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HEALTH CARE FRAUD AND ABUSE

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Health care fraud is a national problem affecting everyone in the US, either directly or indirectly. It is also a growing criminal enterprise. In Fiscal Year 2012 alone, various government teams involved in the Health Care Fraud and Abuse ("HCFAC") Program recovered $4.2 billion dollars from individuals and companies who attempted to defraud federal health programs.[1] The $4.2 billion recovered was returned to the Medicare Trust Funds, the Treasury and others in 2012, a success largely achieved by a joint effort of the Departments of Justice and Health and Human Services ("HHS").

Also in Fiscal Year 2012:

- The Justice Department opened 1,131 new criminal health care fraud investigations involving 2,148 potential defendants;
- A total of 826 defendants were convicted of health care fraud-related crimes during the year;
- The department also opened 885 new civil investigations.[2] (An example: in May, the HCFAC strike force coordinated a takedown that involved 107 individuals in seven cities, including doctors and nurses, that included the highest number of false Medicare billings – about $452 million – in the program's history);
- Other strike force operations in these same cities resulted in 117 indictments, information and complaints involving charges against 278 defendants who allegedly billed Medicare more than $1.5 billion in fraudulent schemes;
- 251 guilty pleas and 13 jury trials were litigated, with guilty verdicts against 29 defendants. The average prison sentence was more than 48 months.

Health care fraud is carried out by many segments of the health care system, including companies or individuals, using various methods. Examples of some of the more prevalent schemes include[3]:

1. ***Billing for services not rendered –*** which can mean that no medical service of any kind was rendered, the service was not rendered as described in the claim for payment or the service was previously billed and the claim had been paid.
2. ***Upcoding of Services –*** when a health care provider submits a bill using a procedure code that results in a higher payment than the code for the service actually rendered. Example: 30-minute sessions being billed as 50-minute sessions.
3. ***Duplicate claims –*** one service is billed two times (i.e., by using two different service dates) in an attempt to be paid twice for one service.
4. ***Unbundling –*** when a provider separately bills services that are usually included in a single service fee.
5. ***Excessive Services –*** providing medical services or items which are in excess of the patient's actual needs. Example: daily medical office visits billed when monthly office visits are adequate.
6. ***Kickbacks –*** when a health care provider offers, solicits, pays or accepts money, or something of value, in exchange for the referral of a patient for health care services that may be paid for by Medicare or Medicaid. Example: a laboratory owner who pays a doctor $50 for each Medicare patient a doctor sends to the laboratory for testing. (Note: kickbacks do not have to be in cash – they can take other forms such as jewelry, paid vacations or other valuable items.

[1] See http://www.justice.gov/opa/pr/2013/February/13-ag-180.html
[2] Ibid.
[3] See FBI - Financial Crimes Report 2010-2011

For the health care provider or the insurer or the companies offering health care to their employees, detecting such schemes can involve various forensic accounting techniques. Among them are analyzing documents and facts, conducting comprehensive individual and group interviews and using data analysis technology in order to scrutinize data and identify transactions that indicate fraudulent activity or the heightened risk of fraud.

Where a potential fraudster may be billing for services not rendered, for example, the dates of service listed on the claim forms should be reviewed before determining if there is any supporting documentation in the patient's file showing that the patient was at a particular medical facility on those dates. If there isn't any supporting documentation, sign-in sheets and/or appointment books indicating that the patient was actually at the facility should be reviewed. Interviewing patients whose names are on suspected claim forms as well as employees and/or former employees of medical facilities can often help support claims of fraud. One way health care organizations detect fraud is when a whistleblower comes forward and/or through whistleblower hotlines. Data analysis techniques are also effective in detecting fraud, though very few health care organizations seek out fraud indicators through data analysis. Effective techniques include the following:

- Stratification of numbers – identifies excessively high or low amounts or excessively high billing by a single physician. Stratification can also help highlight "upcoding" of procedures by identifying outlying numbers;
- Duplicate testing – identifies duplicate transactions such as duplicate claims, payments, expense report items;
- Joining different data sets – identifies matching values, social security numbers, names and addresses where they shouldn't exist. Example: matching vendor names/addresses to payroll records for employees;
- Kickbacks – locate kickbacks paid in exchange for referring business.

Organizations can take a more proactive approach in identifying risk factors early on by bringing in a forensic accountant and by continuously monitoring transactions in order to identify fraudulent transactions using the approaches above and further reduce losses as a result of fraud.

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