Chiropractic Fraud - *Perception vs Reality*

By: Daniel J. Osborne, M.S.

Is health care fraud more prevalent in claims submitted by chiropractors than those submitted by members of other health care disciplines? When looking at the various news-sources, chiropractors are not found to make up either the *lion-share* of health care fraud charges or convictions reported.

Unfortunately, instances of fraud & abuse are present in ALL health care disciplines – Chiropractic, Medicine, Physical Therapy, etc. There is no single discipline that can lay claim to a proportionately higher rate of fraudulent conduct than any other health care discipline. However, despite this fact, there is an ongoing feeding-frenzy of insurers investigating chiropractic claims. These investigations go beyond simply evaluating either the merits or medical necessity of claims to determine if they should be paid.

Insurers are conducting 'post-payment' audits of claims paid in years past – focusing on purported documentation deficiencies in an effort to open the door for carriers to demand the money back! Chiropractors have found themselves faced with large refund demands from insurers. Why?

Is it because the services were not performed? No, the insurer verifies the performance of the services through talking with the patient. Is it because the chiropractor did not document having performed the service? No, the services in question are customarily documented as having been performed. Post-payment audits arise because the insurer has retroactively concluded, perhaps based upon some sense of entitlement, that the services were not documented sufficiently – i.e., to their satisfaction!

Insurers demanding refunds from providers for payments made - *armed with allegations that providers failed to adequately document the services that were billed* - file complaints with licensing & regulatory boards of the providers. If such complaints are made the real test will be in proving the documentation and standards were not met. The standards for documentation, as well as all other practice activity, for health care providers is established and defined by state health care licensing & regulatory boards. The boards, NOT the insurance companies, or managed care organizations, provide administrative oversight of the activity of licensees with sanctions for those who violate the laws and rules.

Allstate Insurance has established a clear-cut policy of suing chiropractors, alleging fraud and issuing press releases with the fanfare of a New Year's Day parade. News sources, including chiropractic periodicals, do little or nothing to either investigate or evaluate the factual bases of these suits prior to joining in lock-step to print the release giving Allstate the press it so desires.

The news media and public-at-large tend to believe that if Allstate sues a health care provider, alleging fraud, the provider must have engaged in fraudulent activities. It must mean that Allstate believes both they and their insured – were somehow defrauded by the provider's actions or conduct. It must also mean that Allstate relied upon the provider's misrepresentations when paying claims?

Well, that certainly was not the case according to the 2007 decision rendered by the United States 5th Circuit Court of Appeals in the case of ***Allstate Insurance Co. et al. v. Receivables Finance Company, LLC et al***. The Opinion handed down by the Court was that Allstate is a major player in the casualty business – thus when Allstate routinely reviews a health care bill submitted by a chiropractor, performs some form of utilization review on the provider's bill and ends up paying a significantly reduced sum based on the explanation that Allstate believed that a significant portion of the bill was either medically unnecessary or not properly documented and thus not subject to payment – Allstate cannot later come back and sue the same provider claiming that it was defrauded by some scam perpetrated by that same provider.

Nor was it the case, based on my personal knowledge, having worked with Accident & Injury Chiropractic ("A&I"), a named defendant in the case. In 1998, following the execution of search warrants by federal authorities, I assisted A&I on implementing a Health Care Compliance program, a program designed to detect and correct any improper, false or fraudulent action by the company and/or its health care providers- primarily chiropractors. Following A&I's implementation of their compliance program, the federal investigation was formally closed.

The Compliance program that A&I implemented included an intensive internal auditing, monitoring and reporting system to facilitate the identification and correction of any form (s) of misconduct. The Compliance program was well-publicized to insurers and others, who were invited to report their concerns relative to alleged improper conduct and/or activities of the clinics, as well as those chiropractors associated, to A&I's Compliance Board to have those concerns appropriately addressed.

Allstate was well aware of A&I's Compliance program implementation, but never, to my knowledge, reported any concerns Allstate had, Allstate alleged in its highly publicized lawsuit, to the Compliance Board. It is significant to note that, while other insurers in positions similar to that of Allstate, did report concerns and such concerns were sufficiently addressed and corrected to the insurers' satisfaction.

Although an integral part of the creation and implementation of A&I's Compliance program, the only contact I had with Allstate was after it had filed its lawsuit. This contact consisted of speaking with a paralegal of Allstate's attorney. The paralegal indicated she understood that I had assisted A&I with its Compliance program and Allstate's attorney would like to talk with me. On no occasion did I ever speak with Allstate's attorney. The only reason that I did not talk with Allstate's attorney is that Allstate's attorney refused to serve me with domesticated process as an out-of-state witness.

This brings us to Allstate's suit filed in Federal Court in Dallas, Texas in March 2008, viz, **Allstate et al. v. Michael K. Plambeck, D.C., Chiropractic Strategies et al**. In this suit, Allstate alleges that Plambeck, who owns and operates Chiropractic Strategies Group ("CSG"), orchestrated a multi-state scam involving doctors, lawyers and telemarketers cleverly designed to solicit auto accident victims for free chiropractic evaluations - asserting that these free screenings were some form of subterfuge to enable CSG doctors to "inform" the patients they had severe injuries and to encourage the patients to sign up for legal representation by attorneys in order to prosecute claims for insurance recoveries and/or to participate in lawsuits against Allstate Insurance.

In a March 6, 2008 release, Allstate reported that the lawsuit against Plambeck was filed following an extensive investigation by their Special Investigative Unit. Edward Moran, Allstate assistant Vice President in charge of the Special Investigation Unit, was quoted as stating, "Insurance fraud is a billion dollar business that costs the average consumer $300 in higher insurance premiums every year… Allstate is **aggressively pursuing** the fight against insurance fraud to protect consumers and help keep insurance costs down".

This must have been an extensive investigation by Allstate's special investigators! For more than 10 years Allstate has known of the manner in which Dr. Plambeck conducted and operated his chiropractic clinics, as described in its press release!

As a Special Agent for the *National Insurance Crime Bureau* (NICB) I, as well as other investigative agencies – including Allstate, was familiar more than a decade ago with the specific type of alleged acts of misconduct described. In fact, Allstate's Complaint identified activity back to 1996.

Nothing new was found in the information provided in the (2008) release – except that the average costs passed on to insurance consumers by insurance companies has now risen to $300.00. This is up from figures of $100 to $200 cited in previous years.

Talk about righteous indignation, the major casualty insurance companies regularly complains in the media that those high costs they pass on to the public are the result of health care fraud on the part of chiropractors and other health care professionals. However, carriers rarely, if ever, mention that they operate out of luxurious office complexes and pay multi-million dollar salaries to their executives.

For example, the CEO of Allstate, in his first year on the job, received an annual compensation package worth over $10.7 million, while the departing CEO, received $18.8 million annually and $25.4 million in retirement benefits. Don't think for a minute that those costs are not passed on to consumers in the form of rate increases!

Allstate's press release on Plambeck et al. contained a **'Call to Action,'** asking persons who have knowledge of, or have been victimized by, the scheme alleged in a lawsuit filed against the chiropractic industry to report this information to the NICB. Why should this information be reported to NICB?

Is the NICB, a quasi-governmental law enforcement agency, assisting Allstate with civil litigation against Plambeck? Does NICB have a concurrent extensive decade-long criminal investigation of Plambeck's activities?

NICB is a not-for-profit corporation under 501(c) (4) of the Internal Revenue Code as a social welfare organization - to combat fraud and theft for the benefit of customers and the public through information analysis, forecasting, **criminal investigation support**, training, and public awareness.

I suspect that NICB will do what Allstate says. Allstate is one of its biggest customers and funding source! This would include helping them on civil cases because that is what they did in the case referenced above. In A&I's discovery-filings against Allstate, A&I accessed information from Allstate that included NICB claims and financial checks conducted on me!

Is the filing of a lawsuit based on information known for over a decade, and the parallel effort to sway public opinion to its point of view, the most appropriate way to aggressively pursue the fight against insurance fraud?

According to a March 7, 2008 article in the *Dallas Morning News* - Bill Mellander, spokesman for Allstate's Special Investigative Unit, reports Allstate's adjusters are trained to identify common fraud indicators, such as similarities in dollar amounts or wording in paperwork. When such indicators appear in a health care claim Allstate's concerns are forwarded to Allstate's special investigative units who then look for wider trends that may point to health care fraud and abuse – perhaps perpetrated through some form of a scam. And, per Mellander, that's exactly what happened with respect to Allstate's investigation of Plambeck et al. and its taking this action in an attempt to recover dollars from fraudulent claims purportedly paid by Allstate.

I suspect Allstate adjusters are trained to do more than just identify fraudulent trends and forward such concerns to Allstate's SIU investigators as reported by Mr. Mellander. They have also been trained on how to evaluate claims submitted to determine if they should be paid utilizing sophisticated insurance industry software programs, such as Colossus, or local peer review doctors who are paid by the insurance industry to review and reduce provider claims by significant sums.

These trained adjusters probably interviewed the patients being treated at Plambeck's clinics to determine the following: (1) circumstances of the accident; (2) whether they were hurt; (3) what were their complaints of injury; (4) did they seek medical attention; and (5) are they still being treated.

Why were there no patients identified as co-defendants in Allstate's lawsuit alleging fraud and a collusive scheme in either the A&I or Plambeck cases? In order for such a "scheme" to exist, there must have been some form of patient claim submitted for payment that Allstate deemed to be fraudulent. If that is the case, are not the "patients" who submit the so-called fraudulent claim responsible for their own conduct? Wouldn't such a scheme, as alleged by Allstate, only be successful if you had willing-accident victims to participate? Not according to Allstate's actions.

Is paying claims and later filing a federal lawsuit seeking $10 million in an attempt to recover dollars paid on the claims by alleging fraud for activity known for over a decade the way to protect consumers and help keep insurance costs down?

In the Spring 2008 edition of **Focus** published by *The Coalition Against Insurance Fraud*, where it is reported that Plambeck allegedly cost Allstate so much money that the insurer is trying to "**gut his operation"** with a $10-million federal lawsuit. It is interesting to note that Mr. Moran, an Allstate Vice President, and NICB's CEO are both on the Board of Directors for the Coalition Against Insurance Fraud.

If Plambeck, et al. named in Allstate's lawsuit are in fact engaged in fraudulent activity, then they should be dealt with appropriately and held accountable by the appropriate authorities – but not by an insurer, functioning as a *de facto* Attorney General, that wants to "gut them" in the public eye – through media releases and press conferences!

Allstate pays NICB large sums of money to facilitate **criminal** prosecutions of just the type of activity it alleged in its 2008 press release. The NICB, in a 2006 Edition of NICB Upclose, states, "Just what the doctor ordered... NICB now has more than 25 Medical Fraud Task Force Units throughout the United States that are creating a big return on investment for NICB members". Interestingly, NICB reports having task force units in all the states identified in *Allstate et al. v. Plambeck et al.*

Could this desire to gut chiropractic businesses also be the reason for their lawsuits against so many other chiropractors? It definitely appeared to be the case with a chiropractor on the east coast who operated a number of multidiscipline practices. I assisted this provider with his Compliance program. This provider's business was in fact "gutted" and forced into bankruptcy trying to pay legal fees to defend the lawsuit of the "Good-Hands" people.

Are Allstate's protestations that it innocently **relied** on Plambeck's representations, and was defrauded thereby, plausible? Does the fact that Allstate has been investigating Plambeck for more than a decade militate against Allstate's claim that it "**relied**" on Plambeck's representations to its detriment?

This issue of **reliance** is the lynchpin of a fraud claim. If one is convinced that another party is a fraud, and proceeds to transact business with that party, may the aggrieved party subsequently cry, "Fraud"?

May Allstate, the "good hands people," also claim to be the "clean hands people"?

Health care fraud may be a billion dollar business as Mr. Moran states – but the insurance industry is definitely a TRILLION dollar business!

It is disingenuous for Allstate to report its fight against insurance fraud is to protect consumers and help keep insurance costs down.

In a August 18, 2005 press release on yet another federal lawsuit filed against chiropractic, this one in Massachusetts against First Spine and Rehab, Allstate reported that since 2001 Allstate has received more than $55 million in court judgments, where Mr. Moran states, "These judgments against criminals range from individuals to sophisticated organized crime syndicates." Interestingly, Allstate's press releases dating back to 2004 found on their web-site reveals that all but one of the releases relevant to its lawsuits against health care providers involved chiropractors.

It should be noted that **American Association of Justice** ranks Allstate Insurance as the worst insurer for consumers, showing a pattern of greed, refusal to pay legitimate claims, and rewarding employees for claim denials with a strategy of "deny, delay, and defend".

In my more than twenty years of working with health care fraud-fighters - including insurers, regulators, law enforcers and health care providers, the one constant I have found relating to chiropractic fraud is that those in the position to make the biggest difference choose to invest the least amount possible in learning how to identify, how to investigate, how to prosecute, and STOP HEALTH CARE FRAUD!

However, these same entities/individuals are likely to COMPLAIN the loudest about how bad the problem is!

This *niche* targeting of chiropractors by insurers for post-payment audits and civil lawsuits does nothing to really reduce HEALTHCARE FRAUD but are diversion tactics to make everyone think that something is being done.

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