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Eli's Hospice Insider

Compliance: OIG Uses Data Mining To ID Fraud

Watchdog agency is intent on stopping fraud quickly with data analysis.

The OIG has its eye on you -- or at least its computers do.

The **HHS Office of Inspector General** wants to make clear that it has vast resources in its fight against fraud. "In the Office of Investigations, our primary mission is to investigate and detect fraud against HHS programs, primarily that relate to Medicare and Medicaid fraud," **Gary Cantrell**, the OIG's Deputy Inspector General for Investigations, said during a recent webcast, "OIG Outlook 2013." "Our greatest resource in that fight against fraud is our people. We have over 600 dedicated, resourceful men and women who are experts in this area of investigating fraud within HHS programs."

Data analytics is another resource that the office uses to find and fight fraud. "We identify where fraud hotspots exist geographically and then locate our resources to have the most impact with investigations," Cantrell said. "In a recent example in South Florida, we had a case where through the use of data, we were able to identify over $1.5 million that had been submitted to Medicare by a fraudulent provider within a month, and we were able to stop those payments and arrest four people."

The OIG makes the most of its investment in fraud fighting, Cantrell added. "For every dollar invested in the anti-fraud efforts, $7 is returned to the Medicare Trust Fund."

Don't Expect Advance Warning If The OIG Targets You

The OIG doesn't talk about its enforcement activities in advance because it doesn't plan them in advance, said **Larry Goldberg**, principal deputy inspector general, during the webcast. "The enforcement activities are a response to uncovering evidence of fraud," he noted. In addition, Goldberg added, the OIG doesn't discuss ongoing investigations because it doesn't want to compromise an investigation or make accusations that are still being researched.

Because the OIG's scope is so wide, the fraud-fighters have to narrow their vision to focus on the areas that will save the government the most money, Goldberg added. "Medicare and Medicaid serve one out of every four Americans," he said. "The Work Plan is written based on areas with the greatest potential for fraud, waste, and abuse, and the areas where the OIG can effectuate the most positive change."

Before the OIG launches an audit or a Work Plan item, it asks itself the following questions, Goldberg noted:

- How many program dollars are at risk?
- How many individuals are affected by this particular program?
- Is anyone's life or health or safety at risk?
- Are there concerns due to previous work done by the OIG or others?

The OIG asks for input from healthcare providers, law enforcement, Congress, and others to find out where priorities should be placed, and uses data analysis, agent information, information from other partners, identified vulnerabilities, and other data to narrow the view. The agency also uses data mining to identify "emerging fraud trends" and deploys resources accordingly, Goldberg added. (For information on 2013's hospice Work Plan topics, see Eli's Hospice Insider, Vol. 5, No. 11).

Definition: Although providers typically associate the term "improper payments" with anything fraudulent, the OIG has a different view. "An improper payment occurs any time the wrong person is paid the wrong amount for the wrong reason," **Gloria Jarmon**, Deputy Inspector General for Audit Services, said during the webcast. "In fiscal year 2011, the

estimated improper payments in the government accounted for $115.3 billion, and the HHS made up over half of that estimated amount, about $65 billion, most of which involved Medicare FFS and Medicaid," she added.

Because the Medicaid program is so large and complex, it is more vulnerable to fraud and abuse, Jarmon added. "Medicaid insures about 62 million low income individuals."