

Patricia Carlson

Kevalina Burbank

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Health Care fraud causes mayhem to the health care system

The Oregon Medical Association has unveiled to the health industry that \$1.00 out of every \$10.00 that is spent on Medicaid and Medicare is lost to fraud (OMA). When going to the doctor's office, hospital, or medical clinic, it should be a safe to go without having to worry about the potential of being a victim of fraud. Health care fraud is a crime we all pay for with higher insurance premiums, higher medical costs, and standard medical services that are no longer offered.

“Collin Wong, a former head of California's Medi-Cal fraud unit explains, ‘Health care fraud often gets overlooked and even trivialized, because it's seen as a victimless paper crime...But, in reality, the financial burden falls on all of us. We pay for it with heightened health care premiums, increased taxes to pay for social service programs...or reduction of services’ (NHCCA).

Health care fraud can happen to anyone at any time, and all because of one thing, greed. It's all about money. Health care fraud can happen in a doctor's office, at the dentist, at a mental or behavioral health facility, as well as in the durable medical equipment supplier, and pharmaceutical divisions that serve the private and public sectors of health care.

Health care fraud takes reveals a hospital scam

In December 2000, HCA, Inc. (formerly known as Columbia/HCA) pled guilty to substantial criminal conduct and was responsible to pay more than \$840 million in criminal fines. Columbia/HCA used the fraudulent monies for their own benefit as well as opening up other hospital and medical facilities as the fraudulent activities continued to progress and increase.

In 2003, the U.S. Department of Justice located in Washington DC published that HCA Inc., had been filing fraudulent health care claims between 1996 and 2001 and had received financial reimbursements and kickbacks beyond what was actually being provided and billed at rates that were above the national standard milking money for years from government sponsored health programs never expecting to be caught. HCA, Inc., a Nashville, Tennessee based health care organization, had to repay the U.S. over \$631 million in criminal fines, civil restitution for penalties and damages from the fraudulent health claims Columbia/HCA submitted with Medicaid, Medicare, and TRICARE, the military's health care system.

The Department of Justice (DOJ) had been investigating this case for seven years finding hard evidence of fraudulent activities including unlawful practices, cost reporting fraud, and payment of kickbacks to physicians before bringing this case to court. The DOJ also reported that the case against Columbia/HCA was the largest health care fraud case in U.S. History (DOJ). This investigation continues by the federal government who are dedicated to bringing charges against all who participated in the fraudulent activities at HCA.

Medicaid and Medicare programs are vastly susceptible to fraud

Health care fraud is especially excessive within the Medicaid and Medicare Health Systems. Individuals under those programs are prone to be susceptible to the fraudulent scams

by the provider they place their trust in and are vulnerable to the medical industry expecting to be helped and not harmed.

Not all health care cases being investigated are actually proven to be cases of provider fraud. Some cases might be resulting from the provider being compassionate about the patients health concerns and being particularly caring providers offering and recommending over and above health care services, medications, or medical services and equipment so that the patients will become well and will not need to return to the office or hospital for further medical assistance or health issues.

Trustworthy providers or medical equipment suppliers can be as vulnerable to health care fraud from inside their own system as patients are vulnerable to receiving a potential fraudulent activity from a doctor or hospital. A provider may have dishonest medical staff that secretly are involved with writing false prescriptions for patients they never see, or possibly by an equipment supplier that gives the provider a higher rate of kickbacks a provider should receive. Honorable health care providers take many precautions and create safe guards that assist them in maintaining a compliant medical facility if they were to be audited or investigated by the regulatory agencies.

Fraud and abuse can happen in any health care field

Health care fraud and abuse has many forms. Fraud can be as basic as a health care provider, patient, or supplier who has the intent to falsify and misrepresent the health care claim by stating that services were provided that were not, prescribing false prescriptions or obtaining the prescription and selling the drugs on the street. "Fraud occurs when an individual or organization deliberately deceives others to gain some sort of unauthorized benefit. Health care

fraud generally involves deliberately billing for services that were not received or billing for a service at a higher rate than is actually justified” (DHS).

FBI Director Louis Freeh was quoted in a health article *Hospitals & Health Networks* “No segment of the health delivery system is immune from fraud...The crime problem is so big and so diverse that we are making only a small dent in addressing the fraud” (Freeh). This reveals that health care fraud is a huge issue for the health care systems and seems to be somewhat isolated from the general public’s awareness of how fraud impacts the overall costs of health care.

Is it safe to trust your health care provider?

Most health care providers, hospitals, pharmacies, and durable medical equipment providers are honest and have a sincere desire to help individuals with their health care needs and basically just want to be paid for the services they are providing. Some health care billing activity or improper payments are caused from honest errors such as entering incorrect billing codes on claims, miscommunication between physicians and their billing office on paperwork, incorrect information from suppliers, or potentially computer program software glitches. The billing system for Medicare is a fairly complex health system that opens the door for errors to happen.

The majority of individuals that make up the medical community consist of trustworthy and respected physicians and health care staff. A health care provider or hospital has to be careful about using one drug for a vendor substantially more than another drug from a different vendor for patient treatment because it may look like preferential conduct or a higher rate of kickback from that vendor. This could seem like fraud but if the specific drug works better over another, it could make the drug selection a little complex for the prescribing physician.

Dishonest patients can cause potential fraudulent issues for providers by altering the physician's written prescription or by stealing and altering a prescription pad from a legitimate physician and changing the call back number so the physician is not reached for questions.

Physicians in the health care industry are passionate about healing their patients' medical and health issues. A provider may recommend higher levels of service or seemingly unnecessary operations to a patient while it may actually be the best option for the patient, and may seem like the provider is always trying to upgrade treatments for higher rates of reimbursements. Medical identity theft or patient medical data theft can cause serious repercussions for both the provider and the patient while trying to reveal the source of the exposure and theft.

Physicians have expressed concern using a national standard for all patient care and billing services as the "Use of national normative, not taking into consideration the patient's demographics may account for discrepancies in billing patterns and broader national trend" (GAO). These specialty billing patterns could look like fraud when they actually are not fraud and cause unnecessary red flags that could cause an investigation.

Fraud is a vicious act that creates a wake behind it

Health care fraud is identified as an 'intentional misrepresentation that an individual knows to be false which will bring an unauthorized benefit (financial reimbursements) to himself/herself or to another person. The Medicare Benefit Protection Team identified key elements to fraud (OMA):

- Billing for services or supplies that weren't provided
- Altering claims to obtain higher payments
- Soliciting, offering or receiving a kickback, bribe or rebate
- Provider filing claims on patients not known to the provider

- Suppliers completing CME's for the physician
- Using another person's Medicare card to obtain medical care

Health care abuse describes behaviors or practices of providers, physicians, or suppliers of services and equipment that are not consistent with acceptable medical practices for a Physician or supplier to provide. Abuse may also be the result of unnecessary costs to the program through improper payments, or providing services that are not professionally recognized in meeting the quality standards of the health care profession. Key elements identified by OMA as health care abuse are:

- Excessive charges for services or supplies
- Claims for services that aren't medically necessary
- Breach of the Medicare participation or assignment agreements
- Improper billing practices

Prescription drugs and organized crime

Pharmaceutical fraud specifically involves prescription drugs. Drug fraud basically covers any services or benefits obtained by misrepresentation or suspicious activity can be classified as prescription drug fraud. Major areas of prescription fraud:

- Physicians writing prescriptions, filling them with the generic brand then submitting the claim for the name brand drug
- Medications that are not picked up, placed back into inventory and the original claim is submitted for reimbursement
- Drug substitution or diluting medications
- Patients stealing prescription pads, writing false prescriptions
- Drug manufacturers providing kickbacks to physicians for referrals

Rx fraud is a real problem with a staggering financial impact on the pharmaceutical division and with overall health care services.

- “Americans spend about \$170 billion each year on prescriptions with an annual increase of 11% to 16%” (BenefitNews.com).
- “The number of prescriptions purchased between 1992 and 2001 increased from 1.9 billion to 3.2 billion” (US DHS).
- “The total prescription drug expenditure for 2001 was \$140 billion. In 2004, that total is expected to increase to \$204 billion. Projections for 2010 total \$373 billion and for 2012 \$445 billion” (CMS).

As the annual expenditures of pharmaceuticals increase along with drug costs rising, the average rate of fraud increases along with it. The FBI has identified that one of the major problems to uncovering pharmaceutical fraud is that it is difficult to investigate. Organized crime factions have chosen to enter the pharmaceutical drug fraud arena as the overall penalties for drug fraud are relatively minor compared to drug smuggling crimes (Freeh).

Investigation into health care fraud

There are several agencies that investigate health care fraud and abuse that include but not limited to the following agencies:

- U.S. Department of Justice (DOJ), Office of Inspector General (OIG)
- U.S. Department of Health and Human Services (DHS)
- Centers for Medicaid and Medicare Services (CMS)
- Medicaid Fraud Control Units (MFCU)
- Internal Revenue Service (IRS)
- Postal Inspection Services
- Department of Defense (DOD)
- State Insurance Department

In a news bulletin published by the Office of Inspector General Department of Health and Human Services (DHS) in the *Office of Inspector General News*, they have recently started a “Most Wanted Fugitives List” on their website asking for the public’s help in tracking down these fugitives. The Office of Inspector General is pursuant that these individuals are to be held accountable as the top ten have allegedly cost taxpayers more than \$124 million in fraud. (OIG)

False statements, false claims and conspiracy are constantly investigated by various enforcement agencies. Conspiracy is to conspire to submit false claims to US Government violations are punishable up to 10 years in prison and a fine of up to \$250,000 or twice the amount of the fraud. Violations of the False Claims Statute & the Civil False Claims Act are punishable by 5 yrs in prison and fine of up to \$250,000 or twice the amount of the fraud (Christopher Spevak).

New regulations and the creation of investigation teams to combat fraud

The federal government and US Department of Justice and are continually expanding their efforts to investigate health care fraud by implementing regional strike force teams and Department of Justice investigation teams on a federal, state, and local level to bring individuals and companies responsible for fraud accountable for restitution to pay back stolen funds allocated for regular health care. It was reported in *The Justice Blog* “...the creation of the Health Care Fraud Prevention & Enforcement Action Team, or HEAT” was formed to help fight fraud. (US Department of Justice).

In 1996 the Health Insurance Portability and Accountability Act (HIPAA) was passed by congress requiring the patient information to be handled in a confidential manner and processed through a secure transmission process and all HIPAA violations are reportable on different levels and potentially punishable through a fine and potential jail time depending upon severity of the

breach of confidence and the loss it caused. HIPAA violations can bring prison terms of up to 10 years (DHHS DOJ).

A Correct Coding Initiative was implemented by HCFA in 1994 to develop coding policies and procedures for all physician billing codes of medical services. The codes, known as CPT codes (current procedural terminology codes), are listed on each medical claim of diagnosis and treatment. (CMSFacts) If a provider uses incorrect billing codes, it could increase the amount of reimbursement the provider receives versus the actual care the patient was rendered, and therefore is another aspect of fraudulent reimbursement.

Investigators fraud informants can include individuals, regulatory agencies, competitors, current or former employees, private individuals or CMS, criminal defendants or law enforcement agencies. Selected federal agencies, including the FBI, are taking health care fraud serious and will investigate these crimes and bring the guilty culprits to pay restitution and for their crime.

Criminal Investigation Statistical Data: Health care fraud

	FY 2008	FY 2009	FY 2010
Investigations Initiated	85	67	81
Prosecution Recommendations	75	74	61
Indictments / Informations	70	41	57
Sentenced	56	68	86
Incarceration Rate	83.9%	79.4%	72.1%
Average Months to Serve	35	24	27

If health care providers are held accountable to a specific national standard for health care and billing processes, this may reduce the instances of fraud but could also cause unnecessary

investigations as the billing system does not account for special cases. Providers and health care facilities can help to reduce the prospects of potential fraud by perform regular internal audits of procedures and medical services billing practices and consistently following the standards of operations. Analyzing real time data reports will bring to the surface any potential fraudulent activity.

Faith in the health care system

Health care fraud is an everyday occurrence that causes ripple effects that spread throughout the health care system and overflows into the current cost of health care that effects us all. We see increases in taxes, it pulls resources away from the health programs, and higher costs are distributed to employers and ultimately to the employees.

Fraud is caused by unscrupulous individuals who are intent on using the health system for their own personal gain without any concern about the individuals or corporate entities that they tarnish and potentially bring harm through their decisions and actions. It's the few who tarnish the reputation of the whole.

Many health care physicians are honest and hardworking individuals that care deeply about their patients and their medical conditions and are dedicated to helping patients. The medical systems and programs that are created by the government and by private and public organizations are in place to help people obtain quality health care and will do what it takes to investigate and bring justice to those who have been harmed by the those involved in fraudulent activity. Quality health care is worth fighting for.

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