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MEDICAL PRACTICE CONSULTANTS, INC.

Series of Medicaid Fraud and Abuse, Part One

Below are excerpts from the "Common Types of Health Care Fraud"

COMMON TYPES OF HEALTH CARE FRAUD

Fraud, waste, and abuse pose major risks for the Medicaid program. "Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person." "Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."[1]

Sanctions under Federal law, for example, can take the form of administrative, [2] civil,[3] and criminal[4] penalties. These penalties range from monetary fines and damages to prison time and exclusion from the Federal health care programs, including Medicaid.

Billing for Unnecessary Services or Items

Under Section 1902(a)(30)(A) of the Social Security Act, States are required to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services."[7] States may "place appropriate limits on a service based on such criteria as medical necessity."[8] Providers are responsible for ensuring authorized services meet the definition of medical necessity in the States where they practice. Intentional billing of unnecessary services or items can lead to the serious consequences mentioned earlier.

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Billing for Services or Items Not Furnished

To be covered by Medicaid, the billed service or supply must be provided. Some providers bill Medicaid for a covered service or item but do not deliver the service or item. These providers may create false records in an attempt to justify the bills. For example, a physician might sign charts and submit bills for examinations and tests that never took place. Providers should only bill for the medically necessary or otherwise authorized services or items provided to beneficiaries, and should ensure that proper documentation is in place. Health care professionals should exercise appropriate caution when evaluating offers of payment in exchange for reviewing medical records written by others.[9]

Upcoding

Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a higher level of complexity than the service actually provided or documented in the file.[10] For example, a supplier of durable medical equipment might bill for motorized scooters while supplying less expensive manual wheelchairs. As another example, a physician might bill simple office visits at the higher rate for complex visits. These practices are illegal. Providers should only bill for the level of services or items provided.

Unbundling

According to the Federal Bureau of Investigation, unbundling "is the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost."[11] For example, a laboratory might receive an order for a panel of blood tests on a patient. Instead of billing for the panel, the laboratory might attempt to increase its income by billing for each test separately. This is like ordering a value meal at a fast-food restaurant and then being charged the higher individual prices for each item. Providers who bill Medicaid are responsible for knowing which procedures are subject to bundling requirements and billing accordingly.

Medical Practice Consultants, Inc.

For the last 24 years Medical Practice Consultants (MPC) has distinguished itself as one of the leading healthcare business consulting firms in the Southwestern and Midwestern states of the United States. Our team credentials include:

- Certified Medical Insurance Specialist (CMIS)
- Advanced Coding Specialist for Evaluation/ Management services (ACS –EM)
- Certified Healthcare Auditor (CHA)
- Certified Public Accountant (CPA)
- Certified Professional Medical Auditor (CPMA)
- Continuous Quality Improvement Plus Green Belt (CQI+)

MPC offers a comprehensive understanding of the complete reimbursement process, documentation, coding, and the ability to challenge and prevail in claim appeals with CMS carrier and program integrity contractors; The knowledge and ability to audit E/M services with attention to the tough scrutiny from the RAC and payer audits; The skills to assist an organization in ensuring they are documenting appropriately to support the E/M levels billed to achieve proper reimbursement and avoid costly denials; and the qualifications to assist organizations with determination of problematic root causes found in the healthcare organization with the performance of gap analysis to assist the organization on corrective actions.

***Full article and references can be seen on the CMS website at* https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-factsheet.pdf**