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Ophthalmology and Optometry Coding Alert

Compliance: 3 Recent Cases Reveal Eye Care Fraud Vulnerabilities

Want to avoid these issues? Keep an eye on your compliance plan.

As healthcare auditors increasingly add new issues to their review lists, eye care practices have remained vigilant, buttoning up their documentation and recordkeeping. If you'd like some insight into the type of cases being prosecuted in this specialty, we've got the details of three eye care-specific issues that were brought to light over the past few months which can help you determine what not to do if you'd like to avoid fraud.

1. Deliberate Double Billing

In March, a New Jersey optometrist was sentenced to 33 months in prison after pleading guilty to health care fraud. He not only sent fraudulent claims to his Part B payer, but also submitted several of the same claims to a vision payer as well, collecting double payments. He said that he sent insurers up to $550,000 in false claims.

At his sentencing hearing, the physician "further acknowledged that he attempted to obstruct justice when he submitted fabricated treatment records to the government in an effort to justify his continued fraudulent billing," the US Attorneys Office said in a March 26 news release about the case.

The takeaway: If you submit a claim to one insurer, you can't report the same services to another payer without coordinating benefits between the two. If you collect from both, you must report the overpayment and return the money. If someone in your practice is erroneously billing services, it's your responsibility to report it.

Resource: For more on this case, visit https://www.justice.gov/usao-wdpa/pr/optometrist-sentenced-33-months-prison-health-care-fraud-involving-least-250000-losses.

2. Reporting Unnecessary Procedures

Also in March, a Montana optometrist was sentenced to probation for Medicaid fraud and theft by insurance fraud after submitting insurance claims for services that were not necessary and for claiming patients had conditions requiring intricate procedures when the patients did not, in fact, have those diagnoses.

The takeaway: Physicians are responsible for the medical decisions they make, so erroneously (and willfully) administering or prescribing care for patients who don't have a medically necessary reason for the service is problematic. Not only will it hurt insurers by overcharging them, but it isn't a sound medical practice, as patients shouldn't be treated for conditions they don't have.

Tip: Remember, Medicare defines medically necessary services as "healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine." And the best way to demonstrate medical necessity is with thorough and accurate documentation. If the medical record does not support the service(s) billed, CMS can certainly recoup the funds paid to the provider.

Resource: This case was originally reported by the Billings Gazette at http://billingsgazette.com/news/crime/former-montana-optometrist-gets-probation-for-submitting-false-insurance-claims/article_ae57ac95-66a9-5e32-a481-4d6becb15383.html.

3. Misdiagnoses Prompting Fraudulent Billing

In February, a prominent Florida ophthalmologist was sentenced to 17 years in federal prison after being found guilty of

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67 counts of healthcare fraud. He also has to pay back more than $42 million to the government. The government says that the doctor falsely diagnosed Medicare patients with macular degeneration and then performed and billed for medically unnecessary tests and procedures, such as injections of expensive drugs and laser treatments.

The physician "showed complete disregard for what was best for his patients and abused their trust for his own personal financial gain," said United States Attorney **Benjamin G. Greenberg** in a Feb. 22 news release. "Today's sentence should serve as a reminder that the US Attorney's Office and our law enforcement partners remain committed to bringing those who illegally divert the community's tax dollars to justice, regardless of their professional position."

The takeaway: "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," CMS says in its "Medicare Fraud and Abuse" booklet. If you realize something fraudulent - such as false diagnoses being reported - is taking place at your practice, it's your responsibility to alert the payer and fix the issue going forward.

Resource: For more on this case, visit https://www.justice.gov/usao-sdfl/pr/south-florida-doctor-sentenced-medicare-fraud-scheme.

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