Verisk™

By John Trovinger, CPCU, CLU

What You Can't See CAN Hurt You

Medical Provider Fraud, Waste, and Abuse— The Unseen Problem That's Costing Insurers Billions

Insurance Automation

From Policy through Claim

- AI, machine learning, and predictive analytics increases speed and precision
- 19 petabytes of data across proprietary databases yields greater accuracy
- Ecosystem of integrated solutions improves customer experience – yours and theirs
- 5,000+ industry experts provides lift across the value chain
- 50+ years safeguarding insurers' data earns confidence

Out of the shadows and into the light

Claims fraud is nothing new to the property/casualty industry—we've been fighting it for years. While we've made some inroads, the problem persists to the tune of **$45 billion** a year.[1] A key reason? Medical provider fraud, waste, and abuse—which has largely eluded insurers—accounts for the majority of the problem.[2] It's been insidious, quietly eroding insurers' margins. And with medical costs on the rise, the trend doesn't seem to be reversing—or even stabilizing—anytime soon.

Insurers can no longer afford to remain in the dark.

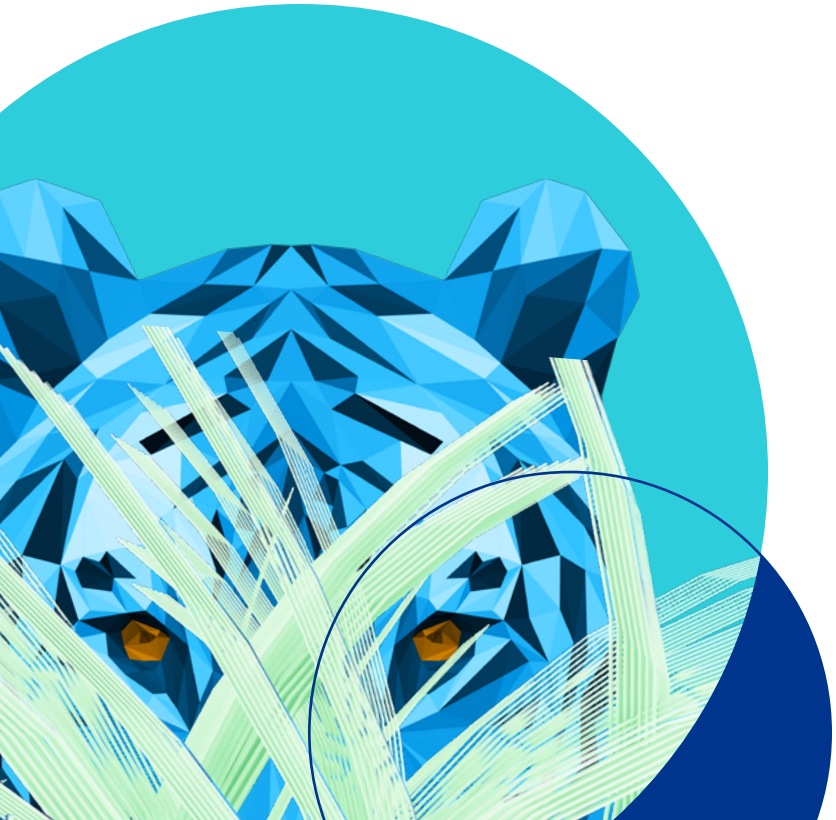
The Scope of Healthcare Overspend

Beyond property/casualty insurance, the scope of overall healthcare fraud, waste, and abuse is estimated to be more than **$200 billion**.[3] One reason it's been so difficult to detect, much less stop, is that the problem encompasses not only outright fraud but also billing for unnecessary procedures and engaging in inefficient care delivery.

Legitimate Medical Costs Are Rising

The data is clear: Insurers are paying much more today than ever before for claims that involve injuries. From 2008 to 2017, the average cost per paid bodily injury liability claim increased **31 percent**, and personal injury protection (PIP) claims increased by **26 percent**.[4] Couple that with escalating prescription drug costs, and your bottom line takes an even bigger hit.

We're also seeing greater numbers of workers' compensation claimants developing dependency on expensive opioid medications to control pain. These medications are highly addictive and being prescribed more often. According to the CDC, **34 percent** of workers' compensation claims with prescriptions had at least one opioid prescribed.[5] While some of these treatments are necessary, you can combat expenses from excessive, unnecessary, and undelivered medical treatments.



The Reasons Insurers Are Struggling to Detect and Prevent Provider Fraud, Waste, and Abuse

1 ***Resources are scarce, and identification is tough***

If you feel like it's just too overwhelming a problem to fix, you're not alone. A *Claims Journal* article cited prioritization of resources as a top challenge facing special investigations units (SIUs).[6] While a number of automated tools assist claimant fraud identification, the SIU needs to do the heavy lifting to identify provider fraud with full confidence that it can be defended.

A thorough understanding of procedure codes and treatments is needed to see just what's aberrant in a treatment plan. The complexity in understanding this as compared to claimant fraud is why medical provider fraud has gotten less attention, and most insurers accept huge losses as the cost of doing business.

2 ***Your medical bill review is fixing coding errors, not helping find fraud, waste, and abuse***

Medical bill review (MBR) vendors analyze provider treatments and billing for proper coding and adjust them to prevailing fee schedules. They're designed to apply edits—not analytics. Your MBR is not going to help you eliminate fraudulent schemes and overbilling practices of questionable providers. That means your bottom line will continue to erode over time.

Property/casualty insurers are losing

$45 billion

a year, much of it to medical provider fraud, waste, and abuse

Proven ROI:

Medical providers that have been "put on notice" reduce their future billings to the tune of tens of millions of dollars

3 ***It's easy to hide abusive and fraudulent behavior in complex medical bills***

Because of the complicated nature of medical billing, it's not very difficult for unscrupulous providers to perpetrate fraud, waste, and abuse, which may include:

- billing for services that were not provided
- billing for higher-priced services than were actually supplied
- performing medically unnecessary procedures or tests
- providing treatments that are not covered and misrepresenting them as medically necessary

In fact, fraudulent billing and billing for unnecessary services accounted for 46 percent of provider fraud cases in 2016.[7]

Taking a Hard Look at Medical Provider Fraud, Waste, and Abuse

While the difficulties of tackling fraud, waste, and abuse previously made it an accepted (albeit high) cost of doing business, tools that allow insurers to make real strides against this multibillion-dollar problem are now far more accessible.

Analytics combined with modeling techniques can uncover patterns of aberrant treatment and billing, such as:

- excessive modalities
- mismatch of diagnosis to procedure
- template (or boilerplate) billing
- mismatch of provider to specialty/diagnosis/procedure
- high time billing

Proven Solution Uncovers Hidden Exploitation

By using a multidisciplinary predictive analytics model and highly tuned algorithms, MedSentry® helps insurers see medical billing fraud, waste, and abuse with greater clarity than ever before. It combines advanced analytics with expert clinical review to verify findings and assure highly accurate detection.

The SaaS solution generates a risk score for every medical provider in your book of business, so claims adjusters can quickly identify suspicious behavior and pass that information to SIU for potential investigation. SIU is provided with a report that details specific issues in the billing data as well as clinical analysis describing the suspect behavior and what to investigate.

Deeper Insight Brings Significant Savings

It's time to shine a bright light on medical provider fraud, waste, and abuse and start saving on unnecessary billing. On average, our clients have realized ROI of 10:1 to 20:1 after implementing the solution. You can do the same with MedSentry, the industry's preeminent medical fraud detection solution for more than a decade.

ABOUT THE AUTHOR

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John has more than 20 years of experience working for the nation's largest property and casualty insurer, with 16 years of SIU experience. He has held multiple leadership roles in various jurisdictions and has deep claim and fraud investigation experience. John moved into the dynamic arena of InsurTech and SaaS and utilizes his knowledge of advanced analytic solution technologies to consult with clients helping them build anti-fraud strategies.

For more information and resources on Verisk's fraud detection, contact:

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