Preventing healthcare claims fraud, waste and abuse

Healthcare claims fraud, waste and abuse (FWA) is a significant issue around the globe. It encompasses a wide spectrum of activities, from deceptive billing for services not rendered, to performing unnecessary medical services, to abusing payment rules by coding services at higher levels than actually performed.

Significant financial impact

Average losses for improperly paid claims are estimated at 6 percent of health payer spending, exceeding $250 billion per year. For the U.S. alone, costs are estimated at more than $60 billion each year. According to the European Healthcare Fraud & Corruption Network (EHFCN), €56 billion is lost to healthcare fraud each year in the EU. In the UK, scams are estimated at £5 billion a year.

Compromised patient care

These losses not only reduce a healthcare payer's bottom line, but they also reduce funds available for treatments for the sick as well as preventative care for people of all ages. Fraudulent activities can even put patient lives in danger. For example, schemes have been uncovered where chemotherapy agents were diluted for profit, and cancer patients did not receive life-saving therapy.

THE NEED FOR A DATA-DRIVEN APPROACH

Payers need an effective way to recover this lost money in order to preserve funds, be more competitive with pricing and products, retain members, comply with new regulations, and even improve patient care. This requires using advanced analytics and workflow tools in a highly secure environment. A best-practices claims FWA solution should include:

- Secure data management environment where claims history, provider and beneficiary data are analyzed
- Edits and algorithms that are configured to a payer's unique reimbursement rules and medical policies
- Predictive analytics that leverage machine learning, visualization, geospatial analysis and predictive modeling to identify trends and patterns of potential fraud, waste or abuse
- Comprehensive workflow including case management, audit tracking and enterprise content management

How CGI can help

CGI has been combating fraud in the healthcare market for more than 25 years. CGI ProperPay is a data-driven solution that predicts, identifies, manages and recovers medical and pharmacy claims that have been improperly paid. It is enabling payers to prevent fraudulent activity with more reliable and repeatable results, review claims with the highest error rates, and, most importantly, preserve funds to focus on patient health.

With our partner, Microsoft, CGI offers ProperPay in the secure Azure cloud to manage highly sensitive personal health data. We also use the Cortana Intelligence Suite to bring the power of advanced analytics to detect inappropriate patterns and trends to more efficiently protect program integrity.

Learn more about how CGI ProperPay combats healthcare fraud, waste and abuse to preserve precious funds for preventative and therapeutic care around the world. Contact us at: healthcompliance_BD@cgifederal.com.