Medical Billers Claims Scenarios

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1.) Several hospital employees in Michigan were fired and others disciplined for accessing the personal medical records of a government official without authorization. The state's governor had been admitted to the facility for abdominal surgery.
2.) A jury awarded nearly $2.3 million to three women whose mental health treatment records were not kept confidential by a West Virginia medical transcription firm.
3.) An Arizona-based firm has recently been the target of a class-action lawsuit brought by medical patients whose identity information was stolen. The action seeks unspecified monetary damages for alleged negligence, breach of contract, and violations of the federal Privacy Act.
4.) A Washington DC jury ordered a local hospital to pay $25,000 for failing to keep a patient's records confidential. The individual's co-workers had learned the details of his medical condition after an employee at the facility revealed the information to them.
5.) A healthcare professional from New Hampshire was fined for repeatedly looking at the medical records of an acquaintance without permission. Because there was no state law making it a crime to breach the confidentiality of medical records, the case was brought under a law against misusing a computer.
6.) 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. Total costs: $124,000
7.) 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. Total attorney fees: $69,000
8.) 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
9.) 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