

# Health Care Fraud

## A Serious and Costly Reality for All Americans

Since the early 1990s, health care fraud—i.e., the deliberate submittal of false claims to private health insurance plans and/or tax-funded health insurance programs such as Medicare and Medicaid—has been viewed as a serious and still-growing nationwide crime phenomenon, linked directly to the nation's ever-growing annual health care outlay, which in calendar-year 2000 alone amounted to \$1.3 trillion (Centers for Medicare & Medicaid Services: "National Health Care Expenditures, 2000").

So strong an invitation to some is the country's ever-larger pool of health care money that in certain areas—Florida, for example—law enforcement agencies and health insurers have witnessed in recent years the migration of some criminals out of drug trafficking and other lines of crime and into the safer and far more lucrative business of perpetrating fraud schemes against Medicare, Medicaid and private health insurance companies.

In South Florida alone, government programs and private insurers have lost hundreds of millions of dollars in recent years to criminal rings—some of them based in Central and South America—that fabricate claims from non-existent clinics, using genuine patient-insurance and provider-billing information that the perpetrators have bought and/or stolen for that purpose.

### **That Some Health Insurance Claims Are Fraudulent Is Beyond Dispute**

It is an undisputed reality that some of the more than 4 billion health insurance benefit transactions processed in the United States every year are fraudulent. Although they constitute only a small fraction, those fraudulent claims carry a very high price tag.

Each year, for example, the Office of Inspector General of the U.S. Department of Health and Human Services conducts a formal audit of

the Medicare program's fee-for-service claim payments. On February 21, 2002, the HHS-OIG reported its finding that of the \$191.8 billion in such claims paid in 2001, 6.3 percent—amounting to **\$12.1 billion**—should not have been paid due to erroneous billing or payment, inadequate provider documentation of services to back up the claims and/or outright fraud.

In May, 2002, the National Health Care Anti-Fraud Association (NHCAA) reported in its Anti-Fraud Management Survey that 59 of its member insurers collectively recovered or prevented payment of just under \$356 million in 2001 as a direct result of their anti-fraud activities—a great deal of money, but a barely measurable fraction of the total estimated loss.

The bottom line: The NHCAA estimates that of the nation's annual health care outlay, at least 3 percent—or \$39 billion in calendar-year 2000—is lost to outright fraud. Other estimates by government and law enforcement agencies place the loss as high as 10 percent of our annual expenditure—or \$130 billion—each year.

Although the immediate targets and victims of that fraud are private health payers and government-funded health plans, all of us ultimately pay for the crime—through higher health insurance premiums (or fewer benefits) for employers and individuals, higher taxes, and higher insurance co-payments for privately and publicly insured patients.

### **A Federal Crime with Stiff Penalties**

In response to these realities, Congress—through the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—specifically established health care fraud as a federal criminal offense, with the basic crime carrying a federal prison term of up to 10 years in addition to significant financial penalties. [*United States Code, Title 18, Section 1347.*]

The federal law also provides that should a perpetrator's fraud result in the injury of a patient, the prison term can double, to 20 years; and should it result in a patient's death, a perpetrator can be sentenced to life in federal prison.

Congress also mandated the establishment of a nationwide "Coordinated Fraud and Abuse Control Program," to coordinate federal, state and local law enforcement efforts against health care

fraud and to include "the coordination and sharing of data" with private health insurers.

In their capacities as health insurance regulators, many states also have responded vigorously since the early 1990s, not only by strengthening their insurance fraud laws and penalties, but also by requiring health insurers—including HMOs—to meet certain standards of fraud detection, investigation and referral as a condition of maintaining their insurance or HMO licenses.

### **Dishonest Health Care Providers Take the Greatest Toll**

Individual patients can, and in some cases do, commit health care fraud—either on their own or in collusion with dishonest health care providers. By far the greatest damage, though, is attributable to fraud committed by dishonest health care providers.

This is not because large numbers of physicians and other health care professionals are dishonest. On the contrary, the vast majority are honest and ethical, and they too are victimized both by the dishonest few within their professions and by the increasing number of professional criminal operations that pose as health care providers for purposes of committing fraud.

The few who make up that dishonest minority, however, have all the necessary tools with which to commit ongoing fraud on a very broad scale:

- The entire population of insured patients to attract and exploit;
- The entire range of potential medical conditions and treatments on which to base false claims; and
- The ability to bill many different third-party payers and, in the case of fraud perpetrators, to spread false billings among many insurers simultaneously—increasing their fraud proceeds while lessening their chances of being detected by any one insurer.

The most common types of fraud committed by dishonest providers are as follows:

- **Billing for services that were never rendered**—either by using genuine patient information to fabricate entire claims or by padding claims with charges for procedures or services that did not take place;

- **Billing for more expensive services or procedures than were actually provided or performed**, commonly known as "upcoding"—i.e., falsely billing for a higher-priced treatment that was actually provided (which often requires the accompanying "inflation" of the patient's diagnosis code to a more serious condition consistent with the false procedure code); and
- **Performing medically unnecessary services solely for the purpose of generating insurance payments**—seen very often in nerve-conduction and other diagnostic-testing schemes; and
- **Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance payment**—widely seen in cosmetic-surgery schemes, in which non-covered cosmetic procedures such "nose jobs," "tummy tucks," liposuction or breast augmentations, for example, are billed to patients' insurers as deviated-septum repairs, hernia repairs, or lumpectomies.

The illicit proceeds of such schemes typically amount to very significant sums of money. In cases involving individual dishonest providers, it is not uncommon to see schemes in which the thefts have ranged from a few hundred thousand dollars to several million dollars in a relatively short period—e.g., two, three, four years—prior to their detection.

In November, 2001, for example, an Arlington, Texas chiropractor was sentenced to five years in prison after pleading guilty to masterminding a broad-based scheme responsible for submitting \$5.7 million in false claims—of which \$3.2 million worth were paid—to a variety of health insurers over a five-year period. (In the same scheme, one physician was convicted, two more submitted guilty pleas, and two former physicians were indicted.)

In "institutional" cases involving such perpetrators as hospital chains, national laboratory companies, transportation, pharmaceutical and medical equipment companies, the totals in various federal criminal and civil fraud cases of recent years have ranged from tens of millions to hundreds of millions of dollars. Several recent high-profile fraud cases involving hospital chains and pharmaceutical companies, for example, have resulted in criminal and/or civil settlements ranging from \$600 million to \$850 million.

### **Fraud's Impact Goes Far Beyond Financial Loss**

Health care fraud features the theft of very large amounts of money. However, the damage it does goes well beyond financial losses. More important are its inherent exploitation of individuals and their insurance information as the basis for falsified claims:

- **Falsification of Patients' Diagnoses and/or Treatment Histories**

By its nature, one cannot commit health care fraud without falsifying something about a patient's medical condition and/or treatment history. Thus fraud perpetrators routinely assign to the patients whom they exploit false diagnoses of medical conditions they do not have, or of more severe conditions that they actually have.

Unless and until discovered (perhaps under adverse circumstances) those phony or "inflated" diagnoses become part of the patient's medical history, at least in the health insurer's records.

A Boston-area psychiatrist, for example, forfeited \$1.3 million and was sentenced to several years in federal prison following his late-1990s conviction on 136 counts of mail fraud, money laundering and witness intimidation related to his fraudulent billing of several health insurers for psychiatric therapy sessions that never took place—using the names and insurance information of many people whom he actually had never met, let alone treated. (He also went so far as to write fictitious longhand session notes to ensure phony backup for his phony claims.)

In fabricating the claims, the psychiatrist also fabricated diagnoses for those "patients"—many of them adolescents. The phony conditions he assigned to them included "depressive psychosis," "suicidal ideation," "sexual identity problems" and "behavioral problems in school."

- **Theft of Patients' Finite Health Insurance Benefits**

Privately insured patients typically have lifetime caps or other limits on benefits under their policies. Every time a false claim is paid in a given patient's name, the dollar amount counts toward that patient's lifetime or other limits.

Part of the aforementioned psychiatrist's fraud involved routinely billing for the maximum number of therapy sessions covered by patients' health insurance, even if he had seen them only a handful of times—a fact that some patients discovered only when

their claims for treatment by different psychiatrists were denied on the basis that they had already used all of their available benefits.

- **Physical Risk to Patients**

Finally, the perpetrators of some types of fraud schemes (e.g., involving medical transportation, surgeries, invasive testing, certain drug therapies) deliberately and callously place their trusting patients at significant physical risk—illustrating vividly why federal law provides for longer potential prison terms in health care fraud cases that result in a patient's injury or death.

In June, 2002, for example, a Chicago cardiologist was sentenced to 12-1/2 years in federal prison and was ordered to pay \$16.5 million in fines and restitution after pleading guilty to performing 750 medically unnecessary heart catheterizations, along with unnecessary angioplasties and other tests as part of a 10-year fraud scheme involving that city's now-defunct Edgewater Medical Center.

Three other physicians and a hospital administrator also pleaded guilty and received prison sentences for their part in the scheme, which resulted in the deaths of at least two patients.

The physicians and hospital induced hundreds of homeless persons, substance abusers, and elderly men and women to feign symptoms and be admitted to the hospital for the unnecessary procedures. How? By offering them such incentives as food, cash and cigarettes.

"There were 750 people who had needles stuck into their hearts purely for profit—not because they needed it," said one of the federal prosecutors.

At the bottom line, health care fraud is a serious crime that legitimately concerns all parties to our health care system—insurers and premium-payers, government and taxpayers, and patients and health care providers—and it is a costly reality that government and society cannot afford to overlook.

### **Private-Public Cooperation Against Fraud is Essential**

Founded in 1985 by a handful of private insurers and law enforcement personnel, the National Health Care Anti-Fraud

Association is a private-public non-profit organization focused solely on improving the private and public sectors' ability to detect, investigate, prosecute and, ultimately, prevent fraud against our private and public health insurance systems.

Today it represents the combined efforts of the anti-fraud units of 90 private health payers and the entire spectrum of federal and some state law enforcement agencies that have jurisdiction over the crime, along with hundreds of individual members from the private health insurance sector and from federal, state and local law enforcement.

The NHCAA pursues its mission by fostering private-public cooperation against health care fraud at both the case and policy-making levels, by facilitating the sharing of investigative information among health insurers and law enforcement agencies and by providing information on health care fraud to all interested parties.

The NHCAA Institute for Health Care Fraud Prevention, a non-profit educational foundation, provides professional education and training to industry and government anti-fraud investigators and other personnel.

### **What Can the Public Do?**

How can you help to detect and prevent health care fraud?

- **Read Your Benefit Statements**

If you receive an "Explanation of Benefits" after your health insurance plan has paid a claim on your behalf, read it carefully to ensure that you actually received the treatments that were paid for, and report apparent discrepancies.

Many such statements list toll-free hotlines that you may call to report suspicious charges.

- **Beware of "Free" Medical Treatments**

Various community-based service organizations periodically offer perfectly legitimate free screenings of vision, cholesterol, blood pressure or other basic health indicators.

However, other, sometimes heavily advertised offers of "free" medical treatments (e.g., "free" footcare, dental treatments, chiropractic visits) often are the lure with which fraud perpetrators seek to obtain patient names and insurance information for use in fraudulent billings.

Question any "free" treatment that features "no out-of-pocket expense" or "no deductibles," or for which you are required to provide your health insurance coverage information.

- **Protect Your Health Insurance Information**

It pays to treat your health insurance card as you do your credit cards, and never give your health insurance number to telephone or door-to-door solicitors.