

The Challenges of Health Care Fraud

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A General Look at Health Care Fraud



The Reality



- U.S. Health care spending was **16.2%** of GDP in 2007 and is projected to grow to **19.5%** of GDP in 2017 – reaching **\$4.3 trillion**.
- For 2007, that translates into more than **\$2.26** trillion in health care expenditures.
- CMS estimates an annual growth rate of **7.2%** in health care spending over the next decade.
- By 2017, **\$1 out of every \$5** in the U.S. economy will be spent on health care.

The Reality



- Consensus among NHCAA members estimates that **3%** of health care expenditures are fraudulent.
- That means that in 2007, **\$67.8 billion** was lost to fraud.
- This is a conservative estimate. Some government and law enforcement agencies place the loss as high as **10%** of our annual health outlay.

General Dental Statistics*

In 2006...

- The U.S. population was 299 million.
- Approximately 42% of the population had a least one dental care expense.
- The average dental care expense was \$607.
- The total dental expense for the U.S. population was \$76.3 billion.



**Statistics from: Agency for Healthcare Research and Quality – U.S. Dept. of Health & Human Services, Medical Expenditure Panel Survey*

Fraud Hurts Everyone

Federal & state governments and private insurance companies

\$186 million lost per day, every day of the year (3% of \$2.26 trillion annual health-care expenditures).

Consumers

Fraud contributes to rising health care premiums and higher taxes.

Patients

Subjected to bodily injury, violations of privacy, falsification of medical records. Fraud can erode aggregate benefits and limit future access to healthcare.

Medical Professionals

Medical professional dignity, credibility undermined for the vast majority of honest, ethical providers.

A Federal Crime with Stiff Penalties

- In response to these realities, Congress – through the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – specifically established health care fraud as a federal criminal offense, with the basic crime carrying a federal prison term of up to 10 years in addition to significant financial penalties. [*United States Code, Title 18, Section 1347.*]
- The federal law also provides that should a perpetrator's fraud result in the injury of a patient, the prison term can double, to 20 years; and should it result in a patient's death, a perpetrator can be sentenced to life in federal prison.

A Federal Crime with Stiff Penalties

- HIPAA created The Health Care Fraud and Abuse Control Program, designed to coordinate federal, state and local law enforcement activities with respect to fighting health care fraud and abuse.

Congressional appropriations to the FBI in FY 2007: \$118.2 million

Quote from the FBI's FY 2007 Financial Crimes Report to the Public:

“Health care fraud investigations are among the highest priority investigations within the FBI and rank behind only Public Corruption and Corporate Fraud in the FBI’s White collar Crime Program Plan.”

Health Care Fraud Enforcement... a Department of Justice Priority

During 2008, Department of Justice (DOJ) prosecutors:

- Opened **957** new criminal health care fraud investigations involving **1,641** defendants
- Had **1,600** active criminal health care fraud investigations involving **2,580** potential defendants

Health Care Fraud Enforcement... a Department of Justice Priority

During FY 2008, DOJ prosecutors:

- Filed criminal charges in **502** health care fraud cases involving charges against **797** defendants
- Obtained **588** convictions
- At the end of FY 2008, DOJ had another **773** criminal health care fraud cases involving **1,335** defendants pending
- Had “**all time high**” counts of federal criminal cases, defendants, and convictions



Health Care Fraud Enforcement... a Department of Justice Priority

On May 20, 2009:

- **Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced the creation of a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat Medicare fraud.**

Health Care Fraud Enforcement... a Department of Justice Priority

New HEAT team includes senior officials from DOJ and HHS who will:

- **Strengthen and expand existing fraud programs**
- **Invest in new resources and technology to prevent fraud, waste and abuse before it happens**

Health Care Fraud Enforcement... a Department of Justice Priority

Strike Force approach...

- **DOJ-HHS Medicare Fraud Strike Force teams in South Florida and Los Angeles have a proven record of success using a “data-driven” approach to identify possible fraudulent activity.**
- **Strike Force teams will expand to Detroit & Houston.**

Health Care Fraud Enforcement... a Department of Justice Priority

Strike Force success includes:

- **Filing 108 cases charging 196 defendants who collectively billed the Medicare program more than a half a billion dollars**
- **Accepted 129 guilty pleas**
- **Handled 14 jury trials resulting in convictions of 18 defendants**
- **Obtained 109 prison sentences ranging from 30 years to 4 months of home confinement, with an average prison term of 48 months**

The Nature of Health Care Fraud

Health care fraud challenges/differences:

1. The vast majority of “claims” are submitted, not by the insured, but by medical care providers – hospitals, physicians, dentists, pharmacies, etc.
2. Detection of health care fraud often requires the application and knowledge of medical and clinical best practices and terminology and arcane coding systems – ICD-9 codes, CPT and CDT codes, DRGs, etc.
3. Government, both Federal and state, are major payors – Medicare, Medicaid, TRICARE – and therefore are very much involved in the fight against health care fraud.

The Nature of Health Care Fraud

Health care fraud challenges/differences:

4. Health care fraud isn't just a financial crime. Patients can be put at risk for, or be a victim of, physical harm through unnecessary or dangerous procedures.
5. The sheer volume of health care and dental claims makes fraud detection a challenge. Those committing fraud have the full range of medical conditions, treatments and patients on which to base false claims.
6. The ability to spread false claims among many insurers (including Federal and state governments) simultaneously, increasing proceeds from fraud while lessening the chances of detection.

The Nature of Health Care Fraud

Health care fraud challenges/differences:

7. The challenges of HIPAA Privacy regulations.
8. The importance of health plan provider networks.
9. ERISA health benefit claims regulations.
10. State prompt pay laws.



Health Care Fraud & Abuse

Most common general types of provider fraud:

- Billing for services not rendered – either by using genuine patient information, sometimes obtained through identity theft, to fabricate entire claims or by padding claims with charges for procedures or services that did not take place.
- Billing for more expensive services or procedures than were actually provided or performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code).

Health Care Fraud & Abuse

Most common general types of provider fraud, continued:

- Unbundling – billing each step of a procedure as if it were a separate procedure.
- Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract.
- Accepting kickbacks for patient referrals.
- Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan.

Health Care Fraud & Abuse

Most common general types of provider fraud, continued:

- Performing unnecessary services solely for the purpose of generating insurance payments – seen very often in diagnostic-testing schemes.
- Billing for covered services, but actually performing cosmetic services.
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that aren't medically necessary.
- Altering claim forms and medical or dental records.
- Routine waiver of a patient's co-payment or deductible.

Specific Examples of Common Dental Fraud & Abuse

- Billing existing fillings as newly placed fillings when patient changes insurance carriers.
- Billing for a new set of dentures but just repairing the old ones that were broken.
- Dentists having hygienists, assistants or other staff perform treatments – even though they are not licensed or qualified and then billing insurers as if the dentists performed the treatment.
- Unlicensed dentists.

Specific Examples of Common Dental Fraud & Abuse

- **D4341 is most highly abused dental code**
 - DDS renders the prophylaxis (code D1110)
Average fee \$50 - \$75 for the entire mouth
 - DDS bills PSRP (4 quads = \$600-\$800)
High reward for no work

Specific Examples of Common Dental Fraud & Abuse

- Performing a simple 1 surface filling, but billing as if a 2, 3, or 4 surface composite was performed
- Billing for full mouth x-rays (ADA code 0210) when only a single periapical, or bitewing x-ray is performed
- Billing for placement of multiple crowns, separately, when in fact, the crowns are part of a maxillofacial prosthetic (i.e. dentures; partials; bridges)
- Billing for surgical extractions when simple extractions were performed

Specific Examples of Common Dental Fraud & Abuse

- **Billing for covered services but actually performs cosmetic services.**
 - Bills for an occlusal guard or night guard (D9940) but in reality performs a bleaching tray to bleach teeth.
- **DDS removes shiny metal fillings and replaces with white resin/composite – issues of dental necessity vs. cosmetic objectives**

Specific Examples of Common Dental Fraud & Abuse

Services billed are not the services received by the patient.

Example:

- Performing sealants but billing for composite restorations, or performing preventative resin restorations, but claiming restorations were necessary following removal of decay

Billing for services that are clearly dental in nature to both a patient's dental plan with CDT codes and simultaneously submitting to their medical plan with CPT codes for the same services.

Example:

- Billing patient's dental plan for periodontal root planing and scaling with CDT code D4341 and also bill under the medical plan with CPT 41805.

Dental Schemes - Unbundling

“The Department is taking the stance that unbundling is a universal scheme to maximize reimbursements and dentists must align with proper billing of codes as defined in the CDT. The bundled codes for full mouth e-rays and prophy with fluoride are the correct way to bill those services. The difference in the unbundled amount paid and the amount allowed for the bundled codes have been tagged as overpayments.”

*--Quote from a manager of a state Medicaid Program
Integrity Section*



NHCAA - Our Role

MISSION

To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud.

NHCAA's Arsenal Against Health Care Fraud

Partnering

Educating

Sharing

Accrediting



Partnering

Bringing to the table public agencies and private payors:

Health Insurance Community

Law Enforcement and Regulatory Community

NHCAA Member Organizations

1199 SEIU Nat'l Benefit & Pension Fund ▪ AdvanceMed ▪ Aetna ▪ American Family Insurance Company ▪ American Medical Security ▪ American Republic Insurance ▪ American Specialty Health ▪ AMERIGROUP Corporation ▪ APWU Health Plan ▪ Arkansas Blue Cross Blue Shield ▪ Assurant Health ▪ Blue Cross Blue Shield Association ▪ Blue Cross Blue Shield of Alabama ▪ Blue Cross Blue Shield of Florida ▪ Blue Cross Blue Shield of Kansas ▪ Blue Cross Blue Shield of Louisiana ▪ Blue Cross Blue Shield of Massachusetts ▪ Blue Cross Blue Shield of Minnesota ▪ Blue Cross Blue Shield of Mississippi ▪ Blue Cross Blue Shield of Montana ▪ Blue Cross Blue Shield of Nebraska ▪ Blue Cross Blue Shield of North Carolina ▪ Blue Cross Blue Shield of Rhode Island ▪ Blue Cross Blue Shield of South Carolina ▪ Blue Cross Blue Shield of Tennessee ▪ Blue Cross Blue Shield of Texas ▪ Blue Shield of California ▪ Capital Blue Cross ▪ Capital District Physicians' Health Plan ▪ CareFirst Blue Cross Blue Shield ▪ Centene Corporation ▪ Central States Health & Welfare Fund ▪ CIGNA ▪ Community Health Network of Connecticut ▪ Crossroads Healthcare Management LLC ▪ Coventry Health Plan ▪ EmblemHealth Services ▪ Excellus Blue Cross Blue Shield ▪ Government Employees Hospital Association ▪ Guardian ▪ Hawaii Medical Service Association ▪ Health Care Service Corporation ▪ Health Insurance Plan of Greater New York ▪ Health Net Federal Services ▪ Health Net ▪ Healthfirst ▪ HealthNow New York ▪ Health Plan of Michigan ▪ Highmark ▪ Horizon Blue Cross Blue Shield of NJ ▪ Humana ▪ Independence Blue Cross ▪ Independent Health ▪ Insurers Administrative Corporation ▪ JMH Health Plan ▪ Kaiser Foundation Health Plan ▪ Keystone Mercy Health Plan ▪ KPS Health Plans ▪ Leggett & Platt ▪ Magellan Behavioral Health ▪ Medica Health Plans ▪ Medical Excess LLC ▪ Medical Mutual of Ohio ▪ Mutual of Omaha ▪ MVP Health Plan ▪ National Elevator Industry Health Benefit Plans ▪ Nationwide Health Plans ▪ Preferred Health Systems ▪ Premara Blue Cross ▪ Principal Financial Group ▪ SCAN Health Plan ▪ State Farm Mutual Automobile Insurance Company ▪ The Health Care Group ▪ St. Paul's Travelers Companies ▪ TriWest Healthcare Alliance ▪ Trustmark ▪ Tufts Health Plan ▪ United Health Group ▪ UPMC Health Plan ▪ ValueOptions ▪ Vision Service Plan ▪ WEA Insurance Corp. ▪ Wellcare ▪ Wellmark ▪ Wellpoint ▪ Western Southern Life Ins. Co. ▪ Wisconsin Physicians Service

Law-Enforcement Liaisons

- Public-sector law enforcement, prosecutorial or regulatory agencies
- Dues-free membership

NHCAA

Law Enforcement Liaisons

FBI • U.S. Department of HHS-OIG-OI • Centers for Medicare & Medicaid Services • IRS-Criminal Investigation • U.S. Dept. of Justice • U.S. Dept. of Defense-TRICARE • U.S. Dept. of Defense –DCIS • Department of Labor-OIG • U.S. Postal Service, Postal Inspection Service • U. S. Dept. of Veterans Affairs, Office of Inspector General • U.S. Gov't Accountability Office, Office of Special Investigations • U.S. Dept. of VA, Health Administration Center, P&C Division • U.S. Railroad Retirement Board • U.S. Office of Personnel Management –OIG • U.S. General Accounting Office • National Association of Attorneys General • National Association of Insurance Commissioners • National Association of Medicaid Fraud Control Units • Ontario Provincial Police • Amtrak, Office of Inspector General • San Diego County District Attorney's Office • South Carolina Dept. of HHS • Massachusetts Office of Inspector General • Kansas Insurance Department • Montana Department of Justice, Division of Criminal Investigation • Medicaid Fraud Control Unit of Vermont, Office of the Attorney General • Medicaid Fraud Control Unit of South Dakota, Office of the Attorney General • Medicaid Fraud Control Unit of Massachusetts, Office of the Attorney General • Medicaid Fraud Control Unit of Kentucky, Office of the Attorney General • Medicaid Fraud Control Unit of Pennsylvania, Office of Attorney General • Los Angeles Police Department, Worker's Compensation Fraud Coordination Unit, Cape May County Prosecutors Office • Maryland Insurance Administration, Insurance Fraud Division • Nebraska Department of Insurance – Insurance Fraud Prevention Division • Miami Dade Police Department • California Department of Insurance • Texas Health and Human Services Commission, Office of Inspector General • Texas Dept. of Insurance, Fraud Unit • Nevada Attorney General's Office, Insurance Fraud Unit • District of Columbia Dept. of Insurance, Securities and Banking • Texas Department of Insurance, Fraud Unit • Minnesota Department of Commerce – Insurance Fraud Division • Connecticut Department of Insurance • Georgia Bureau of Investigation, State Health Care Fraud Control Unit • State of California – Office of the Inspector General • New York State Office of the Comptroller • State of Utah, Insurance Fraud Division • Florida AHCA, Bureau of Medicaid Program Integrity • Connecticut Department of Social Services • Washington State Dept. of Social & Health Services • Idaho Dept. of Health & Welfare • Pennsylvania Insurance Fraud & Auto Theft Prevention Authorities • Arkansas Dept. of Insurance, Criminal Investigation Division • Florida Dept. of Financial Services, Division of Insurance Fraud • New York City Human Resources Administration – Investigation, Revenue & Enforcement Administration • Ohio Bureau of Worker's Compensation • New Jersey Office of the Insurance Fraud Prosecutor • Orange County District Attorney's Office • Massachusetts OAG, Insurance and Unemployment Fraud Division • Inspectorate of Public Health, Netherlands Antilles

Affiliate Members

Other insurers that reimburse medical claims:

- P&C
- Workers' Comp
- Long-term care
- Disability

Educating



The NHCAA Institute for Health Care Fraud Prevention

Educating



The unique nature of health care fraud requires specialized education and training.

- Annual Training Conference
- National Education & Training Series (NETS)
- Online Education Programs
- Monthly Audio Conferences
- Other educational tools and resources

Educating

Annual Training Conference
2009 Location: Orlando, Florida

Sample workshops:

- Emerging Health Care Fraud Schemes
- Top Ten Current Legal Challenges in Health Care Fraud
- Fraud in Pain Management
- Changes in Medicaid Managed Care
- Pharmacy Fraud
- Dental Fraud
- Oncology Fraud
- Hospital Fraud
- Working Effectively with Law Enforcement
- Disability Schemes

Educating

Annual Training Conference
2009 Location: Orlando, Florida

Award Presentations

- Investigation of the Year
- Investigative Excellence Award
- Excellence in Public Awareness

Anti-Fraud Expo

- Dozens of vendors with the latest in services and products



Educating

National Education & Training Series (NETS)

- Educational programs held across the U.S.
- The core curriculum is reviewed annually with new programs added and existing programs updated to keep pace with the latest industry trends and educational needs of fraud investigators
- CPE credits awarded

Information Sharing

NHCAA's Information Sharing toolkit:

- SIRIS
- In-person information sharing meetings
- RIAs for law enforcement
- PERC
- Fraud Alerts
- Work Groups

Accrediting



Accredited Health Fraud Investigator (AHFI) designation for those individuals demonstrating professional experience, formal education and continuing training in the detection and investigation of health care fraud.

Contact NHCAA

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