In this newsletter we will review some of the Fraud, Waste and Abuse regulations. All of the following information has been taken directly from the *CMS Website, Medical Learning Network Booklet (updated November 2017 and current at time of publication.)*

Federal False Claims Act (FCA)

The civil FCA protects the Federal Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government. The terms “knowing” and “knowingly” mean a person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information related to the claim. No proof of specific intent to defraud is required to violate the civil FCA. An example may be a physician who knowingly submits claims to Medicare for medical services not provided.

Physician Documentation

Maintain accurate and complete medical records and documentation of the services you provide, and ensure your documentation supports submitted claims for payment. Good documentation ensures your patients receive appropriate care from you and other providers who may rely on your records for patients’ medical histories. The Medicare Program may review beneficiaries’ medical records. Good documentation helps address any challenges raised about the integrity of your claims. You may have heard the saying regarding malpractice litigation: “If you didn’t document it, it’s the same as if you didn’t do it.” The same can be said for Medicare billing.

Accurate Coding and Billing

As a physician, payers trust you to provide medically necessary, cost-effective, quality care. You exert significant influence over what services your patients receive. You control the documentation describing what services they actually received, and your documentation serves as the basis for claims sent to insurers for services provided. Generally, the Federal Government pays claims based solely on representations in the claims documents.

When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment is illegal. Examples of improper claims include:

- Billing for medically unnecessary services
- Billing for services not provided
- Billing for services performed by an improperly supervised or unqualified employee
- Billing for services performed by an employee excluded from participation in the Federal health care programs
- Billing for services of such low quality that they are virtually worthless
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.

For more information on these and many other topics, go to the CMS website:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf

*More information from The Freedom / Optimum booklet “**Documentation Guidelines**”*

Diagnosis must be clearly Written / Documented:

The condition must be addressed during a face to face visit- Managed, Evaluated, Assessed or Treated (MEAT)

- ***All entries require a Provider Signature, Credentials and Date.***
- ***CMS states EMRs require an “Electronic Signature” authentication indicated on the Medical Record.***
- ***The progress note is validated and sealed by the provider of service and without the ability to alter. Password protected and sealed within 24-72 hours and always prior to claim submission per CMS.***
- ***Examples of acceptable electronic signatures include:***

Electronically signed by/ Authenticated by / Validated by / Signed By / Approved by – followed by the Practitioner’s name