OIG Reports Increased Recoveries Due to Enhanced Data Analysis Capabilities

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On May 29, 2012, the Department of Health and Human Services Office of Inspector General ("OIG") announced recoveries of approximately $1.2 billion from the federal health care programs for the first six months of fiscal year 2012, according to the agency's *Semiannual Report to Congress* ("Report"). The bulk of the recoveries ($748 million) are attributable to 388 criminal and 164 civil actions concluded during this period.

In addition to the expected recoveries, OIG also reported excluding 1,264 individuals and entities from participating in federal health care programs over the first half of FY 2012.

The Report's findings follow a pattern of increased enforcement activity by OIG over the past several years to address health care fraud and abuse. Much of this increase is due to new government anti-fraud initiatives, such as the Recovery Audit Contractor ("RAC") program, and increased funding for fraud and abuse enforcement efforts. From 2006-2011, total funding to the federal Health Care Fraud and Abuse Control Program increased from approximately $240 million to $608 million.

The Report, however, sheds light on another key factor that has led to increased recoveries: data warehousing. "We are using advanced data analytics to help us conduct risk assessments; more effectively pinpoint our oversight efforts; and significantly reduce the time and resources required for audits, investigations, evaluations, and other program integrity activities," OIG Inspector General Daniel R. Levinson said in the Report's introduction.

Levinson said that, among other things, OIG's data warehouse has aided the agency's investigations as the "warehouse integrates data from Medicare Parts A, B, and D so we can develop a more comprehensive picture of beneficiaries' histories of medical care and providers' billing patterns." For example, OIG Chief Counsel Lewis Morris stated that "we can flag Part D prescription drug claims where there is not a related physician or hospital claim under Parts A or B, the absence of which suggests possible fraud."

According to Morris, "[p]rior to developing the warehouse, OIG analysts and auditors often waited months to access a data extract from Medicare's National Claims History." With the data warehouse, "data matches that used to take weeks or months to complete are now performed in-house in a matter of hours," Morris stated.

In the Report's introduction, Mr. Levinson noted that data warehousing has played a key role in OIG's new hospital compliance initiative during the first half of FY 2012. "Instead of narrowly

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focusing our audits on specific risk areas, we are now more quickly and efficiently analyzing a vast array of hospital data to simultaneously identify multiple compliance risks," Mr. Levinson stated.

The hospital compliance initiative referred to by Mr. Levinson pertains to a recent series of audits carried out by OIG pursuant to its *2012 Workplan* that has focused on 27 risk areas, including certain Medicare payments to hospitals for selected claims for inpatient and outpatient services. A review of the published audits shows that the types of claims OIG is reviewing in the compliance initiative include, but are not limited to, the following: (1) inpatient claims with payments greater than $150,000, (2) inpatient short stays, (3) inpatient claims billed with high severity level DRG codes; (4) same-day readmissions, and (5) outpatient claims with payments greater than $25,000.

OIG plans to carry out approximately 65 hospital compliance reviews. As stated by Mr. Morris in testimony before the Senate Committee on Homeland Security & Governmental Affairs, "two years ago, the data analytics for these audits would have taken weeks or months to execute…[n]ow it takes approximately twenty minutes to run the program for each hospital."