SHIFT

TIME TO SHIFT AWAY FROM THE TRADITIONAL FWA DETECTION APPROACH

BY SHIFT TECHNOLOGY

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Introduction

ACCORDING TO the National Office of Statistics healthcare spend in the UK was in excess of £280B in 2021, this amounts to £4,188 per person including both NHS and private healthcare spending. The NHS counter fraud authority found and prevented £500M in healthcare fraud between the years 2020 and 2023, with prescription charge evasion contributing upwards of £93M to the figure. For private healthcare the figures are just as alarming. The Association of British Insurers estimated at least 5% of private medical healthcare claims are fraudulent and accelerating year on year.

How many billions?

As the number of fraudulent actors increases due to economic pressures and as these actors pivot their behavior to avoid detection, it is clear we can no longer rely on simple rules based detection and manual investigation processes to protect genuine patients.

For Insurers offering private medical insurance at both an individual and a group level, bearing the cost of fraud increases premiums and more importantly can ultimately impact the service and care a patient receives.

For these reasons health insurers tend to concentrate efforts in a number of areas:

Provider Behaviour - ensuring services that have been invoiced are correct for the treatment and the diagnosed condition whether or not the invoice error is intentional.

Member Behaviour - ensuring members are claiming for conditions and treatments that they are eligible for, again intentional or not.

Waste - ensuring there is no unnecessary billing, for example duplication of invoices can cause significant waste.

Abuse - ensuring that best medical practices are followed and unnecessary medical care is avoided.

Bogged down by the traditional approach

Traditional approaches to fraud detection in health usually focus on identifying claims for reimbursement that should not have been made – either prospectively or retrospectively – driven by rules-based edits, audits, and/or alerts. This approach to fraud, waste and abuse (FWA) can be effective in spotting individual instances of suspicious claims; however, there are various shortfalls to a rules-based approach.

Rules-based approaches to FWA provide little insight into potential problems with specific provider or provider networks. With the continuous evolution of fraudulent activity, it takes extensive time and manual resources to build and maintain business rules for accurate detection.

For example, someone posing as a healthcare provider or supplier may be submitting fraudulent claims for reimbursement through medical identity theft. As long as the claim codes are correct per the coverage determination guidelines, rules-based FWA or payment integrity solutions can't identify these claims as fraudulent.

The vast majority of FWA vendors in today's market have blended rules-based detection with some form of advanced analytics in an effort to find suspicious providers with large overpayments. Most of these FWA solution vendors fall into one of three categories:

Statistics-based: outliers are defined only by the number of standard deviations

Rules-based: focusing on coverage determination guideline violations

Clinical targeting: based on medical necessity reviews

Regardless of categorical focus, the vast majority of these solutions lack the ability to accurately identify and prioritise suspicious claims, providers, members, and/or networks. In addition, these solutions may entail high false positive rates or an overwhelming number of low value and low confidence alerts for the health insurer to wade through.

> **"At the heart of the FWA challenge is siloed data and lack of collaboration across different business areas."**

Fortunately, health insurers can now call upon a next-generation Artificial Intelligence (AI) solution that upends traditional FWA solutions and delivers actionable insights to empower collaboration across the enterprise. This isn't simply an evolution of FWA detection and prevention; rather, it's a novel way of addressing a health insurer's data access and operational workflow issues that prevents them from reaching essential insights on their own.

A great example of how advanced AI can address an issue of financial loss in a novel way is by identifying provider groups that pass through significant billing to the provider specialty (e.g., medical doctor vs. nurse practitioner) eligible to receive the highest percentage of the allowed amount in the fee schedule.

Most investigation teams are powerless to pursue certain "untouchable" provider groups because of network sufficiency concerns. As a result, huge losses have been historically swept under the rug. But that no longer needs to be the case. Investigation teams can collaborate with other operational business units, such as the commercial team, network management, legal, provider onboarding, and more, to appropriately handle sensitive issues surrounding poor behaviour that otherwise would be counted as a loss.

Connecting data and operational units for actionable insights

Shift Technology looks at FWA from a new perspective, by leveraging AI to break down organizational silos and create operational workflows that enable cross-enterprise collaboration. Shift Fraud, Waste and Abuse Detection is designed to connect business units and drive a new level of organisational insight.

While traditional FWA vendors focus on finding the "bad provider" by rolling claims up to the provider level, Shift goes a step further. Shift can look at claims on their face – just as other solutions do – and roll suspicious data up to the program level across individual providers and provider networks, third parties, members, and more. Shift also uniquely includes historical data with external data sources to increase the accuracy and efficiency of investigative decisions.

Essentially, Shift enables insurers to use their existing data set in more actionable ways:

Provider data: Eligibility demographics, medical licenses, specialty, addresses, age, etc. This data accompanies claim data and is needed to validate that the provider is active and under network contract with the insurer.

Member data: Member eligibility demographics, complex vs non-complex medical cases, addresses, policy type, age, etc. This data accompanies claim data and is needed to validate that the member is alive and has a valid policy.

Reimbursement data: Tying this data to the provider and member data delivers new insights.

Shift goes beyond the traditional approach and incorporates utilisation and quality of care insights. That means the Shift solution is future-proof for health insurers moving to a value-based care payment model.

Shift reverse engineers FWA to provide insights that inform issues across the enterprise. Through this new model, insurers can uncover more fraud, waste and abuse and better understand how to alter behaviour for the future, including:

Provider behavior modification: Shift's approach to FWA creates a feedback loop that empowers the insurer to intervene from a provider network/contract perspective to change behavior.

Incorrect payments: Shift Fraud, Waste and Abuse Detection not only identifies suspicious claims but also improper invoices that negatively impact the bottom line. An actionable insights approach to alerting helps ensure operational efficiency.

This AI-powered approach paves the way for insurers to gain actionable insights they can act upon to reduce financial losses, increase provider quality scores, and ensure the right member is receiving high-quality healthcare.

Shift vs. the traditional FWA solution

How does Shift's AI-powered approach differ from those of a traditional FWA solution?

A traditional FWA solution revolves around an alert engine that pushes a massive amount of alerts into a single queue. Using this type of solution, an investigator must sort based on headers because the data isn't segmented or presorted at the suspicion level. While that's fine if the investigator knows what they're looking for, it's still time consuming. The investigator is looking through hundreds or thousands of alerts manually in an effort to find cases that will generate return on investment.

Shift rethinks the alert queue to accelerate the time to value of an investigator. With Shift Fraud, Waste and Abuse Detection, the journey begins when AI and machine learning (ML) scenarios are applied to claims and rolled up to the provider specialty level, and/or the network detection level.

Once the user selects the claim, provider, and/or network alert of choice (based on our sophisticated ranking and scoring models) the Shift solution presents all the analytic scenarios that apply to this claim, provider, and/or network in one screen. Users can select the option that makes the most business sense based on their role and business focus.

Shift built its solution in line with how the average investigator thinks and how others across the insurer will use such a solution. The Shift solution shows a risk score for providers, individual providers in the group, and other relevant entities, along with utilisation and quality of care patterns.

Once an alert is selected for review, Shift's summary page provides the investigation team with scenario variables that explain the basis for the alert. In addition, the investigator will find several operational insights relevant not only to them, but also to several other business units in the insurer. Examples could include:

Credentialing, which might be interested in:

- Provider eligibility as determined by suspensions, exclusions, inactive medical licenses, liens and judgments from third-party data integration, etc.
- AI-derived false front providers alerting

Utilization management and network management, which might be interested in:

- Metrics such as billing patterns, overutilisation patterns, quality scores
- Shift's AI-derived risk-scoring algorithms like the medical identity theft risk score, the provider utilisation risk score, and the quality index score

Traditional FWA solutions are not designed to provide this level of detail. Their alerts are based on violations of a rule, policy, algorithm, or an outlier compared to their peer group at the provider level, claim level, or claim line level. In this limited way, they are unable to connect the dots the way the Shift Fraud, Waste and Abuse Detection solution can.

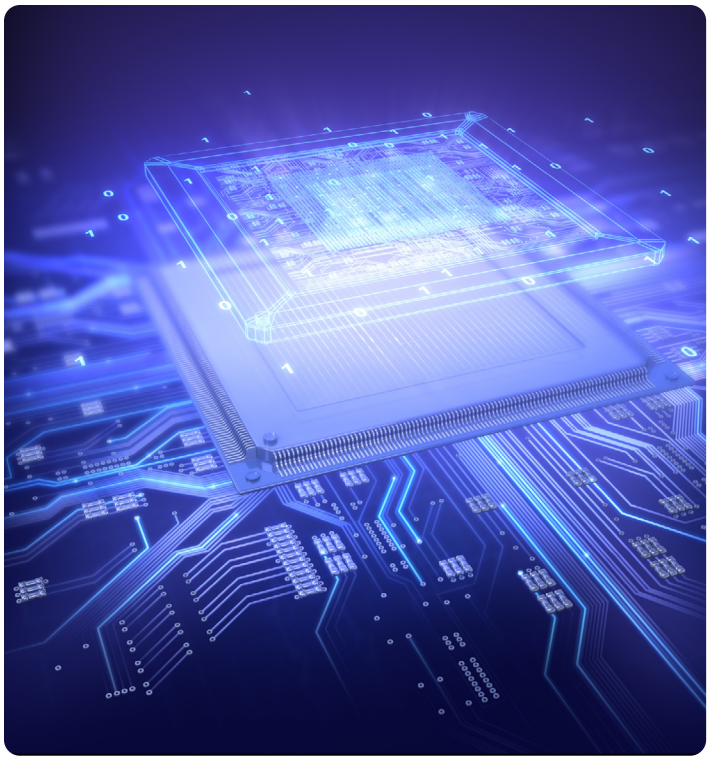
It’s time for health plans to shift their approach

Traditional FWA solutions only shine a light on potential fraud, burdening the investigation and audit teams with manual work to validate the allegation. Shift is changing the game by delivering automated AI/ML based alerts centered on the highest ROI potential.

By delivering actionable insights, Shift empowers insurers to spot suspicious claims based on:

- Continually updated scenarios
- Suspicious relationships within provider networks
- Suspicious member behaviors
- Anomalies across the universe of data

While Shift’s proprietary scenarios point investigators in the direction of ROI relative to the policy, conditions and treatment. The alert details report is designed to bring actionable insights that could bring credentialing, utilisation management, and network management into the conversation. It also includes links that make it easy to verify results, leading to quicker actions – such as automating external data integration allowing the investigator to consume more information about the allegation instead of spending hours or days searching for it.



In essence, the solution enables multiple departments to share a common view, collaborate and manage cases. With Shift, insurers can look at their claims for reimbursement in new ways that will bring value to their organisation.

Learn more about how your organisation can take advantage of Shift’s Fraud Waste and Abuse Detection solution to detect and prevent fraud, waste and abuse with increased speed and accuracy.

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About Shift Technology

Shift Technology delivers AI decisioning solutions to benefit the global insurance industry and its customers. Our products enable insurers to automate and optimise decisions from underwriting to claims, resulting in superior customer experiences, increased operational efficiency, and reduced costs. The future of insurance starts with Decisions Made Better.

Learn more at www.shift-technology.com/en-gb