



Essentials of Fraud Prevention

by Joel Portice

The United States health care system remains large, complex, and inefficient. According to CMS, health care spending in the U.S. will exceed \$2.4 trillion in 2008 and is projected to experience significant growth over the next several years. By 2014, health care expenditures will represent approximately 20 percent of the Gross Domestic Product of the United States.

Health care's impact on society, specifically in terms of economics and quality of life, is substantial and requires efficient practices to deliver superior care in a cost-effective manner. With its convergence in to the financial services industry, the health care system will inherently benefit from existing practices perfected by financial institutions, primarily in the disciplines of data management and consumer account reconciliation. However, the ability to pay health care claims accurately and expediently dictates the need to ensure fraud is identified in a reliable and systematic way that guarantees legitimate transactions are processed appropriately.

The presence of fraud in the health care system is indisputable. According to the National Health Care Anti-Fraud Association (NHCAA), up to 10 percent of all health care expenditures contain some element of fraud or misrepresentation, which calculates to a loss of nearly \$240 billion annually.

Given the facts of the problem and acceptance of the dilemma, as well as the industry's past attempts to contain fraud, the issue remains more prevalent today than ever before. Why? Fraud programs have not been broadly embraced because previous attempts have not met the needs of the market, which is required to balance administrative efficiencies with contractual obligations, compliance requirements, as well as provider and member relations. In fact, according to a 2003 Gartner report, 45 percent of health insurers acknowledged they did not have an anti-fraud solution. Of the 55 percent that had deployed a solution, 80 percent were looking at the problem retrospectively and only 20 percent were addressing the problem prospectively. As a result, billions of dollars were either permanently lost through partial recovery settlements, or never identified in the first place.

The purpose of this article is to describe ten key characteristics needed in an effective pre-payment health care fraud prevention program. The characteristics apply advanced principles of detection and disposition of fraudulent claims. By ensuring all of these factors are present in an anti-fraud solution, the industry will proactively detect and dispose of fraudulent medical transactions with greater proficiency while supporting the operational requirements of the insurers.

It takes a clinical expert to find fraud.

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The characteristics of an effective anti-fraud program:

Reliable — The outcomes of the detection and investigative conclusions must be reliable, and false positives in the identification of fraud need to be minimized. Not only is it inefficient to pursue and deliver unreliable outcomes, the effectiveness of the program depends on trust among the constituencies, and reliable findings are at the core of broad acceptance of the program's recommendations.

Defensible — The results of the program's deliverables will be scrutinized by different parties, and it is imperative the actions given are supported by indisputable clinical, statistical, and quantifiable data. There are opportunities across the fraud continuum to populate fact-based decisions driven by statistically valid analysis, acceptable standards of practice, and sustainable clinical review. Make certain the proper quality-assurance procedures are implemented to strengthen the defensibility of every decision.

Systematic — Four billion medical claims are submitted annually in the United States. Without advanced detection technology systems incorporated into the payment process, the task of preventing fraudulent claims from being paid will be overwhelming and adversely impact the health care system. There are several artificial intelligence

technologies that can be deployed to identify fraud and that depend on the payor's business, scale, and operational process. Regardless, a program that is absent of a systematic-detection function will be disadvantaged in its efforts to address the changing nature of fraud.

Automated — As previously mentioned, the convergence of the financial services and health care industries has introduced automated technologies that are widely accepted — and even expected — in executing the operational requirements of payors. The detection and disposition of fraudulent claims needs to be included in the automated decisions. Market demands and efficiency necessities will mandate the automation of decisions. Guaranteeing the presence of the other characteristics mentioned in this article will promote the acceptance of automating the outcomes of the identification and resolution of fraudulent claims.

Integrated — The Gartner report referenced above illustrates the lack of industry support for a non-clinical and unscientific approach to fraud prevention. The majority of the insurers surveyed by Gartner have chosen to either do nothing or employ limited retrospective tools. The market requires sophisticated and reliable detection solutions that are integrated into the existing operational processes of the payor that enhance — not hinder — the optimization of the claim payment.

Dynamic — Because of the ever-changing nature of fraud and health care, detection models must have the capability to learn and identify shifting patterns. The intelligence collected through ongoing analysis must be able to recognize nuances and subtleties within the data and interpret the likelihood of an emerging fraudulent trend. Applying predictive analytics that are dynamic and multi-dimensional will identify schemes proactively and allow for prevention and reduction of losses.

Comprehensive — To address fraud with the greatest level of effectiveness, a comprehensive approach is best. Not only will the financial interests of the payor be maximized, but the value of the member's experience will be improved. Quality of care will be enhanced if fraudulent providers are identified and removed and questionable practices are modified. The sentinel effect will reach across the health care industry if comprehensive approaches are consistently employed by the claims administrators. The use of detection technology, pre-payment claims disposition, retrospective recovery, and provider and member awareness all contribute to a comprehensive solution that brings important value to our society.

Clinical — Health care administration is clinical and disputed claims require review by clinicians. The core competency of any effective fraud prevention program dictates the involvement of clinical experts. The development of predictive models and automated decisions are dependent on the advice of medical professionals. Leveraging the results of clinical findings as they relate to fraud identification and investigations intrinsically strengthens the defensibility of the output and contributes to automating identical outcomes.

Collaborative — Fraud prevention is a team sport and broad participation should be encouraged. Collaboration cannot be limited to internal groups and should include dialogue and partnerships with external trade associations and the public. Awareness of problems helps everyone improve the likelihood of preventing fraudulent activity, and the sharing of best practices within the industry assures that the effective handling of problematic claim submissions is addressed.

Educational — Ongoing education and awareness of problematic practices is an essential characteristic of any anti-fraud program. As schemes change and market conditions transform, it is important that constituents be aware of the emerging trends so they can recognize problems and patterns before improper care or inappropriate payments are rendered.

What's more, applying disciplined educational outreach helps providers identify unintentional discrepancies that can be modified and helps eliminate future delays in the payment of their services.

Claims administrators have several options on how to address the fraud that exists in the transactions they process. Some payors choose to address with internal resources, some outsource the detection and investigative functions, some take a hybrid approach, and some do nothing. What is clear is that the adjustments made to the market's payment model over the years have not stopped fraud, nor has the advent of provider networks and usual and customary reimbursements.

Adjusting the business model of health care has proven it will not stop the huge financial losses of fraud being perpetrated by a small number of providers. Fee-for-service and managed care models, indemnity and ASO business, providers participating in networks, as well as non-participating providers have all committed fraud. The surest way to reduce the negative economic impact and mitigate the risk of inappropriate care currently experienced through health care fraud is to deploy a program that contains the ten characteristics highlighted above.

Rather than relying on limited retrospective tactics to combat fraud (the dominant choice today), the industry has the opportunity to use techniques that are comprehensive in the continuum of fraud prevention and recovery.

Approaching fraud prevention as a program — and not simply as a single function — will enable payors to leverage a system that is reliable and integrated with defensible and automated results. This will not only improve payor relations with their members, but also have significant and immediate impact on the financial performance of their organization. ■

