# Eli's Rehab Report

## Fraud & Abuse: HEAT Scorches Wrong Doers

**Does your coding meet Medicare requirements?**

With federal enforcement agencies stepping up activity and utilizing technological assistance to close in on fraud and abuse, it's time to focus on strong documentation to support billing and coding.

**Background:** The Medicare Fraud Strike Force charged 301 persons with participation in health care fraud schemes involving approximately $900 million in false billings. In response the Centers for Medicare & Medicaid Services (CMS) has exercised its authority mandated by the Affordable Care Act (ACA) to suspend payments to numerous providers. The Medicare Fraud Strike Force is a part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT).

"Takedowns protect Medicare and Medicaid and deter fraud  sending a strong signal that theft from these taxpayer-funded programs will not be tolerated. The money taxpayers spend fighting fraud is an excellent investment," the Office of Inspector General (OIG) said in a June 22 news release, "For every $1.00 spent on health care-related fraud and abuse investigations in the last three years, more than $6.10 has been recovered."

**No Geographic Limitation to Location of Fraudsters**

Florida, Texas, Michigan, California, Illinois, Orlando, Louisiana  the takedowns were spread across 36 federal districts, indicating that there is no localization in the pattern of fraud and abuse. Ten individuals were charged in six different cases, including "five individuals who were charged for their roles in a scheme involving over $86 million in physical and occupational therapy claims to Medicare and Medicaid," the Eastern District of New York, says a Department of Justice (DOJ) June 22 press release. They are alleged to have "filled a network of Brooklyn clinics that they controlled with patients by paying bribes and kickbacks. Once at the clinics, these patients were subjected to medically unnecessary therapy," the release said.

"The Department of Justice is determined to continue working to ensure that the American people know that their health care system works for them  and them alone," United States Attorney General Loretta E. Lynch said in the press release.

"Office of Inspector General reviews have identified claims for outpatient physical therapy services that were not reasonable, medically necessary, properly documented, and were vulnerable to fraud, waste, and abuse," said a recent report titled A South Texas Physical Therapist Claimed Unallowable Medicare Part B Reimbursement for Outpatient Physical Therapy Services.

The main areas of concern seem to have been in home health care, psychotherapy, occupational therapy services, prescription drug fraud, provision of durable medical equipment (DME), and kickbacks.

**Technology Key to Takedowns**

With CMS advancements in technology, the OIG was able to harness its extensive research using data analytics to uncover a plethora of fraudulent activity with speed and efficiency.

"Our agents are now able to obtain and analyze billing data in real-time," the OIG 2016 National Health Care Fraud

Takedown factsheet states. "Through our use of data, we are increasingly able to stop fraud schemes at the developmental stage, and to prevent the schemes from spreading to other parts of the country."

The enhanced data analytics are a boon to the OIG's law enforcement efforts and mark a turning point for the group. Moving forward, these cyber strengths will surely stamp out both civil and criminal Medicare abuse before it starts.

**Resources:** For a look at the OIG news release about the June 2016 Healthcare Fraud Takedown, visit https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900. For links to the OIG 2016 National Health Care Fraud Takedown factsheet, graphs, pictures, and more, visit http://oig.hhs.gov/newsroom/media-materials/2016/takedown.asp. For report on PT claiming unallowable reimbursement, please see http://go.usa.gov/x3rHJ.