Question 1: Why is coding compliance important?

Answer 1: Coding compliance is part of the overall effort of medical practices to comply with regulations in the coding area. Compliant claims are an indication of a compliant medical practice. Claims that contain errors raise the question of whether the practice is generally acting in a fraudulent manner. To reduce the chances of being targeted for an investigation or an audit, and to reduce the risk of liability if there is an audit, medical practice staff as well as physicians must be aware of, understand, and comply with all applicable regulations and laws.

Question 2: What constitutes medical financial fraud?

Answer 2: "Fraud is an act of deception used to take advantage of another person or entity" (Vines, Rollins, Braceland, & Peterson Miller, 2009, p.172). It is an intentional act carried out to obtain a profit. Fraud occurs when health care providers (or others) falsely represent their services or charges, such as billing for services which were not performed, or upcoding to increase payment. "Misuse of...standardized codes to obtain more money than is allowed by law is commonly termed 'upcoding' or 'upcharging'" (What is "upcoding," n.d.).

Examples of fraud (Common Types of Qui Tam Fraud, n.d.) include the following:

- Phantom billing, or billing for tests that were not performed
- Performing inappropriate or unnecessary procedures
- Charging for equipment or supplies that were never ordered
- Billing Medicare or Medicaid for new equipment but providing the patient used equipment
- Billing Medicare or Medicaid for expensive equipment but providing the patient cheap equipment
- A drug or equipment supplier completing a Certificate of Medical Necessity (CMN) instead of the physician

Question 3: What are the implications of the Federal Civil False Claims Act?

Answer 3: "The Federal Civil False Claims Act prohibits the submission of fraudulent claims or making false statements or representations in connection with a claim" (Vines, Rollins, Braceland, & Peterson Miller, 2009, p.167).
There is also a provision in this act for *qui tam* cases. *Qui tam* allows a private individual, or whistle-blower, with knowledge of past or present fraud on the federal government, to sue on behalf of the government to recover stiff civil penalties and triple damages. The person bringing the suit is formally known as the *Relator* (Common Types of *Qui Tam* Fraud, n.d.).

The following are examples:

- A person who "conspires to defraud the Government by getting a false or fraudulent claim allowed or paid" (31 U.S.C. § 3729. False claims, 2006).
- A person who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government" (31 U.S.C. § 3729. False claims, 2006).

**Question 4:** What constitutes medical financial abuse?

**Answer 4:** *Abuse* is the misuse of money by submitting fraudulent claims for services that were not provided. For example, a doctor orders a patient with Medicare to be seen by physical therapy for 14 visits. The patient is seen only 10 times, but the facility bills for 14 visits.

**Question 5:** What is the National Correct Coding Initiative (NCCI)?

**Answer 5:** The NCCI is Medicare's national policy on correct coding. It is an ongoing process to standardize bundled codes and control improper coding that could lead to inappropriate payment for Medicare claims for physician services. The NCCI list contains more than 200,000 Current Procedural Terminology (CPT) code combinations. These code combinations, called *NCCI edits*, make up the computerized screening process used by Medicare to examine claims.

The NCCI edits determine what procedures and services cannot be billed together for the same patient on the same day of service. In the Medicare environment, these are coding errors even though in the commercial environment they may be correctly coded.
Question 6: What federal agencies are involved in the investigation and prosecution of a suspected fraud and abuse claim?

Answer 6: The Office of the Inspector General (OIG), the United States Department of Justice, and the United States Attorney General work together to investigate and prosecute fraud and abuse.

Question 7: Is it acceptable to say, "I didn't know I had to code those procedures as one code"?

Answer 7: Unbundling codes that should be bundled is fraudulent coding. The NCCI edits and government publications are available on the Centers for Medicare and Medicaid Services (CMS) Web site, which provides the details on the rules and guidelines for billing. All medical billing and coders should refer to this Web site when questioning whether a code has all of the procedure factored in or if a separate code should be applied to receive the proper reimbursement. The response I didn't know is not acceptable, and there may be penalties and fines for billing incorrectly (Vines, Rollins, Braceland, & Peterson Miller, 2009).

Question 8: What can practices do to become coding compliant?

Answer 8: Every practice should have a compliance plan in place. The seven components included in the OIG's Compliance Program Guidance "provide a solid basis on which a physician's practice can create a voluntary compliance program" (Final Compliance Program Guidance for Individual and Small Group Physician Practices, 2000):

- Conducting internal monitoring and auditing
- Implementing compliance and practice standards
- Designating a compliance officer or contact
- Conducting appropriate training and education
- Responding appropriately to detected offenses and developing corrective action
- Developing open lines of communication
- Enforcing disciplinary standards through well-publicized guidelines
Question 9: What are the components of the OIG’s Compliance Program Guidance?

Answer 9: The Federal Register is an official government publication. It publishes the most current rules and regulations, with drafts published 2 years in advance. The following is an excerpt from the Federal Register on the OIG’s Compliance plan (Final Compliance Program Guidance for Nursing Facilities, 2000):

- Implementing written policies, procedures, and standards of conduct
- Designating a compliance officer and compliance committee
- Conducting effective training and education
- Developing effective lines of communication
- Enforcing standards through well-publicized disciplinary guidelines
- Conducting internal monitoring and auditing
- Responding promptly to detected offenses and developing corrective action

Question 10: What should I do if I suspect fraud or abuse at my job?

Answer 10: Your employer should have known policies and procedures for reporting fraud and/or abuse, and you may have a hotline where fraud and abuse can anonymously be reported. The CMS Web site also provides information on how to report fraud and abuse: www.cms.hhs.gov. You should also report the suspected fraud and abuse to your supervisor or his or her superior.

The Office of Inspector General (OIG) works with the U.S. Department of Justice (DOJ), which includes the Federal Bureau of Investigation (FBI), under the direction of the U.S. Attorney General to investigate and prosecute those suspected of medical fraud and abuse.

References


Final compliance program guidance for individual and small group physician practices, 65 Fed. Reg. 59434 (October 5, 2000).

