Part B Insider (Multispecialty) Coding Alert

Compliance: Know How to React If You See Potential Fraud on Your Providers' Claims

Contact physician before panicking.

With compliance in the spotlight, many coders are on high alert. Know what to do if you come

The OIG has issued scores of documents that profile the types of fraud that they are investigating. For instance, the agency provided its Oct. 24 webcast to offer information on this subject. (See our cover page for details).

For instance: The OIG sentenced a physical therapist to six months of incarceration for work that wasn't performed -- in fact, the PT "submitted claims that would have required working more than 15 hours a day, and often more than 24 hours a day, for more than 600 days," a recent OIG report indicated.

Take action: If you notice that your provider has billed an abnormal pattern as the PT in the example did, check the documentation to confirm that you're billing the appropriate codes that match the services performed and recorded.

In some cases, you might discover a discrepancy between coding and documentation that might explain the issue. For example, if the therapist only performed one unit of a 15-minute service, but accidentally marked four on their charge ticket, that would explain the difference.

If the documentation supports the billing but the coder knows that the therapist didn't work 18 hours that day, the coder should approach a manager or compliance officer. In many cases, there will be a simple answer to the situation -- that it truly was a mistake, or something to that effect.

Examine Non-Timed Codes

You can't always count up a physician's hours the same way you could count a physical therapist's or other provider who mainly bills time-based codes.

For instance: If you review claims for E/M codes, you can't assume that the physician will meet the time benchmarks in CPT during every visit.

In some cases, the doctor isn't billing based on time but still meets the requirements of the E/M code. "A 99214 visit may take 15 minutes even though the code says it should typically take 25--unless counseling or coordination of care took up at least half of the visit, you won't be coding based on the time anyway, so if the documentation and the nature of the presenting problem back up the code choice, you can report it.

Consider this: In some cases, the OIG might say that it's impossible for a physician to perform a certain number of visits in a single day but that you've submitted claims implying that he did. Remember that a doctor might look like he's doing more than he did because two or three non-physician practitioners could be billing incident to and it looks like the doctor did three times the amount of work a physician could do in a day.

If you do find fraud: In some cases, you might review the documentation and find that your provider did bill improperly. If a coder knows of an issue and hasn't made an attempt to resolve it, they could potentially be implicated, and would at a minimum be in violation of the code of ethics of whatever professional organization gave them their credential. At maximum, they could be seen as an accessory to the fraud (that would obviously be quite extreme). Let your conscience be your guide--if you see a potential issue that you can't resolve, check with your manager.

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