

9 Biggest Mistakes Health Care Providers Make that Lead to Surprise Visits from Fraud Investigators

By Daniel J. Osborne, M.S.

It's no secret for today's health care provider that investigators from regulatory boards, insurance companies and law enforcement agencies are on the prowl looking for providers who are not following the laws & rules – with a major focus on health care fraud!

And, these investigators, especially law enforcers, are particularly interested in finding health care providers engaged in health care fraud and establishing the evidence to prosecute providers who 1) billed for services not rendered; 2) billed for services that misrepresent the nature of the services provided; 3) billed for substandard and/or unnecessary services; and/or 4) billed for services that misrepresent the actual service provider.

Law enforcement agencies, **even the Fed's**, have limited resources that prohibit them from investigating every provider on whom they receive information alleging health care fraud.

How do fraud investigators maximize their resources, and enhance probabilities for successful health care fraud prosecutions? They search for easy targets! They don't have to search far! ***What is an easy target you ask?***

Here are 9 big ones:

1. Providers who fail to deal effectively with employee or patient complaints resulting in the complaints being made to investigators to get problems resolved. Prosecutors have ready-made story-tellers to testify, if need be, as to the provider's fraudulent activity.
2. Providers who fail to recognize that ALL providers billing insurers for services rendered are under some form of investigation. The key for providers is what happens as a result of initial investigations to determine whether submitted-claims should be paid – if so, are they paid or are they being referred to SIU, regulators and/or law enforcers for further investigation.
3. Providers who have a significantly high volume of patients in one particular payment category, i.e., Medicare, Major Medical, Personal Injury, Workers' Compensation, etc. Claims-handlers see voluminous clinical and billing records from providers where either documentation or coding deficiencies, deficiencies that may otherwise have gone unnoticed, stand out – resulting in referrals for further investigation and other actions.
4. Providers who have ongoing relationships with either practice-consultants or vendors. If either these consultants/vendors or their clients become the target of a fraud investigation, such an investigation may result in providers relying on those consultant/vendor services to be dragged into an investigation. Investigators want to know, and rightly so, whether providers working with targeted consultants/ vendors were engaged in related misconduct, or have information that would further ongoing investigations. A good example of this is what happened to many providers who worked with a major MD/DC practice consultant who was successfully prosecuted.
5. Providers who aggressively market their health care services to the public - especially free services, which are not only seen by their targeted audiences but also by investigators. These efforts cause providers to become well-known (i.e., notorious) to investigators who are motivated to look a bit closer at the clinical & billing records of these very visible and high-profile providers to see if there is something that can be used to prosecute.
6. Providers who fail to completely, accurately and in a timely-manner document health care services rendered to patients. The crime scene for investigations of health care fraud is the clinical and billing records of providers. All providers have heard the saying, "If it's not documented then it didn't happen." Investigators have heard it too, and they follow this concept to a 'T'. Investigators love to find patterns, clinical files that have no notes, computer-generated notes that report similar information for all visits and patients, notes that do not support the services billed, and notes that are minimal in content – It is harder for providers to defend their actions in such instances.

7. Providers who fail to follow the payors' rules, especially when contracts are involved - where providers have agreed to follow specific terms for participation. Investigators search diligently for providers who failed to follow written-agreements. This is a strong piece of evidence for prosecutors to show juries. In such case, the contract contains the providers' signatures, agreeing to specific terms, and is used to show providers (purposefully) violated these terms.
 8. Providers who fail to appropriately use billing codes (ICD-9, CPT, HCPCS) when seeking reimbursement for services rendered. **Follow-the-\$\$\$\$\$** is a key for investigators, and in health care fraud investigations, this process begins with the identification of inappropriate billing practices that result in payments to which providers are not entitled.
 9. Providers who fail to provide appropriate oversight of their practice-activity to ensure it is consistent with the laws & rules. This is a huge mistake in today's aggressive enforcement climate, considering that for nearly a decade now, the government has strongly encouraged providers to employ compliance programs to police themselves. The absence of oversight may be used to demonstrate that the provider engaged in unlawful activity, displaying willful ignorance and acting in reckless disregard of the laws & rules. Documented oversight systems may effectively stop further investigations. Such providers are target-hardened!
- * **BONUS REASON:** Not realizing their testimony in a malpractice case may be used against them. Doctors get caught in the middle when they testify that they did not adjust or treat a certain area, yet their billing records suggest otherwise. So, either the doctor fraudulently billed for services not provided or the doctor treated an area he or she claimed was not treated. Either way, there is no escape from the law.

At a recent seminar, a doctor asked whether law enforcers would actually go after doctors who were trying to do the right thing. The answer is - **Absolutely!** Trying to do the right thing and doing the right thing are two very different things. Law enforcers, armed with probable-cause that illegal activity has occurred, do not care that providers were trying to do the right thing. Remember, the investigator's sole purpose for being at the provider's practice is to collect evidence that demonstrates the provider failed to do the right thing.

Law enforcers invest a lot of time and resources investigating providers prior and subsequent to surprise visits. The investigator's ultimate reward – A successful prosecution!

PUBLISHED: Ezine, September 2008 (not including BONUS REASON)