



SURVEIL Now

Relevant news for the busy PI professional.

Greetings from Health Information Designs, LLC We are pleased to bring you the January issue of SURVEIL Now, our newsletter for you - the program integrity (PI) professional.

You can now access news, reports, analysis, recommended links, the *SURVEIL Now* archive and other valuable tools on our blog at <http://surveilbyhid.blogspot.com>.

Medicaid Managed Care

In December 2011, the Office of the Inspector General (OIG) released “Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards,” a follow-on report to a CMS report released in 2000, “Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care.” The 2000 study outlined six areas of concern:

- Managed care contract procurement
- Marketing and enrollment
- Underutilization of services
- Claims submission and billing procedures
- Fee-for-service payments within managed care
- Embezzlement and theft

The 2011 report includes the following findings:

- All 46 Managed Care Entities (MCEs) in the sample reported taking steps to meet federal program integrity requirements
- All 13 states in the sample reported taking steps to oversee MCEs’ fraud and abuse safeguards
- Although MCEs and states are taking steps to address fraud and abuse in managed care, they remain concerned about their prevalence

Based on these findings, the OIG report provides two recommendations for CMS:

- Require that state contracts with MCEs include a method to verify with beneficiaries whether services billed by providers were received
- Update guidance to reflect concerns expressed by MCEs and states

Read the [OIG report](#).

DOJ Announces \$2.9B in Recoveries

On December 13, Deputy Attorney General James Cole announced in a Cabinet meeting with Vice President Biden that the Department of Justice (DOJ) recovered a record \$5.6 billion in total fraud in 2011—with health care fraud representing \$2.9 billion of this amount.

DOJ continues to increase recoveries on a state-by-state basis. Between 2008 and 2011, DOJ has doubled their fraud recoveries in 21 states and quadrupled their recoveries in 15 of the 21 states.

Read these [statistics](#) on the White House website.

The U.S. Department of Health and Human Services (HHS) also provides guidance to prescription drug plans to withhold payment on suspicious claims. Suspicious claims may be identified when doctor shopping is suspected for painkillers and narcotics, specifically Oxycontin and Percocet.

Read the [DOJ announcement](#) on the DOJ blog. Read the subsequent [news release](#) on the HHS website.

OIG Semi-Annual Report to Congress

The OIG has released their Semiannual Report to Congress for the time period April 1, 2011 through September 30, 2011.

OIG reports that their continued use of data mining, predictive analytics, trend evaluation, and modeling enabled them to better analyze and target the oversight of HHS programs and provide oversight of HHS programs. The use of these strategic measures positioned the Medicare Fraud Strike Force to be successful in filing charges against 70 individuals, obtaining 77 convictions, and establishing \$160.8 million in investigative receivables.

The semi-annual report also contains highlights of the work that HEAT and the Medicare Fraud Strike Force have completed. Download the [OIG Semiannual Report to Congress](#) as a single document.

CMS Expands Efforts to Fight Fraud

On December 13, CMS announced that a 167% increase has occurred in fraud recoveries since 2008. This increase has occurred as result of the partnership between HHS and DOJ, and through the following features of the Affordable Care Act:

- Tough New Rules and Sentences for Criminals
- New Resources to Fight Fraud
- Better Coordination across Government
- Sharing Data across Government
- Enhanced Penalties to Deter Fraud and Abuse
- Enhanced Screening and Other Enrollment Requirements
- Targeting High Risk Entities
- New Focus on Compliance and Prevention
- Raising the Bar on DME Suppliers through Expanded Competitive Bidding and Prior Authorization

To continue their vigilance in this area, CMS announced new steps to strengthen controls in identifying and preventing prescription drug fraud and abuse in the Medicare Part D program. Highlights of the announcement include:

- Investigate and Stop Payment for Suspect Claims
- Use Tools to Help Manage Proper Utilization of Drugs
- Limit Prescriptions to 30-Day Doses

Read the [CMS fact sheet](#).

Affordable Care Act - \$1.1 Billion Savings Potential

The CMS Innovation Center has announced that 32 health care organizations will participate in the new Pioneer Accountable Care Organizations (ACOs) initiative. This initiative begins January 1, 2012 as part of the Affordable Care Act, which encourages primary care doctors, specialists, hospitals, and other caregivers to provide better, more coordinated care for Medicare recipients. It is anticipated that this initiative could save up to \$1.1 billion over five years.

Medicare will reward ACOs based on their ability to both improve the health of their Medicare patients and lower their health care costs. The initiative will test the effectiveness of several innovative payment models and how they can help experienced organizations provide better care for recipients, work in coordination with private payers, and reduce Medicare cost growth. These payment models will allow organizations that are successful in achieving better care and lower cost growth to move from a payment system based on volume under the fee-for-service model, to one in which the ACO is paid based on the value of care it provides.

Read the [CMS Fact Sheet for the Pioneer ACO Model](#) and the [HHS press release](#).

A Medicaid Fraud Victim Speaks Out: What's Going Wrong and Why?

On December 7, Gary Cantrell, HHS Assistant Deputy Inspector General for Investigations, testified before the US House of Representatives Committee on Oversight & Government Reform; Subcommittee on Government Organization, Efficiency and Financial Management; and Subcommittee on Health Care, District of Columbia, Census and the National Archives.

Mr. Cantrell's testimony highlighted a qui tam case against Maxim Home Health that was identified by a former patient. The case led to the largest-ever recovery against a home health company. Mr. Cantrell also highlighted work with Medicaid Fraud Control Units that has led to significant monetary recoveries. Mr. Cantrell concluded his testimony with recommendations to improve Medicaid oversight – specifically, improving access to Medicaid data. [View the report](#).

Increased Transparency in Health Care

On December 14, CMS released a proposed rule to increase transparency in health care. The proposed rule would require:

- Manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the Children's Health Insurance Program to report to CMS payments or other transfers of value made to physicians and teaching hospitals.
- Manufacturers and group purchasing organizations (GPOs) to disclose physician ownership or investment interests to CMS.

CMS Deputy Administrator for Program Integrity Peter Budetti, M.D., stated, "When people are faced with the difficult task of choosing the right doctor, they need all the information they can gather. If your doctor is taking money from manufacturers of prescription drugs, suppliers of wheelchairs or other devices, you deserve to know about it. Disclosure of these relationships will discourage the inappropriate influence on clinical decision-making that sometimes occurs while still allowing legitimate partnerships."

Manufacturers and applicable GPOs will not be required to begin collecting data until after a final rule is published. CMS will accept comments on the proposed rule until Feb. 17, 2012.

[View the proposed rule](#).

OIG Report - Overprescribed: The Human and Taxpayer's Costs of Antipsychotics in Nursing Homes

On November 30, HHS Inspector General Daniel R. Levinson testified before the Senate Committee on Aging. IG Levinson reported that Medicare is paying for anti-psychotic drugs that it should not pay for and Part D prescription drug plans are not able to adequately prevent inappropriate payments for drugs.

The report findings include:

- Half of Medicare atypical antipsychotic drug claims for nursing home residents did not meet reimbursement criteria
- Antipsychotics are prescribed in violation of nursing home quality and safety standards
- The vast majority of antipsychotic drug use in nursing homes was off-label or against black box warning

The report recommends that CMS:

- Consider enhancing claims data to ensure accurate coverage and reimbursement determinations
- Hold nursing homes accountable for unnecessary drug use through the survey and certification process
- Explore other options, such as incentive programs and provider education, to promote compliance with quality and safety standards

View [IG Levinson's testimony](#).

2012 ICD-10-CM Code Updates Now Available from CMS

CMS has posted the 2012 ICD-10-CM code updates to the CMS website. The updates include the 2012 ICD-10-CM index and tabular, code titles, addendum, General Equivalence Mappings (GEMs), and reimbursement mapping files.

Download the [2012 ICD-10_CM and GEMs files](#) from the CMS website. Download the [2012 ICD-10-PCS \(procedure\) files](#) from the CMS website.

RAC Update

The following new RAC issues will be evaluated this quarter for three of the four regions:

- Region B – View the [issues from November 22](#).
- Region C – View the [issues from November 17](#).
- Region D – View the [issues from November 23](#) and the [issue from December 8](#).

The northeast has implemented 66 new medical necessity issues (view the [issues from November 23](#)) and one issue for professional services claims (view the [issue from December 8](#)).

Medicare Learning Network Articles

Each month we highlight fact sheets and articles that MLN has released since our last newsletter. The fact sheets and articles are focused on Medicare but contain many helpful ideas for researching your state Medicaid program to determine if a potential vulnerability may exist. (Click the fact sheet or article name to view the appropriate download page on the CMS website.)

- [Medicare Fraud & Abuse: Prevention, Detection, and Reporting](#)
- [Important Update Regarding 5010 Implementation – Action Needed Now](#)
- [Advance Payment Accountable Care Organization \(ACO\) Model](#)
- [How to Use the Searchable Medicare Physician Fee Schedule](#)
- [How to Use the Medicare Coverage Database](#)
- [How to Use the National Correct Coding Initiative \(NCCI\) Tools](#)

Helpful Website - FBI News Blog

The FBI maintains a blog site that provides current news and information related to their ongoing work. The “News by Subject” portion of the site is divided into the following subject areas:

TERRORISM • FOREIGN COUNTERINTELLIGENCE
CYBER PUBLIC CORRUPTION • CIVIL RIGHTS
ORGANIZED CRIME • WHITE-COLLAR CRIME
MAJOR THEFTS/VIOLENT CRIME

Each subject area contains hyperlinks to specific articles in descending date order. Of particular interest to PI professionals are the “Organized Crime” and “White-Collar Crime” areas, which often contain health care fraud related articles.

Read the [FBI News Blog](#).

OIG Reports

The OIG released the following reports related to vulnerable areas or enforcement action updates regarding health care fraud issues. (Click the report name to view the full report on the OIG website.)

- [\\$90 Million Medicare Fraud Scheme - Owners of Houston Mental Health Company and Assisted Living Facility Indicted](#)
- [\\$60 Million Health Care Fraud](#)
- [Philadelphia Pill Mill](#)
- [\\$40M – Miami Pill Mill](#)
- [\\$30M Health Care Fraud](#)
- [\\$25 Million Health Care Fraud – Miami-Area Patient Recruiter Pleads Guilty](#)
- [\\$23.5M Medtronic Fraud](#)

Discover It. Track It. Recover It.®

The new approach to fighting fraud.



Product Highlight

SURVEIL is a Web-based fraud detection and case management system. **SURVEIL** provides you with a multi-dimensional system that recognizes aberrant patterns and trends in payment data and allows you to drill down into the result set to further evaluate discrepancies.

SURVEIL empowers analysts to exercise broad-based fraud control by providing algorithms that analyze data at multiple levels—transaction, group practice, and multi-party. This analysis supports vigilance in identifying fraudulent schemes as they evolve, so that loopholes can be closed quickly.

Request a demo or additional information by contacting [Dan Olson](#), CFE, Director of Fraud Prevention.

Analysis - Identifying Pill Mills

The objective of this analysis is to identify providers who may be running a pill mill. The analysis evaluates a provider's prescribing practice to determine if there is an unnatural increase in the average number of prescriptions per month (RXs/ Month) a prescriber is paid.

Exception Criteria:

- Step 1 – Filter your query to include only pharmacy claims.
- Step 2 – Filter your query to include only controlled substances: DEA Code 2 – 5. Note: You may choose to filter on a specific therapeutic drug class code rather than all controlled substances.
- Step 3 – Calculate the “# of RXs” prescribed by prescriber based on the results achieved in Step 2.
- Step 4 – Calculate the “Average Number of RXs/ Month” for each prescriber.
- Step 5 – Produce a report by prescriber of the information captured in Step 4.


The results of this analysis may identify prescribers whose prescribing practices exhibit an unnatural increase in the average number of RXs/Month that are being prescribed. You may wish to filter your result outcomes by establishing one or more artificial thresholds. For example, you may only wish to identify prescribers who have prescribed more than 100 controlled substance prescriptions in a month.

Please contact [Dan Olson](#), CFE, Director of Fraud Prevention, at 601-850-3526 or dan.olson@hidinc.com for additional information.

Connect with our Fraud Informatics Team

At HID, we understand that you are busy! Our Fraud Informatics Team is committed to helping you make the most of your time. Connect with the FIT Team to stay up-to-date with news, reports, analysis and more:

 Blog: <http://surveilbyhid.blogspot.com>

 Facebook: [SURVEIL by HID](#)

 Twitter: [@SURVEIL](#)

 LinkedIn: [Health Care Fraud Prevention Group](#)

Fun Facts

- 52% of Americans drink coffee.
- The king of hearts is the only king without a mustache.
- Butterflies taste with their feet.

Learn More

Learn how **SURVEIL** can help you fight fraud. For more information, contact HID at 334-502-3262, surveil@hidinc.com, or visit the [HID website](#).



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