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Employee Benefit Plan Review

Preventing Fiduciary Risk and Financial Loss From Medical Billing Abuse

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With each passing year, it is not only more expensive for self-insured companies and ERISA group plans to provide comprehensive health benefits, it is also increasingly risky. As plans struggle to manage costs, they must also navigate new legal considerations as plan fiduciaries.

A case in point is the recent employee lawsuit alleging Johnson & Johnson failed in its fiduciary duty to the company's health plan participants.[1] In the wake of this litigation and as it reverberates throughout the benefits world, plan sponsors need a new system and data-driven processes to mitigate these risks.

Unfortunately, the support of administrative service providers is deficient as millions of dollars in unjustified medical charges continue to leak through many plans undetected, resulting in overpayments for services rendered. The total cost of pricing failure, fraud, and abuse in American health care is estimated to cost between $289 billion and $324 billion, more than three times the state of Florida's budget.[2]

While an unjustified value transfer of that magnitude from payors to providers poses growing economic and legal risks to payors, there are steps that can be taken to reduce the financial drain and provide protection from legal action. These steps begin with understanding the background and incentives of those involved in the healthcare ecosystem.

The Shifting Role of Health Insurers

Self-insuring an employer or union association health plan has become a popular cost containment strategy. As a result, traditional health insurers have largely been decoupled from the financial risk of medical claims and have transferred that risk back to self-insured groups. This has left the "health insurer" with the administrative tasks of processing and paying claims, under administrative services only (ASO) contracts. This shifting of medical claims risk diminishes the incentive for these ASOs to monitor medical claims for errors or fraud that result in overpayments.

As a result, employers increasingly have disclosed that their ASOs make it more challenging for them to meet their fiduciary responsibilities. Just a few of the recent complaints shared include:

- An employer asked its ASO to provide data on the group's medical claims exceeding $75,000 for plan approval prior to payment. The ASO refused.

Figure 1

WellRithms™

Review and Recommendation

Patient:
Provider:

DOS: 2023
Pat Address

Pat Acct No:

Client:
Tracking No:
Claim No:
Received Date:
Completed Date:

Provider TIN:
Provider NPI:

Provider Ref No:

Cust Doc No:
Member ID:

Bill Type: IPH
Coverage: GROUP
Treat State:

ICD-10 Codes
ADMIT:S33.4XXA
DX1:S33.4XXA
DX2:J15.4
DX3:J80
DX4:S35.511A
DX5:N17.0
DX6:T82.7XXA
DX7:D62
DX8:E87.0

PROC1:02HV33Z
PROC2:0B110F4
PROC3:041K0ZH
PROC4:0QS304Z
PROC5:0U9M0ZZ
PROC6:0BCF8ZZ
PROC7:04LL0CZ
PROC8:06H03DZ
PROC9:0BJ08ZZ

Rev	CPT	Mod	Units	Billed
206			13.00	$110,344.00
208			27.00	$352,566.00
250			1618.00	$54,963.87
270			555.00	$23,734.84
272			262.00	$44,294.50
274			5.00	$607.50
278			18.00	$54,981.00
300			57.00	$3,406.32
301			162.00	$112,902.51
302			38.00	$20,295.59
305			124.00	$51,810.59
306			66.00	$42,382.75
307			3.00	$988.71
320			13.00	$18,860.06
323			2.00	$23,694.10
324			21.00	$19,777.80
351			9.00	$72,254.18
352			18.00	$186,360.01
359			4.00	$0.04
360			1136.00	$346,970.18
361			9.00	$75,692.02
370			1136.00	$160,587.80
390			17.00	$17,514.30
391			8.00	$16,257.76
402			3.00	$5,559.60
410			1.00	$111,959.61
420			1.00	$4,484.00
424			1.00	$2,250.00
430			1.00	$4,017.00
434			1.00	$3,240.00
440			1.00	$5,848.62
444			1.00	$688.00
450			1.00	$3,712.61
460			6.00	$789.36
483			1.00	$3,621.53
636			9999.00	$100,098.54
682			1.00	$19,500.00
710			156.00	$17,261.36
921			3.00	$9,852.98
942			2.00	$159.72
636			1537.00	$15,386.68

Total Charges: $2,119,676.04

- A group requested its annual claims data from its ASO. The ASO refused, stating that such a service would be "redundant."
- A self-insured employer was refused access to its own claims data by a gag clause, which limited data requests to 225 claims every two years.

To achieve fair and accurate payment for services plan fiduciaries must protect their organizations from these impediments. But doing so requires access to data, and an understanding of how the current process of medical billing and reimbursement leads to serious abuse, inflated charges, and subsequent overpayments.

In the billing and reimbursement cycle for self-insured groups, medical providers care for patients and then submit bills to the ASOs serving these patients and their union or employer. However, providers submit what is known as a Uniform Bill, or UB-04. The uniform bill hides a plethora of illegitimate charges that can be found only upon close inspection of the itemized bill, because the uniform bill does not provide details on what services and supplies were provided.

The UB-04 is analogous to a restaurant's bill at the end of a dinner that says, simply, "Dinner for two: $300." Only an itemized statement of appetizers, drinks, entrees and

Figure 2

	42 REV. CD.	43 DESCRIPTION
1	0200	INTENSIVE CARE OR ICU
2	0250	PHARMACY
3	0270	MED-SUR SUPPLIES
4	0272	STERILE SUPPLY
5	0278	SUPPLY/IMPLANTS
6	0300	LABORATORY OR LAB
7	0320	DX X-RAY
8	0321	DX X-RAY/ANGIO
9	0350	CT SCAN
10	0351	CT SCAN/HEAD
11	0352	CT SCAN/BODY
12	0360	OR SERVICES
13	0370	ANESTHESIA
14	0390	BLOOD/ADMIN/STOR
15	0410	RESPIRATORY SVC
16	0450	EMERG ROOM
17	0460	PULMONARY FUNC
18	0611	MRI - BRAIN
19	0612	MRI - SPINE
20	0636	DRUGS/DETAIL CODE
21	0681	TRAUMA LEVEL I
22	0730	EKG/ECG
23		PAGE 001 OF 002

Figure 3

270	07/29/2023	OXYGEN PER HOUR	12	497.04
270	07/30/2023	OXYGEN PER HOUR	12	497.04
270	07/30/2023	OXYGEN PER HOUR	12	497.04
270	07/31/2023	OXYGEN PER HOUR	12	497.04
270	07/31/2023	OXYGEN PER HOUR	12	497.04
270	08/01/2023	OXYGEN PER HOUR	24	994.08
270	08/02/2023	OXYGEN PER HOUR	12	497.04
270	08/02/2023	OXYGEN PER HOUR	12	497.04
270	08/03/2023	BINDER ABD MED LG 12	1	121.00
270	08/03/2023	OXYGEN PER HOUR	12	497.04
270	08/03/2023	OXYGEN PER HOUR	12	497.04
270	08/04/2023	OXYGEN PER HOUR	12	497.04
270	08/04/2023	OXYGEN PER HOUR	12	497.04
270	08/05/2023	OXYGEN PER HOUR	12	497.04
270	08/05/2023	OXYGEN PER HOUR	12	497.04
270	08/06/2023	OXYGEN PER HOUR	24	994.08
270	08/07/2023	OXYGEN PER HOUR	24	994.08
270	08/09/2023	OXYGEN PER HOUR	24	994.08
270	08/10/2023	OXYGEN PER HOUR	24	994.08
270	08/11/2023	OXYGEN PER HOUR	12	497.04
270	08/11/2023	OXYGEN PER HOUR	12	497.04
270	08/12/2023	OXYGEN PER HOUR	24	994.08
270	08/13/2023	OXYGEN PER HOUR	12	497.04
270	08/14/2023	OXYGEN PER HOUR	24	994.08
270	08/15/2023	OXYGEN PER HOUR	12	497.04

desserts could reveal inappropriate charges.

In the world of medical billing and reimbursement, an ASO or TPA receives a uniform bill, applies a contractual discount to the charges (such as 50%), and then facilitates the financial transaction's closure between the payor and provider. While a 50% discount from billed charges sounds like a success for the payor, no one in the chain of events typically asks the question, "50 percent off of what?" The discount is merely a mirage if a uniform bill is laced with charges for services that may have never been provided, surgical implants never used, unbundled or up-coded procedures, or services that are contractually not allowed.

Fortunately, the itemized bill for a patient's care will reveal these and other billing irregularities, which can be substantial, as illustrated in the example discussed below.

A hospitalized patient suffered serious injuries after being struck by a car. The hospital's charges totaled $2,119,676 (see Figure 1).

This billing summary simply reflected revenue code charges (see Figure 1, left column) and hid a multitude of problematic charges. The provider's Uniform Bill contained no details of what was included in the revenue code summaries, or whether all the individual charges were warranted. Instead, each revenue code has a broad description of the item charges included within it, such as REV 272 for sterile supplies, or REV 278 for implants (see Figure 2).

Revenue codes such as those in Figure 2 are a summary description used to indicate and classify accommodations, the department, type and location of specific services provided (e.g., room and board, imaging, etc.). Revenue codes lack details on how much was charged for specific drugs, procedures, supplies, implants and other items.

Hidden among those many items are supplies and services that commercial payors do not reimburse, according to their contractual agreements. For example, imagine a $600 charge for brake work on a car, that included $50 for the wrench to remove the nuts holding the wheels in place and $150 to remove the wheels to get access to the brakes. That wrench and removing the wheels are part of the brake service, and nobody would agree to pay such absurd charges. But that is what happens routinely in medical billing. And the breadcrumbs that reveal those details can only be found in an itemized bill.

Why Administrative Services Only Providers Stop Looking

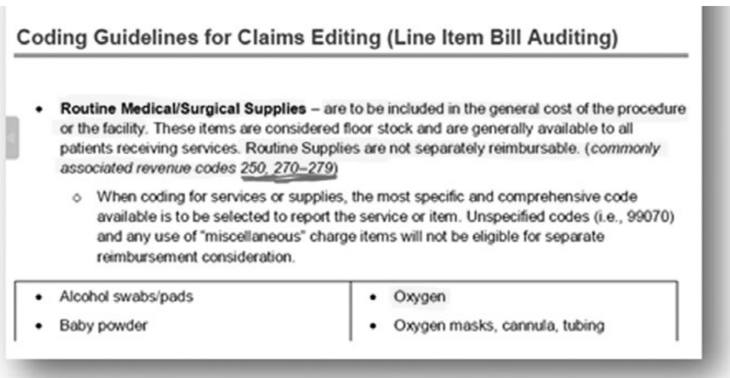
Plan fiduciaries typically assume that their ASO providers review bills for accuracy and only charge plans for reimbursable items. That is not the case. The only way to ensure a Uniform Bill is correct is to review the itemized bill. These itemized charges get rolled up into the Uniform Bill's summary revenue codes. This is where illegitimate charges can be found hiding among legitimate ones.

For example, the itemized bill (Figure 3) for the hospitalized accident victim introduced earlier shows oxygen charged at $497 to $994 per hour, for a total of $22,863.

However, supplies such as oxygen are always included in general facility costs and should never be billed separately (see Figure 4, the ASO's Coding Guidelines for Claims Editing).

In the case of the accident victim's $2,119,676 hospital bill, the carrier network plan offered a 70% discount from billed charges, reducing the bill

Figure 4



Coding Guidelines for Claims Editing (Line Item Bill Auditing)

- **Routine Medical/Surgical Supplies** – are to be included in the general cost of the procedure or the facility. These items are considered floor stock and are generally available to all patients receiving services. Routine Supplies are not separately reimbursable. (*commonly associated revenue codes 250, 270–279*)
  - When coding for services or supplies, the most specific and comprehensive code available is to be selected to report the service or item. Unspecified codes (i.e., 99070) and any use of "miscellaneous" charge items will not be eligible for separate reimbursement consideration.

• Alcohol swabs/pads	• Oxygen
• Baby powder	• Oxygen masks, cannula, tubing

to $629,421. That sounds like a bargain. However, the ASO never bothered to check the itemized services and supplies within the $2,119,676 bill. Had they done so, they would have discovered the bill contained non-allowable charges. Those often can be substantial, as illustrated by the charges of $22,863 for oxygen.

Network ASOs typically pay based upon the UB's s total charges and contractual discount without providing any further scrutiny. The logic for ignoring that scrutiny is clear – in the end the savings go back to the group, not the ASO. Additionally, it consumes time and resources for the ASO to request the itemized bill, fight through provider resistance to get it, then perform a detailed review.

Conducting an itemized review of this $2,119,676 bill using software, artificial intelligence and professional physicians found that the actual allowable charges were $1,717,732, not $2,119,676. In other words, the group was charged $441,944 that the ASO never bothered to investigate or challenge on behalf of its client.

Protecting Your Plan

In the wake of the Johnson & Johnson lawsuit, such failures by ASOs to dig into itemized patient bills can leave employers and unions vulnerable to litigation by plan participants.

Self-funded groups can protect themselves. They can start by working with legal counsel to strengthen summary plan documents language that include robust reimbursement guidelines with definitions and exclusions, ensuring the language protects them from overpaying for services. Here are some specific recommendations:

- Require a copy of itemized bills, medical records, implant invoices, and any other information that may be useful in adjudicating claims.
- Allow for "Audit of Certain Charges" when performing bill reviews. Do not allow on a line-item basis (CPT, HRC, HCPCS, etc.) a greater reimbursement than billed charges. The plan administrator is entitled to rely on all nationally recognized billing and coding edits when performing a bill review.
- Retain an independent third party to perform bill review and repricing, beginning with line-item level review of the itemized bill that includes physician scrutiny. This is more precise and thus more legally defensible than top-down, reference-based pricing using Medicare as a guideline and negotiation as the fallback plan when providers resist.

High Stakes Ahead

Now more than ever, the risks are higher for failing to get the data and advocacy that plans and members need.

- *High Dollar Claims Are on the Rise*: Million-dollar-plus claims per million covered employees rose 8% in 2023 and are up by 50% over the past four years. The number of claims exceeding $3 million nearly doubled.[3]
- *The Problem Is Pervasive*: Various surveys over the past five years show that the percentage of self-insured employers incurring claims over $1 million ranges from 20% to 31%.[4]
- *Catastrophic Claims Pose a Threat to Employer Funded Healthcare*: Nearly 8 in 10 employers consider high-cost claims a significant threat to employer-sponsored healthcare.[5]
- *Healthcare Expenses Are Eroding Incomes and Crushing Patients*: The share of total employee compensation going to health care premiums among American workers soared from 7.9% in 1988 to 17.7% in 2019, and 29% for lower income workers.[6] Americans owe at least $220 billion in medical debt, almost the size of Greece's economy.[7] And surveys show medical debt to be the leading cause of personal bankruptcy.[8]

The time is now to herald in a new age of transparency, to minimize the growing financial and legal risks of medical overbilling and avoid overpayments to ultimately enrich the benefits of members. ❂

Notes

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3. Annual High-Cost Claims and Injectable Drug Trends Analysis Report, Sun Life, May, 2024.
4. Annual High-Cost Claims and Injectable Drug Trends Analysis Report, Sun Life, May, 2023; Aegis Risk Medical Stop Loss Premium Survey, 2019.
5. National Alliance of Healthcare Purchaser Coalitions, High-Cost Claims Fastest Driver

of Healthcare Expense for Employers, June 2, 2023.

6. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families, Kurt Hager, Ezekiel Emanuel and Dariush Mozaffarian.
7. The Burden of Medical Debt in the United States, Shameek Rakshit, Matthew Rae, Gary Claxton, Krutika Amin, and Cynthia Cox, Kaiser Family Foundation, February 12, 2024.
8. Medical Bankruptcy: Still Common Despite the Affordable Care Act, David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler, American Journal of Public Health, March, 2019.

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