Insurance

Medical Billing Fraud

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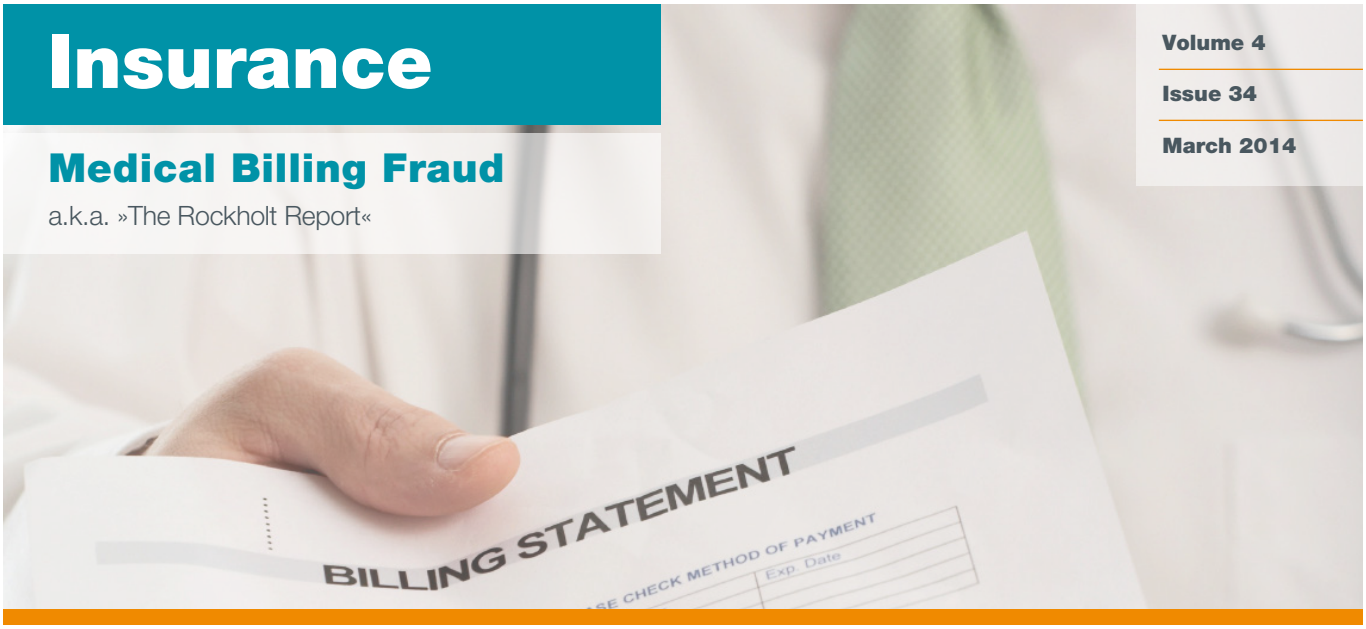

Combating Healthcare Fraud, Waste and Abuse in Today's Market

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In today's healthcare ecosystem, there is a very unfortunate truth: fraud, waste and abuse (FWA) runs rampant across the marketplace. We have known for years that industry sources place the cost of this epidemic at upwards of $200 billion. In fact, in 2011 Medicare and Medicaid fraud, waste and abuse alone accounted for $98 billion in lost dollars not to mention the tens of billions of dollars more commercial health plans lost. Estimates suggest between three and ten percent of all U.S. dollars spent on healthcare services are attributed to FWA. With healthcare costs continuing to hamstring the nation's economy it's one epidemic that insurers and providers simply must get under control.

The Affordable Care Act (ACA) most certainly recognizes the importance of addressing the nation's fraud, waste and abuse problem. The healthcare legislation dedicates $350 million to be spent during the next 10 years to help fight the issue. In addition, the ACA includes several new rules and penalties designed to help reduce the amount of healthcare fraud happening each year.

In a moment of such tremendous loss paired with an impressive federal focus on FWA reduction, there are certainly contributing root cause factors that can further our understanding of why FWA exists and thus ways that it can be overcome.

First, it is important to note that most fraud, waste and abuse occurs when the provider has submitted a claim for reimbursement. During the adjudication portion of the payment cycle. healthcare payers can only view a providers claims from their single source using their own set of data. On the pre-payment side of the equation, claims are flagged early on in the process, requiring additional information from providers to validate the suspicion. But payers struggle with paying claims in a timely manner in compliance with state mandates and with service level agreements (SLAs) in place with their providers. On the post-pay side of FWA, inaccurate contract re-pricing, improper coding and misapplied reimbursement methods result in improper payments to care providers. Once discovered, payers face the painstaking and lengthy recovery process, often times settling for just a portion of the overpayment rather than the full amount.

To combat this narrow view of data, a holistic FWA program can help identify potential problems across the payment cycle in both the pre-and post-pay portion of adjudication. A strong pre-pay approach drives the prevention of unnecessary claims payments and helps payers avoid the expense of processing a claim only to identify an issue with the claim after payment is made. While pre-payment processes assure that claims are paid properly, healthcare leaders must also employ a stronger, more efficient post-pay approach. A strong dedicated staff of audit and coding resources as well as investigators and statistical analysts work alongside modern technology to review available analytics to create predictive models fueled by clinical, pharmacy and financial big data.

But, some healthcare payers may not have the financial, technical or human resources need to tackle this seemingly insurmountable task. Yet, with the proper level of expertise combined with the right solution, organizations can typically experience two to four percent savings as fraud, waste and abuse is monitored and appropriate actions are taken. With such a compelling savings advantage, many organizations are turning to healthcare partners who specialize in pre-payment and post-payment FWA solutions. By working with an expert, they can immediately tap into the expertise needed without adding headcount or experiencing lengthy implementation time.

Leading organizations are also investigating their technology approaches for new solutions. For example, payers can ensure uptime and continued compliance with Software-as-a-Service (SaaS), cloud-based solutions. Cloud-based software allows for 24x7 access to data and easy integration with existing claims systems. And SaaS services offload the IT requirements to the vendor to manage on the client's behalf. The healthcare organization will always need a certain level of IT expertise and integration. API interfaces will need to "talk" with other technology tools to ensure all the information is optimized. But a majority of the IT support needs can be managed by a carefully integrated partner versus having to hire or use expensive IT talent that should be dedicated to other projects.

It is a time of rapid change in the healthcare landscape. Expanded competition, shifting consumer behaviors and tighter legislation all drive intense focus on best practices and innovative solutions that will take your healthcare organization to the next level. Leading organizations are advancing their FWA programs as part of their core business initiatives because they see the financial benefits to their organizations.

Fraud and ICD-10

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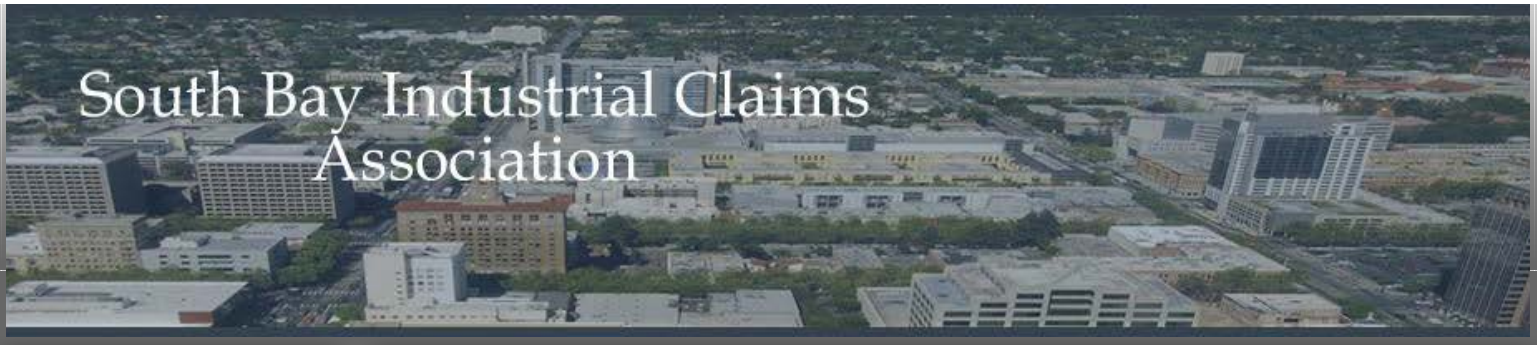
Kelli's article points out some of the complications in the claims payment cycle that can leave the door open for fraud to occur. Some of the key difficulties are inherent in the CPT and ICD-9 coding systems used in the billing process. Between them, CPT and ICD-9 don't contain enough specific information to judge whether or not a procedure matches the diagnosis without examining the medical records. The upcoming transition to ICD-10 is designed to overcome some of these difficulties. ICD-10 contains enough specific information to help the payers to validate a larger number of bills without requiring access to the medical records.



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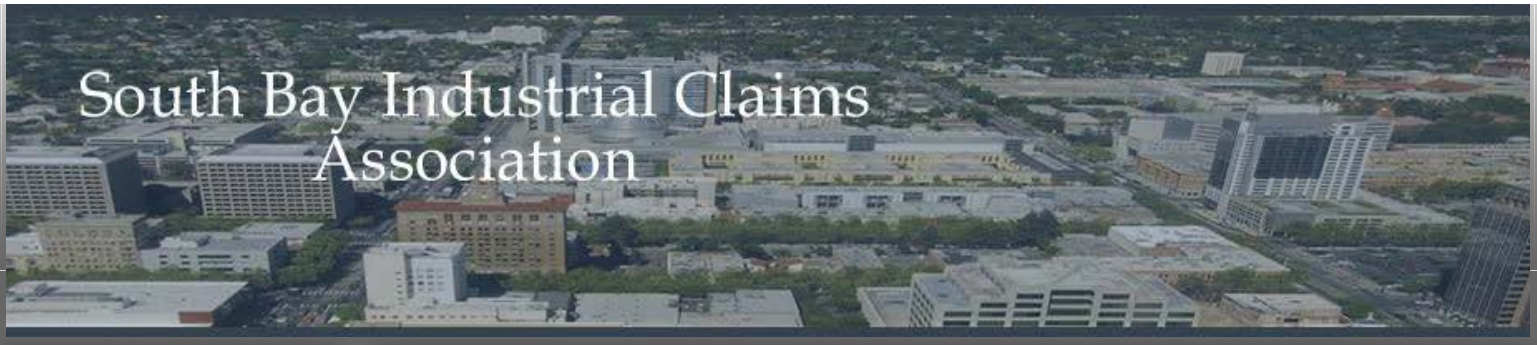

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