

National Conference of State Legislatures Fall Forum

Tampa, Florida

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Emdeon Corporate Overview

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:	3,000
Headquarters:	Nashville, TN
Customers:	Payers, Providers, Pharmacies

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

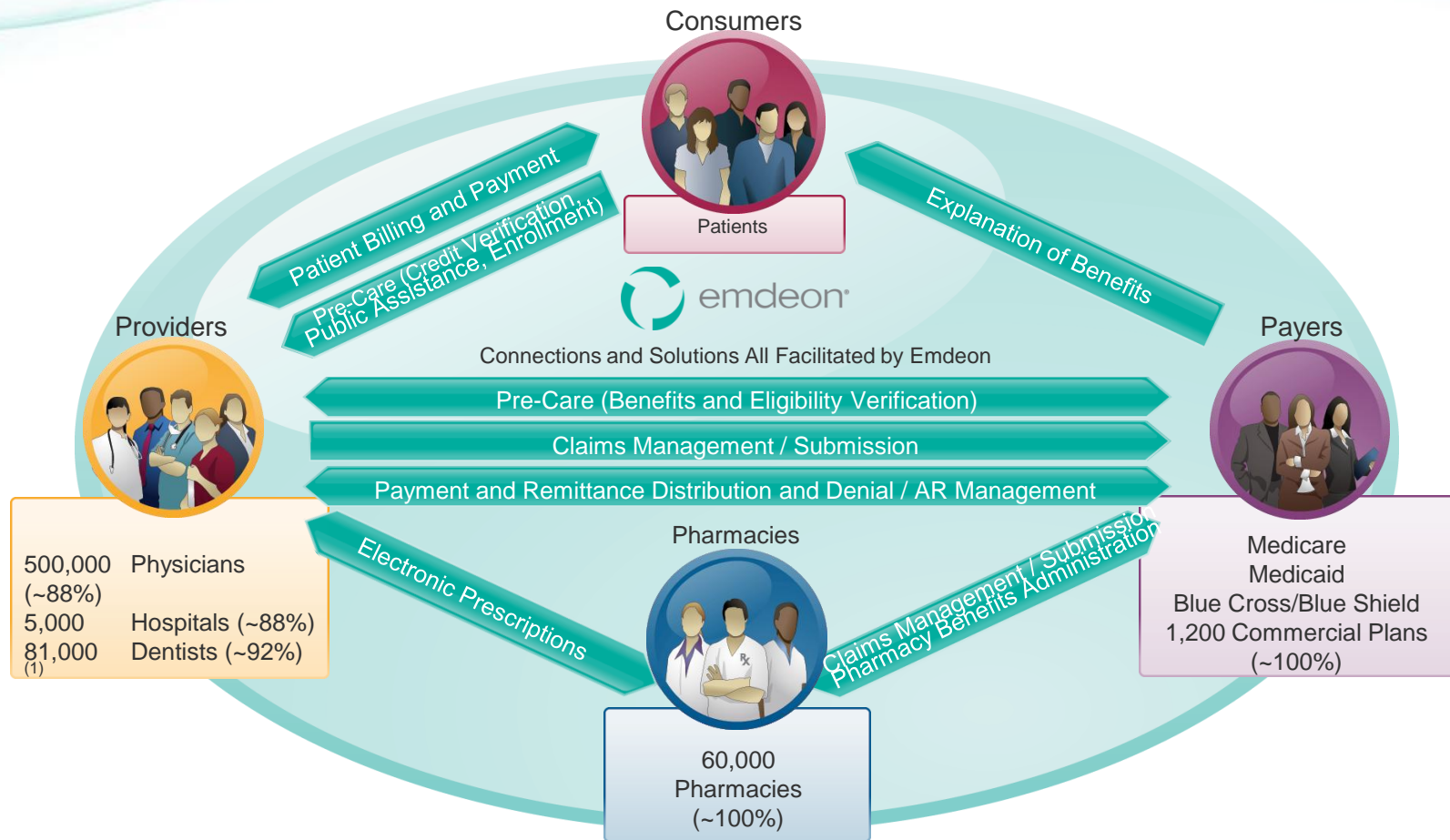
Lincolnshire, IL

Provider Program Integrity Services

Tampa, FL

Emdeon's Ubiquitous Network

We Connect All Principal Healthcare Constituents



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

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*

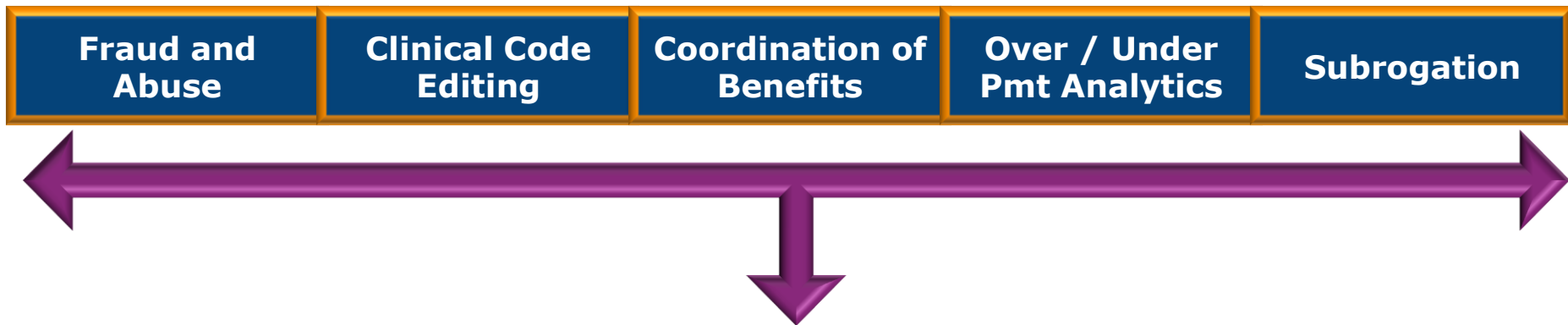
Before cutting benefits, before cutting budgets – Fight Fraud First

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.*



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	Name	Color	Lists	Providers
35:	MARK S MD	Red		87

Element	Description	Rank	Score	Value	Min	Med	Max
COMPOSITE	Provider Composite Score	1	716	0.0	5.8303	241.14	715.66
INFORMATION	Informational & Operand Features Group	0	0	0.0	0.0	0.0	0.0
NM_SIGFEAT	Significant Features	2		18			
BILLING	Billing Group	1	994	0.0	0.0	112.24	994.15
FBG013	% of \$ Eligible vs \$ Charged	2	982	27.559	23.916	62.68	91.49
FBG229	Avg \$ Eligible/Patient	1	1000	3184.0	204.44	518.11	3184.0
FBG230	Avg \$ Eligible/Visit	1	1000	756.6	41.753	183.32	756.6
EXPOSURE	Exposure Group	5	391	8.0	1.461	27.725	644.19
FBG003	Total \$ Charged	1	722	277288.0	4190.0	17821.0	277288.0
FBG007	Total # of Visits	27	53	101.0	11.0	57.0	694.0
FBG019	Total # of Patients	35	39	24.0	4.0	20.0	193.0
FBG160	Total \$ Eligible	3	429	76417.0	3741.0	10377.0	134881.0
FBG334	Total # of Claims	20	80	127.0	11.0	59.0	708.0
FBG449	Total \$ Paid	3	446	71424.0	3204.0	7131.0	121453.0
FREQUENCY	Frequency Group	18	420	0.0	1.0	237.55	668.0
FBG006	Avg # of Pxs/Visit	10	765	9.4257	1.1562	2.7719	24.656
FBG040	Avg # Procedures/Month/Patient	11	864	13.6	1.3157	3.2131	27.207
FBG041	% of \$ Chgd for Most Costly Px	31	52	25.891	8.8578	22.141	50.704
FBG060	Avg # of Procedures/Patient	13	752	39.667	2.1111	6.125	96.351
FBG075	% Miscellaneous Procs	1	0	0.0	0.0	0.0	0.0
FBG081	% of High Level Eval & Mgmt Pxs	62	0	0.0	0.0	1.1994	18.919
FBG093	Avg # Lab Procs / Patient	17	16	0.0416	0.0	0.0	1.5074
FBG126	% High Level Consultation Pxs	40	0	0.0	0.0	0.0	10.811
FBG127	% High Lvl Consult of All Consl	40	0	0.0	0.0	0.0	100.0
FBG320	% Surgical Procedures	19	285	28.782	0.0	11.45	68.0
SUSPICIOUS	Suspicious Group	1	610	0.0	0.0	69.659	610.02
FBF022	# Sinus Endoscopy Procedures	1	0	0.0	0.0	0.0	0.0
FBG012	% of Out-of-Geography Visits	46	0	3.9603	0.0	5.0	71.0
FBG051	% Sun/Holiday or After Hrs Vsts	21	0	8.8	0.0	8.8	5.8823
FBG083	Avg # Surgical Pxs per Patient	1	1000	11.417	0.0	0.6875	11.417
FBG088	Avg # of Radiology Px/Patient	1	1000	0.2916	0.0	0.0	0.2916
FBM027	% Patients w/ Cosmetic Surg Prc	1	1000	50.0	0.0	0.0	50.0
FBY007	Avg # Ultrasounds / Patients	1	0	0.0	0.0	0.0	0.0

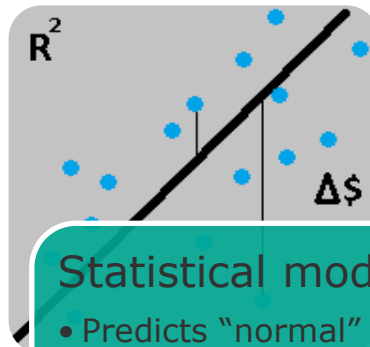
Predictive Analytics & Residual Analysis

- 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.

Date of Service	County	Distance in Miles	Patient ID	CPT Code
3/14/2011	Amarillo	612	patient 1	99254
3/14/2011	Laredo	612	patient 2	99215
3/14/2011	Laredo	612	patient 2	93010
3/14/2011	Laredo	612	patient 3	93010

- 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

provider	DOS	CPT Code	description	Charged Amount
provider A	2011-03-07	80069	RENAL FUNCTION PANEL	\$87.00
provider A	2011-03-07	82435	ASSAY OF BLOOD CHLORIDE	\$45.00
provider A	2011-03-07	82374	ASSAY, BLOOD CARBON DIOXIDE	\$48.00
provider A	2011-03-07	82040	ASSAY OF SERUM ALBUMIN	\$48.00
provider A	2011-03-07	84520	ASSAY OF UREA NITROGEN	\$77.00
provider A	2011-03-07	82310	ASSAY OF CALCIUM	\$50.00
provider A	2011-03-07	82947	ASSAY, GLUCOSE, BLOOD QUANT	\$38.00
provider A	2011-03-07	84295	ASSAY OF SERUM SODIUM	\$47.00
provider A	2011-03-07	84132	ASSAY OF SERUM POTASSIUM	\$45.00
provider A	2011-03-07	82565	ASSAY OF CREATININE	\$50.00
provider A	2011-03-07	84100	ASSAY OF PHOSPHORUS	\$46.00
Total				\$581.00

\$494.00

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.

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Future State

Emdeon's Solutions

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Pay and Chase



Prevention and Detection



2

'One Size Fits All'



Risk-Based Approach



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Innovation



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Transparent and Accountable



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Government Centric



Engaged Public/Private Partners



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Stand Alone PI Programs



Coordinated & Integrated PI Programs



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.

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