Healthcare fraud and abuse assignment

Rising costs of health care is a valid concern for many households in America. A factor in the cost of health care insurance is fraud. Fraud is often very difficult to detect. The magnitude of health care fraud is unknown. Initial reimbursement and payment and billing timeframe of 90 days allow for fast payment of services, however, many times before there is an indication of fraudulent billing the company has closed up and moved on. Fraud in American healthcare costs American's millions perhaps even billions of dollars annually.

Without a doubt, behind every act of fraud lies a lapse in ethics. This paper will review several pieces of literature to look regarding healthcare fraud. It will discuss the different kinds of fraud, legislation used to combat fraud, a few settled cases, and lastly discuss ways to help to combat health care fraud. Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in an unauthorized benefit to himself/herself or another person.

The most frequent kind of fraud arises from a false statement or misrepresentation made or caused to be made, that is material to entitlement or payment under the Medicare program. The violator may be a physician or other practitioner, a supplier of durable medical equipment, an employee of a physician or supplier, a carrier employee, a billing service, a beneficiary, or any other person or business entity in a position to bill the Medicare program or to otherwise benefit from such billing.

Attempts to defraud the Medicare program may take a variety of forms. Billing for services or supplies that were not provided Altering claim forms to obtain a higher reimbursement amount Deliberately applying for duplicate reimbursement in order to get paid twice Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider Unbundling or " exploding" charges Soliciting, offering, or receiving a kickback, bribery rebate False representation with respect to he nature of the services rendered or charges for such services, identity of the person receiving or rendering the services, dates of the services, etc. Filing claims for services that are non-covered but billed as if they were covered services Claims involving collusion between a provider and a beneficiary, resulting in higher cost or charges to the Medicare program Use of another person's Medicare card in obtaining medical care Collusion between a provider and a carrier employee Any act that constitutes fraud under applicable federal or state law. NHIC Corp 2008) Fraud is a serious crime that should concern all parties of the U. S. health care system and is a costly reality that the government cannot overlook. While not all fraud can be prevented, by learning about the many different types of fraud, patients can be educated on how to protect themselves from fraud. There are government programs to inform the public that they can be targeted. An informed public and a properly funded FBI will go a long way in the overall crackdown of health care fraud.

Although some of the practices noted above may be initially considered to be abusive, rather than fraudulent activities, they may evolve into fraud. When fraud has been committed, the government can: seek federal criminal

conviction of the parties involved in the fraudulent activities; negotiate a civil settlement with the parties involved; take administrative action to exclude the responsible parties from the federal healthcare programs; suspend the provider from the Medicare program. (NHIC corp. Federal law defines abuse, as applied to the Medicare program, as incidents or practices by providers, which although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices that directly or indirectly create unnecessary costs to the Medicare program. Improper reimbursement or reimbursement services, which fail to meet professionally recognized standards of care, or which are not reasonable and necessary are examples of such practices.

Abuse takes such forms as, but is not limited to: Over-utilization of medical and health care services; claims for services that are not reasonable and necessary, or if deemed medically necessary, not to the extent rendered or billed; breaches of the assignment agreement which result in beneficiaries being billed for amounts disallowed by the carrier on the basis that such charges exceeded the Medicare Fee Schedule; exceeding the Limiting Charge for non-participating providers; violations of the Medicare Participating Agreements by physicians, suppliers or practitioners.

Many other forms of abuse exist and some, including those described above, are ultimately found to be fraudulent. When abuse is committed, the government can: Recover payment made in error; invoke civil monetary penalties congruent to the degree of abuse; suspend the provider from the Federal Healthcare Programs. (NHIC corp) The U. S. General Accounting Office estimates that $1 out of every $10 spent for Medicare and Medicaid is

lost to fraud. This translates into fewer resources for health care due to the strains on federal and state budgets.

During FY 2005, the Federal Government won or negotiated approximately $1. 47 HIC, Corp. has an aggressive program to combat fraud and abuse, but need the publics help with reporting problems. Most providers of health care are honest businessmen and women who want to provide quality health care to Medicare beneficiaries. However, there remains a relatively small group of providers who take advantage of the Medicare program and engage in schemes or practices that result in inappropriate payments. At the crux of healthcare fraud is billing.

Billing fraud can occur in many ways. Providers commit fraud when they bill for services that are not provided. Sometimes fraud occurs when provider’s bill for medically unnecessary procedures and/or services or bill for services supplied to someone other than a covered member. Services may be billed which are up-coded or unbundled. Up-coding is when the service is billed at a higher rate than what was performed. Unbundling is when a series of services (such as labs) which are normally billed as one service are split into single units to obtain higher rates of reimbursement.

Other examples of healthcare fraud include: Pharmaceutical fraud—substituting and distributing generic drugs for name-brand drugs or knowingly undersupplying prescriptions or their refills, and Kick-back fraud—accepting a certain percentage or something of value in exchange for referrals or services. In 1863 the False Claims Act (FCA) was passed. It provided a way for the government to prosecute unscrupulous and unethical

contractors who were providing substandard contract materials to the government after the civil war.

In 1943, under President Roosevelt an amendment made it primarily used only in times of war reducing its use and authority. Under the amendment, whistleblowers were no longer entitled to collect a percent of the recovery. FCA fell into disuse until 1986, when the Reagan Administration made amendments which gave individuals the ability to once again file Qui tam cases and recover a percentage of the government’s recovery. Qui Tam Actions are: “ A claim under the Federal False Claims Act is filed on behalf of the United States, and often referred to as a “ qui tam” action.

A qui tam suit is a suit brought by an individual on behalf of the United States government seeking to expose and thereby stop the wasting of federal funds. The qui tam relator, often referred to as a whistleblower, if successful in his or her suit, is entitled to a percentage of the funds recouped by the federal government, generally between 15 to 25 % of the recovery. The claim is brought by anyone with knowledge of the fraud, including health care administrators, doctors, nurses and patients. However, a private citizen or company can not file a qui tam action without an attorney.

This is because the relator brings his or her case on behalf of the government, and the U. S. government can not be represented in court by a non-attorney. In order to make a qui tam claim, federal funding must be involved, and the fraud alleged must be substantial and non-frivolous in nature. Anyone who learns credible information that a false or fraudulent claim for federal funds has been submitted or paid is eligible to file a qui tam

action, as long as they didn’t learn about the fraud in the newspapers, or another public forum” (US Legal, 2008).

The United States Government Accountability Office (GAO) in 2006 pursued more healthcare cases with larger recoveries than any other types of fraud cases. The False Claims Act has been very important in the war against fraud. Deputy Assistant Attorney General Michael Hertz (2008) in congressional testimony said: “ 3117 of the 5800 cases filed since the 1986 amendments focused of fraud against government healthcare programs such as Medicare and Medicaid and represented $9. 1 billion, or more than 72 percent of the $12. 6 billion in qui tam recoveries. Other applicable laws which have helped in the prosecution of fraud are the Stark Laws which aid in the prosecution of kick-backs and are used to prevent conflict of interests, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 which among other things established the Health Care Fraud and Abuse Control Program (HCFAC) providing budget funding and prosecution penalties for fraud and abuse cases. According to The Department of Health & Human Services and the Department of Justice (2007) Annual Health Care Fraud and Abuse Control Program Annual Report for

FY 2006, “ the Federal Government won or negotiated approximately 2. 2 billion in judgments and settlements”; “ The HCFAC account has returned over $10. 4 billion to the Medicare Trust Fund since the inception of the program in 1997. ” Some of the largest settled cases according to the Chicago Tribune (2008) include: Tenet Healthcare Corp. , settling with the government for 900 million in June of 2006, for allegedly fraudulent billing for services and supplies that were not rendered to patients.

Hospital Corporation of America (HCA) has settled two cases against them, in 2000–for a sum of 731 million, and in 2003– for a sum of 531 million, for allegedly filing false Medicare reports, paying physician kickbacks to refer patients to company hospitals, billing for tests not medically necessary, and other questionable billing practices. The Chicago Tribune (2008) also cited two recent pharmaceutical claims: Serono, in 2005 settled a claim to pay more than 567 million in alleged fraud for kickbacks to doctors who would prescribe their AIDS-related drug and off label marketing.

More recently in 2008, Merck & Co. settled for 650 million for allegedly over billing for its popular drugs Vioxx and Zocor. According to Modern Healthcare (2007) other large settlements include TAP Pharmaceutical Products in 2001, for 559. 5 million for the fraudulent drug pricing and marketing of Lupron, HealthSouth Corp. , in 2004 for 325 million for alleged Medicare Fraud, Abbott Laboratories in 2003 for 400 million, for alleged kickbacks, Medicare and Medicaid fraud and obstruction of justice, Bayer Corp. , in 2003 for 257. 2 million.

According to the National Health Care Anti-Fraud Corporation (NHCAA) (2007), “ the perpetrators of some types of health care fraud schemes deliberately and callously place trusting patients at significant risk of injury or even death. It’s distressing to imagine, but there have been many cases where patients have been subjected to unnecessary or dangerous medical procedures simply because of greed. ” Physicians are performing unnecessary heart catheterizations, angioplasties and other tests in order to get money from fraudulent schemes.

Hospitals and physicians even bribed homeless men and women to come in with fake symptoms so they can perform tests on them in exchange for cigarettes, food, and money. Sadly, these people are vulnerable and therefore will agree to do tests because they are desperate for money and food. The effort to prevent and detect fraud, abuse, and waste is a cooperative one involving beneficiaries, Medicare contractors, providers, and Federal agencies such as the Department of Health and Human Services (DHHS), the Federal Bureau of Investigations (FBI), and the Department of Justice (DOJ).

These entities are committed to help protect the Medicare Trust Funds from being depleted by fraudulent and abusive practices. The Centers for Medicare & Medicaid Services is the Federal agency that is responsible for the Medicare program. Title XVIII of the Social Security Act provides the statutory authority for the broad objectives and operations of the Medicare program. CMS authorizes Medicare carriers to maintain the integrity of the Medicare program by conducting activities that ensure that only appropriate payments are made.

The CMS Publications provide the practical operating instructions needed for contractors to administer Medicare Part B. As a response to the growing costs of healthcare, there are things that can be done to help combat the war on healthcare fraud. According to the NHCAA, a person needs to protect their health insurance card like they would their credit cards or driver’s license. Do not give out the insurance number to door to door sales people or over the phone or internet.

If for some reason a person should lose their card, they need to report it immediately so that it cannot be used and they get another one sent to them. If someone is aware of fraud taking place, they should report it immediately to their insurance companies. A person needs to be aware of the tests they do receive, and they should keep good records so they can look back at them if they need to. (2007) A simple thing like taking the time to read the Explanation of Benefits (EOB) statements provided by our carriers helps to determine if services that were rendered, were billed correctly?

Did the codes accurately reflect what was performed? Were services medically necessary? Paying attention to what is billed and responding immediately to inconsistencies can save time and money. People need to be aware of “ free” offers. If a company is offering free tests or procedures, than a person needs to be suspicious. There is nothing that is free in health care. Free offers are most likely fraudulent. Every year, billions of dollars are lost to fraud in federal and state health care programs.

Every dollar lost to fraud and abuse is a dollar that is not available to provide home care to seniors, to treat HIV and AIDS, to immunize children, and to discover new treatments for cancer and other diseases. Some fraud schemes even pose a direct threat to the health and safety of patients. Many instances of health care fraud suggest that existing control systems do not work the way they should. Often the manner in which schemes are revealed suggests detection is more luck than system.

Whistleblower lawsuits have exposed billing by health care providers for services not rendered, billing for products not delivered, misrepresenting services, unbundling services, billing for medically unnecessary services, duplicate billing, increasing units of service which are subject to a payment rate, falsifying cost reports resulting in increased payment to the health care provider, and kickbacks. As a Medicare Part B carrier, NHIC, Corp. has established procedures to identify cases of suspected fraud or abuse, and take the necessary actions to ensure that the Medicare Trust Fund monies are utilized appropriately.

In the event of mistaken payments, NHIC may pursue overly of overpaid funds. Suspected fraud and abuse cases are forwarded to the appropriate Benefit Integrity Support Center (BISC) for investigation. At the conclusion of their investigation, the BISC may refer the matter to the Office of Inspector General (OIG) for further consideration and initiation of criminal, civil monetary penalties and/or administration sanction actions. In order to maintain the integrity of the Medicare program, audits and prepayment reviews are periodically performed. (NHIC 2008).

According to FBI agent Brian Waterman, in an interview with Mark Potter from NBC news, “ Every taxpayer funds the Medicare system”, we all pay taxes, we all pay for this. The people that are stealing from Medicare are stealing from us. The amount of money stolen in any given scheme is on the rise, as criminals find new ways to tap into Medicare’s automated computer system, a trust-based operation designed to quickly pay claims from legitimate doctors and medical suppliers” (2010). Certainly, only a small

percentage of health care providers and consumers deliberately engage in health care fraud.

However, even a small amount of health care fraud can raise the cost of health care benefits for everyone. Health care fraud is a crime. It’s committed when a dishonest provider or consumer intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable. Healthcare and healthcare fraud is a growing concern for American families. President Obama has set a five-year deadline for all Americans to have electronic medical records, saying digital records will save billions by cutting waste and eliminating repeated tests and errors.

I have looked at several kinds of healthcare fraud, looked at several pieces of legislation used to combat healthcare fraud, touched on several settled cases of fraud and discussed a simple thing that we can do to aid in the fight against healthcare fraud. The continued effort to report fraudulent acts is imperative from the government, Medicare, Medicaid, other insurance companies as well as honest people. If we all work together to combat the health care fraud and abuse, we can eventually make a difference to the lives of others. References False Claims Act, (Publication GAO-06-320R). Retrieved April 29, 2010 rom http://www. gao. gov/new. items/d06320r. pdf Hertz, M. , General , D. , & JUSTICE, U. (n. d.), CLAIMS FRAUD PREVENTION. FDCH Congressional Testimony, Retrieved May 1, 2010, from MasterFILE Premier database. “ Largest healthcare fraud settlements. ” (2007, June 18). Modern Healthcare, Retrieved May 2, 2010, from MasterFile Premier database. NHIC CORP. , A CMS Contractor. FRAUD & ABUSE 2008 Retrieved

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