CEU INSTITUTE

Medical Fraud and Abuse:

Strategies for the Claim Professional

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Section 1

Summary

Fraud costs the insurance industry billions of dollars each year. The Coalition Against Insurance Fraud (CAIF) estimates that insurance fraud is the second most costly economic crime in America after income tax evasion.

The Insurance Information Institute estimates that the total cost of all insurance fraud is between $85 billion and $120 billion a year. Some studies show that fraudulent claims account for 10 percent of all claim dollars; others suggest a much higher percentage.

Fraud must be detected and prevented by claim professionals because they are most familiar with individual claims. They must be able to identify fraud indicators and make the necessary referral to SIUs for review and action. Although a claim professional may suspect that a claim is fraudulent, he or she must behave ethically and in good faith at all times when dealing with insureds and claimants.

Insurers must maintain a balance between preventing and detecting fraud and treating policyholders with dignity and trust.

Section 2

Key Concepts

Insurance fraud can be committed by anyone – insured, claimant, doctor, lawyer – involved in the claim transaction. Same is defined by AICPCU/IIA as any ***deliberate deception*** for the purpose of ***unwarranted financial gain*** committed against an insurer.

Hard Fraud

Hard fraud occurs when someone ***deliberately plans or invents a loss***, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive payment for damages. Hard auto-insurance fraud can include activities such as staging automobile collisions, filing claims when the claimant was not actually involved in the accident, submitting claims for medical treatments that were not received, or inventing injuries.

Soft Fraud

Soft fraud, which is far more common than hard fraud, is sometimes also referred to as ***opportunistic fraud***. This type of fraud consists of policyholders ***exaggerating*** otherwise legitimate claims. Examples of soft auto-insurance fraud can include filing more than one claim for a single injury, filing claims for injuries not related to an automobile accident, misreporting wage losses due to injuries, or reporting higher costs for car repairs than those that were actually paid. Soft fraud accounts for the majority of fraudulent auto-insurance claims.

Material Fact

A material fact is one that would be ***important to a reasonable person*** in deciding whether to engage or not to engage in a particular transaction. In other words, it is a fact which either its expression or concealment would reasonably result in a different decision.

Materiality

Under the most widely accepted test of materiality, a fact that has been misstated or omitted is deemed "material" if it could reasonably be considered as ***affecting the insurer's decision*** to provide or maintain insurance to settle a claim. Materiality is determined solely by the probable and reasonable effect which truthful answers would have had upon the insurer.

Concealment

Concealment is the ***neglect to communicate*** a material fact which a party knows and knows that he or she ought to communicate. In other words, concealment is an intentional suppression or withholding of, or neglect to communicate, a material fact.

Misrepresentation

Misrepresentation is a contract law concept. It means a ***false statement of fact*** made by one party to another party, which has the effect of inducing that party into responding in a manner that violates the contract. A representation is false when the facts fail to correspond with its assertions or stipulations.

CPT Codes

CPT (Current Procedural Terminology) codes are ***numbers assigned to every task and service*** a medical practitioner may provide to a patient including medical, surgical and diagnostic services. They are then used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer. Since everyone uses the same codes to mean the same thing, they ensure uniformity.

HCPCS Codes

HCPCS Codes, Healthcare Common Procedure Coding System numbers, are the codes used by Medicare and monitored by CMS, the Centers for Medicare and Medicaid Services. They are based on the CPT Codes.

ICD Codes

ICD means International Statistical Classifications of Diseases. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings.

Upcoding

Upcoding is ***charging for a more complex service than was performed***. This usually involves billing for longer or more complex office visits (for example, charging for a comprehensive visit when the patient was seen only briefly), but it also can involve charging for a more complex procedure than was performed or for more expensive equipment than was delivered.

Miscoding

Miscoding is simply using a code number that does not apply to the procedure.

Bundling

Bundling is defined as the ***consolidation of two or more services into fewer categories for payment***. It usually combines two or more CPT Codes, substituting one overarching code, often ignoring modifiers along the way. When codes are bundled, the codes are grouped together with the fee schedule applicable for the resulting one code. In a broadest sense, bundling occurs when a physician submits a claim for separate and distinct CPT services or procedures performed on a single patient during a single office visit and "bundles" them together for just one of the services or procedures.

Unbundling

Unbundling is ***billing separately*** for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.

Section 3

AICPCU/IIA General Fraud Indicators

Exaggerated claims or claims for non-rendered services

The claimant may be working with the medical provider to exaggerate the need for medical treatment. In the alternative, the medical provider may be overbilling the insurer without the knowledge of the claimant.

Diagnosis is inconsistent with treatment

In a simple example, the claimant's diagnosis is diabetes, but the prescription is for an anti-convulsant drug. The discrepancy may indicate an attempt to pad the claim by choosing a diagnosis that would increase the medical bills. In the alternative, it may suggest the need for further investigation to determine whether the diagnosis and treatment really are consistent with one another, as the drug prescribed may have other less common or "off-label" uses.

Provider's reputation for questionable claims

This may indicate the provider's willingness to pad the claim. In the alternative, it may have no bearing on the claim.

Bills are summaries rather than itemized statements

The provider may be attempting to hide information or create documentation for a fictitious injury. In the alternative, the provider may be able to supply itemized statements if asked to do so.

Bills are photocopies and not originals

Photocopies may have been made to camouflage alterations to the original bill. In the alternative, another insurer may have required the original.

Treatment on holidays or weekends

Such bills may indicate an attempt to pad a claim by billing for treatment on dates when the medical provider is usually closed. In the alternative, the facility may have been open or the claimant may have been treated on an emergency basis.

Multiple claimants to one provider

The claimants may have been directed to a particular provider who is participating in a fraud scheme. In the alternative, all the claimants may be members of the same family and use the same provider.

Treatment inconsistent with auto damage

This discrepancy may indicate an attempt to inflate the value of the claim by overtreating the injury. In the alternative, the treatment may be legitimate if the claimant was physically susceptible to a more extensive injury.

Section 4

CPT Code Fraud Detection

Claim professionals are given reams of paperwork that contain confusing numbers and letters. These are medical codes that describe everything from services performed to diagnosis and treatment. A key to detecting medical abuse and fraud is to understand the use of coding on bills and other paperwork.

What exactly is fraud and abuse in medical reimbursement? Fraud refers to the practice of intentional or systematic inappropriate billing to cheat a payer. The areas of fraud most commonly identified by the Department of Justice include billing for services not rendered, billing for services not medically necessary, double billing, upcoding, unbundling (using multiple codes rather than a single code as a means of obtaining greater

reimbursement), and fraudulent cost reporting by institutional providers Fraud would seem to be a problem of limited scope, but it is a serious offense and punishable not only with fines but also with imprisonment.

Abuse refers to the use of inappropriate—nonintentional but nonetheless incorrect—billing practices. Abuse is more insidious. Coding must be performed accurately, with appropriate documentation at all stages, to prevent abuse. Simple, easily preventable errors, such as billing from an out-of-date CPT or ICD-9 manual, can lead to incorrect coding and charges of abuse. Auditors could view repetitive mistakes as abuse, if not fraud. High-risk practices include billing for services not rendered, incompletely documenting reports, or billing for services that are not medically necessary.

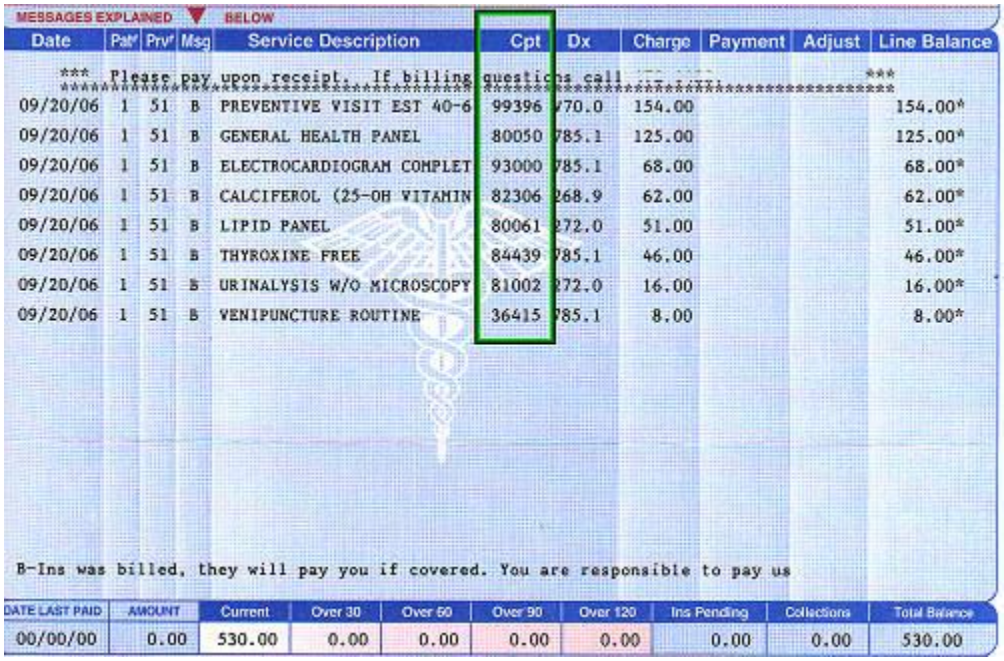
✓ How to look up a CPT code

When you look up a CPT code, you can learn four things: you can use the code to find out what procedure or services it represents; you can use a service or procedure to look up the CPT codes that might apply; you can find out how much is paid a doctor or facility in the specific geographic area for the service or procedure based on the relative value amount (RVU); and you can find out the average amount paid across the US for that code.

- Link to the AMA Website http://www.ama-assn.org/
- To the right at the top of the page, highlight “Bookstore” and select “CPT Code/Relative Value Search”
- Accept End User license
- Parameter screen – enter specific code or keywords. Try using the term you would use to describe the procedure or service. Another way to find just the right code is to look up the medical word for whatever the

procedure is. For example, what we call a jaw, doctors call a temporomandibular joint. Looking up temporomandibular joint, we find Code 21243

✓CPT coding on the medical bill



MESSAGES EXPLAINED BELOW

Date	Pat	Prv	Msg	Service Description	Cpt	Dx	Charge	Payment	Adjust	Line Balance
*** Please pay upon receipt. If billing questions call --- ---- ***										
09/20/06	1	51	B	PREVENTIVE VISIT EST 40-6	99396	V70.0	154.00			154.00*
09/20/06	1	51	B	GENERAL HEALTH PANEL	80050	785.1	125.00			125.00*
09/20/06	1	51	B	ELECTROCARDIOGRAM COMPLET	93000	785.1	68.00			68.00*
09/20/06	1	51	B	CALCIFEROL (25-OH VITAMIN	82306	268.9	62.00			62.00*
09/20/06	1	51	B	LIPID PANEL	80061	272.0	51.00			51.00*
09/20/06	1	51	B	THYROXINE FREE	84439	785.1	46.00			46.00*
09/20/06	1	51	B	URINALYSIS W/O MICROSCOPY	81002	272.0	16.00			16.00*
09/20/06	1	51	B	VENIPUNCTURE ROUTINE	36415	785.1	8.00			8.00*

B-Ins was billed, they will pay you if covered. You are responsible to pay us

DATE LAST PAID	AMOUNT	Current	Over 30	Over 60	Over 90	Over 120	Ins Pending	Collections	Total Balance
00/00/00	0.00	530.00	0.00	0.00	0.00	0.00	0.00	0.00	530.00

✓Simple comparison

Code 99396 on medical bill above for “Preventative Visit” billed at $154.00. By looking up code, you find the following description:

“Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years”

The Medicare payment for same is, however, $99.66 for a physician's office setting and $74.44 for a hospital or other facility setting. Private sector fees will vary in accordance with the RVU.

✓Detailed comparison

Assume a scenario where claimant alleges soft tissue injuries from an auto accident. She is seen as a new patient by a physician who undertakes a physical examination. Based on sworn statement or deposition testimony, claimant states that she was in contact with the physician for 5 minutes in which time he took a general history and ordered physical therapy and medication. The physician billed this activity at $350.00 using CPT code 99203.

Code 99203: office or other outpatient visit for the evaluation and management of a new patient, which requires the following:

- Detailed history
- Detailed physical examination
- Low complexity medical decision
- Moderate severity problem – multiple diagnoses or management options
- Physician time = 30 minutes

The Medicare payment for same is $96.90 for a physician's office setting and $70.73 for a hospital or other facility setting. Private sector fees will vary in accordance with the RVU.

✓Unbundling

If services are considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, they are not eligible for separate reimbursement. Definitions for incidental, mutually exclusive, integral, or global procedures or services are as follows:

- An incidental procedure is carried out at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.

  For example, electrocardiograms (ECG) are considered incidental to a stress test -- a cardiac test which includes an ECG as part of the test and as part of initial hospital care. The electrocardiogram codes as 93000 with payment of $18.40. A pulmonary stress test codes as 94620 with payment of $59.92.

  Unbundled, the provider seeks reimbursement for $78.32. The reimbursement should, however, be appropriately coded and paid only for $59.92.

- Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also include different procedure code descriptions for the same type of procedures for which the physician should be submitting only one of the procedure codes. Only the most clinically intense procedure will be allowed.

  For example, an ECG is considered mutually exclusive to physician services for cardiac rehabilitation coded as 93797.

- Procedures considered integral occur in multiple surgery situations when one or more of the procedures are considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service.

  For example, a cardiac stress test may require the administration of pharmacological agents. An IV injection of a pharmacological agent is

considered an integral component of the stress test. It does not warrant separate reimbursement.

✓ Chiropractic Code Games

It is inappropriate to bill an established office/outpatient E/M CPT code (evaluation and management) on the same visit as a CMT code (chiropractic manipulative treatment) because the CMT CPT codes already include a brief pre-manipulation assessment.

Billing an E/M code on very visit is improper. In cases where a limited number of manipulations are allowed, some chiropractors use an E/M code to get around the time limit on CMT. This is inappropriate. Further, some providers require a patient to return to the office on the next day to perform a service that would otherwise not be covered or that may allow higher reimbursement if done as a "stand-alone" procedure on a separate day. This is quite clearly unbundling.

- For example, E/M code 99211 is for an office or other outpatient visit for the evaluation and management of an established patient. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services. The reimbursement rate is $18.58.

- CMT code 98940 is for chiropractic manipulation of the spine and the reimbursement rate is $24.11. This code includes the functions of evaluation and management.

✓ Radiology and Unbundling

With increased frequency, third-party payers are looking for inconsistencies between the study ordered and the study billed. Radiologists, either directly or indirectly, are advised to work with their referring physicians to eliminate any ambiguity over procedures ordered.

Diagnostic coding for MRIs:

- CPT code 72158 for MRI of the lumbar spine with and without contrast material is reimbursed at $896.25.

Unbundled, this code is broken into the following: 72148 MRI of the lumbar spine without contrast = $608.00; and 72149 MRI lumbar spine with contrast material = $722.00. The unbundled total = $1,330.00.

Diagnostic coding for CT scans:

- CPT code 74170 for CT scan of abdomen with and without contrast material is reimbursed at $478.56.

Unbundled, this code is broken into the following: 74150 CT scan of the abdomen without contrast = $342.00; 74160 CT scan of the abdomen with contrast = $396.63. The unbundled total = $738.63.

Section 5

Strategies

There are, in principle, two distinct types of strategies that may be adopted by insurers to reduce the incidence of fraudulent claiming.

The first is to audit claims that have observable characteristics that are associated with a potential for fraud and then to deny those that are found to be invalid.

The second is to reduce the incentives of claimants to commit fraud by systematically underpaying claims to erode the returns to the claimant of investing in private and costly activities designed to inflate the claim.

The optimal strategy is a combination of the two: audit claims with observable characteristics of fraud and effectuate a claim payment reflective only of those amounts deemed appropriate absent the character of fraud or deny the claim as invalid.

Unfortunately, there is no single profile of fraudulent auto insurance claimants: anyone from professional criminals to ordinary citizens can commit fraud. Risk-mitigating strategies for the insurer should be reliable and effective and be capable of detecting fraud in real-time, when such activities occur. Such strategies should involve effective risk identification, data analysis and reporting, data validation processes, data mining capabilities, visualization techniques and reporting tools to identify questionable behavior before claim payment.

Rules and red flags

Rules-based systems test each transaction against a predefined set of algorithms or claim department rules to detect known types of fraud based on specific patterns of activity. These systems flag any claims that look suspicious due to their aggregate scores or relation to threshold values.

Database searching

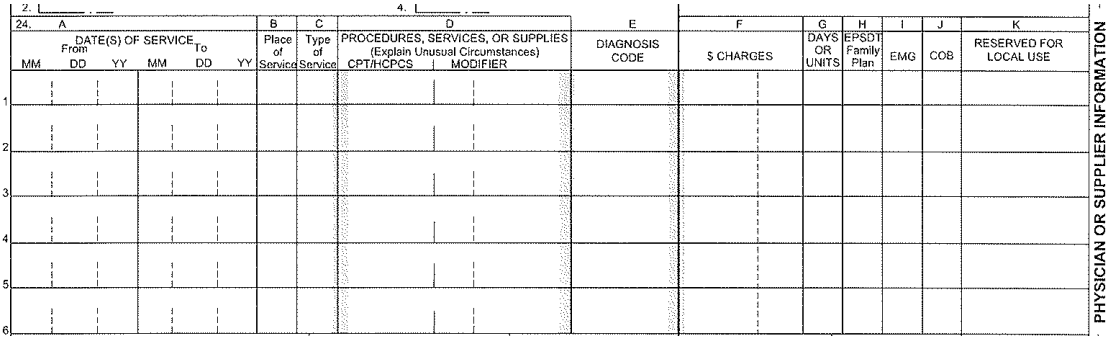
Claims that have been flagged for review can be further investigated using database searching. With this approach, companies subscribe to database search services offered by various vendors. Subscribers submit skeletal data of adjudicated claims and then have access to data submitted by other members of the service. The availability of the huge bank of collective data, powered by search interfaces, allows adjusters to view massive amounts of information from numerous sources.

Predictive modeling

In recent years, many insurers have turned to predictive modeling processes, reducing the need for tedious hands-on account management. Quantitative analysts use data-mining tools and build programs that produce fraud

propensity scores. Adjusters simply enter data, and claims are automatically scored for their likelihood to be fraudulent and made available for review.

Review the HCFA 1500 form



24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

PHYSICIAN OR SUPPLIER INFORMATION

Mutually exclusive coding

As discussed earlier, mutually exclusive procedures are coding combinations billed inappropriately in which two services cannot reasonably be done in the same session, or the coding combination represents two methods of performing the same service. CPT codes that are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. The procedure code with the higher relative value unit (RVU) is reimbursed when code pairs identified as mutually exclusive combinations are billed on the same date of service.

An example of a mutually exclusive CPT code pairing is 98941 Chiropractic manipulative treatment (CMT); spinal, three to four regions and 98940, Chiropractic manipulative treatment (CMT); spinal, one to two regions. If both 98941 and 98940 are billed on the same date of service, only the higher valued CPT code, 98941, is allowed.

Other examples when billed on the same date of service include:

- 97001 Physical therapy evaluation = $69.34
- 95831 Muscle testing, manual = $27.03 cannot be billed same date

- 98984 Chiropractic manipulative treatment 5 regions = $43.05
- 98941 Chiropractic manipulative treatment 3-4 regions = $33.25 cannot be billed on same date

The best manner in which to combat fraud and reduce risk is to thoroughly investigate the claims where fraud is suspected and promptly and fairly pay meritorious claims and vigorously defend claims without merit. If a clear and strong message is delivered to all individuals that fraud will not be tolerated, this can be the strongest reduction of risk. No matter how small, take the approach that all fraud will be dealt with seriously.

Also, ensure your initial response to any alleged fraudulent activity places you in a position of strength. Look for indicators of increased risk at every stage of a claim, such as aggressive behavior, suspicious circumstances such as a delayed claim or delayed medical treatment, and inconsistencies in reported events.