MONEYPILL VOLUME 5

Fraud, Waste and Abuse...Oh My!

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All industries produce employees involved in workplace offending

Accountants that embezzle

Lawyers that scam money from clients

Construction sites that use inferior products

Health care is no different

Pharmacists that violate the Pharmacy Practice Act

Physicians involved in billing scams

Nurses involved in drug diversion

On June 28, 2018, the Department of Justice (DOJ) arrested 601 physicians, nurses and pharmacists in a **$2 billion false billing scheme**, involving 58 judicial districts (Department of Justice website, 2018). The 2018 arrests come after an annual set of similar arrests in 2015, 2016 and 2017, in which 243, 301 and 412 providers were arrested, respectively. Of those charged in 2018, 162 defendants, including 76 doctors, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. Providers participated in schemes that involved submitting claims to the government's insurance carriers for services that were either medically unnecessary or that never occurred. Stated FBI Deputy Director David Bowdich, "Through investigations across the country, we have seen medical professionals putting greed above their patients' well-being and trusted doctors fanning the flames of the opioid crisis (Department of Justice website, 2018)."

Employers paid for these schemes and rarely get restitution. The $2 billion in false billing schemes in 2018 occurred when physicians and pharmacists billed claims to Medicare, Medicaid and private employers for prescriptions that never existed, or which were not necessary, or worse, were for abusive medications fueling the opioid epidemic.

But more important than large busts and illegal activity, **a majority of fraud, waste and abuse is just waste.**

FRAUD

Schemes that involve illegal behavior like submitting phantom prescriptions, medical identity theft, collusion between prescribers and pharmacists, upcoding pharmacy claims, pharmacists changing prescription orders

WASTE

Pharmacists/technicians not adequately performing duties like not returning claims to stock when not picked up, "over filing" quantities, not questioning clinically inappropriate prescriptions, Auto-refills and Auto-Fills

ABUSE

Patients, pharmacist or prescribers billing for prescriptions that contribute to addiction, personal financial gain (selling medical identity)

BETTER GUIDANCE

A conversation with Susan Hayes

Susan consults Fortune 500 employers, group health plans and state and federal government agencies. She is a frequent author and speaker and has testified in over 30 cases as an expert witness regarding issues of fraud in pharmacy benefits and has testified to Congress and the Department of Labor on pharmacy transparency issues.

A conversation with Susan Hayes

How would you define prescription drug fraud?

SUSAN: Prescription drug fraud can be defined as any unlawful act that involves a prescription drug and is performed for financial gain.

Do plan sponsors have the right to investigate fraud, waste and abuse claims?

SUSAN: In most cases the individual employers/plan sponsors do not have the right to investigate these claims because many traditional PBMs hold the contracts with the pharmacies even though employers are paying the bill.

What can plan sponsors do to ensure their plans and participants don't fall victim?

SUSAN: Plan sponsors need to be proactive and have an intentional conversation with their PBMs about fraudulent claims to find out what policies and procedures the PBM has for auditing and prosecuting fraud. Most PBMs have some type of fraud program. However, 'having a program' isn't enough, it is important that your PBM takes a strong and proactive stance on fraud. The goal is to detect fraud before the claims have been paid.

Plan sponsors should also educate plan participants about fraud. It's much less likely for a plan to fall victim to fraud if plan members are diligent about their medical identity information. Inform members that their medical identity (carrier identification number, name, date of birth, address) should be held in the strictest confidence. Plan sponsors should warn participants they risk termination from the medical and pharmacy benefit plan (or termination of employment) as well as prosecution if they are caught selling their identity. Plan participants also should be informed that selling prescription drugs obtained under the pharmacy benefit program is illegal and subject to prosecution.

A conversation with Susan Hayes

We also encourage plan sponsors to send plan participants an annual pharmacy benefit statement. Many participants are unaware their medical identity has been compromised. This can happen when a health care provider staff member (or the provider itself) sells the identity or uses the identity to submit fraudulent claims. In addition, dependents can commit medical identity fraud without the primary cardholder's knowledge.

What are some specific strategies plan sponsors can implement?

SUSAN: It is important that plan sponsors carve out Fraud, Waste & Abuse, just like employers have begun to carve out other important tasks that generate revenue for traditional PBMs: Prior Authorizations, Formulary Management and Specialty Drug Management.

What some traditional PBMs don't want you to know...

Traditional PBMs take an administrative fee by reimbursing the pharmacy less than what is billed to employers for the same transaction. So, a 30-day supply of Lisinopril is reimbursed to the pharmacy at a cost of $4, but is charged to the plan at $20 and the PBM retains a $16 fee for the transaction. But what if this claim was a false claim, meaning there was no patient wanting a bottle of Lisinopril? In this case, the pharmacist simply submits the claims as if there was a patient asking for the prescription to be filled and may even split the proceeds with a prescriber. Since some PBMs do not differentiate between legitimate transactions and non-legitimate transactions, the PBM "takes the spread" (the difference between what is reimbursed and what is charged) on the prescription—including a claim that never existed. Spread is a computer algorithm that does not first determine if the prescription is valid.

But individual employers do not have the right to investigate these claims because many traditional PBMs hold the contracts with the pharmacies, even though employers are paying the bill.

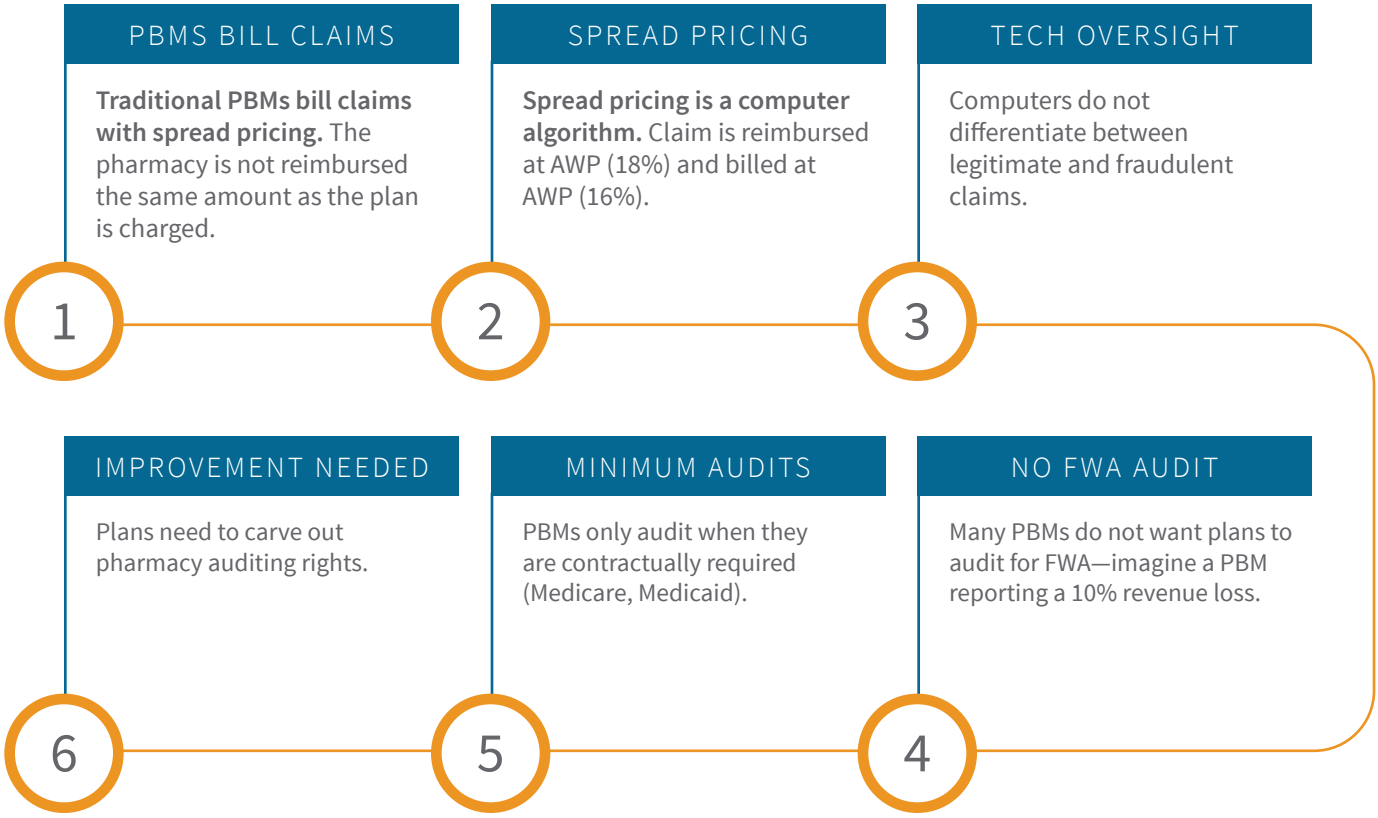
Waste has become an increasing problem with the advent of e-prescribing and auto refills. E-prescribing provides the ability to send error-free, accurate, and understandable prescriptions electronically from the health care prescriber to the pharmacy. E-prescribing is meant to reduce the risks associated with traditional prescription script writing. According to SureScripts 2017 National Progress Report (SureScripts, 2018), electronic prescribing was up 26% from 2016 to 2017, with 13.7 billion prescriptions "e-transmitted" in 2017. E-prescribing does not give a patient time to think if the medication is right for them, or if they elect not to take the medication. If a prescriber e-prescribes, the order arrives at the pharmacy whether the patient has second thoughts or not.

Many traditional PBMs hold the contracts with the pharmacies, even though employers are paying the bill.

When a prescription is sent electronically to the pharmacy, the pharmacist or technician prepare the prescription to await the patient's arrival at the pharmacy. This includes sending the prescription to the PBM to get payment, assuming that every prescription will be retrieved. But that is not the case.

Further, auto-refills mean that any refill that is available is processed and waits for the patient. Even if the patient has not requested the medication to be refilled, the employer is billed for the auto refill as the medication waits for the patient to arrive and take the medication home. Mail order auto-refills are even worse as once the medication is filled, it is billed and sent to the patient's house.

As you can imagine, when the patient does not pick up the medication, there is an avalanche of waiting medications, and technicians do not have the time to reverse every single order, they simply put the medication back on the shelf. And, mail order pharmacies cannot accept returns of medication once it has left the pharmacy, so the patient is stuck with the medication even if he/she does not want the medication.



Results matter.

In a recent case study, $53 million dollars of claims (9,2295,611 claims) were scored using criminological theory and high-level statistics and machine learning to find claims with the best chances for recovery. Investigators then requested copies of prescription orders and signatures of receipt (verifying that patients picked up the medication) for $16 million involving 51,500 claims. Recoveries amounted to 11.25% of the claim costs, or $5,976,497. Of the claims investigated, 35.6% were recovered. (See Chart on slide 5).

The types of recoveries can be seen in the chart below. Most recoveries were derived from claims that were not available for the investigators meaning that these were false submissions. The next most frequent category came from claims which the "signature log" was missing meaning that the patient never signed and picked up the medication. Other recoveries were derived from pharmacists not verifying prescriptions before being passed to the patient, dispensing lower strengths to obtain higher reimbursement and dispensing clinically inappropriate medications.

Number of Recoveries	Error Description	Recovery Amounts
3,438	Missing/Invalid Directions/Documentation	$1,880,092.14
1,842	Signature Log Not Found	$630,031.71
1,620	Prescription reversed or canceled, check adjudication system	$521,095.94
499	No Pharmacist Verification of prescription dispensed	$105,078.95
23	Lower Strength	$36,833.59
70	Missing Prescription	$35,446.13
40	Other	$34,723.03
35	Clinically Inappropriate	$23,376.57
166	Quantity Entry Error	$13,898.11
42	Use As Directed	$9,035.16

Take charge now

Employers should not pay for fraudulent claims or wasteful refills of medications that patients do not pick up and use. PBMs do not want employers to audit pharmacy submissions because it means less revenue for PBMs. However, as US Surgeon General C. Everett Koop famously stated, “Drugs don’t work in patients that don’t take them.” And, employers should not have to pay for waste or fraud.

It was once a radical idea to carve out Prior Authorization services from PBMs or even think that employers should manage their own formularies. But now there are companies that do just that with no financial ties to increasing PBM revenue.

It’s time to say enough is enough. Stop paying for the illegal activities of physicians and pharmacies. Stop paying for waste of prescriptions that are never used. Carve out fraud, waste and abuse investigations from the PBM contract and start saving 10% of your drug spend.

Susan A. Hayes, principal and owner of Pharmacy Investigators and Consultants, has a 40-year career in employee benefits, industrial security, counter-fraud, prescription drugs and facilitating understanding of this highly complex industry dynamic. Susan has an in-depth knowledge of PBM systems and operations, claims data and client management. She is an expert in the pharmacy marketplace and has an in-depth understanding of how prescription drugs are priced and marketed, as well as the overall prescription drug and health care industry. She has consulted to large Fortune 500 employers, group health plans, and state and federal government agencies. She is a frequent author and speaker on the topic of auditing Pharmacy Benefit Managers and instructing plan sponsors on how to best manage the growing cost of pharmacy benefit programs. Susan has testified in over 30 cases as an expert witness regarding issues of fraud in pharmacy benefits and has testified to Congress and the Department of Labor on pharmacy transparency issues. She holds U.S. Patents on two proprietary systems that detect and resolve pharmacy fraud using criminological theory.

Click here to connect with Susan A. Hayes on LinkedIn
Click here to visit the Pharmacy Investigators & Consultants website

L.G. Hanzel, a pharmacy risk management strategist, has more than 25 years experience in healthcare, benefits, managed care and technology. L.G. has an extensive background in and knowledge of the self-insurance industry and healthcare informatics. L.G. is actively involved in the Self-Insurance Institute of America, Health Care Administrators Association, the National Business Coalition on Health and other regional business health coalitions.

About RxResults: RxResults, a joint-collaborative with the nationally recognized University of Arkansas for Medical Sciences, continuously reviews the latest studies and research on drug outcomes and leverages proprietary informatics, clinical expertise and business processes to identify trends, highlight concerns and formulate actionable insights. RxResults' core competencies include Specialty Drug Management and Formulary Risk Management.

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Impact of an Evidence-Based Pharmacy Risk Management Strategy: Download the Case Study Here

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VOLUME 1 How Specialty Drugs Are Making 2/50 the New 20/80 Rule

VOLUME 2 The Formulary for Success Is an Evidence-Based Preferred Drug List

VOLUME 3 Risky Business: Specialty Drugs Impact on the Self-Insured Market

VOLUME 4 Tripping Over Savings to Pick Up Rebates

VOLUME 5 Fraud, Waste and Abuse...Oh My!

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