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White Paper

Payment Policy Optimization: Blending Analytics with Rules to Prevent Wasteful, Abusive and Fraudulent Healthcare Spending

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Although other industries, most notably the credit card industry, have successfully addressed the problem of fraud, waste and abuse, it continues to plague healthcare. For example, the U.S. Federal Bureau of Investigation estimates that 3 to 10 percent of all medical costs are attributable to fraud and abuse — as much as $234 billion annually[1]. This is the same ratio that has been estimated for the better part of the past decade.

However, curtailing the massive drain caused by waste, abuse and fraud in healthcare has never been more important. New, more complex payment models are on the horizon, including bundled payments for episodes of care, and greater emphasis is being placed on payment for outcomes. In 2013, providers and payers will also be adjusting to ICD-10 coding. Experience has shown that each novel payment arrangement or code change presents new opportunities for confusion and abuse — for example, inadvertent or purposeful upcoding.

Given the magnitude and visibility of the problem, along with new medical loss ratio (MLR) mandates associated with reform, healthcare insurers need to avail themselves of advanced and effective means to reduce wasteful, abusive and fraudulent medical spending in the most administratively efficient way possible. This demands a more holistic approach across the payment continuum, using technologies that not only address issues from multiple angles but also facilitate cross-organization partnership.

The Struggle to Stop the Leak

Unnecessary spending — commonly referred to as leakage — has many causes:

- Policy confusion that leads to incorrect coding or billing outside of policies (waste)
- Unwarranted payments due to unintentional inefficiencies in the payment cycle (waste)
- Manipulation of information that is intended to maximize reimbursement (abuse)
- Knowledge and intent to deceive (fraud)

Why has it been so difficult for health plans to get a handle on waste, abuse and fraud in medical spending? There are many reasons, including the following:

- First, payment systems are very complex — spanning many states, with thousands of providers and millions of members — and they operate in a dynamic environment of changing rules, coding systems and provider billing patterns.
- Second, many organizations have dated claims adjudication technology that cannot make changes quickly to keep up with emerging billing schemes.
- Third, payers are expected to be transparent about payment rules. This means that rejected claims are accompanied by an explanation for the rejection, making it possible for entities intent on fraud to figure out how to get claims through adjudication and paid.
- Fourth, manual audits focus on large-dollar claims, leaving many errors undetected. This is especially true for smaller, less obvious abuses that fly under the radar yet drive significant dollar losses for the payer over time due to high claims volume. However, organizations are challenged to address issues more comprehensively, as this process can be time and resource intensive, driving up administrative costs.
- Finally, approaches to limit waste, abuse and fraud vary widely from organization to organization and suffer from a lack of coordination when multiple departments are involved.

Although payment speed and accuracy are the shared goals, a special investigations unit typically uses a manpower-intensive approach that focuses on large cases of potential fraud with the aim of post-pay recovery and referral to law enforcement. Meanwhile, the claims operations department, operating under a fundamentally different approach, is driven to move quickly and efficiently to meet requirements for prompt pay. Many health plans also have initiated a provider audit department to address incorrect billing and coding errors. These departments may have different cultures, conflicting agendas and tools that do not necessarily work with each other — all of which can leave money on the table.

A New Approach: Rules plus Analytics for Optimal Results

There are two primary approaches to catching wasteful, abusive or fraudulent claims:

- **Payment rules** are established as a necessary measure to ensure that payment proceeds in a correct fashion, according to established policies and known areas of potential billing abuse. Periodically, through annual or less frequent audits, health plans identify new areas of waste that can be addressed through new or updated rules, thus preventing those issues from reoccurring. Therefore, traditional rules-based systems, which deliver a stable return over time, will see incremental upticks in return as new rules are added. However, because they are typically a response to observation of historical information that may be a year old or even older, new and revised rules often lag behind the emergence of the issues they address, and effective rule maintenance can be a highly specialized, challenging art. Lagging, missing and misconfigured rules can cost health plans millions of dollars each year in missed opportunities to stop waste, abuse and fraud.
- **Payment analytics**, on the other hand, can identify unknown and emerging issues in a payer's claims that are undetectable to a rules-based system. Healthcare recently has adopted analytic technologies that have successfully reduced credit card fraud. These data-driven analytics digest massive amounts of information, identifying aberrant data points that may indicate an emerging problem. This process is a vast improvement over using random audits or investigating only high-cost claims because of its greater reach, efficiency and proactive nature. For example, claims that are flagged for potential aberrance with analytics can be presented first to an auditor, before payment is made, or identified immediately post-payment during fast-cycle review, allowing the plan to stop the abuse immediately and recover losses faster (helpful particularly where states constrain recovery periods for waste and abuse). When analytics are not tied into a flexible rules-based system, however, the same abuses can crop up repeatedly, leading to a lot of inefficiency as plans chase down the same issues again and again and then address them via post-pay recovery or behavior modification.

The real power — and ROI — in these approaches comes when they are combined. Issues identified by analytics are then addressed going forward by new or revised rules — perhaps even within

[1] "Combating Health Care Fraud in a Post-Reform World: Seven Guiding Principles for Policymakers," A White Paper Presented by The National Health Care Anti-Fraud Association, October 6, 2010. http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/WhitePaper_Oct10.pdf

days of discovery — to permanently and systematically shut down the most persistent and costly leaks. Plans can leverage their investment in investigations, decrease pay-and-chase times, and quickly address emerging schemes that result from changes in coding and reimbursement models. Combining rules and analytics creates a continuous feedback loop that drives continuously escalating ROI. This loop is referred to as payment policy optimization.

Rules and Analytics in Action

The following examples illustrate how inappropriate claims can be flagged by analytics and then addressed with new rules:

- Continuously running analysis of claims data identified an aberrant repeat procedure when a provider billed for "attendance at delivery" on two successive days. This is a "soft duplication" that the claims system missed because the services were billed on different dates of service. An existing duplication rule was then amended within a few days to prevent this same issue from occurring in the future.

- Unsupervised analytics picked up a pattern of high aberrance in billing frequency for a preventive care code within a large physician group, totaling 1,000 paid claims in the amount of $100,000 over a relatively short period of time. A quick investigation showed that some providers, who were capitated for office visits, were increasing their reimbursements by billing excessively for preventive care services. The plan discovered a missing rule that would enforce their medical policy around preventive care. They plugged the gap with a new rule to deny payment for the same type of preventive care for the same person more than once in 12 months.

As a future example, the introduction of ICD-10 codes in 2013 will dramatically increase the opportunity for wasteful or abusive claims submissions, done purposely or by mistake, given the increased granularity of coding. If providers migrate to the highest compensated diagnosis code despite lower patient acuity, analytics will be able to discern which practices are outside their historical norm and their peers' current norm. The providers can be educated about the specific codes involved, and new editing rules can be established to stop potentially abusive claims before they become widespread.

Whether inappropriate excessive claims are intentional or not, questioning these claims — such as submission of a cardiology code by a dermatologist — sends a message that the health plan is alert to unusual claims. This creates a sentinel effect to deter future abuse.

Planning for the Future

Technology has long been in place to auto-adjudicate claims, thus reducing the per-claim cost of manual processing . Additional ROI — through both administrative cost savings and decreased waste and abuse — can be gained from combining analytics with rules technology to provide efficient and effective oversight of the payment process without slowing it down to an unacceptable pace. In addition, health plans benefit by preventing more issues pre-pay, reducing the costs associated with trying to recoup those payments.

Looking to the future, organizations will need these combined technologies and processes even more urgently to identify willful or inadvertent upticks in severity codes, utilization and other aberrancies as ICD-10 becomes implemented and new payment models emerge. Payment optimization depends on the continuous interplay between analytics and rules, as well as having a single, powerful source of information for shared action by all those involved with eliminating waste, abuse and fraud.

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