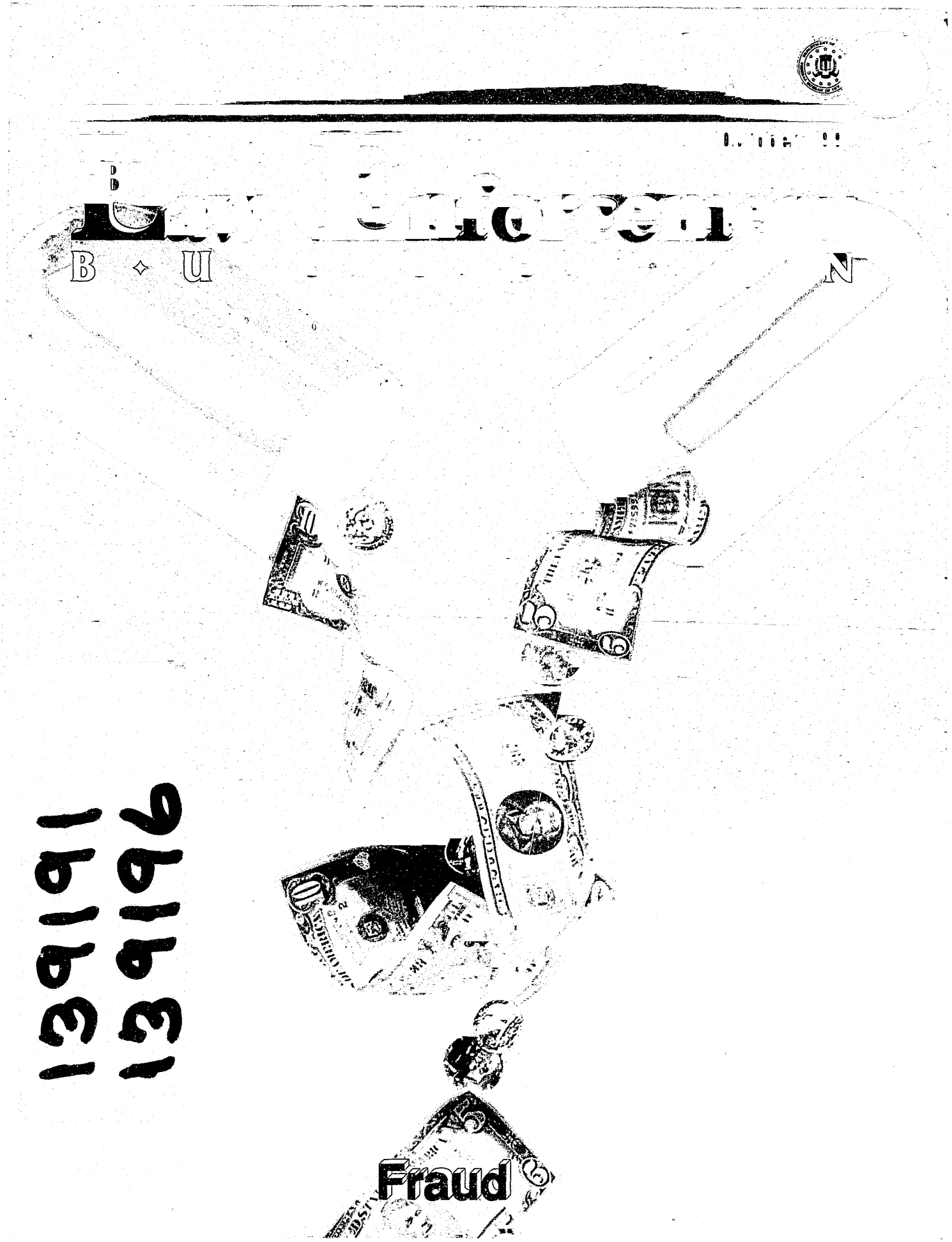


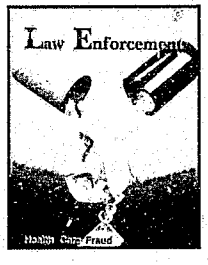
FBI Law Enforcement
B ◇ U ◇ L ◇ L ◇ E ◇ T ◇ I ◇ N

October 1992
Volume 61
Number 10

Features

Focus on Health Care Fraud

Departments



Cover: Health care fraud directly challenges law enforcement. This issue focuses on law enforcement's concerted efforts to strategically address this crime problem. (Cover photo © 1992, M. Simpson, FPG International Corp.)

United States Department of Justice
Federal Bureau of Investigation
Washington, DC 20535

William S. Sessions, Director

Editor—Dr. Stephen D. Gladis
Managing Editor—Kathryn E. Sulewski
Art Director—John E. Ott
Assistant Editor—Karen F. McCarron
Production Manager—Andrew DiRosa
Assistant Art Director—Amelia J. Brooks
Staff Assistant—Darlene J. Butler

The *FBI Law Enforcement Bulletin* (ISSN-0014-5688) is published monthly by the Federal Bureau of Investigation, 10th and Pennsylvania Avenue, N.W., Washington, D.C. 20535. Second-Class postage paid at Washington, D.C., and additional mailing offices. Postmaster: Send address changes to *FBI Law Enforcement Bulletin*, Federal Bureau of Investigation, Washington, D.C. 20535.

ISSN 0014-5688 USPS 383-310

139191

Health Care Fraud
The Silent Bandit

By
JOSEPH L. FORD

Each second, Americans spend approximately $24,000 on health care,[1] making it the second largest industry in the United States, next to education.[2] In the time that it takes to read this article, Americans will spend an additional $12 million on health care. And these figures will continue to skyrocket.

The U.S. Chamber of Commerce estimates that by 1994, spending on health care will reach $1 trillion, and this amount will probably double again by the turn of the century.[3] In 1982, by contrast, expenditures on health care totaled just $280 billion.[4]

Unfortunately, this dramatic increase has been fueled, in part, by growing levels of fraud in the health care industry. While the vast majority of health care practitioners provide competent, equitable services, those who commit fraud cost this Nation significantly. While estimates vary, as much as 10 cents of every dollar spent on health care may be lost to fraud and abuses in the industry.[5]

To a large degree, this occurs because Americans tend to place their trust in health care professionals. People expect good health care and do not mind paying for services that will make them well. To them, cost does not matter when it comes to proper medical treatment for troubling health problems. At the same time, they assume that they will be billed correctly for the treatment received and will not be subjected to unnecessary treatments, tests, or drugs. Unfortunately, this is not always the case.

IDENTIFYING FRAUD

Investigators must remember that fraud affects every level of the health care system—from a doctor who charges exorbitant fees and authorizes unnecessary tests, to a hospital or nursing home that overbills Medicare, to a pharmacist dispensing generic drugs at brand name prices. In addition, another major component of the system easily defrauded by unethical providers includes durable medical equipment (DME) suppliers, who may conspire with other segments of the

health care system to commit a host of fraudulent activities.

Unfortunately, though, not all cases of fraud can be clearly defined. Because malpractice suits can destroy entire careers, the actions of many health care providers are governed by the need to protect themselves from liability. These practitioners believe it is better to perform a battery of tests and authorize extensive treatments rather than find themselves involved in a malpractice suit resulting in a multimillion-dollar settlement. While such cases may border on fraud, they can be considered more accurately as simple abuse of the system.

Fraud, on the other hand, encompasses clear and distinct activities by practitioners and businesspersons in the health care field to make money illegally, primarily by bilking patients, private insurers, or the Federal Government. For the most part, the audit systems established by the various Federal and State regulatory agencies do not detect this type of criminal activity. Law enforcement, then, must take action.

THE ROLE OF LAW ENFORCEMENT

Federal, State, and local law enforcement all must play a role in combating health care fraud. Jurisdiction, investigative expertise, and Federal and State laws govern the levels of involvement of the various agencies. However, success in curtailing the activities of fraudulent health care providers depends on closely coordinated efforts of the entire criminal justice community. No one agency can solve the problem of health care fraud independently; Federal agencies must work with those on the State and local levels to stem the tide of this devastating crime.

Federal Agencies

Several Federal agencies devote extensive resources and a vast number of workhours to health care fraud investigations. These include the Drug Enforcement Administration (DEA), the Food and Drug Administration (FDA), the U.S. Postal Service, the Department of Health and Human Services (DHHS), the U.S. Department of Labor, the Office of Personnel Management, and the Defense Criminal Investigative Service (DCIS). Each agency handles specific areas of health care fraud according to its jurisdictional and legislative mandates.

Health care fraud is also a top investigative priority within the FBI's White-Collar Crimes Program. As a combative measure, the FBI developed a national strategy to investigate incidents of health care fraud.

Because each of these agencies has well-defined investigative responsibilities, they can combine their specific resources to provide a comprehensive effort:

- Diversion units of the DEA monitor and investigate the diversion, misuse, and abuse of pharmaceutically controlled narcotic substances
- The FDA regulates the prescription drug market of noncontrolled prescription medications
- Postal Service investigators become involved in health care cases through jurisdictional mandates authorizing them to investigate fraud committed through the U.S. mail. Since the majority of claims filed by health care providers (as well as subsequent payments) flow through the mail, the investigative resources of the Postal Service can be invaluable in fraud investigations
- The Inspector General's Office of Health and Human Services audits and investigates health care providers accused of fraud against federally sponsored

> ***"While estimates vary, as much as 10 cents of every dollar spent on health care may be lost to fraud and abuses in the industry."***

Special Agent Ford serves in the White-Collar Crimes Section of the FBI's Criminal Investigative Division in Washington, D.C.

programs, primarily Medicare and Medicaid

- The Inspector General's Office of the Department of Labor handles cases involving workmen's compensation claims or fraud in health plans administered by labor unions
- The Office of Personnel Management becomes involved when fraud is suspected in Federal employee health plans. Almost every Federal worker is enrolled in one of a number of health insurance plans, to which the Federal Government contributes billions of dollars annually. Fraud can be committed against Federal health plans as well as private ones
- The Defense Criminal Investigative Service seeks to ensure the integrity of all Department of Defense programs, including the military health care system. In 1991, the cost of medical care to military personnel, both active and retired (and their dependents), reached approximately $13 billion.

The FBI's National Strategy

Although the FBI began investigating incidents of health care fraud in the 1970s, the vast majority of these cases targeted single providers. During the past several years, however, the FBI developed a more comprehensive national strategy against health care fraud and redirected its efforts and resources in this area.

Health care frauds have evolved from single offenders operating in one State to multiple offenders operating throughout several States. The FBI has focused its investigations on these loosely knit, complex conspiracies. In many cases, groups of individuals operate fraud schemes in several different States at the same time. Once detected, these offenders simply move on to other locations within the country to conduct their illegal practices. As a result, the FBI now looks at local problems on a national level and coordinates its investigations accordingly.

> ***"Health care frauds have evolved from single offenders operating in one State to multiple offenders operating throughout several States."***

Simply stated, the FBI's national strategy takes a holistic rather than parochial view of health care fraud. This perspective is essential because the crimes committed against private insurers and Government-sponsored programs often cross State lines. Single defendant prosecutions have given way to multidefendant conspiracy indictments.

Moreover, rather than reacting to isolated allegations, the FBI's current initiative includes deploying unique and sophisticated proactive investigative techniques. Gathering evidence through extensive financial record reviews has given way to the use of undercover operations, electronic surveillance, cooperating witnesses, and consensual monitoring.

In the early 1980s, many prosecutions were lost because of such defenses as "the Government rules were too complicated" or "the bookkeepers didn't know what they were doing." Now, undercover operations and consensual monitoring provide direct evidence of providers' criminal intent.

Within this framework, the FBI established a national intelligence base and trained investigative personnel to handle these types of cases. In addition, white-collar crime squads in seven FBI field offices—Baltimore, Chicago, Detroit, Los Angeles, Miami, New York, and Philadelphia—now focus exclusively on health care fraud cases.

State Regulatory and Law Enforcement Agencies

The current system places most responsibility for regulating the health care industry with the States. For this reason, investigators at all levels should consider working closely with certification boards and other State regulatory entities when developing cases.

Regulatory agencies house important records and can provide relevant information to investigators. State boards can verify whether a suspected offender possesses a license to practice or whether criminal charges have been brought against a suspect in another part of the State.

The decision to bring regulators into a case rests with the investigating agency, but this step cannot be overlooked. Only State licensing

boards have the authority to suspend or revoke the licenses of health care providers to prevent them from operating in that State. And since every State sets its own regulations on license suspension and revocation, it is important to contact these boards at some point in the investigation.

However, State involvement in health care extends beyond regulation to include investigative and statutory responsibilities. State Bureaus of Investigations, State Police, and other State-level law enforcement agencies are generally quite familiar with health care fraud investigations and can provide valuable assistance to local departments developing their own investigative initiatives. Forty-two States operate special Medicaid Fraud Control Units. These units are the frontline in Medicaid fraud enforcement and can provide relevant information to local agencies or work with them to conduct undercover operations.[6]

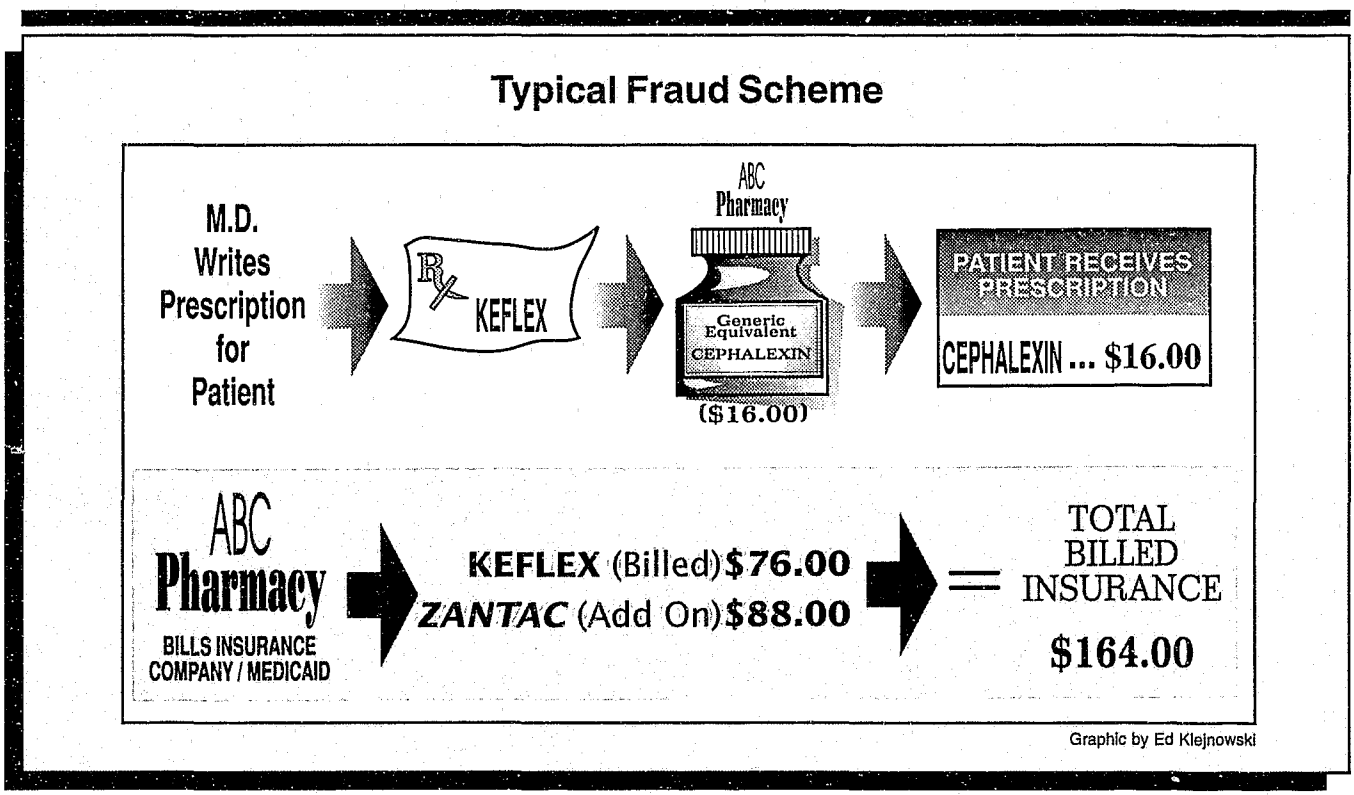
Local Law Enforcement

Often, local police agencies are the first to receive fraud allegations, usually brought to them by patients who suspect that their health care providers are involved in illegal activities. When allegations surface, local agencies can conduct an investigation or notify the appropriate State or Federal agency of possible fraud and patient abuse problems within their jurisdictions.

If police departments decide to conduct their own investigations, they need to develop a plan to gather the information needed to arrest and prosecute the offender(s). Agencies should initiate surveillance, use undercover operatives to verify the al-

Health Care Fraud Investigative Guidelines

- Ensure that the provider is clearly committing fraud, e.g., billing for services not rendered, billing for treatment not administered or for which there is no apparent need, supplying equipment not required by patient, etc.
- Make liaison contacts with other law enforcement agencies, insurance companies, local and State regulatory boards, and Federal entities responsible for investigating health care fraud. Undercover contacts with any health care professional or provider should always be well predicated.
- Remember when analyzing billing data that there may be well-founded reasons for a provider's billings to be high. As an example, pharmacies located close to oncology clinics could easily explain high percentages of controlled narcotics dispensed. Billings by providers should be compared with their peer group instead of all doctors in the metropolitan area. A chiropractor's billing will often be different when compared to a heart surgeon or ENT specialist.
- During undercover operations, use individuals who do not have known illnesses. If diagnosed as being ill, confirm with a reputable provider that the undercover operative is, in fact, well and that the diagnosis has been fabricated.
- Ensure that undercover operatives seek treatment for illnesses that mirror the fraudulent activity. That is, if patients are billed for generic/brand substitutions for pharmaceuticals, the undercover operative should not have a prescription for a drug that has a generic equivalent available at a considerably lower price.
- Compare billings with treatments received and track billings from one central repository. Use fraudulent billings as probable cause for search warrants to seize other documents, either from insurance carriers or Government-sponsored programs. By law, certain patient records are protected. Search warrants should be closely coordinated with the assistant U. S. attorney or district attorney.
- When conducting investigations, do not overlook those who provide ancillary services in the medical profession, e.g., nursing homes, laboratories, medical equipment suppliers, pharmacies, etc.



legations, and elicit corroborating testimony from other patients.

Even on the local level, investigators should take a global approach to health care fraud. If individuals are committing fraud against one program, they are also likely to defraud other programs subscribed to by their patients. As an example, when investigating primary care providers (doctors), it is important to look at all of the doctors' insurance claims (Medicaid, Medicare, private insurers, etc.). In addition, many providers may work in concert with pharmacists, clinics, hospitals, laboratories, and medical equipment suppliers to commit fraud.

Local law enforcement agencies should also contact local professional boards to see if other complaints have been registered against the suspected offender. If these local boards received previous complaints, this corroborating information can form the basis for predication to continue the investigation.

Because proving the *intent* to defraud is extremely important, investigators should attempt to catch offenders in the act of committing fraud. Departments need to show a pattern of criminal activity to get a search warrant and to file criminal charges. Accordingly, suspected offenders should not be able to claim billing errors or administrative mistakes as reasons for their behavior.

Other potential, but often overlooked, sources of assistance to local law enforcement are the private insurance carriers. Annually, these companies pay approximately $400 billion in claims. Their files may contain detailed information concerning allegations of fraud against health care providers.

A number of private insurance carriers operate Special Investigation Units (SIUs) that can work with law enforcement agencies to investigate and prosecute these health care fraud cases. The majority of personnel in SIUs have previous law enforcement experience, and their assistance can prove invaluable in developing successful cases.

PUNITIVE ACTIONS

Because health care fraud is becoming increasingly lucrative, it is not uncommon for a health care provider to be convicted in one State and then begin practicing in another, without even a lapse in defrauding the system. Currently, no law or Federal regulation specifically prohibits such actions. Thus, law enforcement agencies at the Federal, State, and local levels must use every available means to stop these criminals. Strategies may include

securing lengthy jail terms for offenders or seizing offender assets in order to prevent them from establishing fraudulent practices in other jurisdictions.

While State regulatory agencies can suspend or revoke licenses of health care providers, the Inspector General of Health and Human Services can bar offenders from submitting claims against Medicare and Medicaid for a minimum of 3 years up to life. Defrauders can also be subjected to civil action according to false claims statutes, and they can also be civilly fined for their criminal activity.

While these punitive actions impact on health care fraud, asset forfeiture may remain the most effective means to curtail the illegal activities of providers. Since individuals convicted of health care fraud rarely serve significant time in jail (because most are seen as first-time offenders), asset forfeiture is often the only form of punishment applied.

Forfeiture strips accused offenders of their ill-gotten gains and deprives them of their primary motivator—the acquisition of wealth. And, without capital or collateral, defrauders find it difficult to relocate and continue their illegal practices.

Generally, fraudulent claim forms and subsequent payments are either mailed or electronically transferred. When this occurs, violations of Federal mail fraud and wire fraud statutes are committed because the means of transmittal facilitates the fraud scheme. These statutes have been designated as "specified unlawful activity" under the Federal Money Laundering statute. Investigators should remember that the money laundering statute can be used to seize assets, both civilly and criminally.

Once investigators identify a fraud scheme, they should act quickly to freeze, or if possible, seize the tainted assets of the accused. Failure to do so may allow offenders to transfer funds and property so they do not retain outright ownership to anything of value. All too often, law enforcement agencies delay initiating forfeiture proceedings only to find that the accused has transferred bank accounts to offshore financial institutions or has signed over businesses, property deeds, and titles to a spouse or child.

> ***"...law enforcement agencies at all levels must actively investigate allegations of fraud in the health care system."***

The decision to seize assets civilly or criminally rests with the assistant U.S. attorney or the local district attorney. After this decision has been made, investigating agencies then follow their established forfeiture process. The insurance programs harmed as a result of the fraud scheme have an opportunity to make a claim against the forfeited assets. Also, under Federal forfeiture regulations, State agencies working together on the investigation can make a claim to those assets through sharing procedures of forfeiture law.

CONCLUSION

Health care fraud not only squanders national and personal resources but it also places the physical and emotional well-being of millions of Americans in jeopardy. As defrauders divert money away from legitimate services, research efforts, and programs into their own pockets, everyone who accesses the health care system pays for their crimes. For these reasons, law enforcement agencies at all levels must actively investigate allegations of fraud in the health care system.

Through combined and comprehensive efforts, law enforcement and regulatory agencies can have a significant impact in reducing fraudulent activity. Simply by establishing and publicizing an aggressive and effective effort, agencies can succeed in disrupting existing fraud schemes and discouraging new ones. When fraud is detected, every effort should be made to investigate all leads and to secure the strongest penalties possible against offenders.

Understanding that fraud may exist at any level in the health care system is an essential caveat for investigators to remember. Not all criminals wear masks—but some still do. ✦

Endnotes

[1] "U.S. Industrial Outlook 1992," U.S. Department of Commerce, Washington, DC, 1991.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Larry L. Bailey, "Medicaid Fraud," *FBI Law Enforcement Bulletin*, 7, July 1991, 21-23.