

WellPoint's Successful Fraud Prevention Programs

Our goal at WellPoint is to prevent health care fraud and abuse for the benefit of our members' health, as well as for the health care system as a whole. In order to meet this goal, WellPoint has developed a number of different types of programs to identify and prevent health care fraud and abuse:

- Controlled Substance Utilization Monitoring (CSUM) Program
- Medicaid Restricted Recipient Program
- Pre-pay provider review program
- Predictive modeling program
- Bogus providers
- Review of Emerging Technologies

Recommendations:

Based on our experience in combating health care fraud and abuse, WellPoint offers the following recommendations to enhance future efforts throughout all sectors of health care:

- Establish a restricted recipient program in Medicare Part D for those beneficiaries displaying a pattern of misutilization.
- Dual Eligible beneficiaries with evidence of drug-seeking behavior should be locked into one managed care plan, rather than continue to be allowed to switch plans on a monthly basis to evade detection.
- Better coordination and cooperation among CMS, DOJ, and all stakeholders.
- Encourage Fraud Prevention in Private Health Insurance Programs by lifting the current restriction on health insurers' fraud programs in the Minimum Loss Ratio (MLR) calculation.

TESTIMONY

Examining Options to Combat Health Care Waste, Fraud and Abuse

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**Subcommittee on Health
Energy & Commerce Committee
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Chairman Pitts, Ranking Member Pallone, and Members of the House Energy and Commerce Subcommittee on Health, I am Alanna Lavelle, Director of Special Investigations for WellPoint, Inc. WellPoint is one of the nation's largest health benefits companies with more than 33 million people in our affiliated health plans, and approximately 64 million people served through our subsidiaries. I joined WellPoint in 2004 after serving 25 years with the FBI. My experience in the FBI included managing a national health care fraud case during the critical Columbia/HCA investigation, and I initiated the first Health Care Fraud Task Force in Texas. I also served as the Supervisory Special Agent FBI liaison for the Centers for Disease Control (CDC), working closely with the CDC on Bioterrorism matters in the post 9/11 era. I am a registered mediator and a Certified Professional Coder. I hold a M.S. in Conflict Management and a B.A. in International Relations. I also serve on the Data Analysis and Review Committee of the Healthcare Fraud Prevention Partnership, a voluntary public-private partnership recently organized for the purposes of reducing the prevalence of health care fraud. Recently I was named Chair of the National Health Care Anti-Fraud Association, the leading national association composed of both private and public sectors focused exclusively on fighting health care fraud and abuse.

Thank you for the opportunity to provide our input and recommendations on detecting and deterring fraud and abuse in the health care system. We appreciate your leadership on addressing what we believe to be a critically important issue: protecting patient safety and the financial viability of our health care system through detecting and deterring health care fraud and abuse. At a time of rising health care costs, it is essential not only to stop the costly drain on the U.S. health care system, but also to protect consumers' health and safety.

General Principles

In order to truly make inroads into the problems associated with health care fraud and abuse, WellPoint believes that a holistic view needs to be adopted, since the enormous costs of health care fraud and abuse are borne by all Americans whether they have private health insurance coverage or government-provided health care. Health care fraud and abuse is not just a Medicare or Medicaid problem – it is a health care system problem and it is the American taxpayer who is paying for it. Moreover, it is clear that many of the same individuals and entities that perpetrate fraud against government health care programs also engage in fraudulent activity in the private health insurance industry. Thus, the most effective way to address health care fraud and abuse is to forge a close and active partnership between private health plans, government agencies, and the provider community. It is only through cooperation and collaboration between the public and private sectors that health care fraud and abuse can be meaningfully addressed.

In addition, it is important to understand that stopping health care fraud and abuse means that multi-faceted approaches need to be used, as there is more than one problem and more than one source. For example, drug fraud or abuse can be caused by overutilization (drug abuse) or fraudulent prescribing (for financial gain), and can be driven not only by the recipients of the drugs but also by prescribing providers. For this reason, it is important to recognize that a one-size fits all solution does not exist. Congress, the Administration, and the agencies of jurisdiction need to increase their collaboration with each other and with the private sector in order to combat fraud and abuse throughout the health care system.

WellPoint's Experience

One of the significant strengths that WellPoint and other health plans provide is the data available from our integrated health care benefits. This allows us the ability to see the entire health care spectrum and to spot trends and outliers – such as the overprescribing physician or the patient receiving multiple prescriptions from multiple providers or pharmacies. For WellPoint's members that have both pharmacy and medical coverage under WellPoint, we have been able to identify:

- Provider practice patterns regarding the overprescribing of medications or performing unnecessary surgeries or procedures;
- Inappropriate coding by providers to receive greater reimbursement or reimbursement for services not rendered;
- Members in crisis or at risk of harmful prescription drug use, including abusive or potentially addictive usage patterns;
- Members who may benefit from chemical dependency and/or pain management intervention to improve quality of life; and
- Criminal enterprise and/or individuals defrauding the health care system, through the work of our fraud and abuse Special Investigations Unit (SIU).

WellPoint's Special Investigations Unit

To enhance our efforts to combat fraud and abuse, WellPoint has a dedicated fraud and abuse prevention team known as the Special Investigations Unit (SIU). I am one of the lead investigators, overseeing a team in the Southeast region. The SIU, led by a former Los Angeles Assistant United States Attorney, is staffed with employees having prior experience in the FBI, state law enforcement, and state insurance department fraud units. Medical professionals,

including doctors and nurses who have clinical and coding expertise, also work within the SIU. Finally, the data analysis team is comprised of individuals with IT or other computer-related backgrounds. The investigators are responsible for investigating assigned cases in order to detect fraudulent, abusive or wasteful activities/practices and recover funds paid on such claims. Our programs at WellPoint also include collaborative efforts between our SIU and our contracted pharmacy benefit manager, Express Scripts, to identify retail pharmacies cooperating with over-prescribing or inappropriate prescription patterns and to exclude such pharmacies from our provider networks.

WellPoint's Successful Fraud Prevention Programs

Our goal at WellPoint is to prevent health care fraud and abuse for the benefit of our members' health, as well as for the health care system as a whole. In order to meet this goal, WellPoint has developed a number of different types of programs to identify and prevent health care fraud and abuse, a few of which are discussed below.

1. Controlled Substance Utilization Monitoring (CSUM) Program

Our nation has a significant problem with prescription narcotic drug abuse and patients have at times gamed the system by doctor shopping, making multiple emergency room visits, and obtaining multiple prescriptions for narcotic drugs. Through a Controlled Substance Utilization Monitoring Program, (CSUM), health insurers can aid in patient safety and identify those who are engaged in or contributing to prescription drug abuse.

Our CSUM program in our commercial and Medicare business identifies members who, within a three month period, visit three or more prescribing providers, visit three or more

pharmacies, and have filled ten or more controlled substance prescriptions (narcotics, benzodiazepines and hypnotics) without a confirmed underlying medically necessary condition (such as cancer or multiple sclerosis) to justify numerous controlled substances. The goal is to prevent members who have exhibited a pattern of obtaining multiple prescriptions for controlled substances from different providers and multiple dispensations of these medications from continuing to obtain inappropriate amounts and dosages of drugs through their health care coverage. Members who are identified through this program are alerted to oversight of their Schedule II prescription drug activity and case managed. To date, the program has been very successful; for example it has helped saved millions of dollars in emergency department visits for drug-seeking behavior. There has not been significant abrasion, and in fact some members have found the program helpful in managing their treatment.

2. Medicaid Restricted Recipient Program

WellPoint has also implemented a restricted recipient program for our Medicaid plans in Indiana called "The Right Choices Program," and in Virginia called "RX Safe Choice," in which a member who has been identified as an abuser or at risk for abuse of controlled substances can be restricted to the use of only one primary care physician, one retail pharmacy, and one hospital for any non-emergency care. Our case managers, who work specifically with both the Indiana and Virginia membership, work directly with providers and members regarding excessive controlled substance use. Once a member is placed in the program, the primary medical provider must approve all referral providers for the member. Efforts are made to connect members with behavioral health providers, case managers and community resources related to abuse and addictions.

3. Provider Engagement in the Prescription Drug Trade

Provider involvement in the prescription drug trade of narcotics and other expensive drugs is a serious problem in our country, in particular in the state of California. As noted in last week's November 11, 2012 Los Angeles Times article, "federal researchers reported that emergency room visits resulting from the non-medical use of opioid prescription drugs - often used in pain relief - more than doubled from 2004 through 2008. There were as many visits for those prescription medications as for illegal drugs.¹" Times reporters analyzed 3,733 prescription drug-related deaths in four Southern California counties, revealing that just 71 doctors - one-tenth of one percent in those counties- had written prescriptions in 17 percent of such fatalities over six years. WellPoint SIU plays an instrumental part in identifying to California law enforcement agencies those prescribers of narcotics to individuals with no underlying medical conditions, because we have access not only to the pharmacy information, but also the medical records of the recipients of the narcotics and are able to see trends and outliers. We provide quarterly reports identifying the top prescribers in each California county, and prepare individual reports where the recipients of the narcotics do not have underlying medical conditions.

4. Pre-pay provider review program

Part of WellPoint's antifraud program activities includes examining physician practice patterns, to determine whether outlier physicians whose practices are different from the norm are engaging in questionable behavior that not only are driving up costs, but also are impacting patient safety. WellPoint investigators are able to identify aberrant provider practice patterns through data mining and analytics in which they look for outlier activities such as significant dollar spikes in payments or cumulative dollar spikes in certain counties. WellPoint has

¹ Los Angeles Times, November 11, 2012; "Legal Drugs, Legal Outcomes," by Scott Glover and Lisa Girion

implemented two such pre-pay provider review programs in which the most egregious billers who, after being educated and refusing to modify their billing behavior, are placed on “Flagged Pre-Payment Review.” For example, providers are identified as outliers if they show patterns of engaging in billing practices that are extremely aberrant compared to their specialty peers. “Upcoding” (coding a less intensive service as a more intensive procedure), billing an incorrect code to obtain coverage for a noncovered service, or billing at a particular facility to obtain extra reimbursement (e.g., billing a simple toenail clipping performed in an outpatient facility as debridement performed at an ambulatory surgery center) are examples of such outliers.

If a provider shows a pattern of engaging in such outlier behavior, WellPoint investigators and Medical Directors intervene to communicate with the provider to educate and attempt to correct his or her behavior if appropriate. About 60 percent of providers change their practices within 90 days after receiving such communications. However, the 40 percent of providers that continue to engage in incorrect coding may be placed on pre-pay review. In that case, providers must bill with paper claims accompanied by medical records so that we can determine whether the procedures billed for are reflected in the records.

5. Predictive modeling program

WellPoint has recently contracted with a vendor to provide an automated solution to enable WellPoint to continuously monitor medical (professional claims on CMS 1500s) claims across the company in a post-payment or future pre-payment environment. The initial rollout focuses on deploying the solution in the post-payment environment. WellPoint initially rolled out the program in Georgia, with the intent to implement it enterprise-wide in 2013.

The program uses advanced neural network technology from FICO² to identify previously unknown and emerging fraud and abuse provider/member schemes. FICO-based analytics score suspect claims on a scale of 1-1000 and identify aberrant provider/member behaviors. Suspect providers and claims are reviewed by a triage unit and the SIU to identify potential fraud, waste or abuse, and depending on the type of findings are then assigned to the investigative unit to investigate, prevent and stop ongoing fraud and abuse.

Since we began using this tool six months ago, WellPoint's SIU has opened 90 investigations and has achieved \$27 million in projected savings. For example, the program has revealed patients with consecutive days of anesthesia, which is not medically likely, as well as lab testing for cardiac risk or food sensitivities where labs were billing for hundreds of units of antigens. The program has also identified certain weaknesses in our systems and procedures, which we then work quickly to strengthen.

6. Bogus providers

Bogus providers are those providers that, although they may have National Provider Identifier numbers (which are usually stolen or purchased), do not actually perform services for real patients. Instead, bogus providers steal or purchase patient identification numbers, establish a fake storefront office furnished with limited inventory, obtain a post office box, and proceed to bill insurers for fraudulent services and devices. Bogus providers are a significant problem in both commercial health insurance as well as in the Medicare Advantage program.³

² FICO is the acronym for Fair Isaac Corporation, which provides analytics and decision making services to assist financial services organizations in making complex, high volume decisions.

³Of note is that Section 6401 of the Affordable Care Act provides for a ninety-day period of enhanced oversight for the initial claims of DME suppliers where HHS suspects there may be a high risk of fraudulent practices.

WellPoint takes a multifaceted approach to identifying bogus providers and preventing their fraudulent billing. SIU's Provider Database team alerts investigators to the presence of new labs, pharmacies and durable medical equipment (DME) clinics, and performs a full background check as well as a drive-by of the provider's purported office space. WellPoint also matches U.S. Post Office box numbers against our current claims to determine whether multiple bogus providers are using the same P.O. Box to receive payments (or whether the new provider has simply switched names and continues to fraudulently bill). To date, in the state of California alone, WellPoint has stopped over 239 bogus DME providers before they were able to submit fraudulent claims to the company.

A great example of the proactive work of the SIU in identifying bogus providers and also collaborating with our public partners at CMS and DOJ involves identifying and deterring health care fraud in the Medicare Advantage program. After a tip from one of our Medicare Advantage members who received an EOB for thousands of dollars of services he did not receive from an unknown provider, WellPoint commenced an investigation that led to the discovery of what appeared to be a large medical identity theft scheme perpetrated by an organized crime group. Further investigation of this organization resulted in discovery of bogus providers who were submitting fraudulent Medicare Advantage claims. In many cases, the perpetrators had stolen the provider identification numbers from local physicians, and utilized stolen Medicare Advantage identification members' numbers. Once this information was in hand, they began a deliberate and well-executed conspiracy to defraud our Medicare Advantage program. Our investigation revealed that claims paid from bogus providers were often for billings of a high volume of expensive infusion therapy (cancer and HIV-related) treatments for unknown conditions and from unknown providers. The claim profile of these providers exhibited the

characteristics of having invalid contact information (but including identification information from legitimate doctors to make them appear genuine), as well as irregular banking methods to cash payment checks.

Our SIU worked closely with claims operations areas to develop a proactive program to assist in identifying any provider fitting the same claim and provider profile as the bogus providers. The proactive process involves identifying any previously unknown provider billing the suspicious high dollar infusion therapy. These providers and their claims are immediately pending in the system and submitted to the SIU for review. Additionally, with respect to providers already in the claims systems with the same billing and provider profile, an edit process was inserted in the claims system to pending and review claims similar to those used by the bogus providers.

As a result of the investigation, in 2011 SIU identified 36 bogus providers who engaged in this scheme. Due to the proactive work of SIU, \$33 million dollars of fraudulent claims were stopped during the claims adjudication process, or newly issued checks to the perpetrators were stopped before they were negotiated. The total amount in savings to the Medicare Advantage program was \$33,748,292.94.

7. Review of Emerging Technologies

Every week WellPoint reviews newly emerging technologies to determine whether providers are inappropriately billing for services, devices or medications that are currently experimental or investigational. WellPoint performs data mining to detect the wrongful billing of experimental medications and medical services by the use of codes to make the services appear legitimate. In order to receive health insurance reimbursement, some providers bill for experimental/investigational devices, pharmaceuticals, or procedures by using a set of medical

codes that they know the health insurer will pay. It is fairly easy to spot the billing of new technologies as providers typically advertise them on their websites.

One such fraudulently billed new technology was an experimental back treatment known as VAX-D, a mechanical table used to stretch a patient's spine. WellPoint considers VAX-D to be investigational and not medically necessary, and clearly communicated to health care providers that it did not cover the procedure. From 2004 to 2006, WellPoint's SIU began investigating an anesthesiologist who was providing primarily physical medicine procedures at a privately-owned physician's office. Through patient interviews, the SIU determined that the office was providing back treatments using a VAX-D machine, and recovered a document that identified suggested billing codes to use for VAX-D which deviated from the specific HCPCS⁴ code for VAX-D. Most insurers, including WellPoint plans, do not pay on the appropriate HCPCS code for VAX-D, but insurers do pay on the suggested codes.

WellPoint referred its investigation to the FBI in 2005 and worked closely with the federal government, which led to seven indictments, five guilty pleas, two convictions after trial, and a restitution order of approximately \$4 million. Two of the providers went to trial. Evidence at trial showed that the clinic at which the two chiropractors worked billed one of WellPoint's affiliated health plans for more than \$3 million relating to the VAX-D procedure from 2001 through 2005. These defendants were convicted of lying to our affiliated health plan as to the procedures the clinic was performing in order to get paid for this non-covered procedure. Specifically, instead of using the specific billing code assigned to VAX-D, the clinic used a different code that pertained to surgical nerve decompression procedures. The indictment charged that the defendants used that code because they knew our affiliated health plan would pay for it, but would not pay for VAX-D. The proof at trial included testimony from the

⁴ "HCPCS" stands for Healthcare Common Procedure Coding System.

defendants' former employees, several of whom were explicitly instructed by the two chiropractors to not refer to the procedure as VAX-D when speaking to insurers, and to white-out references in documents to VAX-D because the defendants told the employees that insurers do not cover VAX-D.

WellPoint has recovered several million dollars (and expects to recover more through restitution), and the seven main perpetrators of the crime have either pled guilty or been convicted and sentenced.⁵

The VAX-D investigation has benefited WellPoint members by protecting healthcare dollars that would be lost to purveyors of a device that, to date, has not proven to be clinically effective in treating back pain. As such, the investigation has been a valuable tool to uphold the integrity of the health care system. Other plans have also benefited, as WellPoint has shared its findings with many commercial insurers. Other plans can pursue similar investigations and, given the success of the United States Attorney's Office in prosecuting the case, likely involve law enforcement and prosecutorial agencies.

⁵ <http://www.justice.gov/usao/gan/press/2008/07-29-08b.pdf>

Recommendations:

Based on our experience in combating health care fraud and abuse, WellPoint offers the following recommendations to enhance future efforts throughout all sectors of health care:

- **Medicare Restricted Recipient Program**

WellPoint is supportive of giving CMS the authority to establish a restricted recipient program in Medicare Part D for those beneficiaries displaying a pattern of misutilization. WellPoint systematically reports beneficiary-specific concerns— based on objective, standardized metrics—to CMS or to Medicare Drug Integrity Contractors (MEDIC) for appropriate action against the individual beneficiary. To ensure members' safety, WellPoint believes that plans should not implement policies of denying a prescription fill even in cases of suspected overutilization. From a health plan perspective, we would want to work with the prescribing physician and/or refer the case to CMS or its delegate. WellPoint asks that CMS be responsible for taking any enforcement action once members suspected of misuse or overutilization have been identified by the plan sponsor. Once sufficient due diligence has been conducted by CMS or its delegate to demonstrate abuse, or upon recommendation of the provider, the member can be placed in the restricted recipient program which the plan sponsors manage pursuant to clear regulatory protocols.

- **Dual Eligible Beneficiaries**

Through our experience in providing health care coverage through both our Medicaid state-sponsored programs and Federal programs, we have observed that a large portion of the opioid and controlled substance abuses in the Part D program occur among the dual eligible

population – beneficiaries eligible for both Medicare and Medicaid and often under 65 years of age. In calendar year 2011 alone, WellPoint’s SIU unit tracked 34 investigations of Medicare Part D beneficiaries under the age of 65. Under current law, dual-eligible beneficiaries are allowed to change plans on a month to month basis, which permits drug seekers to switch programs frequently in order to avoid detection and escape program edits or substance abuse programs.

WellPoint recommends that dual eligible beneficiaries with evidence of drug-seeking behavior should be locked into one managed care plan, rather than continue to be allowed to switch plans on a monthly basis to evade detection.

- **Improved Partnerships**

WellPoint supports better coordination and cooperation among CMS, DOJ, and all stakeholders. Right now there is little collaboration between the agencies and the health plans that oftentimes have the information, experience and expertise necessary for preventing and fighting fraud and abuse. In order to be truly effective throughout the health care system, both public and private sectors should be working together to share successful anti-fraud practices, effective methodologies and information about ongoing fraud investigations. For example, while health plans currently share information with the MEDIC, we are rarely informed of the ultimate result, and information collected by the agency is rarely shared with the private payers. However, we are excited by the recent creation of the Healthcare Fraud Prevention Partnership, a voluntary partnership composed of both the public and private sector for the purposes of reducing the prevalence of health care fraud. WellPoint is an active participant, and I serve on the Data Analysis and Review Committee. It is our hope that the work of the Partnership will

lead to successful public/private collaboration in the prevention and detection of health care fraud.

- **Encourage Fraud Prevention in Private Health Insurance Programs**

Experience has proven in both private and public program fraud investigations that fraud prevention is much more effective and cost-effective than pursuing “pay and chase” type fraud investigations. “Pay and chase” investigations recoup only about 20 cents on the dollar, while fraud prevention investigations result in dollar-for-dollar savings by avoiding improper payments. Moreover, fraud prevention investigations often remove fraudulent and harmful providers from the healthcare system before they can do more damage to public and private healthcare programs and their members. In recent years the Department of Justice and HHS have adopted successful fraud prevention tactics. The federal government should do everything it can to encourage fraud prevention for private health insurers, as well.

One way this can be done is to permit health insurers to lift the current restriction on health insurers’ fraud programs in the Minimum Loss Ratio (MLR) calculation. All expenses for health insurer anti-fraud and abuse programs should be included as "activities that improve health care quality" in the MLR calculation, since they reduce waste in the health care system, reduce the cost of health care, and enhance patient safety by helping identify and remove providers and individuals engaging in unsafe and fraudulent practices from the health care system.

Currently the MLR final regulation merely gives insurers a limited credit – up to the amount of fraud recoveries – for fraud prevention activities. In essence, this means that insurers will have to include as administrative expenses their largest portion of antifraud expenses --

those dedicated to fraud prevention. It is truly puzzling that at a time when the federal government is accelerating its efforts to prevent fraud in Medicare and Medicaid it has simultaneously issued a regulation that will serve to discourage health insurers' fraud prevention efforts. Ironically, eliminating antifraud programs will tend to increase MLR percentages because claims will be higher, but an increased MLR will be at the expense of patient safety, quality of care, and controlling health care costs, which are the very goals of the Affordable Care Act.

If private health insurers are discouraged from keeping their anti-fraud programs in place at the same time that public program anti-fraud efforts are increasing, federal law enforcement will lose a valuable source of information and tips about providers and recipients who may also be engaging in defrauding public programs. These considerations will also be crucial as the Centers for Medicare and Medicaid Services (CMS) codifies and implements the ACA's MLR for Medicare Advantage.

In conclusion, I would like to thank the Committee for the opportunity to testify today on behalf of WellPoint on this critical issue, and pledge our support in any efforts to make the health care system financially viable and safer for our members.