HEALTH CARE FRAUD: A PRIMER ON THE SCHEMES AND THE TOOLS TO FIGHT HEALTH CARE FRAUD

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As the national debate over health care reform moves forward, one issue with which policy makers must grapple is the percentage of health care dollars lost to fraud and abuse. The General Accounting Office estimates that as much as ten percent of total health care dollars are lost to the inappropriate, and in some cases criminal, practices of health care providers. This article discusses the characteristics of the health care industry that make it particularly susceptible to abuse and then reviews the efforts by the Office of Inspector General, Department of Health and Human Services, to deter and punish those who defraud the federal health care programs.

The Vulnerability of the Health Care System to Fraud

To understand the evolution of health care fraud, it is important to consider the problem in the context of the dramatic increase in overall health care expenditures. In 1967, the United States expended $51 billion on health care. By 1991, that figure had grown to $738 billion and it is estimated that annual health care costs will reach $1 trillion by 1994. Nationally, health care expenditures per person increased from $247 in 1967 to over $2,500 in 1990. Perhaps more significantly, the number of Americans most likely to need health care continues to grow. There are over 32 million Americans who are 65 years of age or older; in 2050, there will be more than 70 million Americans in this age group.

Given the surge in health care expenditures, it is not surprising to find an increase in the number and complexity of schemes devised to steal from the health care system. Unfortunately, many of the characteristics of the health care industry make it particularly vulnerable to fraudulent schemes and abuses. For the successful perpetration of a fraud, for example, the victim must not realize he has been conned. The ambiguous nature of medical treatment, combined with patients who are often weak and vulnerable, presents a potent combination for a scam artist. Medically unnecessary tests, ineffective treatments, and useless equipment are easily foisted on individuals who want to believe that these items and services will make them feel better.

To further disarm the suspicious and skeptical, many frauds offer their medical services "free of charge" by routinely waiving the patient's insurance copayment and deductible obligations. Of course, the services are not free to the health insurance company or Government benefit program. The forgiveness of the patient's share of the cost of the medical treatment or product is intended to make the patient indifferent to the expense or necessity of the service and therefore less likely to complain about the scheme. The practice of waiving coinsurance is particularly prevalent in the scams involving non-invasive diagnostic tests, durable medical equipment, transportation services, and items or services that the patient might forego if required to participate in their payment.

In addition to an unwitting victim, health care frauds often take advantage of the deep trust that the patient places in his or her doctor. A physician is in a unique position to recommend medical treatments, diagnostic and ancillary services and equipment. The average patient has neither the knowledge nor inclination to question those recommendations. Exploiting this trust, industry practices may reward the doctor for referring patients inappropriately. The payoff can be as blatant as cash for each referral or more indirect, such as an inflated return on the doctor's investment in the scheme's joint venture. In either case, the fraud succeeds by overriding the physician's ethical and fiduciary duties to the patient.

A third facet of the health care industry which makes it susceptible to abuse is the complex and often inconsistent set of rules governing the coverage and reimbursement of medical services. Health care providers and consumers are confronted with an array of rules and restrictions that often appear arbitrary and ever chang-

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† For the purposes of this discussion, the term "fraud" encompasses the intentional deception or misrepresentation which the individual knows to be false, with the knowledge that the deception could result in some unauthorized benefit to himself or another person. The most frequent kind of fraud arises from a false statement or misrepresentation which is material to entitlement or payment under the insurance contract or a government health benefit program. The term "abuse" describes practices which, although not usually considered fraudulent, are inconsistent with sound medical, business or fiscal practices. The type of abuse to which health insurance programs are most vulnerable is overutilization of medical services. See Medicare Carriers Manual (HCFA Pub. 14) § 14006.
The Medicare program itself has 34 different carriers administering the Part B program, each with the authority to set its own coverage guidelines within broad parameters established by the Health Care Financing Administration. The Medicare Part A program, which provides hospital benefits, gives similar autonomy to its fiscal intermediaries.

As a result, those intent on abusing the system can hide behind the often plausible excuse of innocent confusion. Furthermore, virtually all health care providers now rely on billing departments to handle the volume of paper involved in operating a medical practice. As a consequence, the provider of services rarely prepares or submits the claim for payment. This in turn gives rise to the ever popular "blame the billing clerk" defense to the submission of a false or improper claim.

The Evolution of Health Care Fraud

While the health care industry contains elements that make it inherently vulnerable to fraud, the problem is compounded by the ever increasing sophistication of health fraud schemes. In the past, many scams operated by billing for nonrendered services, such as nonexistent office visits or medical equipment which was never provided to the patient. This type of fraud is typified by the recent prosecution of a Maryland physician who visited nursing homes, annotated charts of patients he did not treat, and billed Medicare and Medicaid, sometimes for as many 60 to 90 services a day. This type of case is relatively easy to investigate and prosecute, particularly where the claimed service leaves physical manifestations, involves supplying a tangible item or is so intrusive or painful that a patient would remember it.

Insurance companies and Government benefit programs have responded to frauds involving nonrendered services by notifying patients of payments made to providers on their behalf, establishing consumer complaint hotlines, and creating computer edits that screen aberrant claims. These safeguards work. In a recent California case, a psychiatrist was caught billing Medicaid for individual one hour therapy sessions when only group therapy was provided. Aware of the program's computer edit for excessive number of services, the psychiatrist only billed for nine individual sessions each day. He was caught when his personally-designed automated billing system submitted claims for February 30 and 31!

Although claims for nonrendered services continue to be submitted, fraud investigators report a shift toward misrepresenting the nature of the service provided and billing for medically unnecessary services. The practice of misrepresenting the nature of provided service encompasses both billing for a service which is not covered under the insurance policy, as well as billing for a more expensive service than actually provided. For example, a podiatrist may claim that he has treated a patient for a complex and compensable podiatric ailment when in fact he has merely trimmed toenails, a service not reimbursed by Medicare. Similarly, a pharmacist may bill for an expensive brand-name drug rather than the generic drug actually dispensed.

Unlike the "nonrendered service" frauds, these cases involve the provision of some treatment or item which the patient may not be able to distinguish from the treatment or item allegedly provided. Where the services are similar, medical records are ambiguous and the billing codes are imprecise, it can be difficult to prove that the provider intended to submit claims which misrepresent the services actually provided. A defense of innocent confusion (notwithstanding that the errors always favor the provider) is often best rebutted by the testimony of an insider, such as the billing clerk, who can outline the scheme and illustrate the provider's fraudulent intent.

The most difficult type of health care fraud to detect and prosecute is billing for unnecessary services. Unlike the previously discussed schemes, the provider accurately reports what service was provided but misrepresents the medical necessity of the procedure. This type of fraud may manifest itself in a number of different ways, including ordering excessive tests and making unnecessary referrals to other health care providers in which the referring physician has a financial interest. The inappropriate referral of patients for medically unnecessary and excessive services has been a source of particular concern for fraud investigators and health care policy makers.

In order to induce medically unnecessary referrals, some providers of ancillary services offer physicians lucrative investment opportunities which reward the doctor for referring patients to the provider. These investment opportunities, often disguised as joint ventures or other ownership interests, may result in the ordering of unnecessary and expensive services. There can be little dispute that a physician's financial interests can have an affect on his medical judgement. For that reason, the Medicare and Medicaid programs prohibit offering anything of value to influence a provider's decision to order reimbursable services. That prohibition, referred to as the anti-kickback statute, recently was augmented by further prohibitions against physi-
The common sense concern about improper influence over a physician's medical judgment is supported by empirical research. Since 1989, ten published professional studies have reported that doctor-affiliated clinical laboratories, diagnostic imaging and physical therapy facilities, and other ancillary service providers perform more procedures per patient and charge higher rates. A recent article in the New England Journal of Medicine confirms that physician ownership may result in inappropriate services as well as higher rates of referrals. That study compared the rate of negative test results from several expensive procedures, including MRI, between doctors who had an investment interest in the diagnostic center and doctors who had no such affiliation. Doctors who owned a part of a diagnostic center to which they referred their business had 36 percent more tests with negative results as compared to doctors who did not have an interest in the diagnostic center.

More alarming are recent reports that the patient's safety is being compromised because the doctor has put his financial interest before the welfare of his patient. Medicare investigators are uncovering schemes where patients are put in jeopardy by surgical procedures, including cataract operations and pacemaker implants, because the surgeon has received kickbacks. In a recent Florida case, a chiropractor was convicted of a mail fraud scheme in which he subjected many of his patients to 40 or more sets of x-rays in a 9 month period in order to justify his excessive use of physical therapy. In Indiana, a pacemaker distributor was sentenced to 6 years in prison for providing sporting event tickets and prostitutes to cardiologists who implanted used and expired pacemakers.

The difficulties in proving this type of fraud are twofold: First, the ambiguity inherent in medical decision-making makes it difficult to determine what is "medically necessary" treatment; and, second, in order to establish a criminal case, the Government must establish that the provider knew the services were unnecessary. As in other fraud schemes, the best proof of the provider's criminal intent comes from insiders. In the case of the Florida chiropractor, for example, former employees testified that the doctor established a strict protocol which required new x-rays every eight visits and patients who objected were told that Medicare required the x-rays before payment would be made for any therapy. This type of evidence is critical to rebut a defense that the doctor is merely practicing defensive medicine.

**The Tools to Combat Health Care Fraud**

The interest in combating the growth of fraud in the health care industry has increased substantially in the last several years. At present, no fewer than six federal agencies are devoting significant resources to investigating health care fraud. These agencies include the U.S. Postal Service, the Department of Defense, the Department of Justice, the Railroad Retirement Board and the Federal Bureau of Investigations. In addition, there are 41 State Medicaid Fraud Control Units, funded in part by the Department of Health and Human Services (HHS), that perform audits and criminal investigations of abuses of the Medicaid programs. The agency with the most experience in investigating health care fraud and abuse, however, is the Office of Inspector General (OIG) within HHS.

Established by Congress in 1976, the OIG is charged with protecting the integrity of HHS programs, as well as promoting their economy, efficiency and effectiveness. The OIG is comprised of three components - the Office of Audit Services, the Office of Evaluation and Inspections, and the Office of Investigations.

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and are intended to provide independent assessments of HHS programs and operations. For example, a recent OAS review of Medicare accounts receivable credit balances at hospitals revealed that hospitals nationwide owed the Medicare program approximately $266 million, of which only $66 million has been collected.

The Office of Evaluations and Inspections (OEI) conducts short-term management and program evaluations that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in these inspection reports provide up-to-date information on the efficiency, vulnerability and effectiveness of departmental programs. For example, OEI conducted a study to estimate the extent to which physicians are offered gifts and payments from

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**Although this article focuses on the role of the OIG in combating health care fraud, OIG's work covers all the operating division of HHS. For Fiscal Year (FY) 1992, the HHS budget reached $545 billion and covers programs as diverse as the Social Security program, the Medicare and Medicaid programs, the Public Health Service and the Administration on Children and Families. OIG devotes substantial resources to preserving the integrity and efficiency of these departmental programs.**

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pharmaceutical companies. Eighty-two percent of the surveyed physicians indicated that, on at least one occasion in 1990 pharmaceutical companies had offered gifts or payments to the physician. In addition, physicians who frequently issued prescriptions were more likely to receive such offers.

While both OAS and OEI are dedicated to preventing abuses of departmental programs and protecting the health and welfare of the beneficiaries of those programs, only the Office of Investigations (OI) conducts criminal, civil and administrative investigations of wrongdoing in HHS programs. The remainder of this article will examine OI's tools for investigation allegations of Departmental fraud and the use of its three enforcement remedies: (1) criminal prosecution, (2) civil prosecution, and (3) administrative sanctions.

Criminal Prosecutions

The OIG’s highest priority is the criminal prosecution of those who defraud the Department. Cases which merit criminal prosecution are presented to the Department of Justice (DOJ) and OIG Special Agents work closely with federal prosecutors to bring the investigation to a successful conclusion. Prosecutors use a wide array of criminal statutes, including the mail fraud and conspiracy laws, as well as Medicare-specific criminal provisions, to prosecute OIG's cases. As the OIG has developed expertise in prosecuting health care fraud, the number of successful criminal prosecutions has increased dramatically from 20 in 1982 to 168 in 1992. The types of cases prosecuted by the OIG are indicative of the range of fraudulent health care schemes.

- A Florida physician was convicted of conspiring to violate the Medicare anti-kickback statute. He signed certificates of medical necessity for various medical equipment supply companies for patients he neither examined nor treated. He was sentenced to 15 months incarceration, ordered to pay $65,000 restitution and fined $10,050.

- A Maryland physician was sentenced to 10 months in prison and ordered to pay $100,000 in restitution for billing Medicare and Medicaid for services to nursing home patients he did not treat.

- A national independent clinical laboratory pled guilty to submitting false claims and agreed to $110 million in restitution and fines. The laboratory had misled physicians into ordering medically unnecessary tests by manipulating its test order forms.

- The owner of a Florida durable medical equipment supply company was sentenced to 24 months incarceration for paying physicians to prescribe medically unnecessary equipment, including TENS units. Two of the doctors involved in the scheme also were prosecuted and sentenced to over 2 years imprisonment.

- A former senior vice president of the California Medicare Peer Organization was sentenced to prison for falsely reporting the completion of thousands of medical reviews of hospital records.

Civil and Administrative Sanctions

In addition to the criminal laws, the OIG has a broad range of sanction authorities with which to police the health care programs. These sanction authorities are enforced administratively, which has profound implications on the fight against health care fraud. Whereas the criminal process relies on a jury of citizens with a wide diversity of educational and personal experiences, the administrative trial is conducted by a HHS administrative law judge who is familiar with federal health care programs and many of the schemes perpetrated against them. The rules governing the admission of evidence are relaxed in an administrative hearing, so many of the facts which could not be admitted as evidence in a criminal trial may be presented to the administrative fact finder. Additionally, the Government must prove its case by a "preponderance of the evidence," a substantially lower burden of proof than the criminal standard of "beyond a reasonable doubt."

There are two general types of sanctions which may be imposed on an individual or entity that abuses the federal programs. First, HHS has broad authority, and in certain cases is mandated, to exclude problem providers from participation in the Medicare, Medicaid, Maternal and Child Health, and Social Services block grant programs. An exclusion from program participation is a powerful sanction because most health care providers in the United States participate to some degree, and often substantially, in the Medicare and Medicaid programs. Program exclusion means that no Medicare or Medicaid payment may be made for health care services ordered or furnished by the excluded individual or entity. Furthermore, patients may not be reimbursed by Medicare or Medicaid for the cost of the excluded provider’s services. An excluded provider who attempts to circumvent the exclusion is subject to a stiff monetary penalty.

Second, OIG is authorized to impose monetary penalties. In 1981, Congress enacted the Civil Monetary Pen-
alties Law (CMPL), which provides the Government with the means to impose monetary penalties, assessments, and program exclusion administratively. These sanctions may be imposed on any person or entity who is determined to have submitted or caused to be submitted a false or fraudulent claim "for a medical service that the person [knew] or [should have known] was not provided as claimed." The maximum penalty amount is $2,000 per item improperly claimed. An assessment of up to twice the amount improperly claimed is further authorized, along with exclusion from the programs.

A key feature of the CMPL is the broad knowledge standard: liability under the law exists not only where the person intentionally submitted an improper claim, but also where the person should have known of the impropriety. This "should have known" standard subsumes negligence and reckless disregard for the consequences of a person's acts. As a result, the time-worn defense of blaming the billing clerk will not save the dishonest provider from hefty penalties and exclusion from the Medicare and Medicaid programs.

As is the case with the administrative sanction process, health care providers charged with submitting false claims are entitled to due process rights, including an evidentiary hearing and an appeal process which included review by the United States Courts of Appeals. Many providers, however, elect to settle their cases prior to litigation.

In the last 10 years, the OIG has recouped millions of dollars through the CMPL authorities. In the last half of 1992 alone, over $28 million was recovered and returned to the U.S. Treasury and Medicare Trust Fund. Some examples of recent CMPL settlements and hearing decisions include:

- A new Jersey ophthalmologist agreed to pay $1 million to settle allegations of Medicare fraud. From 1985 through 1988, the doctor, who had previously practiced in New York, submitted about 2,500 claims to the New York carrier for patients he treated in New Jersey. He thereby obtained approximately $550,000 more than he was entitled to receive.

- The owner of two New York portable x-ray companies entered into an agreement to pay $543,000 in settlement of criminal and civil liabilities for claims submitted to Medicare. The claims in question were related to medically unnecessary x-rays performed on patients in some 56 nursing homes serviced by the companies.

- An Ohio Durable medical equipment supplier agreed to pay $1 million for charging Medicare for new seat lift chairs when it had furnished used and rebuilt ones.

Conclusion

The billions of dollars spent on health care every year will continue to attract the unscrupulous and those intent on manipulating the system to their advantage. Efforts to undertake national health care reform must include consideration of the potential abuses of the system by these individuals. The Office of Inspector General for the Department of Health and Human Services has been on the front lines of the fight against health care fraud and abuse. That experience should be an important component of any effort to improve and protect the nation's health care system.

References

2. 42 U.S.C. § 1320a-7b(b).
3. See, e.g.:
   - Medicare: Physicians who invest in imaging centers refer more patients for more costly services. GAO Preliminary Findings. April 1993.
7. 42 U.S.C. 1320a-7a(1)(A).