COMBATING SOPHISTICATED HEALTHCARE FRAUD SCHEMES: LESSONS FOR SELF-INSURED HEALTH PLANS

Written By Greg Lyon

Over the course of 2021, 2022, and 2023, malicious actors perpetrated a massive fraud scheme, defrauding Medicare, and the United States healthcare system of up to $2 billion through the submission of phantom claims for intermittent urinary catheters. There are valuable lessons to be learned from this scheme for self-insured plan administrators.

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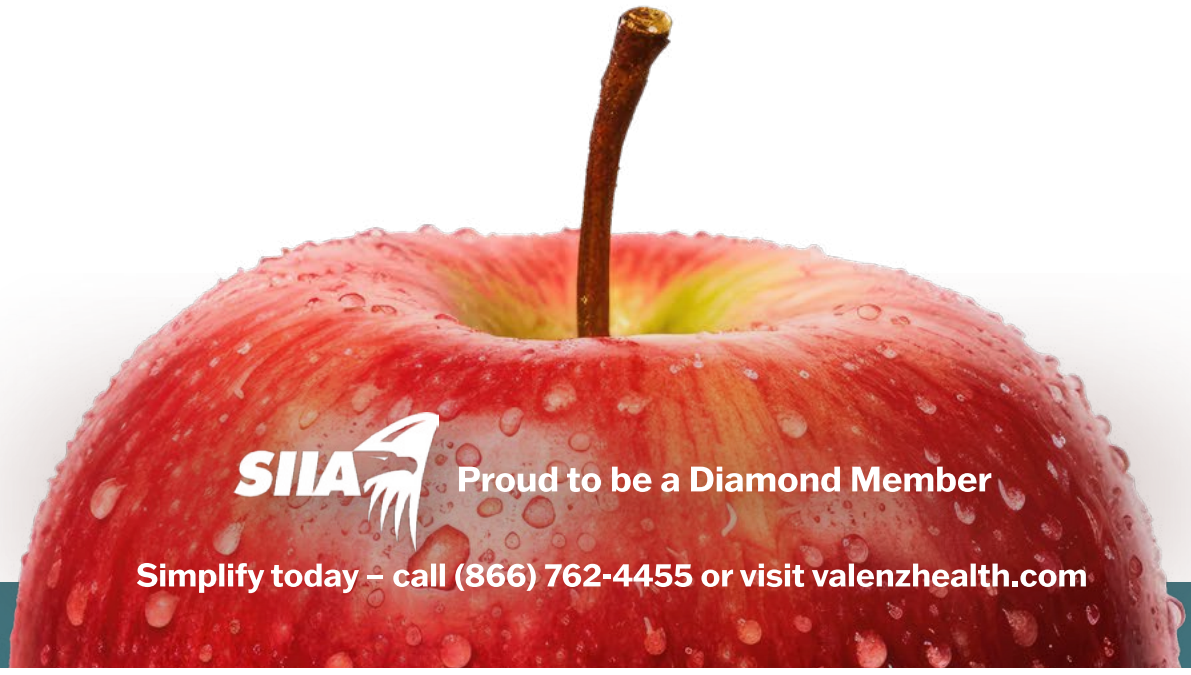

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LESSONS FOR SELF-INSURED HEALTH PLAN ADMINISTRATORS

Healthcare fraud is a massive and growing problem fueled by a technology arms race. The fraud and abuse problem costs self-insured employers billions of dollars annually. It is estimated in various government and private sector reports that healthcare fraud and abuse represent between three and ten percent (3-10%) of total annual healthcare spending.

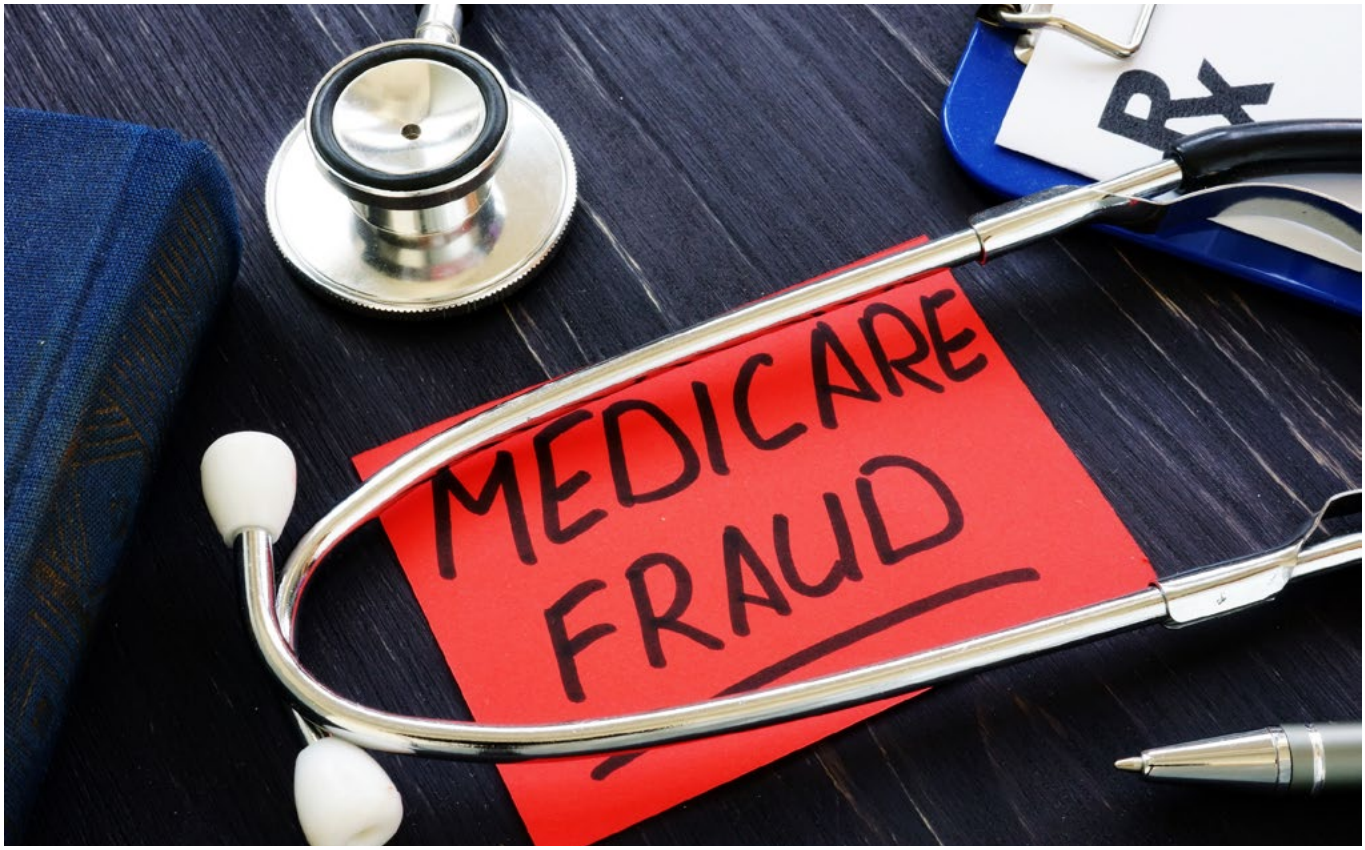
While much of the attention has been focused on fraud perpetrated against government programs like Medicare, self-insured health plans are not immune from the same types of complex dynamic, multi-provider fraud and collusion schemes often associated with CMS program and large commercial health plans. And, where the risk pool of a self-insured population is smaller, these types of schemes can be catastrophic if not detected early.

The recent multi-billion-dollar catheter fraud scheme highlighted in this article serves as a prime example of the sophisticated and costly tactics employed by bad actors to rapidly exploit payer vulnerabilities and get paid for fraudulent claims. This scheme is cautionary for self-insured plans because very few are deploying advanced fraud prevention technologies today due to the historical costs and bare-bones nature of self-insured plan administration. An advanced artificial intelligence-powered provider-centric FWA approach can solve both the risk and cost challenges for self-insured plans.

By understanding the intricacies of the catheter fraud scheme and the technology strategies that could have prevented it, self-insured plan administrators can gain valuable insights into the evolving nature of fraud. They can also learn about the proactive measures necessary to safeguard their plans from similar exploitation.

THE SCHEME: OWNERSHIP CHANGE, TEST & SPIKE

Seven legitimate Durable Medical Equipment companies (DMEs) were purchased by fraudulent individuals. Once the ownership had been transferred, new owners validated their ability to bill Medicare and receive payments. With the ability to



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bill and get paid confirmed, the fraudsters proceeded to spike large volumes of claims to Medicare for intermittent urinary catheters. The claim volumes were:

- 2023 – 406,000
- 2022 – 20,000
- 2021-21

PHANTOM BILLING

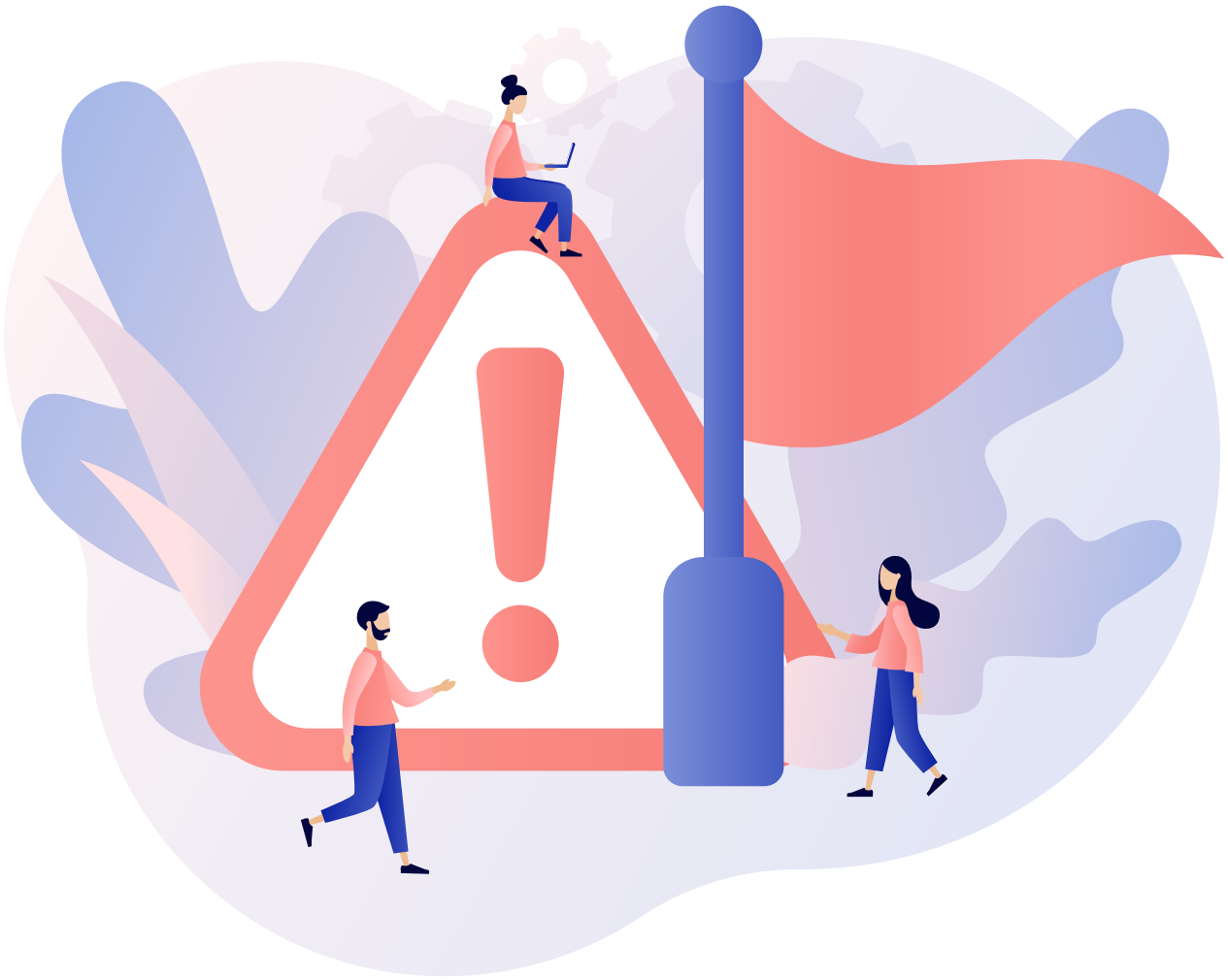
"The catheter scheme had red flags that, in retrospect, look obvious."

The spike from claims submitted by the seven DME companies was so extreme that it caused a noticeable national spike in intermittent urinary catheter claims. This was a 'phantom' billing scheme, where the catheters were not medically necessary and were not physically shipped to the Medicare members.

To perpetrate this fraud, the seven DME companies exploited legitimate Medicare member names and IDs to submit the fraudulent claims. It is highly probable that the member data was illicitly obtained, either purchased on the dark web following a data breach or gathered through deceptive cold calls from fraudulent telemarketers. These telemarketers preyed on unsuspecting Medicare members. Once this phantom billing fraud scheme was detected, the seven DME owners stopped submitting claims and closed the DME businesses.

RED FLAGS

The catheter scheme had red flags that, in retrospect, look obvious. Further, many Special Investigation Units (SIUs) remain challenged with the limitations of claims data-centric, rules-based analytics and periodic (not continuous) provider integrity monitoring. The following red flags could be easily missed when reviewing each claim and each provider in isolation:



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- Rapid increases in intermittent urinary catheter claims for seven DME companies (14 to 20,000 to 406,000).
- No history of significant urinary catheter claims for any of the seven DME companies.
- Sudden spikes in claims (or claim type) shortly after an ownership change.
- Suspicious business locations like strip malls, residences, offices with windows covered, etc.
- Common demographic information shared among the seven DME's (matching addresses, officers, or ownership).
- Numerous negative social media reviews from Medicare members detailing suspicious behaviors.

TECHNOLOGY TIPS TO STOP THE NEXT FRAUD SCHEME

Stopping the catheter fraud scheme or future schemes of a similar nature requires a fundamental shift in how fraud detection and prevention is accomplished. Healthcare payors can no longer afford to depend solely on claims data-centric analytic models to detect potential fraudulent behaviors and relationships fast enough. We must be able to assess each provider's integrity, relationships with other providers, and claims activity in the context of all historical and near real-time claim behaviors. In short, we need to change our mindset and leverage available technology to solve this problem.

There are two technology-forward approaches within reach of any healthcare payor, including large health plans, third-party administrators (TPAs), and self-insured, self-administrated plans. These approaches include:

1. Know Your Provider on Every Claim

Start with a provider-centric approach.

Take a 'Know Your Provider' (KYP) mindset, just like financial services companies employ a 'Know Your Customer' (KYC) approach to anti-fraud work. To detect fraud early, you need to continuously gather and analyze provider data in near real-time to understand their integrity, behaviors, and relationships with other providers on every single claim submitted. Provider-centric data such as licensing, sanctions, address, phone number, social media reviews, bankruptcies, criminal offenses, ownership interests, shared addresses and phone numbers, taxonomy, and other data elements help to continuously flag potential problematic providers around each and every claim on in-network, and out-of-network providers.

For self-insured plans, this can sound costly and technically out of reach. That was true in the past, but with the combination of structured and unstructured artificial intelligence technology combined with a continuously credentialed provider database, this provider-centric approach is not accessible to self-insured plans with a documented return-on-investment.

2. Be Comprehensive & Dynamic

The second step is to continuously integrate KYP data with historical and real-time claims data to understand the context around every claim. Combining KYP data with historical and current claims data

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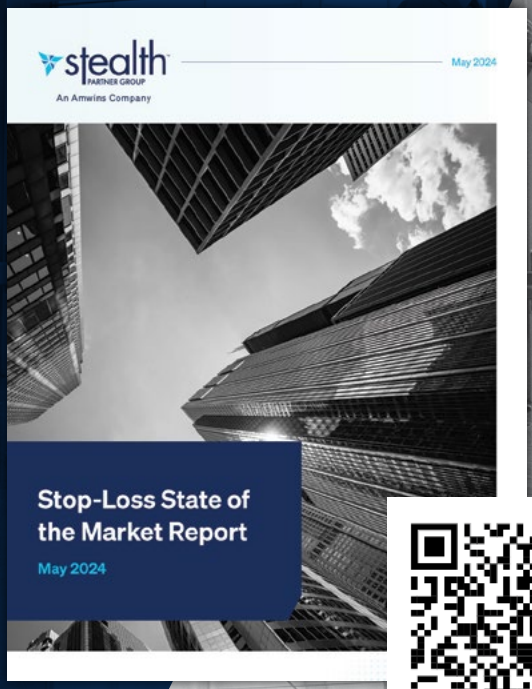

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empowers healthcare payors to analyze provider behaviors in near real-time and stop potentially fraudulent or abusive payments by enabling:

- Every claim submitted to be analyzed in near real-time against that provider's individual historical and current-claims submission behavior, their integrity, and their qualification to be submitting a claim,
- Every provider's relationship with other providers (referring, rendering, billing) to be analyzed around every claim submitted for potential referral or ownership collusion,
- An analysis of each individual provider's historical and current claims submission behaviors vis-a-vis all other providers' claims submission behaviors to detect suspicious behaviors, including outlier billings, billing spikes, and collusion networks.

Like the KYP approach noted above, this a-claim-and-all-claims approach to fraud and abuse detection is all doable today with a combination of the right provider data and provider-centric artificial intelligence technology incorporating supervised and unsupervised machine learning to detect anomalies beyond what rules-based systems can ever detect.

BEING EQUIPPED FOR EARLY DETECTION REDUCES FRAUD SCHEME RISK

Deploying the technology tips mentioned on the previous page would have had a major impact on the catheter scheme or a scheme with similar characteristics. Let's assume that fraudsters were attempting a similar scheme today on a self-insured health plan that employed a KYP solution and integrated provider-centric artificial intelligence technology solution like the one described in this article. And let's assume that the advanced FWA technology combination is affordable for all self-insured plans.

What is likely to happen if a similar scheme was attempted today with advanced FWA prevention technology?

- The payor would be alerted to claim volume spikes in near real-time pre-payment while the scheme is in its initial stages.
- The DMEs responsible for the catheter claims spike would have been identified.
- Current and future payments for the suspicious providers and related parties could be stopped pending investigation.
- Plan investigators would automatically receive pre-packaged, comprehensive KYP integrity data on the submitting DMEs, including data showing the lack of catheter claims history, shared ownership, officers and addresses, Google Earth images of office locations, social media reviews and catheter claims data.
- The integrated, contextual data picture would enable plan administrators to conduct investigations and act in accordance with their organization's policies.

ADVANCED FWA TECHNOLOGY IS ACCESSIBLE, AFFORDABLE, AND ACTIONABLE

The ongoing battle against healthcare fraud and abuse requires the adoption of advanced FWA technology that enables a provider-centric approach to analyzing every claim and every provider in near real time. This technology is accessible today, affordable for self-insured plans, and actionable in everyday claims adjudication workflows. Most importantly, an integrated KYP and advanced artificial intelligence technology solution can reduce the cost of healthcare for companies, administrators, and employees.■

Greg Lyon is a recognized anti-fraud expert with over 25 years of experience in the Financial Services and Healthcare industries, most recently serving as Director of Fraud Prevention at United Healthcare. He can be reached at glyon.lyon@gmail.com