

## Investigating Health Care Fraud

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Investigations relating to health care fraud activity are reportedly at an all time high, and will continue to flourish with the advent of new working groups, task forces and other fraud-fighting activity that existence depends on the development and investigation of health care fraud cases. Simply put, the investigation of health care fraud consists of proving that the provider engaged in an intentional deception or misrepresentation (of material fact) that resulted, or could have resulted, in an unauthorized payment. Some key facts related to health care fraud investigations:

**Complaint Driven:** Private, local, state and/or federal agencies are actively involved in the identification and investigation of health care fraud and abuse, which, for the most part, are initiated by complaints received from patients, insurers and others on a health care provider or entity.

**Complaint Evaluation:** The investigative process starts by the investigator evaluating the information in the complaint to determine if it represents actual misconduct, and then to identify what specific laws, rules, and/or regulations may have been violated. Critical areas to be addressed may include:

- **DOCUMENTATION**-was the services documented as medically necessary, and completely and accurately documented in the patient's health care record?
- **REGULATORY LAWS & RULES**-were the services rendered consistent with the administrative law for the State, including scope of practice, training, supervision and delegation? Additionally, were the services, or the manner in which they were rendered, in violation of prohibited conduct?
- **THIRD PARTY PAYER RULES**-were the services rendered consistent with the rules set by the involved third party payer, including those relevant to limitation of services rendered, and those limiting the service provider?
- **CODING**-were the proper ICD-9 and CPT-4 codes used to identify the condition (s) being treated and the services rendered when seeking reimbursement?

**Investigative Plan:** The investigator will identify potential witnesses to interview, other needed information, such as patient and insurance claim files that may possess evidence of the misconduct. The successful investigation will result in the collection identify and collect all relevant evidence that would indicate the laws, rules and/or regulations governing health care have been violated, and to identify storytellers who will be able to testify on matters relevant to the identified misconduct. The patient file is the crime scene when investigating health care fraud & abuse.

### MAJOR TRENDS IN HEALTH CARE FRAUD

**Problem (Multidiscipline Practices):** Some multidiscipline practices of medical doctors, chiropractors, and other providers working together in one practice entity are formed by some chiropractors as a means to circumvent managed care and other third party payer limitations on reimbursement of chiropractic services. At times, when necessary, multiple corporations are created to allow the chiropractor to employ medical doctors and to maintain control over all revenues of the multidiscipline practice. The services rendered by the chiropractor in cases where there is little or no chiropractic coverage are billed to the third party payer under the license and name of the medical doctor, purportedly following "Incident-to" billing principles after the medical doctor evaluated the patient and referred them for care with the chiropractor. Is the chiropractor billing for their services rendered under the license of a medical doctor?

**Problem (Mobile Labs):** Some external companies, or mobile labs, market their electro-diagnostic testing services extensively to health care providers as a means to increase patient retention and increase revenues. The mobile lab provides on-site electro-diagnostic testing on the provider's patients with their equipment and by their technician. The provider pays the lab a rental fee for the equipment and technician, and agrees to provide a minimum number of patients for testing during one day. The lab bills the third party payer for only the reading of the tests, or the professional component, and the provider bills for administering the tests, or the technical component, because they rented the equipment/technician and supervised its administration. Further, the lab will provide the provider with the CPT codes and amounts that should be

reported and billed for the technical portion of the test. The provider, claiming to have supervised the administration of the diagnostic test, may not have the requisite training and skill on the test. Often, the total amount billed (both professional and technical) for the tests will far exceed the RVU (Relative Value Unit) set for these tests. The client provider usually will have no actual knowledge on what the labs will bill to the third party payer. What service did the provider perform to bill for the technical portion?

**Problem (Rehab):** Some providers implement (active) rehabilitation care into their health care practices by having their unlicensed staff administer therapeutic procedures to patients that are defined as one-on-one with the patient by a licensed provider, and are reported in 15-minute increments. Documentation of medical necessity of therapeutic procedures may not be properly established in the patient's clinical record as part of a treatment plan. Documentation of procedures in file, even when directly provided by licensed provider, may not be properly documented to account for the time component of the service, i.e., Start & End time, which includes pre-intra-post service time. Is the provider's unlicensed staff rendering the rehab services to the patients of the practice? What does the patient's health care record show? Do they support the need and accuracy of the billings?

**Problem (Billing):** Various insurance companies have limitations on what health care conditions and services they will reimburse providers for. Some providers provide their patients with health care services that are not reimbursable by the involved managed care organization or third party payer, but report and bill for these services via use of ICD-9 and CPT-4 codes that are reimbursable. Some providers provide their patients with various health care services based solely on the premise that the involved managed care organization or third party payer will reimburse for those services.

**Problem (Solicitation):** A number of providers market "free" services, such as consults, exams and x-rays to attract new patients that may not be established as medically necessary, or will later be billed to a third party payer. A number of providers' market "free" services, such as therapeutic massage, as a means to attract new patients to the health care practice, which later may become a part of the patient's billed care. A number of providers inform marketed individuals when converting them to patients that they will not be responsible for what the insurance company does not pay. For the health care provider what is a consult? Isn't it a history? Was the promised free service, or a portion of it, later billed? Is it possible to give away a therapeutic massage without first examining the patient to establish need?

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