the patients seen at Hospital ABC had respiratory diagnosis

After seeing the pattern at Dr. Doe's local hospital, we investigated that facility as well. We found that they actually had some billing problems of their own. Not only had 75 percent of Dr. Doe's patients been seen at this hospital, but 55 percent of them had been seen in an emergency room setting — that's a statistical unlikelihood. It *can* happen, but it's a warning sign, a red flag. After further investigation, we discovered Hospital ABC:

- Received $10.5 million for more than 3,000 members
- Shared a large patient population with Dr. Doe
- Almost $500,000 (5 percent of total payments) in potential overpayments identified in numerous algorithms
- More than $130,000 overpaid for unbundling procedures on outpatient claims
- Received payment for a significant number of diagnostic and laboratory tests

The hospital was performing a significant number of diagnostic tests on Dr. Doe's patients. Excessive diagnostic testing is pervasive right now in the healthcare delivery system. There has to be an indication that the test is required. In the case of Hospital ABC, we found that almost 5 percent of the $10 million it received in payments were suspicious.

Provider Vulnerability – Hospital DEF

Key Findings:

- 15 claims, all billed with diagnosis code 780, for general symptoms
- Hospital DEF had $1.2 million in potential overpayments for 197 claims
- More than 50% of potential overpayments for invalid ICD-9 codes
- Identified on 10 algorithms

50 percent of this provider's inpatient stays had an ICD-9 diagnosis code of 780, which is a code for "general symptoms."

Our assessment also revealed a second hospital in our client's geographic area that had been paid a significant amount of money. Ten different fraud algorithms pointed to suspicious practices at this particular hospital. The fact that really drew our focus to this provider was that 50 percent of its inpatient stays, for which they were paid millions of dollars, had an ICD-9 diagnosis code of 780, which is a code for "general symptoms."

Correct coding practices indicate that a hospital has to code for the highest level of specificity possible, all four or five digits of the ICD-9 code on the claim. Without that level of detail, it's very difficult to know if these inpatient stays were appropriate. Why was that patient in the hospital? Why did the hospital spend between $10,000 and 20,000? It's important to know what diagnosis those services were treating.

Sample of Other Findings

- More than $4 million of potential overpayments for outpatient facility unbundling; 2 providers overpaid by $100,000 each
- More than $1.2 million of potential overpayments for physician unbundling
- Almost $1.5 million of potential overpayments for evaluation and management (E&M) upcoding
- $1.3 million of inpatient-only procedures being performed outside a hospital
- Almost $800,000 in payments for incidental services; 2 providers significantly stand out
- More than $1.8 million paid for invalid ICD-9 codes
- Paid claims for providers "sanctioned and excluded" by Medicare
- Almost $6.5 million paid to replace devices that had malfunctioned
- Millions of dollars paid for hospital-acquired conditions
- Tens of thousands of dollars paid for duplicate prescriptions, duplicate ingredients, and early refills — both retail and mail order
- More than $1.3 million in potential overpayments for children receiving inordinate number of dental fillings
- Administrators don't consistently capture the performing provider; use generic or shared names (e.g., International Provider, Professional Provider)

Next Steps

- Truven Health to conduct additional investigation into key results to assist in recoveries and cost savings actions
- Truven Health and Client will share results with Client's claims administrators to facilitate recoveries, provide follow up, and take corrective action
- Client's internal corporate ethics group will decide next steps on member vulnerability issues

Our vulnerability assessment pointed out issues with this large national employer's healthcare claims administration, including cases of potential fraud. Our next step is to drill down into the data, prove the allegations, and help accumulate and tabulate the recoveries. We have also developed a strategy to partner with the employer's claims administrators, who will facilitate getting money back for the employer.

FOR MORE INFORMATION

To find out how to put our Payment Integrity Solution to work for you, contact **employer@truvenhealth.com**.

TRUVEN HEALTH ANALYTICS™

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