Part B Insider (Multispecialty) Coding Alert

COMPLIANCE: OIG Saves Medicare $2.2 Billion Over 6 Months

With 1,291 exclusions and 293 criminal actions, the OIG cracked down

According to the OIG's 2008 Semiannual Report, the agency recouped $2.2 billion through recommendations, investigative efforts, and audit recovery.

The report, which covers OIG actions between Oct. 1, 2007, and March 31, 2008, outlines common enforcements, such as those on durable medical equipment (DME) suppliers, as well as new targets.

-Issues of more recent focus include oversight of Medicare Part D; public health emergency preparedness and response; oversight of food, drug and medical device safety; integrity of information technology and systems; and ethics program oversight and enforcement,- said **Inspector General Daniel R. Levinson** in the report.

Some Money Not Yet Collected

In addition to collecting billions, the OIG may also collect on additional recommendations published in the report.

For example: The OIG found that a DME supplier collected at least $8.2 million in inappropriate Medicare payments, and the OIG -recommended- that the supplier refund the money. The supplier, however, disagreed with the OIG's recommendation. So does the OIG just write off the $8.2 million that it recommended for repayment?

-The OIG has some enforcement authority (e.g., for administrative [civil money penalties]) and some investigate-and-recommend authority (like the case described here),- says **David C. Harlow, Esq**., of **The Harlow Group LLC** located in Newton, Mass.

-Some OIG investigations get turned over to the Department of Justice and result in criminal actions under the False Claims Act (fines and/or imprisonment),- Harlow says. In other cases, the OIG might not yet have the basis to proceed further, or perhaps is still working on the case.

Consider These Examples

Following is a sampling of a few of the OIG's recoveries as outlined in the report:

- **Consolidated billing woes:** A recent investigation found that CMS overpaid almost $107 million for outpatient services for beneficiaries who were covered under Part A SNF visits in 2001 and 2002. At that point, CMS did not yet have edits in place to kick out claims that should have been covered under consolidated billing.

- **Extreme upcoding:** A dermatologist was sentenced to more than 10 years in prison for upcoding surgical procedures, billing for medically unnecessary procedures, and improperly billing follow-up visits.

According to the OIG report, the physician -falsely informed patients that they had cancer when, in fact, laboratory results indicated that their tissue specimens were benign. He then performed surgeries based on these false diagnoses.- In addition, the physician upcoded the surgeries and claimed that the patients experienced postoperative infections when they did not.

- **Therapy overbilling:** A Pennsylvania physical therapist (PT) billed Medicare for more hours of therapy than a human being could possible perform.

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The PT billed his carrier for 145 days of therapy -for which he would have had to have worked in excess of 24 hours per day,- the report noted. The PT was sentenced to six months in prison and ordered to pay $1.2 million in restitution.

- **Modifier 25 misuse:** A Maryland podiatrist had to reimburse $500,000 to Medicare after billing procedures with E/M services -even though she performed no significant, separately identifiable evaluation and management service at the same time that she performed a procedure,- the report stated.

To read the OIG's Semiannual Report, visit the HHS Web site at www.oig.hhs.gov/08/semiannual_spring2008.pdf.

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