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Physicians Need Check Ups Too
Fraud and Abuse Issues for 2006

By: Gregory J. Naclerio*

Each year Government and private carriers target areas they will be scrutinizing and examining and 2006 is no exception. To be forewarned is truly to be forearmed and this article will discuss what you and your practice can do NOW to avoid potential legal and financial consequences in 2006.

The unwitting physician and his/her office manager are "shocked" to learn of improper activities going on in their practices. The shock is compounded when the practice either gets a personal visit from a Special Agent of the FBI armed with a subpoena for up to six years of financial and patient records or a "Dear Doctor" letter from a major insurance carrier requesting hundreds of thousands of dollars back for improper (and potentially illegal[1]) billings. So what then to do? The

solution lies in the very same philosophy physicians try to inculcate in their patients: "Prevention of a health problem should be your goal not seeking a cure." Prevention is difficult: getting off the couch and exercising; stop the high fat diets; watch your weight, etc. Yet, when prevention of illness is practiced salutary results ensue.

Likewise, a physician's office needs to practice "Preventive Financial Health." All too often practices say they are too small to implement a compliance program[2] to monitor their activities.

However, regulators and carriers do not care. If you have overbilled – intentionally or not – they will come after you no matter your size. Thus, at the very least a modified compliance program can and should be implemented as preventative medicine.

The Modified Program

The implementation of a modified compliance program should consist of internal monitoring of the practice and a review of the "Hot List" topics regulators/carriers are focusing on for 2006. Such an internal monitoring program should consist of:

1) Monitoring your Denials

Why is the claim being denied? You should, on a quarterly basis, review your denied claims looking for patterns. Were there coding errors? Is one service you are billing consistently denied? Are you using the correct CPT Codes? Have you been paid twice for the same service? Seeing why your claims are being denied will give you a "heads up" on a potential problem. Those problems should then be followed up looking for the reason behind the denial.

Practice Tip

Some practices seek to save themselves the trouble of doing monitoring by outsourcing the review to an experienced coder or they contact their professional specialty society for that service. CAUTION: Any work product produced by a Coder you hire can be subpoenaed by the Government or sought in discovery during a civil law suit. Therefore, it is recommended that you retain competent health law counsel to assist in reviewing the denied claims and counsel will then hire the Coder so as to bring the Coders activities under the attorney work product thereby making the findings privileged.

2) Monitor Your Credit Balances

Credit Balances will tell you simply – you got more money then you should have. Some practices say "That's tough luck carrier; you don't pay me for what I'm worth anyway." Some practitioners who are currently serving time in the Federal prison system regret taking such a cavalier attitude.

3) Check Your CPT Coding Practices

On at least a quarterly basis perform a run on your CPT Codes for Evaluation and Management ("E/M"). In a typical practice the E/M codes for New/Established patients should follow a bell shaped curve. Carriers profile

practices in a given region and compare E/M codes against their peers. If your Level 4 and 5 E/M's exceed your peers a request for patient records may ensue.

Practice Tip: Remember, not every visit to a specialist is a Level 4 or 5.

4) Consults must be documented as Consults.

The intent of a consultation is that a physician is asking another physician for advice, opinion, recommendations, suggestions or counsel etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting physicians knowledge.[3]

Documentation required to bill a consult must contain:

A request for the consult. The request should be documented in the consulants medical record (and should likewise be documented in the requesting physicians plan of care).

After the consult is provided, the consultant should prepare a written report of findings and recommendations which should be provided to the referring physician.

5) Spot Check Your Documentation

The golden rule is if it is not documented in the patient's chart… "IT DID NOT HAPPEN."

Practice Tip: Pull 10 charts per physician and perform an honest self-evaluation. If you were the carriers auditor; would you pay the billed CPT code based upon the documentation. Then provide feedback to the physician and staff and continue to track outliers.

6) Protect Your Practice

In the event you are requested to provide 20 or more charts to Medicare, Medicaid or a private carrier (the "Carrier"), you must

assume you are the target of an active investigation. All charts provided should be copied for the Carrier. No additions or deletions should be made to the charts. Additionally, all correspondence from the Carrier with respect to the requested charts should be segregated in an "Audit File." In the event of a visit to the office by a representative of a private carrier or an Investigator from the Federal Bureau of Investigation; Office of the Inspector General or Medicaid Fraud Control Unit, it is important to identify the Investigator (take their business card) and clearly understand the purpose of their visit.

Practice Tip: There is no obligation for a physician to submit to an interview by an Investigator. The physician (or preferably the Office Manager) should direct the Investigator to the Practices attorney. This procedure is not designed to obstruct but rather to have the physician and his counsel reflect on the subject matter of the requested interview and respond fully and accurately. Remember, whatever is said to the Investigator will be placed in a written Interview Report, which will become part of any future civil or possibly criminal claim.

The old adage about an "ounce of prevention" is applicable not only to one's health but also the health and financial well-being of a medical practice. The choice is yours to make…choose wisely.

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[1] The HIPPA legislation also made defrauding of any "healthcare benefit program" a Federal crime. (18 USC 1347)

[2] See, http://oig.hhs.gov (fraud prevention and detection) for compliance guidance for individual and small group physician practices.

[3] See, Medicare Claims Processing Manual, Chapter 12, Section 30.6.10.