

Overview

Cost of Fraud, Abuse, and Waste in Healthcare is a colossal problem resulting in billions of dollars. For government health programs this obviously results in a huge impact to the American tax payers.

In fiscal year 2010, the Centers for Medicare & Medicaid Services (CMS) estimated that these programs made a total of over \$70 billion in improper payments.

The amount of improper payments has created urgency to effectively implement strategies – and the Affordable Care Act, and the various resulting initiatives of interconnected healthcare delivery, is aimed at resolving many of these problems stemming from: Unwarranted Use, Fraud and Abuse, Administrative Inefficiencies, Provider Inefficiency and Errors, Lack of Care Coordination, and Preventable Conditions.

Medicare is considered high-risk in part because of its complexity and susceptibility to improper payments; Medicaid because of concerns about the adequacy of its fiscal oversight to prevent inappropriate spending.

Managing more than just the *Tip of the Iceberg*

The current modes, to control issues of Fraud, Abuse, and Waste in healthcare spending, rely on a “Pay & Chase” model. In this case though, it is seen that the recovery of fraudulent claims paid out is less the ten percent (<10%) of the detected cases. What’s more is that this incentivizes one-off fraud patterns from many who look at beating the system.

Insurance Oversight and Integrity Programs within the government and private payer organizations are now looking to get beyond the traditional mode of determining fraud and abuse. Current claims and payment models are built as Deterministic Systems where most data analysis happens after payments are made.

While this method detects specific instances of fraud and the providers committing it, it does NOT account for fraudulent patterns that are repeatable and traceable.

Detecting patterns in claims data is of far greater significance and relies on Probabilistic Inference to identify potential scenarios of fraud and abuse.

"CNSI maintains a commitment to bring technological advancements to the industry and a dedication to provide quality service to its customers."

*S. Priyan Viswanathan
Research Analyst,
Frost & Sullivan*

"Throughout the project, CNSI staff has worked with us as partners in development of CHAMPS. This level of collegiality and cooperation is, in my experience, unprecedented in large systems projects. This has made the degree of success we have achieved possible

*Janet Olszewski,
Ex-Director
State of Michigan, Department
of Community Health*

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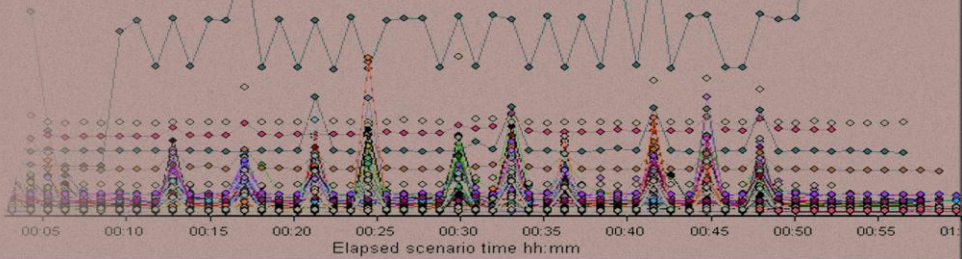
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Proactively Avoiding Wasteful Spending in Healthcare

A continually evolving learning system to estimate probability of claims fraud and abuse



Delivering best-of-breed solutions for healthcare fraud prevention

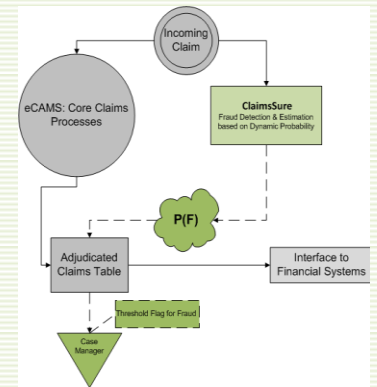
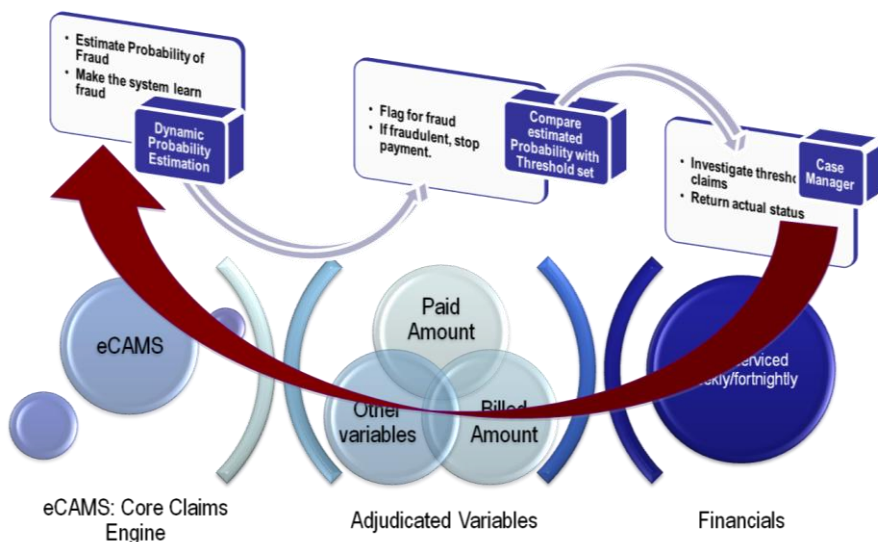
CNSI's flagship payer platform **eCAMS®** now addresses Fraud, Abuse, and Waste with this new level of sophistication in the form of **eCAMS® ClaimsSure**.



While **CNSI's Rule IT®** enables the Deterministic approach for fraud identification, it works in conjunction with **eCAMS® ClaimsSure** to provide a two-step approach to identification and determination of fraudulent claims.

- Dynamic estimation for determining probability of fraud
- Machine learning system that evolves continuously in recognize new fraud patterns

With sophisticated **Outlier Analysis** of claims data patterns, combined with **Bayesian Learning** principles, **eCAMS® ClaimsSure** helps identify claims that may need to be flagged for review and payment determination. With the ability to introduce this level of visibility to claims processing, agencies and payers are able to prevent payment on encounters while still determining the accuracy and validity of these.



- Probability inference approach to detecting fraud
- Dynamic estimation based on history data
- Machine learning to make the system understands new methods of fraud as they happen
- User defined threshold to set parameters of extent of fraud
- Helps manage workload to case managers based on available resources and intended value
- Helps increase fraud detection by 60% compared to deterministic methods
- Calculations are processed in parallel and does not affect performance of adjudication