Trends

Statistics and Strategies for Health Plan Sponsors

Fourth Quarter 2023

Key statistics

Examples of Fraud, Waste and Abuse (FWA)

1,500 per claimant paid for ambulance rides with no associated ER or inpatient visits ($5.4 million total)

up to $2,500 additional annual billing in reimbursement for chiropractic patients with excessive use of procedure modifier 59*

$3,000 per script for probiotics filled by a retail pharmacy over 50 miles away from prescriber and participants

$2,000 for single-tablet combination drug to treat pain with $20 over-the-counter therapeutic alternative

26 hours of telehealth visits billed daily by provider with 95% of claims billed as 60-minute visits

1/3 – 1/2 of plan amounts paid to diabetic durable medical equipment providers were for continuous glucose monitoring (CGM) of Medicare members without a history of diabetes

Source: Case studies identified through Segal's SHAPE data warehouse

* 59 is used to signify that a chiropractic procedure or service is independent of other codes and needs to be paid separately.

Strategies for evaluating FWA

Healthcare FWA can have a significant impact on costs for plan sponsors. Roughly 25 percent of annual healthcare spending in the U.S. is considered wasteful, with 3–10 percent considered fraudulent and abusive billing. FWA contributes to unnecessary costs and premium increases for plan sponsors. Victims of healthcare fraud can also be subject to unnecessary or unsafe medical procedures as well as medical identity theft. Addressing FWA in healthcare is crucial to maintain the integrity of benefits, protect patients and ensure resources are used efficiently.

A closer look at claims adjudication

Approximately 85 percent of medical claims are auto-adjudicated. Claims auto-adjudication systems are not always current with regulations and treatment practices and may be older or cumbersome to update. Carriers also tend to auto-adjudicate claims below a given threshold — typically less than $10,000–$15,000. Claims adjudication software does not catch all FWA from doctor or hospital billings. Consequently, some providers and facilities are paid excessive amounts for testing and services that fall below these thresholds without being challenged. Billing fraud and abuse costs plans between $15 to $83 per participant per month — the equivalent of the entire plan administrative services fee. Often, the FWA program and integrity fee structure outside the base fee arrangement are not transparent.

Common types of fraud and abuse

Most fraud and abuse comes from a small number of enrollees and providers that can cause significant disruption and costs to a plan. The increase in telehealth access to care has created additional vulnerabilities for fraud and abuse schemes.

Some of the more common types of fraud and abuse include:

- **Billing for services that were never rendered** — using patient information, sometimes through identity theft, to charge for procedure or services that did not occur

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- **Upcoding** — coding to a higher level of service than rendered (e.g., treating individual therapy and billing for family therapy) or to a more complex visit (e.g., 15-minute virtual visit billed as 45-minute complex telehealth visit)
- **Improbable days** — occurrence of billing hours that exceed a 24-hour period (e.g., 28 billing hours for patients in a day or multiple providers via telehealth that in total exceed a 24-hour day)
- **Unbundling** — billing for each step of a procedure as if they are separate procedures rather than submitting a bundled rate, to receive a higher reimbursement amount
- **Performing medically unnecessary services** — this often takes the form of diagnostic services, such as excessive lab testing, nerve-conduction and genetic testing, without assessing the patient's medical needs
- **Billing for specialties not appropriate for service** — for example, anesthesiology for telehealth
- **Waiving patient cost sharing, copayment or deductible** — often the provider passes the waived copayment cost on to the plan sponsor through overbilling
- **Misrepresenting non-covered services to obtain payment** — this is often observed with cosmetic surgery (e.g., billing a rhinoplasty as a deviated septum)
- **Accepting a kickback for patient referrals** — referring patients to specific services or platforms in exchange for kickbacks or financial incentives
- **Billing a patient more than the cost-sharing amount determined under the terms of a managed care arrangement**

How to identify FWA

Recognizing patterns that look suspicious is key to preventing FWA. To protect themselves from FWA, plan sponsors can consider the following steps:

- **Monitor claims through data mining.** This practice can check for patterns of overutilization, including outlier charges in provider billing relative to peers and unusual spikes in patient volume. Additionally, the use of predictive modeling and machine learning can help identify new pattens of irregular activity.
- **Use a pre-payment solution.** Post-payment solutions can be labor intensive and have a high level of false positives. Many payers are complementing their solutions with pre-payment vendors that may have fraud-prevention software to ensure detection before payment is made. Plan sponsors should ensure they understand the fee structure and evaluate net savings.
- **Perform routine vendor audits.** These reviews will support provider payment and financial accuracy as well as ensure the plan is being adjudicated according to the plan's benefit intent.
- **Work with payer Special Investigation Units (SIU).** SIUs investigate suspected insurance fraud and resolve billing practice issues to reduce or eliminate future payment issues and, where appropriate, recover overpayment.
- **Request reporting from insurers.** The report should cover what has been done to address FWA.
- **Educate patients.** Encourage participants to review their explanation of benefits/claims history to validate charges and report suspect claims activity to the carrier or plan sponsor.

Compliance

Proposed mental health parity rules suggest major changes

The proposed rules set forth new standards for imposing non-quantitative treatment limitations (NQTLs) as well as requiring additional data collection and evaluation requirements for compliant NQTL documented comparative analyses. Plan sponsors should evaluate the proposed rules and determine the impact on existing Mental Health Parity and Addiction Equity Act compliance efforts. Read more in our August 1, 2023 insight.

Machine-readable Rx files enforcement back on track

The Departments of Treasury, Labor and Health and Human Services (the Departments) issued updated guidance on the Transparency in Coverage (TiC) final rule, reinstating enforcement of the machine-readable file requirements for prescription drug negotiated rates. To meet the requirements for prescription drug machine-readable files, plan sponsors will likely need assistance from their prescription drug benefit administrators. Read more in our October 17, 2023 insight.

To discuss the implications for your plan of anything covered here, contact your Segal consultant or get in touch via our website, segalco.com.

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