**Documentation/Billing (Overpayment) Examples**

* + - **Double Billing:**
	+ A provider attempts to bill a private insurance company or the patient for the same treatment; OR,
	+ 2 providers try to get paid for services rendered to the same patient for the same procedure on the same date
		- **Upcoding** – Coding to describe more complex procedures than what was actually performed, such as:
* if a dentist bills for a surgical extraction when they did not section the tooth and/or remove bone.
* billing for a full periodontal cleaning when less had been performed;
* billing for limited evaluations of patients when such evaluations had been included in the initial payment for the procedure as part of routine post-op care
	+ - **Unbundling** - occurs when a provider breaks one dental event into its component parts. For example:
* a dentist unbundles a tooth extraction when the dentist charges for pulling the tooth and the next week charges for an office visit to see how the patient is doing. The office visit is actually part of the bundle of services involved in a tooth extraction. The dentist cannot bill for those events separately.
	+ - **Credentialing** (billing vs. performing provider)
* Who actually did the work?
* Is performing provider credentialed with carrier/plan?
* Avoid submitting claims under other than performing provider; it pay a higher reimbursement and is fraudulent
	+ - **Disclosure of pre-payment discounts**
* Cannot provide discounts over $10/ to ‘lure’ new patients
* All discounts must be disclosed to 3rd party payor in advance of payment
* Failure to disclose result in higher reimbursement, amounts to fraudulent claim(s)
	+ - **Collection of co-pays/ deductibles**
* Contractual and legal obligation to collect
	+ - **Accuracy and Timeliness of charting and claims submission**
* Within allowable submission period
* Reflects actual service date/ provider
* Reflects actual procedure(s) provided (bill according to what you do, not according to what you want to be paid for
	+ - **Coding**
* Current CDT, ICD-10, CPT
* Correct code(s)
	+ - Billing for full-fee when non-insurance patients are provided the same services for a lesser fee
		- Inaccuracies on claim forms, electronic claim records, clinical documentation, etc.
		- **Billing for Services Not Performed** - A provider bills (or tries to bill) for a treatment, or procedure, or service, which was not actually performed.
* billing for x-rays when none were taken;
* billing for a dental filling when one was not done;
* billing for uncharted services; or,
* billing for appointments the patient failed to keep.
	+ - **Duplicate claims**
* Liability for mistakes made
* Liability for corrections NOT made
	+ - **Unsupported claims/Over-billing**
* Documentation
* Do you have diagnostic quality images
	+ - **Suitable fee schedule**
* you get no more than you ask for
* review and update fee schedules annually
	+ - **Management of credit balances**
* Nacho money? Return it in a timely manner!
	+ - **Unique contract requirements**
* Culprit of most denials for “lack of necessity”
* Lack of necessity is poor lingo for “disallowed by contract”
	+ - No vital signs (when required)
		- No identifiers of author of notations
		- **Unnecessary Services**
* Misrepresentation of diagnosis and symptoms on a patient’s records and billing invoices to obtain payment for unnecessary sedation cases.
* Providing medically unnecessary services.
* Insufficient documentation to support medical necessity
	+ - Lack of documentation to demonstrate necessity of treatment
		- Improper (or no) written consent **@**
		- Treatment plans that do not contain options
		- Billing for services that are actually performed by another provider
		- Billing for more units than provided
		- Services performed by an unlicensed provider but billed under a licensed providers name
		- Alteration of records to get services covered
		- Billing for services at a frequency that indicates the **provider is an outlier** as compared with their peers.
		- Billing for non-covered services using an incorrect CDT code in order to have services covered
		- Prescription forgery/ drug diversion
		- Lack of medical necessity **\***
		- Billing for services not rendered
		- ***Inaccurate claims***
		- Lack of documentation in the records to support the services billed
		- Wrong provider identified on claim
		- **Services provided by unlicensed clinician**
* expired dentist and auxiliary staff credentials
* Impermissible delegation of duties
	+ - Routinely submitting duplicate claims
		- Failure to meet the Standard of Care
		- **X-ray issues**
* not ordered,
* under/over-utilization,
* incorrect number/ type,
* quality issues,
* overlapping bite wings images,
* no apex visible on periapical images,
* inappropriate use of pano, BWs and PAs as FMX
* no-evaluation/ interp., or
* result in improper treatment.
	+ - **Misrepresenting:**
* dates of service, or
* the identity of the patient, or which provider actually provided services.
* billing for a covered service rather than the non-covered service that was actually rendered.
* billing for multiple procedures all performed on a single day as if the procedures had been performed on separate days in order to maximize payment for those procedures.

The following examples are unique to Federally-funded programs (i.e. Medicare, Medicaid, Children’s Health Insurance Program (C.H.I.P.), Tricare, government employee/ retiree plans):

* + - Excluded persons employed/ contracted **+**
		- Kickbacks **++** - A provider may conspire with another to give a kickback, either money, gifts, or products, when they receive a referral from the other provider or use the other providers products or services. For example:
* if a dentist offers to pay a physician $20 for every patient that doctor sends to that dental practice, then both the dentist and the physician have engaged in an illegal kickback scheme.
* soliciting, offering, or receiving a kickback, bribe, or rebate.
* providing remuneration for referrals
	+ - Services provided by excluded provider/ employee

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**@**Considered a failure to meet Standard of Care in some jurisdictions.

**\*** For services to be considered medically necessary they must: 1). Actually be necessary based on the patient’s signs, symptoms and test results. 2). Documentation must state ‘that’ the services are necessary. If not for both part of this two-prong criteria related claims for reimbursement may be denied or payment recouped for lack of medical necessity.

**+**  Claims submitted (or attempted) to be submitted to Federally-funded healthcare programs while the provider contracts with or employees ANY person who is excluded from participation with a federally-funded healthcare program effective taints every claim submitted to the program during the time period the person (or entity) is excluded. Tainted claims are false claims and are subject to recoupments under the False Claims Act, which includes treble (triple) damages and fines from $5,500 to $11,000 per claim.

**++** Violations of the Anti-Kickback Statute are subject to criminal penalties including exclusion from participation with Federally funded programs, license sanction (up to loss of license), fines up to $50,000 per violation, and imprisonment.

**So, if I audit my records – what do I look for?**

1. Care/ services not documented;
2. Care/ services not rendered;
3. Double-billed;
4. Misrepresented (location, date, time, sequence, frequency, quantity, description, licensure/permit, etc.);
5. Upcoded claims;
6. Unbundled claims;
7. Fragmented (separate claims for procedures on different dates that comprise the major procedure);
8. Under/over-utilized codes;
9. Service dates, reason for each visit; appropriate history;
10. Past and present diagnoses; risk factors (i.e. Caries Risk Assessment, smoker, S&S of periodontitis); conditions limiting treatment; medical/dental history, medications, and allergies
11. Progress notes,
12. Use of treatment plans,
13. Response and changes,
14. Medication dosage, timing and route of administration;
15. Anesthesia dosage, timing and placement;
16. Patient and family education;
17. Identify any suspicious or “watch” areas;
18. Patient communications;
19. Information on missed appointments;
20. Legible contents;
21. All notations dated and signed, with full first name, last name and credentials/position of author;
22. Vital signs (when indicated);
23. Same service not billed multiple times, to multiple carriers, or on multiple dates;
24. Multiple codes not used to describe a service where one code is sufficient;
25. Third party and multi-carrier coverage sought, collected, and consistently used;
26. No services deleted after billing insurance carriers;
27. Copayments and deductibles collected and not waived;
28. Ledgers track and balance;
29. Narratives, clinical/treatment notes, and claim information match;
30. Date-of-service changes documented and related to claims;
31. Dates in treatment notes, claims, and financial documentation in sequence;
32. Beneficiary eligibility routinely checked, with face-to-face encounter, as required;
33. Informed consent obtained (signed form) and documented (in clinical note);
34. Treatments medically necessary and appropriate (and documented as such);
35. Number of units claimed plausible;
36. Few resubmitted, re-dated, and recoded claims;
37. Single-seat service not spread out over time or across plan years;
38. Services billed on same day medically compatible;
39. Correct timing and clinical sequence of services;
40. Consultation procedures billed have referring provider information;
41. Count and type of labs, drugs, and X-rays appropriate to treatment;
42. Service dates match appointment dates and copayment receipt dates; and
43. Services delivered are age, gender, and provider appropriate.

Additionally, claims denials should be logged, tracked and investigated (and operational changes made as needed) to prevent future denials, which can flag a provider for an audit by an insurance carrier.