

Health care fraud targeted by new public-private partnership

Commercial insurers and federal agencies agree to collaborate on anti-fraud efforts. The AMA says clinical context must be considered in any claims reviews.

By: Charles Fiegl, amednewsstaff

Federal health programs and private insurers will share ideas, tools and data to go after criminals who are defrauding multiple health payers across the country, Obama administration officials announced July 26 at the White House.

The joint effort acknowledges the limitations of each health care insurer relying solely on its own data and fraud prevention techniques. After a January 2010 summit, 21 private payers and government agencies discovered that they were the victims of the same scams. As a result, the participants pledged to band together against fraud.

“This partnership puts criminals on notice that we will find them and stop them before they steal health care dollars,” said Health and Human Services Secretary Kathleen Sebelius.

The administration plans to share information and best practices to counter illegal claims schemes by analyzing billing codes and identifying new trends in cities and regions. The group has set goals to measure its success. For instance, the partnership hopes to stop payment on the same claims billed to multiple insurers in two different cities.

Officials cited new tools in the national health system reform law that will be an asset to the initiative. Medicare now has additional safeguards designed to keep fraudsters from enrolling in the program. New home health and durable medical equipment suppliers have been identified as high-risk health professionals, and their Medicare enrollment applications are receiving extra scrutiny.

Eliminating fraud and abuse in the health care system must be a national priority for payers, said American Medical Association President Jeremy A. Lazarus, MD. He said, however, that physicians also play a critical role in appropriate program integrity efforts.

“To accurately identify incidences of fraud and abuse, the use of data analytics to review claims data must be targeted, and the analytics system must include appropriate clinical input,” Dr. Lazarus said. “Claims coding and documentation involve complicated clinical issues, and the analysis of these claims requires the clinical lens of physician education and training.”

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**Coalition Against
Insurance Fraud**

crime rings, said Dennis Jay, executive director of the **Coalition Against Insurance Fraud**, which is a member of the partnership. The coordination of anti-fraud intelligence will shut down schemes involving health, auto and workers' compensation plans.

“Information-sharing is critical to stripping back the veil of secrecy allowing many fraud rings to operate,” Jay said. “A joint effort will apply huge and hopefully fatal pressure on crime rings and their costly schemes.”

Republican lawmakers have been critical of the administration's ability to prevent fraud in entitlement programs. Sens. Tom Coburn, MD (R, Okla.), and Orrin Hatch (R, Utah) wrote a July 31 letter questioning the effectiveness of the Medicare agency's fraud prevention system. At the same time, the senators said they were encouraged to see CMS working with private groups to improve fraud detection.

“We are supportive of the goal to reveal and halt scams that cut across a number of public and private payers and think this is an effort which is long overdue,” the letter said.