Addressing Upcoding and Ethical Decision Making

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Major Categories of Health Care Fraud and Abuse

Category of Health Care Fraud and Abuse.	Description of Category and Example from Authoritative Source*
Upcoding	Upcoding is a fraudulent practice where professional healthcare providers seek more reimbursements from the government and regulatory bodies using a fraudulent CPT code than they are entitled to. For instance, if a physician checks a patient for a regular check-up that probably costs $60 but when billing Medicare for reimbursement the physician provides the fraudulent CPT code for an extended check-up and demands a reimbursement of $100 from the government that funds Medicare and Medicaid. Such a practice is a violation of the False Claims Act through which the professionals receive reimbursements of more than what they are entitled to.
Unbundling	Unbundling is a practice that involves fraud and abuse on the part of care providers whose goal is to abuse the Electronic Health Records (EHRs) system of the care organization to document fragmenting procedures that are bundled together into their separate components. This bundling when performed together results in higher reimbursements as part of the standard patient treatment from the Center for Medicare or Medicaid Services (CMS).

Category of Health Care Fraud and Abuse.	Description of Category and Example from Authoritative Source*
Kickbacks	The practice of kickbacks occurs when people bribe healthcare providers to refer medical services from Medicare or Medicaid to help them gain additional benefits from Medicaid or Medicare program and the federal government that funds such healthcare programs. It is counted as a fraudulent practice because it promotes the personal designs and nefarious interests of the physicians over those of the patients that have the moral responsibility to protect (Klein & Campbell, 2006). The decision of gaining additional benefits from care providers is a fine example of how individuals bribe professionals for their personal gains but not the welfare of terminally ill patients and vulnerable ones such as children, elderly patients, and pregnant women.
Double Billing	Double billing is a fraudulent practice in the field of healthcare that involves billing for items, services, consultations, or treatments not provided to patients while they visit hospitals to see their physicians. For instance, the act of double billing occurs when the service provider bills Medicaid or Medicare for a random blood sugar test without searching for the previous history of diabetes in the patient's family which makes him susceptible to the disease.
Asking staff to provide additional hours/time of care than necessary.	In the healthcare sector, professionals ask staff or employees for medical staff retention, but it is an unethical practice for administrators to provide additional care in a prospective payment environment. They direct their staff members to provide long-term care in rehabilitation centers, homes, or other acute care places. An example of such fraud in care facilities is when there is a requirement for a treatment plan for patients entering a skilled and professional care facility.

Five Health Care Fraud and Abuse Laws

Number	Health Care Fraud and Abuse Law	Description of Law	Rationale: How Does This Law Apply to Health Care and Why I Have Included It Here.
1.	The Anti-Kickback Stature (AKS)	The Anti-Kickback Statute (AKS) law is a crucial federal law that prohibits the exchange of remuneration or anything of value in exchange for referrals or services. In case of AKS violation, exclusions from medical programs, jail terms, and penalties are being given to violators. Moreover, there is a provision in the law that prohibits doctors and pharmaceutical companies to pay physicians from referring certain drugs to patients.	According to this legislation, healthcare providers including physicians, doctors, and ANPs are prohibited from giving or receiving kickbacks for any kind of referrals they provide. If medical service providers want to be part of this legislation, they are encouraged to arrange and propose services to eligible entities in order to receive federal government funds.
2.	Physician Self-Referral Law Or Stark Law	According to this crucial piece of legislation, physicians are prohibited from referring unhealthy individuals to other physicians and care facilities. Through such referrals, they may have a financial relationship with the person or organization (Krause, 2013). The financial relationships prohibited in this legislation also involve compensations in the form of salaries or other luxury items.	It is important for a physician to ensure that his referrals do not exploit the medical needs of the patients and just not aim to reap financial gains for themselves.

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3.	The False Claims Act	In accordance with the False Claims Act, government bodies are prohibited from charging or overcharging for procedures that are not necessary in the medical field. If the care provider submits false claims to a medical benefits program, the service provider will be fined three times the loss of program cost plus an additional $11,000 (Krause, 2013).	The legislation of the False Claims Act can be implemented in the healthcare practices that bill Medicaid or Medicare for services and care they were expected to provide but did not. A fine example of the implementation of this law is when a provider asks for the payment of a higher quality of service , but the service is not provided to the patients in real.
4.	Exclusion Statute	In accordance with the Exclusion Statute Law, the Department of Health and Human Services can prohibit care providers as well as healthcare organizations from participating in the healthcare benefit programs such as Medicaid or Medicare funded by the federal government. In case of violation, physicians and other care providers can be excluded from such programs and the Federal Health Care Program is not bound to pay for treatment plans, services, and whatever such physicians prescribe to the patients (McGee et al., 2018a).	The recommendations provided by this law prohibit and deny individuals and organizations from formal participation in the Federal Health Care Programs, Medicaid and Medicare if these individuals and corporations do not meet certain requirements enlisted in this law. The law of Exclusion Statute will be enforced on both individuals and corporations whenever they are found guilty of any fraudulent act in the field of healthcare.

Number	Health Care Fraud and Abuse Law	Description of Law	Rationale: How Does This Law Apply to Health Care and Why I Have Included It Here.
5.	Civil Monetary Penalties Law	As a result, of the enactment of this legislation to the field of healthcare, physicians can be excluded from the healthcare programs by the Department of Health and Human Services if they ever engage in fraudulent activity to defame the medical practice in the United States. The Office of Inspector General (OIG) may seek penalties and exclusions based on the type of violation of healthcare fraud and abuse laws. The penalty can range from $10,000 to $50,000 if the individual or corporation is found misleading the patients.	Misleading vulnerable individuals or providing false information regarding any healthcare practice or care benefit program would be considered fraudulent in any way. Services or information that are provided as claimed will result in the exclusion of the party from the medical field.

Upcoding and the Law

Law Pertaining to Uploading	Explanation of Upcoding and How the Law Applies to It.	Case Example of Upcoding
False Claims Act	To receive financial gains and reimbursements, healthcare providers intentionally assign or upcode a higher-level billing code to a medical procedure that does not warrant it. This unethical behavior leads to increased reimbursements from programs funded by the government or insurance companies. Such a behavior results in financial loss for payers of the services and ultimately higher healthcare costs for the patients. According to the False Claims Act, upcoding is a practice of defrauding healthcare benefit programs funded by the federal government. Moreover, the government is prohibited from charging for unnecessary medical services. For instance, a doctor violates False Claims Act law if he does not fluoridate water when a patient visits him for prophylaxis. However, to get the additional reimbursement, the service provider claims for the fluoride treatment in the bills to Medicare. Such a fraudulent practice can lead to an individual being excluded from federal government programs or a penalty of three times the loss of the program along with an additional $11,000.	A former Sarasota-based dermatologist, Michael Rosin, performed many needless skin surgeries on elderly patients over a period of six years. He defrauded the medical benefits program, Medicare, while performing unnecessary 3086 surgeries on 865 beneficiaries of Medicare. Under the False Claims Act law, he was sentenced to 22 years of imprisonment as he was convicted of 35 counts of misleading and providing false information to the beneficiaries as well as Medicare. Rosin was also convicted to pay $3.6 million as restitution to Medicare, $3.7 million to the government, and $48,866 to the patients he harmed (Rudman et al., 2009).

Evidence-Based Recommendations to Address Upcoding

Recommendation*	Source
Education and Training	Comprehensive education and training programs for healthcare providers will focu on accurate coding practices and documentation as well as ethical considerations and the consequences of upcoding. By implementing this, healthcare professionals will be well-informed about the importance of accurate billing and coding practices and equipped with necessary knowledge and skills to promote fair and transparent practices.

Recommendation*	Source
Corrective Action	It is the ethical responsibility of an individual to inform his management of the organization if he observes any kind of upcoding practices taking place within his organizational facility. If the supervisor of the organization fails to resolve the issue, OIG can issue a compliance program to solve the upcoding problem within the realm of organization without going to court. Corrective actions in the organization also include new policies and procedures, employee education, training, and computer system's medication.
Communication and Collaboration	In the healthcare organizations, there is an urgent need to establish procedures for effective communication. Administrators should ensure that every member of the organization is informed of any additions or changes in rules that are made in the organization. In addition, administrators should establish a procedure where every individual who is affected by upcoding can be communicated and able to report upcoding pressures on them.
Compliance Monitors	The implementation of compliance monitors can be an effective evidence-based recommendation to address upcoding. The management of the organization can utilize the data provided by MedPar billing to address coding practices that deviate from norms assigned by the fraud and abuse laws in the healthcare sector. The organization can use this data as a tool with that of national, regional, and state averages for making necessary adjustments.
Stricter Auditing and Monitoring Systems	To address upcoding, stricter auditing and monitoring systems should be implemented to target care service providers who have been identified as potentially engaging in the fraudulent practice of upcoding. This would help identify potential cases of upcoding in the healthcare practice and ensure accurate reporting. Moreover, this would prevent instances of miscommunication between service providers and medical coders as well as intentional profit-maximizing behavior that may lead to upcoding.

References

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