Insurance Fraud: What Chiropractors Need to Know

By Howard J. Levinson, DC, DABCO

As health professionals know only too well, the health care industry has undergone some drastic changes in recent years. Managed care is now a fact of life, in all facets of health care. Virtually every aspect of patient care, whether under major medical, workers' compensation, or personal injury coverage, has been affected. In some states, the treatment parameters for injury cases are dictated by managed care.

Courtesy Tony Stone Images

Utilization review, quality assurance, claims management, peer review departments, and special insurance investigation units are some of the tools that insurance companies use to assure that their insured patients receive high-quality, efficient, and cost-effective care. Our responsibility, as professional and ethical health care providers, is to provide treatment that is effective in terms of both patient outcomes and cost.

But despite the various safeguards put in place by insurers and the profession's own ethics, there has been some abuse of the health care payment system. For many reasons, but primarily the simple human impulses toward greed and financial gain, some health care professionals have become embroiled in insurance abuse and fraud. Statistics compiled over the past four years have shown a dramatic rise in insurance fraud cases. Federal prosecution for insurance fraud has increased from 83 cases in 1992 to 246 cases in 1996. Civil investigations handled by the Justice Department rose from 270 in 1992 to 2,488 in 1996.*

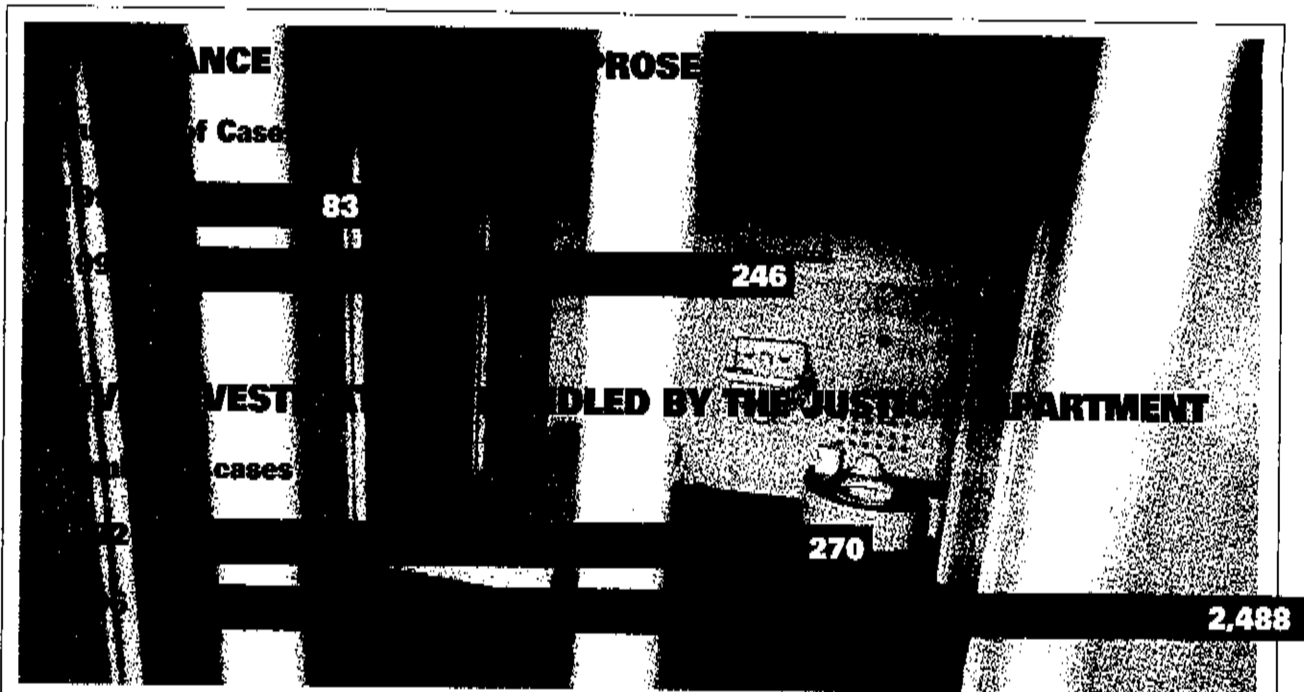
What, in particular, is required for successful prosecution of a health care provider for fraudulent criminal activity? The law specifies that these elements must be present:

1. **Intent to defraud.** The doctor intentionally and deliberately deceived the insurer.

2. **Knowledge.** The doctor knew what he or she was doing. For example, the doctor failed to disclose a pre-existing injury that he or she was aware of, concurrent insurance coverage, or the type of injury. The doctor may have altered, omitted, or falsified records to facilitate payment.

3. **Misrepresentation.** The doctor created a false impression of the patient's condition, which prompted the insurer to pay the claim.

4. **Reliance.** The insurer would not have paid the claim if the company had been informed of the true facts.



5. **Code violations.** The health care provider engaged in a pattern or practice of presenting a claim for an item or service based on a "code" that the provider knows (or should have known) would yield a greater payment than that afforded by the appropriate code.

6. **Medical necessity.** The health care provider submitted a claim that he or she knew (or should have known) was for a "pattern of medical or other item or service that he or she knew (or should have known) was not medically necessary."

7. **Obstruction of justice.** The provider willfully made false statements, or in some way obstructed the communication of information or records, to a criminal investigator examining a violation of a federal health care law. This offense is subject to a fine and/or imprisonment for up to five years.

The Government Responds, Mightily

In August of 1996, President Clinton signed into law the Federal Health Insurance Portability and Accountability Act (HIPAA). One section was specifically aimed at the detection, prevention, and successful prosecution of fraud and abuse in health care.

Some significant provisions in this regard call for the coordination and cooperation of federal, state, and local law enforcement to control fraud and abuse, with respect to health insurance plans. Specifically, the law mandates investigations, audits, evaluations, and inspections with regard to the delivery of payment for health care in the United States. The provisions were included to make it easier to enforce the civil, criminal, and administrative laws that apply to health care fraud. In fact, the civil fines imposed for any violations can be rather hefty.

HIPAA will also help the health care industry by providing education, guidance, and special fraud alerts to keep everyone informed about what kinds of fraudulent health care practices have been recently reported.

Included as well are new provisions for reporting and disclosure of actions taken against fraudulent health care providers, through a new national data bank. The information in this database, which provides some essentials on sanctioned or convicted health care providers, is accessible to federal and state governmental agencies, as well as health insurance plans.

The government does not take fraudulent activity lightly, and has therefore provided the program with sufficient funding to ensure its success. A total of $104 million has been authorized for the Departments of Justice and Health and Human Services for health care enforcement activities.

A Medicare integrity program within the HHS was also put in place. This program reviews Medicare providers, investigates medical utilization review and fraud, and makes a final determination as to whether payments should have been made. For FY 1997, the Medicare review program was support-

ed by $430 million to $440 million.

A beneficiary (informant) incentive program that is part of the new act encourages individuals to report to the HHS any information on individuals presumed to be engaging in potentially fraudulent activities. Informants can receive rewards of at least $100. In addition, a portion of the amount collected in fines from the violator may be passed along to the person who initiated the investigation by providing information on the violator.

The act also includes language for a new health care fraud statute for anyone who knowingly and willfully executes, or attempts to execute, a scheme to defraud any health care benefit program. This provision applies to any doctors, office staff, and physician groups formed with the intention of perpetuating an insurance fraud scheme.

Personal injury schemes. Many of these schemes involve fraudulent accidents and injuries; the following are some of the ones criminals commonly use. Of course, many perfectly legitimate patients may describe similar circumstances, so health care providers should pay close attention to the patient and circumstances of any injury.

1. **Accidents with rental cars.** The perpetrator (patient) rents a car and purchases Personal Accident Insurance (PAI) on the rental agreement. This ensures that damages to the car, the renter, and passengers will be covered by the rental company's insurance. The patient then arranges to have a collaborator intentionally hit his rental car. Finally, the "injured" patient and passengers present at the doctor's office.

2. **Accidents with phantom objects.** The perpetrator presents in the clinic, claiming that he was injured in an attempt to avoid hitting a phantom object, usually a dog, bicyclist, etc., or contends that he was run off the road by a vehicle that subsequently fled the scene of the accident.

Table 1. Possible Indicators of Fraud

• Three or more occupants in a "struck vehicle," all with similar injuries.	• Attorney threatens further legal action unless quick settlement is made.
• All of the injuries are subjectively diagnosed, i.e., headache, neck pain, back pain.	• Physicians' bills are submitted without dates or descriptions of office visits.
• Patient regularly cancels or fails to keep appointments.	• Physician bills workers' comp and health insurance and accepts payment from both.
• Minor accidents produce protracted treatment, excessive medical costs, and lost wages.	• Physicians' treatment includes dates on holidays or days that office would not normally be open.
• All patients are treated by the same physician(s).	• Physician immediately refers patient for a wide variety of tests and specialty consultations.
• Patients obtain legal representation immediately.	• Physician is known for overutilization and excessive fees.
• Physicians' bills are all the same.	• Attorney is known for handling suspicious claims.
• Treatment is always the same in terms of duration and frequency, regardless of patient's type of injury or diagnosis.	• Attorney lien or letter of protection is dated same day as injury.
• Physician's treatment not consistent with the diagnosis.	• Attorney/physician pair repeatedly seen on claims.
• Physician's medical bills submitted are photocopies of originals.	• Attorney fails to provide or limits access to medical evaluations and disability ratings.

Table 2. Possible Indicators of Workers' Compensation Fraud

- [illegible] on Friday, but was not [illegible] Monday morning.
- [illegible] this type employee should be [illegible] clerical staff unloading a truck)
- [illegible] accident are vague.
- [illegible] did not report the injury [illegible]
- [illegible] just before or after [illegible]
- [illegible] is disgruntled, soon to retire, [illegible]
- [illegible] has multiple or suspicious [illegible]
- [illegible] frequently changes doctors, [illegible] home addresses.
- [illegible] worker is experiencing financial [illegible]
- Injured worker protests about [illegible] work and never seems to improve. [illegible]
- No one witnesses the accident.
- Physician's diagnosis is [illegible] treatment.
- Protracted treatment for [illegible]
- Treatment did not begin [illegible] amount of time.
- Physician's documentation [illegible] diagnostic testing, and [illegible] described earlier.
- Attorney lien same day [illegible]
- Attorney/physician [illegible] claims.
- Attorney conduct suspect [illegible] earlier.

3. **Accidents with unsuspecting motorists.** The perpetrator cuts in front of an unsuspecting driver and then slams on the brakes, thereby causing an impact with the unsuspecting car behind, and consequent rear-end damage to his vehicle. In another variation on this type of scam, two cars position themselves in front of an unsuspecting driver. The driver in the front slams on his brakes, as does the second driver, and the unsuspecting driver strikes the middle car, while the lead driver makes his getaway.

4. **Slip-and-fall schemes.** The perpetrator stages an accident in a public place; staged witnesses may be part of the fraud. The alleged "injuries" are usually in soft tissue (hard to visualize with the more common imaging systems).

5. **Workers' compensation schemes.** An employee fakes or stages an injury on the job. Although the physical examination does not support the employee's claim, a treatment program is initiated. The employee, with the physician's assistance, files a disability claim. Then, the doctor bills workers' compensation for treatment that was in fact never rendered or for unnecessary diagnostic testing. (The doctor may have a financial interest in the diagnostic facility used.)

Often, attorneys will be involved in the scheme, too, and will send allegedly injured employees to the same doctor or group of doctors for treatment.

Eye-Openers—Possible Signs of Fraud

Tables 1 and 2 provide a list of indicators common to many cases of fraudulent health care. Of course, these are only the "pieces of a puzzle" in determining whether a case may be fraudulent. The indicators, of and by themselves, may not in any manner indicate fraud.

The Consequence: Imprisonment

Physicians suspected of fraudulent activity are commonly prosecuted on the federal level. Charges of mail fraud, tax evasion, money laundering, conspiracy, and racketeer-influenced corrupt organizations (RICO) are common.

To be charged with mail fraud, the physician must have used the U.S. Postal Service to facilitate the fraudulent activity. For example, a physician mails fraudulent HCFA claim forms for payment to the

insurance company. Note that each item mailed through the Postal Service is a separate "count" of mail fraud. Each "count" for which a doctor is convicted will yield a certain amount of jail time. In addition, if the physician has collected moneys by illegal means, the Internal Revenue Service will certainly have an interest in evaluating his financial status.

Penalties for insurance fraud are assessed according to the number of "counts" and the number of different charges for which the health care provider has been found guilty. The amount of prison time is rigidly defined in the *Federal Prison Sentencing Guidelines*. Each federal judge uses these set guidelines to levy prison sentences to violators.

Unlike the state judicial system, it's not possible to plea-bargain on the federal level. However, it is possible for a violator to reduce his sentence by cooperating in the investigation. If that happens, the judge is allowed to deviate from what is stipulated in the sentencing guidelines and impose a lesser sentence, which is termed a "downward departure" from the guidelines. In any event, though, a conviction will almost always result in some jail time.

Civil penalties, in addition to jail time, are common. Revisions in the civil penalty code consequent to the HIPAA act increase civil penalties (fines) from $2,000 to $10,000, for each item or fraudulent service involved in a violation. Sanctions, including exclusion from federal health insurance programs for a minimum of five years, can also be levied against the physician. That means goodbye to Medicare reimbursement for at least five years.

Investigative Agencies

Insurance companies have their own in-house investigative departments. Typically, these are called Special Investigative Units (SIU). The investigators are usually former law enforcement officers with extensive experience in investigative work.

Local and state law enforcement agencies can also help in investigating insurance fraud. Most states have investigators assigned to insurance fraud units and/or workers' compensation fraud bureaus.

The federal government is highly involved in prosecuting insurance fraud. The Federal Bureau of Investigation, Internal Revenue Service, U.S. Postal Service, Department of Health and Human Services, and the Drug Enforcement Administration all have investigative units whose job it is to combat criminal activity in health care.

One of the most successful and effective organizations working against insurance fraud is the National Insurance Crime Bureau (NICB). The NICB is a national organization supported by more than 1,000 insurers. Its mission, to combat vehicle theft and insurance fraud, is supported by a database that links insurance companies and law enforcement personnel nationwide. Many NICB investigators are former law enforcement officials, with expert investigative skills.

Look in the Mirror

In conclusion, I hope the reader can honestly say he or she is not involved in anything that could be even remotely considered fraudulent.

I have been involved in law enforcement for over 15 years. Many of these years were spent as an investigator. In particular, I assumed a five-year assignment as an undercover detective and was deputized as a federal agent, investigating organized criminal activity.

During that time, I was able to secure information on suspected criminal activity from a wide variety of sources. These people, typically, are called "informants," "storytellers," "songbirds," and, in some circles, "rats."

The informants I worked with were medical doctors, nurses, chiropractors, spurned spouses, ex-wives, ex-husbands, disgruntled employees, and mercenaries—people who provide information to the highest bidder. Given the diversity and extent of this network, any physician predisposed to become involved in fraudulent activity should be warned: Eventually, the truth will come out.

I've done my fair share of knocking on the criminal's door—and in some cases—knocking it down. From the moment the agents first arrive at a doctor's office, his life, as he's known it to that point, is over. I hope that the information provided here will help readers avoid getting involved (or even giving the appearance of involvement) in any fraudulent criminal activity. As chiropractic physicians, we have enough battles to overcome. We shouldn't add the extra burden of criminal legal battles to our agenda. ▼

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