



GEHA catches fraud before payout while improving case targeting twelve-fold

success story: fraud detection



Client	Government Employees Hospital Association (GEHA), the third largest health plan for federal employees, retirees and their families, with 450,000 members
Challenge	Detect healthcare fraud and abuse faster, more accurately and prior to payment
Solution	FICO™ Insurance Fraud Manager—Healthcare Edition
Results	After one year, realized hard dollar savings from one in eight providers, and a twelve-fold increase in case targeting effectiveness



FICO's technology allows us to catch many more potential fraudulent, abusive and erroneous transactions with a high level of accuracy prior to payment. The solution also allows us to keep pace with the volume of claims processed electronically, and takes pressure off manually identifying aberrant claims."

—Bob Greene, Manager of Data Analysis, GEHA

Solution generates twelve-fold increase in effectiveness of case targeting

» CHALLENGE

Government Employees Hospital Association (GEHA) was facing a major challenge: to improve the efficiency of its rules-based, manually intensive fraud detection system that analyzed more than 6 million claims a year. GEHA is the third largest national health plan serving federal employees, retirees and their dependents, with more than 230,000 health plan subscribers and 450,000 insured lives.

"Like many other carriers, we were trying to increase the number of claims processed electronically and without adjuster intervention," says Bob Greene, manager of Data Analysis at GEHA. "At the same time we did not want to advance automated review at the expense of letting fraud get by."

High on GEHA's priority list was a solution that detected fraud and abuse prior to payment. Their existing system worked retroactively: payment was often made before fraud and abuse were detected—and long after it was possible to retrieve the dollars paid out.

» SOLUTION

When GEHA executives began the search for a better system, they were drawn to FICO, Greene says, because of its "strong pedigree as a technology vendor and its success in real-time fraud detection in related industries."

Equally important, FICO™ Insurance Fraud Manager would allow GEHA to realize three important goals:

- **Keep pace** with the increasing volume of claims processed electronically
- **Detect fraud and abuse** prior to payment
- **Accurately identify fraud and abuse** within an environment of low concentration of claims per provider.

As far as realizing the first goal, Insurance Fraud Manager actually accelerated GEHA's claims processing, while at the same time uncovering more inaccuracy, impropriety and negligence than their old rules-based system. Because Insurance Fraud Manager is powered by advanced neural network and dynamic profiling technologies, it "learns" as it goes, continually detecting complex and subtle fraud patterns. This makes it possible to identify fraudulent and abusive activity faster, more accurately and earlier in the life cycle than traditional methods.

A solution that could catch fraud prior to payment was also a very high priority for GEHA. One of the main factors in choosing FICO was that "no other product offered the prospective fraud detection capabilities that would allow us to accurately identify fraud and take action before dollars were paid out," says Greene.

FICO™ Insurance Fraud Manager's fraud scores alert claims professionals to suspicious claims that need to be taken out of the payment stream for further investigation, allowing the rest of the claims to be fast-tracked for payment. Detailed reason codes, which indicate the top reasons the claim received a high fraud score, alert the adjusters to the specific problems and help them to handle the claims quickly and efficiently.

FICO's fraud solution helps GEHA identify fraud and abuse even within their environment of low concentration of claims per provider. This issue of sparse data had been an obstacle to achieving meaningful results with other technology vendors GEHA was considering. Not so for Insurance Fraud Manager.

"We've been very encouraged from what we have seen even from the earliest of test data sets," Greene says. FICO's proprietary technology makes it possible to derive accurate, real-time fraud detection in any data environment to transform data into valuable information.

» RESULTS

One year after implementation, GEHA realized hard dollar savings for one out of every eight providers flagged for investigation.

The range of payment issues Insurance Fraud Manager helped GEHA identify extended beyond fraud. The majority of claims identified, in fact, were billing errors. "What we discovered was that Insurance Fraud Manager is very effective in revealing all types of aberrant behavior—payment or billing error, suspected fraud and abuse, or indications of clinical inappropriateness," says Greene. GEHA also realized a twelve-fold increase in case targeting effectiveness. This saved investigators time and effort in determining which claims warranted review. Even though this overall improvement was significant, in some areas, such as high-dollar cases, the ratio improved even more dramatically.

GEHA has also received positive feedback from its claims and investigative staff, who reported that Insurance Fraud Manager was catching aberrant claims that would never be detected otherwise.

"FICO's technology allows us to catch many more potential fraudulent, abusive and erroneous transactions with a high level of accuracy prior to payment. The solution also allows us to keep pace with the volume of claims processed electronically, and takes pressure off manually identifying aberrant claims," Greene sums up. After a successful one-year pilot program, GEHA is now a customer.

For more information, go to www.fico.com/insurance.



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