

## 'Credit Card' Technology Helps CMS Detect Medicare Fraud

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Health Benefits ABCs

If it works to detect and prevent credit card fraud, why not use the same technology to prevent Medicare fraud? As another step to move Medicare away from the “pay and chase model,” the Centers for Medicare & Medicaid Services (CMS) on July 1 began using predictive modeling software to help identify potentially fraudulent Medicare claims nationwide. The goal is to stop fraudulent claims before they are paid. Medicare fraud is estimated to cost the program more than \$60 billion per year.

Predictive modeling uses data to predict the probability of an outcome – in this case the probability that fraud will occur. It works in much the same way as when your credit card company detects unusual buying patterns, such as purchase of multiple quantities of the same product in a city far from where you live.

“Pay and chase” refers to the current system under which the government pays Medicare claims first and later asks questions about their validity. “Every workday, Medicare pays out more than \$1 billion from 4.5 million claims and is statutorily required to pay claims quickly, usually within 14 to 30 days,” CMS Deputy Administrator and Director for Program Integrity Dr. Peter Budetti told the Senate Homeland Security Subcommittee on Federal Financial Management on July 12. “All claims across the country are now being screened before they are paid.”

In the past, the short timeline for making payments did not allow enough time to detect fraudulent claims. CMS could only do a quick check, such as whether a female is receiving a prostate test designed only for males. Now, instead of evaluating one claim at a time, CMS can analyze claims filed under the Original Medicare program using innovative risk scoring technology that applies predictive models and take action to stop fraudulent payments before they are paid. (Original Medicare refers to the traditional Medicare program, as opposed to the Medicare Advantage and managed care programs.)

### How It Works

Here is how the new system works:

1. CMS awarded a \$77 million contract to Northrop Grumman, which partnered with National Government Services and Federal Network Systems, owned by Verizon, to develop the national predictive model software.
2. The software collects data to determine the likelihood that the named beneficiary received the billed services – for example, is the beneficiary alive and living near the provider?

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3. It can also tell if the provider was actually able to provide the service. For example, it will detect a single doctor claiming he/she performed the same procedure in six cities at the same time.
4. The software identifies patterns and creates a risk score for each claim.
5. Claims with high risk scores receive an alert and are further examined by federal investigators.
6. Claims with the highest risk scores receive immediate attention and additional review by CMS analysts through a new rapid response strategy.
7. CMS then takes appropriate actions, including claim denial, payment suspension or revocation, as well as referral to law enforcement.

The technology also allows CMS to check Medicare’s data against enrollment records and stolen provider and beneficiary identification numbers. In a pilot study, CMS linked to public information from court records, addresses, medical licenses and lists of providers and suppliers excluded from federal health care programs.

### Work Remains to be Done

Nonetheless, under questioning by the Subcommittee on Federal Financial Management, Budetti admitted that it will take time to catch fraudsters. “We did not set this up to automatically stop payments on day one,” he said. But eventually, the government will “stop those payments before they go out the door,” he added.

The Office of Inspector General (OIG) is reserving judgment. “Technology is not a silver bullet,” Lewis Morris, the OIG’s chief counsel, told the subcommittee. “It is important to be mindful that as program integrity efforts

become more technology-driven, so will health care fraud, and we must adapt to this evolving environment. Additionally, even the best fraud prevention technologies will be of little value if not effectively implemented and appropriately overseen.”

“Further complicating matters,” Morris continued, a claim may initially meet all the conditions for payment but subsequently be revealed as improper. “For example, an outpatient laboratory test may appear payable when initially submitted by the hospital. But under Medicare rules, separate payments for nonphysician outpatient services rendered within 72 hours of the day of an inpatient admission are not permitted. When the hospital later submits a claim for an inpatient stay that began within that 72-hour window, the claim for that laboratory test is improper.” In addition, CMS also must determine medical necessity.

### Terminology

- **Pay and chase** means that an insurer (Medicare) pays providers first, then chases them down later to get the money back if there is fraud or an overpayment.
- **Predictive modeling** uses historical data to build a statistical model that can predict future trends.

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“This is a very different scenario from a credit card company stopping someone who attempts to buy a jet ski in Galveston with a credit card issued to a long-time resident of New York City,” Morris added. “Health care is very complex and it is difficult to predict and prevent health care fraud relying solely on data analytics.”

Still, predictive modeling is a good start at ferreting out the most egregious claims. “We will also evaluate the possibility of expanding predictive modeling to Medicaid and CHIP over the next few years,” Budetti said.

## **New Legislation**

Meanwhile, subcommittee Chairman Thomas Carper (D-DE) and member Tom Coburn (R-OK) have introduced a bill, the Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act (S.1251), also known as the FAST Act, to reduce waste, fraud and abuse in Medicare and Medicaid. It contains additional strategies to help phase out the practice of “pay and chase” and use data sharing and smart technologies to curb fraud. The legislation also would enhance awards to individuals reporting fraud and expand the fraud identification and reporting work of the Senior Medicare Patrol (SMP) program. The bill would require HHS to use the SMP program to “conduct a public awareness and education campaign to encourage participation in a revised beneficiary incentive program” to encourage individuals to report fraud and abuse. No action has yet been taken on the legislation. ●

*“Today’s announcement is bad news for criminals looking to take advantage of our seniors and defraud Medicare. This new technology will help us better identify and prevent fraud and abuse before it happens and helps to ensure the solvency of the Medicare Trust Fund.”*

– CMS Administrator Donald Berwick, MD, on the announcement of the new predictive modeling program