HEALTH CARE FRAUD: AN INTRODUCTION TO A MAJOR COST ISSUE

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Abstract

Fraud affects all businesses and industries, but when health care is viewed as a single industry including hospitals, physicians, insurers, pharmaceuticals, etc., fraud in this single industry assumes a monumental identity. Malcolm Sparrow of Harvard University affirmed that the order of magnitude of health care fraud is measured in the hundreds of billions, and provided a range of $100-$600 billion. While fraud is typically discussed in financial terms, some health care industry frauds have an element that is absent in most other industries, i.e., individuals' health and lives may be affected. This paper provides a definitional understanding of health care fraud, defines specific frauds, and categorizes health care frauds into four types; describes the unique nonfinancial consequences of health care fraud; and discusses efforts to mitigate health care fraud. Readers should benefit from

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greater awareness of health care fraud, that could be helpful in developing more effective fraud control processes.

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INTRODUCTION

Fraud is an issue that affects all types of businesses and industries, but when health care is viewed as a single industry including hospitals, physicians, insurers, pharmaceuticals, etc., fraud in this single industry assumes a monumental identity. Total health care costs in the United States exceed $2 trillion, or approximately one-sixth of US GDP (National Center for Health Statistics 2007). Goldberg and Lindquist (2005) estimated health care fraud to be greater than $100 billion. Joanne Silberner, on National Public Radio (August 18, 2009), reported that Malcolm Sparrow of Harvard University affirmed that the order of magnitude of health care fraud is measured in the hundreds of billions, and provided a range of $100 billion to $600 billion (Silberner 2009). The difficulty in determining the extent of fraud is due to the fact that much fraud is never detected, so estimates are very imprecise. These various estimates indicate that the health care industry is victimized by fraud at least as much as the average industry in the United States. Since the health care industry is such a large part of the U.S. economy, fraud in this sector is a serious concern.

While fraud is typically discussed in financial terms, some health care industry frauds have an element that is not present in frauds affecting most other industries, i.e., individuals' health and lives may be affected. Schweitzer, Ordomez, and Doumez (2004) demonstrated that money is not the only motivator for conducting a fraud. Career or job goals provided sufficient motivation to influence some goal oriented people or organizations to perform fraud in order to accomplish a personal goal such as research

notoriety. These frauds expose victims to risk of death or reduction of quality of life instead of, or in addition to, financial costs. These frauds are not easily identified or quantified, but can have extreme consequences. Nevertheless, they exact a very real and substantial cost on the health care system in terms of inefficiency, bad decisions, and undesired outcomes. Such frauds include research fraud such as falsification of research study results, medication substitution, counterfeit drugs and other health products, fake drugs and treatments, administrative corruption, discrimination in providing services, and illegal purchase and sale of transplant organs, e.g., kidneys (Goldberg and Lindquist 2005). However, some actions that have a negative impact on the system, by definition, are not willful schemes to criminally defraud, but instead occur inadvertently, without malice, or intent to defraud. Examples include lack of understanding of coding rules, incomplete training on ethics, and other non-intentional reasons that still contribute to the total cost of health care abuse.

The purposes of this paper are to: (1) provide a definitional understanding of health care fraud, define specific frauds, and categorize health care frauds into four types; (2) provide a brief assessment of the risk of each of the four types of health care fraud; (3) describe the nonfinancial health consequences that make health care fraud unique; and (4) discuss efforts to mitigate health care fraud. Readers should benefit from greater awareness of health care fraud. This increased awareness can be useful in developing more thorough and effective fraud control processes.

SPECIFICS OF HEALTH CARE FRAUD

Shortell and Kaluzney (1997) identified a number of elements that differentiate the health care industry from most other industries. Ginter and Duncan (2000) described additional characteristics that distinguish the heath care industry from other industries from a strategic management perspective. Many of these structural elements also contribute to providing unique

opportunities to conduct fraud. These elements that serve to provide opportunities for fraud in health care include the difficulty of measuring performance output, the variable and complex nature of the work, little tolerance for ambiguity or error, the highly specialized nature of health services, management's lack of control over the individuals doing the work, and third party reimbursement. To this list we add the "win-at-all-costs" mentality with respect to health care that is imbedded in United States culture. The emotional context and the resulting financial irrationality concerning crisis-type health care situational decision making also contribute to the uniqueness of health care. The "win-at-all-costs" mentality and emotional context that we refer to here are demonstrated repeatedly by the extraordinary measures that are undertaken to save a life without considering the consequences of possible outcomes. For example, extraordinary emergency medical care may bring a heart attack or stroke victim back to life, leaving the person confined to a nursing home without the ability to communicate or care for themselves. We are not suggesting that such medical care should, or should not, be performed. Our only point is that the possible outcomes are not considered when making the decision to take such measures.

Definition of Health Care Fraud

The Association of Certified Fraud Examiners (ACFE) defines fraud as having the following components: 1) a material false statement; 2) knowledge that the statement was false when made; 3) reliance on the false statement by a victim; and 4) damages resulting from the victim's reliance on the false statement (Ratley 2006). The question of "intent" is the central issue in determining if the inappropriate act was indeed "fraud," or instead a simple mistake or act of ignorance. If the act is characterized as a willful intent to deceive and profit from the deception, it can be prosecuted as fraud. While the insurers, e.g., Medicare, Medicaid, and private insurers, are the direct financial victims of health care

fraud, the costs flow to the U.S. taxpayers and health care consumers.

Health Care Fraud Schemes by Category

Health care fraud schemes are as varied as people's imaginations. To aid in understanding of the fraud concerns, health care frauds have been categorized into four types below. Also see TABLE 1.

Provider Frauds -- The frauds described in this category have the common element of being committed by the provider, or bogus provider, against the third-party payer such as Medicare, private insurers, and health care research funding organizations, e.g., government and private foundations. Most provider frauds can be collectively called "False Claim Schemes" for which recovery can be pursued under the Federal False Claims Act. False claim schemes include any billing of health insurers for services or procedures that were not performed or were unnecessary and done with the intent of inappropriately receiving financial gain. The most blatant is billing for services that were not performed. More subtle fraudulent billing schemes include:

(1) unbundling claims – splitting procedures normally covered by a single fee into piece parts and separately billing for each;
(2) double-billing – billing multiple times for the same service;
(3) upcoding or miscoding – charging for a more expensive service than was actually performed; and,
(4) kickbacks – payments for referrals are the most common forms of kickbacks. Indirect kickbacks involve overpaying for services or undercharging physicians for services or products provided to encourage more referrals (NHCAA 2008b).

Each of these types of fraud could be simple mistakes by uninformed individuals. The characteristic that makes them fraud is systematic intent to maliciously derive inappropriate financial gain (Ratley 2006).

More complex, but less common, false claim fraud schemes include the following:

(1) Excessive testing by chiropractors – repetitive unnecessary testing performed to "follow progress" of certain procedures performed by chiropractors.
(2) Maintenance care ("adjustments") by chiropractors on symptom-free patients
(3) Personal injury mills – attorneys and health care providers conspire to bill insurance companies for non-existent or minor injuries. The providers create false diagnoses and bill for unnecessary services. The attorneys then attempt to negotiate "settlements" for injuries based on the fraudulent claims. The patient may be participating without knowledge of the fraud, or may receive payments for participating.
(4) Billing for fraudulent or unproven treatments ("Quackery-related miscoding") – billing for "chemotherapy" for fraudulent cancer remedies.
(5) Viatical fraud – viatical settlement companies pay a partial advance settlement on life insurance contracts to terminally ill people in exchange for the right to collect in full once the patient dies. Fraud can be perpetrated in multiple ways. Fraudulent agents may sell multiple life insurance policies to a single terminally ill person. The agent then has a healthy person take the initial qualifying medical exam. The fraudulent viatical settlement company then purchases the life insurance policies and re-sells them to unsuspecting third parties.
(6) Bogus health insurance companies – illegitimate companies claiming to be health care insurers sell coverage to employers and individuals, but never pay any claims. Both

the "covered" individuals who pay the premiums and the care providers that are unable to receive reimbursement for services are hurt in these scams (Barrett 2008).

(7) Nutrigenetic testing scams – the discoveries of genetic influences on risks for diseases has created Internet and retail genetic tests sold directly to consumers. These companies then market diet and exercise programs, and sell at excessive prices, vitamin supplement programs that could be purchased at a fraction of the cost at the local grocery store (United States Government Accountability Office, 2006).

Quality Data Reporting Fraud -- Quality data reporting fraud is an emerging area of concern. The Office of Inspector General of the US Department of Health and Human Services stated

> ". . . (t)he accuracy of the data submitted to government agencies and third party payers is vital. In addition to relying on such information for monitoring quality and patient safety issues, the federal health care programs increasingly use this data for determining reimbursement, . . . Consequently, inaccurate reporting of quality data could result in misrepresentation of the status of patients and residents, the submission of false claims, and potential enforcement action" (Corporate Responsibility and Health Care Quality, 2007, p. 7).

Fraud can be committed by either the provisioning of medically unnecessary services or for failure of care. When medically unnecessary services are performed, the patient is subjected to unnecessary health risks and payers are billed for unnecessary costs. In the case of "failure of care," the provider is deemed to have defrauded the patient by the poor care, and has

defrauded the insurer or the government by billing for services that were not provided. These events are revealed through "the hospital quality data for the annual payment updates, physician quality-reporting data to CMS (Centers for Medicare and Medicaid Services), medical error and 'sentinel event' data reported to the Joint Commission, and quality reporting required under state law" (Corporate Responsibility and Health Care Quality, 2007, p.7). This type of fraud has a financial element in that the provider committing the fraudulent reporting has an indirect financial interest that provides motivation. The provider may be attempting to avoid fines or penalties, or may be avoiding closure of a facility. But this type of fraud is of greater concern because of the potential negative impacts on a patient's health.

The following types of fraud combine elements of provider and data reporting fraud:

(1) Research fraud, falsified drug testing results, and falsified clinical trial results
(2) Unlicensed/uncertified care facilities and unlicensed physicians provide appropriate services and bill appropriately even though they have not been properly licensed or certified. This is not as common as billing for fictitious services, and is more likely to be detected through quality regulators, e.g., Health and Human Services, than via payers such as Medicare.

Consumer Fraud -- In addition to fraud committed by health care providers, individuals commit frauds against providers and insurers that are generally smaller in dollar magnitude than billing or quality frauds. Consumer frauds consist of using fraudulent means to obtain health care services for which a person is not eligible. Some examples include: 1) misrepresenting dependent eligibility for insurance coverage; 2) altering prescriptions to obtain a larger number of pain relievers or other controlled substance than prescribed; and, 3) use of a stolen or fraudulent insurance card to obtain health services.

General Business Fraud -- Hospitals and physicians also must be aware of the same non-health related frauds that plague all business – frauds perpetrated against them by their employees or suppliers/contractors. Health care providers are subject to the same type of frauds perpetrated against any other business. Examples include theft of cash copayments, check kiting, phantom employees in the payroll system, false billings from suppliers for incorrect quantities, multiple billings for the same delivery, and billing from shell company suppliers, to name a few.

BASIC ISSUES CONTRIBUTING TO FRAUD

The ACFE illustrates why fraud occurs using the three corners of their "Fraud Triangle" to represent the three elements that must exist for a fraud to be executed: 1) "Opportunity" to commit a fraud; 2) "Motivation," defined as an unsharable financial need whether real (financial distress), or perceived (greed); and 3) "Rationalization" – finding a way to justify the fraud, such as "they aren't paying enough, so I deserve it." All frauds contain these three elements whether they are health care frauds or some other industry. The multiple-payer system currently operating in the United States provides opportunities that are only limited by the creativity of fraudsters (Singleton et al. 2006). Likewise, motivations are as varied as the number of providers and health care patients. The uniqueness of life and death motivations in health care fraud has been previously discussed in this paper. Rationalizations from the perspective of providers are similar to rationalizations that emerge in any industry, but the life and death aspects of health care provides a unique rationalization, as well as a unique motivation. Health is paramount, so treatment to preserve life, in the most extreme circumstances, should be available at all costs. A fraud perceived to be necessary to preserve someone's life is easily justified in the minds of many people consistent with the win-at-all-costs mentality of our culture. The

extreme emotional aspects of a life-or-death situation can create an additional element to be considered in some cases involving health care. Someone needing a transplant for a family member may resort to extreme actions such as misrepresenting the relative as a covered dependent, altering medical records to elevate the patient's priority, or using a false or stolen insurance card. Again, the list of possibilities is only limited by imaginations and situations that are unique to life-or-death decisions that are only faced in the health care arena.

The term "false statements" in the above ACFE definition of fraud include false claims that are filed for reimbursement. Such billing frauds may potentially be performed by any physician, medical group, hospital, billing company, etc., that has the capability of billing and receiving payment from Medicare or an insurer. "False statements" also include false information placed in a patient's medical record. The damage caused from falsifying medical records is not limited to the excessive reimbursements received by the provider from the payers, but may also negatively affect the patient. Such acts can affect the patient's ability to obtain services in the future by needlessly accumulating costs that apply against his/her lifetime insurance maximum. In addition, erroneous medical records could cause the patient to receive improper medical care in the future, or cause the victim to fail a physical exam to obtain employment (NHCAA 2008a)(NHCAA, 2008b).

The health care industry may provide greater opportunities to perpetrate undetected fraud in health care than other industries. With insurance companies or government agencies paying for services provided to patients by independent physicians and hospitals, the recipient of the services is disconnected from the billing and payment process. Typically, the provider directly bills the insurer and receives payment without the recipient of the services approving the payment. As convenience has driven the popularity of the direct payment process, the control of the patient's participation in billing and payment (indemnity payment

method) has been circumvented. An opportunity for fraudulent billing and payment is created by the absence of this control step.

James W. Skeen explained the evolution of this discontinuous system. He argued that health care fraud is so large because "(t)he system is out of balance because of past policies and decisions that have given excessive power and liberty to the medical services community and insurance providers" (Skeen 2003). He asserted that health care fraud is "systematic" and "normal" due to the "lack of deterrence in the health care system." He argued that the American Medical Association's (AMA) lobbying was able to force Congress to minimize control measures in Medicare and Medicaid in order to be able to garner sufficient political support of these programs. The AMA opposed control measures because they were extremely concerned about physicians losing their autonomy and control over increasing their income. Skeen (2003) cites the Government Accountability Office (GAO) as reporting that "the whole system of billing and payment accounts for numerous vulnerabilities" (p. 521) arising from the complexity and disaggregation of the system. He concluded that "(w) hen computer searches are done to spot unusual billing practices only the most notable cases are investigated further." (p. 521) Skeen also examined the industry from a political philosophy perspective and made a compelling case that extreme liberty enjoyed by the insurance companies and the medical establishment has caused the system to be out-of-balance stating "(t)he enormous financial losses suffered by the public from health care fraud and abuse is a consequence of the excessive liberty and power held by the health care community" (p. 527).

EXISTING EFFORTS TO MITIGATE HEALTH CARE FRAUD AND ANTI-FRAUD PROGRAMS

Several effective fraud mitigation efforts have already been implemented. For example, in the 1990s, the federal government implemented two significant programs to mitigate fraud in

Medicare. The Omnibus Consolidation Appropriation Act of 1997 authorized a community voluntary anti-fraud program to organize thousands of retired accountants, health professionals and others to help Medicare beneficiaries identify and report Medicare fraud. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) funded a similar program to train Medicare agency employees to identify and report fraud. HIPAA established health care fraud as a federal crime, and adopted very stiff penalties including both prison time and large financial penalties. The National Health Care Anti-Fraud Association, through its web site www.nhcaa.org, provides links to a number of recommended computer analysis programs designed to detect health care fraud and abuse, and to provide investigation management tools for recovering overpayments and prosecuting perpetrators of fraud

(National Health Care Anti-Fraud Association, accessed November, 2008).

Whistle-blower payments – qui tam actions under the Federal False Claims Act – involve an insider reporting fraud incidents in exchange for a percentage of the recovery. Not only is the fraudster exposed and prosecuted, but the funds are recovered. This program is proving to be successful in discovering and recovering significant amounts, e.g., $9.3 billion with 40% from pharmaceutical companies (Kesselheim and Studdert 2008).

Greater publicity for the prosecution and resulting consequences could help. Fraud experts cite the risk of being caught and prosecuted as a primary deterrent and whistle-blower tips as the number one way fraud is discovered. Risk of getting caught is a great deterrent to fraud. In their NBER (National Bureau of Economic Research) Working Paper titled "Detecting Medicare Abuse," Drs. David Becker, Daniel Kessler, and Mark McClellan (2004) concluded that increased anti-fraud enforcement action is effective in reducing health care fraud and abuse.

Health Policies Designed to Reduce the Cost of Fraud

No control system can be built that will totally prevent all fraud in health care. However, measures can be taken to mitigate the cost of fraudulent activity. Perceived risk of being caught is a great deterrent to fraud. Encouraging tips by consumers and others, and establishing fraud hotlines raise the perceived and actual risk of getting caught. More frauds are discovered by tips than by any other means. The ACFE reported that, in 2005, more than 40 percent of frauds greater than $1 million were discovered by tips. Fraud hotlines are one of the cheapest and easiest measures to implement. Each organization should have some form of a fraud tip hotline. Each organization can establish its own hotline, or the GAO's FraudNET contact information could be provided for "allegations of fraud, waste, abuse, or mismanagement of federal funds," i.e., Medicare and Medicaid (GAO)(United States Government Accountability Office, accessed November 2008). Tips and audits reduce the opportunity component of the fraud triangle. Each anti-fraud technique adds an element of difficulty to completing a successful fraud. The opportunity component can be influenced by management processes more so than motivation and rationalization.

Much of the fraud activity described above could be lessened by ethics and fraud education. The ACFE reports that the median fraud in companies that have an ethics training program is about 50% of the median level of fraud in companies without an ethics training program. "The goal of such training is to make staff aware of how fraud is committed and to emphasize the importance of being watchful and reporting fraudulent conduct when it is observed or suspected" (Ratley 2006). Physicians and their staffs may not understand that unbundling claims and upcoding could be considered fraud. If they really have no knowledge or intent to defraud, they will probably not be prosecuted. But many who do this type of activity readily accept advice on ways to increase income without realizing it is fraud. Increased fraud education in medical schools and health administration could provide

significant benefits. Simply eliminating some of the unintentional fraud could reduce the magnitude of effort necessary to control fraud. Checks and balances can be built into internal control systems, but the costs may be significant. The fragmentation of the reimbursement process makes understanding the various systems a difficult undertaking. Not only in health care, but in most industries, employees do not have a widespread understanding of the definition of fraud, how to watch for signs of fraud, or the need to publicize and prosecute fraudsters. Physicians have little or no training in identifying billing fraud. Many do not understand that upcoding, or other activities, are considered fraud that is prosecutable.

Potential Impacts of Health Reform

Much progress has been made in combating health care fraud, but this type of fraud continues to be a significant issue. What else can be done? Two independent processes that can be pursued to mitigate health care fraud are suggested in this paper. First is ethics and fraud education. Second is standardization of coding for medical records and billing. Both of these could be implemented through Medicare rulemaking and/or national health care reform. Since national health care is a topic of serious policy discussion, these processes should be included in any plan ultimately adopted.

Education addresses the "rationalization" element of the Fraud Triangle. Fraudsters devise rationalizations that make the fraud seem justifiable in their circumstances. Ignorance allows many rationalizations to emerge and seem acceptable. Knowledge that an action is indeed fraudulent, and will result in penalties and punishment, if discovered, is a strong deterrent. Education can be accomplished by designing ethics courses specifically for the health care community. Ethics courses could be required in medical schools to instill in physicians an understanding of what is and what isn't fraud. Physicians do receive an ethics education in providing health services as outlined in the Hippocratic Oath. This

Oath outlines the physicians' responsibilities from a medical standpoint, but does not address financial issues. Similar education for other health care professionals, including nurses and health administrators, could be modeled on the same platform. Ethics training does not need to be limited to the medical staff and the management team. Everyone in a hospital or practice should have the benefit of at least a minimal exposure to ethics training. Every organization should have a detailed policy that will provide enough of an understanding of the ethical issues that could be faced in that organization and the proper response to those issues. This should be part of the basic, and ongoing, new employee training similar to non-health care entities.

The second step would be to develop and require a standardized coding system to enable more cost effective and efficient use of Computer Aided Auditing Techniques (CAATs). This step would provide greater deterrence to fraud that reduces the "opportunity" to commit fraud. Health care fraud detection and management could greatly benefit from a comprehensive and cohesive suite of computer assisted auditing tools (Li et al. 2008). While these tools exist today and are employed by Medicare and many insurance companies, a consistent coding system required for all providers and payers would greatly enable more sophisticated CAATs to combat health care fraud. Commonality would make implementation of a comprehensive CAAT program a possibility. Standardized coding would enable computerized anti-fraud technology for health care very similarly to the way that computer coding standards have enabled the communication between computers. The standards are critical to interactivity of computers and have enabled further sophistication of e-mail and data transport. Similarly, a comprehensive ubiquitous coding system would enable further development of technological tools. Jing Li, et al in their 2008 article in Health Care Management Science "A survey on statistical methods for health care fraud detection," indicated that . . .

> ". . . more sophisticated antifraud systems incorporating a wide array of statistical methods are needed and are being developed for effective fraud detection. The major advantages of these systems include: (1) automatic learning of fraud patterns from data; (2) specification of 'fraud likelihood' for each case, so that efforts for investigating suspicious cases can be prioritized; and (3) identification of new types of fraud which were not previously documented" (p. 275).

The development of these sophisticated systems would be easier and faster with standardized codes.

Health care reform could potentially increase fraud prevention measures in the federal law. Sec. 1173A of H.R. 3962 ("Affordable Health Care for Americans Act" as of November 16, 2009) contains provisions for standardizing electronic administrative transactions. Sec. 1174 provides for "Strengthening Audit Authority." Sec. 1421 provides for civil financial penalties to be assessed on nursing homes that provide inadequate or substandard care. In addition, multiple anti-fraud provisions are concentrated in Title VI – Program Integrity (Sec. 1601 – 1654) of the proposed legislation that provide for increased penalties for fraudulent acts. Title VII – Medicaid and Chip also contains antifraud rules in Sec. 1751 – 1761. In particular, Sec. 1761 requires state Medicaid programs to use the national coding standards proposed earlier in the bill.

CONCLUSION

Like other industries, fraud in health care results in increasing overall costs for the industry. Estimates of the cost of the health care fraud range from 5% to 10% of total health care costs. Consequently, fraud is a serious contributor to the rising cost of health care. The element of the health and lives of members of society provides additional opportunities and

rationalizations for committing fraud that are not present with other types of fraud. Many anti-fraud processes are active in the Department of Health and Human Services (HHS), Medicare, and private insurance companies. While we cannot realistically expect to completely eliminate fraud, improvements to existing processes can be made. Policy changes that can be implemented to aid the battle against fraud include comprehensive ethics and fraud education as part of higher education curriculums, and developing a standardized coding system for billing and medical records to enable comprehensive computer aided auditing techniques by the payers and regulators.

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TABLE 1

CATEGORIES OF HEALTH CARE FRAUD

- **Health Care Provider Fraud**
  - **Billing schemes**
    - **Double-billing**
    - **Upcoding**
    - **Unbundling**
    - **Kickbacks**
    - **Fraudulent billing re: identity theft**
  - **Viatical fraud**
  - **Fraudulent services**
    - **Excessive testing**
    - **"Maintenance Care"**
  - **Bogus insurance companies**
  - **Nutrigenetic testing scams**
- **Health Care Consumer Fraud**
  - **Misreporting dependent status**
  - **Forging or altering prescriptions**
  - **Using stolen or fraudulent insurance card to obtain services**
- **Quality Data Reporting Fraud**
  - **Medically unnecessary services**
  - **Failure of care**
  - **Physician quality-reporting data to CMS**
  - **Medical error and sentinel event data reported to the Joint Commission**
  - **Research and drug test results**
- **Standard Business Fraud**
  - **Phantom employees**
  - **Misreporting reimbursable expenses**
  - **False vendors and/or invoices**
  - **Check "kiting"**
  - **Misappropriation of assets**