

Same Smoke Different Fire

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The rising demand for health care fraud detection and prevention technology in the government and commercial payor markets is no surprise to industry experts and organizations.

According to the National Health Care Anti-Fraud Association, up to 10 percent of the nation's annual health care outlay is lost to fraud and abuse. With health care spending projections of \$2.4 trillion for 2008, the health care fraud challenge has an estimated total cost between \$72 billion and \$240 billion. This staggering financial loss potential has prompted many payors to investigate and implement sophisticated pre- and post-payment fraud and abuse solutions.

The aim of any effective fraud detection program is to identify and reduce suspect and fraudulent billing activity, decrease unjustified financial outlay, and offset rising health care costs. In today's business environment, a robust fraud, abuse, and overpayment prevention solution relies on rules-based and predictive analytics to pattern and pinpoint suspect and fraudulent provider, facility, and patient activity.

While fraud detection solutions are more prevalent within the health care payor market, solutions designed to identify and prevent fraud in the medical bill component of property/casualty claims remain limited.

Medical fraud is dynamic and often invisible, so a reliable and proven process for accurately detecting, reporting, and tracking providers with aberrant billing patterns is a necessity. To accurately and efficiently identify and prevent fraud in medical bills is a complex undertaking. It requires a combination of tailored — often proprietary — software, robust rules and sophisticated analytics. However, the use of software and technology alone cannot mitigate the fraud problem. The key is to incorporate clinical expertise and

intellect with software tools to validate and accurately target those providers warranted for further review. This clinical validation review process allows for greater efficiency and accuracy in identifying and targeting medical bill fraud.

Fraud schemes continue to plague the insurance industry: stolen physician/patient identities, phantom providers and patients, up-coding, unnecessary cosmetic services, false bills, exploitation of benefit plans, unnecessary diagnostic services, anesthesia abuse, over-treatment, stacked diagnoses, and high fee services. Furthermore, new schemes are being devised every day. Insurers can no longer continue to isolate the identification of suspect and guilty providers. It is increasingly apparent that fraud and abuse in both property/casualty medical bills and health care claims are likely being perpetrated by the same providers.

Leading-edge insurers are looking toward a shared database of known and emerging schemes and the providers who perpetuate them in both health care claims and property/casualty medical bills. The industry needs to move toward centralizing the knowledge base of fraudulent providers in both health care and property/casualty insurance to recognize the true extent of fraud by any single provider. Such a common repository can be a powerful deterrent of fraud for any type of medical bill. A shared and maintainable database of known offenders and their specific schemes is an important fraud mitigation step.

Property/casualty fraud is a growing multi-billion dollar problem and requires tailored solutions to meet the unique business challenges faced by insurers. Applying proven concepts from the health care payor market to the medical bill component of property/casualty will provide opportunities to detect and uncover fraud schemes. In addition, the creation and maintenance of a shared database of known schemes and offenders can be a powerful step in the fight against fraud.

This shared perspective enables a more targeted and robust prevention effort. ■

