National Conference of State Legislatures Fall Forum

Tampa, Florida

Kelli Garvanian
Vice President, Program Integrity

November 30-December 2, 2011
Emdeon is the largest administrative network in the U.S. healthcare system. We are a leading provider of healthcare revenue and payment cycle management solutions, connecting payers, providers and patients in the U.S. healthcare system.

### Employees:

<table>
<thead>
<tr>
<th></th>
<th>3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headquarters:</td>
<td>Nashville, TN</td>
</tr>
<tr>
<td>Customers:</td>
<td>Payers, Providers, Pharmacies</td>
</tr>
</tbody>
</table>

### Other Locations

**Payment Services**  
*St Louis, MO; Salt Lake City, UT*

**Billing And Payment**  
*Toledo, OH; South Burlington, VT*

**Eligibility Screening & Enrollment**  
*Atlanta, GA*

**Pharmacy**  
*Twinsburg, OH; Ft. Worth, TX; Asheville, NC*

**Fraud & Abuse Detection & Prevention**  
*Lincolnshire, IL*

**Provider Program Integrity Services**  
*Tampa, FL*
Emdeon’s Ubiquitous Network
We Connect All Principal Healthcare Constituents

Consumers

Providers

500,000 Physicians (~88%)
5,000 Hospitals (~88%)
81,000 Dentists (~92%)

500,000 Physicians

500,000 Physicians

5,000 Hospitals (~88%)

81,000 Dentists (~92%)

60,000 Pharmacies (~100%)

Pharmacies

1,200 Commercial Plans (~100%)

Medicare
Medicaid
Blue Cross/Blue Shield

Pre-Care (Benefits and Eligibility Verification)

Claims Management / Submission

Payment and Remittance Distribution and Denial / AR Management

Patient Billing and Payment

Pre-Care (Credit Verification, Public Assistance, Enrollment)

Explanation of Benefits

Electronic Prescriptions

Connections and Solutions All Facilitated by Emdeon

Positioned to Drive Healthcare from Paper-Based to Electronic Transactions

Note: (1) Based on electronic claim submitting dentists
State Issues and Concerns

• 46 States are forecasted to have declining revenues in 2012

• Increasing Medicaid populations

• Prevalence in fraudulent activity

• High cost of recovering “pay and chase” fraud dollars

• Continued staff reductions and budget cuts in fraud service areas
  • Less public visibility and outcry to cut “back office” administration vs. education and other direct services

• Regulations which do not allow for dollars saved under fraud detection & prevention programs to fund the programs themselves
Ted Clark, Director Kansas Fraud Bureau and working Chair of anti-fraud committee of the NAIC

“You would think that when the economy is tough and fraud by opportunists is increasing, that the states would devote more resources to fraud. But that isn’t happening.”

Chuck Gregory, Head of Fraud Unit, Arizona

“There’s a lot of fraud going on, and not having manpower is a very big problem. On a lot of cases we’re doing, we’re just putting out fires and working off of case referrals that are coming in. The rest are going by the wayside.”
CMS Direction
From Dr. Peter Budetti’s April 14th NCSL Spring Meeting

Current State | Future State
--- | ---
1. Pay and Chase | Prevention and Detection
2. ‘One Size Fits All’ | Risk-Based Approach
3. Legacy Processes | Innovation
4. Inward Focused Communication | Transparent and Accountable
5. Government Centric | Engaged Public/Private Partners
6. Stand Alone PI Programs | Coordinated & Integrated PI Programs
Putting Healthcare Fraud, Waste, and Abuse in Perspective...

Figure 1: Fair Isaac Fraud Estimates for 2004 based on data from various sources

- Credit Card Fraud: $788M
- Phishing (email and web-based fraud): $1.2B
- Insurance Fraud: $29B
- Identity Theft: $52B
- Healthcare Fraud: $240B
Everyone Knows – This is a Huge Problem

“By taking the fraud, [waste], and abuse problem seriously, this administration might be able to save 10 percent or even 20 percent from Medicare and Medicaid budgets. But to do that, one would have to spend 1 percent or maybe 2 percent (as opposed to the prevailing 0.1 percent) in order to check that the other 98 percent or 99 percent of the funds were well spent. But please realize what a massive departure that would be from the status quo. This would mean increasing the budgets for control operations by a factor of ten or twenty. Not by 10 percent or 20 percent, but by a factor of ten or twenty.”

— Harvard professor Malcolm Sparrow, May 20, 2009, testimony to United States Senate Judiciary Committee

Before cutting benefits, before cutting budgets – Fight Fraud First
Mandate Comprehensive Program Integrity in 2012

Program Integrity spans the continuum from errors to abuse to outright fraud

Definition:
The ability to **efficiently** process and **accurately** pay only those claims which are valid, while removing wasted dollars in the systems and identifying aberrant claims and providers that could be fraudulent or abusive.

Fraud and Abuse  | Clinical Code Editing  | Coordination of Benefits  | Over / Under Pmt Analytics  | Subrogation

The breadth and depth of payment integrity are important for all healthcare constituents: payers, providers, and consumers.
Why Emdeon Program Integrity Solutions?
Multiple Safety Nets for a Holistic Approach

**Provider Data Validation**
- Dead doctors
- Licensure
- Sanctions
- Address validation

**Clinical Integrity for Claims**
- Duplicates
- Unbundled pairs
- CCI Editing
- Custom edits

**Fraud Detection Rules**
- Provider specific
- Clinically appropriate thresholds
- Specialty-specific

**Predictive Analytics**
- Known and unknown schemes
- Phantom procedures
- Overutilization
- Double billing
- Policy gaps

**Investigations**
- Triage or full outsource
- Pend/pay/deny recommendations
- Request and review medical records

**Recovery Audit Compliance**
- Medical billing guidelines
- Contractual obligations
- Reimbursement rates and policies

*Perform pre-payment across entire populations*
## Visualization Report Card

**Entity:** Providers  
**Peer Group:** INDENT  
**Value Set:** AB  
**Model:** ENT  
**Profile:** 001

### Provider: MARK S MD

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Rank</th>
<th>Score</th>
<th>Value</th>
<th>Min</th>
<th>Med</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPOSITE</td>
<td>Provider Composite Score</td>
<td>1</td>
<td>716</td>
<td>0.0</td>
<td>5.8303</td>
<td>241.14</td>
<td>715.66</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>Informational &amp; Operand Features Group</td>
<td>0</td>
<td>0.0</td>
<td>0.0</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NM_SIGFEAT</td>
<td>Significant Features</td>
<td>2</td>
<td>994</td>
<td>0.0</td>
<td>112.24</td>
<td>994.15</td>
<td></td>
</tr>
<tr>
<td>BILLING</td>
<td>Billing Group</td>
<td>1</td>
<td>391</td>
<td>0.0</td>
<td>1.461</td>
<td>27.725</td>
<td>644.19</td>
</tr>
<tr>
<td>EXPOSURE</td>
<td>Exposure Group</td>
<td>1</td>
<td>722</td>
<td>0.0</td>
<td>2777288.0</td>
<td>4190.0</td>
<td>178210.0</td>
</tr>
<tr>
<td>FGB003</td>
<td>Total $ Charged</td>
<td>27</td>
<td>53</td>
<td>0.0</td>
<td>11.0</td>
<td>57.0</td>
<td>694.0</td>
</tr>
<tr>
<td>FGB007</td>
<td>Total # of Patients</td>
<td>35</td>
<td>39</td>
<td>0.0</td>
<td>24.0</td>
<td>193.0</td>
<td></td>
</tr>
<tr>
<td>FGB019</td>
<td>Total # of Patients</td>
<td>3</td>
<td>429</td>
<td>0.0</td>
<td>3741.0</td>
<td>103770.0</td>
<td>134881.0</td>
</tr>
<tr>
<td>FGB160</td>
<td>Total # of Claims</td>
<td>20</td>
<td>80</td>
<td>0.0</td>
<td>11.0</td>
<td>59.0</td>
<td>708.0</td>
</tr>
<tr>
<td>FGB449</td>
<td>Total # of Claims</td>
<td>3</td>
<td>446</td>
<td>0.0</td>
<td>3204.0</td>
<td>7131.0</td>
<td>1214530.0</td>
</tr>
<tr>
<td>FREQUENCY</td>
<td>Frequency Group</td>
<td>18</td>
<td>420</td>
<td>0.0</td>
<td>1.0</td>
<td>237.55</td>
<td>668.0</td>
</tr>
<tr>
<td>FGB006</td>
<td>Avg # of Pxs/Visit</td>
<td>10</td>
<td>765</td>
<td>9.4257</td>
<td>1.1562</td>
<td>2.7719</td>
<td>24.656</td>
</tr>
<tr>
<td>FGB040</td>
<td>Avg # Procedures/Month/Patient</td>
<td>11</td>
<td>864</td>
<td>13.6</td>
<td>1.3157</td>
<td>3.2131</td>
<td>27.207</td>
</tr>
<tr>
<td>FGB041</td>
<td>% of Chgd for Most Costly Pxs</td>
<td>31</td>
<td>52</td>
<td>25.891</td>
<td>8.8578</td>
<td>22.141</td>
<td>50.704</td>
</tr>
<tr>
<td>FGB060</td>
<td>Avg # of Procedures/Patient</td>
<td>13</td>
<td>752</td>
<td>39.667</td>
<td>2.1111</td>
<td>6.125</td>
<td>96.351</td>
</tr>
<tr>
<td>FGB075</td>
<td>% Miscellaneous Procs</td>
<td>1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>FGB081</td>
<td>% of High Level Eval &amp; Mgmt Pxs</td>
<td>62</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.1994</td>
<td>18.919</td>
</tr>
<tr>
<td>FGB093</td>
<td>Avg # Lab Procs / Patient</td>
<td>17</td>
<td>0.0416</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>1.5074</td>
</tr>
<tr>
<td>FGB126</td>
<td>% High Level Consultation Pxs</td>
<td>40</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>10.811</td>
</tr>
<tr>
<td>FGB127</td>
<td>% High Lvl Consult of All Consli</td>
<td>40</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>FGB320</td>
<td>% Surgical Procedures</td>
<td>19</td>
<td>285</td>
<td>0.0</td>
<td>28.782</td>
<td>0.0</td>
<td>11.45</td>
</tr>
<tr>
<td>SUSPICIOUS</td>
<td>Suspicious Group</td>
<td>1</td>
<td>610</td>
<td>0.0</td>
<td>69.659</td>
<td>610.02</td>
<td></td>
</tr>
<tr>
<td>FBF022</td>
<td># Sinus Endoscopy Procedures</td>
<td>1</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>FGB012</td>
<td>% of Out-of-Geography Visits</td>
<td>46</td>
<td>3.9603</td>
<td>0.0</td>
<td>5.0</td>
<td>71.0</td>
<td></td>
</tr>
<tr>
<td>FGB051</td>
<td>% Sun/Holiday or After Hrs Vsts</td>
<td>21</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>5.8823</td>
</tr>
<tr>
<td>FGB083</td>
<td>Avg # Surgical Pxs per Patient</td>
<td>1</td>
<td>1000</td>
<td>0.0</td>
<td>11.417</td>
<td>0.0</td>
<td>11.417</td>
</tr>
<tr>
<td>FGB088</td>
<td>Avg # of Radiology Pxs/Patient</td>
<td>1</td>
<td>1000</td>
<td>0.0</td>
<td>0.2916</td>
<td>0.0</td>
<td>0.2916</td>
</tr>
<tr>
<td>FBM027</td>
<td>% Patients w/ Cosmetic Surg Prcc</td>
<td>1</td>
<td>1000</td>
<td>0.0</td>
<td>50.0</td>
<td>0.0</td>
<td>50.0</td>
</tr>
<tr>
<td>FBY007</td>
<td>Avg # Ultrasounds / Patients</td>
<td>1</td>
<td>1000</td>
<td>0.0</td>
<td>50.0</td>
<td>0.0</td>
<td>50.0</td>
</tr>
</tbody>
</table>
Predictive Analytics & Residual Analysis

- Take large volume of historical claims data
- Look at each patient visit using quantitative input (variables)
  - E.g. procedure code, dollar amount, number of lines, age of patient, etc.
- Fit a statistical model to the data to predict how a normal visit looks for those conditions
- Find providers with visits that charge much more than the model’s prediction
- Monitor on a pre-pay basis to see if providers continue the same pattern
- Sound mathematical basis prevents personal bias against specialties or individual providers
- Identifies known and unknown schemes before payment is made

Electronic Claims Data
- Patient visits
- Quantitative criteria

Statistical model
- Predicts “normal” behavior
- Finds providers/visits that deviate

Providers and patterns to monitor
- Investigate suspect claims identified by model
- Stop fraud and overpayment before it happens
Accuracy Counts:
Inaccurate flagging is costly and wastes precious budget dollars

**True positive:** suspected fraud, waste, or abuse (FWA) is actually FWA

- Example: We identify a provider for unbundling renal panels in the data. After reviewing records it is found that the provider is actually doing this to receive more money.

**False positive:** suspected FWA that is identified is not FWA

- Example: A provider appears to be seeing patients 600 miles from the office the same day he/she sees patients in the home office.

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>County</th>
<th>Distance in Miles</th>
<th>Patient ID</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/14/2011</td>
<td>Amarillo</td>
<td>612</td>
<td>patient 1</td>
<td>99254</td>
</tr>
<tr>
<td>3/14/2011</td>
<td>Laredo</td>
<td>612</td>
<td>patient 2</td>
<td>99215</td>
</tr>
<tr>
<td>3/14/2011</td>
<td>Laredo</td>
<td>612</td>
<td>patient 2</td>
<td>93010</td>
</tr>
<tr>
<td>3/14/2011</td>
<td>Laredo</td>
<td>612</td>
<td>patient 3</td>
<td>93010</td>
</tr>
</tbody>
</table>

- Explanation: This provider has a private jet, and was actually seeing patients in both places

**False positives are costly**

- Medical review of records is time consuming and expensive
- Reducing false positives is crucial due to the large volume of healthcare data
One Example:

Unbundling Renal Lab Panel

CPT 80069 – Renal Function Panel
Comprehensive panel includes 10 codes
Example: Patient Visit on 3/7/2011

<table>
<thead>
<tr>
<th>provider</th>
<th>DOS</th>
<th>CPT Code</th>
<th>description</th>
<th>Charged Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>80069</td>
<td>RENAL FUNCTION PANEL</td>
<td>$87.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82435</td>
<td>ASSAY OF BLOOD CHLORIDE</td>
<td>$45.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82374</td>
<td>ASSAY, BLOOD CARBON DIOXIDE</td>
<td>$48.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82040</td>
<td>ASSAY OF SERUM ALBUMIN</td>
<td>$48.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>84520</td>
<td>ASSAY OF UREA NITROGEN</td>
<td>$77.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82310</td>
<td>ASSAY OF CALCIUM</td>
<td>$50.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82947</td>
<td>ASSAY, GLUCOSE, BLOOD QUANT</td>
<td>$38.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>84295</td>
<td>ASSAY OF SERUM SODIUM</td>
<td>$47.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>84132</td>
<td>ASSAY OF SERUM POTASSIUM</td>
<td>$45.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>82565</td>
<td>ASSAY OF CREATININE</td>
<td>$50.00</td>
</tr>
<tr>
<td>provider A</td>
<td>2011-03-07</td>
<td>84100</td>
<td>ASSAY OF PHOSPHORUS</td>
<td>$46.00</td>
</tr>
</tbody>
</table>

Total                        $581.00
Just Another Example: DME

What is DME?

*Durable Medical Equipment is equipment that primarily serves a medical purpose, is designed for repeated use, and can be used in the home.*

Examples:

- **Diabetic supplies**
- **Wheelchairs**
- **Walkers**
  - Bath benches
  - Respiratory equipment
  - Crutches
  - Scooters
- **Ramps**
- **Cold compression units**
- **Hospital beds**

Why DME Fraud?

- High-cost items (potential for quick profits)
- High percentage of use by seniors
- Lack of professional licensing requirements
- Reliance on lack of patient awareness and cooperation
- Overutilization of miscellaneous DME codes
DME Fraud Scenarios

Fraudulent providers obtain patient insurance information and bill for equipment never ordered or received. Common methods for suppliers to obtain this information include:

- Telemarketing scams
- Free screening offers
- Health surveys
- Illegal purchase of nursing home roster information
- Provider kickbacks
- Patients are offered free health consults. During the office visit, they are sent home with equipment they didn’t request and/or don’t need.
- Suppliers provide patients with medically appropriate scooters for increased mobility, but bill insurance payers for motorized wheelchairs (which are approximately double the cost of the scooters).
- Suppliers delay pickup of equipment no longer needed to try and bill for longer rental periods.
- Etc.
CMS Direction
From Dr. Peter Budetti’s April 14th NCSL Spring Meeting

Current State     Future State

1. Pay and Chase
   - Prevention and Detection

2. ‘One Size Fits All’
   - Risk-Based Approach

3. Legacy Processes
   - Innovation

4. Inward Focused Communication
   - Transparent and Accountable

5. Government Centric
   - Engaged Public/Private Partners

6. Stand Alone PI Programs
   - Coordinated & Integrated PI Programs

Emdeon’s Solutions

- ✓
- ✓
- ✓
- ✓
- ✓
- ✓
What Can You as Legislators Do?

Ensure you have adequate legislation in place to address the problem. The legislation should include/ensure:

• Funding for Program Integrity can be generated from the Medical dollars saved
• Mandates to accelerate all aspects of Section 6028, regardless of the challenges to Healthcare Reform
  - Fraud isn’t going away – Fight Fraud First
• Use of comprehensive, state-of-the art technology to minimize false positives and manual resource requirements
• Move to a prospective detection position, eliminating the “pay-and-chase”

Consider a total population approach – mandating the use of a prospective, predictive analytics detection system for maximum efficiency, regardless of beneficiary enrollment in public or MCO run benefit programs

Understand that cutting budgets and doing nothing is a blank check to your coffers
  - Perpetrators of fraud are savvy and move to less restrictive areas
  - When one State acts, those that don’t are impacted
You don’t need one more partner. You need **one** partner that does **more**.

**You and Emdeon.**

**one.**

**more.**

Contact:
Kelli Garvanian
847.597.4777
kgarvanian@emdeon.com