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Leveraging knowledge and awareness against fraud and abuse: How compliance officers can make a difference

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Sometimes the “why” of a problem can be more vexing than the “what” or the “how” of a problem. That certainly seems to be the case with the growing problem of fraud and abuse in health care. What’s not controversial is the scope of the problem. Leading experts and studies estimate that 5% to 10% of all the health care claims processed annually in the United States are fraudulent or abusive, meaning that providers have filed claims for care never given, for care provided solely to obtain reimbursement, or for inappropriately coded claims or utilized services. If those figures are correct, this country’s health care purchasers and payers (and ultimately, consumers) are paying between \$100 billion and \$200 billion a year in fraudulent and abusive claims.

The challenge that the health care system faces as a result of such activity is massive. And it puts the entire system at risk, given that one of the U.S. health care system’s biggest problems right now is how to pay for itself at a time when the population is

aging, chronic illnesses are becoming more prevalent, and new medical technologies and pharmaceutical remedies are emerging – all with the effect of adding to the nation’s annual health care bill.

For health care providers, the welter of applicable regulations, the sometimes-confusing differences among various health insurers’ submission requirements, and the sheer volume of data involved, can all contribute to the problem from the claims submission side. Indeed, most providers do not purposely aim to fraudulently increase their reimbursement when they submit claims. Among the challenges providers face is an ongoing shortage of highly qualified coding professionals who can efficiently and correctly sort through the thousands of rules and thousands of codes to code correctly, and who can keep up with constant changes in coding procedures and payers’ revised recommendations.

What compliance officers can do

That having been said, it is health insurer organizations that face the greatest direct, negative consequences of this situation; yet it is also within insurer organizations that some core obstacles continue to frustrate progress on this issue. Most health plans still operate day-to-day in a rather routine fashion overall, with the vast majority of claims paid upfront, and potentially, very high

numbers of suspect claims are not flagged or investigated before being paid. Because of the routine approach to paying claims that the majority of health plans still take, those plans are undoubtedly allowing large sums to be paid for claims that should instead be analyzed or investigated. What are some of the reasons for the current situation? For smaller health plans, lack of budget is one of the biggest factors. For others a lack of leadership or forward thinking can be implicated in this area.

Indeed, our view is that senior health insurance executives are only now beginning to wake up to the scope and severity of the fraud and abuse problem. For those at smaller managed-care organizations, the longstanding problem exists of not having a broad enough range of claims to analyze in order to discern patterns, at least when using standard industry processes. For others, the age-old problem of inertia and business-as-usual mentalities is evident. Whatever the cause, this remains an area with great untapped potential for prevention of fraud and recovery of funds paid for fraudulent claims.

What’s more, in our work in the fraud and abuse area, we see one basic fact playing out over and over again: the individuals and groups perpetrating health care fraud spend a great deal more time developing fraudulent schemes than we as a health care industry do in investigating and thwarting them. That’s why the perpetrators of fraud continue to sprint ahead. Indeed, we are seeing crime syndicates that once focused their energies primarily on “dirty” areas of activity (e.g., drug-dealing, prostitution, and gambling schemes) moving into health care fraud, because it’s profitable and the threat of violence is very rare. Yet, as a result of the “business as usual” mentality

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that still reigns in most health plan executive suites, fraudsters are literally making millions off an already-pressured health care industry.

So, what can compliance officers do? We believe compliance officers have a strong potential role in all this, because of their awareness of federal, state, and local regulatory activity and their involvement in day-to-day compliance work. Among other things, compliance officers can leverage their awareness of federal and state-level enforcement activity to inform and persuade health plan executives that trends in fraudulent claims activity need to be addressed. For example, Medicaid fraud control units in every state are seeing an increase in funding and activity, as they adopt a more uniform approach to rooting out fraud.

And in their day-to-day work in auditing and working to detect fraud, compliance officers can work with the managers of their health plans' fraud and abuse units to adopt the most up-to-date information technology (IT) and business intelligence tools available. What should all those involved in making or influencing information technology purchasing decisions be looking for? To begin with, it's very important to develop a consistent

method of applying software edits to the claims being submitted. The goal in this regard is to make sure that your organization is paying individual claims correctly and that the software you are using carries triggers that reliably identify outliers. Many software programs currently on the market simply aren't comprehensive enough; it's important to purchase software that offers both edits and a broad overview approach. All this is one aspect of what should be a three-tiered strategy overall:

Compliance officers can leverage their awareness of federal and state-level enforcement activity to inform and persuade health plan executive that trends in fraudulent claims activity need to be addressed

- Containing costs by paying claims correctly the first time out;
- Recovering claims improperly paid through effective post-payment review; and
- Identifying abusive billing trends and outlier claims.

Fortunately, at the same time that effective software solutions are coming onto the market to assist in these important tasks, the federal and state governments are moving forward in significant areas. Among other trends, the Department of Justice is focusing on fraud and abuse and quality of care; and the Center for Medicare and Medicaid Services (CMS) is increasingly looking at quality of care, and indicating that it will use the False Claims Act to prosecute providers who bill for care that does not merit reimbursement.

In other words, the operational and regulatory environment around health care claims is evolving, at a time when information technology advances are providing health insurers with more effective tools to tackle the fraud and abuse problem. Compliance officers, through their auditing and detection work, can be instrumental in helping their health insurer organizations to become more successful in rooting out fraudulent and abusive provider claims. The good news of better IT tools for the job at hand, and an evolving operating environment, should give compliance officers the encouragement they need to help lead their organizations forward in this area of vital interest to all stakeholders in health care. ■

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