**CHAPTER 12 - FRAUD PREVENTION**

Most physicians report their services honestly. Some physicians may report fraudulent claims that trigger system-wide audits. You should avoid any clinical activity that may be interpreted as fraudulent. Fraud is defined as "*obtaining something of value through intentional misrepresentation or concealment of material facts*". Intentionality is the core feature of the fraud. Things can happen by mistake, and if that is the case, there should not be a pattern of the same mistake happening again and again. A consistent pattern of mistakes, although can be explained by poor billing knowledge, can also be considered as a potential fraud.

Billing for services that are not actually delivered is the most important fraud category. One can consider 2 different categories of billing for services that are not delivered. The first category is billing for non-existent services.

Examples: A physician's 1 pm appointment is 6 months old, WCC. Patient had no show but physician still billed 99491 for WCC. Another physician sees a patient in the office with cellulitis and prescribes antibiotics, but in addition to the E/M service code, such as 99213, the physician also documents and reports the CPT code for incision and drainage that was not actually performed. These cases can be considered as fraud.

The second category involves billing for services that are higher than actually delivered. This is also known as overbilling. There are 2 types of overbilling in MDM based codes, the first one is MDM based overbilling, and the second is time based overbilling.

Example of an MDM-based overbilling. A physician sees a patient with a simple URI, documents it with no delivered care time, yet bills the highest level of code, such as 99215. This may be considered fraud because this patient does not qualify for level 5 based on MDM.

Example of time-based overbilling: A physician sees an established patient in the office and spends only 10 minutes with the patient, but documents 40 minutes in the chart and bills time-based 99215. Although proving overbilling in this case may be very difficult, it is still fraud. Although proving Individual overbilling may be difficult, proving time-based overbilling in a larger sample of patients may be quite easy. Imagine the same physician has a clinic that opens from 7am to 5pm, for 10 hours (600 minutes). During this time, he can only bill for 15 time-based 99215s, because each time-based 99215 is 40 minutes, and 15×40=600 minutes=10 hours. If the same physician bills 20 patients with time-based 99215, then 20×40 = 800 minutes, which is clearly beyond the time the clinic is open. Based on simple math, there may be a potential for fraud.

On the floor, if a hospitalist bills 30 patients with 99233 on the same day, this is also consistent with fraud, as 30 X 50 minutes = 1500 minutes, which is more than 1440 minutes in 24 hours.

A similar situation may happen on the hospital floor or in ICUs. One intensivist can provide critical care to only one patient at a time. This means that an intensivist can bill for only 24 hours of critical care using time-based critical care codes 99291 and 99292. For example, if an intensivist bills 99291 for 30 patients in a day and documents 1 hour per patient, this is clearly fraud, because 30 x 1 hour equals 30 hours, and there are no 30 hours in a 24-hour period. The minimum time required for 99291 is 30 minutes, and based on this, an intensivist may report a maximum of 48 units of 99291 (48 patients × 0.5 hour = 24 hours). If an intensivist bills 50 units of 99291 a day/date, then this is clearly a potential fraud.