White Paper

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Evaluating Solutions to Reduce Health Care Fraud, Waste, and Abuse on a Prospective Basis

With the intensified focus on reducing health care costs across the board, more and more software and services vendors are offering program integrity solutions. These offerings vary from software designed to identify fraud, waste (including errors), and abuse, to fully outsourced solutions designed to prevent and/or recover inappropriate payments. These offerings vary widely in their approach, and ultimately, in their ability to succeed.

This paper provides payers with the information they need to make informed decisions on purchasing software and services from vendors—and focuses specifically on prospective or pre-payment solutions that prevent inappropriate claims from being paid. Stopping inappropriate payments before they are made is far more cost effective than post-payment recovery efforts (of course, a comprehensive approach to fraud, waste, and abuse must also include a retrospective or post-payment function).

In this white paper, we examine the areas of **Claims Editing, Predictive Models,** and **Business Process Outsourcing** in program integrity efforts, and offer the following recommendations and considerations.

Claims Editing

Recommendation: Include in the payment process a claims editor that examines the payer's specific payment rules and publicly sourced medical necessity guidelines including regional practice guidelines.

Every claims processing system includes some level of payment rule edits. However, claims processing systems typically do not include all of the rules that would apply because this would slow down the claims processing stream. There are a number of software solutions that recommend denials on claims based on one or more of the following factors:

- The payer's payment rules
- Claims-specific medical necessity
- Simple cross-claims analysis such as duplicate billing and split bills

While payment systems incorporate most rules that payers have related to claims payment, these types of solutions can provide a backstop to ensure rules are correctly applied to claims. They can also address rules that may be more complex than a claims processing system can handle given its throughput requirements.

Systems that address medical necessity use guidelines that are either proprietary or are extracted from publicly available sources. Those guidelines from publicly available sources have an advantage: the source can be cited in a denial notice issued to the provider, lessening the likelihood of appeal and potentially educating the provider on recommended practices. The most sophisticated systems also include regional practice guidelines.

Predictive Models

Recommendation: Incorporate predictive models that involve multi-factor scoring into prospective payment fraud, waste, and abuse processes.

Considerations: In choosing a software vendor, examine its experience in health care and the extent of different types of analysis that are incorporated into its identification models. Also, evaluate the ability of the vendor to conduct the setup and provide ongoing support to the processes. Obtain the vendor's experience on false positives using two different criteria:

- **The percent of medical records that are requested that do not turn into denials or reductions**
- **The percent of denied and reduced claims that are overturned by appeal**

In recent years, vendors have introduced detection models that identify cases with a high potential to be fraud, waste, or abuse.

Many companies that enter the health care program integrity field have fraud detection experience in other industries. Though their models are typically sophisticated mathematically, **they often do not account for the clinical complexity of health care.** For example, a mathematics-only based outlier analysis on heart surgeons will generally identify the physicians at the regional centers of excellence who handle the most complex cases. Only when the complexity of patients' conditions are diagnosed and adjusted for, can detection models begin to identify those physicians who may have overpayment issues. Less sophisticated models can have very high false positive rates; that is to say that they incorrectly include many proper claims filings in their suspect pool output. False positives can lead to unnecessary and costly follow-up by payer staff and annoying burdens on providers.

Advanced overpayment detection models use multiple factors to score claims, predicting the likelihood that the claim is incorrect when no single factor alone would cause it to be reviewed for denial. The factors examined include intra-claim considerations, such as a high cost treatment for a diagnosis when less expensive care is often, but not always, appropriate. The models take into account provider-specific experience; claims from providers that have not had many claims denied receive lower scores relative to those who have had a larger proportion of their claims denied. Complex cross-claim factors are also examined, including evaluating sets of services that are unlikely to occur at or near the same time.

Proper setup and ongoing customization are essential for advanced detection models to be successful. Vendors who provide the software should also provide the expertise for initial setup and, as a minimum, be available for consultation during customization processes. Involving individuals who know payment rules and policies, whether provided by the payer or by the vendor, is also important to ensure proper setup.

Maintaining adequate networks is an ongoing challenge for payers. Program integrity efforts can significantly impact network satisfaction if providers' time and effort is wasted on claims that were not submitted appropriately. The use of complex scoring models, set up and customized for the payer's rules, can evaluate claims for potential fraud, waste, and abuse in a manner that minimizes the burden on providers to provide excessive numbers of medical records in response to false positives identified by the software.

Business Process Outsourcing

Recommendation: To the extent they are responsible for claims editing or identification of fraud, waste, and abuse through predictive models, the recommendations and considerations in those sections above should be incorporated into the decision on which vendor to choose.

Recommendation: Align incentives of vendors and payers, but hold them to false positive and processing time standards.

Recommendation: Use a transparent approach in which all denials are grounded in specific clinical, coding, or payment rules issues.

Considerations: In choosing a business process outsourced vendor, examine their experience in providing services on a contingent basis or the appropriate basis of payment that will be used. Evaluate their commitment and experience in provider outreach, contact center operations, and medical records review, to the extent included in the payer's desired model.

There are vendors that will provide varying degrees of fraud, waste, and abuse identification and avoid outsourced services to payers. Because of the volume of their activity, they are able to obtain and utilize expertise that payers often cannot. Depending upon the desire of the payer, the vendors will request medical records, conduct medical records review, conduct additional investigation as needed, provide contact centers for questions that arise, conduct provider outreach campaigns, and assist in appeals defense preparation.

The volume of reviews conducted by vendors who serve multiple clients allows them to establish processes and procedures that are efficient and incorporate the latest in fraud, waste, and abuse thinking, while still addressing payer-specific requirements.

Vendors can be paid on a fixed price, time and material, or contingent basis, as appropriate.

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Providing proper incentives for vendors to reduce inappropriate payments, such as performance based or contingent payments, should be combined with some level of control and/or contract standards to ensure that network issues are minimized. These standards include:

- ← Holding vendors to standards for false positives, both the overturned denials/reductions and the medical records requests that do not turn into denials/reductions
- ← Maintaining final decisions on large dollar denials with the payer
- ← Processing time standards
- ← Contact center responsiveness

There are two approaches to providing information to providers. Some vendors will only deny a claim when there is a clinical, coding, or payer's rule that has been violated and they will provide that information to providers in claims denial notices. This "transparency" has the advantage that provider network issues are minimized and fewer false positives are likely to occur.

Other vendors will deny a claim when their multiple factor evaluation results in a score high enough that the claim is suspect, even without validating with a medical record review. Providers are not always offered reasons for denials. This "black box" has the advantage in cost to the vendor (and presumably to the payer) and amount of recoveries. These are offset somewhat by additional appeals, more contact from providers, and the reductions due to more denials being overturned.

About the Company

More than 1,200 payers now look to Ingenix for solutions to their complex business challenges. By integrating a diverse suite of products and services, Ingenix helps its clients increase revenue, manage medical costs, and simplify complex administrative and financial processes with powerful data, software, consulting, and outsourcing solutions. Consistent capital investment, stability of resources, and continual innovation have made Ingenix one of the largest and fastest-growing U.S. health care information companies.