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Psychiatry Coding & Reimbursement Alert

Medicare News: Get the Latest News Regarding OIG's Takedown of Practices Taking Kickbacks

OIG pulls down a major fraud amounting to more than $900 million.

If you are not aware of the latest with the Office of Inspector General (OIG), you should get informed that they have set their target on bringing down those practices who were trying to make a quick buck through scrupulous means such as upcoding or taking illegal kickbacks.

Background: A few weeks ago, in an unprecedented sweep that spanned 36 judicial districts, the Department of Health and Human Services' (HHS) OIG charged over 300 defendants in a variety of Medicare and Medicaid hustles. You should know that this was a huge fraud takedown,and the total volume of services that were improperly billed amounted to about $900 million.

"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 OIG said in a June 2016 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."

Have a Look at Who the Top Offenders Were

You should be aware that OIG has looked through the entire network and has brought to book every person or practice that was into this fraud.

With 301 offenders total, both criminal and civil actions were pursued by over "1,000 law enforcement personnel" that included federal, state, and local officials, including "350 OIG special agents," the OIG Takedown fact sheet said. Of this list, about 61 of the defendants were actually medical professionals physicians, nurses, therapists and more all caught abusing the system in one capacity or another.

According to the OIG media materials and fact sheet, the focus was on treatment and services that were performed when it was completely unnecessary or it wasn't performed at all. The areas and actions mentioned and detailed in the research included:

- Home health care
- Psychotherapy
- Occupational therapy services
- Prescription drug fraud
- Durable Medical Equipment (DME)
- Kickbacks.

Know How OIG brought Defaulters to Book

OIG used the latest in technology and they built up their lists using extensive research through data analytics to expose the huge volume of fraud that was happening within the industry with ease 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 potential turning point for the group. Moving forward, these cyber strengths may allow authorities to stop fraud schemes at the developmental stage and to prevent the schemes from spreading to other parts of the country.

"At first glance, the size and scope of the recent sweep can be scary," says **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians. "However, upon further reflection the typical physician or clinician who is making an honest effort to comply with Medicare billing rules should not be concerned. As noted in the fact sheet, this takedown involved only 60 licensed medical professionals, including 30 physicians, out of the hundreds of thousands who serve Medicare beneficiaries. Furthermore, the fact sheet makes clear that those caught in the takedown were outliers whose actions indicated intent to defraud or abuse the Medicare program. That does not describe the typical provider of psychiatric services under Medicare," Moore adds.