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## Next Generation Fraud, Waste and Abuse Tool Kit

Data, Linking Technology,  
Contributory Databases

EXECUTIVE SUMMARY

# EXECUTIVE SUMMARY

## Overview

The FBI estimates that fraud in the health care industry costs American taxpayers roughly \$80 billion a year. Indeed, with the rise of digital technologies and the use of electronic payment systems, opportunities to defraud the health care sector abound. But the same technologies and data-analytic tools can also help the payer community detect and reduce instances of fraud, said Mark Isbitts, director of market planning for payment protection at LexisNexis Health Care.

LexisNexis, a leader in health care fraud identification and prevention analytics, has long understood the need for health care to adopt more innovative methodologies and approaches to mitigating its exposure to fraud, waste and abuse (FWA). Most recently, LexisNexis released its latest innovation around linking. Discussed during a recent webinar, Isbitts showed attendees from the payer industry how aggregating, combining and linking disparate data sets improve fraud detection.

## The value of data and linking analytics

The reality is that managing and linking data are not core competencies for most health care organizations, and they often do not have the data or the analytics to do so. As a result, analytic efforts usually leverage internal data sources alone, which in many cases can be outdated, incomplete or both. Specifically, when it comes to understanding the risk of fraud that exists within provider and member populations, Isbitts urged payers to expand their data analytics to include information beyond claims data, which has traditionally been the sole source of data used. While claims data remain vital in identifying instances of fraud, it is also like looking at one side of a six-sided cube: By limiting their data perspective, payers are also restricting their ability to see the entire fraud, waste and abuse picture.

“Obviously claims data is the most prevalent and prominent data used for fraud detection and analysis,” said Isbitts. “We do see some plans using other data, such as provider and member

To better illustrate the problem, Isbitts cited a recent example of fraud in Brooklyn, N.Y. A ring of 10 doctors, nine clinics, and 105 corporations conspired with the Russian mafia to defraud multiple payers of \$250,000. The conspirators were billing excessive and unnecessary medical procedures for “victims” of staged accidents. While the FBI and local law enforcement eventually shut down the ring, the effort took considerable time and resources—and was stopped only after the fraudsters stole hundreds of thousands of dollars.

data, but not in a cohesive, integrated fashion.” The types of data Isbitts suggested a payer should have in contributory databases include claims, member, provider, non-health care data such as banking and criminal records, and other public information, which might include business-related records and relationships. The next step is to link all these data to form a fuller picture and identify key players, connections between the players—businesses as well as individuals—and frequently missed “patterns of behavior.”

As an example, Isbitts discussed a fictional case of a company that produces motorized wheelchairs. A payer that notices that the company’s referrals for the wheelchairs are excessively high might discover that 70% of those referrals come from just three doctors. But further analysis of the combined data, such as criminal records, could also reveal that the company’s part-owner had been convicted of bank fraud. Because the co-owner does not submit claims, he is probably not even on the radar of the payer. But by unearthing data such as this, a payer would be better able to detect instances of criminal activity.

“That’s taking in a lot of different information, but it gives you a much more complete picture and something you may not necessarily know without incorporating that information,” said Isbitts.

While combining this depth of data takes time, the benefits far outweigh the expenditures. Isbitts listed four key advantages of taking a comprehensive data approach to fraud, waste and abuse:

- 1. Reduce overpayments and enhance recoveries.**
- 2. Efficiently allocate resources and reduce investigative effort.**
- 3. Uncover collusive schemes and relationships quickly.**
- 4. Share information with other affected organizations, including other payers and law enforcement.**

To close the webinar, Isbitts recounted a case study of a LexisNexis client that showed the benefits of using multiple data sets. In this example, the client suspected brokers were enrolling fictitious or ineligible people (such as the deceased or minors without parents) or both through the organization's exchange. A review of the data revealed that 86% of the names were, indeed, fictitious. The early detection ended up saving the client between \$50 million and \$90 million in fines and erroneous commissions, not to mention the months that would have been spent investigating the fraud.

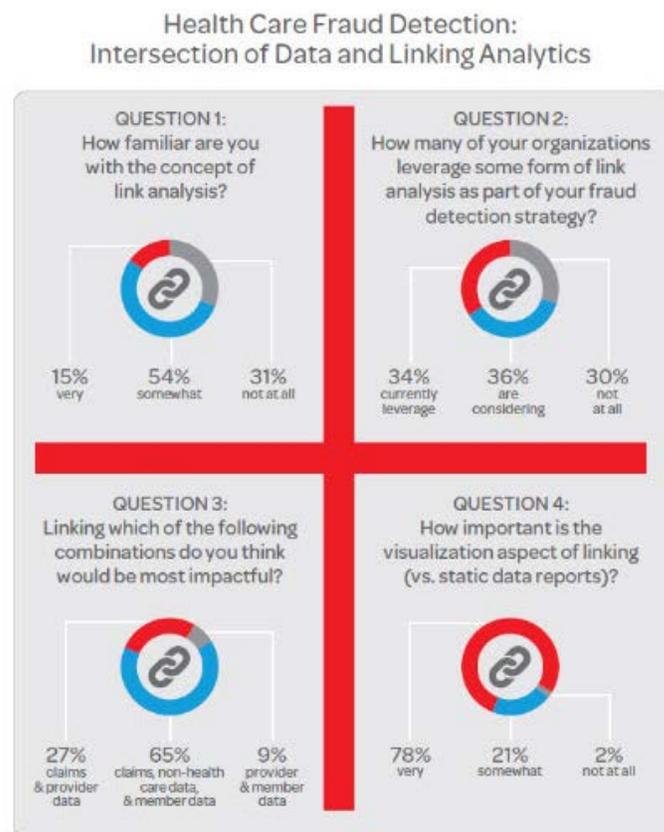
## Enhancing FWA toolkits

Isbitts listed three methods for payers interested in enhancing their data-analytic capabilities to improve their overall FWA program.

- 1. Determine appetite for fighting FWA:** For instance, as a payer, do you want a program that includes pharmacy fraud, emphasizes provider fraud or tries to do it all?
- 2. Determine data, analytics and resources available:** Inventory available data and technical capabilities. "If you had access to all the data, can your systems handle that?" said Isbitts. If not, then he suggested partnering with a third party such as LexisNexis.

- 3. Determine criteria for success and ROI:** How are you and your team evaluated, and will this continue as health care payments continue to change? For example: If you are assessed today primarily on recoveries and your goal is to move toward prepayment detection, your recoveries may decrease. How are your customers, such as employer groups, evaluating your organization's ability to protect their money (if they are self-insured)? "What is it that will bring value to your organization?" asked Isbitts. One of the key components to this ROI, he stated, is whether or not cost avoidance is considered in the ROI and which part of the organization is credited for it.

By taking these steps, and realizing the great potential in a robust, comprehensive data-analytics program, payers can help stem the tide of health care fraud.





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Our health care solutions assist payers, providers and integrators with ensuring appropriate access to health care data and programs, enhancing disease management contact ratios, improving operational processes, and proactively combating fraud, waste and abuse across the continuum.

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Health Care

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<sup>1</sup>Improving Quality and Patient Experience: The State of Health Care Quality 2013. National Committee for Quality Assurance (NCQA). October 13, [www.ncqa.org](http://www.ncqa.org).