Amerigroup RealSolutions in healthcare

Waste, Fraud and Abuse Prevention

Each year in the United States, health care fraud results in the loss of billions of dollars and unnecessary or unsafe procedures. At Amerigroup, staying true to our value proposition to deliver quality health care and save taxpayer dollars, we continue to successfully reduce fraud, waste and abuse in the markets we serve. We maintain a corporate culture in which ethics and integrity are core values. It is because of this dedication from all of our associates—as well as designated departments—that we are considered to be a leader in fraud, waste and abuse prevention.

Defining Waste, Fraud and Abuse

Type	Definition	Examples
Waste	Incidents or practices that result in expenditure of resources in excess of need and unnecessary costs	• Misunderstanding of what is allowable billing code • Not appropriately documenting medical records to support service rendered or billed
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person	• Billing for services not rendered • Billing for more expensive services or procedures than were performed
Abuse	Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs	• Prescribing, performing and billing for services that are not medically necessary or fail to meet professionally recognized standards for health care • Submitting claim with incorrect current procedural terminology (CPT) code or wrong diagnosis code

Amerigroup has created a two-pronged approach in confronting fraud, waste and abuse:

- The Coding Validation Initiative (CVI) resides in the Premium and Medical Claims Integrity department and is comprised of a focused team of individuals whose goal is to identify aberrant provider billing practices and modify provider behavior through education.
- The Corporate Investigations Department (CID) concentrates its efforts on investigating the allegations of fraud, waste and abuse.

The CVI Program: Identifying Deviant Practices

Through a collaborative effort with various departments and through the use of various tools used to analyze medical trends and billed procedure codes, along with antifraud software, the CVI program identifies providers billing outside the norm. These "outlier" providers are determined by:

- The percentage of code utilization of each provider based on the number of members the procedure was performed on, divided by the total number of members seen by the physician
- The average and standard deviation of code utilization of the peer group as a whole
- The comparison of each individual provider to the average to find the number of standard deviations from the norm.

Educational Efforts That Make a Difference

In 2009, the CVI had $2.7 million in savings and changes in billing patterns.

Although some outliers are referred directly to CID, Amerigroup recognizes that most outlier providers unintentionally fall outside of the norm, and the company takes actions to improve the billing practices of these providers. Most identified outlier providers are placed in CVI's educational program. These providers are initially sent "educational" letters detailing the specific aberrant behavior along with proper coding instructions. Multiple mailings are sent to the providers during this educational period. Additional educational materials are placed on the provider portal where all providers can access the information. The providers' behaviors are monitored and, if the coding patterns are unchanged or inadequate response is received, the providers may be subject to post-payment or prepayment claims reviews. Referrals are also made to the CID, depending upon provider response and findings during this period.

Results of Added Benefits Through CVI

In Texas, we implemented a prepayment review process for hospital claims, meeting specific criteria for well-baby and sick-baby reviews.

In New Mexico, we implemented a program to minimize the potential for provider steerage that utilizes a validation process for durable medical equipment (DME), home health and personal care attendants. By implementing this process, the health plan identified a number of cases where the changes that were requested by providers were not in line with the member's request. Amerigroup also implemented a new assessment process focused on removing variability and subjectivity when evaluating home services. By adding a consistent scoring methodology, the health plan will begin to see a reduction in higher level services that are not necessary.

In Maryland, we implemented a hospital audit program to help identify any possible fraud, waste or abuse. This initiative resulted in the recovery of $5.8 million.

Preventing fraud, waste and abuse is a collaborative effort, and CVI coordinates with numerous departments within the company. For example, CVI coordinates its activities with CID to ensure that an identified provider is not currently under investigation and also makes referrals to CID for investigation where aberrant billing practices cross into suspected fraud.

The CID Program: Investigating Allegations

Amerigroup's CID works to prevent, detect and investigate allegations of fraud, waste and abuse. Backed by key internal and external resources, the CID utilizes data mining tools to identify suspicions of fraud. The department investigates allegations identified by

Results: Maryland Pediatrician Modifies Billing

CID interviewed a Maryland pediatrician who always billed the

members, providers and associates. The most common allegations include prescription fraud/abuse, marketing compliance, upcoding and misrepresentation of services.

In 2009, CID opened 492 potential fraud and abuse cases, identified $10.5 million in overpayments and estimated savings of about $5.9 million in reduced medical costs across all health plans.

Our Corporate Investigation associates include investigators, certified professional coders, nurses and analysts. The CID management team and investigators have assigned responsibility for identifying fraud, waste and abuse in specific markets, enabling them to promote compliance with state-specific requirements and to build relationships with plan management, state regulators and law enforcement. The CID's approach includes:

- Collaborating with internal and external partners
- Acting on referrals
- Leveraging antifraud technology
- Utilizing provider data reviews
- Educating providers, members, associates and the general public
- Utilizing the latest software and technology
- Using medical management processes
- Taking appropriate action when fraud is uncovered.

highest paying developmental testing codes when performing developmental screenings. When interviewed, the doctor acknowledged he knew he should not have submitted the higher level code, but billed it to pay his two staff pediatricians. Amerigroup identified an overpayment of approximately $268,000 and the pediatrician modified his billing patterns, saving an estimated $175,000.

Results: Provider Convicted of Health Care Fraud

Amerigroup was recognized by the U.S. Attorney's Office for providing assistance in a recent fraud case in Washington, D.C. Dr. Ehigiator O. Akhigbe billed for services not rendered and inappropriately modified members' medical records. Akhigbe was sentenced to 53 months in federal prison, fined and ordered to pay Amerigroup $133,418 in restitution based upon CID's investigation, referral and testimony. U.S. Attorney Ronald C. Machen Jr., FBI assistant director Shawn Henry and D.C. Inspector General Charles J. Willoughby extended their appreciation to Amerigroup's internal fraud investigators for first detecting and reporting Akhigbe's conduct.

Claims Payment Validation Program: Auditing Hospitals

The Premium and Medical Claims Integrity department also looks at Claims Payment Validation initiatives where there is a robust, well-coordinated hospital audit program. Working with third-party vendors to perform hospital audits, this program accomplished $9.4 million in savings for the year 2009.

A Hidden Value to Those We Serve

In our vigorous pursuit of fraud, waste and abuse, Amerigroup is determined to be at the forefront of the health care industry with our unique processes and approach. In the past year alone, Amerigroup has partnered with law enforcement on at least 235 cases nationwide.

Our standards and expectations in each market we serve are high. Of our health plans, we require a thorough understanding of our goal with each initiative and the impact that it will have on their providers and networks. In return, we offer training, assistance, timely notification of provider interventions, ultimately resulting in the ability to lower medical costs due to decreased provider waste and abuse.

With a full understanding of the impact of fraud, waste and abuse on our organization, our members and our state partners, we will continue our corporatewide efforts. We will build upon our experience and proven processes by exploring additional innovative tools and methods to increase our efficiency in detecting and preventing fraud, waste and abuse. That's a special part of the value we deliver to those we serve.