CASE STUDY:

Finding Fraud, Waste, and Abuse in Medical Provider Billing

Verisk

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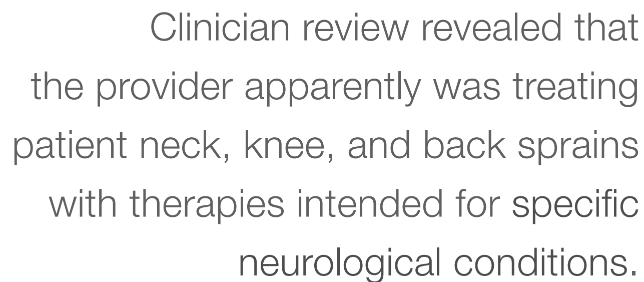
To help tackle medical provider fraud, waste, and abuse, ISO developed a game-changing solution that combines advanced predictive analytics and expert case analysis. So, when a Michigan chiropractor/physical therapy practice billed a top ten insurance company a total of **$358,135 for 12 patients** over two years, the carrier submitted the claims data to us. At the time of review, the carrier had paid **$158,440—the second-highest amount paid to any U.S. chiropractor** during the review period. ISO MedSentry® quickly uncovered a clear case of medical provider billing abuse.

Suspect Billing Patterns Were the First Sign

Practitioners from a physiotherapy clinic saw 12 patients a total of 781 times between August 2013 and August 2015. ISO MedSentry advanced analytics flagged four behaviors typical of provider fraud, waste, and abuse:

1. high average dollars billed and excessive number of visits
2. boilerplate billing or routinely billing for the same type(s) of treatments for each patient
3. high average number of treatments per patient
4. multiple and ill-defined diagnoses

In this case, the clinic's average number of patient visits was 65, compared with the industry peer average of 18 visits during the same period. Also, all the patients were treated with the same five modalities, a sign of boilerplate billing. Further evidence of boilerplate billing was that the five treatments were coded on 96 percent of all bills the provider submitted for payment. Without the ISO MedSentry provider trend analysis, predictive analytics, and multivariate models, these suspect billing patterns likely would have gone undetected amid two years of medical information.



> Clinician review revealed that the provider apparently was treating patient neck, knee, and back sprains with therapies intended for specific neurological conditions.

Clinician Review Reveals More Than Suspect Patterns

Also hidden within the clinic's billing data was medical care that didn't appear to address the patients' injuries and treatments or diagnoses. Most physical therapy providers treat to correct the effects of injuries. ISO MedSentry clinician review found that the suspect physiotherapy clinic didn't correct injuries as expected. Also, 44 percent of all patient visits were billed with diagnosis codes such as "840.9 – Unspecified Sprain of Shoulder/Arm" and "845.00 – Unspecified Sprain of Ankle." This is unusual, because these codes are often intended for use before confirming a diagnosis—not as a basis for prolonged treatment.

A surprising finding was that the suspect clinic billed for neuromuscular reeducation on almost two-thirds (65 percent) of all patient visits. This treatment is typically intended for neurological conditions and trains the patient's body to make up for a lack of function in another part of the body. Shoulder and ankle sprains rarely require the application of neuromuscular reeducation.

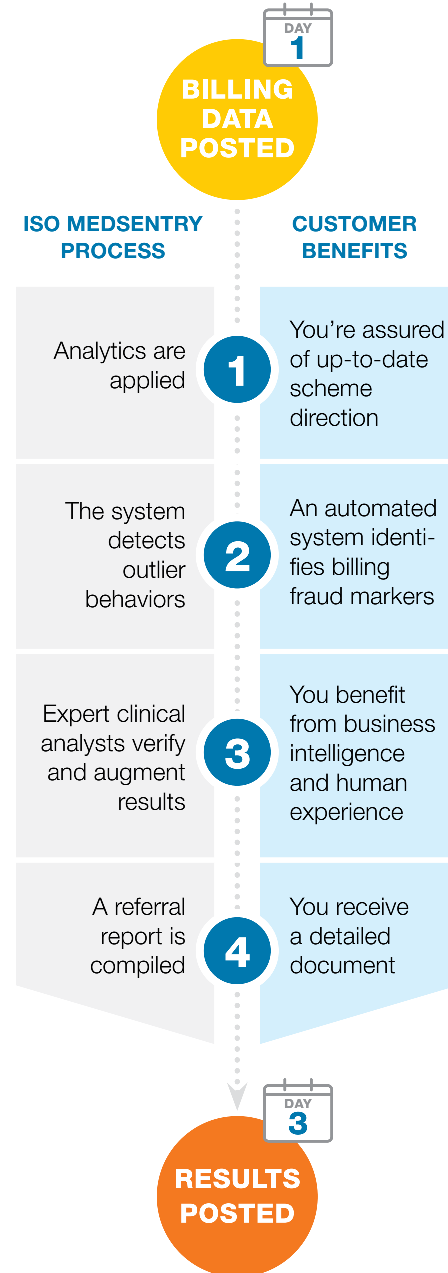
Also, for some patients, neuromuscular reeducation and chiropractic manipulation treatments were billed on the same date of service. That combination of physical medicine is unusual and often inappropriate. ISO's expert clinical vetting proved very effective in rooting out mismatches between diagnoses and treatments and determining whether treatments billed on the same day were medically appropriate.

Changing the Landscape of Medical Provider Fraud

ISO MedSentry referred the case to the National Insurance Crime Bureau (NICB), which issued a MedAware Alert for the provider.

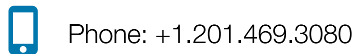
The case demonstrates that using fraud detection methods, including advanced analytics combined with expert clinician review, can be an incredibly thorough way to combat medical provider fraud. Analytics can reliably identify suspect billing and behaviors, and an expert clinician can determine whether billed medical services meet the standards of patient care for the provider's discipline and jurisdictional rules, where applicable.

ISO MedSentry is changing the landscape for the detection of medical provider fraud, waste, and abuse and is intended to augment the work of your internal teams—from SIU to medical management and claims. Customers have seen an overall **69 percent decrease in billing activity from suspect providers** after ISO MedSentry uncovered provider fraud, waste, or abuse patterns in insurer data and SIU then notified the providers. No other solution is as powerful—or as proven.



Learn more about ISO MedSentry, the ISO ClaimSearch® medical fraud solution

Shane Riedman | Director of Product Innovation
ISO Claims Analytics


Phone: +1.201.469.3080

Shane.Riedman@verisk.com

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