



Introduction to Healthcare Fraud

Truth is often eclipsed but never extinguished.

—LIVY, HISTORIAN (59 B.C.–A.D. 17)

When Willie Sutton, an infamous twentieth-century bank robber, was asked why he robbed banks, he replied, “Because that’s where the money is.” The healthcare industry, too, has lots of money. Long considered a recession-proof industry, healthcare continues to grow. Statistics from the Centers for Medicare and Medicaid Services (CMS), formally known as the Healthcare Financing Administration, show that, in 1965, U.S. healthcare consumers spent close to \$42 billion. In 1991, that number grew in excess of \$738 billion, an increase of 1,657 percent. In 1994, U.S. healthcare consumers spent \$1 trillion. That number climbed to \$1.6 trillion in 2004, which amounted to \$6,280 per healthcare consumer. The figure is expected to hit over \$2.2 trillion by 2008, which translates to about \$250 million per hour.

How many of these annual healthcare dollars are spent wastefully? Based on current operational statistics, we will need to budget \$550 billion for waste. A trillion-dollar market has about \$329.2 billion of fat, or about 25 percent of the annual spending figure. The following statistics are staggering in their implications:

- \$108 billion (16 percent) of the above is paid improperly due to billing errors. (Centers for Medicare and Medicaid Services, www.cms.gov)
- \$33 billion of Medicare dollars (7 percent) are illegitimate claims billed to the government. (National Center for Policy Analysis, www.ncpa.org)
- \$100 billion private-pay dollars (20 percent) are estimated to be paid improperly. (www.mbanews.com)
- \$50 billion (10 percent) of private-payer claims are paid out fraudulently. (Blue Cross/Blue Shield, www.bcbs.com)
- \$37.6 billion is spent annually for medical errors. (Agency for Healthcare Research and Quality, www.ahrq.gov)
- Ten percent of drugs sold worldwide are counterfeit (up to 50 percent in some countries) (www.fda.gov). The prescription drug market is \$121.8 billion annually (www.cms.gov), making the annual counterfeit price tag approximately \$12.2 billion.

What do these statistics mean? About \$25 million per hour is stolen in healthcare in the United States alone. Healthcare expenditures are on the rise and at a pace faster than inflation. The fight against bankruptcy in our public and privately managed health programs is in full gear.

Use this how-to book as a guide to walk through a highly segmented market with high-dollar cash transactions. This book describes what is normal so that abnormal becomes apparent. Healthcare fraud prevention, detection, and investigation methods are outlined, as are internal controls and anomaly tracking systems for ongoing monitoring and surveillance. The ultimate goal of this book is to help you see beyond the eclipse created by healthcare fraud and sharpen your skills as an auditor or investigator to identify incontrovertible truth.

WHAT IS HEALTHCARE FRAUD?

The *Merriam-Webster Dictionary of Law* defines fraud as

any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage; specifically: a misrepresentation or concealment with reference to some fact material to a transaction that is made with knowledge of its falsity or in reckless disregard of its truth or

falsity and with the intent to deceive another and that is reasonably relied on by the other who is injured thereby.

The legal elements of fraud, according to this definition, are

- Misrepresentation of a material fact
- Knowledge of the falsity of the misrepresentation or ignorance of its truth
- Intent
- A victim acting on the misrepresentation
- Damage to the victim

Definitions of healthcare fraud contain similar elements. The CMS website, for example, defines fraud as the

Intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is more specific, defining the term *federal health care offense* as “a violation of, or a criminal conspiracy to violate” specific provisions of the U.S. Code, “if the violation or conspiracy relates to a health care benefit program” 18 U.S.C. § 24(a).

The statute next defines *health care benefit program* as “any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract” 18 U.S.C. § 24(b).

Finally, *health care fraud* is defined as knowingly and willfully executing a scheme to defraud a healthcare benefit program or obtaining, “by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by . . . any health care benefit program” 18 U.S.C. § 1347.

HIPAA establishes specific criminal sanctions for offenses against both private and public health insurance programs. These offenses are consistent with our earlier definitions of fraud in that they involve false statements, misrepresentations, or deliberate omissions that are critical to the determination of benefits payable and may obstruct fraud investigations.

Healthcare fraud differs from healthcare abuse. *Abuse* refers to

- Incidents or practices that are not consistent with the standard of care (substandard care)
- Unnecessary costs to a program, caused either directly or indirectly
- Improper payment or payment for services that fail to meet professional standards
- Medically unnecessary services
- Substandard quality of care (e.g., in nursing homes)
- Failure to meet coverage requirements

Healthcare fraud, in comparison, typically takes one or more of these forms:

- False statements or claims
- Elaborate schemes
- Cover-up strategies
- Misrepresentations of value
- Misrepresentations of service

WHAT DOES HEALTHCARE FRAUD LOOK LIKE?

It is important to appreciate that healthcare is a dynamic and segmented market among parties that deliver or facilitate the delivery of health information, healthcare resources, and the financial transactions that move along all components. To fully appreciate what healthcare fraud looks like, it is important to understand traditional and nontraditional players. The patient is the individual who actually receives a healthcare service. The provider is an individual or entity that delivers or executes the healthcare service. The payer is the entity that processes the financial transaction. The plan sponsor is the party that funds the transaction. Plan sponsors include private self-insurance programs, employer-based premium programs, and government programs such as Medicare and Medicaid. A vendor is any entity that provides a professional service or materials used in the delivery of patient care.

What does healthcare fraud look like from the patient's perspective? The patient may submit a false claim with no participation from any other

party. The patient may exaggerate a workers' compensation claim or allege that an injury took place at work when in fact it occurred outside of work. The patient may participate in collusive fraudulent behavior with other parties. A second party may be a physician who fabricates a service for liability compensation. The patient may be involved in an established crime ring that involves extensive collusive behavior, such as staging an auto accident. The schemes repeat themselves as well as evolve in their creativity.

SAMPLE PATIENT FRAUD CASE

At an insurance company, all payments of foreign claims are made to insured's and not to foreign medical providers. An insured patient submitted fictitious foreign claims (\$90,000) from a clinic in South America, indicating that the entire family was in a car accident. A fictitious police report accompanied the medical claims. A telephone call to the clinic revealed that the insured and the dependents were never treated in the clinic.

What does healthcare fraud look like from the provider's perspective? The fraud schemes can vary from simple false claims to complex financial arrangements. The traditional scheme of submitting false claims for services not rendered continues to be a problem. Other activities, such as submitting duplicate claims or not acknowledging duplicate payments, are issues as well.

Some schemes demonstrate great complexity and sophistication in their understanding of payer systems. One example is the rent-a-patient scheme where criminals pay "recruiters" to organize and recruit beneficiaries to visit clinics owned or operated by the criminals. For a fee, recruiters "rent," or "broker," the beneficiaries to the criminals. Recruiters often enlist beneficiaries at low-income housing projects, retirement communities, or employment settings of low-income wage earners. Detecting complicated misrepresentations that involve contractual arrangements with third parties or cost report manipulations submitted to government programs requires a niche expertise.

SAMPLE PROVIDER EMPLOYEE FRAUD CASE

A woman who was affiliated with a medical facility had access to claim forms and medical records. She submitted claims for heart surgery, gall bladder surgery, finger amputations, a hysterectomy, and more—27 surgeries in all. The intent was to cash in on the checks for the services. The anomaly was that if a patient has surgery, a corresponding hospital bill should have been submitted and it was not.

What does healthcare fraud look like from the payer's perspective? The fraud schemes in this group tend to be pursued mostly in response to transactions between the payer and a government plan sponsor. They include misrepresentations of performance guarantees, not answering beneficiary questions on claims status, bad-faith claim transactions, and financial transactions that are not contractually based. Other fraudulent activities include altering or reassigning the diagnosis or procedure codes submitted by the provider. Auditing payer activities requires a niche expertise in operational as well as contractual issues.

SAMPLE PAYER FRAUD CASE

A third-party administrator (TPA) processing claims on behalf of Medicare signed a corporate integrity agreement (CIA) with the Department of Justice (CIAs are discussed later in this book) in response to a number of allegations by providers that the TPA (1) failed to process claims according to coverage determinations; (2) failed to process or pay physicians' or other healthcare claims in a timely fashion, or at all; (3) applied incorrect payments for appropriate claims submissions; (4) inaccurately reported claims processing data to the state, including a failure to meet self-reporting requirements and impose self-assessment penalties as required under the managed care contract with the state; (5) failed to provide coverage of home health services to qualified beneficiaries; (6) automatically changed CPT-codes (current procedural terminology codes, used to explain the procedure provided); (7) did not recognize modifiers (modifiers are additional codes

that providers submit to explain the service provided); and (8) did not reliably respond to appeals from patients, sometimes not responding at all or waiting over 6 to 12 months to do so.

What does healthcare fraud look like from the employer's perspective? Schemes include underreporting the number of employees, employee classifications, and payroll information; failing to pay insurance premiums, which results in no coverage; creating infrastructures that make employees pay for coverage via payroll deductions; engaging in management activities that discourage employees from seeking medical treatment; and referring employees to a medical facility and in turn receiving compensation for the referrals.

SAMPLE EMPLOYER FRAUD CASE

An employer who colludes with applicants to receive benefits illegally or who commits fraud to avoid taxes will be penalized at least \$500, and may also be prosecuted. Collusion is knowingly helping applicants obtain benefits to which they are not entitled, for example, cash wages or other hidden compensation for services performed. In other words, the employer misrepresents the eligibility of the applicant so that he or she can receive benefits not qualified for.

What does healthcare fraud look like from a vendor's perspective? This category has numerous examples that involve a range of participants, from professional healthcare subcontractors to suppliers of equipment, products, services, and pharmaceuticals. These schemes include false claims, claims for altered products, counterfeit medications, and unlicensed professionals. They include collusive behavior among several entities as well as between individual professionals.

THREE SAMPLE VENDOR FRAUD CASES

A third-party medical billing company, Emergency Physician Billing Services, Inc. (EPBS), provided coding, billing, and collections services for emergency physician groups in over 100 emergency departments in as many as 33 states. Based on allegations presented by a *qui tam relator* (whistleblower reporting a fraud), the United States charged that EPBS and its principal owner, Dr. J. D. McKean, routinely billed federal and state healthcare programs for higher levels of treatment than were provided or supported by medical record documentation. EPBS was paid based on a percentage of revenues either billed or recovered, depending on the client.

In a second case, a supply vendor delivered adult diapers, which are not covered by Medicare, and improperly billed them as expensive prosthetic devices called “female external urinary collection devices.”

In a third example of a vendor fraud case, an ambulance company billed ambulance rides for trips to the mall.

Overall, healthcare fraud schemes target one of the following:

- Pursuit of money
- Avoidance of liability
- Malicious harm
- Competitive advantage
- Research and product market advantage
- Addiction
- Theft of personal effects
- Theft of individual and/or corporate identity

HEALTHCARE FRAUD IN THE UNITED STATES

Healthcare fraud is growing at an accelerated rate in the United States. Traditional schemes include false claim submissions, care that lacks medical

necessity, controlled substance abuse, upcoding (billing for more expensive procedures), employee-plan fraud, staged-accident rings, waiver of co-payments and deductibles, billing experimental treatments as nonexperimental ones, agent-broker fraud relationships, premium fraud, bad-faith claim payment activities, quackery, overutilization (rendering more services than are necessary), and kickbacks. Evolved schemes include complex rent-a-patient activities, 340 B program abuse activities (setting aside discounted drugs, making them unavailable to those in need), pill-mill schemes (schemes to falsely bill prescriptions), counterfeit drug activities, and organized criminal schemes.

HEALTHCARE FRAUD IN INTERNATIONAL MARKETS

Healthcare fraud knows no boundaries. The U.S. Medicare and Medicaid programs are equivalent to many government-sponsored programs in other countries. Regardless of country, the existence and roles of players within the healthcare continuum are the same. All healthcare systems have patients, providers, TPAs (third-party administrators) that process reimbursements to third parties, plan sponsors (usually government programs or private-pay activities), and support vendors.

Examples of international healthcare fraud are plentiful. In France, a psychiatric nursing home took advantage of patients to obtain their property. In 2004, a newspaper in South Africa reported that “a man who posed as a homeopathic doctor was this week sentenced to 38 years in jail—the stiffest term ever imposed by a South African court on a person caught stealing from medical aids.” An Australian psychiatrist claimed more than \$1 million by writing fake referrals of patients to himself; he also charged for the time spent having intimate relations with patients.

In Japan, as in the United States, there are examples of hospitals incarcerating patients, falsifying records, and inflating numbers of doctors and nurses in facilities for profit. A U.K. medical researcher misled his peers and the public by using his own urine sample for 12 research subjects. Switzerland, known for its watches, had providers sanctioned for billing 30-hour days. All of these examples include patterns of behavior consistent with the definitions of healthcare fraud in the United States.

WHO COMMITS HEALTHCARE FRAUD?

Do not limit your imagination or develop tunnel vision when it comes to healthcare fraud. Fraud is committed anywhere and by anyone. The list includes providers; insured patients; individuals, both domestic and foreign; approvers (employees) who pay claims to themselves or friends; rings, or a group of criminals who commit healthcare fraud; nonproviders, or non-medical, nonrelated healthcare players who create fraud schemes; payers, agents, and personnel; and vendors and suppliers providing services within the healthcare industry. They are found as employers providing benefit coverage; personnel employed by providers, payers, employers, or various vendors; and formal organized crime entities. The key element as to who they are is always defined by the defrauder's *action*, not by his or her title or role. The literature focuses heavily on provider fraud. Limiting the focus on a particular player in the market merely creates opportunities for other players to concentrate their efforts on areas not receiving the same attention, thus potentially bleeding the system dry.

Regardless, a key element of healthcare fraud (or of any type of fraud, regardless of industry) is that the individuals who commit these types of frauds tend to have no conscience. For example, consider those who suffer from antisocial personality disorder (APD). This disorder affects about 4 percent of the population. That number represents about 11,840,512 individuals in the United States. Worldwide, 4 percent represents about 257,553,015 individuals. In essence, then, there are potentially 269 million people with the perfect psychological profile to commit fraud.

APD should be considered when an individual possesses at least three of the following seven characteristics: (1) failure to conform to social norms; (2) deceitfulness, manipulateness; (3) impulsivity, failure to plan ahead; (4) irritability, aggressiveness; (5) reckless disregard for the safety of self or others; (6) consistent irresponsibility; (7) lack of remorse after having hurt, mistreated, or stolen from another person. How do you look for clues of APD? First, note examples of outrageous logic—for example, this statement from Al Capone:

“I am going to St. Petersburg, Florida, tomorrow; let the worthy citizens of Chicago get their liquor the best they can. I am sick of the job—it’s a thankless one and full of grief. I have been spending the best years of my life as a public benefactor.”

Another clear sign is direct denial of an event, “I never did that,” regardless of any incontrovertible evidence. In addition, look for statements that are inconsistent with known events. Follow this by noting examples of inconsistent emotional responses under similar circumstances within the subject’s life, lack of any emotional responses at all, or inconsistent emotional responses in comparison to social norms. Finally, another hallmark sign is a series of failures due to lack of planning and consistent irresponsibility in various walks of life.

WHAT IS HEALTHCARE FRAUD EXAMINATION?

Auditing and investigating healthcare fraud is about seeing beyond the eclipse created by defrauders and deciphering *who, what, where, when, why, and how*. It is about creating an archaeological road map into the discovery of truth. Audit and investigative techniques excavate information that appears to have been extinguished.

To *examine* means “to observe carefully or critically; inspect” or “to study or analyze” an issue (*American Heritage Dictionary*, 4th ed.). Fraud examination, then, is the thorough inspection, study, or analysis of an issue relating to fraud. The Association of Certified Fraud Examiners (ACFE) is an organization dedicated to the study of fraud across all industry sectors. It is a global professional association providing antifraud information and education to help members fight fraud effectively. As of this writing, the ACFE has 40,000 members in 125 countries; its 103 local chapters provide education, outreach, and networking opportunities. In its coursework, the ACFE provides the figure describing fraud examination shown in Exhibit 1.1.

One common type of fraud examination is forensic analysis, which reconstructs a past event using the health data transactions made by some or all of the parties shown in Exhibit 1.2; that reconstruction is often used in some judicial proceeding (e.g., criminal court, civil court, deposition, mediation, arbitration, settlement negotiation, plea bargaining) (www.acfe.com).

The blend of both figures illustrates the cyclical and often contemporaneous nature of forensic healthcare analysis. In Exhibit 1.3, note that five major players use recognized operational structures, or business functions.

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| Fraud Prevention |
| Fraud Deterrence |
| Fraud Detection |
| Fraud Investigation |
| Fraud Loss and Costs Recovery |
| Antifraud Controls Remediation |
| Antifraud Education and Training |

EXHIBIT 1.1 ACFE Fraud Examination

Source: Association of Certified Fraud Examiners (www.acfe.com).

These structures include the patient, the provider, the payer, the employer, and the vendor. Healthcare as an industry is unique in that one episode of care at some given time will hit three or more operational systems. This understanding is critical from a forensic perspective because your ability to conduct a forensic analysis of one entity often requires an understanding of at least one other entity in this continuum. Due to the increasing amount of

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|-------------------------|--------------------------|-----------------------|----------------------------|--------------------------|------------------------|---------------------------------|
| Patient Activity | Provider Activity | Payer Activity | Fraud Investigation | Employer Activity | Vendor Activity | Organized Crime Activity |
|-------------------------|--------------------------|-----------------------|----------------------------|--------------------------|------------------------|---------------------------------|

EXHIBIT 1.2 Healthcare Forensic Analysis

Source: Medical Business Associates, Inc. (MBA) (www.mbanews.com).

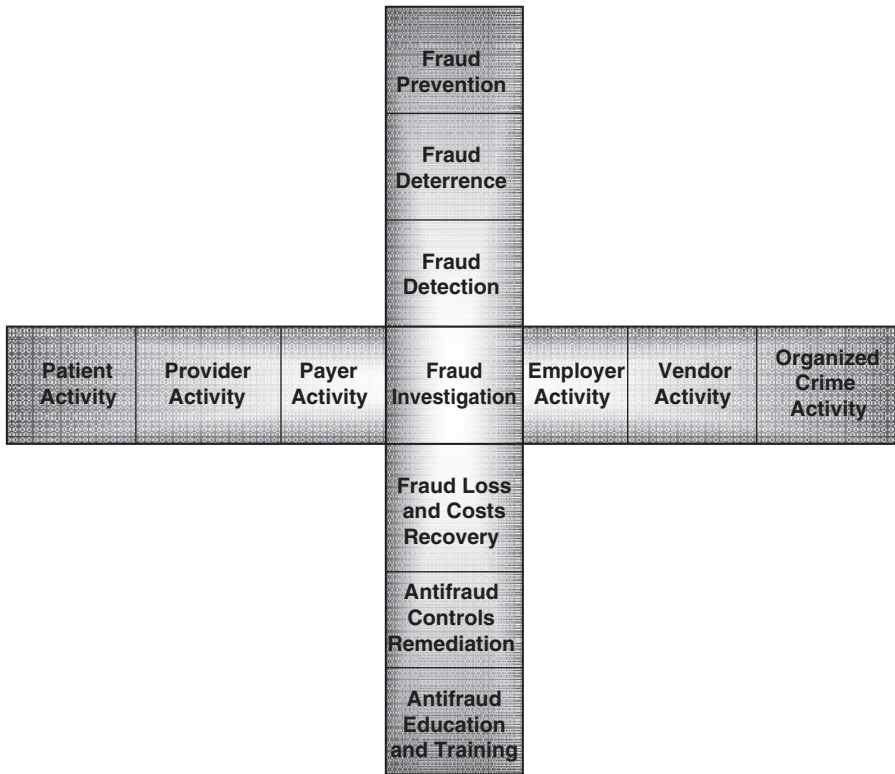


EXHIBIT 1.3 MBA and ACFE Forensic Model

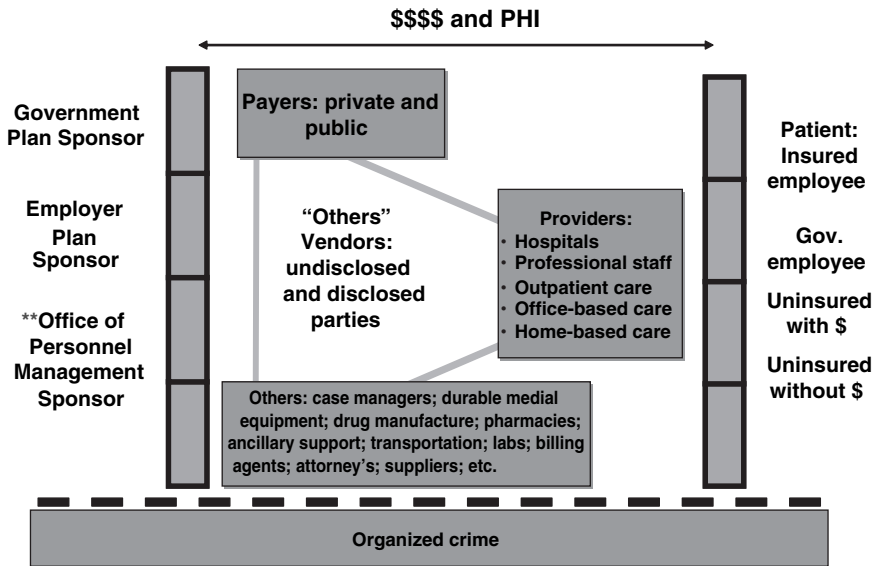
Source: Association of Certified Fraud Examiners (www.acfe.com) and Medical Business Associates, Inc. (www.mbanews.com).

fraud by outside parties, organized crime is given its own designation within this continuum.

THE HEALTHCARE CONTINUUM: AN OVERVIEW

The healthcare continuum (HCC) is shown in Exhibit 1.4 as a diagram representing entities that can and will most likely impact an episode of care. The chapters that follow this one break down the components of this diagram and introduce new terms. The HCC includes health information pipelines (HIPs) for each market player. In addition, this book will guide you through the monetary transactions referred to as *accounts receivable pipelines*

Health Care Continuum (HCC): Follow the \$ and PHI



HCC CHART

EXHIBIT 1.4 Healthcare Continuum

Source: Medical Business Associates, Inc. (www.mbanews.com).

(ARPs), which are monetary transactions as well as audit trails of protected health information (PHI). In the HCC model, money is viewed as equivalent to PHI. Note in Exhibit 1.4 that each entity has PHI generated or processed. At each transfer point, money is generated or processed at the same time. Exhibit 1.4 shows organized crime as a disconnected illegitimate third party. It is given its own designation as an entity because of the growing number of complex organized crime schemes integrated into the normal flow of business.

HEALTHCARE FRAUD OVERVIEW: IMPLICATIONS FOR PREVENTION, DETECTION, AND INVESTIGATION

Job security for fraud auditors and investigators remains strong: The healthcare industry continues to have large amounts of cash running

through it. It continues to attract the ethically challenged, whose stealing from the system shows no sign of stopping. Implications are many, particularly in the areas of prevention, detection, and investigation. These three areas require a detailed understanding of every legitimate and illegitimate player in the HCC, an ability to identify HIPs and ARPs, and an understanding of how PHI is utilized among all of the players.

It is important not only to understand how the HCC works, but also to follow healthcare market trends and how they impact fraud prevention, detection, and investigation. Fraud usually begins with a tip. That tip leads to an investigation. A comprehensive investigation requires you to understand the dynamics of the healthcare business. Healthcare fraud is often buried within the critical business functions. The purpose of the HIP and ARP process is to identify the functions that should be investigated. Detection will follow once an understanding has been achieved. Investigations and detections will identify vulnerabilities that in turn should be used as prevention tools. Prevention requires an understanding of how the healthcare entity functions and the cycle repeats itself.

With all aspects of auditing and investigations, keep current on activities that are initiated by the Department of Health and Human Services (HHS) and its Office of the National Coordinator for Health Information Technology (ONC). For example, in 2006, initiatives were made on the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of healthcare; one objective is to eventually convert all current health records to electronic versions.

On October 17, 2005, the ONC published two reports: “Report on the Use of Health Information Technology to Enhance and Expand Health Care Anti-fraud Activities” (www.hhs.gov/healthit/documents/ReportOnTheUse.pdf) and “Automated Coding Software: Development and Use to Enhance Anti-fraud Activities” (www.hhs.gov/healthit/documents/AutomaticCodingReport.pdf).

One of the major findings that emerged from the field research done for the “Report on the Use of Health Information Technology” was that fraud in the healthcare context is defined in many different ways by a number of legal authorities, but all definitions have common elements: a false representation of fact or a failure to disclose a fact that is material to a healthcare transaction, along with some damage to another party who

reasonably relies on the misrepresentation or failure to disclose. The report identifies healthcare fraud as a serious and growing nationwide crime that is directly linked to the nation's ever-increasing annual healthcare outlay.

The report continues with the reference that in the calendar year 2003, healthcare expenditures amounted to \$1.7 trillion (Centers for Medicare and Medicaid Services, www.cms.hhs.gov/TheChartSeries/downloads/us_health_chap1_p.pdf).

In that same year, estimated losses due to fraud were 3 to 10 percent of the total amount of healthcare expenditures, or \$51 to \$170 billion. Another finding compared the healthcare industry to the financial services industry. The report noted that the healthcare industry is in a strikingly similar position to that of the financial services industry 15 years ago. At that time, the banking industry began its transformation from a paper system to a sophisticated electronic environment. With a well-thought-out vision and strategy, the banking industry addressed the inefficiencies of paper systems and invested heavily in the information technology infrastructure. Credit card fraud, estimated today to be less than 7 cents out of every 100 dollars, is widely perceived as a major problem. However, healthcare fraud is 100 times more costly.

The report focuses also on the role of technology. Its authors believe that technology can play a critical role in detecting fraud and abuse and can help to pave the way toward prevention. Although technology cannot eliminate the fraud problem, it can significantly minimize fraud and abuse and ultimately reduce healthcare fraud losses. The use of advanced analytics software built into the national health information network (NHIN) is critical to fraud loss reduction.

Information available via the NHIN must comply with all federal and state laws. The federal government continues to expand its initiatives to uncover healthcare fraud, waste, and abuse. It is important that healthcare organizations have an effective compliance program in place. It is particularly important to develop a corporate culture that fosters ethical behavior. Many healthcare organizations are developing such corporate cultures through the adoption of corporate compliance programs.

The ONC is expected to release a second report in 2007. Expect continued follow-up from this office on electronic healthcare record formats that will impact future audits and investigations over the next ten years.