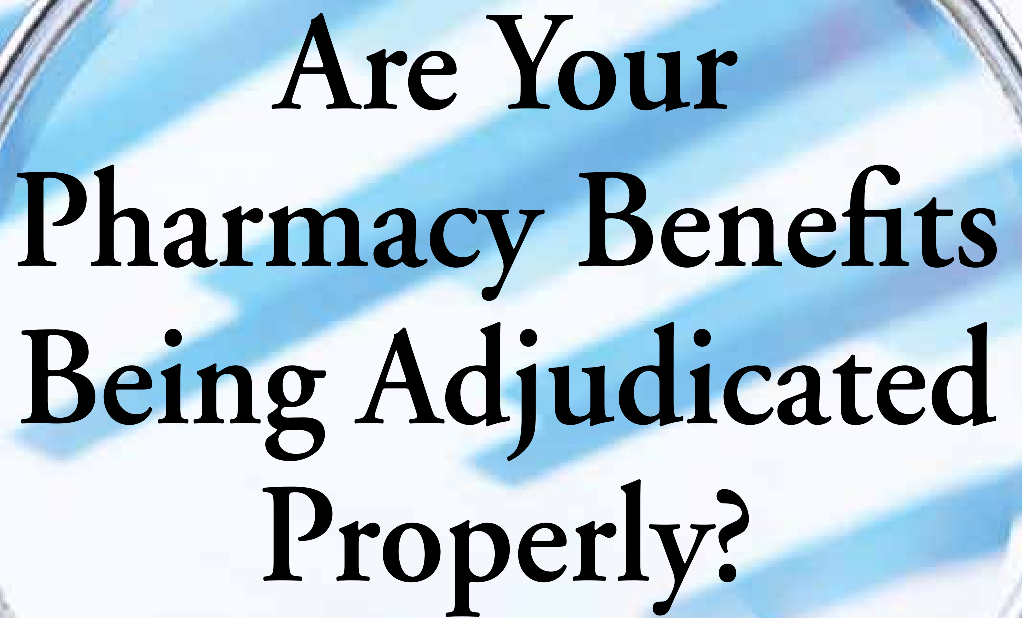

Are Your Pharmacy Benefits Being Adjudicated Properly?

A PBM Audit Can Tell You

by | **Brian N. Anderson**

While almost all pharmacy benefit manager (PBM) contracts include audit provisions, many plan sponsors underestimate the value of auditing their PBM. Ensuring that a pharmacy benefits plan is set up correctly and performing as intended is not only a fiduciary duty, but also a potential opportunity to recover funds lost through overpayment or system errors. Employers, health plans, Taft-Hartley funds, Medicare Advantage Part D plans, brokers and other pharmacy plans should seriously consider conducting a claim audit.

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takeaways >>

- A PBM audit is a potential opportunity to recover funds lost through overpayment or system errors.
- Even a minor coding error can result in a large number of incorrectly paid claims.
- Audits verify that the benefits spelled out in the contract are being provided.
- On average, the return on investment in an audit is six to ten times the price of the audit.
- An audit typically examines financial elements, plan design, claim eligibility, rebates and performance guarantees.
- A comprehensive audit usually involves electronic testing of all available claim data, followed by a manual evaluation of claim issues that the electronic testing flagged.
- An implementation audit should be done soon after a plan has been set up, followed by a claim audit every one to two years.

With more than 4.5 billion pharmacy claims occurring each year, it is easy for a consumer or health plan to just pay the claims, assuming they are accurate. Because most pharmacy claims are automatically adjudicated electronically, even a minor coding error could result in a large volume of incorrectly paid claims with a serious financial impact. Common errors may include duplicate billing, incorrect or missing discounts and rebates, and mistakes in member eligibility. A comprehensive audit checks every claim during a fixed period of time (e.g., a plan year) to assure compliance with contractual guarantees.

The most important aspect of auditing focuses on pricing—verifying that the benefits spelled out in the contract are in fact being provided, especially the discounts that may apply to average wholesale price (AWP) or other forms of pricing.

Additionally, a claim audit should review manufacturer contracts regarding rebates and reconcile rebate payments received with the plan sponsor's contractual guarantees. The approach to the audit may vary depending on whether the client has *spread pricing* (where the PBM charges its client more than the PBM pays the pharmacy for filling a prescription) or *pass-through pricing* (the PBM charges the client the same price the PBM paid the pharmacy) returns in place.

Return on Investment

On average, problems are found in 3% to 5% of paid claim costs, with recoveries of 1% to 2%. The return on investment is estimated to be six to ten times the cost of the audit.[1] Additionally, one of the biggest returns is from prospective savings resulting from a contract market check review conducted in conjunction with the audit. The market check review helps to clearly define ambiguous contract terms to achieve more competitive market terms and rates. Contract market check reviews are becoming increasingly more common. Market check provisions also come with a variety of contract considerations such as their timing (e.g., midterm with changes effective the next plan year); what pricing can be compared; whether the PBM or the consultant (or both) conducts the market check; and, if by the consultant, the amount of information the market check will require.

With both audits and market checks written into their contracts, plan sponsors are doubly armed to maximize their potential for savings, and PBMs will benefit from a more transparent relationship.

Goals of the Audit

The primary goal of a PBM claim audit is to verify the accuracy of claim payments according to the pharmacy plan's parameters and contractual agreements. This process covers a number of other contractual terms and parameters as well. The audit should have at least the following specific objectives:

- Verify that the plan is being administered in compliance with contractual obligations and that the plan sponsor is receiving all benefits of the contracted arrangement
- Confirm the proper application of various pricing elements related to claim cost determination, such as negotiated discounts and maximum allowable cost (MAC) applications
- Identify errors, propose solutions, determine the efficiency of administrative practices and assess the recovery potential
- Review whether claim cost-management features and clinical protocols are being administered appropriately and are providing the intended value
- Compare vendor performance against guaranteed standards to ensure quality administration.

Elements of the Audit

An audit typically examines financial elements, plan design, claim eligibility, rebates and performance guarantees.

Financial Elements

The audit:

- Assesses whether the contracted pricing arrangement—including discounts, MAC price lists for generic medications, dispensing fees, taxes, etc.—is being properly applied
- Reviews all records for possible duplicate payments
- Reconciles claim and administrative fee invoices
- Tests all rebates for "reasonableness"
- Tests to validate the amount of spread pricing
- Tests to verify benefits pass-through performance.

Plan Design

The audit:

- Evaluates the accuracy of member cost sharing
- Identifies any payments that exceed plan limits and maximums
- Checks for compliance with formulary and generic product provisions, as applicable
- Verifies that clinical edits are applied properly (e.g., step therapy, utilization reviews, etc.)
- Reviews prior authorization history for the proper application of designated plan protocols for selected medications
- Determines whether covered and excluded medications are being properly handled
- Validates early refills and compliance with frequency limitations
- Ensures proper application of quantity limits established for selected medications and other plan features as defined by either the PBM setup document or the plan summary plan description (SPD).

Eligibility

The audit compares plan eligibility files to claim files to verify claims were paid only for covered members and their dependents from their effective dates to their termination dates. Plans can also use the opportunity to conduct broader eligibility audits at this time to ensure that all covered employees and dependents are eligible for coverage through the plan.

Rebates

The audit assesses the financial and procedural accuracy of rebate reimbursement based on the plan sponsor's contracted arrangement with the PBM. The rebate audit process reviews:

- The agreements between pharmaceutical manufacturers and the PBM
- The rebate invoicing, compared with the manufacturer agreement terms, for consistency and reconciliation
- Historical reports of rebates generated and their conformance with the plan manager's contractual guarantees.

Performance Guarantees Review

Finally, the audit reviews the PBM's compliance with established performance guarantees as defined in the contractual agreements.

The Auditing Process: First Stage

A comprehensive audit usually takes place in two stages. The first entails a thorough electronic testing of all available claim data, including claim adjustments and reversals. The second stage is a manual evaluation of claim issues that the electronic testing identified.

Today's computer-assisted audit tools and techniques make it possible to examine 100% of a plan's data in the first stage. The efficiency and completeness make this far preferable to the earlier practice of manually reviewing only a sample. Reviewing all of the electronic claim records, including claim adjustments and reversals, gives the plan sponsor the most accurate final audit report possible.

The Auditing Process: Second Stage

In the second stage, the auditor examines individual claims (or groups of claims) that the electronic testing flagged from the complete data set because of apparent discrepancies. The purpose of this stage is to determine whether the electronic testing of those claims was accurate. In addition, the auditor will go on site for a firsthand operational review of how the PBM is managing the plan.

Often, when issues are identified, the auditor finds groups of claims paid incorrectly for a single reason. The objective at that point is to determine if the PBM has a systematic error in its processing system for the plan and, if so, how to correct the issue.

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F. Randy Vogenberg. International Foundation. 2011.
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The Report

At the end of the audit, the auditor compiles the findings and delivers a preliminary report to the plan sponsor and the PBM for review, comment and clarification. There follows a reconciliation assessment, in which the auditor reevaluates identified claim errors based on the PBM's response to the preliminary report.

Final Report

The final report takes the review and reconciliation process into consideration, explains the auditor's position on each item, and makes recommendations for any corrective action needed.

The final audit report includes:

- A description of the auditing process and its findings
- A listing and description of any material systematic or repetitious errors, noncompliance with contractual requirements, or inadequacies in claim control procedures and clinical programs
- An evaluation of the financial and service impact of the audit findings
- An identification of any specific problem areas warranting further investigation and/or additional focused auditing.

How Long Does It Take?

A claim audit typically can be completed in three to six months depending on a variety of circumstances. A rebate audit can be completed in approximately the same amount of time but is more heavily dependent on the transparency of information related to manufacturer arrangements.

Once the audit is complete and the report delivered to the plan, the recovery effort begins. This process is separate from the audit, and the plan sponsor must decide whether to engage an outside consultant for this matter or handle it in-house. The recovery effort can take longer than the audit, because it involves multiple communications between the PBM and the consultant (or in-house administrator) to ensure that issues are resolved to the plan sponsor's satisfaction, that any reimbursement is made, and that all administration concerns are resolved and corrected.

Implementation Audit

Over the life of a plan, it is best to have claims audited every one or two years—preferably every year. But it is equally important to apply what is called an *implementation audit* to a plan soon after it has been set up—after, say, three months of experience with a new vendor or under a new contract with a continuing vendor. The purpose of an implementation audit is to ensure the plan has been set up correctly and that the plan sponsor is realizing all benefits it contracted for during the implementation process.

Conclusion

Thanks to electronic auditing, claim audits are more ef-

<< bio

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fective than ever before. They can identify workings of a plan that can be improved, whether it is a single isolated issue or systematic/repetitive errors, noncompliance with the terms of a third-party contract or simple data entry errors.

As noted, PBM audits are generally cost-effective. While certainly not guaranteed, it is not unusual to find savings in excess of the cost of the audit. At minimum, the plan sponsor is able to rest assured that it has met its fiduciary responsibilities in the areas of managing its PBM contract and ensuring its plan participants receive the benefits to which they are contractually entitled.

Endnote

1. Return of investment estimates are rounded for illustrative purposes and do not always apply.