Office of the Inspector General
U.S. Department of Justice

OVERSIGHT ★ INTEGRITY ★ GUIDANCE

Procedural Reform Recommendation for the Federal Bureau of Prisons

Investigations Division 2016-008873

December 2017

SYNOPSIS

During the course of recent Office of the Inspector General (OIG) Office of Data Analytics efforts and investigative activity, we have learned that the Bureau of Prisons (BOP) has incomplete and inadequate healthcare claims data in electronic format and that its claims adjudication vendor has not provided all contractually required services, including fraud monitoring.

Incomplete claims data and ineffective analysis of that data significantly increases the BOP's fraud risks and diminishes both the BOP's and the OIG's ability to detect past and present fraud schemes. Improved data aggregation will ensure better oversight of BOP's health care contracts.

DETAILS

Background

In fiscal year 2016, the BOP spent approximately $1.1 billion on health care, $311 million of which it paid to outside health care providers. While the majority of inmate healthcare is provided within BOP institutions, the BOP also has Comprehensive Medical Services (CMS) contracts with private companies and hospitals to provide healthcare services outside of institutions such as surgeries, diagnostic procedures, and consultations with specialists. The estimated value of BOP's CMS contracts between 2011 and 2020 totals $1.2 billion.

On August 1, 2008, the BOP awarded a contract for third-party claims adjudication services to process and analyze electronic claims from CMS contractors. The primary purpose of medical claims adjudication for healthcare service providers/contractors paid under Medicare-based rate structures is to ensure compliance with the National Correct Coding Initiative (NCCI). The NCCI is an attempt to standardize medical coding conventions defined in the American Medical Association's Current Procedural Terminology manual and other national guidelines. The NCCI was developed by the Centers for Medicare and Medicaid Services, in part, to control improper Medicare claims based on inappropriate coding. Standardized coding guidelines are an essential tool to identify, evaluate, and enforce against potential health care fraud schemes. Third-party claims adjudication ensures the basic accuracy of claims information, verifies that claims are not being presented or paid more than once, and calculates local Medicare rate premiums under the CMS contracts.[1]

When the OIG recently sought electronic claims records from BOP as part of our data analytics efforts, we learned that, although BOP has had CMS contracts since 2008, as of February 2017, only 16 of BOP's 122 institutions were submitting electronic claims for processing by the claims adjudication vendor. The remaining 106 BOP institutions process CMS claims manually in a paper-driven process in which BOP staff review and verify claims amounts. BOP has paid the claims adjudication vendor approximately $13 million from the inception of the contract in 2008 through August 2017.

The revised 2016 adjudication contract statement of work section entitled "Fraud, Waste, and Abuse" states that the "contractor shall describe and submit surveillance programs for detection and tracking of deliberate fraud and abuse (i.e., billing for services not likely to have been furnished as billed, misrepresenting the diagnosis to justify payment, deliberate unbundling)." The Statement of Work also states that "when a pattern of fraud and

[1] In 2016, the OIG issued a report evaluating BOP's reimbursement rates for outside medical care. *The Federal Bureau of Prisons' Reimbursement Rates for Outside Medical Care* (Evaluation and Inspections Division 16-04, June 2016), https://oig.justice.gov/reports/2016/e1604.pdf#page=1. The OIG found that between fiscal years 2010 and 2014, BOP spending for outside medical services increased 24 percent. We also found that at the end of fiscal year 2014, all of the BOP's comprehensive medical services contracts paid a premium above Medicare rates for medical services, in part because the BOP is the only federal agency that pays for medical care not covered by statute or regulation under which the government sets the agency's reimbursement rates, usually at the Medicare rate.

abuse is identified, the BOP will be contacted immediately with a detailed report of the suspected issue." Similarly, the 2008 original contract specified that the contractor has an obligation to describe programs for detection of fraud and abuse. The OIG confirmed that the claims adjudication vendor has not provided any such fraud detection reports to the BOP since the contract originated in 2008.

To date, as part of its data analytics efforts, the OIG has collected data from the claims adjudication vendor related to 337,388 claims which resulted in $399 million in payments for the period 2008 to April 2017. The OIG has identified a number of potential fraudulent claims through an analysis of the available data. For example, the OIG identified one CMS-contracted psychiatrist who billed BOP for visiting an average of 24 inmates per day and who billed all of his new patient consultations with the Current Procedural Terminology (CPT) billing code 99204.[2] The 99204 CPT billing code for new patient encounters requires a comprehensive history, a comprehensive examination and at least moderately-complex medical decision making. According to CPT guidelines, if a patient encounter is billed as a 99204 based on time, the face-to-face session is expected to last at least 45 minutes. Thus, in order to see 24 inmates in a day, this CMS-contracted psychiatrist would have had to have seen inmate-patients for at least 18 hours that day.

The claims adjudication vendor recommended to BOP that it pay this psychiatrist $11,036.49 for as many as 61 psychiatric consultations in a single day. Of these 61 consultations, 19 were billed as new patient 99204 consultations, and 42 were billed as follow-up 99213 consultations. The 99213 CPT code is used for follow-up visits with established patients and these sessions are expected to last approximately 15 minutes. Thus, on a single day, the psychiatrist billed for approximately 24.75 hours of services if the billing approximated the expected amount of face-to-face time with the inmates. The OIG reviewed the psychiatrist's sign-in/sign-out logs and confirmed additional instances of suspicious billing. Between January 2013 and December 2015, the claims adjudication vendor approved this psychiatrist for $408,183.74 in payments by the BOP, and it never informed the BOP of this suspicious billing pattern despite contract language specifying surveillance and fraud detection requirements. Similar suspicious billing patterns are likely to go undetected without claims data monitoring and analysis. The OIG is currently reviewing this issue.

The adjudication contract also states that "as a condition of a contract, the contractor agrees the BOP owns all data generated by the medical claims adjudication process and the BOP will have access to the data," and that the "contractor shall also provide technical documentation regarding all data files and formats, as well as provide updated documentation as changes occur." The OIG found that, in response to our data request, the claims adjudication vendor was unable to provide all requisite claim-level data elements upon demand; we also identified several deficiencies in the claims data produced. For instance, of the records provided to the OIG, 99 percent contained no information about specific types of drugs prescribed, 34 percent contained no information about procedure codes billed, and 89 percent contained no information about diagnostic related groups (DRG). DRG's are commonly billed in hospital claims, which constitute a large segment of BOP's total health care spending through its CMS contracts. The claims adjudication vendor cited technical issues with its inability to reproduce complete claims data.

Many health care providers and insurers now use data analysis methods and/or algorithmic controls to detect anomalous and potentially fraudulent claims. For example, since 2011, the U.S. Department of Health and Human Services has identified $820 million in healthcare cost savings using data analytics, including advanced predictive analytics techniques. However, without electronic healthcare payments information, neither the BOP nor the OIG is able to use data analytics tools to detect potential billing fraud.

[2] CPT codes are published by the American Medical Association, adopted by the Centers for Medicare and Medicaid Services, and provide a numerical coding methodology to accurately communicate across many stakeholders, including patients, the medical, surgical, diagnostic, and therapeutic services provided by medical practitioners. CPT codes provide the most widely accepted medical nomenclature used to report medical procedures and services for processing claims, conducting research, evaluating healthcare utilization, and developing medical guidelines and other forms of healthcare documentation.

Issue Presented

BOP's health care claims continue to be processed primarily through manual methods because BOP has failed to transition all CMS contracts to electronic third-party adjudication and has failed to hold the vendor contractually accountable for producing claims data and maximizing the use of its fraud surveillance program as outlined in the Statement of Work.

The deficiencies with BOP's health care claims data limit BOP and other stakeholders' ability to identify and respond to potentially fraudulent billing schemes such as claims for services not rendered, duplicate claims, or inflated bills. The OIG has observed that the paper-based internal claims review process is extremely time-consuming for BOP staff and subject to human error. Moreover, because the vast majority of BOP's health care claims are processed by paper at each individual institution, billing activity cannot be analyzed in any meaningful way.

Additionally, BOP is unable to efficiently track the totality of inmate health care procedures and diagnoses across multiple institutions through time because only a select minority of institutions use the claims adjudication company, and that data is largely incomplete. Cross-agency medical claims data would more quickly and efficiently provide an inmate's history of medical procedures for BOP decision-makers.

Recommendations

The OIG recommends that BOP move immediately to require all CMS contractors to submit electronic claims, ensure those claims are properly analyzed and maintained by BOP's adjudication vendor, and enforce existing contract language that requires the adjudication vendor to perform fraud analytics and report any indicators of fraud to the BOP. The BOP should also ensure that the adjudication vendor is able to reproduce on demand all necessary data elements used to adjudicate the claims (e.g., DRG, all procedure codes, and drug information). The universe of claims data should be available to BOP on a national scale in a format that allows for thorough analysis and oversight regardless of institution.

While we recognize that these measures will likely require additional resources, the BOP is currently spending hundreds of millions of dollars on healthcare with what appears to be outdated and seemingly ineffective oversight. Based on the information that we have reviewed to date, taking the actions that we recommend will provide the BOP with substantial cost and time savings by eliminating duplicative, unnecessary, and fraudulent claims and other types of improper payments.

Attachment

1. Historical data of claims submitted to claims adjudication contractor, sorted by BOP institution.

ATTACHMENT 1

BOP Claim Volume Through Adjudication Vendor Q1 2015 - February 2017

Facility	Actual Q1 2015	Actual Q2 2015	Actual Q3 2015	Actual Q4 2015	Actual Q1 2016	Actual Q2 2016	Actual Q3 2016	Actual Q4 2016	Actual Dec-16	Actual Jan-17	Actual Feb-17
Allenwood	1,501	1,722	1,805	2,082	1,721	1,663	1,386	2,142	445	625	567
Atwater	286	432	308	230	261	216	239	196	110	41	86
Beckley	295	348	392	341	384	507	238	88	5	-	2
Brooklyn	924	1,178	614	45	3	3	7	4	-	1	2
Bryan	494	503	386	465	447	309	452	120	22	-	-
Butner	2,975	2,937	2,729	4,242	3,180	3,571	3,207	2,691	909	958	1,007
Coleman	2,927	3,203	3,817	3,884	1,726	220	54	12	1	4	-
Dublin	549	395	370	383	390	531	344	321	94	89	108
Estill	385	357	336	385	351	312	247	346	120	143	79
Ft. Worth	3,757	4,817	3,917	4,360	4,795	3,508	3,074	1,476	135	153	101
Honolulu	54	59	47	130	72	145	91	75	13	29	25
Lewisburg	606	757	768	576	816	904	633	676	269	172	189
Los Angeles	65	115	52	83	67	65	94	84	34	-	-
Memphis	596	640	873	920	667	833	536	855	259	129	137
New York	430	512	336	27	4	2	4	2	1	-	-
Otisville	514	566	548	400	353	423	381	377	153	99	149
Petersburg	744	1,510	1,120	1,201	1,320	1,430	1,204	1,402	430	382	334
Phoenix	588	377	405	607	528	628	457	538	110	84	70
Ray Brrok	-	1									
Tallahassee	160	197	274	247	238	251	243	447	252	57	70
Terre Haute	1,342	1,725	1,352	1,606	1,957	1,949	1,836	1,816	621	198	74
	19,192	22,351	20,449	22,214	19,280	17,470	14,727	13,668	3,983	3,164	3,000

*Data provided by BOP

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