CCH Health Care Compliance LETTER

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IRS analyzes community benefit and executive compensation standards

by Stacey Fahrner, J.D., M.P.H., Contributing Editor

In a final audit report concerning the Internal Revenue Service's (IRS) tax-exempt hospital compliance project, the Treasury Inspector General for Tax Administration (TIGTA) stated that community benefit and compensation practices are being studied, but further analysis is needed to address any noncompliance.

The executive compensation and community benefit practices of non-profit hospitals have been under intense scrutiny at both the federal and state level in recent years. The Government Accountability Office has stated there is often little to no difference between for-profit and tax-exempt hospitals when it comes to charity care and community benefits provided.

The compliance project began when the IRS' exempt organization (EO) function sent a nine page questionnaire to 544 tax-exempt hospitals soliciting information on compensation practices and the community benefit standard. The EO function is responsible for ensuring organizations exempt from federal income tax comply with applicable Internal Revenue Code sections and regulations.

According to TIGTA, if information gathered in the compliance project shows hospitals are performing only minimum actions to meet the community benefit standard, the EO function will consider a closer examination of the community benefit standard. Project information also may assist in differentiating tax-exempt hospitals from for-profit hospitals and in determining whether legislative action would improve the IRS' ability to administer tax laws in the tax-exempt hospital industry. Additionally, the compliance project will gather information about the practices and procedures tax-exempt organizations use to assign compensation to executives and other outsiders and enhance compliance.

Based on TIGTA's recommendations, an interim report on the project will focus on the community benefit issue and include an assessment of how tax-exempt hospitals are providing community benefits, as well as any planned actions deemed necessary to address the community benefit standard. Such actions could include revised revenue rulings, discussions with Department of the Treasury officials on potential regulatory changes, necessary education and outreach efforts, or potential examinations.

An interim report on the analysis of the questionnaire data is due in July 2007. It is unclear whether the interim report will be made publicly available; however, the final report, due September 2008, will be available to the public. ■

TIGTA Audit Report, 2007-10-061, March 29, 2007.

Wolters Kluwer Law & Business

Fraud and Abuse

Medicare fraud continues to grow

by Catherine Hubbard, M.A., Contributing Editor

CMS has seen a marked increase in fraud and abuse activities over the past few years that can directly be tied to provider enrollment issues. In testimony before the House Committee on Energy and Commerce, Subcommittee on Health, on April 18, 2007, CMS Acting Administrator Leslie Norwalk stated that these activities are focused in high vulnerability areas such as Los Angeles, Miami, and Houston, where there is a large number of beneficiaries, providers, and suppliers.

According to Norwalk, "The fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) suppliers continue to cost the Medicare program billions of dollars." Stuart Wright, HHS Deputy Inspector General for Evaluations and Inspections, said "[The Office of Inspector General (OIG)] has found that fraudulent suppliers continue to enroll and participate in the Medicare program." According to Wright, from 2002-2006, OIG excluded from the Medicare and Medicaid programs 121 DMEPOS companies and 457 individuals associated with DMEPOS. During that time, OIG's investigations yielded 289 successful criminal prosecutions of DMEPOS suppliers and imposition of 76 civil judgments, resulting in more than $796 million in restitution, fines, and penalties.

Norwalk stated that CMS is implementing new DMEPOS accreditation standards to ensure compliance with CMS' supplier certification standards. All DMEPOS suppliers must comply with CMS quality standards to receive Part B payments and retain a supplier billing number, she said, adding that the National Supplier Clearinghouse will not issue a supplier billing number to any nonaccredited supplier. CMS will phase-in the accreditation process and require accreditation organizations to prioritize their surveys to accredit suppliers in the selected Metropolitan Statistical Areas and competitive bidding areas, Norwalk said.

Meanwhile, Norwalk noted, claims payment errors have dropped. In November 2006, HHS reported a Medicare fee-for-service paid claims error rate of 4.4 percent, a significant decrease from the 5.2 percent reported in 2005, and significantly lower than the 10.1 percent rate reported in 2004. "We have far exceeded our expectations, having reduced the error rate beyond the 2006 goal of 5.1 percent. With continued monitoring and error reducing efforts, we aim to achieve our future targets of 4.3 percent in 2007, 4.2 percent in 2008, and 4.1 percent in 2009." ■

CCH Washington Bureau, April 19, 2007.

HIPAA

New technologies present challenges for health care privacy officers

by Catherine Hubbard, M.A., Contributing Editor

With each new advance in technology, privacy officers have to look more broadly at measures to secure data and ensure its privacy, according to Nadia Fahim-Koster, Information Privacy and Security Director at Gwinnett Health System in Lawrenceville, Georgia. Fahim-Koster was one of four privacy professionals who spoke about the changing landscape of information security and the role of privacy officers during a recent American Association of Health Information Management (AHIMA) roundtable on health care privacy.

The privacy and security rules enacted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) began an ongoing process to balance access to information with privacy and security concerns. In addition, many states have enacted privacy and security regulations of their own, some of which have more stringent requirements than HIPAA. Technological advances also represent new challenges for those charged with managing health information, particularly in light of numerous high-profile security and privacy breaches.

"We have a broader role today," said John Gildersleeve, System Privacy Officer with Geisinger Health System, Danville, Pennsylvania, noting that privacy officers are responsible for in-

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terpreting and applying the (HIPAA) to day-to-day practices and for monitoring compliance activities. "On any given day we have requests for interpretation in new areas involving the work force and corporate activities and have to look at the technical and physical safeguards we have in place to protect information," he said.

Jana Chvatal, Manager, Privacy and Information Security Office at Texas Children's Hospital, Houston, Texas, said that initially privacy officers focused exclusively on protecting patient information; now the scope of responsibilities has evolved to include protecting employee information and other proprietary information. "We started as privacy officers for patient information and have evolved into privacy officers for any sort of information that's protected," said Chvatal.

Training and education. Joan Kiel, HIPAA Compliance Officer, Duquesne University, Pittsburgh, Pennsylvania, noted the privacy officer needs to be involved in training the work force to educate them about what is allowed and what procedures need to be followed. They also need to be available to answer questions and interpret the standards, she added. The privacy rule was meant to give the public greater access to their records, but it becomes a hindrance if health professionals are not trained properly. "They can't be in that position and telling patients they can't have access to their charts because of HIPAA."

Chvatal said there is a lack of consumer education about HIPAA. "We've had people who've wanted to make a complaint because they think we violated HIPAA, but they've read part of the statute or an article with inaccurate or incomplete information," she said. Privacy officers need to explain the regulation and describe what a HIPAA violation is, she said.

State and federal initiatives. Privacy officers need to be aware of initiatives at the state and federal level that deal with personal and electronic health records, oversee implementation and compliance with HIPAA as well as other initiatives, and discuss the regulations with patients, said Chvatal. Fahim-Koster said privacy officers also have to be concerned with notification laws of other states in the event they have patients from those states.

Kiel noted that when state laws and HIPAA conflict, one has to adhere to the more stringent law. For example, according to Gildersleeve, nearly half the states have mandatory reporting if a patient's Social Security number is disclosed, but HIPAA doesn't require proactive disclosure in that circumstance.

Chvatal added that between HIPAA and state laws, there are a few contradictions and there are also inconsistencies in state law. In addition, some counties even have regulations about how information can be shared. "State laws add an extra layer of complexity," she said.

Accounting for unauthorized disclosures. Fahim-Koster also discussed some requirements of HIPAA that privacy officers find burdensome, such as the accounting for disclosures requirement. The accounting requirement is resource-intensive and time-consuming to comply with, yet produces few requests from patients, she said. In addition, HIPAA "brought nothing new to the table from the standpoint of good security practices that any organization should have in place," she said.

Gildersleeve said that despite having a significant infrastructure to track where data flows and whether there have been any unauthorized disclosures, the requests for accounting of disclosures have not exceeded 10 in his entity. He called the burden an "unintended consequence" of HIPAA.

In conclusion, Kiel said that privacy officers have to be an effective advocate and know what's going on at all levels in the organization. That means checking daily with staff to see if they've had requests to amend records or other issues or concerns. Privacy officers also need to participate in continuing education, get certified, go to conferences, talk to other people, look at best practices, and learn from each other, she suggested.

Chvatal added that it's important for privacy officers to be involved and have a voice with their local, state, and federal governments when privacy and security laws are being drafted and implemented.

"There are certain areas of HIPAA that are still extremely gray," said Gildersleeve. These gray areas, such as the availability of information electronically for research, require privacy officers "to be very scrupulous in our approach," he said. ■

CCH Washington Bureau, April 10, 2007.

Physician profiling: What do doctors really do?

by Bill Dacey, M.H.A., M.B.A., C.P.C, Contributing Editor

As Medicare program costs rise steadily federal scrutiny cyclically turns to the evaluation and management (E/M) codes as a potential source of either the problem or a locus for corrective action. Paradoxically, although the last minute-conversion factor freeze in late 2006 would appear to hold costs steady in this area, changes in relative value unit calculations actually boost payments for the highest volume E/M codes. This article discusses the impact of flawed reporting patterns that result from physician under coding.

The evaluation and management (E/M) codes account for nearly 40 percent of all Medicare program payments to physicians and are the biggest single target for carrier review. Although currently exempt from Recovery Audit Contractor (RAC) activity, this area of payments is just too large to avoid becoming involved in the expected $20 billion of recoveries that Congress is budgeting by 2010.

Carriers continue to scrutinize high volumes of higher level E/M codes, and 2006 saw a dramatic increase in the numbers of private payer audits for these services as well. The basic premise underlying the intensifying scrutiny is that physicians have not understood how to code for their services, haven't documented these services appropriately, and thereby present some risk of loss to federal or private programs by causing claims to be presented and paid that are either incorrect or unsupported. There is some truth in this, although in this auditor's experience many providers have gotten significantly better at both coding and documenting

The current E/M service codes and their documentation requirements s have been the subject of countless lectures, articles, books and carrier education programs since their implementation in 1992, yet both code assignment and documentation compliance has been woefully inaccurate. There seems to be a very slow learning curve for the proper identification of these services. CMS, however, contends that these services are regularly over-represented, or upcoded, and this perception is, in this author's experience, somewhat of a false claim.

In the fifteen years of reviewing tens of thousands of charts for correct CPT® coding and documentation compliance, spanning the same period of 1992-present when such activity became quantitatively possible, the numbers of charts reviewed in this office overwhelmingly indicate that many physicians under code their services, and the ratio is close to 5 to 1 under-coding to upcoding. There are of course some providers who, through either ignorance of the coding and documentation process, or by willful misrepresentation, have upcoded services, but in our experience this is the minority.

There does continue to be occasional programmatic institutional abuse of these service codes. For example, in 1996 the University of Pennsylvania paid $30 million in a settlement agreement regarding, in part, issues of mis-coding services. In recent years, coders employed by the University of Washington brought a suit alleging the hospital committed Medicare fraud by billing for surgery-related procedures performed from 1967 to 1995 in which attending physicians were not physically present. There is also clear evidence that some physicians have "gamed" the system and committed true fraud. All of this considered, it seems likely that all the overpayments, penalties, and fines either assessed to date, or potentially levied against cases of upcoding or under-documentation, total far less than the dollars unbilled to and unpaid by the government and other health plans by virtue of the under representation of services that has predominated all along.

Much of what the government deems upcoding would be better termed "under-documentation." For example, if a physician admitted a patient to the hospital, performed the relevant comprehensive history and physical as well as properly documented medical decision-making – but the review of systems (ROS) contained only 8 or 9 systems – is it upcoded? Technically it is; you can't bill for the "comprehensive history" because this one doesn't meet the letter of the law in terms of a ten system ROS – but it may better be termed under documented than upcoded. The point is that the real work associated with the code as created by the American Medical Assoication (AMA) was performed, but it lacked some documentation detail.

The distinction is important because the problems are different: in the one case the provider may not know what code represents the level of work they performed and hence selected the incorrect code, and in the second case the provider may not have known what the documentation demand associated with that code really was.

The best way to view the current E/M codes are as performance standards: if a certain amount of work is performed and documented as defined by a given code – then the provider has met the standard for that code. Rather than looking at the required documentation as the documentation burden associated with the codes, it is better to view it as the itemized account of work performed. This helps physicians match up the actual clinical work with the code and it's attendant documentation demand.

Impact of increased government attention on E/M coding

The constant climate of regulation and watchfulness surrounding the E/M area has already had two separate and opposite effects. In the first case, many physicians are afraid to code correctly for fear that they lack the correct documentation or don't quite understand the process. This comprises the vast majority of physicians who focus on patient care, never pay too much attention to the business side, and elect to take the safe course and under code. This result is not surprising, given the threat of false claims penalties, imprisonment, and exclusion from Medicare and/or Medicaid.

Other physicians now view the coding process and the now well-defined differentiation between levels of medical management, as an opportunity to stand up, be counted, and be recognized for the true levels of service they have long provided. Some of them may simply learn the levels of service to directly address the revenue or income side of the equation. We have seen little in the way of movement in the last few years towards greater use of codes 99205 or 99215 by primary care providers, so even those with a revenue bent tend to steer clear of the codes with the heaviest regulatory burden. Or perhaps those codes truly aren't to be reported in much higher frequencies than they are based on the acuity or breadth of patient management – we can't know for sure because the codes just aren't accurately reported. This will be most evident when we consider the profile data in the next section.

A common response by physicians when shown the correct way to code and document is "what will happen when my profile shifts to reflect these higher levels of service? Won't this attract greater scrutiny and maybe get me in trouble?" The answer is yes and no. Yes, a shift may attract some attention from a carrier or payer, and may well generate letters asking you to look more like your peers. But if the documentation is also present to support the correct level of service then at the end of the day there really is no problem on a claims level.

Provide the services to patients as their condition warrants, code the service correctly, document the service correctly, and invite any and all auditors, payers, and regulators to come inspect your work. The atmosphere of fear and uncertainty has prevailed long enough. The rules (Federal Documentation Guidelines) have been with us for over ten years now; teach your physicians how to code and document, monitor them for accuracy, provide feedback, and carry on. Medicare carrier pre-payment audits, post-payment audits, and private payer requests for supporting documentation should be viewed as an opportunity to demonstrate your good work on all fronts.

The Reporting Problem

The concept of pattern monitoring is what we are really talking about here. When either Medicare or another third party payer determines that you are an outlier, what data are you being benchmarked against? When physician's coding patterns are reported collectively, the data seems to make for some interesting conclusions. Here we will review the E/M profile data that Medicare calculates from physician reporting them for services provided to Medicare beneficiaries in calendar year 2005.

The graphs that follow represent codes reported by physicians of several specialties. For family medicine and internal medicine the data is provided for two years, 2004 and 2005, to show movement over time. The notation OB is ObGYN (obstetrics and gynecology) (really GYN for Medicare) and CD is cardiology. These specialties were chosen form the larger data set just to provide contrast and to make a few points.

When we look at the new patient data it is apparent that levels 4 and 5 are well-represented by all specialties shown. Family medicine shows over 30 percent of these higher levels in both years, OBGYN is over 50 percent, internal medicine over 60 percent and Cardiology almost 75 percent.

If we know what these codes are this makes a certain kind of sense. New patients will certainly require that more history and exam be performed to deal with their problems, but what of the level of decision-making? The level 4's and 5's represent respectively moderate and high complexity decision-making. New patient codes require all three elements of history, exam and decision-making –so we know that decision-making is part of the code selection process here.

On the face of it, the levels shown make some sense – if you agree that close to 65 percent of new patient visits for a Medicare patient to a family practitioner are for low level decision-making or less – that is single system problems that are stable and uncomplicated. For cardiology it does make sense that close to 75 percent of these Medicare beneficiaries will have at least one problem with exacerbation or progression, or an unknown new problem – or at the higher levels –face a serious or high morbidity/mortality problem.

Doctors that practice internal medicine certainly have an older population than some family practitioners, but these are all Medicare patients, so why would internists have close to double the number of 4's and 5's that FPs have? Some of this data does raise questions.

Of far greater interest is Table B –the data for established patients. There are many more of these, so the averages should theoretically be more precise – but there appear to be some odd statements being made here if the data is presumed to be correct.

Take the range of E/M codes within a code type, e.g., 99211 through 99215. The middle code of this range, 99213, has long been the most widely reported E/M code. It also represents close to one relative value unit (RVU), the basic unit of physician work. As above, per the AMA codes and Medicare guidelines this code represents the work involved in caring for

a patient with 1 stable chronic illness or an acute uncomplicated illness or injury. The Medicare tables that governs this say one problem – or even if recent trends are taken into consideration, make it one or two problems of this nature.

Consider again that the distribution of codes in the table below was reported for Medicare patients, for whom one would expect to see a higher average acuity or breadth of management than for the general population. You will see that the Medicare national percentages for family medicine indicate that only 26 percent fall into 99214, or the moderate range of decision-making. Per the code definitions, and federal guidelines, this again represents those patients with two or three stable chronic illnesses, or one chronic illness with mild to moderate exacerbation, progression, or side effects of treatment. Given that these are Medicare patients, don't these percentages seem low?

Conversely, look at 99212, involving straightforward decision-making, indicative of a sub-acute encounter with little or no risk, treatment, or acuity. Don't these seem high? For family medicine we see 7 or 8 percent, for internal medicine 6 percent, even cardiology logs in at 5 percent. What do these codes represent? These are sub-acute services – by Medicare definition again – "self-limited problems" with treatment options such as "rest, gargle, bandages." Now perhaps there are some Medicare visits for internists that are about a healing pressure sore, and there must be some resolved upper respiratory infection (URI) follow-ups –but 6-7 percent? (not sure if this should end in a question mark or not) And what about cardiology – 5 percent. It's unclear what these visits would be. Perhaps they were higher level services the cardiologist just didn't bother to document.

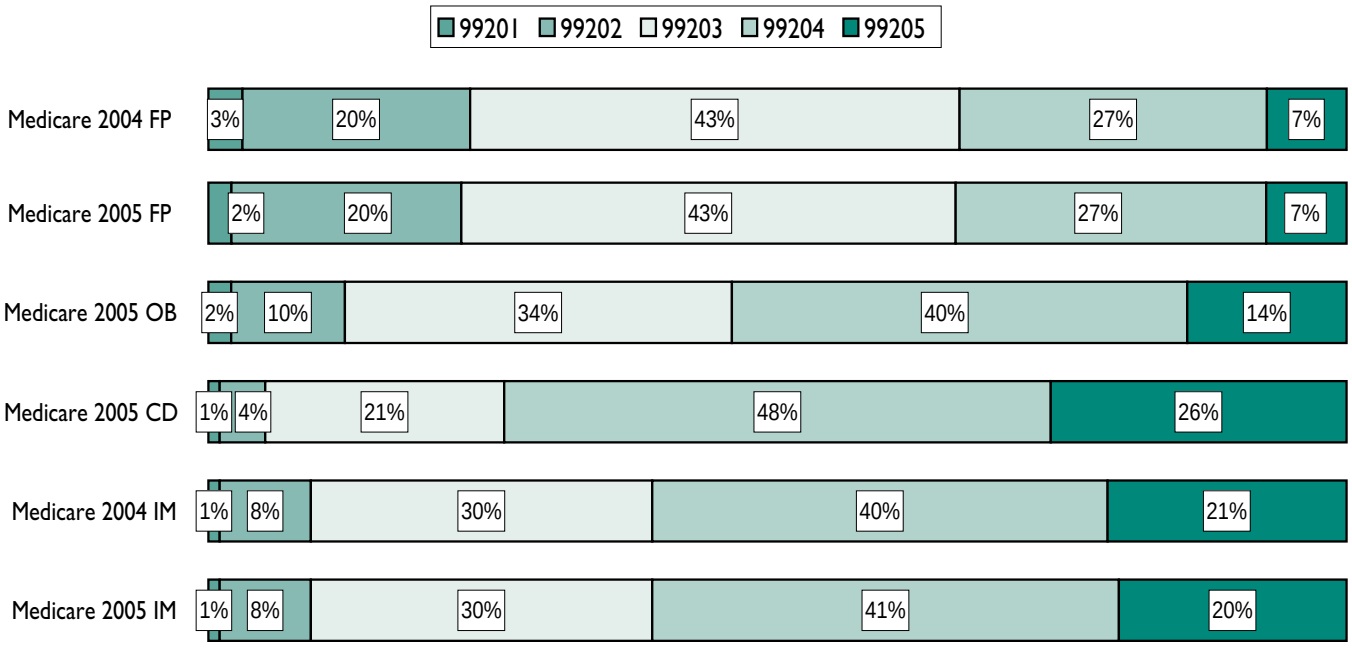
Looking at OBGYN, what could account for 17 percent level 2 visits for Medicare patients? These numbers just can't truly represent what physicians do.

These profiles do seem to illustrate that if coding by medical decision-making is any indicator, the reported codes reflect rampant under coding of services. One state Medicare medical director has been on the record as saying that they would "expect most established patient visits for Medicare patients to be of the 99214 variety." If this is so, why are almost 70 percent of these encounters for Medicare family medicine patients coded at the 99212 and 99213 levels?

The distribution of codes across this spectrum illustrates that most physicians under code services when compared to the work actually performed for this population. Perhaps we are seeing the cumulative result that occurs when physicians are either afraid to code for what they do, or don't understand what the codes mean. The distribution, or profile of codes reported is distorted. By extension then, so too is the profile used by CMS and other payers by which they benchmark providers. The "norm" isn't actually normative at all in terms of what work is really being performed. The profile does not represent the work actually being performed, so variance from it doesn't mean much to begin with. That's why a well-tuned practice may well not look at all like the 'normative' profile data.

Anything derived from the artificial profiles, this data that federal and state entities use to determine outliers and potential upcoders—is wrong. The profile is artificially skewed by virtue of coding habits, and reflects physician under coding. For the compliance officer or manager to monitor physician coding for true compliance, productivity, and reimbursement purposes, a baseline profile for each practice will need to be established. This can be accomplished through a process of chart reviews that measures both correct coding and correct documentation. Once again, the guidelines and federal scrutiny combine to provide the practice with the tools and incentive to code correctly and to monitor supporting documentation. Don't look at "bell-curve" data.

Table A - 2005 Medicare Data: Multi-Specialty - New Patients



Perhaps, when physicians have even more time to practice coding (or when the financial crunch becomes unbearable), the greatest code shift effect will come in the area of high-level decision-making. When physicians realize what 99205, 99215, or 99245 are intended to represent, shifts to these codes will have a significant economic impact on Medicare and other payers' payments to physicians. Shifts to the higher codes are especially meaningful as the difference in payments between the higher codes are greater than the entire payment for the lower range of codes.

CMS is currently mulling over a one-level amnesty for code selection in its review process –we'll see where that lands. In the meantime watch physicians with E/M profiles higher than the average. Although the coding may be correct, it involves areas with the highest documentation demands and, thus, the highest exposure for noncompliance.

Many subspecialists may exhibit either apathy or "attitude," not to mention annoyance, regarding E/M documentation. Largely, this stems from frustration with the intrusion of nonclinical interests into the realm of the medical record and the treatment of complex medical problems. Be patient and explain that higher codes—which often reflect their specialty work—entitle them to higher reimbursement, but only after the codes are substantiated by documentation.

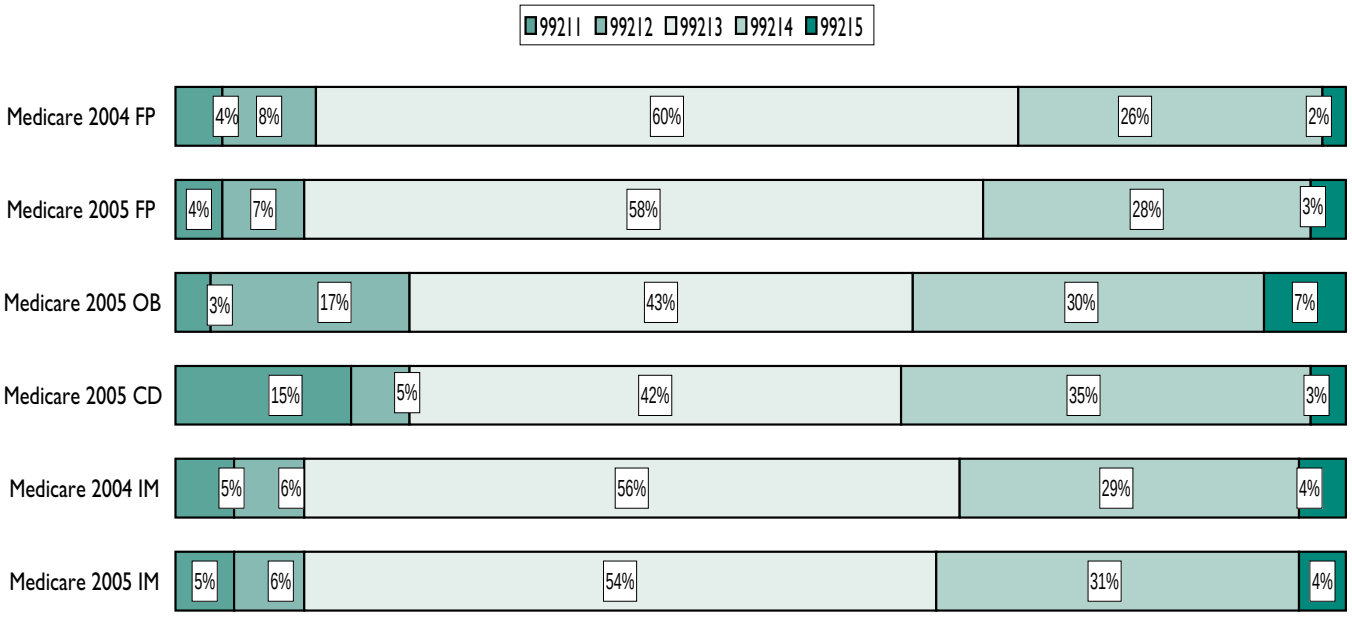
Certain specialties that are procedurally-based, e.g. surgery and orthopedics, often regard E/M as a nuisance, and a small segment of their practice. Point out that this small part could constitute the bulk of their liability with regard to compliance. For some specialties, orthopedics and surgical specialties in particular, the physical exam requirements of the codes are also somewhat unreasonable. If an orthopedic surgeon is dealing with severe degenerative spinal disease, and surgery is the option, this is likely at the level five code range. But do they need to examine 8 or 9 organ systems, or document five findings from each of six body areas to deal with this problem? Be certain that supporting documentation, if present, has some basis in medical necessity, and isn't just cloned or templated to "fill-in" the code.

On the other end of the spectrum, physicians may under code, particularly in the primary care areas in part as a response to documentation and compliance pressures. It is easy to comply with documentation requirements when reporting a code that reflects less work than actually performed. Physicians with high documentation compliance rates may achieve these simply by under coding. And there it is.

The moral of the story is to get as close to your physicians' work as possible, match it up with the correct code, and the appropriate amount of supporting documentation. The profile data is wrong; it comes from these same docs who don't know how to code well. So educate and motivate, before the data you've created puts you out of business. ■

Bill Dacey, MHA, MBA, CPC founded The Dacey Group, Inc. to address physician needs relative to coding and compliance. Through physician profile analysis and extensive exposure to physician documentation practices, Bill has become nationally recognized in both coding and compliance. As Director of Coding and Reimbursement, and later a Vice President of Compliance for a large Integrated healthcare system, Bill had oversight responsibilities for over 500 physicians with annual revenues in excess of $350 million. Bill also has worked extensively with carriers and private payers to promote correct coding and accurate reporting and processing of professional services. Bill was elected by the membership of the American Academy of Professional Coders (AAPC) to the National Advisory Board from 2003 through 2006. Bill also serves on the Editorial Advisory Board of the CCH HealthCare Compliance Newsletter and numerous coding and compliance publication boards. Please direct questions or comments about this article to Bill at 727-773-2515.

Table B - 2005 Medicare Data: Multi-Specialty Established Patients



Medicare

Transplant center conditions of participation finalized

by Jay Nawrocki, Contributing Editor

Conditions of participation (CoPs) for transplant centers in hospitals that perform heart, heart-lung, intestine, kidney, lung, and pancreas transplants, as well as pediatric organ transplantations have been established under a new *Final rule*. This is the first time there have been conditions of participation for these activities. Previously, kidney transplant facilities operated under conditions for coverage for suppliers of end-stage renal disease (ESRD) services; extra-renal organ transplants were governed by the pertinent parts of the national coverage decisions for extra-renal organ transplantation.

Medicare approval. Existing Medicare-approved transplant centers will have until December 28, 2007, to submit a request for approval under the new CoPs. Once approved, those facilities will operate under the CoPs and not the requirements of the national coverage decisions for renal or extra-renal transplant centers. A transplant center must be located in a hospital that is a member of and abides by the rules and requirements of the Organ Procurement and Transplant Network (OPTN) and has an existing written agreement with an organ procurement organization.

A transplant center that wishes to continue to be Medicare approved, or a facility first applying to be approved by Medicare as a transplant facility, must be in compliance with the new CoPs and submit a signed request. Facilities that wish to perform pediatric transplants must submit a separate application as a pediatric transplant center.

Patient management. Transplant centers must have written patient management policies for the transplant and discharge of patients. Each transplant patient and living donor is to be under the care of a multidisciplinary team coordinated by a physician. Candidates for transplantation must receive a psychosocial evaluation, have their blood typed, and be given a copy of the selection criteria. Living donors must have medical and psychosocial evaluations prior to donation and have given their consent. ■

Final Rule, 72 FR 15198, March 30, 2007.

In the News

Owner of counseling service admits defrauding Medicaid

A woman who owned and operated a counseling center pled guilty in federal court to one count of health care fraud, according to the U.S. Attorney of the Northern District of Texas. She admitted that from January 2003 through August 2004, she and others defrauded Medicaid by submitting claims for services allegedly provided to Medicaid beneficiaries through the School Health and Related Services (SHARS) program. The counseling center submitted a fraudulent school district affiliation agreement to Medicaid in order to participate in the SHARS program, and admits that the counseling services were never provided to the named beneficiaries. The owner admitted that she, and other participants, caused Medicaid to pay more than $250,591 in fradulent claims to the counseling center. The owner faces a maximum sentence of 10 years in prison, a $250,000 fine, and restitution.

DOJ Press Release, April 3, 2007.

Psychologist sentenced for TRICARE fraud

A psychologist has been sentenced to 12 months and one day in prison for health care fraud. According to records filed in the case, the psychologist billed TRICARE for therapy sessions with patients that never took place. He also illegally billed for sessions handled by phone and billed for a higher level of service than that provided. When TRICARE asked for treatment notes for claims that had already been submitted, the psychologist made up notes, including notes for sessions that in fact had never occurred, but for which he had previously submitted claims.The judge who imposed the sentence told the psychologist, "the raw facts are that you got money that you weren't entitled to," and in making up notes to support false claims "you created medical histories that were not true and that can affect patients for years."

U.S. Attorney's Office, W.D. Wash. Press Release, April 6, 2007.

HIV clinic and DME owners indicted in fraud scheme

The U.S. Attorney for the Southern District of Florida announced the unsealing of an indictment charging ten owners of durable medical equipment (DME) companies and HIV clinics in connection with a multi-million dollar health care fraud and money laundering scheme. According to the indictment, the owners submitted more than $12.5 million in false claims for DME, expensive HIV treatments, and related medications. The indictment further alleges that the owners operated an HIV clinic, recruited and then paid patients to attend the clinic, and, instead of administering prescribed medications, injected the patients with saline while billing Medicare for the cost of the prescribed drugs. In furtherance of the fraud scheme, the co-conspirators allegedly laundered a substantial portion of the proceeds through a series of shell corporations set up for the sole purpose of concealing the illicit monies. The indictment also alleges obstruction of federal investigations into the fraud and money laundering scheme, and seeks forfeiture of a series of properties purchased by the owners during the course of the conspiracy.

U.S. Attorney's Office, S.D. Fla. Press Release, April 3, 2007.