WHITE PAPER

COST CONTAINMENT

Improper Payments, Fraud, Waste and Abuse

How Payers and Providers are Tackling Losses to Improper Payments

There has always been a certain degree of fraud, waste and abuse in the healthcare system; however, the sheer size and scope of the problem is becoming more acute as healthcare payers and providers increasingly focus on managing costs to account for every dollar spent.

The Centers for Medicare & Medicaid Services estimates that $60 billion[i]—more than 10 percent of Medicare's total budget—was lost to improper payments last year. At the same time, the Office of Management and Budget estimates that improper payments in the Medicaid program amounted to $17 billion[ii]—about five percent of the program's total cost. Commercial payers are not immune to deceitful activities, experiencing significant financial losses from these occurrences as well.

There are solutions available, which can provide the oversight needed to combat improper payments for both government and commercial payers. This, along with the Medicare Recovery Audit Contractor (RAC) program, are just a handful of ways to recoup the losses to fraud, waste and abuse.

Leveraging Predictive Analytics for a Preemptive Approach

To breathe new life into prevention programs, many forward-thinking payers are starting to take a more proactive view of loss avoidance—using data analytics to search for disconcerting patterns and anomalies. This concept is already common in other financial sectors. For example, credit card companies use detailed algorithms to scan for concerning charge patterns and outliers, enabling the companies to nip improper charges in the bud.

In healthcare, predictive analytics tools integrating into the payer's workflow review data from billions of claims to create a typical billing model for various providers by specialty. A specific claim or group of claims can then be compared to the model to highlight patterns where they diverge from the norm. If there are no extenuating circumstances that would support any differences, the payer can reach out to the provider to discuss a discrepancy. In many cases, just making the provider aware of the concern and educating them on the correct approach can help resolve issues. However, in those instances where intentional miscoding is suspected, organizations can and should take further action.

As the industry becomes more sophisticated with predictive analytics, payers will be able to more consistently spot some of the most common types of improper claims. For example, analytic tools that review data from multiple payers can identify those providers who cumulatively bill at or beyond 24 hours in a single calendar day. This anomaly is virtually undetectable by a single payer because the total hours are spread across multiple entities.

A Valuable Safety Net

Although leveraging predictive analytics as a first line of defense is a smart choice, payers should not shutter their audit programs. Operating at the back-end of the payment cycle, these programs can pinpoint instances of improper coding, inaccurate repricing, lack of medical necessity and so on that may have been missed in a predictive analysis, allowing the payers to recover funds where possible.

Although inappropriate payments may result from innocent mistakes, lack of knowledge or providers' unintentional errors, the losses result in a negative impact on the payer's bottom line. To address these occurrences of improper payment, an organization should have a team with deep expertise in proper clinical coding, coded edit engines and statistics that can effectively and efficiently review claims for improper submission.

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Providers' Role In Prevention

Providers can also play a role in preventing improper payments. Those that methodically review their claims for errors, omissions, duplications and so on can ensure they send the most accurate claims for payment. This leads to more timely reimbursement and prevents denials and can also more quickly draw providers' attention to incorrect coding and billing patterns. By self-monitoring wasteful behavior, providers can reduce the cost of more global efforts to monitor illegal activities, which can ultimately translate into lower costs for doing business and better prices for patients.

Thinking Ahead

As the spend in U.S. healthcare tips $3 trillion[iii], there has never been a better time to double down on preventing improper payments. With 20 million people projected to enter Medicaid as new beneficiaries by 2023[iv] and an aging population increasing Medicare rolls, the healthcare system faces ever-growing risk. By collaborating on proactive and reactive strategies to reduce improper claim submissions, and subsequent improper payments, payers and providers can make a dent in this problem, improving efficiency for the entire healthcare community.

Learn how our Intelligent Healthcare Network™ and robust payment integrity solutions and services are enabling payers and providers to better detect and defend against improper payments at every step of the claiming process at www.changehealthcare.com.

i Avila, J., Marshall, S., & Kaul, G. (2015, July 23). Medicare Funds Totaling $60 Billion Improperly Paid, Report Finds. Retrieved October 13, 2016, from http://abcnews.go.com/Politics/medicare-funds-totaling-60-billion-improperly-paid-report/story?id=32604330

ii Health Care Fraud and Program Integrity: An Overview for Providers. Retrieved October 13, 2016, from https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf

iii National Health Expenditure Data. Retrieved October 13, 2016, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html

iv 2013 Actuarial Report on the Financial Outlook for Medicaid. (2013). Retrieved October 13, 2016, from https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/medicaid-actuarial-report-2013.pdf