

The Next Generation of Multidiscipline Practice Fraud

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The evolution of multi-discipline fraud has included the advent of practices created on the advice of practice building consultants as a means of avoiding or eliminating limited chiropractic insurance coverage by associating an MD. However, this type of practice has lost its popularity of late due to increased scrutiny and investigative interests on the part of third party payers, state regulators and law enforcers. The next generation of multi-discipline practice fraud no longer necessitates the involvement of an MD, just a physical therapist willing to join the practice to expand reimbursement potentials and avoid coverage limitations.

One must be careful not to use a broad-brush to paint all multi-discipline practices with fraud. Most providers have patient care in mind and not only the financial bottom-line, where most use due care to ensure that their practice operates in compliance with the laws, rules and regulations governing health care.

It could be a next generation multi-discipline practice fraud if...

- The practice was created to maximize reimbursements for health care services by (1) reporting services similar in nature rendered by providers of differing disciplines; (2) avoiding limited insurance coverage of one provider by having a provider of a different (covered) discipline render the health care; and/or (3) allowing the non-covered provider to bill for their rendered services under the license of the covered provider.
- The practice has differing practice names and tax identification numbers, based on the discipline rendering care, to avoid detection that a provider - with limited available insurance, is involved in the control and direction of health care services.
- The practice sees a high volume of patients, typically obtained as the result of extensive marketing of free health care services, where patients are told that their health care won't cost them anything, that insurance will pay. Patients are not informed on amounts billed, where the practice will forgo collection of deductible, co-payment and/or co-insurance amounts.
- The practice provides services based on available insurance and not the medical need of the patient. The same treatment on a similar schedule is provided to all patients, where the treatment remains the same, including multiple modalities, even when the patient is better.
- The practice fails to properly document referrals from the physician to the physical therapists and the physician's review of the physical therapist's work; and/or documents physician referrals to the physical therapist ordering specific services that is not followed by the physical therapist.
- The practice reports multiple provider encounters with the patient on the same day, where the patient reportedly sees providers of differing disciplines for the administration of health care services that could be administered by one provider.
- The practice reports extensive physician examinations, physical therapy evaluations which are not adequately documented in the patient's clinical record to have been performed - including treatment plans to describe the type, amount, frequency/duration of services to patients that indicates the diagnosis, anticipated goals, and specific functional goals with an estimate of when they will be reached.
- The practice reports extensive electro-diagnostic testing (especially range of motion and muscle testing), typically the day after an exam/eval, with little or no documentation as to why, and how used in the care and treatment of the patient.

- The practice reports services that are not completely and accurately documented in the patient's clinical record to account for the specific activity performed, the body area treated, the intensity and duration of the service, as well as the time spent rendering time-based services and procedures.
- The practice delegates the administration of services to unlicensed staff, despite requirements that the services be performed by a (licensed) provider in direct one-on-one contact with the patient.
- The practice reports extensive time-based services with minimal qualified (licensed) providers on staff that were actually administered by unlicensed staff, and/or provided for less than the required 15 minute increment without use of appropriate modifier.
- The practice reports services rendered by one provider under another disciplined provider that would otherwise be non-covered.
- The practice reports health care service combinations rendered to the same body area during the same patient encounter under differing disciplined providers that would otherwise be non-covered.
- The practice reports services not accurately reflective of the actual service/procedure rendered.

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