

# **“Health Care Fraud”**

## **18USC, Ch. 63, Sec. 1347**

- **Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—**
- **1. To defraud any health care benefit program; or**
- **2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care services, shall be fined under this title or imprisoned not more than ten years, or both.**

# **“Health Care Claims Fraud”**

## **NJ, 1997**

- **Health Care Claims Fraud means making, or causing to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omitting a material fact from, or causing a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically, or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted for payment or reimbursement for health care services.**

# Why Commit Health Care Fraud?

- **2000: \$1.3 *Trillion* National Expenditure**
- **54% Private-Sector \$\$\$**
- **46% Public-Sector \$\$\$**
- **13.2% of GDP**
  
- **SOURCE: Centers for Medicare & Medicaid Services.**

# **Inherent Vulnerabilities**

- **Assumption of Honesty**
- **Number of Payers**
- **1,000,000 Providers**
- **4 billion+ Transactions Annually**
- **Evolving System**
- **Perceived as Low-Risk Crime**

# **HIPAA Highlights**

- **New Federal Criminal Offenses**
  - Health Care Fraud
  - False Statements
  - Obstruction of Investigation
  - Theft or Embezzlement
- **New Law Enforcement Tools**
  - \$\$\$
  - Coordinated Private-Public Approach
  - Healthcare Integrity & Protection Databank

# **HIPAA Implementation**

- **Information-Sharing via Designated Information-Exchange Coordinators**
  - Payer-to-Payer
  - Payer-to-Law Enforcement
  - Law Enforcement-to-Payer
- **DOJ Statement of Principles (10/98)**

# State Action

- **More Insurance Fraud Bureaus**
- **Anti-Fraud Mandates on Insurers**
  - **Anti-Fraud Plans**
  - **SIUs**
  - **SIU/Other Training**
  - **Case Referrals**
  - **Annual Reports**
- **Need Understand How Health Insurance Differs from Other Lines**

# **Dishonest Provider Tools**

- **Patient Population**
- **Possible Conditions & Treatments to Bill**
- **Wide 3rd-Party Billing Authority**

# **Most Common Types of Suspected Provider Fraud**

- **Billing for Services Not Rendered (54%)**
- **Misrepresentation of Services Provided (27%)**
- **Provision of Medically Unnecessary Services (9%)**

– SOURCE: NHCAA PINS DATABASE

# **Fundamental Characteristics**

- **Multiple Targets Simultaneously**
- **Private-Public Targets Simultaneously**
- **Elimination of Patient's Financial Interest**
- **Often Follows New/Expanded Benefits, New Treatments & Technologies**
- **Occurs Across Entire Provider Spectrum**

# Estimated \$\$\$ Impact

- **3% to 10% of Annual U.S. Expenditure**
- ***Translation:* \$39 Billion to \$130 Billion in 2000 alone**

# NHCAA

- **1985**
- **Private Health Payers**
  - Commercial Insurers
  - BCBS Plans
  - MCOs
  - Self-Insureds
  - TPAs
- **Public Sector**
  - Law Enforcement (Investigation/Prosecution)
  - Administrative (Detection)

# NHCAA

- **Education & Training**
  - The NHCAA Institute for Health Care Fraud Prevention
- **Information-Sharing & Investigation Support**
  - On-Line PINS Database of Active Investigations
  - L.E. Requests for Investigation Assistance
- **Professional Interaction**