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Big Data: Medical Billing Fraud and Abuse Claims Increasingly Based on Data Analysis

By Ingrid S. Martin
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With medical billing fraud and abuse cases increasingly driven by data analysis, it has never been more important for healthcare providers to carefully assess the claims data they provide to the government.

In analyzing billing data, government investigators are looking for providers with suspect billing patterns, including high utilization of expensive billing codes, being a top biller for any particular code, or billing in a manner that is different from other providers of the same type.

For example, a Tennessee pain management clinic recently drew the attention of federal investigators because it was an outlier in its billing for urine drug screens. The clinic paid $312,000 to resolve allegations that it was ordering medically unnecessary screens in violation of the federal False Claims Act.

To avoid these kinds of entanglements, healthcare providers need to monitor and to analyze their own claims data. The key questions healthcare providers need to ask are: What billing codes are they most commonly using? Are the people choosing which codes to bill properly qualified and up to date? Does the electronic medical records system make it easy for providers to capture necessary information to support the billing?

To minimize the risk that auditors and investigators will find a basis to allege overpayment or fraud, and to help prevent drawing their attention in the first place, healthcare providers should include some simple steps in their compliance programs.

First, healthcare providers should identify the most commonly used billing codes. For example, the most common services provided by many medical practices are some type of physical examination that is billed with an evaluation and management code. These medical practices should determine what level they are most commonly billing – a simple visit, medium visit, or complex visit?

Once this data is obtained, providers have to ask, does the resulting billing pattern make sense? Routine use of more expensive billing codes does not necessarily equate with fraud and abuse, since good reasons might support why a provider is regularly using these codes.

The second step is to assess the current requirements for commonly used billing codes. Providers should review at least annually resources such as the current CPT coding definitions by the American Medical Association, Centers for Medicare & Medicaid Services (CMS) Manuals, and Medicaid regulations. Another important note: private insurers can have their own rules and guidelines for billing that deviate significantly from Medicare and Medicaid requirements.

Once you identify the key requirements for the billing codes, you need to determine whether your medical records support the billing codes you are using.
For example, billing codes for a physical therapy practice often require recording how many minutes a patient spent with the therapist. Does the medical records system make it easy for the therapist to accurately record the length of the visit?

Another common example is when a non-physician provider's services are billed as "incident to" the services of a physician. Does the medical records system document that the physician is present at the clinic when the non-physician provider is providing the services to the patient?

The third step in reviewing your compliance program is to look for billing number and diagnosis code outliers, as government investigators are particularly on the lookout for odd or unusual billing or diagnosis codes for patient services submitted by healthcare providers.

For example, the Office of Inspector General for Health and Human Services has investigated a number of hospitals who were billing Medicare for the treatment of Kwashiorkor, a form of severe protein malnutrition that mostly affects children in famine-stricken areas and developing countries. Hospitals pursued by the OIG have generally agreed that it was incorrect to submit claims for Kwashiorkor treatments, and have for the most part indicated that the billing errors resulted from insufficient training on how to

correctly code malnutrition conditions. Regular review of billing for unusual or outlier codes and diagnoses will help identify and minimize these types of mistakes.

In sum, an effective compliance program implemented by a healthcare provider should:

- Identify the provider's most common billing codes
- Detect and assess outlier billing and diagnosis codes
- Determine whether a provider is documenting what is necessary to support billing codes submitted to the government, and whether the electronic medical records system encourages the needed documentation
- Ensure that the provider remains current on updates and changes to billing code requirements and definitions

Ingrid S. Martin is a partner at Todd & Weld LLP in Boston, where she concentrates her civil and criminal litigation practice on representing healthcare providers in a wide range of matters, including defending against false claim submissions and exclusion from Medicare, Medicaid, and other federal healthcare programs.

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