



Kyle Cheek
Director of Data Analytics
Health Care Service Corp.

PREVENTING PAYMENT OF FRAUDULENT CLAIMS

HCSC seeking to save millions on healthcare fraud with SAS®

Industry

Health Insurance

Business Issue

Spot fraudulent claims before they get paid.

Solution

SAS® Enterprise Miner™ helps spot suspicious activity among claims data.

Benefits

Potentially save millions of dollars.

Costing billions of dollars a year for both health insurers and the insured alike, fraud has emerged as a perilous criminal industry in the United States. While the vast majority of healthcare-related organizations are made up of honest, hardworking providers, sometimes a dishonest few can cause problems for the entire system.

Some unscrupulous employers might enter ineligible or even nonexistent participants in a health plan and submit claims on their behalf. Some medical device suppliers will bill hospitals for equipment they never supplied. A pharmacist might conspire with an individual to distribute painkillers on the black market, or third-party billers might submit claims for nonexistent services using a real physician's name, even though the physician isn't involved.

All of these scenarios not only hurt the insurance carrier, but, more importantly, they hurt member groups by contributing to escalating healthcare costs. With help from SAS, insurers like Health Care Service Corp. (HCSC) are enhancing their ability to identify cases of fraud proactively before schemes become fully developed and result in significant costs, while putting an end to a practice that costs the industry billions of dollars each year.

"The industry estimate is that somewhere between 4 and 10 percent of all health benefits dollars that are paid out are paid on fraudulent claims," says Kyle Cheek, Director of Data Analytics. "In a \$2 trillion a year industry, even a small percentage is a huge amount of money."

Spotting suspicious patterns

At HCSC – which is the parent company for the Blue Cross and Blue Shield plans in Illinois, Texas and New Mexico – the focus is on proactive identification of fraud, which means detecting it before money goes out the door. Using SAS Enterprise Miner™, Cheek and his associates have a more powerful and efficient formula for predictive analysis that is designed to identify potential fraud among the 300,000 claims that pour in each day.

"SAS helps us protect the integrity of our company," Cheek says. "If we're taking the steps we can take to stop bad behavior more quickly, we save costs. And that's an impact clearly felt by the employers we serve."

Using SAS, HCSC mines years and terabytes of data relating to claims, providers, members, groups, accounts and products from all three of its Blue Cross and Blue Shield plans.

"SAS gives us the ability to connect multiple data sources so that we can efficiently access the data that we're analyzing," Cheek says. "We have many data sources with proprietary front ends. SAS gives us a common interface that allows us to bring the disparate data into a common format and manipulate it so that we have integrity when we put all the data together."

Saving millions of dollars

Health insurance fraud can take on varying degrees of sophistication. On the surface, everything looks legitimate. But by taking a closer look,

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HCSC’s fraud detection analysts might discover that a provider is submitting bills for services that far exceed the hours within a day. Using SAS, Cheek’s group can decipher the nuances in the data to see, for example, when a cardiologist is billing for 80 hours of service in one day. That’s the hook Cheek needs to turn the case over to HCSC’s special investigation team of former federal law-enforcement agents, lawyers, claim experts, CPAs and physicians.

At the same time, SAS can help HCSC determine when several providers are submitting claims using the same provider code, which is an indication that they’re part of the same practice. That’s an instance when a provider might legitimately bill for 80 hours in a single day, which helps HCSC avoid needless investigations that are costly for both the company and the providers.

“But sometimes we come across providers who are billing us for 16 hours a day every day – and they’re the only provider in the office,” says Asha George, Senior Statistical Analyst in HCSC’s Special Investigations Department Intelligence Unit. “In one such case, on closer investigation, we uncovered that the provider had been on probation for alcohol and drug abuse for the past 10 years. Since he was

displaying aberrant behavior again, we felt like we had a good case for the FBI.”

And that’s another HCSC goal: In addition to stopping fraudulent claims from ever being paid, the company wants to have solid cases to turn over to law enforcement for investigation and prosecution. “If we stop a provider who’s been committing fraud for a year, we’ll save our customers millions of dollars in the future,” explains Bob Walsh, HCSC’s Vice President of Special Investigations. “We’re making an impact not only on our own business, but on our customers’ [businesses] as well.”

Stopping fraud in real time

But the focus remains on proactive identification, George says. That’s because, with SAS, HCSC now has the means to sleuth through all the data to uncover suspicious activities that require a closer look. “Since we started using SAS, the number of cases that have been identified proactively have increased significantly to 30 cases a year per analyst,” George says. “I can only imagine how much bigger it’s going to get.”

HCSC expects that growth to get a boost from an enhanced application it’s developing in cooperation with SAS and IBM. The new

fraud application will combine the power of SAS®9 data access and advanced analytics with IBM’s FAMS (Fraud and Abuse Management System), which includes 3,800 health insurance industry-specific features and rules. The goal is to detect fraudulent claims and stop payment on them in real time.

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