PEEK A BOO: UNCLE SAM SEES YOU!

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Peek a Boo: Uncle Sam Sees You!

- Data Analytics – What can the Government see?
- What does your data say?
- What can you do to be prepared?
PRESENTATION OVERVIEW

• The Current State of Data Analytics
• Overview of OIG Work Plan
  – How the Government Uses Data Analytics
• Proactive Use of Data Analytics
• Implications on the Compliance Program
• Implications on FCA related issues

ACA COMPLIANCE MANDATE

• ACA requires, as a condition of participation, providers and suppliers to establish and maintain satisfactory compliance programs
• Secretary of HHS to determine timeline and required compliance program elements for specific types of providers and suppliers
• Implementation date still to be determined
7 ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

1. Implementing written policies, procedures and standards of conduct.
2. Designating a compliance officer and compliance committee.
3. Conducting effective training and education.
4. Developing effective lines of communication.
5. Conducting internal monitoring and auditing.
7. Responding promptly to detected offenses and undertaking corrective action.

OPENING DISCUSSION

Interviewed Current/Past Government Enforcement Individuals:

- Data analytics has changed the way they do their jobs
- Increased productivity
- Improved morale
- Increased collaboration
- Improved ability to find fraud, waste and abuse
OPENING DISCUSSION

Paradigm Shift

• Pay and Chase ----------> Prevent and Detect
• ‘One Size Fits All’ ----------> Risk-based Approach
• Legacy Processes ----------> Innovation
• Government-centric ----------> Engaged Public & Private Partners

NEW INVESTIGATIVE AND ENFORCEMENT STRATEGIES

“Twin-Pillar” Approach

• Fraud Prevention System (“FPS”)
  • Utilizes three data analytic strategies:
    1. Anomaly detection models
    2. Predictive models
    3. Social network analysis
• Automated provider screening program
  • Identifies ineligible providers or suppliers before they are enrolled or revalidated by using enhanced screening procedures
THE FRAUD PREVENTION SYSTEM

“The Fraud Prevention System (FPS) is the state-of-the-art predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA). Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment.”

“For the first time in the history of the program, CMS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis as part of its comprehensive program integrity strategy.”

Report to Congress: Fraud Prevention System, Second Implementation Year 2014

THE FRAUD PREVENTION SYSTEM

“In the second implementation year, which aligned with Fiscal Year 2013, CMS took administrative action against 938 providers and suppliers due to the FPS.”

“The identified savings, certified by the OIG, associated with these prevention and detection actions due to FPS was $210.7 million, almost double the amount identified during the first year of the program. This resulted in more than a $5 to $1 return on investment, an increase from last year’s $3 to $1 return.”

Report to Congress: Fraud Prevention System, Second Implementation Year 2014
HEALTHCARE FRAUD PREVENTION PARTNERSHIP

“Data collected and shared across payers can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, and potentially uncover schemes or bad actors they could not otherwise identify using only their own information. Such collaboration is the purpose of the Healthcare Fraud Prevention Partnership (HFPP) which brings together both public and private, federal and state-level individuals and organizations combatting health care fraud across all payers.”

The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013

MEDICARE PROVIDER UTILIZATION AND PAYMENT DATA

“As part of the Obama Administration’s efforts to make our healthcare system more transparent, affordable, and accountable, the Centers for Medicare & Medicaid Services (CMS) has prepared a public data set, the Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use File (Physician and Other Supplier PUF), with information on services and procedures provided to Medicare beneficiaries by physicians and other healthcare professionals.”

“The data in the Physician and Other Supplier PUF covers calendar year 2012 and contains 100% final-action physician/supplier Part B non-institutional line items for the Medicare fee-for-service population.”

CMS.gov
OPEN PAYMENTS

“The Social Security Act requires CMS to collect information from applicable manufactures and group purchasing organizations (GPOs) in order to report information about their financial relationships with physicians and hospitals. Open Payments is the federally run program that collects the information about these financial relationships and makes it available to [the public].”

CMS.gov

EVIDENCE OF MOMENTUM

“In 2013, more than 100 bills designed to combat Medicaid fraud and abuse were introduced in state legislatures in at least 23 states, according to the National Conference of State Legislatures, and at least 35 of them became law.”

“At least 10 states — Arizona, Arkansas, Florida, Illinois, Kansas, Michigan, New Jersey, New York, Texas and Utah — have passed laws creating Medicaid inspectors general, according to NCSL.”

“Arkansas, Virginia and West Virginia plan to participate in an all-payer claims database, which collects and analyzes data from all health insurance claims and can be used to spot suspicious trends in Medicaid claims.”

Arkansas SMP Newsletter April – June 2014
EVIDENCE OF MOMENTUM

“Arkansas, Colorado, Massachusetts, Texas and Washington have enacted, and several other states are considering, new laws calling for investment in so-called “predictive modeling” software similar to what credit card companies use to reveal patterns of illegal activity, according to NCSL.”

“The Affordable Care Act requires states to stop payments to Medicaid providers when there is “credible evidence” of fraud, and mandates tighter screening of providers seeking Medicaid reimbursement. The law also requires all states – even those not expanding Medicaid – to set up Recovery Audit Contractor programs to spot overpayments and recoup the money”.

Arkansas SMP Newsletter April – June 2014

NEXT GENERATION DESKTOP

“The Next Generation Desktop (NGD) was developed to provide single access point that interacts with all Medicare claims processing systems and multiple other government data sources. NGD has been adapted for law enforcement purposes, providing investigators the ability to examine all claims associated with a specific provider tax ID or a Medicare beneficiary.”

“CMS and NGS developed tailored training material for law enforcement partners and have conducted several 3-day training sessions in FY 2013. CMS trained 100 individuals in FY 2013.”

The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013
THE COMMAND CENTER

“CMS opened its state-of-the-art Command Center on July 31, 2012...”

“CMS is using the Center to collaborate in unprecedented ways with the private sector, law enforcement, and our State partners. The Center’s advanced technologies and collaborative environment allow multi-disciplinary teams of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. These collaborative activities enable CMS to take administrative actions, such as revocations of Medicare billing privileges and payment suspensions, more quickly and efficiently.”

The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013

ONE PROGRAM INTEGRITY

“In FY 2013, CMS continued making improvements and changes to One Program Integrity (One PI), CMS’ centralized portal that provides CMS contractors and law enforcement with a single access point to Medicare data as well as analytic tools to review the data.”

One PI users have access to the CMS Integrated Data Repository (IDR) to perform data analytics. The IDR contains a comprehensive and accurate set of Medicare provider, beneficiary and claims data from Medicare Parts A, B, and D back to January 2006.”

“With claims available from 2006, ZPICs will also be able to improve their analytics for post-payment detection of fraud, waste, and abuse.”

The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013
NEW INVESTIGATIVE AND ENFORCEMENT STRATEGIES

- No whistleblower, less reliance on traditional investigative techniques
- Using data mining, the Government detected a spike in the number of patients that Dr. Roy certified for home health care services.
- HHS IG Levinson: “In this case, our analysts discovered that in 2010, while 99% of physicians who certified patients for home health signed off on 104 or fewer people – Dr. Roy certified more than 5,000.”

HOW THE GOVERNMENT USES DATA ANALYTICS

• Overview of OIG Work Plan
• Law Enforcement
  » Using data analytics to identify potential issues for law enforcement consideration
  » Discussion around data accuracy (validation or lack of validation of this data)
  » Extrapolation and sentencing
• Recent Government Actions and Investigations
EXAMPLE DATA ANALYSIS OF CMS OPPS DATA
TEXAS: OUTPATIENT HOSPITALS

Identification of Potential E&M Up-Coding
Distribution of E&M Codes Billed by Texas Hospitals

Identification of Potentially Abnormal Billing Patterns
Outpatient Therapy: CPT 97530
EXAMPLE DATA ANALYSIS OF CMS OPPS DATA
TEXAS: OUTPATIENT HOSPITALS

Identification of Potentially Abnormal Billing Patterns
Diagnostic Sleep Tests: CPT 95810 & 95811

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<th>Hospital</th>
<th>Billing Amount</th>
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<tr>
<td>A</td>
<td>252.75</td>
</tr>
<tr>
<td>B</td>
<td>243.50</td>
</tr>
<tr>
<td>C</td>
<td>164.08</td>
</tr>
<tr>
<td>D</td>
<td>122.08</td>
</tr>
<tr>
<td>E</td>
<td>130.25</td>
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TX Average: 26.43

SAMPLE DATA ANALYTICS FROM ENFORCEMENT REPORT

Table 1. Overall Provider Summary

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<th>COL1</th>
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<tbody>
<tr>
<td>Provider Name</td>
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<td>429</td>
</tr>
<tr>
<td>Number of Claims</td>
<td>264</td>
</tr>
<tr>
<td>billed Amount</td>
<td>$2,148,577</td>
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<tr>
<td>Allowed Amount</td>
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<tr>
<td>Paid Amount</td>
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<tr>
<td>billed Services</td>
<td>2,076</td>
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<tr>
<td>Allowed Services</td>
<td>2,068</td>
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<tr>
<td>Dental Services</td>
<td>75</td>
</tr>
<tr>
<td>Proc Code</td>
<td>Description</td>
</tr>
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<td>-----------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>91170</td>
<td>RECTAL SENSATION, TONE, AND COMPLIANCE TEST (DE, RESPONSE TO GRADED BALLOON DISTENTION)</td>
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<tr>
<td>51194</td>
<td>ELECTROMYOGRAPHY STUDIES (EMG) OF ANAL OR URETHRAL SPHINCTER, OTHER THAN NEEDLE, ANY TECHNIQUE.</td>
</tr>
<tr>
<td>95010</td>
<td>PREGNANT ANUS TESTS (SCRATCH, PUNCTURE, PEECH), SEQUENTIAL AND INCREMENTAL WITH DRUGS, BIOLOGICALS OR VENTOS, IMMEDIATE TYPE REACTION, INCLUDING TEST INTERPRETATION AND REPORT BY A PHYSICIAN. SPECIFIC NUMBER OF TESTS</td>
</tr>
<tr>
<td>83181</td>
<td>ECHO-DOPPLER, TRAVATHORACIC, REAL TIME WITH DOPPLER DOCUMENTATION (DD), INCLUDES MUSCULAR RECORDING, APPLIED TO PERFORMED, COMPLETE, WITH SPECIFIC DOPPLER ECHO CARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHO CARDIOGRAPHY</td>
</tr>
<tr>
<td>92090</td>
<td>OFFICE OUTJ NEW AD SIN</td>
</tr>
<tr>
<td>93924</td>
<td>NCV AS PHYSIOLOGIC STD LTER ART COMPL</td>
</tr>
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<td>93997</td>
<td>DOPPLER SCAN OF EXTREMITY VEINS INCLUDING RESPONSE TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY</td>
</tr>
<tr>
<td>57057</td>
<td>UL TRASOUND, ABDOMINAL REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE</td>
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<td>93865</td>
<td>DOPPLER SCAN OF EXTRACRANIAL ARTERIES, UNILATERAL OR LIMITED STUDY</td>
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<td>PULMONARY STRESS TESTING, SIMPLE (5 TO 6 MINUTE WALK TEST, PROLONGED EXERCISE TEST FOR BUNCHOPHARM WITH PRE- AND POST SPHYROMETER AND EXERCISE)</td>
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OIG WORK PLAN: OVERVIEW

- OIG assesses relative risks in programs, identifies “hot spots,” and allocates resources accordingly

- OIG Work Plan is a manifestation of this:
  - Outlines OIG’s current focus
  - States primary objectives of each project
  - Provides useful guidance for health care companies
OIG WORK PLAN: MEDICARE PART A AND PART B

- Hospitals
  - Inpatient and Outpatient Payments to Acute Care Hospitals
  - Inpatient Outlier Payments: Trends and Hospital Characteristics
  - Admissions with Conditions Coded Present on Admission

- Nursing homes
  - Questionable Billing Patterns for Part B Services During Nursing Home Stays

OIG WORK PLAN: MEDICARE PART A AND PART B

- Hospices
  - Marketing Practices and Financial Relationships with Nursing Facilities
  - General Inpatient Care

- Medical Equipment and Supplies
  - Diabetes Testing Supplies
    - Potential Questionable Billing for Test Strips in 2011
    - Improper Supplier Billing for Test Strips in Competitive Bidding Areas
- Other Providers and Suppliers
  - Program Integrity
    - High Cumulative Part B Payments
    - Medical Review of Part A and Part B Claims Submitted by Top Error-Prone Providers
  - Ambulances: Compliance with Medical Necessity and Level-of-Transport Requirements
  - Ophthalmological Services: Questionable Billing
  - Electrodiagnostic Testing: Questionable Billing

- Other Providers and Suppliers (cont.)
  - Plan B Imaging Services: Payments for Practice Expenses
  - Laboratory tests: Billing Characteristics and Questionable Billing in 2010
  - Evaluation and Management Services: Potentially Inappropriate Payments in 2010
  - Sleep Testing: Appropriateness of Medicare Payments for Polysomnography
OIG WORK PLAN:  
MEDICARE PART A AND PART B

- Prescription Drugs
  - Payments for Multiuse Vials of Herceptin
  - Payments for Outpatient Drugs and Administration of the Drugs
- Recovery Audit Contractors: Identification and Recoupment of Improper and Potentially Fraudulent Payments

OIG WORK PLAN:  
MEDICARE PART D

- Drug Payments: Characteristics Associated With Atypically High Billing
- Drug Payments: Questionable Claims for HIV Drugs
- Coverage Gap: Quality of Sponsor Data Used in Calculating Coverage-Gap Discounts
- Reconciliation of Payments to Sponsors: Discrepancies Between Negotiated and Actual Rebates
OIG WORK PLAN: MEDICAID

- Patient Safety and Quality of Care: Claims For and Use of Atypical Antipsychotic Drugs Prescribed to Children
- Dental Services for Children—Billing Patterns in Five States
- Early Review of the Transformed Medicaid Statistical Information System Pilot Project

PROACTIVE USE OF DATA ANALYTICS

Implications on the Compliance Program and Risks to the Organization
- Could lead to a more robust Compliance Program
- Could lead to the discovery of certain gaps that require Self-Disclosure
- Place resources where needed
- Mitigate real risks rather than perceived risks
PROACTIVE USE OF DATA ANALYTICS

What can and should organizations do?

- Define the scope of the review in detail before beginning the analysis, with full consideration of the government’s focus in that area
- Utilize all available data to perform the analysis
  - Clinical data
  - Billing data
  - Contract terms
- Use the results to develop a plan of action to mitigate future risk

Consider the following:

• What are your most utilized codes?
• Who are your highest paid providers?
• Who utilizes the highest and lowest E&M codes?
• Who receives reimbursement from potential referral sources?
• Who is responsible for denials?

Do you know the answers to the above questions?

Can you evidence why they are not problematic?

- Any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval is liable to the United States Government.

- “Knowingly” means that a person, with respect to information –
  1. has actual knowledge of the information;
  2. acts in deliberate ignorance of the truth or falsity of the information; or
  3. acts in reckless disregard of the truth or falsity of the information

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THANK YOU