Identifying DME Fraud with our Accountable Care Organization Customer

Background

Our customer operating as an Accountable Care Organization (ACO), works in tandem with a clinically integrated network and oversees patient populations covered by eight distinct Medicare Advantage and Commercial plans. They coordinator care for more than 18,000 beneficiaries in the PA & NJ regions through the ACO Medicare Shared Savings Program (MSSP) and nearly 60,000 total members.

Situation

Ten durable medical equipment companies may have cost the Traditional Medicare system close to $2-3 billion in potentially fraudulent payments, though CMS has not yet confirmed this. As part of its participation on the Benchmarking Committee late in 2023, our customer was given a heads up of the potential fraud and began its research. Furthermore, the National Association of ACOs (NAACOS), as part of their advocacy for their ACOs, reached out to our customer in early February 2024 about research conducted by the Institute for Accountable Care, calculating individual ACO spending on urinary catheter billing codes (A4352 and A4353) in 2022 and 2023 to quantify an increase in billing. The customer's 2022 Catheter Payments showed as **$297,339**, whereas 2023's Catheter Payments reported an astounding **$2,166,189**, showing a **$1,868,851** difference and a **629%** increase in billing when comparing 2022 to 2023, as well as **17,732** Unique Beneficiaries in 2023.

This surge in claims data information prompted an investigation into potential Durable Medical Equipment (DME) Fraud. Our customer contacted CMS to address the heightened expenditure and was subsequently requested to provide additional information and data points. These included identifying provider/supplier names suspected of fraudulent activity, associated NPIs or Provider Transaction Access Numbers (PTANs) suspected of involvement, the timeframe in which the alleged fraudulent claims were made, a short description of the purported fraud and its detection methods such as Claim Type and CPT/HCPCS codes, as well as any available evidence detailing financial impact to their ACO, or a list of ACO assigned beneficiaries for whom claims were submitted by the fraudulent providers/suppliers.

Solution

Our customer reached out to The Garage seeking assistance in acquiring the information requested by CMS. The Garage promptly supplied the required information in a Data Warehouse (DW) and offered guidance on which data points to focus on when compiling a PowerBI dashboard and report to be submitted to CMS. Additionally, a Garage Senior Data Analyst conducted a peer

review of the SQL query developed by the client's data team, ensuring output accuracy with necessary corrections.

Outcomes

Leveraging the structured data availability provided through The Garage's data warehouse in addition to The Garage's Senior Data Analysts peer review conducted on the customer's Data Team's findings, the corroborative evidence provided indicating potential fraud flagged by the analyst. With only 2 months of runout, the customer determined a Potential Shared Savings Loss amounting to **$2.8M** to CMS and **$2.0M** in shared savings payments to themselves, over **25%** of projected total shared savings earned. Additionally, the customer is building out an entire suite of PowerBI visualizations to monitor for fraud monitoring and detection based on this experience that will be used in their processes in all their value-based contracts. The financial outcome remains to be seen. According to their CMS Coordinator, our customer has provided CMS with more detailed information than other ACOS. With this additional information, the customer is hopeful CMS will exclude these expenses in their final accounting.

"We are dedicated to delivering top-notch, efficient care to our community. However, the threat of losing $2.5 million due to undetected fraud by CMS jeopardizes our ability to provide additional shared savings crucial for enhancing and innovating new care programs to our primary care physicians. Our meticulous attention to detail in analyzing claims data at a patient level not only safeguards against fraud but also empowers us to furnish CMS with concrete examples for a potential expectation, reinforcing our commitment to exceptional care."

– Operations Manager

Interested in learning how The Garage can empower your organization?
Request more information **here**.