

Health Care Fraud, The Perfect Storm

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Today, health care fraud is all over the news. There undoubtedly is fraud in health care. The same is true for every business or endeavor touched by human hands, e.g. banking, credit, insurance, politics, etc. There is no question that health care providers who abuse their position and our trust to steal are a problem. So are those from other professions who do the same.

Why does health care fraud appear to get the 'lions-share' of attention? Could it be that health care fraud is the perfect vehicle to drive agendas for divergent groups where taxpayers, health care consumers and health care providers are dupes in a health care fraud shell-game operated with 'sleight-of-hand' precision?

Take a closer look and one finds this is no game-of-chance. Taxpayers, consumers and providers always lose because the problem with health care fraud is not just the fraud, but it is that our government and insurers use the health care fraud problem to further agendas while at the same time fail to be accountable and take responsibility for a health care fraud problem they facilitate and allow to flourish.

• Astronomical Health Care Fraud Estimates

What better way to report on fraud than to tout health care fraud cost estimates, e.g.

"Fraud perpetrated against both public and private health plans costs between **\$72 and \$220 billion annually**, increasing the cost of medical care and health insurance and undermining public trust in our health care system... It is no longer a secret that fraud represents one of the fastest growing and most costly forms of crime in America today... We pay these costs as taxpayers and through higher health insurance premiums... We must be proactive in combating health care fraud and abuse... We must also ensure that law enforcement has the tools that it needs to deter, detect, and punish health care fraud." [Senator Ted Kaufman (D-DE), 10/28/09 press release]

The General Accounting Office (GAO) estimates that fraud in healthcare ranges from **\$60 billion to \$600 billion per year** – or anywhere between 3% and 10% of the \$2 trillion health care budget. [Health Care Finance News reports, 10/2/09] *The GAO is the investigative arm of Congress.*

The National Health Care Anti-Fraud Association (NHCAA) reports **over \$54 billion is stolen every year** in scams designed to stick us and our insurance companies with fraudulent and illegal medical charges. [NHCAA, web-site] *NHCAA was created and is funded by health insurance companies.*

Unfortunately, the reliability of the purported estimates is dubious at best. Insurers, state and federal agencies, and others may gather fraud data related to their own missions, where the kind, quality and volume of data compiled varies widely. **David Hyman**, professor of Law, University of Maryland, tells us that the widely-disseminated estimates of the incidence of health care fraud and abuse (assumed to be 10% of total spending) lacks any empirical foundation at all, the little we do know about health care fraud and abuse is dwarfed by what we don't know and what we know that is not so. [The Cato Journal, 3/22/02]

• Health Care Standards

The laws & rules governing health care – vary from state to state and from payor to payor – are extensive and very confusing for health care providers and others to understand as they are written in legalese and not plain speak.

Healthcare providers use specific codes to report conditions treated (ICD-9) and services rendered (CPT-4 and HCPCS). These codes are used when seeking compensation from payors for services rendered to patients. Although created to universally apply to facilitate accurate reporting to reflect providers' services, many insurers instruct providers to report codes based on what the insurer's computer editing programs recognize – not on what the provider rendered. Further, practice building consultants instruct providers on what codes to report to get paid – in some cases codes that do not accurately reflect the provider's service.

Healthcare Consumers know what services they receive from their doctor or other health care provider but may not have a clue as to what those billing codes or service descriptors mean or an explanation of benefits received from insurers. This lack of understanding may result in consumers moving on without gaining clarification of what the codes mean, or may result in some believing they were improperly billed. The multitude of insurance plans available today, with varying levels of coverage, add a wild card to the equation when services are denied for non-coverage – especially if it is Medicare that denotes non-covered services as not medically necessary.

- **Proactively addressing the health care fraud problem**

The government and insurers do very little to proactively address the problem with tangible activities that will result in detecting inappropriate health care claims before they are paid. Indeed, payors of health care claims proclaim to operate a payment system based on trust that health care providers bill accurately for health care services rendered, as they can not review every claim before payment is made because the healthcare reimbursement system would shut down.

They claim to use sophisticated computer programs to look for errors and patterns in health care claims, have increased pre- and post-payment audits of selected health care providers to detect fraud, and have created consortiums and task forces consisting of law enforcers and insurance investigators to study the problem and share health care fraud information. However, this activity, for the most part, is dealing with activity after the claim is paid and has little bearing on the proactive detection of health care fraud.

- **Exercise health care fraud with the creation of new laws**

The government's reports on the health care fraud problem are published in earnest in conjunction with efforts to reform our health care system, and our experience shows us that it ultimately results in the government introducing and enacting new laws – presuming new laws will result in more fraud detected, investigated and prosecuted - without establishing how new laws will accomplish this more effectively than existing laws that were not used to their full potential.

With such efforts in 1996, we got the ***Health Insurance Portability and Accountability Act*** (HIPAA). It was enacted by Congress to address insurance portability and accountability for patient privacy and health care fraud and abuse. HIPAA purportedly was to equip federal law enforcers and prosecutors with the tools to attack health care fraud, and resulted in the creation of a number of new health care fraud statutes, including: Health Care Fraud, Theft or Embezzlement in Health Care, Obstructing Criminal Investigation of Health Care, and False Statements Relating to Health Care Fraud Matters.

In 2009, the ***Health Care Fraud Enforcement Act*** appeared on the scene. This act has recently been introduced by Congress with promises that it will build on fraud prevention efforts and strengthen the governments' capacity to investigate and prosecute waste, fraud and abuse in both government and private health insurance by sentencing increases; redefining health care fraud offense; improving whistleblower claims; creating common-sense mental state requirement for health care fraud offenses; and increasing funding in federal antifraud spending.

Undoubtedly, law enforcers and prosecutors **MUST** have the tools to effectively do their jobs. However, these actions alone, without inclusion of some tangible and significant before-the-claim-is-paid actions, will have little impact on reducing the occurrence of health care fraud.

What's one person's fraud (insurer alleging medically unnecessary services) is another person's savior (health care provider administering tests to defend against potential lawsuits from legal sharks). Is tort reform a possibility from those pushing for health care reform? Unfortunately, it is not! Support for legislation placing new and onerous requirements on health care providers in the name of fighting health care fraud, however, does not appear to be a problem.

If Congress really wants to use its legislative powers to make a difference on the health care fraud problem they must think outside-the-box of what has already been done in some form or fashion. Focus on some front-end activity that deals with addressing the fraud before it happens. The following are illustrative of steps that could be taken in an effort to stem-the-tide on health care fraud and abuse:

DEMAND all payors and health care providers, suppliers and others only use approved coding systems, where the codes are clearly defined for ALL to know and understand what the specific code

means. Prohibit anyone from deviating from the defined meaning when reporting services rendered (providers, suppliers) and adjudicating claims for payment (payers and others). Make violations a strict liability issue.

REQUIRE that all submitted health care claims to public and private insurers be signed or annotated in some fashion by the patient (or appropriate representative) affirming they received the reported and billed health care services. If such affirmation is not present claim isn't paid. If the claim is later determined to be problematic investigators have the ability to talk with both the health care provider and the patient...

REQUIRE that all claims-handlers (especially if they have authority to pay claims), consultants retained by insurers to assist on adjudicating claims, and health care fraud investigators be certified by a national accrediting company under the purview of the government to exhibit that they have the requisite understanding for recognizing health care fraud, and the knowledge to detect and investigate the fraud in health care claims. If such accreditation is not obtained, then neither the employee nor the consultant would be permitted to touch a health care claim or investigate suspected health care fraud.

PROHIBIT public and private payors from asserting fraud on health care claims previously paid where it is established that the payor knew or should have known the claim was improper and should not have been paid. And, in those cases where fraud is established in paid claims any monies collected from providers and suppliers for overpayments be deposited into a national account to fund various health care fraud and abuse education programs for consumers, insurers, law enforcers, prosecutors, legislators and others; fund front-line investigators for state health care regulatory boards to investigate health care fraud in their respective jurisdictions; as well as funding other health care anti-fraud related activity.

PROHIBIT insurers from raising premiums of policyholders based on estimates of the occurrence of fraud. Require insurers to establish a factual basis for purported losses attributed to fraud coupled with showing tangible proof of their efforts to detect and investigate health care fraud, as well as not paying fraudulent claims.

• Insurers are victims of health care fraud

Insurers, as a regular course of business, offer reports on health care fraud to present themselves as victims of fraud by deviant health care providers and suppliers.

It is disingenuous for insurers to proclaim victim-status when they have the ability to review claims before they are paid, but choose not to because it would impact the flow of the health care reimbursement system that is under-staffed. Further, for years, insurers have operated within a culture where fraudulent claims were just a part of the cost of doing business. Then, because they were victims of the putative fraud, they pass these losses on to policyholders in the form of higher premiums (despite the duty and ability to review claims before they are paid). ***Do your premiums continue to rise?***

Insurers make a ton of money, and under the cloak of fraud-fighting, are now keeping more of it by alleging fraud in health care claims to avoid paying legitimate claims, as well as going after monies paid on claims for services performed many years prior from providers too petrified to fight-back. Additionally, many insurers, *believing a lack of responsiveness by law enforcers*, file civil suits against health care providers and health care entities alleging fraud.

• Increased investigations and prosecutions of health care fraud

Purportedly, the government (and insurers) have assigned more people to investigate health care fraud, are conducting more investigations, and are prosecuting more health care fraud offenders.

With the increase in the numbers of health care fraud investigators, it is not uncommon for law enforcers assigned to work health care fraud cases to lack the knowledge and understanding for working these types of cases. It is also not uncommon that law enforcers from multiple agencies expend their investigative efforts and numerous man-hours by working on the same fraud case.

Law enforcers, especially at the federal level, may not actively investigate health care fraud cases unless they have the tacit approval of a prosecutor. Some law enforcers who do not want to work a case, no

matter how good it may be, seek out a prosecutor for a declination on cases presented in the most negative light.

Health Care Regulatory Boards are often not seen as a viable member of the health care fraud investigative team. Boards regularly investigate complaints of inappropriate conduct by licensees under their purview. The major consistency of these boards are licensed healthcare providers, typically in active practice, that have the pulse of what is going on in their state.

Insurers, at the insistence of state insurance regulators, created special investigative units to address suspicious claims to facilitate the payment of legitimate claims. Many insurers have recruited ex-law enforcers who have little or no experience on health care matters and/or nurses with no investigative experience to comprise these units.

Reliance is critical for establishing health care fraud, and often a major hindrance for law enforcers and prosecutors on moving fraud cases forward. Reliance refers to payors relying on information received from health care providers to be an accurate representation of what was provided in their determination to pay claims. Health care fraud issues arise when providers misrepresent material facts in submitted claims, e.g. services not rendered, misrepresenting the service provider, etc.

Increased health care fraud prosecutions and financial recoveries? In the various (federal) prosecutorial jurisdictions in the United States, there are differing loss- thresholds that must be exceeded before the (illegal) activity will be considered for prosecution, e.g. \$200,000.00, \$1 million. What does this tell fraudsters – steal up to a certain amount, stop and change jurisdictions?

In the end, the health care fraud shell-game is perfect for fringe care-givers and deviant healthcare providers and suppliers who jockey for unfettered-access to health care dollars from a health care payment system incapable or unwilling to employ necessary mechanisms to appropriately address health care fraud – on the front-end before the claims are paid! These deviant providers and suppliers know that every claim is not looked at before it is paid, and operate knowing that it is then impossible to detect, investigate and prosecute everyone who is committing health care fraud!

Lucky for us, there are countless experienced and dedicated professionals working in the trenches to combat health care fraud that persevere in the face of adversity, making a difference one claim/case of the time! **These professionals include, but are not limited to:** Health Care Providers of all disciplines; Regulatory Boards (Insurance and Health Care); Insurance Company Claims Handlers and Special Investigators; Local, State and Federal Law Enforcers; State and Federal Prosecutors; and others.