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THE NEW WILDWEST

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Driving Change in Payers' Fraud, Waste and Abuse Recovery Efforts

PPACA pressures insurers to focus on prevention, not post-payment recovery.

By Gary Stuart

Health insurers and the federal government don't see eye-to-eye on many facets of the Patient Protection and Affordable Care Act (PPACA). But when it comes to preventing fraud, waste and abuse (FWA), private payers are in full support of provisions designed to enhance data sharing efforts and impose stricter

penalties. The need is clear: As much as 10 percent of healthcare spending is lost to abuse, according to recent studies , with the federal government alone losing more than \$70 billion to improper Medicare and Medicaid payments, according to the Department of Health and Human Services (HHS).



True, the new rules written into the PPACA are largely devoted to eradicating FWA in Medicare and Medicaid, but health insurers will no doubt benefit from increased screening and data sharing efforts designed to prevent FWA, rather than trying to recoup payments later determined to be the result of a billing error or fraudulent activity (i.e., pay-and-chase).


Prevention. It's a model that some private healthcare payers have already employed, assisted by analytical technologies that detect claim anomalies. Those that haven't – about

70 percent of private payers, according to the National Health Care Anti-Fraud Association (NHCAA) – must understand that under new circumstances, prepayment FWA avoidance programs are a vital component of payers' strategies to lower costs and improve profitability.

Challenges Payers Face Now and in the Future

Annually, FWA drains between \$68 and \$226 billion from the United States' healthcare





system – and taxpayers’ pockets. The causes of these erroneously paid claims are many. Along with mistakes introduced during the revenue cycle, organized crime rings steal patient IDs and create fictitious services and procedures that defraud payers, mar medical records and even endanger patients’ health and safety.

Further complicating the scene for payers are complexities on the horizon for healthcare providers. These changes are not just the children of reform, but also include the previously directed mandates to implement ICD-10 diagnosis coding. ICD-10 will require providers to change their systems to reflect new codes for thousands of diseases, symptoms, injuries and abnormal findings. If providers are

not prepared to submit claims using ICD-10, and payers are not prepared to accept these updated codes, the door is left wide open for more error-filled claims in inappropriate payments.

Without a comprehensive payment integrity solution that includes advanced prepayment detection tools, many erroneous claims – including those submitted for medically inappropriate procedures or services that were never performed – will slip through the cracks. Further, using only traditional pay-and-chase tactics, health plans will rarely recover the amount originally paid on the fraudulent claim. A significant percentage will likely be lost in fees, staff resources and settlement costs.

Prepayment FWA Detection: The Case for Advanced Analytics

Payers that have implemented a prepayment FWA model are leveraging analytic tools to identify potential claim discrepancies. These solutions typically combine predictive, data-driven analytics, rules-based analytics, integrated code edits, clinical aberrancy rules and provider verification to catch potentially fraudulent or erroneous claims. The analytical tools are designed to examine how claims are being paid according to rules and codes in an effort to detect common patterns and trends. From this data, the software identifies claim outliers prior to or during adjudication.

While a rules-based approach can identify a predetermined set of known schemas, a data-driven analytical solution examines hundreds of variables in various combinations simultaneously, allowing it to detect previously unidentified and emerging schemes that rules-based analytics alone may not recognize – enabling the payment integrity solution to intelligently evolve. As it evolves, the subsequent models provide new actionable and contextual information so investigators and analysts can make rapid, informed decisions. Intelligent evolution of detection models is critical given the complexity and rapidity of fraud scheme proliferation.

Furthermore, solutions that combine data from multiple sources provide a more complete view of potential FWA by providing a conduit between clinical edits and predictive analytics to determine clinical aberrancy rules. Unlike traditional clinical edits or fraud-based rules, aberrancy rules look across multiple data variables and time to identify claim anomalies, which trigger an alert requesting additional review of the claim. Not only does this provide

one more layer to a multifaceted payment integrity program, it also gives clinical context to the analytics, allowing even more certainty that a claim may be aberrant.

A programmatic payment integrity approach has emerged as the new best practice. Progressive payers are combining technology with expertise offered by knowledgeable investigators with backgrounds in law enforcement, criminal justice, private investigation, claims investigation, statistics and analytics. These individuals are tasked with reviewing and analyzing historical claims data, medical records, suspect provider databases and high-risk identification lists while also conducting patient and provider interviews. This integrated, holistic approach to fraud detection and prevention combines predictive, data-driven analytics with expert analysis and investigation, to help payers meet regulatory guidelines, reduce unnecessary payments due to FWA and recover erroneously paid claims.

Prepayment Analytics: Proven Benefits to the Bottom Line

HealthMarkets, a health and supplemental insurance carrier covering more than 350,000 lives in 44 states, has been reaping the rewards of a comprehensive FWA prevention program by implementing a broad payment integrity solution. The organization has realized significant results through dedicated prepayment analysis efforts conducted over the last two years.

In 2007, the payer processed 4,154,322 claims – flagging 178 as potentially fraudulent via manual fraud detection efforts, lacking the resources to make FWA prevention activities a more effective and automated process, HealthMarkets didn't pay 175 of the scrutinized claims, saving an underwhelming \$50,000—less than 1/100



Recovery

of a percent of the overall value of claims paid that year. After implementing a prepayment analytics solution in 2009 that enabled the organization to systematically detect erroneous and fraudulent claims, HealthMarkets achieved \$9.5 million in savings in the first year alone.

Despite demonstrating significant results in their FWA prevention efforts, technology alone isn't enough. HealthMarkets has learned that, although a payment integrity program must include the best and latest IT solutions, there needs to be balance in technology and staff. For a comprehensive plan, payers may need fraud analysts and investigators, certified claim coders and a medical director or other medical personnel. Even when fraud is detected

prior to payment, there is always a need for discerning and experienced fraud investigators and analysts, many of whom have uncovered millions of dollars of fraudulent or abusive claims. The leading technology vendors employ investigative personnel with these broad backgrounds and expertise in FWA that can fully outsource a payer's investigative unit or augment the team already in place.

Adapting for the Future

Ongoing industry challenges, including claim processing complexities, healthcare reform and competition often force payers to impose increased premiums and coverage limitations for patients. Payers that once presumed they

could not afford to invest in fraud prevention now realize that federal mandates, market forces and internal financial pressures make it critical to identify and prevent unnecessary claims payments.

Detecting erroneous claims prepayment is a strategic way for payers to reduce liabilities and improve their overall financial health. However, health insurers often don't have the depth of information gleaned from analyzing multiple payers' claims data. Traditionally employed pay-and-chase approaches to FWA management have not proven to be comprehensive enough, compelling payers to consider switching to prepayment solutions to achieve payment integrity.

Effective prepayment FWA solutions that draw upon multi-payer/multi-provider/multi-geography data and sophisticated analytics are emerging to fill the void. Further, by leveraging the power of predictive analytics to continuously identify new forms of FWA, and by prioritizing suspicious claims for maximum financial benefit and fewer false positives, payers can take tremendous steps toward effectively combating FWA and minimizing lost healthcare dollars.

About the Author



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