Second edition

HEALTHCARE FRAUD

Auditing and Detection Guide

Rebecca Saltiel Busch

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In dedication to my grandmothers, Rebecca and Gregoria, and my mother, Francisca, who have modeled perseverance; and to my father, Alberto, who has modeled incontrovertible truth.

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Preface

Before reading this book, recall an experience in your personal or professional life, preferably both, in which you have been told a lie, believed it, and acted on it. Hold onto that thought and then ask yourself, "Why? What gut reaction did I ignore? What clues did I miss? What evidence walked by me?" Follow those questions with, "What price did I pay personally or professionally?"

That is the frame of reference required to appreciate the behind-the-scenes look that the charts, tables, diagrams, rules, and audit to-do lists that are given throughout this book. In the course of all life experiences—and, in particular, audit, detection, and investigation—seeking 20/20 vision is the objective. This vision is further enhanced by the ability to see what no one else has seen. Each chapter begins with a reflective quote that has inspired the work contained within. The book progresses by providing the building blocks for understanding the entire healthcare market and its respective players. Intertwined throughout are subject matter and skill set expertise. The cases and methodologies presented provide actual audit and investigative tools. Theoretical applications are identified, and I include those from various studies and established organizations. The case studies are actual public cases, in addition to cases on which I worked personally. Some of them are modified in detail, location, and names to avoid identification.

The methodologies and tools that I use in my practice are explained in this book, with the goal being to answer any question presented at any point in the healthcare continuum. Keep in mind that learning is a process. By no means is this book meant to cover all possible scenarios. It is presented from my lessons learned, with the expectation that it will complement your own evolving experiences. Further, your own methods and checklists should evolve with ongoing regulatory changes and emerging market tools. New questions that cannot be answered within the current models will generate new algorithms within the audit checklists noted in this book. The concepts of theft, waste, and abuse, of course, remain the same.

The school of hard knocks has resulted in my drive to share and teach all I have learned about the audit and detection of healthcare fraud. I wrote this book to share with others the processes that I have developed to reach

a state of incontrovertible truth. As new challenges and unique behaviors of the ethically challenged enter the market, updates on these concepts will be provided. That aside, the tools provided in this book are structured to move with market changes. The original publication focused on one healthcare continuum. The current version has five additional continuums to ensure a more comprehensive approach. The first book used the term healthcare continuum to discuss market players. In this edition, market players are now referred to as the primary healthcare continuum. The model now has six layered continuums to effectively obtain information and evidence during an audit and or investigation. The introduction of the Healthcare Continuum Audit Model involves the following six layers:

- Primary Healthcare Continuum (P-HCC) is about the players
- Secondary Healthcare Continuum (S-HCC) is about the benchmarks
- Information Healthcare Continuum (I-HCC) is about the information systems
- Consequence Healthcare Continuum (C-HCC) is about measuring damages
- Transparency Healthcare Continuum (T-HCC) is about recognizing road block
- Rules Based Healthcare Continuum (R-HCC) is about knowing the relevant rules

The complexity of health information systems, specifically the I-HCC, was discussed in more detail in a 2008 publication entitled "Electronic Health Records: An Audit and Internal Control Guide."

My background gives me a number of different perspectives. I started off as a nurse and this evolved into the role of a medical auditor for a hospital. Internal audit expertise then complemented my clinical background. My expertise continued to evolve as I began setting up internal controls for documentation- and reimbursement-related issues. The addition of healthcare finance allowed me to move on to the next level. My career progressed to setting up audit programs for insurance carriers. In 1991, I started my own company, Medical Business Associates, with the idea of taking clinical nurses and training them in audit and finance. During this time period, my audit experience led me to employer advocacy of healthcare benefits, and eventually into additional audit programs for controlling employee healthcare expenses. All roles involved data analytics and research. In between, I have audited on behalf of patients and other ancillary market players. The investigation of fraud and abuse was a natural evolution. In each context, scenarios involving ethically challenged behavior have presented themselves, leading me to get involved with forensics and disputes. The legal world often requires experts to "answer that question" or "contribute to the tier of facts."

I became that expert. Finally, the detailed avenues of this process have been filed in a patent referred to as an *anomaly tracking system* that integrates some of the concepts in this book. Thus, this book is written from a number of perspectives—clinical, research, internal audit, investigative, data intelligence, and forensic.

Why is healthcare so complex and difficult to manage? The healthcare market is fragmented, layered, and segmented. We have too many current and changing rules, too many relationships, and too many old dynamics whose historical and political roots are often lost or forgotten.

What have we created in healthcare? A Tower of Babel! The market, the U.S. legislature, executive branch, and various stakeholders have pursued six attempts at national healthcare reform since 1927. In 2010, historic legislation referred to as the Affordable Care Act was signed into law. Components of the Act have been implemented, some are in route, and other attributes continue to be challenged. Regardless of the political or market climate, use this book as a navigation guide to break apart and discover all the relationships involved, and to answer whatever questions are at hand. The goal is to create a common language to understand the events in question.

A general comment on fraud: Outside of the legal context of its definition, simply view it as individuals or entities taking things that do not belong to them. Do not bury yourself in one particular market player, such as "provider" fraud. The ethically challenged can look like providers, but also like payers, employers, plan sponsors, patients, and vendors. This guidebook is structured to identify what is normal at any point in the healthcare continuum, on both individual and aggregate scales, with the assumption being that everything else is *abnormal.* The building blocks contained within this book will help you whether you are just beginning your career or are an experienced professional looking for an out-of-the-box perspective or a new set of application skills.

The world of healthcare fraud is my passion. It is much more than just stealing money or a corporate asset. Healthcare fraud steals the very essence of human life. Stories include false claims by perpetrators who perform needless procedures that disable or kill, fake insurance broker or inappropriate payer denials that can leave a patient disabled or with an untimely death, and even adulterated drugs that almost take the life of a 16-year old liver transplant survivor. The list of examples is shocking, demoralizing, and generates a sense of hopelessness and another book in itself. More disturbing is that the world of healthcare fraud has become one of high-tech, highly skilled, educated, and professional perpetrators.

When was the last time you witnessed a consumer walking into a used car dealership with his guard up? When didn't you! Unlike buying cars, healthcare is a personal, intimate experience with a high level of trust from

a patient who more than likely is in a compromised physical and emotional state. In other words, the guard is down. With this in mind, if anything I have written and shared within this book helps any party prevent, detect, and shut down a perpetrator, then I will consider that my greatest accomplishment. Thank you for taking the time to learn and participate in this very important subject.

Acknowledgments

Personal acknowledgments cannot go without thanking my whole family for support and for instilling a fountain of youth for learning. I especially want to acknowledge my children, Rebecca Samantha, Andrew Bering, and Alberto William. They have taught me more about life than any degree or credential. I have also been privileged to work with some amazing women for the past 20 years—Janet McManus, Donna Graham, and Mary Glynn, the ultimate patient advocates. I would like to acknowledge the editorial assistance of Tara McManus and Laura Spangler.

Professionally, as of this writing, I have more than 100 combined articles and presentations. A special thank-you to all the students and professionals who have participated in my classes, read my articles, emailed responses to my questions, and shared their experiences. These experiences have generated insight and thought-provoking conversations, all of which have contributed to the writing of this book. Further, in my own professional development, a thank-you to all the professors and academic organizations that continue to educate and refine my understanding of this subject.

Finally, in this second edition I need to acknowledge the story behind the story. The first edition was written as an act of penance. I was involved in a case with a client who had issues with his billing company and representation by a disbarred attorney. During the course of this investigation I met an FBI agent who, during my interview, asked why I was helping this doctor. I told her simply that it appeared he was victimized. I didn't take it lightly the FBI was investigating my client, so I asked her if there was anything she could share. She simply stated, "You have encountered a thicket of thieves." Being first-generation Cuban American, and feeling somewhat compromised with Spanish as a first language, I thought great, an American colloquialism. What the heck was she talking about?

It took me about a year to appreciate the true meaning of the phrase. I encountered evidence that I could label as an incontrovertible truth—my lie detector test. My conclusion about the disbarred attorney was correct, issues with the billing entities involved were also correct. What I failed to see was that my client was also a thief—and a liar himself, thus the thicket of thieves. I encountered a group of con artists that were stealing from each

other. Since that first edition, I have continued to refine the methodology to respond to any query presented. The hard lesson learned is this: an effective audit or investigation is totally reliant on the ability to execute your audit or investigations by creating a path of incontrovertible truth. The purpose of the healthcare continuum models is to obtain objective evidence that is immune from our own subconscious biases.

I went back to visit with the agent after I had assembled the puzzle, with a little egg on my face, and said, "I now understand your reference to 'a thicket of thieves'." She smiled and sincerely expressed "It is never the fault of the individual who was deceived." The perpetrator alone is accountable for their actions. My act of penance was to develop a methodology that would prevent a similar outcome, write about it, and teach others.

The FBI agent who inspired me to write? Well, she chooses to remain anonymous, and I respectfully oblige the request. So I will simply say, thank you.

Healthcare Fraud

CHAPTER 1

Introduction to Healthcare Fraud

Truth is often eclipsed but never extinguished.

—Livy, Historian (59 B.C.–A.D. 17)

When Willie Sutton, an infamous twentieth-century bank robber, was asked why he robbed banks, he replied, "Because that's where the money is." The healthcare industry, too, has lots of money. Long considered a recession-proof industry, healthcare continues to grow. Statistics from the Centers for Medicare and Medicaid Services (CMS), formally known as the Health Care Financing Administration, show that in 1965, U.S. healthcare consumers spent close to $42 billion. In 1991, that number grew in excess of $738 billion, an increase of 1,657 percent. In 1994, U.S. healthcare consumers spent $1 trillion. That number climbed to $1.6 trillion in 2004, which amounted to $6,280 per healthcare consumer. The figure hit $2.5 trillion in 2009, which translates to $8,086 per person or 17.7 percent of the nation's Gross Domestic Product (GDP).[1]

How many of these annual healthcare dollars are spent wastefully? Based on current operational statistics, we will need to budget $550 billion for waste. A trillion-dollar market has about $329.2 billion of fat, or about 25 percent of the annual spending figure. The following statistics are staggering in their implications:

- $108 billion (16 percent) of the above is paid improperly due to billing errors. (Centers for Medicare and Medicaid Services, www.cms.gov)
- $33 billion Medicare dollars (7 percent) are illegitimate claims billed to the government. (National Center for Policy Analysis, www.ncpa.org)
- $100 billion private-pay dollars (20 percent) are estimated to be paid improperly. (www.mbaaudit.com)
- $68 billion in health insurance fraud (3 percent of expenditures). (www.insurancefraud.org)

- $50 billion (10 percent) of private-payer claims are paid out fraudulently. (BlueCross BlueShield, www.bcbs.com)
- $37.6 billion is spent annually for medical errors. (Agency for Healthcare Research and Quality, www.ahrq.gov)
- 10 percent of drugs sold worldwide are counterfeit (up to 50 percent in some countries) (www.fda.gov). The prescription drug market is $121.8 billion annually (www.cms.gov), making the annual counterfeit price tag approximately $12.2 billion.

What do these statistics mean? About $25 million per hour is stolen in healthcare in the United States alone. Healthcare expenditures are rising at a pace faster than inflation. The fight against bankruptcy in our public and privately managed health programs is in full gear.

Use this how-to book as a guide to walk through a highly segmented market with high-dollar cash transactions. This book describes what is normal, so that the abnormal becomes apparent. Healthcare fraud prevention, detection, and investigation methods are outlined, as are internal controls and anomaly tracking systems for ongoing monitoring and surveillance. The ultimate goal of this book is to help you see beyond the eclipse created by healthcare fraud and sharpen your skills as an auditor or investigator to identify incontrovertible truth.

What Is Healthcare Fraud?

The Merriam-Webster Dictionary of Law defines fraud as:

> *any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage; specifically: a misrepresentation or concealment with reference to some fact material to a transaction that is made with knowledge of its falsity or in reckless disregard of its truth or falsity and with the intent to deceive another and that is reasonably relied on by the other who is injured thereby.*

The legal elements of fraud, according to this definition, are:

- Misrepresentation of a material fact
- Knowledge of the falsity of the misrepresentation or ignorance of its truth
- Intent
- A victim acting on the misrepresentation
- Damage to the victim

Definitions of healthcare fraud contain similar elements. The CMS website, for example, defines fraud as the:

> *Intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).*

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is more specific, defining the term *federal health care offense* as "a violation of, or a criminal conspiracy to violate" specific provisions of the U.S. Code, "if the violation or conspiracy relates to a health care benefit program" 18 U.S.C. § 24(a).

The statute next defines a *health care benefit program* as "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract" 18 U.S.C. § 24(b).

Finally, *health care fraud* is defined as knowingly and willfully executing a scheme to defraud a healthcare benefit program or obtaining, "by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by . . . any health care benefit program" 18U.S.C. § 1347.

HIPAA establishes specific criminal sanctions for offenses against both private and public health insurance programs. These offenses are consistent with our earlier definitions of fraud in that they involve false statements, misrepresentations, or deliberate omissions that are critical to the determination of benefits payable and may obstruct fraud investigations.

Healthcare fraud differs from healthcare abuse. *Abuse* refers to:

- Incidents or practices that are not consistent with the standard of care (substandard care)
- Unnecessary costs to a program, caused either directly or indirectly
- Improper payment or payment for services that fail to meet professional standards
- Medically unnecessary services
- Substandard quality of care (e.g., in nursing homes)
- Failure to meet coverage requirements

Healthcare fraud, in comparison, typically takes one or more of these forms:

- False statements or claims
- Elaborate schemes

- Cover-up strategies
- Misrepresentations of value
- Misrepresentations of service

Healthcare Fraud in the United States

Healthcare fraud has grown and continues to grow at an accelerated rate in the United States. Traditional schemes include false claim submissions, care that lacks medical necessity, controlled substance abuse, upcoding (billing for more expensive procedures), employee-plan fraud, staged-accident rings, waiver of co-payments and deductibles, billing experimental treatments as nonexperimental ones, agent-broker fraud relationships, premium fraud, bad-faith claim payment activities, quackery, overutilization (rendering more services than are necessary), and kickbacks. Evolved schemes include complex rent-a-patient activities, 340 B program abuse activities (setting aside discounted drugs, making them unavailable to those in need), pill-mill schemes (schemes to falsely bill prescriptions), counterfeit drug activities, and organized criminal schemes.

Healthcare Fraud in International Markets

Healthcare fraud knows no boundaries. The U.S. Medicare and Medicaid programs are equivalent to many government-sponsored programs in other countries. Regardless of country, the existence and roles of players within the healthcare continuum are the same. All healthcare systems have patients, providers, TPAs (third party administrators) that process reimbursements to third parties, plan sponsors (usually government programs or private-pay activities), and support vendors.

Examples of international healthcare fraud are plentiful. In France, an executive director of a psychiatric nursing home took advantage of patients to obtain their property.[2] In 2004, a newspaper in South Africa reported that "A man who posed as a homeopathic doctor was this week sentenced to 38 years in jail—the stiffest term ever imposed by a South African court on a person caught stealing from medical aids." An Australian psychiatrist claimed more than $1 million by writing fake referrals of patients to himself; he also charged for the time spent having intimate relations with patients.

In Japan, as in the United States, there are examples of hospitals incarcerating patients, falsifying records, and inflating numbers of doctors and nurses in facilities for profit. A U.K. medical researcher misled his peers and the public by using his own urine sample for 12 research subjects.

Switzerland, known for its watches, had providers sanctioned for billing 30-hour days. All of these examples include patterns of behavior consistent with the definitions of healthcare fraud in the United States.

What Does Healthcare Fraud Look Like?

It is important to appreciate that healthcare is a dynamic and segmented market among parties that deliver or facilitate the delivery of health information, healthcare resources, and the financial transactions that move along all components. To fully appreciate what healthcare fraud looks like, it is important to understand traditional and nontraditional players. The patient is the individual who actually receives a healthcare service or product. The provider is an individual or entity that delivers or executes the healthcare service or product. The payer is the entity that processes the financial transaction. The payer may be the party that takes on risk or manages risk for a plan sponsor providing the covered services. The plan sponsor is the party that funds the transaction. Plan sponsors include private self-insurance programs, employer-based premium programs, and government programs such as Medicare and Medicaid. A vendor is any entity that provides a professional service or materials used in the delivery of patient care.

What does healthcare fraud look like from the patient's perspective? The patient may submit a false claim with no participation from any other party. The patient may exaggerate a workers' compensation claim or allege that an injury took place at work when in fact it occurred outside of work. The patient may participate in collusive fraudulent behavior with other parties. A second party may be a physician who fabricates a service for liability compensation. The patient may be involved in an established crime ring that involves extensive collusive behavior, such as staging an auto accident. The schemes repeat themselves as well as evolve in their creativity.

Sample Patient Fraud Case

At an insurance company, all payments of foreign claims are made to the insured patient instead of to foreign medical providers. An insured patient submitted fictitious foreign claims ($90,000) from a clinic in South America, indicating that the entire family was in a car accident. A fictitious police report accompanied the medical claims. A telephone call to the clinic revealed that the insured and the dependents were never treated in the clinic.

What does healthcare fraud look like from the provider's perspective? The fraud schemes can vary from simple false claims to complex financial arrangements. The traditional scheme of submitting false claims for services not rendered continues to be a problem. Manipulation of required "costs reports" for the Medicare program is a different type of behavior. Other activities, such as submitting duplicate claims or not acknowledging duplicate payments, are issues as well.

Some schemes demonstrate great complexity and sophistication in their understanding of payer systems. One example is the rent-a-patient scheme. The complexity of this scheme requires cooperating providers, both facility and professionals, cooperating employees and work peers, and inside employer and payer information. In this scheme the criminals pay "recruiters" to organize and recruit beneficiaries (employees who are insured) to visit clinics owned or operated by the criminals. For a fee, recruiters "rent," or "broker," the beneficiaries to the criminals. Recruiters in this type of scheme often enlist beneficiaries at low-income housing projects, retired employees, or employment settings of low-income wage earners.

Detection of schemes involving the coordination of participation of multiple nontraditional parties is complicated when we miss critical relationships with one or more party. Overall, detecting complicated misrepresentations that involve contractual arrangements with third parties or cost report manipulations submitted to government programs requires a niche expertise.

Sample Provider Employee Fraud Case

A woman who was affiliated with a medical facility had access to claim forms and medical records. She submitted doctor claims for heart surgery, gall bladder surgery, finger amputations, a hysterectomy, and more—27 surgeries in all. The intent was to cash in on the checks for the services. The high volume was an issue in of itself. The key anomaly was that if a patient has surgery, a corresponding hospital bill should have been submitted and it was not.

What does healthcare fraud look like from the payer's perspective? The published fraud schemes in this group tend to be noted mostly in response to transactions between the payer and a government plan sponsor. Civil litigation tends to be resolved in the context of nondisclosure agreements, so specific details of findings and resolutions are often not known. Those that are publically available tend to include misrepresentations of performance guarantees, not answering beneficiary questions on claims status,

bad-faith claim transactions, and financial transactions that are not contractually based. Other fraudulent activities include altering or reassigning the diagnosis or procedure codes submitted by the provider. Auditing payer activities requires a niche expertise in operational as well as contractual issues from a plan sponsor and provider perspective.

Sample Payer Fraud Case

A third-party administrator (TPA) processing claims on behalf of Medicare signed a corporate integrity agreement (CIA) with the Department of Justice (CIAs are discussed later in this book) in response to a number of allegations by providers that the TPA did the following eight acts:

1. Failed to process claims according to coverage determinations
2. Failed to process or pay physicians' or other healthcare claims in a timely fashion, or at all
3. Applied incorrect payments for appropriate claims submissions
4. Inaccurately reported claims processing data to the state, including a failure to meet self-reporting requirements and impose self-assessment penalties as required under the managed care contract with the state
5. Failed to provide coverage of home health services to qualified beneficiaries
6. Automatically changed current procedural terminology (CPT) codes (used to explain the procedure provided)
7. Did not recognize modifiers (modifiers are additional codes that providers submit to explain the service provided)
8. Did not reliably respond to appeals from patients, sometimes not responding at all or waiting over 6 to 12 months to do so

What does healthcare fraud look like from the employer's perspective? Schemes include underreporting the number of employees, employee classifications, and payroll information; failing to pay insurance premiums, which results in no coverage; creating infrastructures that make employees pay for coverage via payroll deductions; engaging in management activities that discourage employees from seeking medical treatment; and referring employees to a medical facility and in turn receiving compensation for the referrals.

Sample Employer Fraud Case

An employer who colludes with applicants to receive benefits illegally or who commits fraud to avoid taxes will be penalized at least $500, and may also be prosecuted. Collusion is knowingly helping applicants obtain benefits to which they are not entitled, for example, cash wages or other hidden compensation for services performed. In other words, the employer misrepresents the eligibility of the applicant so that he or she can receive benefits that he or she is not qualified for.

What does healthcare fraud look like from a vendor's perspective? This category has numerous examples that involve a range of participants, from professional healthcare subcontractors to suppliers of equipment, products, services, and pharmaceuticals. These schemes include false claims, claims for altered products, counterfeit medications, and unlicensed professionals. They include collusive behavior among several entities as well as between individual professionals.

Three Sample Vendor Fraud Cases

A third party medical billing company, Emergency Physician Billing Services, Inc. (EPBS), provided coding, billing, and collections services for emergency physician groups in over 100 emergency departments in as many as 33 states. Based on allegations presented by a *qui tam relator* (whistleblower reporting a fraud), the United States charged that EPBS and its principal owner, Dr. J. D. McKean, routinely billed federal and state healthcare programs for higher levels of treatment than were provided or supported by medical record documentation. EPBS was paid based on a percentage of revenues either billed or recovered, depending on the client.

In a second case, a supply vendor delivered adult diapers, which are not covered by Medicare, and improperly billed them as expensive prosthetic devices called "female external urinary collection devices."

In a third example of a vendor fraud case, an ambulance company billed ambulance rides for trips to the mall.