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Using Advanced Decisioning Tools to Curtail Healthcare Fraud

by Joel Portice

The widespread practice of healthcare fraud is a significant factor in the industry's inability to contain escalating costs. According to the National Healthcare Anti-Fraud Association, as much as 10 percent of every dollar spent on healthcare claims involves some sort of fraud. That's more than 100 billion dollars a year. While it's a tremendous problem to commercial healthcare payers, it's statistically even more so on the federal and state level with programs like Medicaid.

Regardless of their designation, however, all organizations must be able to diagnose and treat fraudulent healthcare claims in the same way a doctor does a patient. A claims adjuster's investigative talents, however, much like a doctor's, are often considerably challenged. Yet, with the right tools at their disposal, organizations can make rapid progress in eliminating fraud, abuse and billing errors before – and after – claims are paid. In doing so, they operate more efficiently and more profitably, and can spend more time on what they do best: providing quality payment and care services.

Advanced Decision Systems

Advanced analytical and intelligent software has been used in a number of industries for decades. One of the more popular applications today is its detection of fraudulent behavior and occurrences. Most people know that the financial service industry employs automated technology to detect credit card fraud with heralded success. And the basis for the software technology adept at spotting and stopping credit card fraud and abuse has been advanced for new applications. It's now capable of performing similar successes in

the more complicated and intricate world of healthcare fraud detection. This is highly significant as the annual costs lost to healthcare fraud dwarfs that of the financial services industry by more than 100 fold. That's right, annual healthcare fraud now surpasses the 85 million dollars lost to credit card fraud 100 times over.

The sad fact is that many healthcare providers have discovered unscrupulous – and often illegal – ways to take advantage of imperfections in the healthcare system for their own financial gain. This is especially true now that legislation has been adopted across America to ensure prompt payments to providers, making it more difficult to adequately screen suspicious claims during the pre-payment phase. And fraud is ubiquitous in all areas of healthcare: county hospitals, doctors' offices, dental facilities and pharmacies. One might be surprised to learn how many doctors get away with billing for two surgeries on a single patient in the same day, or the number of pharmacists who abuse the system in their prescription practices. But organizations armed with the latest intelligent software – advanced decisioning systems – can combat such deviance with dramatic results. For instance, organizations using Fair Isaac's Payment Optimizer system have eliminated by half their losses from fraudulent claims, ones that went previously undetected and sucked revenue to the tune of millions of dollars.

Timely and accurate analysis of healthcare claims information really requires software technology that can interpret vast amounts of complex data, perform simultaneous mathematical calculations, and establish proper outcome scoring and recommendations. While such technology is new to the operational side of the healthcare industry, it has been used for many years as a disease management tool to help diagnose and treat patients. And while detecting fraud, abuse and error in submitted claims is its principal purpose, maintaining an organization's payment integrity in handling valid claims – the clear majority of filings – is equally important. This is especially true since the aforementioned passing of prompt payment legislation, as hefty fines are levied on companies and organizations that don't abide.

Healthcare payers using advanced decisioning applications find themselves a step ahead of the game. Once data analysis is performed by the system, claim outcomes appear in the form of scores, each coming with explanations and recommendations. Claims adjusters, fraud investigators, case managers and other personnel then review the reports. Scoring criteria and thresholds can be used to automatically determine the priority given to individual claims. This allows healthcare payers to operate more efficiently from a personnel standpoint in addition to reducing costs lost to fraud.

Advanced decisioning systems can be, in part, rule based, where decisions are made from data using a definite and consistent means. The system can be used on a number of levels; it can alert case managers of inconsistencies in treatment, or fraud investigators of inconsistencies in billing. It also can establish predictive modeling through profiling technology, which compresses terabytes of claims data into dynamic "profiles," allowing system models to perform detailed analysis of such information in a matter of seconds. And since it's dynamic, the system is able to detect fraud with even greater accuracy over time, giving organizations a greater opportunity to catch fraud, abuse and erroneous claims before the checks are cut.

Fair Isaac's payment optimizer also deploys "neural network models," which are used in a number of cutting-edge business applications, like airline security and infectious disease control. Neural network models are able to discover patterns and discern otherwise cryptic relationships among complex data the way the human brain's circuit of neurons processes information simultaneously. These neural models are also used prevalently in Fair Isaac's leading applications for credit card fraud detection that handle 85 percent of all automated fraud detection for the industry.

Prospective and Retrospective Detection

In the particular case of Payment Optimizer, the system is both prospective and retrospective in use, and eliminates healthcare fraud, abuse and erroneous filings in all stages of the historical claims process: pre-payment, fast-cycle points and post-payment.

In other words, the possibility of fraud is being reviewed before, during and after each and every claim is paid.

Once claims are already paid, the time, effort and expenses exhausted when trying to recoup losses from fraud rises exponentially. Therefore, it's in the best interests of healthcare payers to detect such claims before they're paid, whenever possible. And with advanced decisioning systems such as Payment Optimizer, claims that are most at risk for fraud, abuse or error can be quickly detected with very high accuracy. They can be viewed individually – in real time – or in batches; in either case results are delivered prior to payment. A patient's personal data, both current and historical, can be compared to other patients undergoing similar treatment and diagnoses. In addition, applicable history of the patient's provider(s)- and care-giving history can be considered, resulting in well-founded analysis and recommendations instantaneously.

While healthcare payers typically hold off on thorough post-payment analysis until fiscal year end or similar duration, organizations that use advanced decisioning systems like Payment Optimizer can latch on to a year's worth of aggregate patient data any day of the year. The system provides fresh analysis and recommendations that combines the most recent patient activity with all visits up to a year before. It allows payers to eliminate losses to fraud from providers who might not be as risky as some, but nonetheless abuse and defraud the healthcare system for their own gains. If proposed time limitations of a year are imposed by state courts for recouping losses to questionable claims, such a capability becomes even more of a necessity.

Products such as Payment Optimizer reap healthcare payers extraordinary benefits after payment as well. Their intelligent processes enable organizations to successfully review suspicious claims without expending laborious hours chasing red herrings or lollygaging on time-intensive cases, ultimately enriching the organization's bottom line. And when payers utilize post-payment analysis, they are able to detect fraud that's only apparent over the long haul, and not necessarily detected in smaller data sets. One such example is the case history of patients who require ambulance services initially, but surprisingly

present no follow-up. And, as opposed to rule-based-only systems, if/then scenarios do not restrict software solutions like Payment Optimizer. If a heretofore-unknown fraud risk is buried in a claim, it will be unearthed since it's dynamically changing and not bound to any preconceived "rules," like other detection programs.

Industry Specific Models

Advanced decisioning systems can expertly analyze claims from every side of the healthcare sector. Payment Optimizer, for instance, comes with specific models for medical, pharmacy and dental payers.

When used for medical claims, its profiling allows organizations to detect unusual medical practices and charges that are inconsistent with a given peer group. So orthopedic surgeons are compared to and against one another, dialysis units to other dialysis units of similar size and treating similar populations. It also detects inconsistencies with regard to inpatient and outpatient activity. The rampant industry fraud comes in many shapes and forms. In one case, and payer using Payment Optimizer discovered a psychiatrist seeing 112 patients in a single day – for a 75-minute procedure! It just doesn't add up no matter how you do the math.

For dental payers advanced decisioning systems may profile not only general practitioners, but also orthodontists, oral surgeons, and other specialists in the field. Any questionable or suspicious treatment or billing practices is quickly detected. Payment Optimizer once saved a payer millions of dollars when it discovered a provider who billed an abnormally high number of pulp vitality tests compared to his peers. At eight dollars a tooth, the costs – and cost savings, afterward – added quickly.

Curbing fraud and abuse among pharmacy services is particularly important in this day and age, as prescription drug benefits are becoming more integral to both Medicaid and commercial benefit coverage. Like medical and dental models, pharmacy claims are automatically analyzed in depth using peer-profiling models. Problems such as a line item for a drug never dispensed (on an otherwise legitimate claim) can be spotted,

leading auditors, in some cases, to pharmacies that habitually bill for unprovided services, or those diverting pharmaceutical drugs for resale.

Benefiting the System

When payers succeed in cracking down on fraud, everyone wins. The system runs more smoothly and efficiently, and the cost savings to payers enable more affordable coverage plans and costs to patients themselves. While advanced analytic tools have been used successfully for years in disease management, healthcare organizations are now finding it equally useful in claims processing and fraud detection. In an industry with more than 100 billion dollars a year lost to fraud, it's high time for healthcare organizations to study the potential impact advanced decisioning systems may have on their bottom line.

Joel Portice is Fair Isaac Corporation's vice president of Healthcare Solutions. He is a certified fraud examiner and has served on the Board of Governors for the National Health Care Anti-Fraud Association.

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