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Part B Insider (Multispecialty) Coding Alert

FRAUD & ABUSE: Resident Supervision, Upcoded E/Ms Spell $1.9 Million Payback

Nail debridement, ASCs on OIG hit list

If you're skating close to the edge with some of your coding or billing practices, beware a sudden draft from the **HHS Office of Inspector General.**

The OIG cites several cases of physician fraud in its semiannual report for the first half of fiscal 2005. The fraud watchdog reaped $266 from provider audits and $1.1 billion from investigations, and federal health care programs saved nearly $17 billion by following the OIG's recommendations.

The biggest ticket item this time around may be the $1.9 million paid by **Temple University Physicians** in Pennsylvania to settle charges they submitted false claims to Medicare. TUP's physicians allegedly didn't document, or inadequately documented, their presence while residents and interns provided services. The government also alleged that TUP doctors submitted claims for upcoded evaluation and management services.

Also, the OIG says a South Carolina doctor was excluded from federal health programs for 26 years and sentenced to 235 months in prison. The doctor took part in a scheme to sell prescriptions for OxyContin, Percocet and other "controlled substances."

Freestanding surgery clinic **Lansing Surgery Center** in Lansing, MI agreed to pay $76,000 in civil monetary penalties to settle allegations it submitted improper pain management claims. The physician who supposedly provided the pain management services had been convicted in 1999 of mail fraud, wire fraud and health care fraud for providing medically unnecessary pain management services and upcoding office visits.

An Ohio podiatrist was ordered to pay $1.8 in restitution and serve 11 years and three months in federal prison. The podiatrist had already been convicted of health care fraud in 1998 and then created a "fictitious transaction" to sell his podiatry practice and get around his exclusion from Medicare. He created a management company with a different "owner" so he could receive income from both companies.
And a California psychologist was sentenced to three years plus $250,000 in penalties for **billing Medicare** for testing, evaluations and services that he didn't actually provide to patients with developmental disabilities. He tried to cover his tracks by billing under a fake "group" number as well as his own number, and setting up four fictitious businesses in a scheme to claim Medicare income as business expenses.

Radiology Regional Center in Florida agreed to pay $2.5 in penalties to settle claims it billed for services that treating physicians didn't order, plus upcoding and unbundling.

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