Part B Insider (Multispecialty) Coding Alert

Part B Mythbuste: 10 Compliance Realities That You Can't Afford to Ignore

Check out these misconceptions and why you shouldn't keep believing them.

Think you've got your payer's billing protocol all figured out? Think again. Chances are strong that you're probably falling under one or more of the most common Medicare billing and coding misconceptions, and that could cost you.

If you put your faith in any of the pervasive billing myths, you're putting your practice at risk of repaying money if you're found to have coded incorrectly on audit. "And in the worst case, you're putting your practice under investigation for a fraud indictment, which could either be civil or criminal," said **Barbara J. Cobuzzi, MBA, CPC, CENTC, COC, CPC-P, CPC-I, CPCO** of CRN Healthcare Solutions, who shared over a dozen common misconceptions during the Audioeducator conference, "Anatomy of a Fraud Indictment and Ultimate Acquittal." And remember criminal charges mean that the doctor and maybe even the coders and billing managers potentially could end up in jail, Cobuzzi added.

Below are ten of the most common misconceptions that could get you in hot water.

1. Only large practices are at risk of a fraud indictment. "To tell you the truth, most of the practices I've been working with and I've been helping are small practices one doctor practices that have been either investigated, indicted and had problems with authorities," Cobuzzi said. "It seems to me that they go after the small practices because they know they don't have the resources in the bank to go and fight them and they're more prone to settle even when they're not guilty."

2. You're safe because you have a compliance plan on the bookshelf. "Just because you have a compliance plan doesn't mean you're safe," Cobuzzi said. "Your compliance plan has to be a living, breathing thing that you have to always be referring back to." In fact, she adds, "a compliance plan that's sitting on the bookshelf or sitting in a file on your computer that you are not following is actually more damaging to you than if you had no compliance plan. That compliance plan you have has to be part of an active engagement with your practice, and that's so very, very important."

3. Your MACs have always paid you and you have never been audited, so you're safe from fraud charges. "That's not true, because the payers get a CMS-1500," Cobuzzi said. "The claim form says you did 'A' for reason 'B' and the payer pays you. But they've never looked at the documentation. They've never had the opportunity to compare it. So that doesn't necessarily mean they don't think something is not right in your operation, and sometimes when they've always paid you, they then start looking at patterns and they say, 'Gee, we've paid a lot of money to this practice for these types of services where we haven't paid to other practices' and then that's when they start doing the investigation."

4. None of your staff would ever turn you in for doing things that bend the rules. "Don't believe that one," Cobuzzi says. "First of all, lots of times staff thinks that a Qui Tam whistleblower suit is going to be their payday. Secondly, your employees want to be listened to, and if your employees come to you and say 'We are not doing this right, we need to change how we're doing something,' listen to them. They usually know what they're talking about. And if they don't know, the only way you'll find whether they do or don't know is by investigating and checking it out."

Most whistleblowers say they've been telling their bosses over and over again about what they're doing wrong but the executives don't listen. Then the whistleblower feels like the inability to change is putting them personally at risk, and they're concerned. If your employee complains and after investigating, you find that they're wrong, then go back and talk to them about why they might have a misconception, but don't ignore their concerns.

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5. You believe you're a highly valued specialist who is worth the money for high-level services. "Sorry, it's not the 1980s and you're not going to get paid for being a 'highly valued specialist,'" Cobuzzi said. She cited one Manhattan specialist who refused to bill any codes below 99214 because he felt like he deserved it, rather than what his documentation supported.

6. A MAC can't come after you because you don't participate with them and you only collect directly from the patient, not from the payer. "This is not true, because as long as you give a receipt to the patient and it has CPT® and ICD-9 codes on it so the patient can get reimbursed so it goes against the patient's deductible and copays, you are still participating from the perspective of the fact that the data goes to the payer in order to reimburse the patient," Cobuzzi advised. "If you're billing a 99214 or a 99215 and you're not doing it, they can go after you because it's determining what the patient gets reimbursed, and you've said that in the documents you've provided the patient for reimbursement."

7. The U.S. attorney can and will only prosecute fraud and abuse having to do with Medicare and Medicare. "I have been involved in cases where private insurance companies didn't want to spend their own money to go after it, so they' pointed it out to the U.S. attorney and said 'we found a pattern, we don't like what this doctor is doing with our insurance company,' and the U.S. attorney says, 'Well maybe they're also doing it with Medicare or Medicaid,'" Cobuzzi said. The attorney will then find some component of it with Medicare or Medicaid, and then they will go after the physician or practice and prosecuting for both the private payer and the government payer.

8. You're not responsible for reading every single government fraud alert, article, compliance document, carrier bulletin and every other Medicare transmittal, because if they can't prove you knew about the laws, they can't prove you knowingly committed fraud. "Nope," Cobuzzi said. "If a rule is out there, you need to follow them. It's just like from a speeding perspective: If you're on a road with a 50 mph speed limit and a sign drops the speed limit to 30 mph and you didn't see it and you're still going 50 mph and the police stop you, they can give you a ticket for going 30 mph in a 50 mph zone...it doesn't matter if you saw it, it was there, it was your obligation to be aware of the signs. It's the same thing with Medicare, Medicaid and the private payers because they then use the system to go after you if you don't follow their rules."

9. You can just code everything and see what they MAC will pay. "You're breaking the rules," Cobuzzi said. "If you code everything you're not following the rules of bundling and all that, you're throwing it at the wall and seeing what will stick. That could hurt you and that could hurt them. You could not necessarily be catching everything payable to you, and you'll definitely get into trouble for the issue that the OIG has put into the model compliance plan called unbundling, and you have to be careful with that."

10. If you sent in a copy of the notes for the op report with the claim, you have to assume the payer agrees with your coding. Their payment to you means you coded correctly, and if you coded wrong, they'll fix it to match the documentation you submitted. "If you send an operative note with the claim, the operative note or the documentation for an E/M gets separated from the claim, it doesn't get read, they don't code for you, and unless they request the operative note for processing of your claim, they are not going to read that and have that affect the processing of your claim," Cobuzzi said. "Just because you send the operative notes with the claim and they pay you, it doesn't mean you coded it right."

Resource: For more on the common billing misconceptions and how you can avoid them, visit www.audioeducator.com/medical-coding-billing/criminal-fraud-indictments-and-acquittal-04-30-2015.html.

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