

HFMA South Texas Annual Meeting

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Fraud Statistics

- ▶ 3 out of 10 employees actively looking for ways to commit fraud
 - ▶ Additional 3 out of 10 employees will commit fraud if opportunity arises
 - ▶ Remaining 4 out of 10 employees are honest!
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Employee Theft Statistics

- ▶ Amount stolen annually from U.S. businesses by employees – \$50 billion
 - ▶ Percent of annual revenues lost to theft or fraud – 7%
 - ▶ Percent of employees who have stolen at least once from their employer – 75%
 - ▶ 29% Average time fraud occurs before detected – 2 years
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Insurance Fraud

- ▶ Cost \$80 Billion per year
 - ▶ 10% of property–casualty losses are fraudulent
 - ▶ Other types of Insurance Fraud
 - Contractor fraud
 - Auto Accidents
 - Arson
 - Workers compensation
 - Healthcare
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U.S. Frauds by Industry

1. Banking 17%
2. Government 11%
3. Manufacturing 9%
4. Health Care 7%



Top Ten Healthcare Frauds

1. Billing for services not rendered.
2. Billing for a non-covered service as a covered service.
3. Misrepresenting dates of service.
4. Misrepresenting locations of service.
5. Misrepresenting provider of service.
6. Waiving of deductibles and/or co-payments.
7. Incorrect reporting of diagnoses or procedures.
8. Overutilization of services.
9. Corruption (kickbacks and bribery).
10. False or unnecessary issuance of prescription drugs.



Most Common Health Care Frauds

- ▶ Billing for services that were never performed.
- ▶ Performing unnecessary medical services.
- ▶ Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance payments—widely seen in cosmetic-surgery schemes.
- ▶ Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary.
- ▶ Unbundling – billing each step of a procedure as if it were a separate procedure.
- ▶ Billing a patient for services that will be paid in full by the benefit plan.
- ▶ Providing kickbacks for patient referrals.
- ▶ Overbilling the insurance carrier or benefit plan



Scam Alerts

- ▶ ACA enrollment phone calls
- ▶ Fake health plans
- ▶ OIG Hotline employees
- ▶ Goals of Scams
 - Obtain personal information
 - Receive payments



- ▶ HIPPA established a comprehensive program to combat fraud committed against all health plans, both public and private.
- ▶ The Health Care Fraud and Abuse Control Program (HCFAC) was established and is designed to coordinate Federal, State and local law enforcement activities with respect to health care fraud and abuse.
- ▶ <https://oig.hhs.gov/>



Where is Health Care Fraud most prevalent?

- ▶ South Florida
- ▶ California
- ▶ New Jersey
- ▶ Health Insurance Portability and Accountability Act of 1996 established health care fraud as a federal criminal offense
 - Prison term up to 10 years plus penalties
 - Time doubles if injury to a patient

Medicare Fraud Strike Force Locations



LAPORTE
CPAs & BUSINESS ADVISORS

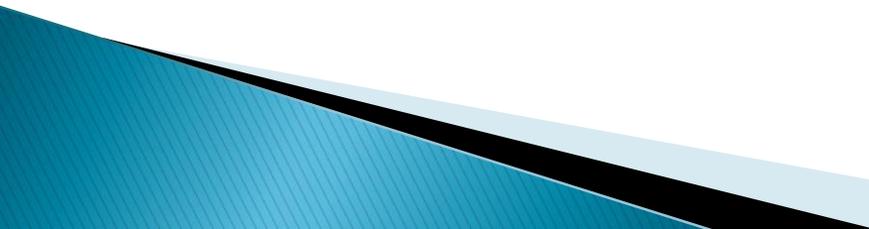
Latest Strike Force Actions

- ▶ May 8, 2017; U.S. Department of Justice
▶ [Detroit–Area Physician Convicted in \\$17.1 Million Health Care Fraud Scheme](#)
- ▶ April 13, 2017; U.S. Department of Justice
▶ [Detroit Podiatrist Charged for Role in \\$13.9 Million Medicare Fraud Scheme](#)
- ▶ March 31, 2017; U.S. Department of Justice
▶ [Second Detroit–Area Physician Pleads Guilty in \\$17.1 Million Health Care Fraud Scheme](#)
- ▶ March 30, 2017; U.S. Department of Justice
▶ [Home Health Agency Owner Pleads Guilty to Conspiring in \\$17 Million Medicaid Fraud Scheme](#)
- ▶ March 17, 2017; U.S. Department of Justice
▶ [Houston–Area Registered Nurse Pleads Guilty to Conspiring to Defraud Medicare of More than \\$5 Million](#)
- ▶ March 14, 2017; U.S. Department of Justice
▶ [South Florida Home Health Owner Charged for Role in \\$15 Million Medicare Fraud Scheme](#)

Third Detroit–Area Physician Convicted in \$17.1 Million Health Care Fraud Scheme

- ▶ Physician for home visiting service
 - ▶ Visited patients who did not qualify
 - ▶ Billed to Medicare at highest rates
 - ▶ Visits were 15 minutes or less but billed Medicare for 60 minutes
 - ▶ Unnecessary tests also ordered
 - ▶ 2 other physicians pled guilty and testified at trial.
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Detroit Podiatrist Charged for Role in \$13.9 Million Medicare Fraud Scheme

- ▶ Podiatrist falsely conveyed to his patients that they needed weekly or bi-weekly shots and minor surgeries, which were allegedly medically unnecessary.
 - ▶ As a result, these patients returned to his practice on a regular basis every month for shots and minor surgeries.
 - ▶ Podiatrist also allegedly billed Medicare for other podiatry services which were not provided.
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Home Health Agency Owner Pleads Guilty to Conspiring in \$17 Million Medicaid Fraud Scheme

- ▶ Provider Attendant Service Fraud
 - ▶ Paid illegal kickbacks to patient recruiters
 - ▶ Paid cash to patients
 - ▶ Paid physicians kickbacks
 - ▶ The owner and operator of five Houston-area home health agencies pleaded guilty to conspiring to defraud Medicare along with daughter, registered nurse and patient recruiter.
 - ▶ Largest PAS fraud case in Texas history.
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Houston–Area Registered Nurse Pleads Guilty to Conspiring to Defraud Medicare of More than \$5 Million

- ▶ Kickbacks paid for referring patients for home healthcare services.
 - ▶ Homeless recruited as patients for home healthcare agencies.
 - ▶ Saw some patients in groups at the home of a patient recruiter
 - ▶ Examinations typically lasted 5 to 10 minutes.
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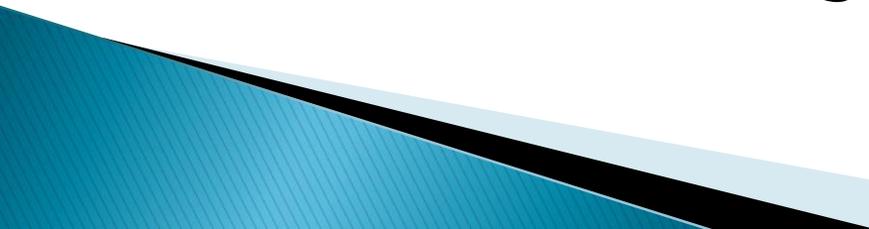
Sales Rep for North Alabama Compounding Pharmacy Charged in \$13 M Insurance Conspiracy

- ▶ Prescription drug reimbursements from Blue Cross Blue Shield
- ▶ Conspiracy to generate high-reimbursement prescriptions.
- ▶ Recruited close relatives of doctors as sales representatives.
- ▶ Co-pay waived for prescriptions
- ▶ Encouraged every sales rep to get SilaPak (skin repair complex) prescriptions for themselves and each family member

Houston Ambulance Company Owner and Brother Sentenced in \$6 Million Health Care Fraud Conspiracy

- ▶ Operated healthcare company from their home.
 - ▶ Submitted claims to Medicare and Medicaid for ambulance services that were not provided or not needed.
 - ▶ One patient walked to her therapy session, but the company billed Medicare \$51,952 for ambulance transportation.
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Dallas Father and Son Charged in \$16 Million Health Insurance Fraud Scheme

- ▶ Optical and Hearing Aid Center submitted claims to Blue Cross Blue Shield for hearing aids not needed.
 - ▶ Offered free sunglasses for taking hearing test.
 - ▶ \$100 gift certificates for referrals of family and friends.
 - ▶ American Airlines employees recruited because no limit on cost of hearing aids and allowed one per year.
 - ▶ Conducted hearing tests at DFW airport.
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Ransomware

- ▶ Company's computers infected because employee clicked a malicious link or attachment
- ▶ Ransomware blocks company's access to files
- ▶ Message received demanding payment or all data will be deleted
- ▶ California hospital paid \$17,000 in bitcoin and network access restored
- ▶ Other California hospitals subsequently hit by ransomware after publicity



Business email

- ▶ Email to wire funds for company official
- ▶ Clone of email after months of monitoring company's internal procedures.



Theft of Patient Information

- ▶ Free Screening
- ▶ Medical personnel
- ▶ Purchases from others who have stolen the information
- ▶ ***Always review the explanation of benefits forms sent from the insurance company.



Business ID theft

- ▶ Government registration records amended to include additional officer or representative
- ▶ False bank accounts opened

Risks of Health Care Fraud

- ▶ Health Care Fraud costs the U.S. tens of billions of dollars each year
- ▶ Increased health insurance costs
- ▶ False diagnosis and unnecessary treatment
- ▶ Identity theft



April 2017 DHHS OIG Report

- ▶ ***New Jersey claimed at least \$30.7 million in Federal Medicaid reimbursement over 4 years for adult partial hospitalization services that were unallowable.***
- ▶ All 100 of the New Jersey Department of Human Services' (State agency) sampled claims for Federal Medicaid reimbursement for partial hospitalization services did not comply with Federal and State requirements, and 92 contained more than 1 deficiency. Partial hospitalization services are provided on a hospital-outpatient basis to adults with serious mental illnesses to prevent inpatient hospitalization and achieve community integration. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$30.7 million in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.

New Jersey deficiencies

- ▶ For 87 claims, services did not meet the Federal requirement that hospital outpatient services be provided by a licensed hospital.
- ▶ For 83 claims, services were not documented or supported.
- ▶ For 59 claims, services did not meet staffing ratio requirements.
- ▶ For 21 claims, services were improperly paid at the partial hospitalization rate.
- ▶ For 13 claims, progress notes were not documented.



Pittsburgh Doctor and His Employee Charged with Illegal Rx Drug Distribution, Health Care Fraud

- ▶ A physician and office employee in Pittsburgh have been indicted by a federal grand jury on charges of distribution of Oxycodone, a Schedule II controlled substance, and Amphetamine, a Schedule II controlled substance, outside the usual course of professional practice.
- ▶ For the physician, the law provides for a maximum total sentence on all counts of incarceration of up to 270 months, a fine of \$13,250,000, or both. For the employee, the law provides for a maximum total sentence of 20 years, a fine of \$1,000,000, or both.

Pacific Hospital of Long Beach

- ▶ Workers' Compensation Scheme
- ▶ Illegal kickbacks paid to doctors, Chiropractors, marketers and others who referred patients
- ▶ Over \$500 million in fraudulent bills submitted between 2005 and 2013
- ▶ claims for spinal surgeries
- ▶ Referring parties typically received kickbacks of:
 - \$15,000 per lumbar fusion surgery
 - \$10,000 per cervical fusion surgery
- ▶ Kickbacks financed with inflated prices for implanted medical devices
- ▶ Bribed CA state senator to delay or limit changes in workers compensation laws



Pacific Hospital Conspirators

- ▶ CEO
- ▶ CFO
- ▶ Orthopedic Surgeons
- ▶ Health Care Marketers
- ▶ Payments to disguised as:
 - Option to purchase medical practice not exercised
 - Contracts for collection work not performed
 - Rent for office space not used
 - Consulting Services not provided



Staged Automobile Accident Fraud

- ▶ Individuals stage accidents and claim therapy treatment needed
- ▶ Three therapy clinics in Michigan provided unnecessary treatment
- ▶ False insurance claims sent to auto insurance companies



Dallas Anesthesiologist and Forest Park Medical Center Founder Pleads Guilty to \$40 Million Kickback Scheme

- ▶ Hospital founded in 2008 with focus on bariatric and spinal surgeries
- ▶ Out-of-network
- ▶ Kickbacks paid to surgeons and chiropractors
- ▶ Waived co-insurance or limited to in-network patient responsibility amounts
- ▶ Investment opportunities offered to surgeons!

Olympus Imaging Scandal

- ▶ Produces medical imaging equipment
- ▶ Losses turned into profits on financial statements
- ▶ Consulting payments and gifts to doctors to purchase Olympus products
- ▶ President and CEO blows whistle on his own firm
- ▶ Arrests of executive team and 80% decline in stock price
- ▶ Lawsuits against former Board Chairman and other company officials

How are Health Care Frauds Discovered?

- ▶ Whistleblower
- ▶ Government Investigation based on large data



Final Thoughts

- ▶ Beware Phishing Schemes
- ▶ Never click a link in an email or on social media
- ▶ Manually type the intended web address

