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Intent to deceive isn't necessary for billing fraud charges

Avoid the top six ways you can stumble into fraud

As physicians push to maximize their revenue, it can be easy to stumble into fraud through simple oversights and failing to understand how regulators look for claims that don't quite add up. Don't rest on the fact that you have no intention to defraud the government; sometimes you can get in just as much trouble by accident.

There are many scenarios in which a practitioner can be charged with healthcare claims fraud, even when he or she thinks a legitimate service has been provided and billed accordingly, cautions **Riza I. Dagli, JD,** who previously held several key posts within the U.S. Office of the Attorney General, including director of the Medicaid Fraud Control Unit, where he supervised investigations and prosecutions of Medicaid and Medicare fraud, healthcare fraud, patient abuse and neglect, off-label marketing, and kickback litigation. He is now a partner in the health law practice at Brach Eichler in Roseland, N.J., and chairs its criminal defense and government investigations practice.

Traditionally, healthcare fraud has been considered to be billing for treatment you did not provide, Dagli says. That definition has changed lately and physicians must understand how good intentions will not necessarily keep them out of trouble.

TRENDSPOTTING

$10 per visit/ $50 per year

The value of gifts you can give patients without regulators considering it a kickback.

-1.5%/+0.5%

The change in reimbursement that can happen depending on whether you report quality measures under PQRS.

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"Nowadays the laws are so strict that people are more careful not to do phantom billing, but unfortunately there are situations where you provide a service to the patient, the patient leaves, and all of a sudden you're in a fraud investigation," Dagli says. "Physicians have to be mindful that mismanagement or sloppy business practices can land them in a lot of hot water because prosecutors are looking for other manner of fraud besides making up a patient name or billing for someone who never really came to your office."

Dagli cites these top six areas in which physicians can unwittingly stumble into Medicare fraud:

1. **Billing with an expired license.** If you are billing when your license is expired or your staff's license is expired, you could be charged with fraud even though you are providing the service. Treatment provided in any gap period between renewals or when a staff member did not realize his or her license had expired technically was not provided, Dagli explains.

   "This is not theoretical. There are people who have been convicted, paid sanctions, or lost their license because they let their license lapse. It happens to pharmacists, nurses, doctors," he says. "There have been cases where a lapse of just a few days resulted in allegations of Medicare fraud."

   In those cases the fraud charges are sometimes driven by the managed care company, which is always looking for opportunities to declare claims invalid and save a few dollars, Dagli says. Licenses are easily verified by payers and prosecutors find the prosecution of such cases to be a slam dunk, he says. No license means there was no treatment, which means the claim was fraudulent.

2. **Not supervising closely enough.** If you are not in the same building, or in the same room or available by phone in some cases, you are not supervising, and this could be fraud. Requirements for physician supervision of other providers, such as therapists, will vary, but it is important to know what is required and that "supervision" is not a general term. It has a specific meaning for some treatments that must be met and documented.

   "People have been indicted for not providing supervision, because in the eyes of the state if you did not supervise properly, you did not provide the service," Dagli says. "They take a very strong line with these things."

FROM THE FIELD

"People have been indicted for not providing supervision, because in the eyes of the state if you did not supervise properly, you did not provide the service."

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3. **Patient didn't pick up the medications.** If you are not crediting back the medication that was not dispensed or picked up, this could be fraud. There must be a system in place to flag medications that were prescribed and billed for, but which the patient never received.

4. **Billing clerk assumes doctor performed certain services.** If he or she didn't, even if the doctor was supposed to, the billing could be fraudulent. This can be an easy mistake to make because physicians depend on their billing staff to understand some routine treatment and know that certain services are always provided in particular cases. That can ease the billing process, but it can lead to fraud if the clerk automatically charges for that treatment when, for whatever reason, it was not provided to that patient. "This can turn into sloppy management if you're not careful," Dagli says. "We know that everyone wants to streamline the systems and depend on staff to know certain things without being told, but that's a slippery slope that can lead to bills being automatically generated when the doctor decided to change the treatment routine for some reason or just forgot to do something."

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—Riza I. Dagli, JD

5. **Helping out poor patients with food or food coupons.** This could be a kickback, even though it seems like harmless charity. A well-intended act of generosity could come back to haunt you because regulators are always wary of your motives.

   "From the state's perspective, they know that some people don't do these things out of goodwill but because they think it encourages the patient to come back to their office instead of going somewhere else for care," Dagli says. "It's unfortunate that you have to think about that when you're just trying to be a good guy by giving them food or a gift card, but it is something that the state is going to look at and possibly misinterpret."

   The guidelines for such gifts state that, in general, a single gift worth $10 or less, or an aggregate of $50 in one year, will not be considered an inducement, Dagli explains. Keeping track of the free doughnuts and hamburger coupons you hand out may not be worth the trouble, but Dagli says regulators will be more attuned to a systematic program that seems to reward patients for their business.

"Any program in which you offer some kind of gift for visiting regularly will get you into trouble, even if your real goal is just to encourage people with chronic conditions to come in for checkups"

—Riza I. Dagli, JD

"Any program in which you offer some kind of gift for visiting regularly will get you into trouble, even if your real goal is just to encourage people with chronic conditions to come in for checkups," he explains.

6. **Working too quickly.** Some CPT codes are estimated to last 20 minutes to a half-hour, for example. If you are billing for these procedures five times an hour or 50 times a day, your justification that you are just faster than average may not cut it.

   "In your mind that is not fraud because you know you provided the service," Dagli says. "But an outside observer will say that is just not possible. You may be far more efficient than some of your peers, but you cannot bill for more than what Medicare says can reasonably be done in the time specified."

Remember that with many of these examples, the actual error may be committed by the practice staff. Even so, the physician can be investigated and charged, and have a difficult time defending the charge, Dagli says.

"The physicians ultimately are going to be accountable, so it is to their benefit to get involved directly in preventing these pitfalls," he says. "You should be able to concentrate on patients and leave the billing to someone else, but the reality is that you have to know what's happening."

Auditors incentivized to find even smallest billing errors

Medicare and Medicaid audits are increasing sharply, notes **Stephen M. Azia, JD,** an attorney with the law firm of Baker Donelson in Washington, D.C., who focuses on reimbursement, compliance, and appeals. RACs are paid a contingency fee for finding fraud by doing post-payment reviews, so Azia says they act as aggressive bounty hunters who can allege fraud long after you have received payment and thought there was no dispute. Zone Program Integrity Contractors have wide latitude to investigate fraud and abuse, which includes requiring pre-payment or post-payment reviews for physician practices under scrutiny, and Medicare Administrative Contractors have similar authority.

An increasing threat to physician practices is a tool, used by the various auditors, called extrapolated overpayments, Azia notes. For example, the auditor may look at a sample of 30 of the physician's claims and find an error rate of 60%. They then extrapolate that error rate to a much larger universe of claims by that practice.

"You may have an initial overpayment of $10,000 that becomes a #1 million extrapolated overpayment."

— Stephen M. Azia, JD

"You may have an initial overpayment of $10,000 that becomes a $1 million extrapolated overpayment," he explains. "It is a very dangerous situation facing providers."

Providers may not recognize the original request for repayment as a RAC audit, cautions **Sharon Hollander,** CEO of STAT Medical Consulting in Los Angeles. Accepting one allegation of fraudulent billing could open the door to many others.

"You may get a single patient refund request and so the doctor tends to just accept it and repay the $70. But Medicare may take that as an admission of guilt and ask you to repay for every time you used that code in the past three years," she says. "You have to look at that claim and appeal it if you can, rather than just sending a check to be done with it."

In her book *Medical Billing Horror Stories,* Hollander details such incidents, including one physician who was dunned for overpayment on a single claim and paid it, only to have the auditors extrapolate the same code overcharge for the past seven years. The practice ended up paying $100,000 back to Medicare.

"It's a game of 'gotcha' they play sometimes, and even if you win those on appeal, it's a headache."

— Sharon Hollander

Documentation is the key to avoiding that kind of extrapolation disaster, Azia says. You should document well all the time, of course, but when asked for documentation for a sample of claims, take the time to provide thorough documentation on the front end. If you skimp on justifying that first batch of sample claims, you could jeopardize the validity of a much larger number of claims, he says.

"Don't neglect the petty little things in documentation" Azia cautions. "We've seen claims thrown out because they weren't signed, the date was wrong, or even because the signature was illegible. These contractors are looking for technical errors that allow them to put this claim in the fraudulent column. It's a game of 'gotcha' they play sometimes, and even if you win those on appeal, it's a headache."

In addition to the auditors nitpicking your claims, you could be turned in by one of your staff. The False Claims Act includes enticements for staff to blow the whistle on healthcare fraud and offers substantial rewards, notes **Dan Purdom, JD,** a partner in the Health Care and White Collar practice in law firm Hinshaw & Culbertson's Lisle, Ill., office. He has represented numerous medical providers who have been involved in federal, state, and regulatory investigations of alleged healthcare fraud and related problems. Purdom taught healthcare fraud investigation

at the FBI Academy in Quantico and was an author of the *Department of Justice Manual on Prosecution of Healthcare Fraud*. In 1986, as an Assistant U.S. Attorney in the Northern District of Illinois, he prosecuted what was then the largest healthcare fraud in the United States, dismantling a $20 million Medicaid fraud scheme.

Under the False Claims Act, intention to deceive payers is not necessary to prove guilt and liability, Purdom explains. Rather, the government only needs to prove reckless disregard resulting in invalid claims, a much lower standard. Reckless disregard can occur when a coder submits incorrect bills repeatedly, perhaps making the same mistake over and over for some period of time, and the practice does not catch the error. An auditor may find that error, but often a practice insider will realize the problem and report it to regulators. The problem is compounded if the whistleblower can show that he or she notified practice leaders but no action was taken to stop the billing errors or correct past claims, Purdom says.

"If you don't have systems in place to catch those kinds of mistakes, internal audits, that's where you get in trouble," he says. "The Fraud Enforcement and Recovery Act in 2009 expanded the False Claims Act so that not only are false and fraudulent submissions a violation of the act, but now if you have knowledge that you received an overpayment and you don't return that, the inaction can be a false statement. You have an obligation to act on that overpayment."

Selecting the right E/M code can be a challenge, and some providers think they are playing it safe by choosing a code with a value somewhere in the middle of high and low, Hollander says. They hope that by doing that they will stay under the radar with Medicare.

"By doing that they are flagging their claims by essentially telling Medicare that they don't know how to properly E/M code," she explains. "Submitting a flat line value for the codes stands out because Medicare is looking for standard distribution in a bell curve. Not every person in your practice is going to need the intensity of care, so not using the right E/M code doesn't keep you under the radar and instead it gets their attention."

Quality measures increasingly important, but focus on right ones

It has become mantra in the healthcare community that your future will be determined by quality measures. Your quality scores will determine your participation in accountable care organizations (ACO), your reimbursement rates, and pretty much your financial future. But what quality measures are we talking about? How can a physician practice assess where it stands now on the key quality measures and work to improve them in time?

The measures used for ACOs vary widely, but the closest there is to a standard are the 33 quality and cost measures included in the CMS-based ACOs, says **Greg Chittim,** director of analytics and performance improvement at Arcadia Solutions, a consulting company based in Burlington, Mass., that works with ACOs. (Those ACO measures can be found online at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf*.)

Twenty-two of those are considered "clinically sensitive," meaning that they are influenced directly by the physician and trackable in an electronic health record (EHR), Chittim notes. These measures fall into categories such as Chronic Care Management, with measures for percentage of individuals with an A1c test, percentage of individuals with a documented blood pressure, and similar measures. In the Care Coordination category, the measures include the percentage of referred services that are completed, and Care Transitions includes the percentage reduction in hospital readmission rates.

"Physicians need to first focus on aggregating their data from multiple sources—at a minimum EHRs and claims, but more often from multiple different EHRs, claims, and other ancillary systems like practice management and general ledger," Chittim suggests. "Bringing all this data together is no easy feat, but then the focus shifts to change management."

The Physician Quality Reporting System (PQRS) also provides an outline for the quality measures that will matter most in the future, says **Michael Nugent,** managing director in the healthcare practice and leader of the Managed Care Pricing team with Navigant Consulting in Chicago. PQRS will use payment adjustments starting in 2015 to report specific quality measures, offering a 0.5% increase in Medicare payments for reporting and potentially a 1.5% reduction for not reporting, Nugent explains. (More information on PQRS is available at *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Index.html.)*

"The quality metrics are about more than getting paid more or getting paid less."

— Michael Nugent

"The quality metrics are about more than getting paid more or getting paid less," Nugent says. "Ultimately the measures are intended to provide some value to the physicians and patients, so we should remember to look at them as a guide for clinical management and practice decisions. Meeting the quality measures certainly will have an impact on how you are paid, but it would be shortsighted to look at them as merely a financial incentive."

Change management requires identifying areas for improvement, setting interim milestones toward the ultimate ACO measure goal, and then bringing to bear the clinical, operational, and management expertise to drive the necessary training, tracking, and improvement, Chittim says. More managed care contracts are including quality measures that determine payment rates, but the measurement process will vary not just according to specialty, but also what data is available, notes **Jim Otto,** senior principal in consultant Hay Group's Healthcare Practice in Atlanta. The data that physicians and other healthcare professionals want to use might not be available yet because the emphasis on measurement is relatively new, he says.

"I'm seeing process measures now more than quality outcome measures," he says. "For pediatricians, for instance, you might measure how many kids are vaccinated by age 2. That's a process measure rather than an outcome measure. But I think four years from now we might see a focus on different measures as that outcomes data becomes available."

Variability among practices, even in the same specialty, may require an effort to make treatment more uniform so that quality measures will be more useful, Otto says. Reporting on quality measures also will spur individual physicians to improve their performance, he says.

"Show them how they are doing and the bottom feeders in particular start feeling pressure to catch up with their peers," he says. "That can be a big motivator for people picking up their game."

In addition to clinical and financial metrics, patient satisfaction also will be an important quality measure in the future, says **David Friend, MD,** managing director at BDO Consulting in New York City. Many physicians are getting used to clinical report cards, but their future success also will depend increasingly on patient satisfaction. Just as hotels, restaurants, and retailers rely on good online customer reviews, Friend predicts that physicians will see similar reviews determining their practice success.

"We're not there yet but we're headed in that direction," Friend says. "I think the more enlightened medical groups are thinking about making their customers happy, the providers they interact with happy, and the payers happy."

Questions? Comments? Ideas?

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Oncologists turn to medical home model for better value

Oncologists are adopting a medical home model that they say will improve care and produce better quality measures for the physicians. Legislators and CMS leaders may use the model as an example of how physicians can meet expectations for quality while preserving reimbursement rates.

The project has been underway for two years, says **Ted Okon,** executive director of the Community Oncology Alliance (COA), a nonprofit based in Washington, D.C., that advocates for oncology practices and their patients. The patient-centered medical home model has emerged in the primary care arena as a partial solution to fragmented care delivery, he says, and oncologists are seeing it as a promising response to the demand for improved quality and recent reductions in reimbursement for oncologists.

"The patient-centered oncology medical home is an enhanced version of clinical care and also can provide greater efficiencies," Okon says. "We pulled together a number of stakeholders and they have developed 19 measures of quality and value in cancer care. We also have developed a very progressive payment model, working with payers and the federal government."

Oncologists are incorporating some of the same features from primary care medical home models, including open access, enhanced care coordination, comprehensive care, and sustained personal relationships. The Oncology Patient-Centered Medical Home model was developed by Consultants in Medical Oncology and Hematology (CMOH), a private practice in southeastern Pennsylvania, the first oncology practice in the nation to achieve level III recognition from the NCQA. COA leaders see the model as a potential solution for many of the challenges facing oncology, including issues of cost control, quality assurance, outcome measurement, and process improvement, Okon says. (For more details on the model, see *www.communityoncology.org/site/medical-home-aco.htm.)*

The oncology medical home model at CMOH ensures that each patient is managed by a physician-led care team. When the patient is diagnosed with a malignancy, the practice becomes the central coordinator of care throughout all phases of treatment, Okon explains. Some non-oncologic medical issues continue to be managed by the patient's primary care physician, but the model encourages extensive communication between the oncology team and the primary care team.

"Measuring quality will be important for any practice in the future, and the oncology home model provides a blueprint for how to achieve that."

— Ted Okon

Other efforts to reduce spending in oncology have focused on drug utilization, but Okon says the oncology medical home places more emphasis on areas in which oncologists can truly affect costs, such as ER utilization and hospitalization rates. Hospitalization costs for a cancer patient are close to or more than the cost of drugs in cancer care, he notes. The model aims to reduce those costs through improved care coordination, open access, and avoidance of potential complications.

"When legislators and healthcare leaders look at the quality measures and our specific payment model, they tell us that we are very far along in meeting the goals that they're setting for the entire healthcare community," Okon says. "If you can pull off payment reform in cancer care, you can pull it off anywhere. These drugs have to be monitored because they're so potentially toxic, so you cannot separate the physician from the payment model in any way."

Measuring quality will be important for any practice in the future, and the oncology home model provides a blueprint for how to achieve that, Okon says.

"The days of playing golf without a scorecard are over," Okon says. "You need to be measured, but set those measurements yourself instead of waiting for someone else to set them. Quality and value are both important goals and important to measure, and whatever your specialty, you should have a say in determining the most meaningful ways to measure them."

Risk adjustment can be effective measure for ACOs

A new study from the Society of Actuaries (SOA) finds that risk adjustment, a statistical method used to explain differences in medical costs between patients, can be an effective tool to help evaluate how effectively accountable care organizations (ACO) manage factors not related to patient health, such as physician practice patterns and patient preferences.

"Evaluating ACO Efficiency: Risk Adjustment Within Episodes" is the third in a series of SOA-commissioned studies that examine specific aspects of reform under the Affordable Care Act (ACA), notes **Rina Vertes,** chair of the Project Oversight Group for the study.

"The SOA has been working to provide insight and assistance to health actuaries during this time of unprecedented transformation in the U.S. healthcare market," Vertes says. "The ACO strategy, an important component of the ACA designed to improve both care coordination and health system affordability, will be effective when opportunities to reduce healthcare costs are taken while maintaining or improving quality and patient outcomes."

The study found that after taking into account factors relating to patient health through risk adjustment techniques, an ACO can be evaluated on how well it manages other important factors that affect costs for certain specific episodes of care. Just as important, Vertes says, the study found that for certain episodes of care, patient health does not play a significant role in determining episode cost. This study provides an approach for insurers, states, and federal regulators to evaluate the cost-effectiveness of ACOs for certain patient types, she suggests.

Specifically, the study analyzed the application of risk adjustment within health episodes, which are defined periods of connected health conditions or acute events. This approach helped the authors determine whether risk adjustment could separate out the effects of patient health status on the variation of costs among ACOs. Controlling for variations in patient health enables ACOs to be fairly evaluated by how effectively they are able to control other factors that contribute to overall healthcare costs, such as their own physician practice patterns.

The study's findings indicate that there is an opportunity for cost savings among ACOs that are able to manage factors that are within their own span of control, Vertes explains. But she says it is important to note that risk adjustment must be used judiciously in assessing ACO success, because patient health status does not seem to play a decisive role in affecting costs for certain types of episodes.

The report findings, which shed light on the efficacy of risk adjustment within episodes to control patient health status, may help actuaries and insurers develop fairer provider payment models, and may also help regulators make sense of changing cost structures resulting from new provider reimbursement methods, Vertes says.

Reimbursement up only 0.3% in 2013

The amount of money paid to physicians for their services increased only 0.13% in 2013, the slowest rate in more than a decade.

The Producer Price Index (PPI) measures changes to reimbursement paid to physician offices, hospitals and other healthcare providers. The 0.3% change in physician office prices in 2013 is much lower than the increase of 1.2% in 2012. To see a worse PPI, physicians have to look back to 2002 when the index declined by 0.1%.

On average, physician office prices have increased 1.8% per year since the data collection began in 1997. Physician office prices declined by 0.4% in December 2013 after remaining flat the prior month. The December 2012 decline was 0.1%.

Hospitals fared better in 2013, with a PPI growth of 2% last year, but still lower than the 2.6% in 2012. Acute care hospitals have averaged an annual increase 3% since 2005. In December 2013, acute care hospital prices increased 0.5%, a slight increase from 0.4% in November 2013.