Medical Billing Auditing

Understand It and Know
the Facts About It

VeriAccount, LLC

What does a Medical Bill Auditor do?

- Assessing the scene a Medical Bill Audit to determine problematic trends or areas of increased risk.
- Checking the frequency of provider services and analyzing codes and usage by billing staff and providers.
- Identify payment deficiencies and opportunities for appropriate payment.
- Conduct internal and external reviews of coding accuracy, policies and procedures of a medical provider to ensure efficient and cost-effective delivery of care.

What are some of the reasons for a medical audit to be conducted?

Protect against fraudulent claims and billing activity.

Identify and correct problem areas before insurance or government payers challenge inappropriate coding.

Identify payment deficiencies and opportunities for appropriate payment.

Bill appropriately for documented procedures and services.

Identifying Medical Billing Fraud or Schemes…

- Billing for services not rendered.
- Billing for a non-covered service as a covered service.
- Misrepresenting dates of service.
- Misrepresenting locations of service.
- Misrepresenting provider of service.
- Waiving of deductibles and/or co-payments.
- Incorrect reporting of diagnoses or procedures (includes unbundling).
- Overutilization of services.
- Corruption (bribery).
- False or unnecessary issuance of prescription drugs.

Can a patient be an auditor?

- No, third-party payments can also work against ethical behavior: patients are largely insulated from actual medical costs and therefore from waste, fraud, and abuse in medical payments. Patients often lack the knowledge and incentive to audit a statement that explains, in incomprehensible detail, the expenditure of someone else's money.
- High-deductible health plans may act to shift the incentives, and insurance premiums (and taxes) will almost certainly rise, but for the foreseeable future, an overwhelming majority of people enrolled in benefit plans will remain shielded from the real impact of medical care charges. It remains the health plan's responsibility to act in the place of the astute consumer, and to replace perverse financial incentives with efficient systems, purposeful oversight, and effective monitoring to combat fraud and abuse.
- Bottom line, its better to get an auditor or professional to examine, review, audit your insurance plan..etc.

How to evaluate unusual claims ?

- Here are some examples of medical practices and facilities with unusual claims activity to see how different approaches to scrutinizing claims might work:
- A. A contracted; credentialed physician performs complex services very unlike peers in that medical specialty.
- B. A long-standing, contracted home infusion vendor suddenly shows an alteration in trend: billing new codes, representing frequent, expensive services, differing significantly from the previous pattern.
- C. A non-contracted physician submits bills for out-of-network services in a pattern that does not align with peers in the same medical specialty.
- D. The community hospital has, over the past six years, recruited new medical specialists and has developed several lines of service to provide high-level care in several disease categories. A verification of the context of these claims, specifically for the consistency within known patterns of disease and episodes of treatment, adds the relevant clinical information that verifies the legitimacy of the acceleration and transformation of claim patterns.

Misrepresentation or Fraud?

Some examples might represent misrepresentation or fraud:

- A. The physician's office manager or biller may be submitting additional expensive service codes in connection with an embezzlement scheme.
- B. The home infusion vendor, under new management, may be billing for more frequent, more expensive, or fictitious services, in collusion with a collaborating physician.
- C. The non-contracted physician billing might not actually represent the licensed physician. This supposedly separate practice location may be fictitious, and the patients for whom services are billed are taken from a list of stolen enrollment information.
- D. The community hospital may be engaged in purposeful misrepresentation of diagnoses with the goal of increasing payment via more severe diagnosis-related group (DRG)grouper categorization.

Unsolicited Offers

- Patients should protect their Medicare numbers the same way they would protect their Social Security number
- Patients should be urged to cautiously select medical providers. Choose one based on trusted referrals, not free offers.

REQUEST DETAILED NOTES

- When visiting a health care provider (or having in-home health providers), patients should keep track of names, dates, times, and types of procedures so they can more easily compare their own account to the bill when it arrives weeks later
- Keeping detailed notes is even more crucial for patients involved in repeated procedures because they build a base for comparing future billing. If patients don't feel up to the task themselves, they could ask a trusted loved one to accompany them and keep records.
- It requires a lot of diligence on the part of the patients to keep track of their information.
- Use the help of a family member, noting each procedure or drug purchase on a calendar can provide valuable information for a Medical Billing Auditor to check charges for validity. For example, charges for services that were never provided can be identified in that manner.

Medical Billing Fraud After Death? Did you know ?

- A. Claiming reimbursements for the treatments and procedures that were never performed.
- B. Medicaid and Medicare can only reimburse for the procedures that are authorized. Provider can never bill for tests, treatments or procedures which are not authorized.
- C. Both Medicare and Medicaid issue a list of authorized tests and procedures which a patient can avail, but manipulating the diagnosis, healthcare providers can add procedures that were not required.
- E. Healthcare providers offer medical treatments that were not necessary and were provided only to increase reimbursements. These are the most common type of unethical medical billing practices and is a serious violation of the healthcare act.

THIS COULD HAPPEN TO YOU!!