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## Medicare Fraud

### *A Proactive Approach*

*By: Ward Keever, CTG HealthCare Solutions Executive Director of Executive Services and John Dooley, CTG HealthCare Solutions, Director, Strategic Services*

Several of you have asked on occasion how I pick topics for these *Insights* newsletters. You probably asked because the range of topics is wide enough that there does not seem to be any rhyme or reason or a common theme. But you would be wrong. My common theme is to pick topics that I believe will inspire, inform, and sometimes educate you in your role as a healthcare CIO. How's that for defining a big enough "tent" to cover almost anything?

Well, this month I want to offer a few thoughts on a topic that could be very educational. And, perhaps more important, this *Insights* may inspire you to take a preemptive action that could eliminate a lot of trouble for your organization. I want to discuss Medicare fraud, waste, and abuse.

#### **The past**

For several years, HCFA would audit healthcare providers, mostly academic health systems; find that Medicare had been overcharged; and assess a fine. The organization would grudgingly pay the fine, viewing it as a cost of doing business with HCFA. No one was identified as a criminal, no one was taken to court, and, most assuredly, no one was put in jail.

However, in recent years, this situation has changed dramatically. The Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1998 strengthened efforts to monitor and prevent fraud and abuse in the Medicare and Medicaid programs. The question is no longer *whether* your health system will ever be subject to such an audit, but rather, *when*. And the legal implications could include criminal arrests.

#### **The present**

According to an independent study by Thomson Reuters issued October 26, 2009, the U.S. healthcare system wastes \$505 billion, perhaps as much as \$805 billion, every year. That is one-third of our total healthcare costs. The study attributes most of the waste to unnecessary care, such as overuse of medications and diagnostic tests.

The next largest category of waste is healthcare fraud, which according to the report costs \$125–175 billion each year and includes everything from fraudulent



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Medicare claims to kickbacks for referrals for unnecessary services. That is a very big target. Or stated another way, your organization is a very big target.

### ***Truth and consequences***

To take aim at this target, the federal government (CMS) conducted a three-year pilot project in New York, California, Florida, Arizona, South Carolina, and Maine. The project utilized recovery audit contractors (RACs) who identified \$1 billion of improper payments from Medicare Parts A and B. As a result, CMS determined the program was effective (i.e. lucrative) and mandated that all states fully implement RACs no later than 2010. Every state will assign RACs to specific geographical areas. The RACs will be reimbursed based on results—a percentage of the findings.

Every healthcare provider will be subject to an audit of its bills for the past three years, back to October 1, 2007. As you might expect, RACs will target claims with a high likelihood of impropriety such as a) incorrectly coded services, b) medically unnecessary services, and c) insufficient documentation related to the billed service.

On January 12<sup>th</sup> of this year the Department of Health & Human Services announced the expansion of RAC operations in Brooklyn, Tampa, and Baton Rouge. This is in addition to programs already operating in Miami, Los Angeles, Detroit, and Houston. So far indictments have been obtained for more than 460 individuals and organizations that have collectively falsely billed the Medicare program for more than \$1 billion, according to the release.

A few examples:

- According to a press release dated January 7, 2010, a hospital in Texas has agreed to pay \$990,509.50 to resolve allegations it violated the civil False Claims Act by submitting improper claims to Medicare for pulmonology-related items and services.
- In a press release dated December 3, 2009, a New Jersey hospital will pay the federal government \$3 million to settle a suit alleging Medicare fraud.
- A press release dated August 6, 2009, stated that the CEO of a California hospital was arrested and jailed for alleged Medicare fraud.

### ***Your future: be prepared***

In a previous newsletter, I quoted Louis Pasteur, saying that “Chance favors the prepared mind.” Here’s your opportunity to take the initiative and prepare your organization for that anticipated RAC inquiry by doing the following:

1. Designate a RAC team that will be responsible for all internal and external RAC inquiries
2. Review and revise admission and continued coverage requirements PRN
3. Ensure patients receive medically necessary services and validate that such services occurred



By 'connecting the dots' among different types of information, ontological models can identify erroneous coding that may otherwise not be identified.

- 4. Ensure all technical, certification, and recertification requirements are met prior to claim submission
- 5. Ensure all claims are coded correctly
- 6. Understand the well-defined appeal process and evaluate the appropriateness of any subsequent appeal following the RAC audit

An effective RAC initiative will include both perspective reviews prior to claims submission as well as prospectively (look ahead) to monitor operations.

### A proactive approach

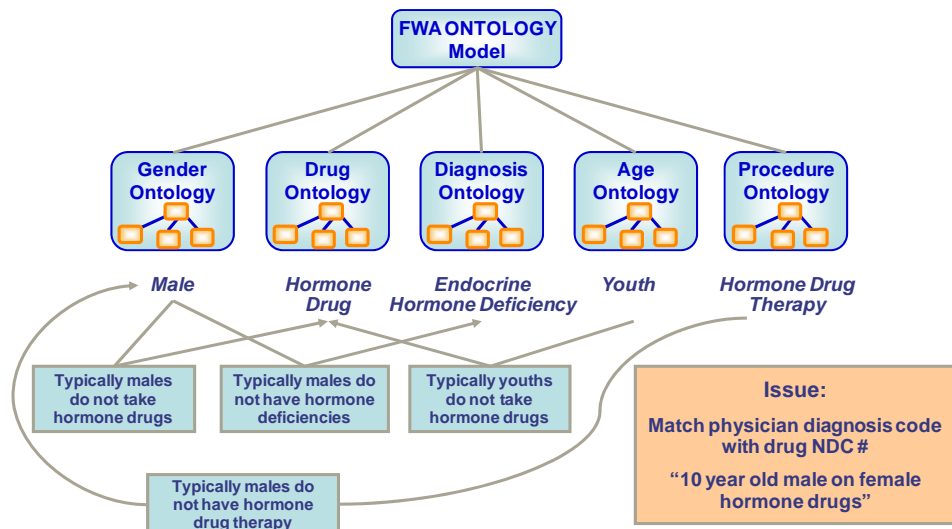
In addition to employing traditional approaches such as concentrating on a review of CPT and ICD-9 coding (with no true understanding of medical implications), it is important to understand that at the heart of a RAC audit is software that scans millions of claims looking for patterns, inappropriate services (e.g. mammograms on a male), erroneous and excessive drug prescriptions, etc. You may want to proactively deploy equivalent software and apply an ontological approach using data mining.

Say what??

Ontology is computer science that rigorously and exhaustively organizes a knowledge domain into a structure that is usually hierarchical and contains all the relevant entities and their relationships. By 'connecting the dots' among different types of information, ontological models can identify erroneous coding that may otherwise not be identified.

## Ontological Approach

### Encoding medical knowledge with ontology





*If a RAC finds the errors, it most likely will be a criminal offense and someone could go to jail—especially in 2010 as CMS is diligently looking for a few “poster children” to serve as examples.*

You may be thinking “Why do all this work?” “Why not just wait for the audit and respond to the RAC’s request for claims and related medical records?” Not a good idea—especially if you’re counting on some of the stimulus money to help pay for your new clinical systems as soon as you can show meaningful use. If you’re involved in a RAC audit and any red flags are raised, it’s not beyond belief that CMS may suspend the opportunity to receive stimulus funds.

If you take the initiative, find a problem, and alert CMS of the findings and your intention to take corrective actions (including reimbursement for the discovered errors), you are not considered criminally negligent and your organization will avoid criminal prosecution. If a RAC finds the errors, on the other hand, it most likely will be a criminal offense and someone could go to jail—especially in 2010 as CMS is diligently looking for a few “poster children” to serve as examples.

### ***Leveraging analytical tools to do the heavy lifting***

“Business analytics” is the buzzword of the day and certainly can be leveraged to manage and track fraud, waste, and abuse. Look beyond the rudimentary software tools available today for an exhaustive database that contains key clinical and laboratory values for functional tests associated with primary medical conditions. It should also take into account co-morbidities that could inhibit treatment or healing.

The technology should be very robust and comprehensive to effectively assess the complexity of all your claims—inpatient, outpatient, and physician. Regardless of what billing system(s) you have, the tool should be able to identify/target the following:

- Claims for suspended/excluded/unlicensed providers
- Duplicate claims submitted for payment as though they were different dates of service
- Unbundled, piecemeal, or fragmented claims for services already included in other claims
- Appropriateness/relationship, found by linking principal diagnosis codes in medical record (CPT, ICD-9, etc.) to billed claims
- Unnecessary procedures, found by matching patient conditions (diagnosis) to medical necessity criteria (rules) established by insurer
- Upcoding of diagnosis-related groups (DRGs) and/or diagnosis codes, adding false patient complexities (for example: stroke vs. TIA, excision vs. debridement, or incorrect discharge code for enhanced payment)
- Inappropriate match of physician diagnosis code with drug NDC number
- Mismatch between durable medical equipment (DME) ordering physician claims/visits and DME claims
- Overutilization/false claims, found by linking oxygen, diabetic supplies, etc. to diagnoses and clinical standards



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- Unbundled components of automated lab tests actually performed as a panel
- And more

### **More than just damage control**

The benefits of proactively leveraging analytic tools are many:

- Provides an over-arching, ontology-based knowledge repository that complements your other RAC initiatives as suggested above
- Interfaces with your existing systems
- Greatly improves efficiency of your compliance department, thereby reducing the work (and staffing needs) of this onerous task
- Identifies fraud patterns that would not be identified by review of individual claims
- Facilitates evidence collection and case building
- Significantly deters fraudulent activity and associated fines
- Reduces expenses related to unnecessary treatment
- Reduces interest, penalties, and over-extrapolations (by self-reporting to RAC)

The problem is real: you will be audited! However, it's possible to get ahead of the problem and take a very aggressive position that will undoubtedly benefit you and your organization. Remember, "Chance favors the prepared mind."

Analytic tools offer a very unique and critical component of your game plan.

*For more information on CTG's Compliance, Auditing, and Monitoring Solutions (CAMS), please contact Ward (302/379-4406), your CTG HealthCare Solutions Account Executive, or our Cincinnati headquarters at 888/564-0909.*

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