Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

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To cite this article: Roberta L. Buell (2000) Fraud and Abuse in Billing and Coding, Oncology Issues, 15:4, 12-12, DOI: 10.1080/10463356.2000.11905142

To link to this article: https://doi.org/10.1080/10463356.2000.11905142

Published online: 17 Oct 2017.

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Fraud and Abuse in Billing and Coding

by Roberta L. Buell, M.B.A.

Q *Why is there so much emphasis now on fraud and abuse?*

A The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which is comprehensive in its scope, has expanded surveillance (with regard to billing fraud) to all payers. Health care fraud is now a federal offense, and many agencies are working together to find and punish those who deceive the government.

Prosecution for fraud is under the False Claims Act of 1863 (yes, a 237-year-old law). What this means is that the government can impose a civil monetary penalty on persons (including corporations) who, among other things, present or cause submission of false or fraudulent requests for payment to the government.[1]

Q *What if I don't know I'm committing fraud?*

A You may not have *knowingly* submitted a false claim to Medicare or Medicaid. However, under the False Claims Act, *knowingly* can mean if you act in "reckless disregard" of the truth or falsity of the claim. "Reckless disregard," which is a vague term, can mean anything from not reading your carrier bulletins to not understanding CPT coding guidelines.

Q *What constitutes "reckless disregard"?*

A Any misrepresentation on a Medicare claim can constitute a false claim to the Medicare program. Here are some examples that can occur in oncology:

- *Cancer centers that bill drugs sent home with the patients for self-administration as if they were given by the clinic or office.* Misrepresentation of the site of service constitutes a false claim.
- *Billing of services that were not an expense to the provider.* Items that may be billed incorrectly to insurance companies are free drugs for indigent patients, services paid under management fees for trials, samples, and infusions by nurses who are not employees (W-2 or leased) of the clinic.
- *Billing services at a higher code level than were performed or medically necessary.* Radiation oncology encompasses many levels, which can be billed for service delivery, planning, and devices. Billing at the most complex level means that documentation in the chart supports that level and the patient's condition warrants it. The same is true for high-level Evaluation and Management Services.

Q *How can fraud be discovered?*

A Fraud can be found when a provider is audited. Medicare Parts A and B have increased the number of provider audits performed. Teaching institutions have been one focal point for these audits. Aberrant billing patterns may also subject providers to audits as can statistical "screens" set up by fiscal intermediaries or carriers for certain codes.

Also, under the False Claims Act any private citizen can file a *qui tam* suit in the name of the U.S. government. Basically, this means that someone can blow the whistle on your facility. The Act provides for the "relater" (the whistle blower) to receive 15 to 25 percent of the recovery (dollars) if the government intervenes, or 25 to 30 percent from the defendant if the government does not intervene. According to a 1998 Justice Department statistical report, the average amount paid to "relaters" where there has been a recovery is $1.09 million.

Q *What can we do to prevent coding and billing fraud?*

A Today, most hospitals and office-based clinics have compliance plans that are written to *find* fraud. Here are some simple steps necessary to *prevent* fraud:

- *Ensure that everyone in your facility that generates charges is familiar with the billing guidelines relevant to items or services.* Make sure that all new employees who generate charges are educated about the proper use of charge sheets, code books, and charge systems.
- *Be sure that you have the best tools to educate the staff about billing rules.* This means the latest code books, *ACCC's Compendia-based Drug Bulletin*, parts of Medicare manuals relevant to your specialty, and all newsletters from your fiscal intermediary or carrier.
- *Don't use outdated charging tools.* For hospitals, this will be very important under Ambulatory Payment Classifications (APCs). Your hospital's charging tool (*The Charge Description Master*) may be causing your clinic to misrepresent services. Update your charging tools immediately!
- *Document, document, document.* "If it wasn't written, it wasn't done."

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[1] The False Claims Act, 31 U.S.C., Paragraphs 3729-3733.