In Pursuit of Healthcare Fraud

by Ellen King

How broad is the scope of healthcare fraud and abuse? Here's a look at the many ways the Federal Bureau of Investigation is tackling the problem.

Healthcare fraud takes billions of dollars away from federally funded healthcare programs. These programs, particularly Medicare and Medicaid, provide essential healthcare services to millions of elderly, low-income, and disabled Americans. But government programs are not the only targets. Those who commit fraud cheat private insurance companies as well; as a result, fraud affects every person in this country. Moreover, healthcare fraud cannot be measured solely in dollars -- fraud schemes can also threaten the health and safety of patients.

Relatively recent actions by Congress, namely passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), are clear indications that Congress recognizes the severity of the problem and is concerned enough to give law enforcement new legal tools and increased funding to combat this growing crime problem. As Figures 1-3 indicate, the increased funding has been used to increase the number of FBI agents assigned to investigate healthcare fraud. As a result, the number of investigations and convictions have increased.

Figure 1 -- FBI Resource Utilization (related to fraud)

Fiscal Years	Agents
1992	111
1993	147
1994	225
1995	260
1996	290
1997	370
1998	420

A recent case that involved many federal and local agencies working together was "Operation Overdraw." This undercover operation became affiliated with a medical "business" that dealt with dozens of healthcare-related companies -- including clinical laboratories and suppliers of durable medical equipment -- that were suspected of engaging in healthcare fraud. During the course of the investigation, more than 20 search warrants were executed.

The first phase of Operation Overdraw culminated in January 1998, with the filing of criminal charges involving the payment of kickbacks and other fraudulent activity against eight defendants in Connecticut and New Jersey.

The FBI is not a regulatory agency for the healthcare industry and has no audit or inspection component for providers. Rather, it is the principal investigative component of the Department of Justice (DOJ). The bureau's agents conduct both criminal and civil healthcare fraud investigations that are brought to its attention through a variety of means.

With increasing frequency, FBI investigations are initiated based on qui tam civil false claim lawsuits. Qui tam lawsuits are brought by individuals called "relators." The relator files the action under seal, alleging that the defendant somehow defrauded the US government. The government has the opportunity to review the case while it is still under seal to determine if it wants to adopt the allegations contained in the complaint and participate in the lawsuit as the plaintiff. (If the government ultimately prevails, the relator receives a percentage of the recovery.) The DOJ will consider the qui tam referral and decide whether to intervene and join the case or decline to participate.

Qui tams are filed against all types of providers. Relators can include employees, doctors, nurses, competitors, and researchers. The number of qui tam cases in the healthcare fraud arena has increased dramatically within the last few years, from 17 in 1992 to more than 178 in 1996. One recent study estimates the deterrent effect of the Federal False Claims Act (FCA) over the last 10 years to be $148 million.[1]

Qui tams, or "whistleblower" suits, have dramatically increased the detection of and monetary recoveries for healthcare fraud. Debra Cohn, former special council for healthcare fraud to the Deputy Attorney General, in a January 1997 interview with the Bureau of National Affairs (BNA), predicted that whistle blower, or qui tam cases, will see a dramatic increase in the number of healthcare cases brought to the DOJ and in the number of cases in which the DOJ decides to be involved. "Qui tams are a

challenge to the government," Cohn said, "because DOJ uses significant resources to determine which ones are meritorious and which are frivolous."[2]

Setting Standards: What is Reasonable?

The increased emphasis on pursuing these cases has brought the DOJ some criticism as well. In the news recently, the American Hospital Association (AHA) asserted that the DOJ uses the FCA "as a blunt instrument to victimize hospitals who make innocent errors."[3] The AHA lobbied Congress to impose a "reasonable standard" under the FCA. Under current FCA law, the government must prove its case by the same standard used for most civil litigation -- a preponderance of evidence. The proposed "reasonable standard" would mean that in FCA cases, the government would have to prove its case by clear and convincing evidence. It also contained a proposal to establish a safe harbor for hospitals that submit a false claim based on advice given by fiscal intermediaries and carriers. At the AHA's February 1998 annual meeting, Attorney General Janet Reno promised to work with the hospitals to address their concerns about the use of the FCA. "It is not the DOJ's policy to punish honest billing mistakes . . . or mere negligence," Reno said. "But where there is reckless disregard and people go beyond simple negligence, I will use the law."[4]

In response to congressional and industry concerns, the DOJ issued new guidelines regarding the use of the FCA. In a press release statement Deputy Attorney General Eric Holder, Jr., said, "This guidance is being issued to emphasize the importance of pursuing civil FCA cases against healthcare providers in a fair and even-handed manner."

The new guidelines outlined legal and factual predicates for determining whether a false claim exists and whether the provider knowingly submitted the false claims. The guidelines include the following factors, which must be considered in each case:

1. Was the provider given notice of the rule/policy upon which the case would be based?
2. Consider the clarity of the rule/policy at issue
3. Consider the pervasiveness and magnitude of the false claims
4. Does the provider have a compliance plan in place and are they adhering to it?
5. Did the provider identify the wrongdoing, take steps to remedy it, or report it to a government agency?
6. Did the provider seek guidance from the Health Care Financing Administration (HCFA)?
7. Has the provider been previously audited regarding a similar billing practice?

The DOJ must also consider "any other information that bears on the provider's state of mind in submitting the false claims." The guidelines further state that the factors noted in the memo are "not intended to be exhaustive."[5]

Recent FBI Investigations and Initiatives

While most healthcare professionals and firms provide honest treatment and billings, they unfortunately coexist with those who choose to commit fraud. Fraud takes place in many settings and in many forms -- such as unbundling charges, miscoding, waiver of copayments and deductibles (a ploy that is illegal for government-sponsored programs), billing for services not rendered, false diagnosis (billing for a nonexistent covered expense rather than the actual uncovered expense as in weight loss programs or uncovered experimental treatments), falsifying medical records, billing for services not rendered, billing for phantom drugs, billing for services performed by a less qualified person, and inflating the number of visits. Other types of healthcare fraud schemes can include cost reporting fraud, kickbacks, billing for equipment never provided, drug diversion, and inflated medical bills to inflate the basis for a claim.

Figure 2 -- FBI Pending Caseload

Fiscal Years	Cases
1992	591
1993	1051
1994	1500
1995	1878
1996	2200
1997	2582
1998	2800

The following examples reflect the broad variety of cases that, in 1997-98, have recently fallen under the heading of healthcare fraud.

Ambulance Fraud

Former owners of an ambulance company in Jackson, MS, were convicted of conspiring to use their ambulance company to defraud Medicare. Former employees testified that they routinely changed reports of dialysis patient transports to say that patients transported were bedridden, although many were not. Testimony also indicated that patients were sometimes driven four at a time while sitting upright in the cab. (Medicare regulations require that ambulance transportation be covered only if medically necessary and that the patients need to be bedridden and unable to be transported by any other means.) Medicare was charged between $290 and $650 for each round trip.

The former owners paid more than $2.25 million in damages and penalties to settle the civil side of this investigation. Each defendant was sentenced to 80 months in prison and ordered to pay restitution and fines totaling more than $250,000.

Durable Medical Equipment

FBI agents from the New York field office recently arrested 11 doctors for healthcare fraud and conspiracy relating to willful solicitation and accept ance of kickbacks and bribes for referral of Medicare patients to various durable medical equipment and MRI/radiological companies.

Private Insurance Fraud/International Claims

Operation "Sure Buck" was an FBI undercover operation addressing a crime problem involving false medical claims submitted to US-based insurance companies by billing companies for services allegedly provided by Mexican physicians. The billing companies and doctors conspired to submit more than $800,000 in false claims.

The indictment included charges of mail fraud, conspiracy to defraud, and cash transaction reporting violations. The main subject was also indicted on money laundering charges. Two lead defendants both pled guilty to mail fraud conspiracy. The main subject received an 18-month sentence and fines totaling $192,000. The other 17 defendants pled guilty to mail fraud charges; four received jail terms. Of the 17 doctors charged, 11 have already pled guilty.

Contractor Fraud

A 14-count indictment was returned against five former and current senior-level management officials of Healthcare Services Corporation (HCSC) (also known as Illinois Blue Cross and Blue Shield) for conspiring to defraud the US and HCFA, obstructing a federal audit, committing mail fraud and wire fraud, and making false statements.

HCSC, a Medicare contractor that operates five regional offices, is responsible for processing claims submitted by healthcare providers in Illinois and Michigan. Their contract with the federal government provided that they would receive incentive payments if performance exceeded specified standards. These standards were determined by yearly audits and evaluations based on Contractor Performance Evaluation Program (CPEP) scores. Consistently low scores would have an effect on the contractor's incentive payments and/or its ability to retain a government contract.

In a 1995 qui tam investigation, it was found that HCSC obstructed federal auditors by altering the audit samples used in their CPEP. This activity was perpetrated at all levels of management by personnel who conspired to conceal poor performance by "structuring" audit samples. HCSC management also concealed processing errors by discarding or creating fictitious documents.

The defendants pleaded guilty to eight felony counts and agreed to pay more than $144 million. They admitted to concealing evidence of poor performance in processing Medicare claims. Of the $144 million, $4 million was paid in criminal fines and $140 million in a civil settlement.

"Medicare contractors provide a critical service," said Holder in a press release statement after the company pleaded guilty. "If they don't meet the highest standards of honesty and integrity, then we will intervene on behalf of Medicare patients' and America's taxpayers."

Bribery

With the cooperation of Transamerica (an insurance company responsible for processing Medicare claims in California) and its auditor, the FBI was able to develop sufficient evidence to charge two doctors with conspiracy and bribery.

The doctors were charged with allegedly bribing an auditor who was conducting an audit into claims they submitted to Medicare. The first doctor employed a Medicare consultant to approach the auditor. The consultant told the auditor that the doctor was willing to pay cash to end the audit. Two bribe payments totaling $5000 were allegedly paid to the auditor. The doctor was charged with one count of conspiracy and two counts of bribery.

The second doctor, through the same consultant, allegedly gave the auditor $20,000 cash to close the audit. That doctor was charged with one count of conspiracy to bribe an auditor. The Medicare consultant pleaded guilty to one count of conspiracy to bribe an auditor.

Organ Transplants

Reports made to the FBI contained information of two individuals purported to be supplying transplant organs for sale to patients in the US. The organs were allegedly harvested from prisoners executed in Chinese jails. These individuals reportedly received substantial payments from American clients.

An investigation followed, and two individuals were arrested by FBI agents in New York and subsequently charged with conspiracy to violate the National Organ Transplant Act.

Home Health Agencies

In Miami, FL, 12 people were indicted in one of the largest home healthcare fraud scams. Among the defendants were five physicians and two healthcare administrators associated with Mederi of Dade County Inc., one of the largest and oldest home healthcare agencies in the country.

The two administrators, while employed by Mederi, allegedly created a large network of bogus nursing groups that were used to submit false Medicare billings for beneficiaries not qualified to receive home health services and for others for which few or no services were provided. They held hidden ownership interests in these bogus nursing groups. The proceeds from the false billings were funneled back to the defendants through fictitious owners, bank accounts, and corporate entities. The administrators were also charged with instructing Mederi employees to fabricate the necessary records to support the false billings. They falsified documents and patient files used to inflate Medicare payments.

The defendant doctors allegedly received cash kickbacks and other payments in return for signing home health plan of treatment (POT) orders for patients they never examined.

The 12 co-conspirators were indicted on charges of conspiracy, false claims, kickbacks, and wire fraud. In addition, the two administrators were charged with money laundering.

In June 1998, a Florida state senator and his wife were charged with multiple counts of Medicare fraud in connection with this investigation. The senator was charged with conspiracy, filing false claims, wire fraud, money laundering conspiracy, and witness tampering. It is alleged that the senator was a hidden owner in several of the bogus nursing groups. The profits from the fraud were allegedly funneled to him through other persons' names. It is further alleged that the senator personally paid a physician $1500 cash in order to induce him to sign several POTs, and that he induced several witnesses to make false statements to the grand jury to hide evidence linking him and his co-conspirators to the Medicare fraud conspiracy.

Workers' Compensation

A Texas federal grand jury indicted nine individuals in August 1998 in a 23-count indictment. According to the indictment, the fraud scheme was one in which insurers were billed for services not performed on patients who had workers' compensation and personal injury claims. The scheme was allegedly engineered with the help of the brother of one of the participating doctors, who served as the attorney for many of the patients. The federal government and private insurers were defrauded of more than $15 million.

Figure 3-- Healthcare Fraud Convictions

Fiscal Years	Cases
1992	116
1993	316

Clinical Laboratories

1994	311
1995	345
1996	475
1997	485
1998	469

Four former executives of Damon Clinical Laboratories were indicted by a federal grand jury on a criminal charge of conspiracy to defraud the Medicare program of more than $25 million. The four individuals allegedly conspired to manipulate the way physicians order blood testing, causing Medicare to be billed for thousands of medically unnecessary blood tests. Moreover, thousands of Medicare program beneficiaries underwent unnecessary monthly blood draws that were conducted solely to allow the defendants' company to bill for tests that would not otherwise have been billable to Medicare.

The indictments stem from criminal charges filed against Damon to which the corporation pleaded guilty to conspiracy to defraud Medicare and paid $119 million to the US.

The investigation involved the bundling of serum ferritin tests with a basic blood chemistry panel. Before the bundling, doctors ordered a separate test for ferritin and serum iron less than 10 percent of the time. After the bundling, the frequency rose to 90 percent. This resulted in an additional charge to the Medicare program of $20 for each unnecessary ferritin test and an additional $11 charge for each unnecessary serum iron test.

"While Damon has pled guilty and paid an appropriately large fine," the US attorney said at the time of the indictment, "today's indictment seeks to hold former high-level executives in the company accountable for these allegedly criminal acts."[6]

SmithKline Beecham Clinical Laboratory and Laboratory Corporation of America (Labcorp) were also investigated on similar charges. SmithKline paid the government $325 million for the filing of false federal claims. The company falsely billed for certain tests that were not performed and others that were not medically necessary. Labcorp paid the government $187 million in criminal and civil fines for the submission of false claims for medically unnecessary tests.

Physical Therapy

The owner and operator of a large rehab company was recently indicted, along with nine other defendants (including four chiropractors and a licensed physical therapist), with conspiracy to commit healthcare fraud and mail fraud. The owner is further charged with bank fraud, money laundering, and failure to pay taxes.

According to the charges, the company hired physicians, chiropractors, physical therapists, and exercise physiologists to staff its facilities. Exercise and personal training were provided to "patients" by unlicensed employees and then billed as physical therapy under the names and provider numbers of physicians and a physical therapist to maximize reimbursement from insurance companies.

False diagnoses and false medical progress notes were used to support the false insurance claims. Some insurance companies were billed for the purported treatment of patients who never even visited the rehab center.

Furthermore, it is alleged that the owner and another defendant solicited more than $2 million from more than 100 investors by falsely claiming that the investors could purchase interest in their expanding company.

Future Challenges

Managed Care

Managed care is one of the major challenges facing healthcare fraud investigators in the future. The percentage of individuals participating in federally funded managed care plans continues to grow. However, in the managed care environment, fraud takes on a whole new perspective. Fraud prevention and detection focus on ensuring that patients receive the quality of care and range of services that the providers contract to furnish.

Of the various types of fraud committed in the managed care arena, depriving patients of necessary medical care is of greatest concern to government insurers. In a managed care environment, providers have a financial incentive to provide fewer services than may be medically necessary. Each patient has a certain amount budgeted to them for care, and the managed

care group must absorb any costs above that amount. This may discourage some providers from giving necessary care in order to meet budget goals.

In this type of underutilization, there may be pressures from management that trickle down to the providers of care. These pressures could be in the form of monetary incentives or job intimidation.

Forced disenrollment is another type of fraud related to the managed care environment. A plan may use marketing techniques designed to enroll only "healthy" patients, with the incentive being that their care is less costly. The plan may "disenroll" patients who cost them too much. Ways to disenroll this type of patient include long waiting periods before seeing a doctor, inconvenient office hours, refusing to refer patients for more specialized care, or even offering them inducements to leave the plan.

Other fraud schemes related to managed care include inflating historical costs, thereby obtaining higher capitation payments. It may misrepresent its financial picture or its ability to medically care for the patients.

Protecting Patients

Another growing concern is the quality of care received by the nation's elderly in nursing home settings. Poor quality of care can have the bleakest consequences, especially for vulnerable adults unable to be their own advocates. The FBI, along with other government agencies, is participating in developing the tools necessary to prevent this abuse in the future.

With the prevalence of managed care in the healthcare arena and the possible harm to vulnerable patients that can occur, fraud investigation takes on a new way of looking at things. The FBI, along with the DOJ, the Office of Inspector General, and other government agencies, is participating in various working groups throughout the country whose purpose is to keep abreast of all these emerging concerns. Through continued cooperation, we intend to continue to make a difference in exposing and prosecuting existing fraud and deterring fraud before it happens.

Click here for a useful list of reources for those seeking information on maintaining compliance.

Notes

1. Stringer, W. "The 1986 False Claims Act Amendment: An Assessment of Economic Impact." Department of Justice Health Care Fraud Report for Fiscal Year 1997. Washington, DC: GPO, 1998.

2. "Justice Aims to Increase Prosecutors, Focus on Managed Care Quality of Care." *BNA Health Care Fraud Report* 2, vol. 1 (Jan. 15, 1997): 8-9.

3. "Qui Tam Advocates Say Government Bowing to Political Pressure to Curtail Use of False Claims Act." *BNA Health Care Fraud Report* 2, vol. 2 (June 17, 1998): 440.

4. "Reno Willing to Work with Hospitals to Ensure Proper Use of False Claims Act." *BNA Health Care Report* 2, no. 3 (Feb 11, 1998): 84.

5. "Department of Justice False Claims Act Guidance." *BNA Health Care Fraud Report* 2, no. 2 (June 17, 1998): 459.

6. "Four Top Executives Indicted for Overbilling on Clinical Lab Tests." *BNA Health Care Fraud Report* 2, no. 2 (Jan. 28, 1998): 52.

Compliance: Getting on Track

A useful list of resources for those seeking information on maintaining compliance.*

AMA CPT Information Services
(Subscription service available to answer CPT questions)
515 N. State St.

Chicago, IL 60610
(800) 634-6922

Coding Clinic for ICD-9-CM
American Hospital Association
(800) 261-6246

CPT Assistant
American Medical Association
(800) 621-8335

Web Sites

AHA	www.aha.org
AHIMA (Including discussion forum on fraud and abuse)	www.ahima.org
AMA	www.ama-assn.org
Balanced Budget Act of 1997	www.ihshealth.com/medicare_medicaid/mml/budget/budget.htm
Blue Cross-Blue Shield	www.bluecares.com
Blue Cross of California	http://www.bluecrossca.com/index.asp
Centers for Disease Control	www.cdc.gov
Central Office on ICD-9-CM	www.icd-9-cm.org
Compliance Program Guidance for Hospitals	www.hhs.gov/progorg/oig/modcomp/
Department of Health and Human Services (HHS)	www.dhhs.gov
Empire Medicare Services	www.empiremedicare.com/home.htm
Federal Register (1995 - 1998)	www.access.gpo.gov/su_docs/aces/aces140.html
Health Care Financing Administration (HCFA)	www.hcfa.gov
Healthcare Financial Management Association (HFMA)	www.hfma.org
Medicare Integrity Program	www.hcfa.gov/medicare/mip/default.htm
Medicare Professional/Technical Information	www.hcfa.gov/medicare/mcarpti.htm
Model Compliance Plan for Laboratories	www.os.dhhs.gov/progorg/oig/modcomp/cpcl.html
National Committee on Vital and Health Statistics (NCVHS)	aspe.os.dhhs.gov/ncvhs/
National Center for Health Statistics (NCHS)	www.cdc.gov/nchswww/
OIG-Office of Inspector General (HHS)	www.dhhs.gov/progorg/oig/
OIG-Office of Audit	www.dhhs.gov/progorg/oas/topicpdf.html
OIG Reports-Media Advisories	www.dhhs.gov/progorg/oig/medadv/medadv.html
OIG Reports-Fraud Alerts	www.hhs.gov/progorg/oig/frdalrt/index.htm

*List of resources taken from AHIMA's July 16, 1998, audio seminar *Fraud and Abuse: The Coder's Role in Compliance.*

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