On the Audit Trail

Real-Life Findings from Claims Audits of Self-Funded Medical Plans

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Anyone who has spent time on the road auditing medical claims administrators for self-insured employers will have evocative tales of what they have seen when peering into the Pandora's Box of claim administration.

Opening up that Pandora's Box through a medical claims audit will often reveal instances of decision-making by the claims administrator that appear to run counter to the intent of the plan sponsor whose nice, neat plan design is laid out so clearly in the Summary Plan Description. What the self-insured employer does with the knowledge gained from the auditor's revelations is up to them, however.

As an experienced auditor, I know there is no such thing as a perfect audit. I approach every audit assignment **expecting** to find errors in claims administration, whether of commission or omission, whether grave or trivial, as that is just the nature of the beast. Expecting to find perfection would be unrealistic; rather, I look for a level of service and performance that meets a fiduciary standard, specifically: care, due diligence and prudence.

But along with the typical processing errors seen in a claims audit (e.g., payment of duplicate claims; application of incorrect network rates; incorrect coordination of benefits methodology) come situations that reflect a passive approach to claims handling by the claims administrator, one that will cause the self-insured employer to spend more in claims than might be expected.

However, the intent here is not to discuss the "typical" claim payment errors seen in an audit. Rather, this article's intent is to reveal some of the unexpected outcomes when claims administrators apply their own version of rationality to real-world claim situations.

We Won't Call it Fraud, but if it Walks Like a Duck, Quacks Like a Duck and Smells Like a Duck, Maybe it Is a Duck

It is not unusual for a provider's claim submission to set off red flags during the course of a claims audit. However, experienced auditors are loath to use the word "fraud" when interacting with the claims administrator, nor will we use that word in our audit report to the client. If anything, we might call it "aberrant billing practices" and hope the client and claims administrator will read between the lines.

SCENARIO 1

The Surgeon is In-Network, but the Assistant Surgeon is Not?

Perhaps the most problematic scenario is the network surgeon whose status as a network provider opens the door for out-of-network "assistant surgeons" to be paid as if the assistant were also a network provider. Whereas the network surgeon has agreed to accept a reduction in their "normal" fee for being part of a network, the non-network assistant has no such agreement in place, and is therefore paid full (undiscounted) charges, simply for being "attached" to the network surgeon.

Is selecting a non-network assistant a benign (or innocent) act on the part of the network surgeon, or a diabolical Trojan Horse strategy?

Is it purposeful or innocent when an in-network (INN) surgeon selects an out-of-network (OON) physician's assistant (PA) or registered nurse first assistant (RNFA) as an assistant surgeon? On a recent audit, we found three separate claims where the claims administrator paid the undiscounted charges of an OON PA and an OON RNFA acting as "assistant surgeons."

Sample Claim	INN Surgeon (M.D.)		OON ASSISTANT (PA or RNFA)		
	BILLED	PAID		BILLED	PAID
A	$2,260	$819	RNFA	$3,000	$3,000
B	$9,880	$1,139	PA	$6,900	$4,613
C	$11,850	$1,652	PA	$8,887	$8,887

Each provider billed services independently of the surgeon. In all three cases, the benefits paid to the PAs and the RNFA were greater than those paid to the INN surgeon, a Medical Doctor. How does this happen? The claims administrator explained its processing by citing its internal "managed care processing" guidelines: because the surgeon was in-network, the assistants would be considered in-network also, and paid at full charges, to spare the claimant from additional out-of-pocket expenses.

This inequity in reimbursement rates is disturbing. It is illogical and contrary to standard industry practice for an assistant surgeon (who is not even an M.D.) to get paid three, four, or five times as much for a surgery as the primary/supervising surgeon, particularly when standard claims processing protocols allow no more than 20% – 25% of the primary surgeon's allowance for the assistant (and an allowance of 10% – 16% when the assistant is not an M.D.).

Could this be an innocent attempt by the INN primary surgeon to control costs by utilizing the services of a PA or RNFA rather than another M.D., or a deliberate effort to maximize revenue by employing the services of an OON surgical assistant who the surgeon knows will be paid in full by the claims administrator?

In this auditor's view, since a PA or RNFA can provide services only under the supervision of a physician, it appears that reimbursement of PAs or RNFAs, billing independently, would not be appropriate. Absent any state insurance regulations that require a PA or RNFA to be reimbursed as if equivalent to a physician, and absent evidence that a PA or RNFA may bill as an independent practitioner in that state (i.e., separately from a supervising physician), we would ask the claims administrator to explain why the PA and RNFA charges were not included in the INN fee allowed for the primary/supervising surgeon. We would also ask why the charges of the OON assistant were not reduced to the industry standard percentage of the surgeon's fee.

Within this scenario there is a serious potential for inappropriate billing practices to maximize reimbursement. Consequently, the claims administrator should have a plan in place to proactively address such situations and apply reasonable cost controls for claims from non-M.D.s acting as assistant surgeons. Further, the claims administrator should investigate the financial relationship between the primary surgeon and the surgery assistants, and the claims administrator's Network Management should educate these network providers on the need to utilize network physicians as assistants in surgery. (Perhaps the surgeon's contract should **require** the use of INN assistant surgeons whenever possible.)

The Line Between In-Network and Out-of-Network Is Not As Clear As You Think

Although it may be the "right" thing to do to limit member out-of-pocket costs to be equivalent to in-network (INN) liability when a non-network provider renders services in a situation where provider selection is out of the member's hands (such as in an emergency room situation); sometimes a claims administrator will seemingly go too far in protecting the member.

SCENARIO 2
A $120,000 Ambulatory Facility Bill for Foot Surgery?

An INN podiatrist performs surgery at an out-of-network ambulatory surgery center (ASC). Should the facility charges be paid as in-network or out-of-network? According to the claims administrator on this sample claim, the services would be considered INN because the surgeon was INN, and thus the ASC's charge of $120,402 would be paid in full to protect the member from out-of-pocket costs (because the INN podiatrist drove the care to the out-of-network ASC).

When questioned by the auditor as to whether any effort had been made to determine the appropriateness of an ASC charge that appears exorbitant, the claims administrator responded: "The claim was sent for repricing and no discount was available." When the auditor further questioned whether the podiatrist had any interest or ownership in the facility, the claims

- Engage your claims administrator
- Know your administrator's strategies and philosophies
- Understand your administrator's standard practices

take control

administrator responded, "We will continue to research." Why this effort was not made before the claim was paid is unclear.

At a minimum, the claims administrator should require that INN physicians utilize INN facilities. Ideally, this should be contractually required; but if it can't be, this claim should have triggered the involvement of the claims administrator's Network Management. In addition, this claim should have also triggered a podiatrist consultant review (whether an internal or external consultant) and a comprehensive review of this provider's billing history. Further, the podiatrist's financial interest in the ASC should be examined for the possibility of self-dealing. Finally, it is unclear why the member was held harmless in this situation. Although the auditor recognizes the need to protect members from liability in situations where provider selection is outside their control, the selection of a facility for foot surgery is not outside the member's control. (When a claimant allows the surgeon to select an OON facility for non-emergency services, shouldn't the member be forced to accept the additional liability inherent in such a selection?)

The auditor considers the claim administrator's standard practice in this situation to be overly liberal and more supportive of administrative simplicity than plan intent. In addition, such liberalizations could have the effect of encouraging aberrant provider billing practices that maximize reimbursement, particularly in light of the absence of any limits on out-of-network facility charges (i.e., no "usual and customary" limitations). The auditor recommends that the claim administrator amend its standard practices and limit in-network upgrades to situations where provider selection is truly outside member control.

SCENARIO 3
A $13,000 Bill for Laboratory Services?

The claims administrator paid in-network benefits for an out-of-network laboratory on a claim for services that totaled in excess of $13,000. The claim was classified

as in-network (in accordance with the administrator's standard practices) because the laboratory service had been ordered by an in-network physician. From the auditor's perspective, although the selection of the laboratory was *somewhat* out of the hands of the claimant, the plan sponsor should expect the claims administrator to apply reasonable claim payment controls in such situations. At a minimum, Network Management should ensure that network providers refer to other network providers, as a network physician who routinely selects a non-participating laboratory should raise a red flag. In addition, the claims administrator should conduct an analysis of out-of-network referral situations focusing on frequency, trend and specific provider practices, and use the analysis to develop an action plan to protect plan funds going forward.

What Should the Self-Insured Employer Do?

Like the proverbial child with a hammer – to whom everything in the world looks like a nail – as an auditor I would be remiss if I didn't attempt to convince any self-insured employer to audit their medical claims administrator on a regular basis. The bottom line is, the quality of plan administration services has a profound effect on benefit costs. And when the above types of audit findings are brought to light, the employer, as plan sponsor, should be prepared to engage the claims administrator in frank conversations about fulfilling its role as a prudent guardian of plan funds. The situations described in this article can be used by plan sponsors as talking points for an in-depth discussion with their claims administrator. What is the administrator's philosophy and strategy in these types of situations? The more an employer knows about the claim administrator's standard practices and propensities for "liberalizations," the better control the employer has over plan costs and the administration of its own plan.

This is the first in an occasional series on real-life findings from claim audits of self-funded medical plans.

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