

Claims Scenario #1:

Nature of Loss:

A physician's routine post-payment review, conducted by a fiscal agent of the Federal Medicare Program, focused on claims paid by Medicare to determine the appropriateness of Medicare payments made to specific providers over a selected period of time. The findings alleged that the doctor was over-utilizing certain procedure codes and Medicare calculated that they had overpaid \$751,507 to the physician. When Medicare requested reimbursement, the physician retained an attorney to challenge the allegations.

Two years later, Medicare re-calculated the amount which was reduced to \$635,118. After continued appeals for another two years, and an appearance before an administrative law judge, the review findings were dismissed and Medicare was obligated to reimburse money to the physician.

ATTORNEY COSTS: \$75,000
Plus costs for an independent Consultant to review his records

Claims Scenario #2:

Nature of Loss:

A physician was the subject of a routine post-payment review conducted by a fiscal agent of the Federal Medicare Program which focused on claims paid by Medicare to determine the appropriateness of Medicare payments made to specific providers over a particular period of time. The findings alleged that the doctor had been reimbursed for unnecessary procedures of over \$6 million. The physician retained an attorney to challenge the findings.

Two years later, Medicare revised its findings and calculated that only a \$60,000 refund of was due.

REFUND PAID TO MEDICARE: \$141,000
ATTORNEY FEES: \$ 69,000+

Claims Scenario #3:

Nature of Loss:

A large healthcare system self-disclosed its conduct to the OIG for allegedly billing Medicare for hospital services which were medically unnecessary.

AMOUNT PAID: \$1,142,973

Claims Scenario #4:

Nature of Loss:

A physical therapy clinic allegedly submitted false/fraudulent claims for services over a two-month period when there was no licensed physical therapist in staff, in addition to submitting upcoded claims for *individual* therapy services under incorrect CPT codes when those claims should have been submitted under a specific *group* therapy CPT code.

AMOUNT PAID: \$398,357

Claims Scenario #1:

A provider contracted a software vendor to develop and maintain an online system to capture demographic and other personal patient health information for the purpose of scheduling appointments. The website was not properly secured by the vendor and patient information was able to be viewed by anyone visiting the site. A regulatory complaint was filed by a patient against the provider.

The regulatory agency immediately contacted the provider regarding the sensitive information available to unauthorized users on the website and requested the site be shut down immediately. The provider contacted the software vendor, who promptly corrected the defects in the program.

Claims Scenario #2:

A chain drugstore admitted that it made patient prescription records available for use by direct mail and pharmaceutical companies. They stated that their intent was to track customers who do not refill prescriptions and send letters encouraging them to refill their prescriptions and consider alternative treatments.

Due to the outrage and concern expressed by the customers, both companies planned to discontinue the marketing and direct mail campaigns.

Claims Scenario #3:

A large state University mistakenly revealed the names of the kidney donors to 1200 transplant recipients who were participating in a long-term research study. And while some of the recipients knew the identity of their donors, more than 400 recipients learned the names of their donors for the first time. A software upgrade had neglected to suppress the donors' names, and was stated as the reason for the breach. However, this was the second time that this University's computer problems violated patient confidentiality. A couple of years earlier, a psychologist from that University mistakenly posted the mental health records of 20 children on a public website

Claims Scenario #4:

One of the nation's largest health insurers had insurance claims forms transported by truck to a recycling center when the forms blew out of the truck and scattered on a highway during rush hour. The papers should have been previously shredded, per company policy, but were not.

Claims Scenario #1:

Nature of Loss:

Two pulmonologists allegedly violated the Anti-Kickback Statute provision of the Stark Law by accepting gifts, including tickets to professional football games and meals, in exchange for patient referrals to a durable medical equipment supplier.

The doctors entered into a 3-year Integrity Agreement to resolve their liability, in addition to paying violation fines.

TOTAL AMOUNT PAID: \$122,096

Claims Scenario #2:

Nature of Loss:

A New York physician was alleged to have solicited and received remuneration in exchange for referring beneficiaries for MRI and/or CRT scans to an imaging center.

The physician agreed to enter into a 5-year Integrity Agreement to resolve the allegation of violating the Stark Law, in addition to paying the fine.

AMOUNT PAID: \$75,000

Claims Scenario #3:

Nature of Loss:

A healthcare system self-disclosed acts of violating the Anti-Kickback Statute provision of the Stark Law.

The government alleged that the healthcare system provided IT resources to non-employee physician groups without prior written contracts.

The healthcare system reported that it failed to document IT agreements with multiple physician practices/groups, and failed to bill and collect for those IT sources.

AMOUNT PAID: \$780,000

Claims Scenario #1:

Nature of Loss:

A Florida-based healthcare system was fined for allegedly violating the Patient Anti-Dumping Statute by:

- Inappropriately transferring a female in active labor
- Not accepting a patient referred to one of its facilities under the Baker Act
- Failing to provide an appropriate medical screening exam for a patient in its emergency department

AMOUNT PAID: \$85,000

Claims Scenario #2:

Nature of Loss:

A Missouri hospital was fined under the EMTALA statute, allegedly having failed to provide appropriate medical screening exams to three patients in their emergency department:

- A baby with life-threatening bronchitis and exacerbated asthma
- A woman whose intestines were protruding due to an incorrect C-Section procedure
- A teenage boy who claimed he could not move, stand, walk, or feel his limbs

AMOUNT PAID: \$75,000

Claims Scenario #3:

Nature of Loss:

A California hospital was fined under the Patient Dumping Statute for allegedly failing to provide appropriate medical screening examinations to 16 individuals in its emergency department.

The individuals complained of various complaints including chest pain, abdominal pain, vaginal bleeding, fever, vomiting, dizziness and coughing.

They were triaged by a nurse and directed to wait in the waiting area, where they waited unattended from three to six hours and ultimately left without receiving the appropriate medical screening examinations.

AMOUNT PAID: \$75,000