Abolishing Fraud from Your Practice

Take these steps to prevent becoming a victim.

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According to the Association of Certified Financial Examiners (ACFE), organizations worldwide lose an estimated 5% of revenue to fraud each year.[1] Is your practice one of them? No practice or business is immune to the risk of fraud, waste, and abuse, and even the smallest practices should take it seriously.

However, there are steps you can take to protect your practice from intentional fraud by employees, vendors, patients, and others, and from unintentional fraud "discovered" by the Office of Inspector General (OIG) due to reporting errors. Make sure your management reads the annual and semi-annual OIG reports. Share with your staff the key issues in each report.

First, let's address intentional fraud. No matter how well you vet new hires and how loyal you consider your employees, there is always the temptation to "borrow" a few dollars from petty cash or pocket that cash payment. Once those first few dollars are not missed, it gets easier to take a little bit more; and a bit more until the perpetrator can no longer survive without that "bonus" income.

What can you do? The following steps can help, but no business is completely free of risk from fraud.

- You and the administrators must set the tone. If you regularly take money from petty cash to buy lunch, others may feel entitled to do so as well unless it is a practice policy to provide lunch to everyone.
- Have a Practice Policies and Procedures Manual and train every new employee as well as having regular updates and refreshers.
- Although cross-training is necessary, segregate duties as much as possible.
- Maintain strong internal controls.
- Regularly test your systems for effectiveness.
- Establish mechanisms for reporting fraud, waste, and abuse.
- Take a firm stand against fraud.
- Educate your staff as to the consequences of fraud.
- Provide help for employees who may be under financial pressure.

Although fraud of any kind can be financially devastating to a business, Medicare, or other insurance fraud also can ruin a practice's reputation, whether it is intentional or just a result of poor systems and training. All practices should comply with the OIG's voluntary fraud, waste, and abuse guidance to reduce the chances of a Health Care Financing Administration (HCFA), CMS, and OIG audit, which can result in substantial penalties. Medicare abuse also can expose providers to criminal and civil liability.

In addition to avoiding audits by the OIG or other insurance carriers, implementing a well-designed compliance program can minimize billing errors and optimize claims payments.

Every practice should develop a compliance program as part of its Practice Policies and Procedures Manual. The Federal Register has stated that "the creation of compliance program guidance is a major initiative of the OIG in its effort to engage the private [healthcare] community in preventing the submission of erroneous claims and in combating fraudulent conduct." Including internal controls, clear separation of duties, regular updates and training, and periodic self-audits in your manual can allow a practice to efficiently monitor its adherence to applicable statutes, regulations, and program requirements.

Physician practices are not expected to implement a full-scale compliance program, but the OIG guidance emphasizes developing and implementing a voluntary compliance program.[2] Just having a written compliance program is an important aspect of showing the OIG that any

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discrepancies were not intentional.

Every compliance plan should include these components:

- Written policies, procedures, and standards of conduct;
- Compliance program oversight;
- Training and education;
- Open lines of communication regarding compliance issues, education, and concerns;
- Auditing and monitoring, including reporting any misconduct within 30 days to the OIG and CMS;
- Implementing consistent discipline; and
- Taking corrective action.

Two compliance concerns for practices are improper payments and violating the anti-kickback statute. Medicare abuse of payments includes:

- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim by up-coding or unbundling codes.

This abuse can run the gamut from mistakes to intentional deception. Improper claims can be due to:

- Error caused by incorrect coding;
- Waste through providing medically unnecessary services;
- Abuse through misuse of codes by up-coding or unbundling; and
- Fraud through billing for services or supplies that were not provided.

The Anti-Kickback Statute

The anti-kickback statute makes it a criminal offense to knowingly and willingly offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a federal healthcare program. An example would be a provider who receives cash or below-fair-market-value rent for medical offices in exchange for referrals.[3]

More detailed information on OIG compliance guidance and tools for implementing compliance policies can be accessed at https://oig.hhs.gov and www.cms.gov. **PM**

References

[1] Association of Certified Fraud Examiners. Report to the Nations 2020. https://acfepublic.s3-us-west-2.amazonaws.com/2020-Report-to-the-Nations.pdf.

[2] OIG. Compliance program for individual and small group physician practices. Fed Regist. 2000;65:59434-59452.

[3] Medicare Fraud & Abuse, Department of Health and Human Services Centers for Medicare & Medicaid Services, Medicare Learning Network, January 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf.

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