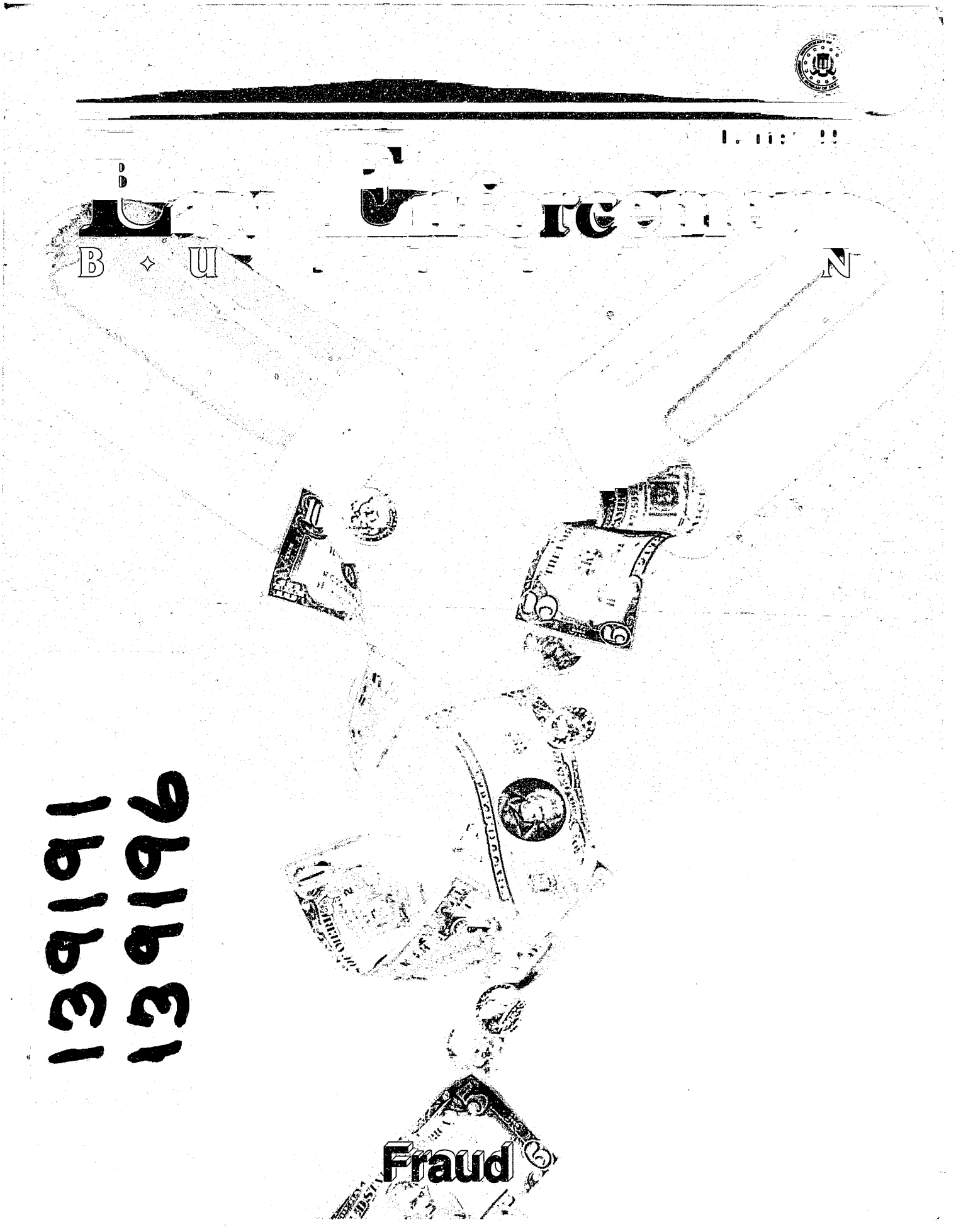

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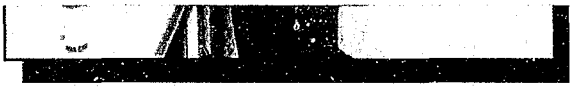

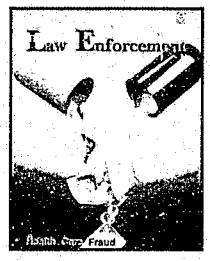

Cover: Health care fraud directly challenges law enforcement. This issue focuses on law enforcement's concerted efforts to strategically address this crime problem. (Cover photo © 1992, M. Simpson, FPG International Corp.)

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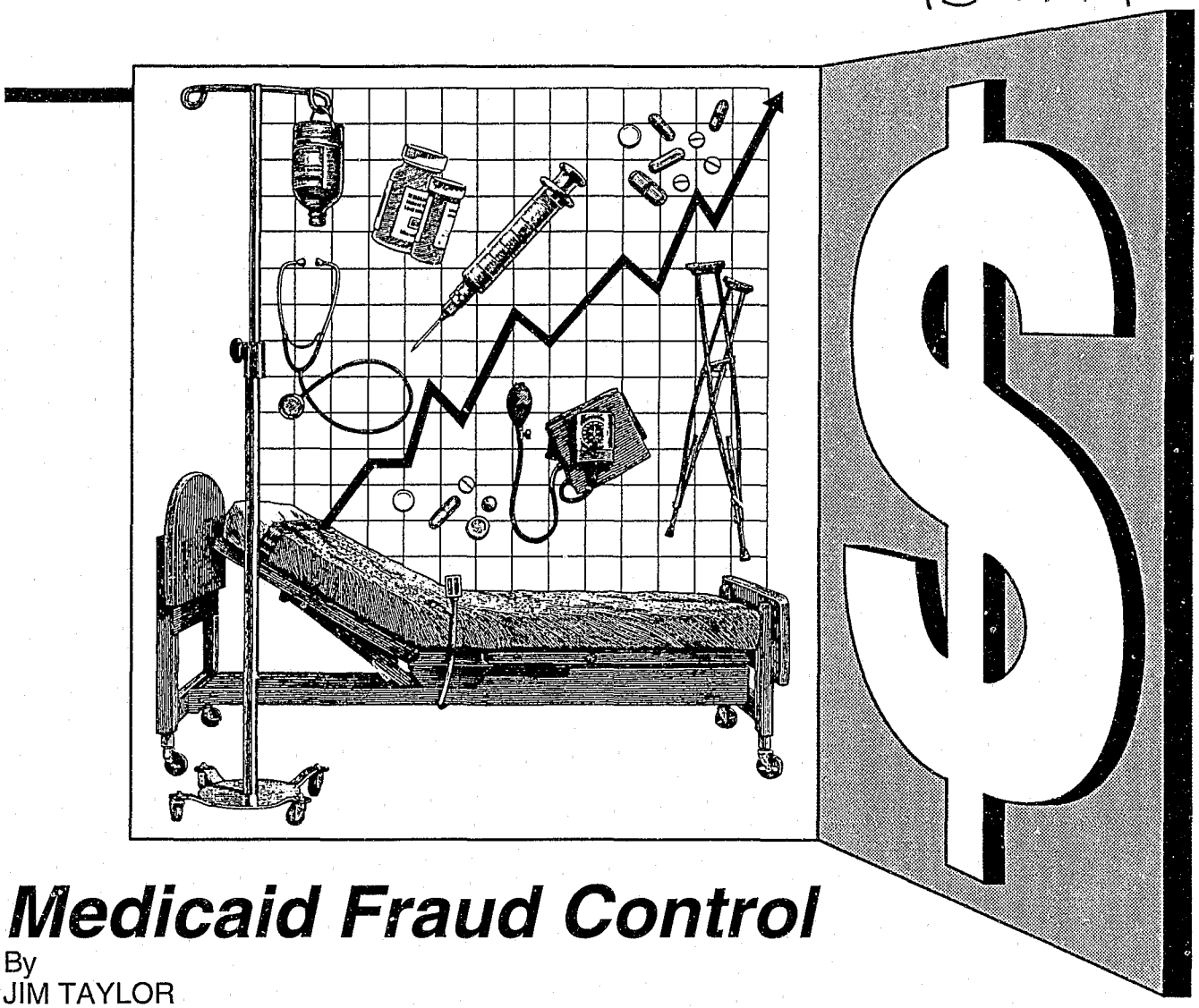

Medicaid Fraud Control

By
JIM TAYLOR

Until recently, few people paid much attention to one of the most lucrative crimes inflicted on American society—health care fraud. It wasn't until investigations of this crime began to take place across the country that the criminal justice system realized how widespread and profitable this crime is. Today, experts estimate that health care fraud costs taxpayers $50 to $80 billion a year.[1]

This article centers on the issue of Medicaid fraud and the various schemes used by those in the health care profession. It then covers the State of Tennessee's efforts to bring these criminals to justice and the problems encountered in Medicaid fraud investigations.

FRAUD SCHEMES

Health care fraud investigations typically center around six main schemes—upcoding, phantom billing, billing for unnecessary services, double billing, unbundling, and giving or receiving kickbacks. Investigators should recognize that Medicaid providers often engage in several such schemes, even though investigations may begin with indications of only one scam.

Upcoding

For the most part, upcoding occurs when health care providers bill for a more expensive service than the one they provide to the patient. However, upcoding can also come in the form of generic substitutions—filling a prescription with a less expensive generic drug, while billing Medicaid for the more expensive form of the drug.

Medical fraud investigators for Tennessee initiated one such case, "Operation Rx," because of a pervasive problem across the State with generic drugs being substituted for prescribed medicines. Investigators

> ***"Medicaid recipients deserve the best efforts of law enforcement in protecting their safety and welfare...."***

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were concerned that health care providers were defrauding the State, since generic drugs tend to cost less than brand name drugs. However, an even greater concern was that these substitutions could seriously affect the health of the patients.

Therefore, investigators developed an investigative profile that targeted those pharmacies that did a given dollar amount of business with Medicaid each year and also obtained a certain percentage of payments from some 50 brand name drugs also available in the generic version. In most cases, the generics had not yet been approved for use in the State's Medicaid Program.

Once investigators decided which pharmacies to target, they obtained valid Medicaid cards for the areas in which the pharmacies were located, as well as valid prescriptions for the targeted brand name, noncontrolled drugs. Then, agents, posing either as patients or as friends or relatives of the patients, attempted to fill the prescriptions at the targeted pharmacies. After receiving the drugs, these agents checked the pharmacies' Medicaid billing information for any discrepancies.

As a result of the first phase of this operation, 33 pharmacists were convicted of Medicaid fraud. Each case involved a minimum of 10 felony counts gained through 4 months of undercover work. Each case also involved at least two different Medicaid "recipients."

At the conclusion of the first phase of Operation Rx, which covered middle and east Tennessee, the Medical Care Fraud Unit applied the same selection criteria to pharmacies in west Tennessee and found virtually no generic drug substitutions. Either the problem did not exist in that area of the State, which is unlikely, or the grapevine and resulting publicity proved to be an effective deterrent.

Phantom Billing

Phantom billings—billing for services not performed—also occur frequently in health care fraud cases. To address this fraud scheme, investigators revised the original investigative profile to identify a number of pharmacies in each part of the State that exceeded the State average cost per prescription by $4 to $20. Each of these stores dispensed a high number of expensive antibiotic, anti-inflammatory, or ulcer medicines. While not all of the pharmacies billed for medicines they did not dispense, several billed for more medicine than they dispensed. In addition, investigators found that several pharmacies either filled unauthorized refills and then billed Medicaid, or they billed for a more expensive medicine of the same class.

Other cases of phantom billing involve home health agencies that bill for services not received. For example, some of these facilities falsify records to show that LPNs or RNs made home visits to patients when the visits either did not occur or were performed by untrained, unlicensed individuals.

Billing for Unnecessary Services

Another type of health care fraud involves billing for unnecessary services. For example, some medical supply companies forge the signatures of physicians in order to certify that particular services are necessary. These same companies also bill for items that patients may not need at all, such as oxygen concentrators, hospital beds, or wheelchairs.

Physicians also engage in this type of scheme. One Tennessee physician billed the government for unnecessary services that were improperly performed, as well as services that were never performed. He put heart patients on treadmills without bothering to connect them to a monitor; he also billed for hundreds of other diagnostic tests with no medical value. Instead of the

hours needed to perform these tests properly, he completed the tests within minutes, which resulted in useless medical information.

In addition, this same physician falsified patient complaints to justify performing the tests, a common tactic among dishonest practitioners. He also billed for tests incompatible with a patient's age, such as performing pregnancy-related tests on a 60-year-old woman.

Some physicians also add unnecessary tests that they can perform in the office to their Medicaid billings. These tests—rarely detected by Medicaid—include routine blood tests, x-rays, and urinalysis tests. Therefore, when any single diagnostic test exceeds about 20 percent of a provider's billing (excluding services directly related to a specialist's practice), health care fraud investigators may want to examine the physician's billings.

If investigators suspect fraud, undercover visits may be useful in proving the case. However, undercover personnel should keep their complaints simple, and they should avoid allowing invasive medical tests.

Double Billing, Unbundling, and Kickbacks

Some home health care providers defraud the Medicaid Program through double billings. In one case, a home health care provider received over $1 million in payments from Medicaid after receiving payment for the same services from Medicare.

Health care providers also defraud the system by billing Medicaid twice in one month for the same services to the same patients. They bill Medicaid once at the beginning of the month and then again—for the same patients—at the end of the month.

The unbundling scheme used by some physicians involves billing Medicaid separately—as if they were performed on different days—for procedures that the doctor performed during one operation. For example, a physician may bill for procedures done on the right side of the patient and then bill separately for procedures done on the left side of the body.

> ***"To counter the escalating rate of health care fraud, States need to form special units to deal specifically with these crimes...."***

Another health care fraud scheme involves giving or receiving kickbacks. In this scheme, medical suppliers, home health care agencies, etc., give kickbacks to physicians who recommend their businesses to patients.

HEALTH CARE FRAUD UNITS

To counter the escalating rate of health care fraud, States need to form special units to deal specifically with these crimes, such as the Tennessee Bureau of Investigation's (TBI) Health Care Fraud Unit. However, in order to increase their chances of successful prosecutions, health care fraud investigators must take certain steps.

First, investigative personnel in these units should familiarize themselves with the many schemes used in health care fraud. They also need to be familiar with regulations that govern the Medicaid Program. This not only helps to develop cases but it also helps investigators to avoid wasting valuable time on cases that are not prosecutable because of vague or nonexistent Medicaid regulations.

One particular challenge is common to most, if not all, health care fraud units. Simply put, in order to investigate fraud against the Medicaid Program, an agency frequently must first *find* the fraud. This problem exists primarily because:

- Most Medicaid recipients do not know what services their physicians bill in their names; therefore, fraud units receive few direct complaints of fraudulent billing
- The medical community rarely expresses suspicions about its own members
- Problems inherent in the Medicaid Program tend to keep to a minimum complaints of suspicious billings.

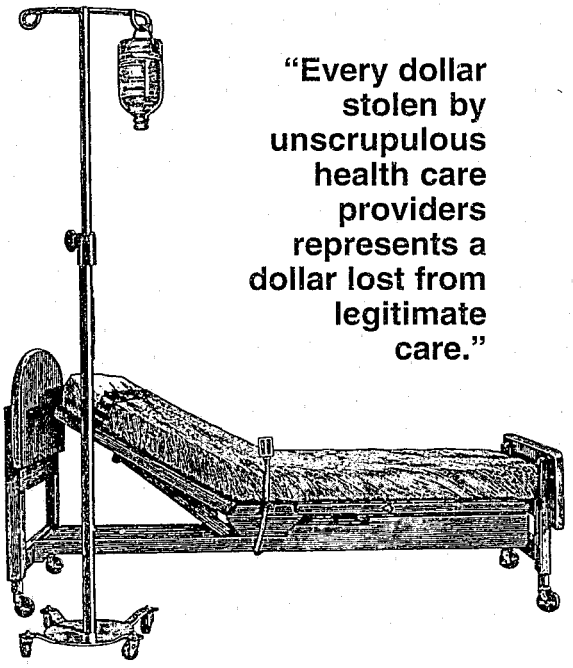
However, once investigators suspect fraud, they can initiate investigations in different ways.

INITIATING INVESTIGATIONS

Medical fraud unit investigators sometimes initiate cases based on complaints received from patients or from insurance companies. Insurance companies alert health

care fraud units when they discover fraud, because those who defraud health insurance companies also often defraud the Medicaid Program.

Other times, fraud units initiate cases based on investigative profiles. In these cases, investigators determine what criteria to use when targeting certain pharmacies, health care providers, or medical supply companies by examining computer printouts of billings to Medicaid.



"Every dollar stolen by unscrupulous health care providers represents a dollar lost from legitimate care."

Before initiating a case, investigators should be alert to any special investigative problems they may encounter. How investigators work the case may make the difference between success and failure.

INVESTIGATIVE PROBLEMS

While the State of Tennessee has several major urban areas, it remains primarily a rural State with many areas of extreme poverty. Because of this, Tennessee's health care fraud investigators deal with specific problems unique to these types of settings.

For example, health care providers sometimes use the defense that their offenses are merely business errors. In order to eliminate this possible defense, investigators often use multiple agents who make repetitive visits to a suspect provider. However, rural settings, where residents know one another well, make such operations difficult. Because this type of environment breeds clannishness, strangers stand out, and residents often suspect outsiders.

In addition, residents of these areas tend to protect the health care providers available to them. They know that the serious shortage of primary health care workers in many rural areas means that communities sometimes lose access to medical care for years if their local providers face criminal charges. Therefore, citizens often do not report suspected cases of health care fraud.

For the above reasons, developing medical fraud cases in rural areas tends to take longer than developing cases in urban settings. It may take several months to introduce two or three new "recipients" (undercover agents) to a pharmacy, physician, or clinic. After this, it takes on the average of three visits before any fraudulent billing appears, because well-publicized cases against health care providers make dishonest providers wary of submitting fraudulent bills for services provided to unfamiliar patients.

CONCLUSION

Even though Tennessee budgets only approximately $2 billion a year for Medicaid, the TBI encountered numerous schemes to defraud the system of substantial amounts of money. Not all of the schemes posed a direct threat to the health of the patients; however, they all impacted negatively on each recipient, as well as each taxpayer.

Every dollar stolen by unscrupulous health care providers represents a dollar lost from legitimate care. Health care fraud also impacts on programs that must go unfunded due to lack of money, such as eye and dental care for the elderly, or programs that must be limited, such as the monthly prescription limit for Medicaid recipients.

Every law enforcement agency *must* work to eliminate health care fraud. Medicaid recipients deserve the best efforts of law enforcement in protecting their safety and welfare, and taxpayers deserve the best efforts of law enforcement in reducing the escalating rate of health care fraud—the modern way to steal. ✦

Endnote

[1] *U.S. News and World Report*, February 24, 1992, 34.