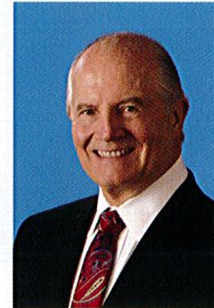
Avoiding Billing Pitfalls in the Age of Affordable Care

By Thomas C. Morrow



IN THE SECOND DECADE OF THE 21st century, many healthcare providers are struggling to decide whether or not to accept patients who have Medicaid. A key issue is the provider's ability to ensure compliance with its myriad reimbursement regulations.

Failure to maintain familiarity with the requirements can result in withheld reimbursement, civil lawsuits for restitution of past payments, and even federal and state criminal prosecution. As the pool of Medicaid-enrolled patients increases, a growing number of providers will need to navigate complex and confusing reimbursement procedures. Thorough knowledge of proper billing procedures is not optional. Failure to adhere to reimbursement regulations and requirements can be disastrous to individual and institutional providers.

The Patient Protection and Affordable Care Act (ACA) includes provisions that Medicaid payments may be suspended as the result of an audit, even without proof of fraud. A credible allegation of fraud is the sole requirement. Section 6402(h) of the ACA requires a state to suspend payments to an individual or entity providing medical services pending investigation into such allegations. A state may decline to withhold payments only if it determines that there are good reasons not to withhold such payments, and these are limited.

Potential Sources of Fraud Allegations

Sources of allegations include the obvious, such as "whistle blowing" from a disgruntled employee or tips to a fraud hotline. Sources also may include virtually any allegations that may ultimately be deemed "credible." Increasingly, such allegations originate from computer analyses of claims data that produce atypical, and therefore suspicious, patterns compared to similarly situated providers. An example is "up-coding," where a provider uses a higher billing code than the norm among similar providers.

Another example involves consistent failure to provide documentation that the auditing entity requires to justify the procedure associated with a specific code. Obvious examples of fraud include billing for services not provided or multiple billings for single procedures. Outright false billing aside, allegations can arise from errors made when providers delegate the coding/billing process to persons inadequately trained in the complexities of the billing process.

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Maryland Law

In Maryland, a provider may appeal a notice of suspension to the Office of Administrative Hearings (OAH). The OAH does not conduct an independent review to determine if the suspension is justified, but limits its determination to whether or not the allegation of fraud is credible. This standard is far from the "preponderance of evidence" standard used in civil trials, and demands less proof than the "probable cause" standard required to initiate a criminal charge.

The criteria to justify a suspension are probably most analogous to "reasonable belief," which requires only that the specifics of the allegation itself be verified by a state entity and that the source has the indicia of reliability. Thus, the appellate review of a suspension in the Maryland OAH is typically limited to an inquiry into the nature of the allegation and the reliability of its source.

Once the state has "verified" an allegation of fraud, the ACA requires the allegation to be referred to the Medicaid Fraud Control Unit (MFCU), an investigation and prosecution unit of the Attorney General's Office in most states. CMS has published standards for evaluating fraud allegations.

Know When to Seek an Attorney

Because suspension of reimbursement is usually based on a "credible allegation of fraud" that will inevitably be evaluated by MFCU, a provider notified of a pending suspension should immediately contact an attorney. Aggressive intervention by counsel familiar with reimbursement issues may have the suspension terminated through negotiated settlements and help a provider establish that the coding was justified.

Where coding practices are erroneous, an attorney can help establish that errors were not the result of intentional fraud. This may lead to settlement options ranging from reimbursing the Medicaid program for overpayments, implementing corrective action plans and educational programs, reorganizing and upgrading medical records and other remediation options. Most importantly, early resolution of such investigations can avoid the economic devastation of defending a complex false-claims suit or the professionally catastrophic impact of defending criminal charges.

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