Medicare's Fraud and Abuse Program

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By Lucien W. Roberts

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The federal government is coming to a medical practice in your town soon - it might be yours. Amidst all the changes to the structure of modern healthcare, including ACOs, e-prescribing, EHR stimulus money, and meaningful use, the feds aggressively have stepped up their fraud and abuse efforts. Your practice may play by the rules, but that does not guarantee it will escape federal scrutiny.

The size of Medicare's fraud problem
Here's the core problem: we have some bad apples. Unethical DME suppliers, physicians, pharmacists, and others submit perhaps $60 billion in fraudulent claims to Medicare annually. That total represents more than 10 percent of total Medicare expenditures. A home improvement store could not survive if 10 of every 100 lawn mowers it bought were stolen; a clothing store that has 10 percent of its inventory disappear will go out of business. Medicare is doing what any prudent business would do - taking steps to prevent fraud so that it can control its costs. Medicare recovered $4 billion in fraudulent payments in 2010. That represents a healthy 56 percent increase over its 2009 take. Still, the $4 billion represents less than a tenth of suspected fraud payments, and Medicare, the Office of Inspector General (OIG), and Congress know it. The initial Recovery Audit Contractor (RAC) demonstration projects resulted in a net savings of $693.6 million to the Medicare trust funds. Further, the Department of Health and Human Services (where Medicare resides) has determined that for every $1 it invests in combating fraud, it gets $1.55 in return. Healthcare fraud policing has an excellent return on investment.

Alphabet-soup enforcement
In coming years, a new set of healthcare acronyms may become ominously familiar. RACs, ZPICs (Zone Program Integrity Contractors), MICs (Medicare Integrity Contractors), MACs (Medicare Administrative Contractors), QIOs (Quality Improvement Organizations), and PSCs (Program Safeguard Contractors) are all charged with monitoring and maintaining the integrity of the Medicare and Medicaid programs. As their names suggest, many of these programs are comprised of independent contractors hired by Medicare to detect fraud. The Patient Protection and Affordable Care Act of 2009 (often referred to as ObamaCare or ACA) includes an additional provision that sets aside $350 million in funding for these acronym entities to combat healthcare fraud. These entities differ from traditional Medicare enforcement in two critical ways:
1. Most of these contractors are paid on commission. The more fraud they find, the bigger their cut.
2. These contractors are using automated analytics and data mining. Patterns of claims and even individual claims are being scrutinized as never before.

Think about how quickly Google can do a search. Now consider how similar search techniques might be used to assess trends and anomalies in billing. If you order more MRIs than average or if you code 99214 more frequently than your peers, you might stand out. It is quite scary. One of the best things you can do to protect yourself is to make sure your documentation is solid.

In their brief history, the RACs have devoted most of their efforts to areas where their ROI is greatest: large ticket items such as hospitalizations and traditional areas of higher fraud activity such as DME. The principal tool of the RACs is post-payment reviews. However in the next five years, RACS will turn their focus to smaller targets - looking at physician billing and the medical necessity of tests ordered by physicians.

Complementing the work of the RACs, MICs will discover probable overpayments; PSCs and ZPICs will be charged with identifying suspected fraud; and QIOs will conduct medical necessity reviews. As you can see, there is much overlap between the casting nets of these entities, and I expect there will be unprecedented coordination of fraud and abuse detection and enforcement efforts.

Evidence-based defense
Evidence-based medicine is not a cure-all - the art of medicine will never be fully supplanted by the...
science of medicine - but it is clear that evidence-based medicine will become a yardstick in many of these enforcement efforts. In gauging appropriate care and medical necessity, these healthcare enforcers will use evidence-based standards to identify potential targets.

My advice? Document your thought processes and actions; your best protection remains good documentation. Understand how your coding patterns and utilization compare to others - you might unknowingly be an outlier. And finally, become a student of evidence-based standards in your field, and apply these standards to the care you provide. Practicing good medicine is nothing to be ashamed of, but going forward, you can expect that you will have to prove that the care you provide is, indeed, good medicine.

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