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Combating Medicare Fraud: A Struggling Work In Progress

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ABSTRACT

INTRODUCTION: The United States has spent approximately $2.6 trillion on healthcare in recent years. This accounts for 17.9% of the national gross domestic product. Fraud has been identified as one of the leading causes of the nation's increasing health expense. Medicare fraud has taken many forms including overutilization, upcoding, billing for services not provided and filing false cost reports. Fraud has been found throughout the healthcare industry and has been difficult to detect.

METHODOLOGY: The methodology for this qualitative study was a literature review. Four electronic databases and several government websites were utilized. Thirty nine sources were referenced for this literature review.

RESULTS: Medicare fraud has recently been found to be much easier and more lucrative than dealing drugs. Many flaws within the system have been identified, primarily in billing procedures. The organization of the Medicare system has made it susceptible to corruption. Not only have providers committed fraud; insurance agents have manipulated new Medicare enrollees, adding to the fraud problems. Some provisions have been put in place to help prevent Medicare fraud. Government agencies such as the Center for Medicare and Medicaid Services, the Department of Justice, and the Department of Health and Human Services have joined together to address this matter; however fraud has continued to plague Medicare. Efforts to revise the system have led to the detection of several fraud schemes in the past two years. Many more schemes may be identified and stopped as the government becomes more proficient in combating Medicare fraud.

CONCLUSION: Fraud has been identified throughout the healthcare industry and has been difficult to detect. The many flaws in the billing system and lack of responsibility and commitment by the government have led fraud to be a significant issue. To address the problem of fraud, an effective strategy must be put in place that better detects, deters, and remedies vulnerabilities. Part of such a strategy is being implemented by the current presidential administration, however further prevention programs may be required to continue this trend.

INTRODUCTION

The United States (US) healthcare spending has reached $2.6 trillion in 2010, accounting for 17.9% of the national Gross Domestic Product (GDP) (Kaiser Foundation, 2010). Spending has been projected to increase through 2020, with national health spending expected to reach $4.6 trillion, or 19.8% of the GDP. The average annual health expenditure growth of 5.8% has been anticipated to outpace average annual growth in the overall economy by 4.7% (CMS, 2010a). As a result of the Affordable Care Act's coverage related expansions, these costs have been

projected to grow 8.3% by 2014 (CMS, 2010a). Conversely, half of the nation's health expenditures have come from hospital care (31%) and physician/clinical services (20%) (Kaiser Foundation, 2010).

Medicare was formed as a health insurance program for people age 65 and older, people with disabilities, and people of all ages with End-Stage Renal Disease. Four parts of Medicare have been created since its inception: hospital insurance (Part A); medical insurance (Part B); Medicare Plans or Managed care (Part C), and prescription drug coverage (Part D), (CMS, 2005). Many factors have increased the cost of Medicare and healthcare. These factors have been identified as growth in pharmaceutical expenses, costly new technologies, the aging population, increases in consumer demand, and healthcare labor (AHRQ, 2001). Additionally, other factors that have increased the cost of healthcare include defensive medicine, unnecessary services, duplicative costs of administering different plans and unproductive documentation, prices that are higher than competitive levels, medical errors and uncoordinated care, and poor delivery of clinical prevention services (Regence, 2011). The Medicare program has paid millions of dollars annually for fraud. Consequently, U.S. citizens have paid higher healthcare premiums and healthcare costs (DHHS and DOJ, 2012). The National Health Care Anti-Fraud Association (NHCAA) has estimated that about three percent, or more than $60 billion, of national healthcare spending has involved fraud (NHCAA, 2008).

Medicare fraud has been a serious problem that has required the attention of everyone (CMS, 2011). Fraud has been defined as intentional deception or misrepresentation often including failure to disclose the truth (Fraudlaw, 2010). Fraud, in terms of Medicare, has been defined as knowingly and willfully obtaining information by means of false pretenses, deception, or misrepresentation in order to receive inappropriate payment from the Medicare program (NCPTRC, 2009). Medicare fraud has taken different forms such as providing more services than are medically needed (overutilization), assigning a wrong Current Procedure Terminology (CPT) code or up coding, creating a false amount of service actually provided, billing for services not provided, and filing false cost reports (Quitamonline, 2004). The NHCAA has defined Medicare fraud as falsifying a patient's diagnosis to justify tests, surgeries or other procedures not medically necessary, each step of a procedure being billed as a separate entity, billing patients more than their co-pay amount for prepaid services, accepting kickbacks for

patient referrals, and having patient co-pays or deductibles waived and having insurance carriers or benefit plans over-billed for services (NHCAA, 2008).

Fraud has been found everywhere, both in the healthcare industry and within Medicare, however, it has been difficult to detect. The U.S. Department of Health and Human Services (DHHS) and U.S. Department of Justice (DOJ) have been working together to identify and investigate fraudulent activities that have had a negative financial impact on Medicare (DHHS and DOJ, 2012). Finally, the Affordable Care Act also has provided concrete steps toward combating health care fraud, waste, and abuse as it has provided $350 million over 10 years to boost anti-fraud efforts and to **enhanced screening (**

The purpose of this research was to explore how susceptible Medicare is to fraud and the efforts in combating Medicare fraud.

METHODLOGY

The literature review was comprised of professional journals, peer reviewed journals, online articles, and federal agency websites such as Medicare, the Center for Medicare and Medicaid Services (CMS), the Department of Health and Human Services, the Department of Justice, the Kaiser Foundation, and the National Health Care Antifraud Association. The research followed the basic principles of a systematic search conducted in stages. The stages included defining a search strategy, identifying the inclusion criteria, assessing which articles retrieved were relevant and valid, and extracting the data relevant to the purpose of this study.

The search was conducted by utilizing the online databases EBSCO host, PubMed, Google Scholar, and LexisNexis. Key words searched were “Medicare” OR Center for Medicare and Medicaid Services OR“CMS” AND “Medicare Fraud” OR “healthcare fraud” OR “fraud”. This literature review yielded 39 articles which were significant resources for this research. To ensure the information used would be as current and relevant as possible, all sources referenced were articles published since 2000 in the English language.

RESULTS

The results presented were extracted from journal articles, case studies and different websites from diverse sources, to illustrate several aspects of Medicare fraud that should be considered such as financial impact, legislation, prevention and detection of fraud.

According to Suderman (2011), Medicare fraud has been portrayed to be much easier and potentially more lucrative than dealing drugs. When seeking health assistance, providers give Medicare recipients whatever treatment thought necessary, pass a few CMS requirements, complete some forms, but the government doesn't audit it and only reimburses it (Suderman, 2011). Cannon (2011) found that for providers, Medicare was too easy to access. All that is needed is a computer, billing software to match diagnoses and procedures, and black market lists of patient IDs. The Medicare system has a number of weaknesses in its billing code system which makes it susceptible to fraud. The system is imprecise and significant overlap occurs. Two similar devices or services can have billing codes that are similar to one another. If one device or service is ineligible for reimbursement, the same claim can be easily submitted under the code of the alternate device or service (Suderman, 2011).

Morris (2009) found that for the U.S. health system to be more proficient in providing medical care and to continue to have solutions for the future, the government has to pursue an effective strategy that both prevents and detects fraud, waste, and abuse, and moves promptly with investigations, prosecutions, and remedies. According to this researcher, several principles have been used to help reduce fraud. Robust pre-enrollment screening has been implemented. Payment methodologies have been established that are reasonable and responsive to changes in the marketplace. Providers and suppliers have been assisted in adopting compliance practices and there should be more oversight, and monitoring programs for evidence of fraud, waste, or abuse. The Office of Inspector General (OIG) has found that there has been an increase in organized crime elements in healthcare. Lower penalty rates than other organized crime-relate offenses have made health care fraud more attractive to professional (Menke, 2010).

According to Iglehart (2009), improper Medicare payments have been a long standing, significant problem for the federal government, but Congress has not always been willing to appropriate the monies that the executive branch seeks for antifraud activities. Since the Affordable Care Act was passed in 2010, a range of provisions has been put in place to reduce waste, fraud, and abuse which could save the U.S. $4.9 billion over a ten year period starting from 2010 (CMS, 2010b). These provisions have included forming task forces as well as the Center for Program Integrity to detect and prevent Medicare Fraud. Further, the Obama administration has used funds to implement the Fraud Prevention System (Carlson, 2012). These

systems would require patients to have face encounters with physicians before receiving certain services and would also require greater data matching capabilities (CMS, 2010b; Daly, 2012). Iglehart (2010) has stated that new efforts by the government have reworked the pay-and-chase model that the Medicare system has had in place. Also, as part of the antifraud provisions of health reform, rules have been tightened for Medicare contractors. The enrollment process has become more secure and screening procedures have been implemented with criminal background checks, fingerprinting, unannounced site visits, and database checks of providers (Federal Register, 2011). Providers, suppliers, and managed care organizations have been required to report and repay within 60 days an overpayment from Medicare and Medicaid. Refusal to pay has been identified as a violation of the False Claims Act. Medicare providers and suppliers have been required to participate in Medicare compliance programs (Federal Register, 2011). These efforts have been put in place and the success of these reforms can be measured by the amount of improper Medicare payments they have prevented (Iglehart, 2010); Daly, 2012;.

According to Troy (2010), Medicare waste has been made worse via the CMS payment processing system. CMS has been pressured to reimburse billing quickly to prevent providers and suppliers from opting out of the system. Payments have been investigated only if CMS or the OIG later discovers or is informed about some impropriety (Troy, 2010). According to McGuire and Sheider (2007), civil and criminal sanctions have been implemented for any person or legal entity that provides healthcare goods and services in a fraudulent or abusive manner.

There have been many fraud schemes discovered within the past two years. One large scam unfolded February 28, 2010 in Texas, where Dr. Jacque Roy was among seven individuals accused of fraudulently billing Medicare and Medicaid for nearly $375 million (U.S. News, 2010). Additionally, CMS suspended 78 home health agencies associated with Dr. Roy. The seven were charged with participating in sophisticated Medicare fraud and money laundering schemes (U.S. News, 2010). On October 14, 2010, an Armenian crime organization was charged with creating $163 million in false bills and creating at least 118 phantom medical clinics in 25 states. The medical clinics used stolen identities to bill for and receive $35 million in claims. At least 73 of the defendants were located in California, Georgia, New Mexico, and Ohio (Golding, 2010).

On February 18, 2011, the largest Medicare fraud case in U.S. history was uncovered as law enforcement charged 111 people in nine cities for filing millions of dollars in false claims. In

Tampa Bay, Florida, ten people were charged for claims totaling $5 million (Velde, 2011). In Clearwater, Florida, a physician, Jayam Krishna Iyer was accused of submitting $457,000 in claims for services not performed and received about $165,000 for submitting the claims. Also, among those arrested were owners and employees of several different medical facilities, rehabilitation facilities, and pharmacies across nine cities. In total CMS lost $225 million (Velde, 2011). On April 27, 2012, among the 111 defendants arrested, four came forth and admitted to falsifying documents that helped two area businesses collect $37.9 million in false claims to Medicare (Anon

In November 2011, in New York, 12 individuals were charged for fraudulently billing Medicare for more than $95 million (DOJ, 2011a). A second indictment in Flushing, New York, accused six defendants who participated in a fraud scheme at two local medical centers. Medicare was billed for $11.7 million in false claims for physical therapy, electric stimulation treatments, and other services (DOJ, 2011a). According to the DOJ (2010), Jose and Denisse Martinez billed Medicare for unnecessary medical services or services never provided. Between November 2006 and March 2007, Jose and Denisse Martinez filed $970,631 in false and fraudulent claims, in which Medicare paid more than $649,000 (DOJ, 2010a).

In Detroit, Michigan, Lil Vargas-Arias plead guilty to one count of conspiracy to commit healthcare fraud and was sentenced to ten years maximum in prison and a $250,000 fine (DOJ, 2009a). Between September 2006 and March 2007, Vargas-Arias and her accomplices submitted approximately $6.6 million in false and fraudulent claims to the Medicare program, in which Medicare paid approximately $4.9 million (DOJ, 2009a). In 2009, in Los Angeles, California, 20 individuals were charged in healthcare fraud cases involving durable medical equipment (DOJ, 2009b). The defendants were charged with submitting more than $26 million in fraudulent Medicare claims (DOJ, 2009b). In May 2010, Jose Garcia, a fugitive since 2008, was arrested. He and Nayda Freire, his partner, were charged with conspiring to submit $10 million in claims to the Medicare program for Human Immunodeficiency Virus (HIV) infusion services provided at Global Med-Care Corp, operated by Garcia and Nayda Freire (DOJ, 2010b).

In April 2011, a Miami physician was convicted in a $23 million dollar scheme. The doctor was manipulating HIV injections and infusion claims to Medicare. Rene De Los Rios was convicted of five felony counts: one count of conspiracy to commit healthcare fraud, and four counts of submission of false claims to the Medicare program (DOJ, 2011b). For the conspiracy

charges, De Los Rios received 10 years in prison and a $250,000 fine. Each false claim carried a maximum penalty of five years in prison adding another 20 years (DOJ, 2011b).

In Texas on April 5, 2012, the owner of Standard Health Community Services, Tony Obi was arrested for a $45 million physical therapy fraud scheme. Obi also allegedly accepted more than $1 million in kickbacks (Langford, 2012). The owner was already on one year probation for submitting $86,000 in false substance abuse counseling claims to Medicaid (Langford, 2012). The defendant pled guilty in order to avoid a conviction which allowed him to serve his original sentence of one year of probation.

Another case was filed on April 5, 2012 in Cleveland, Ohio where a local chiropractor was accused of overbilling Medicare and private insurers for more than $1 million and was indicted on 55 federal counts. The defendant, John Heary, billed for medical equipment a patient had no need for and billed for patient physical therapy that was never received. Heary also advertised free consultation in order to receive more patients and offered to waive co-payments or provide patients with free dinners in exchange for office visits (Gazette, 2012). In Boulder, Colorado, on April 19, 2012, social worker Karen Stevens was convicted of defrauding Medicare of nearly $200,000 for psychotherapy services that were fabricated or not received (Snider, 2012). Stevens was sentenced on June 25, 2012 to one year of work release and ten years of probation (Daily Camera, 2012).

DISCUSSION

Medicare fraud has continually occurred in the healthcare industry and has been identified as more profitable than dealing drugs. Fraud has been attractive to professional criminals because penalties have been less harsh than other organized crime-related offenses. Fraud has been most prevalent in larger cities in states such as New York, Michigan, Florida and California. Medicare fraud has been easily committed as a computer, billing software, and patient IDs are all an individual needs to begin billing Medicare. The Medicare billing code system has had several flaws. There has also been a lack of responsibility on the part of the federal government in anti-fraud efforts, primarily in that the government has invested a significant amount of funds, around $161 million on fraud prevention; however, system implementation has been slow (Carlson, 2012). More recently, these efforts have appeared to have had increasing success, with more than $10.7 billion having been recovered from 2009 to 2012 (HealthCare, 2011).

Ethical Implications

Several ethical implications have been identified as a result of this study. Ethical training and moral behavior has been lacking in the healthcare and medical vocations. Providers in healthcare have been thought of as more service oriented and less profit motivated than other sectors of business. Mandatory ethics training has been part of most professions. However, the training has been ineffective and often has not improved ethical behavior. Providers, lawyers, accountants, business school graduates, and others have been required to have ethics training with annual ethics-education updates. Such training has not led to a reduction of business and healthcare fraud (Sikula and Sikula, 2008).

The main source of information for this research study was from the use of federal agency and news websites due to the subject being a government issue so publication bias cannot rule out a. The databases chosen for the search and the search terms used were carefully selected to provide the largest amount of relevant articles, however, it is possible that some articles were not included. Further research will be required to address the efficiency of the currents efforts to prevent and stop Medicare fraud which was beyond the scope of this study.

CONCLUSION

The Medicare billing system is flawed, making it susceptible to fraud. To fix the system, the government must have an effective strategy that detects, deters, and remedies vulnerabilities. Current government program implemented by the Obama administration have had some success in Medicare fraud detection and prevention, however further prevention programs may be required to continue this trend.

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