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## Health Care Fraud (January 2013)

“Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party”.<sup>1</sup>

### How It Happens

According to the National Health Care Anti-Fraud Association “the most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state. Other common forms of health care fraud include;<sup>2</sup>

- Billing for procedures, supplies or services that were never provided
- “Up-coding” and “unbundling” are methods of fraud, frequently used by medical providers.
  - o Up-coding, is defined as billing for a more costly service or procedure than was actually performed.
  - o Unbundling of charges is health care provider code fragmentation, used when a provider bills services separately that are usually included in a single service fee.
- Misrepresenting for the purpose of fraudulently obtaining payment or for obtaining a payment greater than that to which a provider is legally entitled, any of the following.
  - o The nature or amount of medical services provided
  - o Dates on which services were rendered
  - o The condition of the recipient of the medical service at the time of treatment
  - o The diagnosis of the recipient of the medical service
  - o The identity of the person to whom services were provided

- The deliberate performance of medically unnecessary services, for the purpose of financial gain
- Improper billing for services rendered
  - See “unbundling” above
- Paying kickbacks to providers for referring beneficiaries for specific services.
- “Doctor shopping”. involves traveling from doctor to doctor or emergency room to emergency room, seeking medical treatment for the purpose of obtaining prescription drugs by delivering their prescription slips to different pharmacies thereby obtaining more drugs than they are entitled to.
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With the recent passage of the Affordable Care Act, Director of the U.S. Department of Health and Human Services, Kathleen Sebelius, noted that with the passage of the Affordable Care Act, a new wave of health care scams has surfaced. Due to the complexity of the new law and the confusion over its’ contents, scam artists have set up 1-800 numbers, and even gone door to door, selling insurance policies that do not exist.<sup>3</sup>

In these cases the patient is unaware of the fact that their identity, their insurance information and their treatment is being used to defraud the Medicare/Medicaid system. Aside from the monetary damage to the U.S. health care system, these practices can create some significant problems for the patient in the form of false medical histories in whose names these false claims are filed. The issue becomes even more serious when a consumer needs actual medical treatment and that treatment is influenced by a fictitious medical history, potentially resulting in improper treatment and physical risk or the patient applying for a job or insurance coverage, suddenly finds themselves classified as a health risk based on inaccurate medical records used to defraud the health care system.

As mentioned above, the majority of offenders in health care fraud, are medical facilities or medical service providers; however, there are instances where individual recipients have been found to have been involved in health care fraud. This can happen when the individual, in an attempt to exploit their own health insurance provider, manages to persuade a medical provider to inflate or misrepresent the services provided, creates forged receipts for doctor visits that never occurred or modifies actual receipts with the goal of increasing the monetary gain per claim and then filing them with the consumer’s insurance provider.

## **Costs and Statistics**

The costs to the American health care system of health care fraud waste and abuse is more than half again as large as the global black market in heroin.<sup>4</sup> In a memo from the Chair of the House of Representatives Committee on Energy and Commerce to its’ Health Subcommittee, the following statistics were cited;

According to testimony before the U.S. House of Representatives in November of 2012, the U.S. health care system currently spends \$2.8 trillion dollars and generates billions of claims every year

from millions of health care service and product providers. Medicare alone represents 47 million beneficiaries, pays over 4.4 million claims each working day to 1.5 million providers.<sup>6</sup>

During FY 2011, the Justice Department, working in collaboration with the U.S. Department of Health and Human Services was able to recover nearly \$4.1 billion in funds stolen or taken improperly from federal health-care programs which represents the highest amount ever recovered in a single year.<sup>7</sup> Unfortunately this record breaking recovery accounts for only less than one percent of the total funds lost through fraud waste and abuse in 2011.

A report by the U.S. Government Accountability Office discovered that medical facilities and durable medical equipment providers were the most frequent subjects of criminal fraud cases involving Medicare or Medicaid with hospitals and medical facilities cited as the most frequent subjects of civil fraud cases resulting in judgments or settlements. Only 11.1% of the cases or 103 individuals investigated and prosecuted for health care fraud involved individual citizens as the perpetrators.<sup>8</sup>

## High Profile Examples/Case Studies

The U.S. Department of Health and Human Services in conjunction with the FBI have stepped up investigation of health care fraud cases since the passage of the Affordable Care Act. A review of enforcement actions cited by the Office of the Inspector General for HHS a number of criminal investigations resolved in 2012 are discussed:

- In Miami, a former director, nurse and two marketing personnel were all convicted in a \$205 million Medicare fraud scheme.
- In Detroit, seven people were arrested in a \$22 million home health care fraud scheme.
- In another Florida based medical facility the director was convicted in a \$26.2 million fraud scheme.

The U.S. Department of Health and Human Services has also managed to settle many cases without criminal prosecution. Examples of instances of health care fraud that were resolved without criminal prosecution includes:

- A Florida based company, American Sleep Medicine, agreed to repay \$15.3 million for false billing charges.
- A San Diego Pharmaceuticals corporation paid a total of \$11.1 million to resolve allegations of false claims in the sale of pharmaceuticals and violations federal anti-kickback allegations.
- The Northern Ohio Heart Center agreed to repay over \$4 million for submitting false claims to Medicare.
- In Newark NJ, the Cooper Health System reached an agreement with the U.S. Attorney's office and the State of NJ to repay \$12.6 million for violations of the state false claims act and improper billing for physician services.
- In Brooklyn New York, American biotechnology company Amgen agreed to pay \$762 million to resolve criminal and civil liability involving their sale and marketing of certain drugs.<sup>13</sup>

The above by no means represent a comprehensive list of the investigations undertaken by federal authorities in their efforts to reduce the incidence of health care fraud, however it should give a sense of the amounts of health care funding being lost through fraud.

## The Response/Current Efforts

According to Joel C. Williams, Managing Director, of Information Technology for the Centers for Medicare and Medicaid Services (CMS), one of the reasons for the staggering losses through fraud in the U.S. Healthcare system is due in large part to the ponderous size and complexity of the system. To further complicate the situation, states are allowed to administer their own programs and left to their own resources to investigate and prosecute violators, there is no system in place for sharing of information between states, private insurers are often being victimized by and investigating the same perpetrators as governmental entities and it becomes easier to understand how losses can total close to \$70 trillion every year. With the enactment of the Affordable Care Act, several new measures have been implemented aimed specifically at curtailing the extensive fraud, waste and abuse that has come to characterize Medicare and Medicaid.<sup>15</sup>

- **Tough new rules and sentences for criminals:** The ACA increases the federal sentencing guidelines for health care fraud offenses by 20-50% for crimes involving more than a million in losses and establishes penalties for obstructing a fraud investigation or audit and makes it easier for government to recapture any funds acquired through fraudulent practices
- **Enhanced Screening and other Enrollment Requirements:** in 2011, CMS published rules to enforce some of the ACA's most powerful new fraud prevention tools. Providers and suppliers wishing to participate in Medicare, Medicaid, and CHIP who may pose a higher risk of fraud or abuse are now required to undergo a higher level of scrutiny.
- **Increased Coordination of Fraud Prevention Efforts:** the law expressly authorizes CMS, in consultation with OIG, to suspend Medicare payments to providers or suppliers during the investigation of a credible allegation of fraud. States must also withhold payments to Medicaid providers where there is a pending investigation of a credible allegation of fraud unless the state Medicaid agency has good cause not to do so.
- **Health Care Fraud Prevention and Enforcement Action Team (HEAT):** A joint effort between HHS and DOH to fight health care fraud.
  - o In May 2012, Medicare Strike Force teams charged 107 individuals including doctors, nurses and other licensed medical professionals, in seven cities for their alleged participation in Medicare fraud schemes involving more than \$452 million in false billing
  - o In 2011 HEAT coordinated the largest ever federal health care fraud takedown of \$530 million. In one action, Strike Force teams charged 115 defendants in nine cities, including doctors, nurses, health care company owners and executives, or their alleged participation in Medicare fraud schemes involving more than \$240 million in false billing.
- **Use of State-of-the-art Fraud Detection Technology:** CMS has implemented the new Fraud Prevention System, which uses advanced predictive modeling technology to fight fraud.
- **New focus on compliance and prevention:** Under the new law, some preventive measures focus on certain categories of providers and supporters that historically have

presented concerns, including Home Health agencies, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers.

- **Expanded Overpayment Recovery Efforts:** The ACA expands the Recovery Audit Contractor (RAC) program to Medicaid, Medicare Advantage, and Medicare Part D programs, which is projected to save \$2.1 billion over the next five years of which \$900 million will be returned to the states.
- **New Durable Medical Equipment (DME) Requirements:** On August 27, 2010 CMS issued final rules enhancing Medicare enrollment standards for DME suppliers such as more stringent operations and facilities requirements to ensure only legitimate suppliers can participate in Medicare.
- **New Resources to Fight Fraud:** The Affordable Care Act provides an additional \$350 million over 10 years to ramp up anti-fraud efforts, including increasing scrutiny of claims before they've been paid, investments in sophisticated data analytics, and an increased number of law enforcement agents and others to fight fraud in the health care system.
- **Greater Oversight of Private Insurance Abuses:** The new law also provides enhanced tools and authorities to address abuses of multiple employer welfare arrangements and protect employers and employees from insurance scams. It also gives new powers to the Secretary and Inspector General to investigate and audit the health insurance exchanges.
- **Senior Medicare Patrols.** Groups of seniors, funded in part by the ACA, comprised of senior citizen volunteers to educate and empower their peers to identify, prevent and report health care fraud<sup>16</sup>

In addition to the fraud waste and abuse fighting measures made possible by the ACA, private insurers, who are also being victimized by the same types of fraud often by the same perpetrators, are making changes in their systems as well. **WellPoint, Inc.** is the largest managed health care, for-profit company in the Blue Cross Blue Shield Corporation. In testimony before the House Subcommittee on Health Energy & Commerce Committee several programs were discussed that WellPoint has developed to assist in the battle against healthcare fraud waste and abuse.

- **Controlled substance Utilization Monitoring (CSUM)** program which identifies members who, within a three month period, visit three or more prescribing providers, visit three or more pharmacies, and have filled ten or more controlled substance prescriptions without a confirmed underlying medically necessary condition to justify numerous controlled substances.
- **Medicaid Restricted Recipient Program** in which a member who has been identified as an abuser or at risk for abuse of controlled substances can be restricted to the use of only one primary care physician, one retail pharmacy, and one hospital for any non-emergency care.
- **Provider engagement in the Prescription Drug Trade** in which WellPoints' Special Investigative Unit analyze aberrant provider practice patterns through data mining and analytics in which they look for outlier activities such as significant dollar spikes in payments or cumulative dollar spikes in certain counties.
- **Development and use of a Predictive Modeling program** which uses advanced neural network technology to identify previously unknown and emerging fraud and abuse provider/member schemes.

- **Bogus Providers** steal or purchase patient identification numbers, establish a fake storefront office furnished with limited inventory, obtain a post office box, and proceed to bill insurers for fraudulent services and devices.
- **Review of Emerging Technologies** in which WellPoint reviews newly emerging technologies to determine whether providers are inappropriately billing for services, devices or medications that are currently experimental or investigated.<sup>17</sup>

One of the more popular recommendations from the private sector, concerning the ability to successfully identify, prevent, investigate and prosecute health care fraud waste and abuse, involves a call for public – private sector sharing of information and collaboration in the investigative and prosecution efforts. At present there are two analytic tools being used on a limited basis in the federal system, for identification and investigation of potential health care fraud. The Integrated Data Repository (IDRO) and the One Program Integrity (One PI) web portal both are seen as having the potential to reinvent the manner in which healthcare data analytics are utilized. The ability to gather information on forms of fraud waste and abuse and the characteristics of those responsible for it is crucial in effectively preventing as well as investigating and prosecuting those responsible for the abuse of the healthcare system. Calls to expand coverage of these analytic tools nationwide and to open access to the information and analytical tools contained in these two powerful programs are steadily coming from not only the private insurance sector, but from the Government Accountability Office as well.<sup>18</sup>

## “For More Information” Links

- National Health Care Anti-Fraud Association – [www.nhcaa.org](http://www.nhcaa.org)
- Centers for Medicare and Medicaid Services – <http://cms.hhs.gov>
- Federal Bureau of Investigation Health Care Fraud Unit – [www.fbi.gov](http://www.fbi.gov)

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## Endnotes

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<sup>1</sup> National Health Care Anti-Fraud Association, “Consumer Info & Action” <http://www.nhcaa.org/resources/health-care-anti-fraud-resources/consumer-info-action.aspx> retrieved from the internet, Jan.17.2013

<sup>2</sup> ibid

<sup>3</sup> Letter to State Insurance Commissioners and to State Attorneys General regarding health care fraud scams coming on the heels of the signing of the Presidents Affordable Health Care Act. Retrieved 1/17/13 from <http://www.hhs.gov/news/press/2010pres/04/insurance20100406.pdf>

<sup>4</sup> United Nations Office on Drugs and Crime 2012 report. P. 60 [http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR\\_2012\\_web\\_small.pdf](http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf). Retrieved from the internet January 30, 2013.

<sup>6</sup> Testimony of Louis Saccoccio, , Chief Executive Officer of the National Health Care Anti-Fraud Association before the U.s. House of Representatives energy & Commerce Committee Subcommittee on Health, November 28, 2012

<sup>7</sup> Attorney General Eric Holder Speaks at Health Care Fraud and Abuse control Program Report Press Conference, Washington, D.C. Tuesday, February 14, 2012. [www.justice.gov/printg/PrintOut3.jsp](http://www.justice.gov/printg/PrintOut3.jsp)

<sup>8</sup> “Health Care Fraud; Types of Providers Involved in Medicare Cases, and CMS Efforts to Reduce Fraud” Government Accountability Office, Report GAO-13-213T Statement of Kathleen M. King, Director, Health Care, before the Subcommittee on Health, Committee on energy and commerce, House of Representatives. released November 28, 2012

<sup>13</sup> U.S. Department of Health and Human Services, Office of the Inspector General, Civil and Criminal Court Archives <https://oig.hhs.gov/fraud/enforcement/criminal/index.asp> retrieved on January 30, 2013

<sup>15</sup> U./S. Government Accountability Office report # GAO-11-822T. p. 3

<sup>16</sup> Press Release, HealthCare.gov “New Tools to Fight Fraud, Strengthen Federal and Private Health Programs, and Protect consumer and Taxpayer Dollars” <http://www.healthcare.gov/news/factsheets/2012/02/medicare-fraud02142012a.html> retrieved from the internet January 10, 2013.

<sup>17</sup> Testimony of Ms. Alanna M. Lavelle, Diirector, Special Investigations WellPoint Inc. before the Subcommittee on Health Energy & Commerce Committeed, November 28, 2012

<sup>18</sup> “Tackling Fraud, Waster, and Abuse in the Medicare and Medicaid Programs: Response to the May 2, Open Letter to the Healthcare Community” by Don Olson, CFE Health Information Designs [http://www.hidinc.com/assets/files/Tackling%20fraud\\_waste\\_abuse%20white%20paper.pdf](http://www.hidinc.com/assets/files/Tackling%20fraud_waste_abuse%20white%20paper.pdf)