Playing a Part: The FBI's Role in Healthcare Fraud Investigations

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Healthcare fraud is a multibillion dollar problem costing every taxpayer significant amounts of money. Fraud also jeopardizes the health and safety of patients. It has been estimated that fraud accounts for about one-tenth of the $1 trillion spent annually on healthcare.

Several law enforcement agencies, both federal and state, have responsibility for investigating healthcare fraud allegations. The FBI is the only federal investigative agency with authority to investigate all healthcare fraud offenses. The Office of the Inspector General (OIG) is authorized to conduct civil, administrative, and criminal investigations of frauds associated with the federal Medicare/Medicaid program. The Postal Inspection Service, which investigates fraud schemes using the US mail system, generally investigates frauds perpetrated against private insurers. The Defense Criminal Investigative Service (DCIS) investigates frauds committed against the military's health insurance programs. Medicaid Fraud Control Units investigate fraud associated with the Medicaid program. The FBI's authority extends beyond specified federal programs and includes all victims of a crime, whether they are federal programs, private insurance companies, business entities, or individuals.

The FBI may become involved in a healthcare fraud investigation in various ways. A referral may be made by another federal agency, such as OIG or DCIS, requesting that the FBI work jointly with it. The Health Care Financing Administration (HCFA) also may refer a case. Public complaints are received through calls, letters, or visits. It could also be the result of an audit or a qui tam case (a "whistleblower" case where a private citizen or corporation brings a civil action suit for violation of the False Claims Act on behalf of themselves and the federal government).

The FBI is currently investigating various types of fraudulent activities, including billing for services not rendered. "Upcoding" and "unbundling" are two other prevalent issues in many cases. "Upcoding" is when a provider bills for a higher level of service than rendered in order to receive a higher reimbursement rate. "Unbundling" is when a provider bills separately for each component of a procedure, instead of using the proper procedure code for the entire procedure, which results in a higher reimbursement.

The investigative process is usually a long one, often taking several years, involving the participation of numerous federal or state agencies. The process may include conducting interviews, serving federal grand jury subpoenas, or executing search warrants. Documentation is also sought from sources other than the target, such as banks, HCFA, billing services, or private insurance companies through a subpoena or administrative summons. All the evidence gathered is carefully examined to determine whether there is a case of fraud and whether or not the company or individual should be charged.

The investigating agency does not generally alert a target that an investigation is being conducted. Often, at the beginning of an investigation, it is not known who the targets are. An individual or organization may find out it is the target of an investigation through any of the investigative processes already mentioned.

One of the best ways for anyone in the healthcare profession to avoid becoming a target of a fraud investigation is to establish a compliance program to identify fraud and abuse. Section 8A1.2/K of the US Sentencing Commission Guidelines for the Sentencing of Organizations provides seven major compliance requirements. Taking these steps could decrease an organization's chances of becoming a target of a criminal investigation:

1. Establish compliance standards and procedures to be followed by all employees
2. Assign specific individuals with overall responsibility to oversee compliance with Step 1
3. Use due care not to delegate substantial discretionary authority to individuals who may have a propensity to engage in illegal activities
4. Take steps to communicate effectively to all employees and other agents the standards and procedures

5. Take reasonable steps to ensure compliance with the standards
6. Use consistent enforcement of the standards to include disciplinary actions
7. If an offense has been detected, take all reasonable steps to respond to the offense and to prevent any further offenses

The FBI and other agencies have had some significant accomplishments in the last few years in the fight against fraud and abuse. Caremark, one of the nation's largest providers of intravenous home health services, pled guilty in 1993 and paid approximately $161 million in criminal fines, civil restitution, and false claims damages. SmithKline, LabCorp, and Damon Clinical Laboratories have all agreed to pay the government a total in excess of $900 million. National Medical Enterprises pled guilty in 1994 and paid $379 million in fines and penalties in connection with the submission of fraudulent billings.

In fiscal year 1996, the FBI had 475 convictions with regard to healthcare fraud and had more than half that many convictions by the end of the second quarter of 1997. Fines imposed in 1996 totaled $29 million, while the first two quarters of 1997 netted fines of $47 million. And with an initiative funded by the Healthcare Insurance Portability and Accountability Act of 1996, federal agencies now have more resources to fight this growing problem.

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