

“Know Your Fraud” - It could be fraud if the health care practice...

by Daniel J. Osborne, M.S.

Uses extensive marketing efforts to attract potential new patients that include free health care services.

TRUE. *Inducing patients for care with promised “free” health care services may raise questions as to the medical necessity of subsequently (billed) services and result in allegations that the provider rendered medically unnecessary and substandard health care services that were based on available insurance identified during the intake process of the free service and not medical need. Further, such activity may be contrary to federal and/or state laws.*

Reports extensive time-based services on patients with minimal licensed staff.

TRUE. *Time-based services are those that indicate a provider (someone licensed) administers the service one-on-one with the patient. If the practice has insufficient licensed staff it could be an indication that the time-based services are not being administered by a licensed provider, are being administered for less than the indicated time, and/or are not being administered one-on-one.*

Unbundles billing for diagnostic testing (e.g. range of motion and muscle testing) by performing and reporting on visits following an exam.

TRUE. *This practice activity could result in allegations that the testing administered in such a fashion is done so for the purpose of expanding reimbursement potentials, as these tests, if reported separately on the exam date would be seen as unbundling components of the exam service. Remember that diagnostic tests are an extension of the exam, and are performed for the purpose of gaining information not already known. Do the specialty diagnostic tests performed on visits following an exam provide information that is not already known; have an impact upon treatment decisions, etc.*

Avoids use of unlisted service/procedure (CPT) codes for services/procedures performed that do not have a specific assigned CPT code because unlisted codes may not be paid.

TRUE. *This billing practice is extremely problematic and could result in allegations that the practice reported CPT codes that misrepresented the nature of the actual service provided. Practitioners should fully explore how to report new diagnostic/treatment devices that have no specific CPT code assigned. CPT instructs providers using the CPT coding system to pick the code that most accurately identifies the service/procedure performed, including the use of unlisted service/procedure codes with a description of the service/procedure performed when a specific code is unavailable. Remember that the primary purpose of CPT is to facilitate the ability of health care providers to accurately report their work!*

Determines the appropriateness of their practice activity based on what they perceive “everyone else is doing”.

TRUE. *If you are a practitioner who benchmarks the appropriateness of practice activity on what everyone else is doing could soon find yourself the target of a fraud investigation if everyone else is, or your perceptions are wrong! It is critical that sound reason and judgment is used in all practice decisions that are based on the laws & rules governing health care!*

Uses practice building consultants who advertise with promises of increased revenues.

TRUE. *“Trust but verify” is the key here! Trust that you are being properly instructed on what practice activity to engage in to increase your income but verify that the instruction provided is consistent with ALL relevant laws, rules and regulations that govern health care prior to its implementation.*

Fails to adequately document all health care services rendered in the patient’s clinical record.

TRUE. *If it is not documented then it did not happen! Poor documentation could result in allegations that you billed for services not rendered, that you billed for services that were substandard and/or medically necessary, that you billed for services that misrepresented the nature of the service provided, as well as having billed for services that misrepresented that actual service provider.*

Misrepresents provider performing in-network services as if the credentialed provider rendered them when they were in fact performed by a non-credentialed provider.

TRUE. *This practice activity could result in allegations that you billed for services that misrepresented the actual service provider. Providers should pay close attention to contracts/agreements signed with payers and be familiar with all participation requirements and restrictions.*

Uses mobile diagnostic testing services for specialty diagnostic testing on patients.

TRUE. *This activity could result in allegations that medically unnecessary services were administered to the patient if it is determined that a potential “kickback” relationship exists where the referring provider is financially rewarded by the lab company for the testing referral. Practitioners should use due care to ensure that all relationships with external vendors are consistent with the laws & rules by having their own legal counsel review the relationship prior to its inception and implementation.*

The principal purpose of the entity’s creation as a multi-discipline practice appears to have been to circumvent third-party payer restrictions/limitations on reimbursements of chiropractic services.

TRUE. *If the practice setup and structure facilitate the ability of the chiropractor to be reimbursed for services in the name of another provider that would otherwise be non-covered is a BIG practice risk, and could result in allegations that the practice billed for services that misrepresented the actual service provider, etc. Practitioners should consult with experienced legal counsel and/or other compliance resources to ensure that their multi-discipline practice is setup and is operating consistent with the laws & rules.*

PUBLISHED: Chiropractic Economics, Issue 13, September 15, 2005