Part B Insider (Multispecialty) Coding Alert

Compliance: Government Rakes in Record-Breaking $4.2 Billion From Fraudulent Billers in 2012

For every dollar spent on health care fraud investigations, the government recovered a whopping $7.90.

Attempts to defraud the Medicare program are getting ever bolder by the week.

That's the word from the government's latest report, entitled The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2012, which indicates that the Department of Health and Human Services (HHS) recovered a record $4.2 billion from those who attempted to defraud federal health care plans. With the government now recovering $7.90 for every dollar spent on health care fraud and abuse investigations, it seems clear that such a profit will only inspire the OIG to be even more vigilant in ensuring that medical practices stay on the straight and narrow.

"This was a record-breaking year for the Departments of Justice and HHS in our collaborative effort to crack down on health care fraud and protect valuable taxpayer dollars," said Attorney General **Eric Holder** in a Feb. 11 statement.

Most of the recoveries were the result of Medicare's HEAT team and the Medicare Fraud Strike Force, which now has nine units across the United States. These programs have gone across the country to find and investigate fraud, and have been responsible for recovering billions and putting it back in the Medicare Trust Fund's coffers.

Among the government's recoveries from Part B practices, HHS revealed the following in its recent report:

A family practice physician went to jail for 10 years and had to repay $5.4 million after fraudulently billing for diagnostic tests and services that weren't medically necessary, and for receiving kickbacks. In addition to wasting government money, the doctor is also accused of exposing the patients to unnecessary radiation as part of the unnecessary diagnostic testing.

A psychologist is facing up to 20 years in prison after submitting claims to Medicare and Medicaid for psychotherapy services totaling 17 hours a day for 364 days a year, which he later admitted he did not actually perform. He was fined $500,000 and forfeited the $1 million he was overpaid.

A neurologist repaid the government $747,013 after the government alleged that he billed for intraoperative monitoring (IOM) improperly. Investigators discovered that he counted time toward performing IOM and billed individually for multiple patients at the same time rather than billing on an hourly basis regardless of the number of cases he was monitoring (as Medicare requires).

Resource: To read the OIG's complete report, visit https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf.