FICO™ Insurance Fraud Manager—Healthcare Edition delivers unprecedented value to payer organizations by substantially reducing losses from healthcare billing error, abuse and fraud. It's the first system to detect these billing problems both prior to payment (through claim scoring) and after payment (through provider scoring). Detection is extremely precise at all of these points in the claims spectrum because FICO Insurance Fraud Manager analyzes claims data in the full context of historical billing behavior by the provider, its peers and other participants in the healthcare network. As a result, FICO Insurance Fraud Manager catches billing problems that are invisible to claims editing and adjudication systems, and even rules-driven fraud detection—including redundant payments submitted by different providers or masked by missing claim information, upcoding, collusion among providers and facilities, abusive billing taking advantage of policy loopholes, fraud related to quality of care issues and even emerging, unknown fraud schemes.

This white paper describes the three major areas of value delivered by FICO Insurance Fraud Manager: prepayment savings from avoiding unnecessary and excessive payments, systemic savings from identifying and correcting policy weaknesses, and postpayment savings from identification of suspicious providers. It looks at why predictive analytics reduces losses and costs while improving recovery opportunities far more effectively than detection relying on rules alone.
Healthcare payers are paying tens of billions of dollars in erroneous, abusive and fraudulent claims that look just fine in editing and adjudication systems—and that pass right through rules-driven fraud detection systems too. While the majority of such claims appear legitimate when viewed in isolation, they actually shouldn’t be paid in full, and many of them should not be paid at all. Once they are, only a tiny fraction of the dispersed funds will ever be recovered.

The problem is that claims data, in and of itself, only goes so far in revealing billing problems. Claims edit and adjudication systems, as well as fraud detection systems that rely on rules alone, do not go much beyond examining the data on the claim—something like looking at just one leaf on a tree. These systems do not recognize that claims which are correct in isolation may actually be part of a larger pattern of fraudulent activity, repeated error or systemic weakness. They do not notice providers manipulating the system by upcoding or those billing for services that are unrealistic and for amounts that are out of alignment with their peers. Focusing on the leaves, they cannot see the trees—much less the vast forest of costly billing problems.

Nevertheless, claims data is the key to detecting and stopping these problems. It contains rich data on providers, patients and other healthcare participants. FICO™ Insurance Fraud Manager—Healthcare Edition (formerly known as Payment Optimizer), a detection system with powerful statistical modeling, extracts data from all payer claims on an ongoing basis. It captures meaningful information from this vast quantity of data and mathematically distills it down into a highly compressed and efficient form. Then Insurance Fraud Manager analyzes each incoming claim against this rich context.

The results of this complex multidimensional analysis—which enables FICO Insurance Fraud Manager to minimize losses and even prevent them before payment—are output in simple, actionable form. Scores and rankings focus analysts on the most problematic claims and providers. Explanations, with links to evidence, enable analysts to rapidly understand the source of a problem and can seamlessly navigate a line of reasoning from the leaf to other parts of the tree, other parts of the forest, and vice versa. Intuitive online tools are at hand to translate understanding into efficient action, including correcting errors on the spot, opening and referring investigative cases and recommending policy changes to address systemic issues.
Healthcare payers stepping up to this higher level of detection achieve several types of savings—described in detail on the next page—which occur across the continuum of claims activity. In fact, FICO™ Insurance Fraud Manager is the first detection system to provide this range of value—from prepayment claims scoring that prevents funds from being dispersed unnecessarily, to weekly rankings of problematic providers that enable early investigation, to comprehensive postpayment analyses that reveal large-scale fraud and substantially improve recoveries. As a result, customers using FICO Insurance Fraud Manager consistently produce savings that add up to as much as 10:1 ROI or more.

FICO Insurance Fraud Manager is the first system for detecting healthcare billing error, abuse and fraud that works across the spectrum of claims management—from prepayment to postpayment. By analyzing claims data at different depths, and at different points in the spectrum, FICO Insurance Fraud Manager generates layers of cumulative value.

Each type of analysis generates additional savings, as shown below. In addition, during implementation and training of FICO Insurance Fraud Manager, the system typically identifies systemic and policy weaknesses that allow, and perhaps even attract, fraud and abuse. When these weaknesses are addressed, the resulting savings are significant and ongoing.

1. **Prepayment**—savings from avoiding unnecessary and excessive payments
   - **Detection advantages**: Catches errors on claims that comply with payer policies and thus have passed through claims edit and adjudication; catches potentially fraudulent or abusive billing, including a single suspicious element on an otherwise legitimate claim.
   - **Savings realization/magnitude**: Immediate and near-term. Typically, yields an average of 30 cents per claim across entire book of business.

   See page 7 for a full discussion and examples of prepayment claims-level scoring.

2. **Systemic and policy weaknesses**—savings from closing holes in claims-edit rules and rooting out vulnerabilities in procedures and plan designs (concentrated at implementation, but ongoing)
   - **Detection advantages**: Enables payers to take steps to eliminate core problems causing repeated losses.
   - **Savings realization/magnitude**: Immediate to long-term. Savings can be similar to that from prepayment claims-level scoring.

   See page 9 for a full discussion and examples of prepayment claims-level scoring.
3. Provider cases—savings from identifying healthcare providers engaged in fraudulent and abusive billing

Early postpayment is the weekly rolling up of provider-level scores based on a year of statistically aggregated claims scores.

- **Detection advantages:** Early warning system—detects patterns indicating potential fraudulent or abusive billing, including emerging, new schemes at the first possible moment. Enables payers to investigate suspicious providers and other entities sooner, and to take early action, if warranted, to prevent the behavior from continuing. This also enables payers to get a head start on recovery efforts.

- **Savings realization/magnitude:** Near-term to long-term. Loss rates can typically be cut to a fraction of what they would otherwise be, since fraudulent and abusive billing can be caught and stopped months to years earlier than traditional methods.

*See page 10 for a full discussion and examples of postpayment weekly rolling provider-level scoring.*
4. Annual, or more frequent postpayment analyses, is comprehensive healthcare provider-level scores based on a deep retrospective analysis of several years' worth of claims data.

- **Detection advantages:** Detects patterns of fraud, abuse and systemic/policy errors that are not evident in smaller data sets, emerge gradually over an extended period of time or are highly complex and subtle.
- **Savings realization/magnitude:** Long-term, tens of thousands or millions of dollars.

See page 11 for a full discussion and examples of postpayment comprehensive provider-level scoring.

Healthcare payers adopting the full spectrum of protections gain the full spectrum of savings. In addition, analytics operating at each stage of the detection spectrum can amplify results at other stages, increasing return on investment even further.

**Why Predictive Analytics Are So Effective at Reducing Losses and Costs**

FICO™ Insurance Fraud Manager delivers unparalleled results:

- Detects more fraudulent, abusive and erroneous billing behavior than any other method—both before and after claims are paid.
- Transforms the review and investigative processes into newly powerful means of stopping, recovering and preventing losses.

These detection and review benefits are closely linked. In fact, the complex detection analyses are embodied in simple, actionable form for review.

**Accurate Detection—Maximizing Loss Prevention and Recovery Opportunities**

The prevalent methods of error, abuse and fraud detection used by healthcare payers today rely on rules alone. Such methods prevent only a fraction of the losses being incurred because they catch primarily problems associated with the claim. They aren't aware of problems signaled by missing data, nor can they recognize problematic behavior hidden in complex, subtle relationships between claims, providers and patients. Rules-based systems are also of limited effectiveness because they detect only well-defined, known issues and scams. These rules-based systems get thrown off the scent as known patterns evolve and morph into new types of schemes, and they are completely blind to the signs of emerging schemes.

Detection systems with advanced predictive analytics, however, excel at finding the full range of billing problems—from simple errors claims edit and adjudication systems miss to highly refined and finessed attacks by organized criminal networks. Here's why.

Predictive analytics are far more precise than solutions relying on rules alone. Rules created to catch billing fraud, abuse and errors are necessarily based on known information and, to some degree, on judgment. FICO Insurance Fraud Manager, in contrast, uses statistical pattern recognition to understand from data the characteristics of a peer group—then detects healthcare claims and providers departing from this norm in ways indicative of fraudulent, abusive or erroneous billing. Which norms are applied during an analysis is also driven by the data. Rather than relying on what physicians say, for example—since declared specialties are frequently at variance with actual practice—FICO Insurance Fraud Manager uses what they do, as evidenced in actual claims data, to assign providers to appropriate peer groups. And because FICO Insurance Fraud Manager constantly
analyzes new, incoming data, it keeps up with shifts in peer group behavior, can reassign healthcare providers based on their activities, and detect new and evolving fraud types, whether these changes occur abruptly or evolve subtly over time.

Dynamic profiling enables an enormous quantity of data to immediately be brought to bear on each scoring decision. To recognize normal and aberrant patterns of behavior during the fraction of a second devoted to scoring a particular claim, the predictive analytic models used by FICO™ Insurance Fraud Manager must have instant access to a vast quantity of historical data. A proprietary FICO technique called dynamic profiling fulfills this requirement. Profiles—which can be generated for virtually any entity, including patients, providers and procedures—can distill a terabyte or more of data down to compact mathematical descriptions. The profiles capture the relevant details of claims activity, including dimensions such as the sequence and speed of transactions (a patient checking into a hospital, a procedure performed, a drug prescribed, etc.), in key variables proven to have predictive value in the detection of fraudulent, abusive and erroneous healthcare billing. Furthermore, as the profiles are applied to each incoming claim or other current transaction, they instantly update themselves with any new information.

Powerful analytic models find complex patterns in the multidimensional characteristics and interactions of healthcare providers. Using dynamic profiles as input, the predictive analytic models simultaneously examine numerous predictive variables. It would take thousands of rules to look at the data a single model can encompass, and even then the rules-based system would miss the big picture.

Although such systems can fire any number of rules in sequence, each rule examines only a few data points in a relatively straightforward manner. The predictive models used by FICO Insurance Fraud Manager analyze complex non-linear relationships between data to recognize characteristic behavior of healthcare providers and peer groups, and detect aberrations from them, including subtle, hidden and emerging patterns of fraud. Detection accuracy increases over time, as the constantly updated dynamic profiles provide the models with deeper, richer descriptions of healthcare provider historical behavior and periodic updates enable changes in the data to affect how the models interpret inputs and combine them to form scores.

Detecting healthcare fraud, error and abuse is difficult. FICO™ Insurance Fraud Manager handles the complexities...

- Brings massive quantities of data efficiently to bear on analyses that can be as quick as real time
- Analyzes complex, non-linear data relationships
- Detects fraud despite missing data and claims that have not yet been received
- Takes into account each procedure code’s unique characteristics (e.g., typical intervals between repeat procedures)
- Scores and ranks physicians for aberrance within peer group of other physicians in their specialty
- Scores and ranks facilities for aberrance against peers in a manner that is independent of size and volume

...and provides payers with simple, actionable answers.

- Claim is suspicious because it includes a fee for professional interpretation of an automated lab test, which is an atypical service
- Provider is suspicious because of a preponderance of atypically high billing amounts per day
Actionable Results Enable Efficient Review—
The Analysis Is Largely Done by the Time the Referral Hits the Desk

Productivity goes up because reviewers are focused where they can make the most difference and because the problem analysis is already largely done when they receive the referral. The review workload is reduced, first of all, because the precision of the detection process minimizes false positives (legitimate claims and providers receiving high scores for potential fraud and abuse). In addition, whereas a rules-only system may dump an unprioritized batch of flagged issues into reviewer queues, FICO™ Insurance Fraud Manager delivers high-scoring healthcare claims or providers in the form of a ranked list, with the most suspicious (highest score on a 1 to 1000 scale) at the top of the list.

Each score is accompanied by one or more explanations, which eliminate most of the analysis task, pointing the reviewer to why the claim or provider is suspicious. In many cases, these explanations immediately illuminate simple problems that were invisible to edit and adjudication systems—enabling claim adjusters to correct mistakes and properly adjust claim payment amounts. Typically such decisions can be made in 30 seconds to 3 minutes per claim.

For more complex cases of potential abusive or fraudulent billing behavior, the fact that much of the analysis has already been done means that reviewers can rapidly traverse a path from explanation to evidence in linked reports and data. This patent-pending method, which FICO calls a “Reason-based Report Tree,” rapidly elucidates the source of billing problems.

Through FICO Insurance Fraud Manager’s end-user interface, users can also move fluidly between provider-level scores and data to claims-level scores and data, or jump sideways to other healthcare providers performing services for the same patients. These efficient paths through “the forest” enable analysts to quickly determine if the billing behavior in question is an error, an instance of a systemic problem or a probable case of fraud. Arriving at understanding, they can immediately take appropriate action, using the same interface to correct the error, recommend the policy change or open and assign the fraud case.

The next section presents several examples of navigating Reason-based Report Trees to systemic, prepayment and postpayment savings.

Full-Spectrum Savings

Prepayment Avoidance of Losses

Claims are analyzed in the context of historically typical patterns by and between relevant healthcare providers and patients. Each claim is scored based on its degree of aberration from historical patterns. Output is a ranked list of scored claims, beginning with the most suspicious.

Claims analysis and scoring typically follows existing claims edits, rules engines and adjudication, just prior to payment. By identifying fraud, abuse and errors before checks are issued, and thereby enabling payers to avoid unnecessary or excessive outlays, FICO Insurance Fraud Manager generates post-adjudication savings in the average of $30 per claim reviewed. When averaged out across the entire book of business, savings generally amount to 30 cents per claim. In addition, by avoiding paying fraudulent claims, you can reap dollar-for-dollar savings. And prepayment claims scoring occasionally leads to the identification of systemic and policy problems, whose correction can prevent future losses.

Usually claims scoring takes place in batches (although FICO Insurance Fraud Manager can also support real-time, transactional analysis) hourly, several times a day or overnight. Most payers set score review thresholds at about 1% of claim lines and use the powerful business rules management
functions of FICO™ Insurance Fraud Manager to route referrals to the appropriate adjuster and/or medical management team. Incremental review costs, thanks to powerful combination of effective and accurate analytics and simple review tools, are generally only a couple of cents per claim.

**EXAMPLE: PAYING TWICE FOR X-RAYS**

<table>
<thead>
<tr>
<th>Score:</th>
<th>992</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation:</strong></td>
<td>Missing modifier. A claim for a chest x-ray has a missing modifier for a professional component. The default, as a result, is for global reimbursement—and there’s already a claim for the x-ray for the patient on that day. This redundancy would be missed by most claims edit systems, which aren’t designed to catch problems from missing information.</td>
</tr>
<tr>
<td><strong>Understanding:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| ![Diagram](image)
| **Claim level** Check to make sure that the test is being double billed |
| **Action:** | Deny the technical component of the claim, reducing the amount by 30%. |

**EXAMPLE: AVOIDANCE OF AN ILLEGITIMATE PAYMENT**

<table>
<thead>
<tr>
<th>Score:</th>
<th>975</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation:</strong></td>
<td>High-dollar day. The payment for this patient is nearly 10 times higher than what is typical for the procedure code.</td>
</tr>
<tr>
<td><strong>Understanding:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| ![Diagram](image)
| **Claim level** Look at all claim lines performed by this provider on this patient. There is a repeating pattern of 13 skin lesions being removed and $1,012 billed every few weeks. |
| **Claim level** Drill down to the claim level on some of the patients to confirm that the pattern is pervasive and to see if there are any other suspicious patterns. |
| **Provider level** Looking at all claims by this provider shows that this pattern is being repeated across several patients. |
| **Action:** | Open a case and assign it to a fraud investigator. By catching this error at the prepayment stage, the payer avoids erroneously paying this potentially fraudulent claim as well as subsequent claims from this provider. Launching an early investigation also enables the payer to avoid cumulative losses that would otherwise be likely to continue for many months. |
Systemic and Policy Weakness Corrections

Systemic and policy weakness corrections are a beneficial by-product of the model implementation process and also an occasional outcome of ongoing claims-level or provider-level scoring. Such loopholes and vulnerabilities previously enabled fraudulent and abusive billing to pass through undetected.

During FICO™ Insurance Fraud Manager implementation and training, the system invariably reveals areas of systemic and policy weaknesses. Payers find “holes” in their claims edit rules and areas in their policies and plan designs that are vulnerable to exploitation. By addressing these problems and thereby avoiding future losses, they can realize substantial ongoing savings, usually of the same order of magnitude as those from prepayment scoring.

Claims or providers that receive high scores for fraud potential point to inherent problems that invite abusive billing. In such instances, payers will often choose to overlook the transgressors and focus on fixing the problems to prevent them and others from taking further advantage of it. In other cases, providers who have been clever about exploiting systemic and policy weaknesses will also be engaged in more clear-cut fraudulent behavior, and detection of one will lead investigators to the other.

**EXAMPLE: BEING “NICELED AND DIMED” WITH SMALL EXCESS CHARGES AMOUNTING TO TENS OF MILLIONS OF DOLLARS PER YEAR**

<table>
<thead>
<tr>
<th>Score:</th>
<th>985</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation:</strong></td>
<td>Unusual modifier for this procedure code—professional interpretation of an automated glucose blood reagent strip test, which normally does not require this.</td>
</tr>
<tr>
<td><strong>Understanding:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Claim level</strong></td>
<td>Look at detail to make sure there is nothing unusual about this test.</td>
</tr>
<tr>
<td><strong>Cross-provider level</strong></td>
<td>Review a list of all claims with a combination of this procedure code and modifier to see if it is a generalized problem.</td>
</tr>
<tr>
<td><strong>Action:</strong></td>
<td>Deny and mark as a policy issue to be addressed with a claims edit rule.</td>
</tr>
</tbody>
</table>
Postpayment Identification of Opportunities to Recover Losses and Stop Ongoing Abuse

Healthcare providers are scored in the context of historically typical behavior, by and between other relevant healthcare providers. Each healthcare provider is scored based on its degree of aberration from norms. Output is a ranked list of scored healthcare providers, beginning with the most suspicious.

Postpayment analysis has traditionally been performed long after claims have been paid, with results coming too late to stem the flow of losses. FICO™ Insurance Fraud Manager also scores healthcare providers once a year, using deep retrospective analytics. But it also provides an early-warning mechanism that bridges prepayment and postpayment analytics in a manner that generates statistically accurate provider scores weekly throughout the year, bringing problems to the attention of payers sooner.

Provider Cases

Savings come from accelerating visibility into fraudulent activity at the provider level, enabling payers to identify the worst perpetrators and act quickly to stop losses. Each week all the claim-level scores resulting from the prepayment analytics performed during that week, as well as during the 51 previous weeks, are statistically aggregated at the healthcare provider level. The result is a fraud score for each provider and a weekly ranking of the most suspicious providers.

**EXAMPLE: PROVIDER ENGAGING IN HABITUAL UPCODING**

| Score: | 980 |
| Explanation: | High paid. In the weekly ranking of providers, this one is the most aberrant from the peer group. |
| Understanding: | **Provider level**  
There's a concentration of consultation and hospital follow-up visits billed at the highest level, with an unusual absence of mid-level codes.  
**Claim level**  
There is a clear pattern of high charges for 1-hr consultations when patients are first admitted to the hospital. That is strange, and so are the diagnostic codes, for relatively minor ailments such as back pain and abdominal pain. |
| Action: | Open a case and assign it to a fraud investigator. Catching this at the early postpayment stage saves the payer many months worth of potential losses. |
EXAMPLE: PROVIDER MAY BE BILLING MULTIPLE TIMES FOR THE SAME SERVICE

Score: 983

Explanation: Repeated procedure. While specific instances of repeated procedures are caught during prepayment claims-level scoring, the weekly analysis of provider characteristics based on a year’s worth of claims data puts this provider near the top of the list because of a concentration of atypical characteristics.

Understanding:

- **Provider level**: Among the repeated procedures highlighted is a charge for a routine child check-up for the same member on subsequent days.
- **Claim level**: Drill down to the claim to check for diagnoses. There doesn’t appear to be anything that would justify a repeat visit, so this doesn’t look like a simple miscoding problem.
- **Provider level**: Back up to see if there is a payment differential between routine check-ups and problem-focused visits. And, if so, whether or not there seems to be a preponderance of the higher-paid routine check-ups as part of a pattern of multiple billing.

Action: If there is a pattern of multiple billing for higher-paid routine check-ups, open a fraud case.

Annually, or on a more frequent basis, FICO™ Insurance Fraud Manager also performs a deep retrospective analysis on several years of claims data. Savings come from identifying providers engaged in significant fraud and major opportunities for recovering losses from payments made to them, usually in the hundreds of thousands or millions of dollars. FICO Insurance Fraud Manager also provides the tools and data for taking definitive legal action, including graphical reports that are often used as evidence in court.

Because postpayment models analyze years of claims using a richer set of predictive variables than invoked during prepayment scoring, they can detect patterns that aren’t evident in smaller data sets. Individually, all of the claims involved may appear to be legitimate. When the provider is considered as a whole, however, aberrant patterns emerge. These might be an unusual mix of activity or unusually high utilization rates for certain procedure codes spread out over a long period of time. Postpayment analysis also reveals very complex and subtle fraud schemes, organized fraud, and occasionally, overlooked payer systemic and policy vulnerabilities that are like an open door to fraudsters.

Provider-level profiles can also employ multiple models to provide a broader view of the dynamics in the healthcare network. Provider models, for example, can be run alongside models that score facilities such as nursing homes, or analyze provider/facility links, including patient sharing and the frequency and speed of patient movement between them. A patient abuse and neglect model can be added to identify providers and facilities that may be engaging in patient neglect and abuse—which often accompanies billing fraud—and objectively sort out responsibility for poor healthcare outcomes.
Each model run generates a score for the healthcare provider, ranks providers by score, or score plus any payer-specific criteria, and creates a summary report of the results for each healthcare provider. Summary reports provide quick, meaningful statistics—average number of visits per patient annually, quarterly and monthly, top 10 procedure codes, top 5 patient statistics and top 3 busiest days. They also list scores from any other models that were run; users can click on these to jump to that model’s summary report for the same healthcare provider.

**EXAMPLE: DENTIST PERFORMING AN UNUSUAL MIX OF PROCEDURES**

<table>
<thead>
<tr>
<th>Score:</th>
<th>990</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation:</strong></td>
<td>Unusual procedure ratio. In the comprehensive year-end analysis, this provider ranks high for a preponderance of aberrant billing behavior.</td>
</tr>
<tr>
<td><strong>Understanding:</strong></td>
<td></td>
</tr>
<tr>
<td>Provider level</td>
<td>Ratio of root canals to pulpotomy is atypically high.</td>
</tr>
<tr>
<td>Claim level</td>
<td>Detail on numerous claims seems suspicious, such as claiming to perform pulpotomies on several teeth during the same visit. Also see a lot of restorations.</td>
</tr>
<tr>
<td><strong>Action:</strong></td>
<td>Open an investigation, pointing investigators to what looks strange in the claims detail.</td>
</tr>
</tbody>
</table>

**EXAMPLE: POTENTIAL COLLUSION BETWEEN A PROVIDER AND A NURSING HOME**

<table>
<thead>
<tr>
<th>Score:</th>
<th>995</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explanation:</strong></td>
<td>Unusual concentration of provider services to facility patients.</td>
</tr>
<tr>
<td><strong>Understanding:</strong></td>
<td></td>
</tr>
<tr>
<td>Cross-provider level</td>
<td>A nursing home’s patients have a large number of claims for a particular provider.</td>
</tr>
<tr>
<td>Provider level</td>
<td>The billing rate per patient is low, but the quantity of low-level charges is unusually high. Provider may be trying to “fly under the radar,” making a lot of money in small increments.</td>
</tr>
<tr>
<td>Provider level</td>
<td>The age range of the nursing home’s patient population is low for the type of services being rendered by the provider.</td>
</tr>
<tr>
<td>Claim level</td>
<td>The services provided to this patient, given her age and the diagnosis, seem suspicious.</td>
</tr>
<tr>
<td><strong>Action:</strong></td>
<td>Open an investigation.</td>
</tr>
</tbody>
</table>
Healthcare payers should derive greater value from their claims data. This rich source of behavioral information can be analyzed in complex ways to provide payers with simple answers to one of the most important questions facing their business: How can we reduce losses and costs?

While the industry has become enormously efficient at processing paying claims correctly and on time, it has paid the price. Every healthcare insurer is incurring unnecessary losses by paying claims that appear legitimate when viewed individually. In fact, these claims are actually part of larger patterns of fraudulent or abusive billing that are invisible using conventional claims edit systems and detection solutions—ones that rely solely on rules or simplistic analytics.

But payers no longer need to accept these losses as the price of efficiency. FICO™ Insurance Fraud Manager provides the advanced statistical pattern recognition needed to detect, pend and dispatch many of these claims before payment, in minutes and at an incremental cost of just pennies per claim. FICO’s advanced analytics scrutinize large retrospective sets of claims data, unearthing subtle and complex fraud, large-scale and organized fraud and emerging fraud patterns. Using these insights and evidence, healthcare payers can boost recoveries; prevent providers from abusing the system by siphoning off funds; and close vulnerabilities in systems, policies and plan designs.

Similar analytic technologies have already drastically reduced fraud in the financial services and telecommunications industries. In healthcare, while still the path less taken, predictive analytics is already leading early adopters out of the woods to higher profits.
FICO™ (NYSE:FIC) transforms business by making every decision count. FICO’s Decision Management solutions combine trusted advice, world-class analytics and innovative applications to give organizations the power to automate, improve and connect decisions across their business. Clients in 80 countries work with FICO to increase customer loyalty and profitability, cut fraud losses, manage credit risk, meet regulatory and competitive demands, and rapidly build market share. FICO also helps millions of individuals manage their credit health through the www.myFICO.com website. Learn more about FICO at www.fico.com.