

## Do you commit accidental fraud, abuse?

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Health care fraud and abuse are reported to be major and costly problems in the United States today that have affected the affordability and availability of health care. Simply put, health care fraud is an intentional deception or misrepresentation that could result in an unauthorized payment. Whereas, health care abuse is conduct that is inconsistent with accepted industry standards that could result in unnecessary costs to a health care program.

As a result, of the seemingly ever-growing problem, significant attention and resources have been directed by insurers, regulators and law enforcers to combat health care fraud and abuse. A key development in this area has been the promulgation of new laws and rules to assist on administrative, civil and/or criminal prosecutions by enhancing investigative and prosecutive interest, as well as making health care fraud / abuse easier to prosecute. Today, enforcement interest in health care fraud and abuse is at an all time high, caused in part by these types of cases providing enforcers monetary incentives, as well as making it easier to collect the information necessary to facilitate successful investigations and prosecutions.

Unfortunately, some health care providers will become investigative targets – not because they knowingly engaged in illegal conduct – but because they lacked the necessary knowledge and/or understanding on the laws, rules and regulations that govern health care. Take the following mini-quiz to see where you stand on some critical issues for today's health care provider.

**Q. Saying it was a mistake caused by not knowing the laws & rules governing health care is a sound defense to allegations of fraud or abuse?**

*A. **False.** Ignorance of the laws, rules and regulations governing health care is not a valid defense in today's enforcement climate, as your lack of knowledge could be seen as a reckless disregard, or that you paid no regard to whether the information presented on a claims was true or false, and with deliberate ignorance, or that you choose to deliberately ignore the truth or falsity of the information on the claim.*

**Q. Per CPT (Current Procedural Terminology) it is alright for a non-licensed person to render therapeutic procedures (CPT codes 97110 – 97546)?**

*A. **False.** CPT defines these codes as those procedures administered to effect change through the application of clinical skills and/or services that attempt to improve function that are rendered by licensed health care providers who are required to have direct (one-on-one) patient contact. Further, CPT indicates that they do not get involved in State regulatory decisions on delegation, or do they get involved in third-party payor reimbursement decisions, and instructs providers to contact these sources when deviating from the code definitions to determine the appropriateness of your actions. Sound advice to avoid potential allegations of material misrepresentation of fact – Fraud!*

**Q. Per CPT, the time for time-based services / procedures starts when the provider (a licensed health care provider) is in direct one-on-one contact with the patient to set-up, administer, and clean-up the service / procedure.**

*A. **True.** The time interval for these codes involves all of the provider's contact with the patient, or the work done by the provider, which also includes the time it took you to document the patient encounter. Further, one should consider that all CPT codes reflect three basic components: (1) amount of provider involvement or work done, (2) the level of judgment used by the provider, and (3) the medical risks to patients, that is used not only by CPT in defining the service / procedure, but is also used in reimbursement decisions by third-party payers that is reflected in relative values assigned to CPT codes. Simply put, the time in time-based codes, per CPT, involves all necessary time the provider is in direct contact with the patient to render the time-based service / procedure. Cautionary Note: Medicare guidelines on time-based services only include the actual clinical time of the service and do not include pre- and post-service time.*

**Q. To properly document time in the patient's clinical record on time-based services / procedures rendered, the start and end time of the service / procedure should be reported?**

A. **True.** Proper documentation of health care services rendered equates to accurate and complete reporting of the patient encounter, and should show what you did, how you did it, results of what you did and, in the case of time-based services / procedures, includes your time. The time component of the time-based codes is not an estimate but is the actual time it took you to administer the care, which can only be accurately reflected by knowing when you started and when you ended. Further, by clearly documenting in the patient's clinical record the start and end time of these services you will find you have an excellent risk reduction mechanism in place for your practice against risks that a third-party payor will ask your patient how long it took you to administer the care and their reporting less than 15 minutes!

**Q. Per CPT, it is appropriate for a health care provider to report a CPT Code that closely resembles the service rendered if the third party payor does not reimburse the actual service or procedure rendered, i.e., unattended electrical muscle stimulation (97014) performed but attended electrical muscle stimulation (97032) is billed?**

A. **False.** CPT instructs providers using the CPT Coding system to pick the code that most accurately identifies the service / procedure performed (and documented in the patient's health care record). Billing for service / procedure via any code than the one that does not accurately reflect what was performed can result in serious repercussions as the result of allegations of fraud. This type of billing practice should only be engaged in with the specific approval and knowledge of the involved third-party payor.

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