Avoiding Fraud and Abuse Problems

By Brad R. Kruse

The National Health Care Anti-Fraud Association (NHCAA) has estimated that between three and ten percent of all annual health care benefits paid nationwide are paid on fraudulent or abusive submissions. Some fraud analysts indicate that there is a higher percentage of fraud and abuse in dentistry than in areas of medical practice. As a result, there is potentially more scrutiny on dentistry with respect to fraudulent and abusive practices.

Against this backdrop, and with heightened scrutiny on health care fraud and abuse, it is more important than ever for all practitioners, including dentists, to be aware of how to avoid fraud and abuse pitfalls, and to know how to respond should they receive an audit or investigation from a governmental agency or insurance company.

The first step in avoiding fraud and abuse pitfalls is for practitioners to be aware of practices and conduct that are typically viewed as fraudulent and abusive. Generally, fraud is defined as any act of intentional deception or misrepresentation of treatment facts made for the purpose of gaining unauthorized benefits. Specific types and examples of fraudulent and abusive practices include the following:

a. Billing for services not performed. Although the problem is basically self-explanatory, certain situations can be more complicated. For example, if a crown is billed at the prep date rather than the cementation date, the question arises as to when the service was actually performed. Many insurance carriers consider the crown completed only after it is cemented. This example illustrates the importance of checking the applicable benefits manual. Upfront disclosure of the situation is typically the best practice for avoiding any problems with the carrier.

b. Upcoding. This occurs when a coding procedure with a more extensive degree of difficulty than what was actually performed is used.

c. Waiver of co-payments. Co-payments are considered an essential element of the cost structure of the policy between the insured and the insurance carrier. The waiver of co-payments arguably encourages more usage of the coverage by the insured than would normally occur. As a result, the cost structure of the insurance policy in question may become distorted.

d. Waiver of deductibles. As with co-payments, deductibles are also considered an essential element of an insurer’s cost structure, and their waiver arguably distorts such cost structure.

e. Altering dates of service. The date a service is performed relates directly to patient eligibility requirements and waiting periods, and therefore, it is considered fraudulent to submit a claim for treatment using a date other than the actual date of service.

f. Unbundling or improper use of codes. The American Dental Association defines unbundling as “the separating of a dental procedure into component parts with each part having a charge, so that the cumulative charge for the components is greater than the total charge to patients who are not beneficiaries of a dental benefit plan for the same procedure.” Therefore, it is improper for a practitioner to submit several codes when the procedure in question could have been billed under one code. An example of unbundling would be when a practitioner, instead of charging a global fee for the extraction of a tooth, submits separate codes for items incidental to and incurred in connection with the extraction, such as elevating the flap, curcuting out the periapical tissue, incision, drainage, and suturing the socket.

g. Misrepresenting patient identities. This occurs when services are performed on one patient but a claim is sent in for a different person.

h. Not disclosing existence of additional primary coverage. Sending in multiple claims to different carriers as if they were each the primary carrier is considered fraudulent.

i. Performing unnecessary services. This is largely self-explanatory, though there often may be a legitimate debate as to the necessity of services in certain circumstances.

j. Misrepresentation of services. This occurs if the appropriate code is changed to a different code to increase the amount of the claim.

k. Unlicensed employees. This occurs when hygienists, assistants or other staff are used to perform treatments in situations where such persons are not licensed or qualified and/or the procedure is billed improperly as if the procedure was actually performed by the practitioner.

In addition to being aware of these fraudulent or abusive practices noted above, there are other important steps that practitioners should take to guard against fraud and abuse issues.

One of the best protections that practitioners can take is to work with and monitor their staff closely. Without proper oversight, a practitioner may not be aware of a staff member who is improperly coding, whether intentionally or not. Additionally, practitioners should take steps to insure that staff is not incentivized to use higher or improper codes to increase the staff’s (incentive) compensation.
Practitioners should also look for “red flags”, such as overutilization of particular codes, providing all or most patients with the same or similar treatment, or consistently billing the highest level of codes. Doing these things, especially over a period of time, is likely to attract the attention of governmental or insurance carrier auditors. Most practices should typically show a broad mix of codes, both in terms of types and level of treatment. If a practitioner’s practice necessarily gravitates towards a high usage of a certain level or type of code, extra attention should be given to documenting the underlying basis for such coding.

If a practitioner does become the subject of an inquiry or audit, it is important that the practitioner respond and cooperate accordingly. Ignoring or otherwise refusing to cooperate with auditors will invariably make what is often a very manageable situation much worse. If there is confusion as to what the auditor is requiring, or as to the implications and impact of the audit, practitioners are strongly encouraged to consult with legal counsel familiar with and experienced in dealing with such audits.

Lastly, it is also very important for practitioners to heed warnings and educational correspondence from investigators and auditors. Once a practitioner is educated or warned regarding a particular practice or problem, any similar conduct in the future that once may have been previously been viewed as mere abuse or waste, would then likely be considered fraudulent following the warning. This is because the practitioner is presumed to have actual fraudulent intent for engaging in similar conduct in the future as a result of being previously warned. If a practitioner does not agree with a particular warning or educational correspondence, the practitioner should respond in writing to the auditor or investigator documenting the disagreement. If the issue cannot be resolved, practitioners are strongly urged to seek legal advice.

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