Part B Insider (Multispecialty) Coding Alert

Physician Notes: Doc Faces 30 Years In Prison For Alleged Double Billings, False Claims

And "pay for performance" quality care incentives are in the pike

Pleasanton, CA, physician **Dilbagh S. Chattha** managed to score an indictment for a whopping 94 counts of health care fraud and another 94 counts of mail fraud in an alleged Medicare fraud case in the U.S. District Court for Northern California.

Prosecutors say Chattha defrauded Medicare and other federal health programs. Among other things, he allegedly billed for higher levels of service than he performed. And he allegedly claimed to have submitted "special reports" that "included more information than that which is usually included on medical billing forms." He also allegedly billed for needle electromyography tests that he either did not perform or performed fewer times than he claimed. Finally, he tried to bill twice for the same procedure.

Chattha faces up to 20 years in prison for the mail fraud counts and 10 years for the health care fraud counts. He also faces a maximum fine of $250,000. These indictments come as a result of an investigation by a taskforce of federal, state and local law enforcement personnel.

There's bipartisan interest in giving the Centers for Medicare and Medicaid Services authority to reward providers with extra payments if they achieve quality goals, say Capitol Hill insiders. The **Medicare Payment Advisory Commission** recommended "pay for performance" recently and provided detailed analysis of different options.

But there's no consensus among legislators regarding how much money to give high-quality providers, when this should take place or under what conditions. Traditionally, Congress has coaxed providers to accept new quality initiatives with extra money. That may be hard to do when Congress has set reducing the federal budget deficit as a major goal, insiders note. Congress will probably have to include some Medicare cuts in any deficit-reduction package, they say.

When carriers examine a claim they suspect is a duplicate and discover that it's actually legitimate, the National Claims History data don't reflect this fact. Thus, when the **HHS Office of Inspector General** accused CMS of paying duplicate claims, the OIG actually was mistaken, CMS insists. The carriers investigated many of the claims the OIG believed were duplicates and found they weren't. To avoid this sort of confusion in the future, CMS instructed the carriers to add a new indicator to the Common Working File that shows the carrier has examined an apparently duplicate claim and found that it was payable, according to Transmittal 432 (Change Request 2965).