An Honest Mistake?

by Cindy Parman, CPC, CPC-H, RCC

President Barack Obama today will announce a new effort to crack down on waste and fraud in Medicare, Medicaid, and other government programs through the expanded use of payment recapture audits.

—March 10, 2010, White House press release

While most healthcare providers, suppliers, and practitioners are honest, a small minority commit healthcare fraud and abuse that costs the Medicare Program a lot of money every year.

—The Centers for Medicare & Medicaid Services, Medicare Fraud and Abuse Fact Sheet, January 2009

[We] estimate that up to $230 billion is lost to healthcare fraud, waste, and abuse annually.

—The National Healthcare Anti-Fraud Association, NHCAA in the News, July 2006

[The OIG] documented recoveries of about $3.1 billion, exclusions of 1,935 individuals and entities and 164 civil actions.

—The Office of the Inspector General, Semi-Annual Report to Congress, Oct. 1, 2009 – March 31, 2010

As you can clearly see, the federal government is recovering a lot of money with its investigative programs, so they are definitely here to stay. Community cancer centers need to understand that these payment recapture audits offer specialized private auditors—with cutting-edge tools and technology—financial incentives to detect improper payments.

Medicare Fraud, Waste, and Abuse

The Medicare Program Integrity Manual, Chapter 4, Section 4.2.1, states that the most frequent type of fraud occurs when a false statement results in payment under the Medicare program. The manual specifically states: "*Providers have an obligation, under law, to conform to the requirements of the Medicare program.*"

The term "waste" is defined as the extravagant, careless, or needless expenditure of healthcare benefits or services that result from deficient practices or decisions. In contrast, "abuse" is generally defined as any practice that is inconsistent with generally accepted medical standards, especially when the result is unnecessary costs for services that are not medically necessary. Abuse may directly or indirectly result in unnecessary costs to the Medicare program, improper reimbursement, or payment for services that fail to meet professionally recognized standards of care or that are deemed to be medically unnecessary.

Some of the possible fraudulent situations listed in the *Medicare Program Integrity Manual* include, but are not limited to, misstatements of a material fact, such as:

- Incorrect reporting of diagnoses or procedures to maximize payments
- Billing for services or supplies not furnished
- Altering medical records or claim forms to obtain higher payments
- Unbundling charges
- Misrepresenting dates or descriptions of services
- Misrepresenting the provider of services
- Billing non-covered services as payable services.

A number of entities perform audits to prevent, detect, and/or deter Medicare fraud. In addition to Recovery Audit Contractors (RACs), there are Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs). If a violation of the False Claims Act is detected during the investigation, the situation may be referred to the Department of Justice (DOJ), the Office of the Inspector General (OIG), and the Federal Bureau of Investigation (FBI) or other prosecuting agency. In addition, the Department of Health and Human Services and the DOJ have formed a task force, called Project HEAT (Health Care Fraud Prevention and Enforcement Action Team), to target cities where suspicious billing suggests a high probability of fraud. Medicare Fraud Strike Forces, which are composed of federal, state, and local agents, currently operate in seven cities nationwide. These teams follow up on tips, but also use data mining

(computer programs that sift through claims data) to detect charges that are out of the ordinary. According to the OIG Semi-Annual Report Oct. 1, 2009 to Mar. 31, 2010, Strike Force efforts have resulted in the filing of charges against 119 individuals or entities, 42 convictions, and $16 million in investigation recoveries.

Third-Party Insurers

A recent publication by the BlueCross BlueShield Association (BCBSA) reports $510 million dollars in fraud savings and recoveries in calendar year 2009. According to Scott P. Serota, CEO and president of BCBSA:

"Blue companies are actively identifying and pursuing healthcare fraud in partnership with federal and state authorities, law enforcement, and licensing boards. These efforts protect consumers' healthcare safety and safeguard healthcare affordability. Aggressive anti-fraud investigations help ensure critical healthcare dollars are being spent appropriately."

WellCare of Ohio, a managed care insurer, publishes a list of frequently asked questions relating to fraud and abuse, and states that failing to adequately document services provided according to accepted medical record standards would be considered an abusive practice.

Many third-party insurers have developed Special Investigation Departments (SIDs) or Special Investigation Units (SIUs). WellCare's SIU was established to:

- Comply with statutory, regulatory, and contractual requirements regarding fraud and abuse
- Effectively prevent, detect, investigate, and report suspected fraud and abuse
- Identify and recover lost funds through negotiation and/or litigation, including criminal prosecution when warranted
- Provide fraud and abuse training to providers, members, and associates.

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7 Components of Compliance Plan Development

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards
3. Designate a compliance officer or contact
4. Conduct appropriate training and education
5. Respond appropriately to detected offenses and develop corrective action
6. Develop open lines of communication
7. Enforce disciplinary standards through well-publicized guidelines

Community cancer centers should remember that Medicare and government agencies are *not* the only insurers that perform medical record audits. Most third-party managed care contracts or participation agreements include a provision for medical record review when the payer believes it is necessary.

Just a Mistake

Remember, there is a difference between a fraudulent practice and a coding or billing mistake. WellCare defines a coding or billing error as:

"…an isolated, unintentional event resulting from a mistake or misunderstanding of rules, policies, or generally accepted guidelines. Errors may occur as the result of miscommunication, misunderstanding, assumptions, outdated reference guidelines, inexperienced personnel, or other administrative problems."

Examples of errors may include the transposition of a number in a charge amount, isolated instances of upcoding or unbundling, or the occasional incorrect use of a modifier.

However, when a pattern of incorrect coding or billing exists, it is not considered to be an error. An active compliance program will ensure that the physician, practice, facility, or cancer program does not allow incorrect coding or billing to evolve from a single mistake into a fraudulent practice.

Compliance Programs

According to a publication of the National Association of Criminal Defense Lawyers (NACDL):

"Those medical providers who become the target of a criminal healthcare fraud prosecution must prepare for the literal fight of their lives. Their world will be turned upside down. They will face a grueling legal battle, with the potential for substantial jail time, monetary fines, and the loss of their medical license. In addition, even if they are not convicted, they may face a hailstorm of negative publicity, loss of patients, loss of in-network status with insurance companies, exclusion from both government and private health insurance programs, and licensing problems."

The best way to avoid allegations of fraud, waste, and abuse is to ensure that your community cancer center or oncology practice has a compliance program in place, and that it constitutes an active plan for ensuring correct coding and billing practices. The OIG publishes sample program guidance for physician practices, hospitals, laboratories, skilled nursing facilities, third party billing companies, and hospitals. While slight variances exist based on the type of healthcare entity, the box above identifies seven actions needed to develop any compliance plan.

Stay Alert!

According to the federal government, a provider of service may be considered guilty of fraud, waste, or abuse

if it knew or *should have known* that the service was incorrectly billed. The False Claims Act imposes liability only when the claimant acts "knowingly," and it does not require that the individual submitting the claim have actual knowledge that the claim is false. A healthcare entity that acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information can also be found liable under the Act. However, the implementation of an active compliance program that includes monitoring of coding and billing guidelines should serve to ensure that any reimbursement mistakes are quickly corrected and do not escalate into accusations of fraud, waste, or abuse.

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Resources

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