Benchmarks as the Signposts Along the Fraud Case Trail

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by Karen Kaldal

Traditionally, payers in the healthcare industry have relied on external tips or complaints for starting points for fraud investigations. But recently the number of leads on fraud activity has increased as the public becomes more aware of the issue. To combat this problem, payers have begun to use benchmark reference points to help accelerate their review and pursuit (if warranted) of such leads and to lend a level of objectivity to the review. These benchmarks -- namely, provider profiles, norms, trends, and patterns -- show how the provider in question compares to his/her peers and the frequency with which questionable practices may be occurring. While most tips turn out to be misunderstandings on the subscriber's part, occasionally a tip proves to be the "tip of the iceberg" and evolves into a full fraud investigation.

Most payers in the public and private sectors have formed special investigation units (SIUs) to focus on fraud, abuse, and waste. Increasingly, these units are deploying high-tech computer systems to help them identify, analyze, and report their cases. Increasingly, too, experience is showing that benchmarks are valuable tools for pointing out suspects, assessing the validity of hotline "tips," and assuring objectivity in the process.

Benchmarks Help Put Allegations in Perspective

As important as they are, benchmarks are not the definitive word on whether or not a fraud has been perpetrated. For each benchmark (whether a statistical computation or a rules-based pattern), there are many possible explanations. The most serious conclusion is that intentional fraud has been committed. However, it is also possible that the same set of "indicators" could lead to the conclusion that innocent billing errors have occurred; or that a medical policy or billing instruction has been poorly conceived, poorly communicated, or both.

The key to effective data analysis in the fraud arena is to take benchmarks into consideration and then to conduct expanded data analyses and investigative legwork to prove or disprove their implications. SIU personnel specialize in "drilling down" into the data and laying bare the underlying meaning of fraud indicators. Ultimately, the path to unraveling the components of healthcare crimes relies on three components: the reliability of benchmarks, the flexibility and variety of complementary data analysis tools, and the interpretive skills of investigators who must delve into the intricate details of a potential case.

Benchmarks Find Outliers Who May be Fraudulent

The breakthrough in fraud detection today is the ability for payers to generate their own data-driven "tips" through the use of a variety of benchmarking methods. There are no industry standards in this area; fraud-detection benchmarks are constantly evolving as payers learn more about fraud schemes and how to differentiate "normal" from "abnormal" billing patterns.

Fraud operates on a number of different levels. It may be perpetrated by a lone provider falsifying the nature of services rendered, by rings of individuals perpetrating sophisticated scams, by subscribers working on their own or in collaboration with providers, or by "corporations" incorporated for no purpose other than to rip off the healthcare system. Indicators of these different forms of fraud are detected by viewing the data from different angles.

The role of technology in the fight against healthcare fraud, then, is to serve as an enabling tool for the analyst or investigator. In 1997, the Health Care Financing Administration (HCFA)expanded its emphasis on such technology-based methodologies for detecting fraud in the Medicare Program. HCFA purchased a license from VIPS Healthcare Information Solutions for the use of VIPS Services Tracking, Analysis, and Reporting System (STARS"™). Under the terms of the agreement, HCFA has made the system available to all Medicare carriers and intermediaries in the country. Using STARS, analysts at Medicare offices are empowered to spot aberrancies in very large databases, navigate through telltale details, and systematically accumulate evidence along the way (including evidence of a dead end). The benchmarks that are incorporated into the product serve as

starting points and measures of potential problems, if not as determinants of fraud. Consequently, analysts can evaluate data through a variety views, including:

- *Provider profiling* -- Through a series of online reports, analysts can establish baseline billing levels by procedure code for each specialty within geographic areas. Individual providers are compared to their peers and ranked according to the degree by which their individual billing levels deviate from the norm (either high or low). All claims associated with a provider -- even if billed under multiple provider numbers -- are accumulated so that the entity's full billing history is profiled. This approach finds providers that are trying to compartmentalize and "hide" their true billing levels. When a provider bills dollar amounts or numbers of service in excess of his/her peers by a statistically significant amount, or when the percent of change in payment from one period to the next significantly exceeds the average, that provider warrants review.

- *Norm analysis* -- Payers can load external normative data into their environment. These external sources are benchmarks by which individual payers can compare their actual experience to a broader base of activity or to an accepted standard. Based on data accumulated by HCFA, Medicare carriers can routinely compare their local payment levels to national Medicare figures. Among the benchmarks analyzed for procedure/specialty combinations are average amount paid per 1000 patients, average charge per patient, average denial rate per procedure, and percent of payment change. For instance, it is worth analyzing why a local Medicare carrier experiences a 56 percent increase in payment for a diagnostic x-ray when the national rate of payment of that x-ray decreases by 8 percent. The reason may be differences in local medical policy, a regional facility that specializes in the procedure, or perhaps just a single provider fabricating claims for the code.

- *Trend analysis* -- Analysts can now monitor and measure the change in payment level over time for every procedure code, revenue code, diagnosis/DRG, type of bill, and provider (and combinations thereof). Trend data helps payers spot "hit and run" cases, uncovering loopholes in their claims systems that have recently been discovered and exploited by unscrupulous individuals and pinpointing when a fraudulent scheme started. Sudden spurts or changes in billing levels are natural red flags.

- *Pattern analysis* -- An entity that sets out to flagrantly falsify claims -- especially billing for services never rendered or misrepresenting the patient's diagnosis -- runs the risk that the claims will contradict bills from legitimate providers for legitimate services and supplies. Pattern analysis can be used to search the database for contradictory, illogical, and unexpected combinations of services. These are rules-based algorithms that incorporate the individual payer's best practices and policies. The system provides a set of pattern templates; the specific rules (values, thresholds, data combinations) are specified by the user. This means that users do not have to rely on the software vendor in order to respond to new fraud schemes. When they need to test for new scenarios, change a medical policy, or automate a new best practice, they can adapt their pattern template and immediately put the new rule into effect. Patterns search for situations such as missing predecessor procedures/ tests, services billed in conflicting places of service, too many services within the time frame for the reported diagnosis, conflicting/unrealistic diagnoses billed by multiple providers, or too many hours in a day. Examples include:

    - ambulance trips with no complimentary medical service on the same day
    - speech therapy billed during a time when other providers' claims indicate the patient was comatose
    - lab work billed both on a UB-92 (as inpatient tests) and on a HCFA-1500(as outpatient tests)
    - bills for office visits during a SNF stay
    - violation of Medicare's 72-hour rule
    - prescription drugs reportedly ordered by a physician who has not seen the patient recently
    - a psychotherapist billing for 37 hours' worth of therapy in a single day
    - major surgery billed without the expected pre-surgery tests

Launching In-depth Data Analysis from the Benchmark Starting Point

Uncovering the occasional indicator -- such as a problem pattern, an outlier profile, or spike billing -- is not, in and of itself, the same as deciding fraud is being committed. The occasional billing blip will almost assuredly result in a request for repayment of funds, but it will not necessarily lead to an accusation of fraud. After reviewing the benchmarks, payers will gather detailed claim data, verify the provider's eligibility and credentials, review patient charts, interview patients, and otherwise research the

situation before determining the appropriate action. In the process, they will use other methods, including data drill-down, on-the-fly data summarization, random data sampling, ad hoc query and reporting, geographic mapping, graphing, and free-flowing sorts, filters, etc. In this way, analysts can assess the severity of the situation and document their findings in a professional manner.

Benchmarking the activities of healthcare providers and developing profiles of "normal versus abnormal" billing patterns are sound means of determining which providers and subscribers may be submitting fraudulent claims. As payers become increasingly sophisticated in their approach to resolving the problem of fraud and abuse, more and more benchmarks will be developed and deployed. Each new measure that makes illegitimate claims stand out among all of the legitimate claims will help payers effectively stem the loss of benefit dollars.

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