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MEDICAL PRACTICE CONSULTANTS, INC.

Overbilling Medicare for Evaluation and Management Services

ATLANTA—A settlement with dermatologists Margaret Kopchick, M.D., and Russell Burken, M.D., and their group practice Toccoa Clinic Medical Associates was reached with the U.S. Attorney's Office for the Northern District of Georgia. The settlement agreement reached was repayment of $1.9 settlement to settle claims that they violated the False Claims Act by billing Medicare for evaluation and management (E&M) services that were not permitted by Medicare rules.

"Physicians and practice groups are expected to bill Medicare for the costs of the services they provide. However, when they improperly bill for those services, it affects those who depend on Medicare by taking available dollars away from the program," said U.S. Attorney John Horn. "Those who inflate their Medicare billings can expect recovery of any overpayments, as well as significant penalties under the False Claims Act."

"The improper billing of evaluation and management services cost the taxpayers millions of dollars each year and drain the Medicare Trust Fund," said Derrick L. Jackson, Special Agent in Charge of the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) for the Atlanta region. "The OIG and the U.S. Attorney's Office will continue to hold health care providers like these responsible for improper claims."

Providers are not permitted to bill both E&M services and a procedure on the same day under the Medicare program's regulations unless a significant, separately identifiable service has been performed. In addition, where a significant, separately identifiable service has been performed, providers must bill the appropriate level of E&M service. More complex E&M services are reimbursed at higher rates. Here, the United States alleged that Drs. Burken and Kopchick billed for E&M services along with procedures where no significant and separately identifiable service was performed, and upcoded E&M services to higher levels than were appropriate, leading to overpayments by Medicare.

The civil settlement resolves the United States' investigation into Drs. Burken and Kopchick's billing for E&M services on the same day as a procedure.

HHS-OIG has identified the growing concern in billing for inappropriate E&M services as a national issue costing taxpayers billions of dollars. The resolution was part of the government's emphasis on combating health care fraud under the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which was announced by the Secretary of the Department of HHS in May 2009. The partnership between the HEAT and HHS departments has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act.

Since January 2009, the Justice Department recovered more than $27.4 billion through False Claims Act cases, with more than $17.4 billion of that amount recovered in cases involving fraud against federal health care programs.

This article can be seen at https://www.justice.gov/usao-ndga/pr/dermatology-physicians-and-practice-pay-19-million-settle-false-claims-act

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Office of Inspector General (OIG) 2016 Work Plan—Excerpts

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Work Plan* (*Work Plan*) for fiscal year (FY) 2016 summarizes new and ongoing OIG reviews and with respect to HHS programs and operations.

OIG Purpose: it was created to protect the integrity of HHS programs and operations and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal health care laws.

OIG Method: Work planning is a dynamic process, and adjustments are made throughout the year to meet priorities and to anticipate and respond to emerging issues with the resources available. We assess relative risks in the programs for which we have oversight authority to identify the areas most in need of attention and, accordingly, to set priorities for the sequence and proportion of resources to be allocated. In evaluating proposals for the *Work Plan*, we consider a number of factors, including:

- Mandatory requirements for OIG reviews, as set forth in laws, regulations, or other directives;
- Request made or concerns raised by Congress, HHS management, or the Office of Management and Budget;
- Top management and performance challenges facing HHS;
- Work performed by partner organizations;
- Management's actions to implement OIG recommendations from previous reviews; and
- Timeliness.

OIG 2016 Work Excerpts

Physical therapists—high use of outpatient physical therapy services

The Office of Inspector General (OIG) will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Prior OIG work found that claims for therapy services provided by independent physical therapists were:

- Not reasonable or were not properly documented or
- That the therapy services were not medically necessary.

Their focus will be on independent therapists who have a high utilization rate for outpatient physical therapy services.

Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Documentation requirements for therapy services are in CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, Ch. 15, § 220.3. (OAS; W-00-11- 35220; W-00-12-35220; W-00-13-35220; W-00-14-35220; W-00-15-35220; various reviews; expected issue date: FY 2016

Physicians–referring/ordering Medicare services and supplies

They will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements.

Pursuant to ACA Sec. 6405, CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or DME are required to be Medicare-enrolled physicians or nonphysician practitioners and legally eligible to refer/order services, supplies and DME. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid. (OAS; W-00-15-35748; expected issue date: FY 2016, ACA)

"Begin each day with a little courage, a little curiosity, and a little spring in your step."
-Doe Zantamata