

STATE SELF-INSURED HEALTH AND WELFARE FUND GROUP



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USA

Industry:
Government and Healthcare

CGI Federal Inc. undertook a complete pharmacy claims audit of a large Southwestern U.S. State's self-insured health and welfare fund group. The pharmacy claims history covered a 19-month time span including 947,303 claims paid totaling \$26,339,454. The prescription plan was uniform for all subscribers and limitations were placed on several drug categories that were excluded.

The Challenge

The plan was dissatisfied with its pharmacy benefit firm and Drug Utilization Review (DUR) vendor due to complaints and a lack of response to the plan's requests for improvements in their administrative functions and accountability procedures. Also, as a result of administrative errors, lack of proper adjudication edits and a low level of cooperation by the PBM when requests for information from the network pharmacies were made, the pharmacies were lackadaisical in making attempts to correct plan parameter errors potentially leading to additional misuse of the prescription benefit.

How CGI Helped

Using our proprietary pharmacy claims auditing system, CAS-RX, CGI audited and verified the integrity of all parameters of the benefit design, plan pricing and retrospective DUR programs. An audit of the highest dollar prescriptions dispensed showed five claims totaling over \$16,000, where the quantity dispensed was unrealistically high, that escaped the internal edit of the PBM to flag these claims for adjustment. An audit of intravenous medications showed 363 claims totaling \$91,973 erroneously billed through retail pharmacies for items such as chemotherapy, medications administered prior to inpatient surgery and IV admixtures. The client, trying to lower the frequency of dispensing fees charged for repeat prescriptions of maintenance drugs by mandating 90-day supplies, requested an audit of the number of prescriptions and claims dollars that were dispensed in less than thirty-day supplies. The audit showed a total of 75,539 claims dispensed in under a thirty-day supply. If the proper edits had been in place, two-thirds of the dispensing fees could have been eliminated for an additional savings of approximately \$100,000. A duplicate therapy audit was designed to assess the quality of the DUR and oversight that was occurring by the PBM. Duplication of therapy is costly not only because of unnecessary prescriptions that are being dispensed, but also because of medical complications that can occur. The audit was designed in a very conservative fashion to display duplication at the extremes. Maximum daily adult dosages were used to calculate a minimum day supply range. There were 14,921 instances suggesting that an increased effort in DUR screening would be beneficial to the plan and its patients. The audit system, including analyses of subscribers, pharmacies and physicians, also highlighted instances where case management and DUR would be likely to save prescription benefit dollars in the future with intervention strategies and showed members utilizing high cost medication, with the highest utilization rates and greatest dollars in prescription spending.

The Results

The recovery from the audit totaled \$771,695 involving 391,254 prescription claims. This represented 2.9 percent of the prescription claims dollars and 41 percent of the claims respectively. 30 percent of these dollars were attributed to duplicate claims, 39 percent to AWP pricing errors and incorrect discounting and 31 percent were excluded drug category prescriptions that were dispensed. Almost 97 percent (377,908) of the claims recovered resulted from incorrect AWP prices and/or discounts being applied to brand name drugs. Over 342,000 of these claims were incorrectly priced by up to \$1.00, 33,000 claims were incorrectly priced between \$5.00 and \$1.00 and the rest of the claims were incorrectly priced between \$1,000 and \$10.