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WHY DO WE PAY INVOICES FOR ELECTRONIC PRESCRIPTION CLAIMS AS IF THEY WERE PAPER?

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Why isn't every invoice audited? In an age of high speed computers, and financial software why aren't Accounts Payable procedures updated to match the ability to verify every claim payment?

Accounts Payable procedures need to reflect the need for enhanced screening that can be accomplished with high speed computers and financial software. Invoices from PBMs, Health Plans, and TPAs ("providers") for pharmacy services need to be screened like any other bill for services; namely, they need to be analyzed for pricing, benefit compliance, contract compliance, clean claims policies, etc. Why is this necessary when these services are outsourced to providers that are expert at oversight of pharmacy services? Further, what is to be gained from enhanced screening of invoices when providers set up the benefits correctly and then replicate the set up electronically? Isn't this an audit function? This author posits the position that this is a direct Accounts Payable review function.

Current Accounts Payable procedures commonly reflect validation of claim counts and totals of payables. Any further validation is commonly referred to internal, or external, audit. Yet, audits are expensive, resource intensive, and time consuming. There are, however, multiple reasons to enhance Accounts Payable policies and procedures, as noted below:

1. Errors should be corrected with each invoice so that the "financial bleed" is corrected early rather than "downstream"
2. Electronic input still provides ample opportunities for error. Even if a sample is chosen and no errors are found, there can still be system errors
3. Providers have the responsibility to correct errors as soon as they occur. This can only be done when the company is more vigilant in their review of invoices
4. Screening/analysis of invoices can result in corrective actions being taken, rather than waiting for the lengthy and often contentious process of audit reconciliation and recovery
5. The company is protected by enhanced compliance with Sarbanes-Oxley Section 404, ERISA Sections 404 and 405, Medicare Part D, and applicable Department of Insurance or State regulatory and legal requirements when invoices match the company's best practices

In a time when invoices are supported by claim detail and computer resources are readily available, it is time to modify the best practice standards used to pay bills. Invoices for pharmacy services provide an example of the type of best practice criteria that can be extended to medical invoices as well. Accounts Payable practices no longer need to be based on paper claims. Companies can meet their regulatory and shareholder oversight obligations in a real-time mode as well as ensuring expense reduction in any business environment.

The reliance on electronic claims adjudication has dramatically improved accuracy and reduced the cost of claims payments. It has also allowed for more complex benefit structures. It has not, however, ensured that all claims are paid correctly or are consistent with benefits. It is imperative that every company establish more extensive best practices for its claims payment policies. The establishment and publication of these policies will ensure that all vendors are held to the company's best practice accounting standards for claims payments and assist internal auditors with their oversight functions.

BEST PRACTICES FOR ACCOUNTS PAYABLE (DIAGNOSTIC TOOLS)

The following is a list of issues to consider for designing best practice policies for Account Payable policies and procedures. Although this list is extensive, it is not exhaustive. Companies may choose to include all or some of these issues in their policies.

Claim Adjudication Issues to Consider

The fundamental reasons why claims can vary after set up are the following:

- The client definition was not set up correctly. This is a manual process so there is potential for errors. Each new set up needs to be validated and signed off by the company. In addition, each time a new group or plan is set up there is potential for manual errors. This needs to be verified.
    - Did the provider interpret the contract correctly? Did they interpret the benefit correctly?
    - SAS70 identifies that the claims adjudication process has been tested according to specific criteria, but not all. It is not a claim audit. Providers may reference SAS70 as validation of claim adjudication processes and to qualify the scope of all claim audits.
    - If the provider has system set up's that are not consistent with benefits, then the claims adjudication regresses to the provider standard rather than to the benefit.
- Files required for pricing must be updated and edited regularly. This process requires constant validation. Questions to ask and areas of focus are as below:
    - If a claim is run on a plan/group basis, validate that updates made timely, and that effective dates were changed appropriately.

      NOTE: As an example, suppose the provider uses a maximum allowable cost (MAC) list as one of the elements of the pricing formula. The providers frequently indicate that the MAC file is proprietary so it has not as yet been made available for testing against claims.

    - Medicare Part D claims must be verified for transparency, even if all pricing elements are not made available.
    - Usual and customary (U&C) is submitted by the pharmacy with every claim and is an element of the "lesser of" pricing formula. If U&C is not submitted than the pricing formula cannot be validated. If the provider does not test the U&C submitted against the pharmacy chains' published U&C (e.g., Wal-Mart $4 generics), then the company pays a higher fee than a cash paying patient.
- Provider policies may not allow for validation of pharmacy submitted usual and customary (U&C) charges. As a result, the pharmacy may submit a U&C price in excess of their published

discounted price. The provider may not be verifying the U&C or any prorating necessary based on the published discounts.

- Dirty data leads to poor claim adjudication. The invoice screens identify multiple instances of invalid claims, null fields, etc., that can cause adjudication problems in individual claims. If procedures for adjudicating "clean claims" are not followed, then adjudication problems occur. In addition, this allows for random variance errors.
- The order of processing of claims demonstrates errors. Depending on which elements of the claim are adjudicated, a change in the order can change the results.
    - For example, is eligibility, pricing or benefit tested first? If a claim is paid before the enrollment file is updated, then does the contract language cover what to do?

Common Issues to Analyze For "Clean Claim" Violations

Potential violations based on invalid prescriber identifier issues

- Are there claims where the physician identifier is invalid or unknown? Is this prevalent in areas where abuse or fraud is common? Are both narcotics and non-narcotics an issue?
    - If these issues exist, then the company should require that a valid DEA (not just compliance with the algorithm), State License number, Tax identification number, or NPI be used for at least narcotics and an NPI used for non-narcotics. Both the NPI and DEA files are available to the provider.
- Drug Enforcement Agency (DEA) numbers are currently used for claims for pharmacy services. There are two methods to verify the validity of a DEA number: (1) an algorithm, (2) the DEA file of licensed prescribers. Many providers claim they have no way to effectively audit DEA numbers beyond checking an algorithm. However, this is insufficient. Anyone who searches the internet can use Wikipedia where there are explicit instructions for constructing a DEA number for anyone who would wish to fabricate one. Also, there is a DEA data storehouse that any person can validate or lookup any DEA. This issue may not be cured with NPI numbers as the new NPI numbers are only required of the provider presenting the bill.

Potential violations based on invalid prescription information

- Invalid drug identifiers (NDC numbers) indicate that claims cannot be priced correctly
- Old drug identifiers (NDC numbers) indicate that prices have not been verified
- Null or invalid quantities or days supply indicate that claims have been submitted that should not be paid either because there is no amount dispensed or because the dose could not have been verified by a pharmacist.
- Invalid pharmacy numbers indicate that the claim was not verified for potential abuse or fraud

Areas to Review: Invoices Validated to Claims

1. Where is the charge for the claim administration fee? If it is rolled into the ingredient cost, dispensing fee, or total amount paid, then there is no separate accounting in the claims or in the invoice. Since the administration fee is paid to the provider, then it needs to be separate from the drug payable to insure compliance with contractual guarantees.
2. Is the company paying for reversed claims (debits) that match credits in the reversals? Why is the company paying for these debits?
3. Is there a correlation between the claims file and the file that supports the invoice? Can the process that the provider uses to reject or pay claims for the invoice be independently verified?

   a. All invoices need to be having the raw claims file and the file supporting the invoice are compared to validate the claims supporting the invoice.
4. The provider should also supply a claim scrubbing procedure to the company to use as a basis for the system documentation of how credits/reversals are reflected in the claims system.

Pricing Validation Issues

Pricing is based on verification of brand, generic, multisource, over-the-counter, and specialty injectable claims. Every claim can, and should be, checked to ensure compliance with contracts and appropriate brand, generic, and multisource coding. For example, miscoding of multisource drugs as brand can cost the members higher brand copays and the payer higher brand cost. Also, it is necessary to verify if there is a variance between the invoice price, the national pricing source, and all pricing elements.

The following information should be provided by the provider to support variances found in each invoice:

1. Source documentation for prices of exception claims that allow the company to test the drug pricing, e.g. a complete First Data Bank price list.
2. Monthly summary report (change or exception report) of all individual drug prices that have changed -- increased or decreased.
3. Documentation of date and price changes for these changed drugs (e.g. the notice from First Data Bank and the provider's screen print with effective date noted).
4. Monthly summary report of any changes in the calculation or application of discounts.
5. Monthly summary report of any changes in NDC codes, e.g. new or expired drugs.

Best Practice Accounts Payable Policy and Procedures for Pharmacy Service Payments

Accounts Payable policies and procedures must be designed to establish best practices for the company that minimizes the risk of overpayments and overstating expenses. Procedures should document best practices for financial reporting and the conditions for valid payments. These policies and procedures must also comply with legal, regulatory, State requirements, and shareholder protection, if applicable.

The following policies and procedures should be considered for inclusion in Account Payable polices and procedures for employee benefit payments for pharmacy services. These issues are also common to all employee benefits expenses.

1. Establish best practices for all invoice payments and emphasize all areas that minimize the company's risk for overpayments
2. Pay only for clean claims, i.e., claims that contain only valid information for all required fields
3. Establish certain screening parameters for all invoices that include validation of claims payments, benefit compliance, and contract compliance.
4. Inform all vendors that the company has internal best practices to screen the work of third-party vendors on every submitted invoice
5. Add policies for services that require a "match up" of pharmacy services with payments that is similar to the policies used for buying merchandise
6. Establish policies to ensure that vendor invoices contain only those services that are compliant with applicable State; legal; regulatory; and when applicable, Department of Insurance, Sarbanes-Oxley Section 404, ERISA Section 404 and 405, and company best practices.

7. Require that the provider have a SAS70 on file for all procedures required by company best practice. This is not substitute for company oversight, only insurance that the vendor has internal validation for certain procedures of their own.

In summary, this author has outlined very specific areas for review and analysis to ensure that electronic prescription claims have been adjudicated, or paid appropriately. In our experience there is as at a minimum approximately 7-11% opportunities for performance improvement. This equates to a significant amount of bottom line drug spend to leave essentially "unattended". This area warrants regular and ongoing oversight, management and scrutiny. It behooves us to include these policies and procedures in our accounts payable functions. It makes good business sense.

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