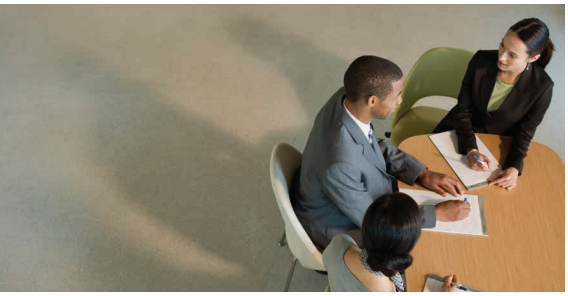
PAYMENT INTEGRITY

SUCCESS STORY

TRUVEN HEALTH ANALYTICS™



Truven Health Payment Integrity Vulnerability Assessment Identifies **Nearly $200 Million in Potential Fraud, Waste, and Abuse Overpayments**

Overview

Large national employer with approximately 150,000 employees

- Phase 1: reviewed 24 months of claims from 6 administrators
  - 4 medical administrators
  - 2 pharmacy benefit managers
- Identified nearly $200 million in potential overpayments
- Recommended $20 million in recoveries and $50 million in potential future savings

Truven Health Analytics™ consulted for this large national employer with approximately 150,000 employees and members and analyzed six of their administrators. Based on 24 months of claims data, we identified $200 million in payments that looked inappropriate. To address the problem, we developed a strategy to pursue recovery of approximately $20 million in overpayments and save an additional $50 million by tightening policies and strengthening administrator relationships.

By reviewing all of the data and identifying the vulnerabilities, we could hone in on the top three to five issues that were costing the company millions of dollars and prioritize those specific problems for immediate action.

Issue #1: Member Vulnerability — Drug Seekers

- Found members going to 30 to 40 different prescribers for Schedule II Controlled Substances and having them filled at 10 to 20 different pharmacies
- Uncovered more than $5 million paid for Schedule II drugs by 1,500 members seeing more than 6 different prescribers
- Identified nearly $4.8 million paid for Schedule II drugs for patients without medical care for 90 days prior to the prescriptions

Our analysis revealed numerous members going to 30 to 40 different prescribers and having prescriptions filled for OxyContin®, Vicodin®, and other painkillers at 10 to 20 different pharmacies.

We discovered more than $5 million in potentially fraudulent payments for 1,500 members who were seeing more than six prescribers each. In addition, approximately $4.8 million was paid for Schedule II drugs for individuals who were not under medical care in the prior 90 days. Clearly, this is an area that would benefit from tighter controls.

Issue #2: Out-of-Network (OON) Billing Patterns

Our analysis found a group of four providers and an ambulatory surgery center where:

- One provider was OON and sanctioned
- Remaining providers and the facility were in-network
- Each provider was in the "top" results of many algorithms
- Overpayments exceeded $2 million
- OON provider received four times more than other providers for same procedures
- OON provider billed for more services than the others (likely billing for partners' surgeries)

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

The second major finding for this particular employer has to do with OON billing patterns. We found a particular group practice that included four providers who owned and managed their own ambulatory surgery center. Each one of the providers showed up in the top findings of many of the algorithms for excessive diagnostics and performing inpatient surgeries in their ambulatory surgery center. However, the theory is that they were performing fewer surgeries, but upcoding the diagnostics, the diagnosis, and the procedure for the patient.

The overpayment for this one group of four providers has exceeded $2 million, and the one OON provider saw the majority of the patients. Our large national employer has hundreds of patients going to this one group, yet they all seem to have their surgeries done by the OON provider, who was paid four times *more* than his three partners doing that same surgery.

Sample of Other Findings

- Identified more than $20 million in evaluation and management (E&M) upcoding
- The E&M upcoding algorithm determined that the top 40 providers all worked in the same group
- Inpatient-only procedures accounted for more than $5.4 million in potential overpayments; one large outlier was paid for jaw reconstruction in an outpatient setting
- More than $5.3 million of potential overpayments for one-day inpatient stays
- Other algorithms identifying more than $1 million include physician unbundling, outpatient facility unbundling, duplicate payments, and incidental services
- More than $600,000 of payments for outpatient services while the patient was in a hospital
- More than $36 million was paid for replacing devices that malfunctioned; device manufacturers may be responsible for some of these payments
- Tens of millions of dollars were paid for hospital-acquired conditions

Other areas we identified in this analysis include $20 million in upcoding of services, $5.4 million for inpatient-only procedures performed in outpatient settings, and $5.3 million for one-day inpatient stays. Keep in mind these vulnerabilities cost the employer tens of millions of dollars.

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 monitor corrective action

While there is still much action to be taken, the good news is that there is $20 million to $70 million in savings potential for this employer from taking charge of fraud detection. As their partner, our next steps are to drill down, come up with the strategies, take the proactive actions to stop or mitigate the most significant issues in the data, and find immediate savings.

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