Using Data to Identify Fraud, Waste and Abuse Risks

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Objectives

- Define fraud, waste and abuse and understand common fraud schemes
- Discuss methods and tools to obtain and analyze data
- Identify aberrant utilization patterns: a case study in understanding the data
- Discuss the need to improve compliance with Medicare documentation, coding, and billing regulations to reduce audit risks
Fraud, Waste, Abuse Defined

- **Fraud** - deliberate deceit, trickery, or breach of confidence, perpetrated for profit or to gain some unfair or dishonest advantage. An intentional falsification of information.

- **Waste** - the over-utilization or inappropriate utilization of services and misuse of resources.

- **Abuse** - practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care and health care coding.
Common Fraud Schemes

- Using unlicensed individuals
- Billing for unnecessary services
- Upcoding or Unbundling
- Altering documentation
- Billing for services when recipients are deceased
- Billing for services never performed
- Replacing name brands for generic drugs
- Billing scooters for wheelchairs
- Giving “kickbacks”
- Changing diagnosis to bill higher procedure code or justify unnecessary tests or services
Clues of Possible Fraud

• Patterns of billing known fraud schemes
• Unusual practice patterns for specialty or area of practice
• No physician visits but other services
• Dramatic increases in billing from year to year
• That which looks out of place; anomalies
Tools for Data Analysis

• Excel
• Access
• Business intelligence platforms
• Analytic program such as SAS or SPSS
• Specialized fraud detection system
Value of Data Analytic Tools

• Why use an analytical tool?
  – Empower data analyst
  – Improve consistency of data
  – Enhances decision making

• What can be done using these tools?
  – Query, reporting, and analysis
  – Advanced analysis
  – Standardized or ad hoc reporting
  – Create effective graphs or charts
Questions Prior to Analysis

• How did the provider come to your attention?
• What are the concerns?
• When and where were the services performed?
• Who is the provider; what do we know about them?
• Who works for the provider? Are they licensed?
• Does the provider have a criminal history?
• Has the provider been educated previously and for what?
• Are there board complaints, investigations, disciplinary or sanctions?
• Who is the peer group?
Data Analysis

• Compile and analyze claims or billing data
• Assess practice patterns
  – Identify billing practices
  – Compare patterns to appropriate peer group
  – Compare to validated benchmarks if possible
• Identify outliers
  – Identify aberrant billing practices
  – Identify potential over- or under-utilization
  – Review sample of claims to understand practice patterns
  – Identify need for further analysis
• Drill down on individual provider(s)
Case Study
Results of Analysis

Billed for 853 patients in 6 months
  – 14,106 procedure codes

Total Paid – $336,171.38
  – Medicaid Paid - $ 181,320.87
  – Medicare Paid - $ 154,850.51
## Results of Analysis

<table>
<thead>
<tr>
<th>Data Analysis Per 853 Patients</th>
<th>Performed</th>
<th>Average per Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Services billed</td>
<td>14,106</td>
<td>16.54</td>
</tr>
<tr>
<td>Outpatient (OP) Visits</td>
<td>3,412</td>
<td>4.00</td>
</tr>
<tr>
<td>High Level OP Visits</td>
<td>1,475</td>
<td>1.73</td>
</tr>
<tr>
<td>Lab Services</td>
<td>6,826</td>
<td>8.00</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>2,393</td>
<td>2.81</td>
</tr>
</tbody>
</table>
## Results of Analysis

<table>
<thead>
<tr>
<th>Data Analysis Top Paid Procedures</th>
<th>Performed</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214 OP Visits, Established</td>
<td>1470</td>
<td>$44,426</td>
</tr>
<tr>
<td>99213 OP Visits, Established</td>
<td>1011</td>
<td>$31,446</td>
</tr>
<tr>
<td>87804 Influenza Assay with Optic</td>
<td>802</td>
<td>$7,938</td>
</tr>
<tr>
<td>85025 Automated Hemogram</td>
<td>730</td>
<td>$4,174</td>
</tr>
<tr>
<td>87430 Step A AG, EIA</td>
<td>614</td>
<td>$8,425</td>
</tr>
</tbody>
</table>
Results of Analysis

Top Paid Procedure Codes
Results of Analysis

Outpatient Office Visits

- DI Paid Amt
- DI Billed Quantity Amt
Results of Analysis

Diagnostics & Labs Paid

[Chart showing data on diagnostics and labs paid over time, with specific codes and amounts indicated.]
## Peer Comparison

<table>
<thead>
<tr>
<th>Profile Analysis Criteria</th>
<th>PR/PG Ratio</th>
<th>PR Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Services Per Patient</td>
<td>3.83</td>
<td>5.96</td>
</tr>
<tr>
<td>Avg OP Visit/Pt with Visit</td>
<td>4.06</td>
<td>1.66</td>
</tr>
<tr>
<td>Pct High Level Est OP Visit</td>
<td>3.86</td>
<td>27.8%</td>
</tr>
<tr>
<td>Pct Patients with Lab Services</td>
<td>2.71</td>
<td>63.6%</td>
</tr>
</tbody>
</table>
# Peer Comparison

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</tr>
</thead>
<tbody>
<tr>
<td>Avg Diagnostics/Pt with Services</td>
<td>6.38</td>
<td>4.64</td>
</tr>
<tr>
<td>Pct Patients with Injections</td>
<td>1.80</td>
<td>7.53%</td>
</tr>
<tr>
<td>Pct Inter Level New OP Visit</td>
<td>1.80</td>
<td>100%</td>
</tr>
<tr>
<td>Pct Patients with POS 2 Visits</td>
<td>7.0</td>
<td>0.14%</td>
</tr>
</tbody>
</table>
## Peer Comparison

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</tr>
</thead>
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<tr>
<td>Pct Patients with Antibiotic Inj</td>
<td>2.98</td>
<td>6.41%</td>
</tr>
<tr>
<td>Pct Patients with Routine Echo</td>
<td>1.37</td>
<td>2.93%</td>
</tr>
<tr>
<td>Pct Patients with Evoked Auditory Test</td>
<td>4.62</td>
<td>2.63%</td>
</tr>
<tr>
<td>Pct Services with modifier 59</td>
<td>3.41</td>
<td>1.98%</td>
</tr>
</tbody>
</table>
Record Review Findings

• No documentation submitted for the billed date of service
• All required components of health screening not performed but billed
• Lab handling charge not appropriate
• No modifier to indicate PA/NP performed service
Record Review Findings

• Documentation does not:
  – Support the level of E/M code selected
  – Include sufficient pertinent history or physical examination findings to support the medical necessity for the service billed
  – Support the service billed
  – Support a follow-up medical visit
  – Include test result
  – Meet vaccine documentation requirements
Comparison Data Sources


- [http://hcupnet.ahrq.gov/](http://hcupnet.ahrq.gov/)


- [http://www.mgma.com/Store/ProductDetailsaspx?id=38994](http://www.mgma.com/Store/ProductDetailsaspx?id=38994)
Documentation Risk

• As you document, consider the risks!
• Malpractice Risk
• Profiling Risk
• Audit Risk
• P4P/VBP
Audit Risk - Documentation

MD Documentation

Medical Records/billing

Coding translation

Severity
Audit Risk - Documentation

MD Documentation

Medical Records/billing

Coding translation

Severity
Audit Risk - Documentation

Severity

MD Documentation

Medical Records/billing

Acuity/Profile Loss

$$ Lost/Fraud Risk

Coding translation
Profiling Risk

• Profiling Risk
  – Public data
  – Government agency audits; Insurer audits

• Pay-for-Performance/Value Based Purchasing
  – Hospital/Physician Profiles are being utilized to determine those eligible for favorable treatment under emerging pay-for-performance methods

• Negligence
  – Insurability
  – Tort

• Typical Clinical Outcome Data
  – Mortality Rate – aggregate mortality data is highly impacted by correct documentation and coding
• Physicians: CPT-4 is based on work performed and DOCUMENTED using Evaluation & Management (E&M) codes
• Signs and symptoms are fine to use as an admitting or discharge diagnosis
• Adjectives can not be coded as a part of the diagnosis
Issue

• Inpatient: ICD-9 is based on diagnosis/presumed diagnosis (clinical impression), goes to a Diagnosis Related Group (MS-DRG), paid on average resources consumed

• Signs or symptoms as a DISCHARGE diagnosis have very low impact on severity profiles and these admissions are often declared to not be medically necessary

• Adjectives ARE codable
The Issue – Two Systems

• 2 systems (E&M vs. MS-DRG) with 2 sets of rules, but only 1 set of documentation

• Probable/Suspect/Clinical/Likely (Not R/O)
Coders Cannot

• Infer a Diagnosis, procedure or linkage
• Assume something was done
• Assume a Comorbid Condition/Complication (CC) is present
• Code anything that treating physicians don’t specifically write down!
• Core measures – most must be documented by the physician to count
ICD-9-CM vs ICD-10-CM/PCS

• Differences between the ICD-10 and the ICD-9 code sets are primarily in the overall number of codes, their organization and structure, code composition, and level of detail

• ICD-10-CM has about 70,000 diagnosis codes vs. about 14,000 ICD-9-CM diagnosis codes

• ICD-10-PCS has about 70,000 procedure codes vs. about 4,000 ICD-9-CM procedure codes
Comparative Performance

Expected
• Cost
• LOS
• Mortality
• Outcomes

Less Known
• Profiles like CMI
• DRG driven
Birthing a DRG

• Principal Diagnosis—must clearly state was present on admission (POA)!
• Determination can be made at any time during the hospitalization
• Procedure
• “CC” - Comorbid Condition/Complication
If not present on admission, what is it?

• Now becomes a “hospital acquired condition”, which may be coded as a complication

• So doctor, was it likely present on admission?
Some Resources

• Benchmarking (All based on Medicare data!)
  – HealthGrades.com
  – Hospitalcompare.hhs.gov
  – Medicare.gov/find-a-doctor
  – Dartmouthatlas.org
Audit Risk

- Upcoding
- Billing w/o Supporting Documentation
- Fraud!
Questions?
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