Phantom Billing, Fake Prescriptions, and the High Cost of Medicine

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Fee-for-Service Shenanigans

After a four-week trial, a former Florida dermatologist was sentenced to twenty-two years in prison, ordered to pay $3.7 million and to forfeit an additional $3.7 million, and slapped with a $25,000 fine for performing 3,086 unnecessary invasive surgeries on 865 Medicare beneficiaries. Between 1998 and 2004, the doctor used faked biopsy results to generate diagnoses of skin cancer. Some of the specimens were actually slides containing chewing gum, Styrofoam, or skin tissue from the dermatologist’s employees. By performing five surgeries a day and billing Medicare between $1,500 and $2,000 per procedure, the doctor’s crooked business resembled a gigantic ATM machine with a huge cash-withdrawal limit.\(^1\)

Take one health care provider. Add a fee-for-service system. Then mix. What you have here is a perfect prescription for health care fraud and abuse. The reality is simple. Under fee-for-service, the more care or services a health care provider delivers, the more revenue the provider generates. It is really no surprise then that fee-for-service arrangements encourage a variety of money-generating frauds and abuses. Here is a partial list: making false diagnoses, upcoding insurance claims, ordering bogus laboratory tests, committing home health care frauds, submitting false billings for psychological and psychiatric services, and selling unnecessary or substandard durable medical equipment. These schemes are used in every imaginable way. Not only are they used to cheat public and private health insurers, but they are also used to fleece the most vulnerable and needy—such as elderly and low-income persons.
Probably the most common health care fraud that is linked directly to fee-for-service is the submission of fraudulent claims to the Medicare program. The following two cases reported by the Department of Health and Human Services are typical of what occurred in the Miami area, a major center for health care fraud.

Eight individuals who owned two home health care centers were indicted and their company and personal assets frozen in June of 2009 after they were accused of engineering a $22 million Medicare fraud scheme. Federal prosecutors claimed that the defendants recruited beneficiaries and paid kickbacks and bribes to them in exchange for their Medicare beneficiary numbers. The numbers were then used by the defendants to file phony Medicare claims for home health care services. One defendant, a medical assistant, also falsified medical tests and records to make it appear that the services were needed.

A 54-year old Miami physician was sentenced on June 29, 2009 by U.S. District Judge Paul C. Huck to 97 months in prison for a Medicare fraud. A month earlier, the doctor pleaded guilty before Judge Huck to conspiracy to commit healthcare fraud. He was a co-owner and practicing physician of a Miami HIV clinic where he and his co-conspirators routinely billed the Medicare program for services that were either medically unnecessary or were never provided. The doctor admitted further that he purchased only a small fraction of the drugs that were administered to patients at the clinic.

Most of the services billed to the Medicare program were treatments for thrombocytopenia, a disorder involving a low blood platelet count. According to the court documents, none of the patients treated for this condition actually had low counts. But, to fake the results, he employed chemists to alter the patients’ blood samples before they were sent to a laboratory.

The doctor also admitted that he had engaged in similar criminal activities between October 2003 and February 2005 while working as a medical director and practicing physician at five other Miami area HIV infusion clinics. He admitted to billing the Medicare program for phony HIV infusion services, claiming he was directly responsible for more than $20 million in false Medicare claims.

Since both honest and dishonest fee-for-service arrangements have produced ever-escalating health care costs, efforts to rein in costs were initiated in the 1990s with the introduction of more and more managed-care plans that tended to micromanage hospitals, doctors, and other health care providers. So, is it fair to say
that replacing fee-for-service health care with managed care will mark the end of health care fraud and abuse? Definitely not.

Managed care encourages money-saving frauds that impose fees on patients and insurers for little or no service. Money-saving frauds typically involve prepaid services such as health maintenance organizations (HMOs). The fraudulent health care provider accepts payments from patients and then shortchanges them by cutting corners or by spending as little money as possible on their care. Of course, many health care frauds combine both money-generating and money-saving strategies. Moreover, as I discuss later, the second fraud—shortchanging patients on care—is particularly complex and raises many vexing questions. For example, is it fraud or a highly unethical practice when an HMO picks subscribers—using advertising schemes to try to find the healthiest people and trying to discourage the sickest—in the hope that it will have to provide as few services as possible? What if an insurer routinely denies 10 percent of all customer claims, expecting that many of those people will not fight the denial? Is using a technicality to deny payments to patients an act of fraud? If not, why not? Changing the methods of health care delivery will not eliminate fraud, although it may change the tactics used by perpetrators to commit such frauds.

The Major U.S. Public Insurance Programs: A Criminal’s Favorite Target

The public insurance programs Medicare and Medicaid (including the State Children’s Health Insurance Program) are primary targets for criminals bent on committing health care fraud. Perpetrators of fraud have learned three things about these programs. The first thing that attracts them is the sheer size of the pot they can poach from. Public health insurance programs have claims budgets amounting to hundreds of billions of dollars. Medicare and Medicaid together financed some $755.2 billion in health care services in 2007. And an aging population and higher unemployment rates are driving up both Medicare and Medicaid expenditures. Medicare expenditures are projected to be $528 billion in 2010, up 6 percent from 2009. By 2020 annual Medicare expenditures are expected to exceed $1 trillion.5

Furthermore, health care providers, patients, and regulators expect Medicare, Medicaid, TRICARE, or other insurance claims to be processed quickly. Expediting payments for claims usually takes priority over fraud detection.

Finally, the antifraud measures of these programs have been aimed mainly at stopping the blatant, high-dollar frauds. The more mundane, low-dollar frauds, however, may be slipping undetected through the reimbursement process.

Later, in chapter six, I discuss the often inadequate detection and preventive methods used by these public programs to deter and reduce health care fraud
and abuse. A perpetrator’s imagination seems to be the only limit when it comes to planning and committing health care fraud, however. Such imaginations come in both big and small packages. Those who commit health care fraud and abuse may be as small time as a street hoodlum or as big time as a preeminent professor at an elite medical school. Whether big or small, however, health care fraud cases prosecuted by the federal or state governments usually involve one or more of the following schemes.

**Intentional False Diagnoses and Unnecessary Treatments**

For physicians, nurses, or other health care providers, the diagnosis is the starting point for any treatment. It is also one of the starting points for health care fraud. False diagnoses—as opposed to erroneous diagnoses—enable a health care provider to obtain payments from patients or insurers for unnecessary medical treatments, pharmaceuticals, or durable medical equipment. Here are just a few examples of how these scams work.

- A regional medical center in Louisiana agreed to pay $3.8 million to the federal government to settle allegations of Medicare fraud. The center submitted claims for medically unnecessary angioplasty and stent procedures performed between 1999 and 2003.6
- A Kansas ear, nose, and throat specialist had his medical license suspended and was sentenced to six years in prison for performing unnecessary sinus and ear surgeries. The government’s expert witness found 40 percent of the 105 sinus surgeries and all but one of the 40 mastoid ear surgeries performed by the defendant were unnecessary.7 And these are not benign procedures. In an article posted on the website of the American Rhinologic Society, Jay M. Dutton, M.D., of the Rush–Presbyterian–St. Luke’s Medical Center in Chicago, lists nine complications of nasal and sinus surgery. These include leakage of cerebrospinal fluid, meningitis, and, in rare cases, blindness, not to mention voice changes, nasal obstruction, numbness, and infection.8 Thus, more than 80 patients were anesthetized and subjected to significant and painful side effects for no clinical reason at all.
- A provider of anatomic and clinical pathology services, patient information, and business-practice solutions for physicians paid $4.8 million in conjunction with Medicare and TRICARE billing frauds. The company billed for medically unnecessary DNA tests and for second-opinion consultations and reports that it failed to provide.9
- Two chiropractors were convicted of conspiracy and health care fraud against Medicare for using marketing techniques to attract customers with “good” health insurance policies and then tailoring patient treatments to their insurance coverage rather than to their medical needs.10
As noted earlier, false diagnoses can lead to unnecessary and dangerous treatments as well as to pain, suffering, and psychological damage. An Ohio physician was sentenced to life in prison for administering unnecessary and painful “trigger point” injections of the UN’s Single Convention on Narcotic Drugs Schedule II and III narcotics, causing the deaths of two patients. He was also ordered to pay $14.3 million in restitution for false billings to Medicare, Medicaid, and the Ohio Bureau of Workers’ Compensation. A Manhattan dermatologist was ordered to repay $880,000 for billing public and private insurers for services not provided to patients. The doctor lured patients back for more office visits by providing them with prescriptions for addictive drugs. This scam led to the death of one individual.11

Another form of unnecessary service is the practice of “ping-ponging.” A network of health care providers may refer a patient to other providers in the network for bogus examinations or treatments. These reciprocal referrals generate illicit revenues as the patient bounces as a ping-pong ball from one health care provider to another with each provider collecting a fee for providing services the patient did not need.

**Medical Identity Theft**

The 1995 movie *The Net* is about Angela Bennett (played by Sandra Bullock), a computer analyst vacationing in Mexico who meets computer hacker and scoundrel Jack Devin (played by Jeremy Northam). Over the course of the film’s ninety minutes, viewers watch a nefarious group of criminals who are intent on gaining access to secret government files, stealing Bennett’s identity, and wreaking havoc. The group hacks into medical records, and they seem bent on destroying the lives of their victims before Bennett finally uses her considerable computer skills to foil their plot and reestablish her stolen life. The Net’s plot was far-fetched by 1995 standards. Today, however, such plots in real life are anything but. Many forms of identity theft are becoming increasingly common, with plots more insidious and convoluted than even the most creative screenwriter could have imagined. And, unlike Angela Bennett, people who are victims of identity theft suffer its consequences for months, or even years. Now, added to other forms of identity theft, we have the medical version, which occurs when one person (the perpetrator) uses the identity of another person (the victim) to obtain health care services from a provider or reimbursement from an insurer.

Anyone who peruses a patient’s medical records will find a treasure trove of information—name and address, Social Security number, driver’s license number, insurance information (e.g., Medicare number), and other documentation. And health care institutions have begun to store more and more confidential information on computers. Thieves can steal the computers, often with the help of insiders, and then circumvent security barriers, decode the data (if the data was
encrypted), and either sell it to other criminals or use the data to file phony insurance claims. Unauthorized access may range from health care personnel who want to pry into the personal affairs of celebrity patients, as was the case with hospital workers who snooped through the medical files of the Britney Spears, George Clooney, Maria Shriver, and the late Farrah Fawcett—possibly selling information about their medical treatments and prognoses to tabloids—to scams leading to tens of thousands of dollars in fraudulent billings. \(^{12}\) At least eight employees at a California hospital breached the records of Nadya Suleman, the publicity seeking “octomom” (and mother of fourteen). A total of $437,500 in fines was levied against the hospital under a California privacy law that went into effect at the beginning of 2009. The law also imposes fines on individual health care workers.\(^ {13}\) In a bizarre case at a Miami hospital, an ultrasound technician pleaded guilty to selling patient medical records to a so-called medical records broker who, in turn, sold them to a personal injury attorney. The attorney used the patient information to find clients, sharing any money he earned with the broker.\(^ {14}\) Fraudulent billings caused by acts of identity theft have forced victims to deal with harassment by health care institution billing firms, collection agencies, and attorneys.

- A fifty-six-year-old retired teacher in Florida received a $66,000 surgical bill for the amputation of her right foot. She told a Federal Trade Commission workshop that her troubles started after someone stole her daughter’s wallet, which contained the family’s health insurance card. The thief even managed to get her blood type changed, something that could have been a disaster had she ever required emergency health care. Even after sending photographs to the hospital to prove that both of her feet were intact, the woman soon discovered that straightening out the fraudulent billings and correcting the errors in her medical records was a full-time job.\(^ {15}\)
- A Colorado victim had his medical identity stolen by a man who received multiple surgeries in his name. The victim was uninsured and lost property and a business due to the theft. Two years after being victimized, the man was so destitute that he had difficulty even paying his cell phone bill.\(^ {16}\)
- A twenty-two-year-old Marine first realized something was amiss in 2005 when his mother called to tell him he was a lead suspect in a car theft in South Carolina. He had lost his wallet more than a year earlier while celebrating with friends after completing boot camp at Parris Island, near Beaufort, South Carolina. An imposter used his military ID and driver’s license to not only test-drive new cars and then steal them, but also to receive treatments for kidney stones and an injured hand. The identity thief ran up nearly twenty thousand dollars in medical charges, destroying the young soldier’s credit. “It was horrible,” he said. “And what made it worse is that
no one really knew what to do when it first started happening.” Although the imposter was eventually arrested, the soldier’s identity theft problems persisted, even while he was serving a tour of duty in Iraq. His tax refund money was confiscated by the state as he continued to try to clean up his credit. If the Marine ever needs medical attention—his records, now possibly contaminated with errors—could put him in danger. And if those medical records someday become linked electronically to a nationwide health information network, correcting the errors could be even more difficult.17

In a nutshell, medical identity theft is even worse than its counterpart, financial identity theft. And its victims find no easy solutions. Although the Federal Trade Commission is well aware of the plight of identity theft victims, and although tougher laws have been enacted to deter criminals from committing identity theft and to help victims repair their credit ratings, the effects of this crime can plague its victims for months and even years. No central office exists where one can go for a quick repair job on his or her credit history or medical information. Adverse credit information connected to victims of identity theft has a way of staying stubbornly in the computers of the major credit bureaus. And if these battles are not punishment enough, medical identity theft can also damage the employment prospects and future insurability of someone whose medical records contain erroneous data about a physical or mental impairment.18 As is the case with other forms of health care fraud, medical identity theft may consume a victim’s health benefits, possibly reducing or exhausting his or her lifetime coverage limits.19

Medical identity theft can also damage a victim’s family life and reputation. A woman answered a knock on her door and was horrified to see law enforcement officers standing on the threshold. They accused her of being an unfit mother because she had given birth to a drug-addicted baby. The real mother, who was the perpetrator in this fraud, had used the woman’s identity to receive labor and delivery services from a hospital. Nevertheless, authorities threatened to take custody of the innocent woman’s four children, and she was saddled with a $10,000 hospital bill.

A similar incident occurred to a woman who was informed by hospital personnel that her newborn had tested positive for illegal drugs. The woman, however, had not given birth in years. She was the victim of a drug-abusing mother who had stolen her driver’s license and used it as an ID to obtain admission to the hospital.20 These cases illustrate how a moment of inattention and a stolen wallet may subject the victim to a seemingly never-ending stream of nightmarish hassles. Health care institutions want to settle past-due accounts, the police and social agencies want to ensure the safety of children, credit bureaus want to keep their huge databanks up to date, and collection agencies want to harass “deadbeat” consumers into paying their bills. If you are accused of a crime, the legal
system assumes you are innocent until proven guilty, and it goes to great lengths to ensure that you receive due process. If your identity and credit are stolen, however, the “court of commerce” seems to say that you, the victim, are assumed guilty until you can somehow produce strong evidence of your innocence. Obtaining such evidence, however, is a herculean task.

Perpetrators of medical identity fraud not only leave a wake of financial destruction and psychological trauma behind them, but their schemes often place erroneous information in a victim’s medical records. If the victim and the identity thief have different blood types, for example, posting the wrong blood type in her medical records could be life threatening. One industry expert posed the hypothetical situation of a medical identity theft victim with an acute case of appendicitis. On entering the hospital, medical personnel note all of the symptoms of acute appendicitis, but the patient’s records indicate he has already undergone an appendectomy. Of course, it is the imposter patient, not the current patient, who has undergone the earlier surgery. The victim, in the meantime, is placed at risk as medical personnel look elsewhere for the source of his abdominal pain.21 This scenario sounds eerily similar to the plot of The Net.

**Overbilling for Services and Equipment**

When you leave the doctor’s office, you often pay your health insurance deductible or copayment. Later, you may receive additional statements from your provider or insurer that lists the services you received along with a summary of payments and outstanding charges.

Now the fun begins as you try to decipher the exact billings for these services, how much you will be required to pay, and how much your insurer will pay on your behalf. Reading hieroglyphics is probably easier. And the process becomes almost impossible when the fees are spread among multiple health care providers—doctors, hospitals, labs, therapists, medical equipment firms, and so forth. The paperwork produced by health care providers and insurers—paperwork that is seemingly shrouded in secrecy—is unlike that of any other purchase, with the possible exception of real estate. But at least with real estate buying and selling, an attorney is usually present at the point of sale (closing) to guide you through the legal mumbo jumbo. We are usually on our own, however, to make sense of the obfuscated charges, the arcane insurance policy provisions, and the price haggling between providers and insurers. In this byzantine system, the left hand often does not know—or care—what the right hand is doing. So, we have a system that is ripe for fraud, especially when the right hand is up to no good.

One of the frauds that is encouraged by our current system is the practice of double billing—that is, submitting duplicate (or multiple) invoices to a patient or to an insurer for the same service. The double billings may be made by one or by
more than one provider. A Tennessee physician pleaded guilty to overbilling insurers by nearly $117,000 for submitting duplicate claims for ear tests. Instead of billing for the standard two-ear test, he doubled his charges by submitting separate claims for each ear. The doctor, whose medical license was revoked, was also accused of sexual assault, subornation of perjury, and other improper practices.22

Another form of duplicate billing is for two providers to bill for the same service. A family physician might submit a bill to Medicare for the analysis of X-rays even though a radiologist has already performed and billed Medicare for the same service.23 In other cases, a single X-ray is taken, but the insurer is billed for multiple X-rays. Unless the patient receives billing information from each source and recognizes that a double or multiple billing has taken place, the fraud—or error—may go undetected.

It is not only the small providers that practice this scam. The big providers do it too. A New York hospital agreed to pay $2.3 million to resolve civil charges of defrauding the federal government by double billing Medicare for outpatient services between January 1992 and June 2001. According to the complaint, the hospital “submitted these duplicate claims for payment even though it knew, or acted with deliberate ignorance or reckless disregard of the fact, that it had already been paid for the very same services, and thus its claims for payment were false.” The complaint also indicated that Empire Medical Services, the government’s Medicare claims processing intermediary, notified the hospital of the double billings and directed them to stop. These warnings were ignored.24

How, one wonders, can people get away with this practice? Is no one watching the store? The answer seems to be that some providers, such as the Tennessee doctor described above, have such an inflated sense of self-worth that they believe they are above the law. Health care providers work far from the view of regulators, and they may assume boldly—and often correctly—that their patients are either too naive or too afraid to blow the whistle. The Tennessee doctor worked in a small town where it was probably difficult to attract and retain physicians. He was probably a revered figure among the townspeople, and it took a set of extremely brash, irresponsible, and dangerous acts on his part before a public outcry arose. When his license was revoked in November 2004, the Notice of Charges accused him of working on patients while he was intoxicated and engaging in sexual acts with female staff, at times “in full view of patients.” This doctor also allowed patients and his staff to reuse prescription medicines, and he allowed untrained and unlicensed staff to diagnose, prescribe, and administer medicines.25 The seemingly incomprehensible audacity exhibited by the likes of this “loose cannon” of a physician is a sure-fire recipe for abominable fraud.

The more modest offenders may believe, and rightfully so, that they can fly under the radar and avoid detection. They bank on the fact that their treatments and billings will not come to the attention of the authorities as long as they resist
becoming too greedy and careless and stick to filing false claims only for ordinary treatments and services.

Some health care fraud perpetrators use hard-to-track multiple billings scattered over a wide geographic area, organizations with multiple names, or multiple provider addresses. A psychiatrist billed Medicare for services he provided in seven different states. His scheme entailed duplicate billings through two separate businesses that used twenty-four different mailing addresses, twenty-three different telephone numbers, and at least twelve different provider numbers.26

University teaching hospitals have been a source of concern regarding double billing in possible violation of the False Claims Act. The Physicians at Teaching Hospitals (PATH) initiative was initiated in June 1996 by the U.S. Department of Health and Human Services, OIG. The initiative focuses on double payments made to faculty teaching physicians and resident physicians under their supervision. A teaching physician is allowed to receive payment for a service only if he or she personally provided the service or was present when the resident furnished the treatment. If the resident alone provided the treatment, the teaching physician cannot submit a claim for the same service without violating the FCA.

One of the nation's most respected medical schools entered into an $800,000 settlement with the OIG over allegations of false Medicare claims by faculty physicians. The university had no documentation to prove these physicians were personally involved in services delivered by interns or residents at the teaching hospital.27

A northeastern medical school agreed to pay a $2 million false claims settlement over charges that it double billed Medicaid. Between 1993 and 2004, the university's hospital charged Medicaid for outpatient services that were also billed by faculty working at its outpatient clinics.28 Similar settlements for disputed Medicare billings were reached earlier at other prominent medical schools. The settlements in these cases ranged from $8.6 million to $30 million.29 Again, in our health care system, these respectable players seem to do whatever they think they can get away with to increase their revenues, even though they are ostensibly not-for-profit institutions.

Overcharging for treatments or products is another ubiquitous health care fraud.

- An Ohio podiatrist was sentenced to a seventy-eight-month stretch in prison for (in part) providing only nail-trimming services but billing Medicare for more complex procedures.30
- A supplier of lymphedema pumps billed Medicare $4,500 each for pumps worth only $600 apiece.
- A psychological service billed Medicare for patient sessions reputedly lasting 45 to 50 minutes when, in reality, the sessions lasted only 20 to 30 minutes.31
• A large health care system in New Jersey paid $265 million to resolve allegations of overcharging Medicare for inpatient and outpatient services at nine of the system’s hospitals.32

• A Connecticut hospital provided outpatient surgical services for kidney dialysis patients, a procedure earning a $1,500 Medicare reimbursement. But by admitting the patients and keeping them overnight, the hospital obtained a $13,000 reimbursement. The hospital settled the civil suit with the federal government for $632,000.33

• A provider of kyphoplasties, an orthopedic procedure for controlling pain, agreed to pay the federal government $75 million to settle a suit that accused one of its recently acquired companies of engaging in a seven-year scheme to defraud Medicare. Rather than submitting bills to Medicare for the less costly clinically appropriate kyphoplasties, the company submitted bills for the more expensive inpatient kyphoplasties. This whistle-blower case was initiated by two former employees who shared $14.9 million of the recovery. The employees’ attorney said, “A big, inpatient price tag allowed [the company] to make thousands of dollars each time it sold a kyphoplasty kit. Because of its scheme, the Medicare program paid many millions of dollars more than it needed to pay.”34

• The state of Alabama filed suit against seventy-nine drug companies for overcharging Medicaid. One of the defendants charged $928 dollars for a unit of sodium chloride (table salt) worth only $1.71.35

• A major pharmaceutical company agreed to pay $671 million to settle claims of overcharging the government and bribing physicians to prescribe its pharmaceuticals. The nationwide scandal centered on four of the company’s most popular drugs.36

• A university health center reached a $475,000 settlement with the federal government after being accused of overcharging Medicare for cancer treatments between 2002 and 2004. The government charged the center’s hospital with billing Medicare for the number of hours it spent on patient care rather than for the services it provided to each patient. This billing practice inflated charges by two to seven times the normal Medicare payment limits.37

• The CMS accused twenty California hospitals of overcharging Medicare after evidence indicated Medicare had overpaid these hospitals by as much as $2 billion a year over a three-year period.38

Hospitals have prematurely billed federal programs for outpatient services even though the patient still occupied a hospital bed. In this scheme, a hospital discharges the patient “on paper,” and Medicare is billed a flat diagnosis-related group (DRG) amount for the hospital stay (rather than billing Medicare based on the length of the stay). The hospital can then begin to bill Medicare for the more
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lucrative outpatient services, even though the patient remains in a hospital bed. A related scam is to hold a patient under observation for several days rather than admitting him or her to the hospital. Since hospital observation charges under Medicare Part B are usually higher than inpatient stay charges under Medicare Part A, the hospital receives a larger reimbursement.39

It is sometimes difficult to distinguish between fraud and billing errors. Health care billings can be complicated, and the staff responsible for such billings are often pressed for time and overworked. This situation leads both to fraud and to honest mistakes. Common errors include duplicate billings, overcharging the patient for the number of days spent in a hospital room (e.g., charging for both the day of admission and the day of discharge), incorrect hospital room charges (e.g., billing the patient for a private room when he or she stayed in a semiprivate room), overstating the amount of time a patient spent in the operating room, charging patients for work that was scheduled but then cancelled, and simple keystroke errors.40

Although random errors are possible, a pattern of such errors may be a sign of fraud. According to the CMS, Medicare recovered more than $1 billion through its Recovery Audit Contractor (RAC) program between 2005 and 2008. About 85 percent of the recoveries were from hospitals. Most claims were the result of billing and coding errors resulting in duplicate billings. Health care providers appealed 14 percent of RAC overpayment decisions, but fewer than 5 percent of the appeals were reversed.41

Upcoding, Unbundling, and Billing for Uninsured and Bogus Services

A prevalent and vexing problem for insurers is a scam called “upcoding.” Medicare and Medicaid billings use a standardized system of codes, known as CPT (current procedural terminology) codes, for various diagnoses and procedures. The coding system tells the claims processor what services or equipment have been provided to the patient. For example, a therapist for a fifteen-minute span of treatment cannot bill certain pairs of CPT codes for outpatient therapy services.42 Software is available to speed claims processing, to reduce errors, and to calculate the amount to be reimbursed to the health care provider.43

When providers are “upcoding” (also known as “upcharging” or “DRG drift”), they are, in fact, providing a less expensive service and then submitting an insurance claim using the code for a similar, but more expensive, service. Different codes or code combinations can produce significantly different reimbursements from Medicare or Medicaid. These claims might include billing for surgical assistants when none were required during a specific procedure, charging for life-support transportation when only wheelchair transportation was provided by an ambulance operator, billing for physician services when the services were
performed by medical technicians, and submitting claims for critically ill kidney dialysis patients when only routine dialyses were provided to patients who were not critically ill.44

A Baltimore medical center agreed to pay $2.75 million to settle false claims charges pertaining to upcoding. Two hospital employees claimed that between July 1, 2005, and February 28, 2007, they were told to review charts and upcode the severity of two secondary diagnoses—malnutrition and acute respiratory failure—even if the patients neither had nor were treated for these conditions.45

Dartmouth College medical researchers Elaine Silverman and Jonathan S. Skinner investigated the problem of upcoding. They zeroed in on hospital admissions that were for pneumonia and respiratory infections. As they point out, it is sometimes difficult to tell the two apart, except for one very clear thing—respiratory infections net the hospital about $2,000 more. Silverman and Skinner found the incidence of the most expensive DRG for pneumonia and respiratory infections increased by 10 percentage points among stable not-for-profit hospitals and by 37 percentage points among hospitals converting to for-profit status.46 Although not-for-profit institutions are not guiltless, this study points out that for-profits are especially tempted to use upcoding with more regularity. The researchers made an additional observation: “Upcoding behavior exhibits a close correspondence with tax evasion, where disputed tax returns are often settled quietly (with penalties), litigated, and only rarely the subject of criminal proceedings.”47

Upcoding can be done by individual doctors or it can be a group effort. A physician billing service used an automatic coding software system that “routinely upcoded emergency room visits.” The company agreed to a $15 million settlement with the federal government, and the whistle-blower received $2.4 million.48 Similarly, one of the largest hospital chains serving small towns and rural areas in the United States entered into a $31.8 million settlement for widespread upcoding of diagnostic codes. The company initiated an aggressive coding procedure, encouraging its hospitals to meet unrealistically high coding-volume goals.49

Several emergency-physician groups agreed to reimburse the government for over $2.6 million in conjunction with overpayments received from upcoded claims. A former employee of an Oklahoma billing company launched the case, and, for this, her estate was awarded $443,502 as part of the whistle-blower settlement.50

Some especially daring health care providers may recode and resubmit a rejected insurance claim. A geriatric hospital paid $800,000 to settle charges it defrauded Medicare. Claims denied by Medicare for room and board were resubmitted by the hospital as claims for supplies, laboratory work, and other covered services.51

Not content to up the ante, some criminals may “unbundle” it. That is, they may take services typically offered as a group or bundle and disentangle them so that they can bill each one separately to obtain a higher insurance reimbursement. A Florida ophthalmology service agreed to a $2.85 million payment as settlement for
the fraudulent Medicare billings made by its billing company. The billing service fragmented claims for surgical procedures that Medicare had already reimbursed the provider for as part of a global payment. The company, seemingly a chronic offender, had previously paid several million dollars in other fraud settlements.52

Laboratories are among the most frequent perpetrators of unbundling. Blood chemistry tests performed using a multichannel analyzer, for example, measure twenty different tests on the same specimen. These tests include cholesterol, total protein, and various electrolytes (including sodium, potassium, chlorine, and others). Medicare typically bundles a daily blood test under a single reimbursement rate. An unscrupulous laboratory operator, however, may inflate Medicare or Medicaid claims by charging separately for some of the tests. Bundling and duplicate payments can also be combined by submitting a claim for a bundled set of procedures and then unbundling the same procedures and billing the insurer again.

During the 1990s and into the early years of the twenty-first century, the Departments of Justice and Health and Human Service's Operation LABSCAM targeted laboratory unbundling practices. The federal government recovered more than $850 million from the nation's largest clinical laboratories as a result of its LABSCAM and related investigations.53

So why do laboratories unbundle tests, and how do they get away with it? The answer probably lies in the huge volume of work they perform. The profit added by unbundling just one lab test is small. But when a laboratory performs hundreds of thousands of tests, that margin becomes highly significant. The sheer number of tests performed and the claims submitted to public and private insurers also makes it easier to hide the unbundling activities. But as the federal authorities begin to scrutinize this illicit practice, it may diminish. Although the unbundling of services was a major problem in the 1990s, it has once again become an investigative priority for the U.S. Department of Health and Human Services, possibly making this fraud a less attractive option for dishonest providers.

Public and private insurers may be defrauded by being billed for services or items not covered by their plans. Doctors and other health care providers commit fraud when they knowingly provide their patient with an uninsured treatment but file a claim for an insured treatment. The costs of cosmetic surgeries are not reimbursable under Medicare, Medicaid, or most private health insurance plans. Uncovered services, however, may be billed falsely as covered procedures. Performing a liposuction but billing for a hernia repair, removing unsightly spider veins but billing for varicose vein surgery, or performing cosmetic nose surgery but billing for surgery to correct a deviated septum (and to relieve a patient's breathing problems) are all examples of insurance fraud. The operators of a Seattle acupuncture center pleaded guilty to falsifying Medicare and Medicaid claims when they provided patients with $375,000 in uncovered acupuncture treatments, but disguised the claims as covered physical therapy services.54
In some cases, a patient has no idea whether his or her health insurance covers a particular medical procedure and accepts the provider’s word that the claim is legitimate. In other cases, a patient may never see the claim documents that are submitted to the health insurer and, as a result, will know nothing of the fraud committed on his or her behalf. In still other cases, however, the health care provider and the patient may conspire to submit a false claim covering a nonreimbursable service, making both parties liable for fraud charges. Because public and private insurers were not in the room when the treatments were delivered, they must depend on auditors or whistle-blowers to bring the fraud to light. Obviously, the chance of a single fraud being revealed is small.

Michael F. Mangano, a principal deputy inspector general for HHS, testified before the Senate Committee on Governmental Affairs, Permanent Subcommittee on Investigations regarding deceptive Medicare billings. According to Mangano, one medical supplier agreed to plead guilty to conspiracy to defraud Medicare of more than $70 million. The supplier sold adult diapers to nursing homes (not reimbursable by Medicare) but billed the program for urinary collection pouches (reimbursable by Medicare). In another case, a group of sales people were charged with recruiting Medicare beneficiaries by giving them nonreimbursable items, such as microwave ovens and air conditioners, but billing Medicare for reimbursable items, such as hospital beds and wheelchairs.55 Again, the beneficiaries just took the microwaves and had no idea that Medicare was being dunned for the more expensive items.

As in the case my father encountered, ambulance companies also run afoul of the law by billing Medicare for nonallowable services.56 The fraudulent schemes ambulance operators have perpetrated include overstating the miles traveled, double billing patients and insurance companies for the same services, billing for oxygen and advanced life support services not provided to a patient, and billing for emergency ambulance trips when a taxi cab or nonemergency vehicle was used.57 One form of ambulance fraud, for example, involves transporting dialysis patients.58 In most cases, these patients do not require ambulance services, and they can travel at significantly less expense to a dialysis treatment center using personal or public transportation. Patients have been filmed, however, walking to the vehicle, riding in the front passenger seat of the ambulance, and being transported in an automobile with Medicare being billed for ambulance services. Patients may not realize—or not care—how they are being transported if Medicare or their private insurer is footing the bill. In other instances, the patients may assume that sitting in a passenger seat instead of being transported in a supine position is “standard operating procedure.” Ambulance operators also take advantage of unsuspecting patients when they transport two or three patients on a single trip and then bill Medicare for separate trips.59

Billing insurers for services not provided is yet another major health care fraud. A Beverly Hills physician defrauded Medicare of more than $216,000 by
billing for treatments to patients who were dead, incarcerated, or living in distant locations where the doctor could not have possibly seen them on the dates in question.\footnote{60}

In Delaware, a physician specializing in pain management was convicted of submitting bills to insurance companies for services she did not perform. She duplicated test results, used cut-and-paste or white-out techniques to replace one patient’s name with another, and sent these documents to insurance companies. In over one hundred cases, test results for two patients matched perfectly, something that is almost a statistical impossibility. This ham-handed attempt at fraud is one that even an ineffective fraud-detection system should be able to uncover. It is no surprise then that the scam was revealed and that—for her dishonesty and ineptness—the doctor received a six-and-one-half-year prison sentence.\footnote{61}

Medical laboratories have billed for services that were neither ordered nor provided. In a sixty-day period, one lab submitted 717 claims to Medicare amounting to $330,000 for 416 beneficiaries (some of whom were deceased). Even more incredible, one of the physicians who had allegedly made a referral had also been dead for two years.\footnote{62}

Medical school graduates are normally at the top of the IQ scale. Such was obviously not the case with a Texas doctor who conspired with his attorney (and brother) as well as with a certified public accountant, a physician’s assistant, office managers, patients, and staff members. This diverse group of conspirators devised a large cross-referral scheme to commit automobile accident, personal injury, and workers’ compensation fraud. Telemarketers hired by the group solicited and referred accident victims to the attorney and to the doctor. They provided trumped up services to the clients and made phony claims to insurance carriers.

When the FBI conducted a computer analysis of the group’s billing records, it revealed widespread upcoding, falsified medical reports, and multiple billings for the same service. According to claims records, the doctor would have had to work ninety hours a day to generate the $34 million in office visits he billed to insurers. Much of the money from this scam was laundered through Central American and Caribbean banks. The brothers and their accomplices were required to pay steep fines and restitution. They were also forced to forfeit assets derived from their criminal activities and faced lengthy prison terms.\footnote{63}

\section*{Nursing Home Fraud and Abuse}

As baby boomers age, nursing homes will become a rapidly growing part of the health care system. Once a person is admitted to a nursing home, he or she is out of the daily sight of regulators and insurers. And even the patient’s family may know little about their loved one’s care and treatment regimes, especially for
patients suffering from dementia. They are unable to judge the quality of their care or to report incidents of fraud and abuse.

Some nursing home administrators take advantage of the fact that their patients are "dual eligible," being covered under both Medicare and Medicaid. More fortunate patients may be entitled to benefits under Medicare as well as benefits under a private long-term care plan or a retirement program. Dual coverage enables administrators to submit duplicate claims to both programs, knowing that the likelihood of their being caught is low.

Nursing homes also commit durable medical equipment fraud by supplying inexpensive items to a patient, such as a seat cushion, but billing Medicare for a more expensive item, such as a "custom-fitted orthotic body jacket" that is designed to protect and immobilize the patient's spine. Similarly, unscrupulous providers may bill the Medicare program for more-costly hospice care, but provide terminally ill patients with less-costly standard nursing home services.

Another area rife with fraud is the provision of mental health services to nursing home patients. Psychologists who conduct group counseling sessions for nursing home residents—sometimes referred to as "coffee, cookies, and conversation"—have fraudulently billed Medicare for individual patient sessions. Weight reduction programs, taking residents on shopping trips, listening to music, and other recreational activities have also been billed to Medicare as psychological services. Similarly, "gang visits" result in fraud when practitioners such as physical therapists, optometrists, or podiatrists "stop by" and visit with nursing home residents as a group but bill Medicare for individual services. Some nursing homes have also been prosecuted for employing unlicensed or unqualified staff.

As noted earlier, substandard nursing home care billed to Medicare or Medicaid is automatically regarded as fraudulent. Patient neglect and abuse has long been a critical nursing home problem. Nursing home employees who physically abuse patients are subject to criminal prosecution. A joint federal-state investigation revealed an appalling quality of care at a Connecticut nursing home because of inadequate staffing and patient-care plans. One obviously neglected resident had died of septic infection allegedly caused by bed sores, and others suffered from severe pressure sores and ulcers, dehydration, and weight loss. In some cases, patients suffer from being physically or chemically restrained in violation of federal or state law.

Lewis Morris, chief counsel for OIG, testified in May 2008 before the U.S. House of Representatives Subcommittee on Oversight and Investigation on Energy and Commerce about the substandard care still found in many nursing homes despite the threat of severe sanctions by the government. Morris cited examples of serious cases, such as failing to attend to patient medical needs, neglecting to supervise patients who fell repeatedly, ignoring patients suffering
from malnutrition and dehydration, and allowing patients to go for extended periods of time without being cleaned or bathed. One particularly horrible example of patient neglect involved a Georgia nursing home patient who had maggots in her mouth and died of larvae infestation because staff failed to provide her with basic oral hygiene care.66

Abuse also becomes fraud when nursing home management denies allegations or conceals evidence of patient mistreatment. A question that has not been answered fully is at what point do frauds that are born out of a desire to maximize profits lead to charges of reckless endangerment, manslaughter, or even murder? An analysis of eighty-two studies of U.S. and Canadian nursing homes conducted between 1965 and 2003 indicates that nonprofit nursing homes provide better care than for-profit ones.67 Nevertheless, it takes a special breed of provider to place the financial bottom line of a nursing home business over the welfare, dignity, and basic comfort of its patients. It seems, however, that this “special breed” is becoming more commonplace.

**Home Health Care Fraud and Abuse**

The introduction of for-profit health care has also increased the problem of fraud and abuse in the home care setting. Home health care enables elderly, chronically ill, or disabled persons to remain self-sufficient by receiving the care they need in the familiar surroundings of their own homes. This form of care also offers a useful transition for patients who have been discharged from the hospital but who still need medical supervision. Furthermore, home health care is significantly less expensive than nursing home or hospital care. Over 70 percent of home health care patients are age seventy or older, and they frequently require care for heart problems, diabetes, and cerebral vascular diseases.

Home health care services include in-home skilled nursing services, counseling, physical and occupational therapy, equipment and supplies, pharmaceutical services, homemaker and companion services, social services, dietary and nutritional services, intravenous therapy, speech therapy, audiology, and even twenty-four-hour home care. The home health care industry is highly fragmented, consisting of over twenty thousand small companies that primarily serve local markets. The top-performing home health care companies, on the average, in 2007 had been in business for more than sixteen years, employed about 217 workers, and had revenues of $17.3 million—up by over 30 percent from the previous three years.68 Not surprisingly, these companies depend heavily on revenues from the Medicare and Medicaid programs. In 2008 the Medicare program spent $16.5 billion on home health care, an amount that will probably increase in the years ahead.

Regulation of the home health care industry is uneven at best. Although it is among the fastest-growing occupations in the United States, home health care
workers are often poorly paid, which may lead to the hiring of persons who are unreliable, dishonest, or lacking in critical skills. Because of the vulnerability of their clients, home health workers must, in most states, be screened for criminal backgrounds. In nineteen states, however, these workers can be hired without a criminal background check. And even in states requiring such checks, persons with criminal records may slip through the cracks and pose a danger to elderly homebound patients.

In most instances, dishonest home health care workers commit property crimes—pilfering items from their clients’ homes or stealing money from their clients’ checking or credit card accounts. Direct violence, although rare, is always a possibility. An eighty-five-year-old bedridden California woman, for example, was murdered by a home health care worker. Indirect violence, a hallmark of white-collar criminals, is also possible. An eighty-five-year-old bedridden California woman, for example, was murdered by a home health care worker. According to the Boston Globe, a personal care attendant was accused of leaving a quadriplegic with cerebral palsy undressed, with no water, and without stockings that were supposed to help prevent blood clots.

Because of the irresistible temptation to unscrupulous entrepreneurs, the rise in the number of for-profit home health care patients means a concomitant rise in home health care fraud. A Los Angeles man was sentenced to 120 months in prison and ordered to pay over $7 million in restitution to Medicare after he pleaded guilty in July 2007 to health care fraud. He admitted that during an eighteen-month period he defrauded Medicare by recruiting beneficiaries who were neither homebound nor in need of skilled nursing services. The beneficiaries were paid anywhere from one hundred to four hundred dollars in cash. This fraudulent patient recruiter profited handsomely from the scheme; he received kickbacks from the home health care service, ranging from $1,200 to $4,800 per patient. The case also involved conspiracy charges because the fraudster had an accomplice, the owner of the home health care service. The owner was sentenced to forty-six months in prison for his part in the scheme. Money-laundering charges were also levied because the fraud artist tried to cover his tracks by having the kickback checks made payable to other businesses.

In March 2008, a St. Louis woman was sentenced to forty-eight months in prison and ordered to pay $545,713 in restitution for health care fraud, failure to pay employment taxes, and the misuse of a Social Security number in a banking transaction. She operated a homemaker and personal-care service business for homebound elderly and disabled clients. The woman lied about the training and certification of her employees, and she submitted claims for home-care services that were never rendered. She also failed to pay more than $73,000 in employee federal withholding taxes. In addition to requiring restitution, the court also placed her company on probation for five years.

To qualify for Medicare reimbursement, a patient must be homebound (i.e., unable to leave his or her residence without undergoing considerable hardship).
According to the 2009 document on Medicare and home health care from the Centers for Medicare and Medicaid Services, “you must be homebound or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to attend religious services. You can still get home health care if you attend adult day care.” Yet Medicare is often faced with billings for patients who do not meet the definition of “homebound.” A similar problem occurs among hospice patients who are ineligible for Medicare benefits because they are not terminally ill.

For these reasons, the issue of home care fraud and abuse is a complex one that may force us to rethink how we define fraud and abuse in the first place. Medicare demands that patients meet the definition of “homebound” described above. Perhaps nurses or social workers, not doctors, have a more realistic idea of the issues confronting the homebound. For example, homebound patients are often capable of making short excursions from their living quarters. A homebound elderly woman may have just enough energy to walk down the block to socialize with neighbors. Another might be able to make it to the grocery store to pick up a few basic necessities. Getting out of the house for a short walk can have healthful benefits, but these individuals may still desperately need home health care services to maintain their fragile conditions. According to Medicare’s eligibility requirements, however, such a patient may not be considered “homebound.” A visiting nurse or therapist who is paid by Medicare for providing services to this patient could conceivably be charged with fraud.

And sometimes the patient is the culprit. California’s In-Home Supportive Services (IHSS) program had a $5.42 billion budget in 2009 to help 440,000 low-income and elderly residents avoid more expensive nursing home stays. But the program became a target for fraud because beneficiaries were allowed to hire services from anyone they choose, including relatives. A man who claimed he was disabled to the point of being bedridden cheated the IHSS program out of $150,000. As it turned out, this “bedridden patient” spent eight to ten hours a day working on an ice cream truck. Investigators watched him stock the truck and, despite his “severe disability,” were amazed to see him muster the strength to drag a washing machine across his driveway. According to Michael Ramsey, the district attorney in Butte County, California, “this program is very easy to abuse. It invites chicanery and fraud.” Apparently the program has a backlog of fraud cases and few investigators to pursue them. As a result, Governor Arnold Schwarzenegger has threatened to cut IHSS’s budget. This case could be another example in which the actions of a fraudulent few make life difficult for thousands of law-abiding elderly who need home-care services.

But for crooked providers, home health care is a gold mine. As with corrupt nursing home managers and workers, corrupt home health care workers bank
on the fact that their clients are often elderly, suffering from dementia, and easily confused. They also know that regulators cannot directly observe what they do inside a patient’s home. Unfair marketing practices, billing for more visits than are actually made, performing housekeeping and custodial services but submitting claims for skilled nursing or therapy services, kickbacks to physicians for referrals, physician self-referrals, and other frauds discussed in this book are also common among home health providers. More and more Americans will need home health care services in the decades ahead, and more money will be directed toward this industry. Distinguishing between the honest and dishonest uses of home health care will be essential to controlling health care costs as the population ages.

Rent-a-Patient Schemes
Rent-a-patient schemes depend on two things: greedy health care providers who want to make a quick buck and “patients” with health insurance coverage—Medicare, Medicaid, or private insurance—who are willing to undergo painful medical procedures in exchange for under-the-table cash payments. In this scheme, the patients are taken by “associates,” also known as “recruiters” or “runners,” to health care facilities that are operated by fraudulent health care providers—usually doctors. The patients may be told to complain about or exaggerate certain symptoms. They may also be coached on how to fill out a patient questionnaire. Once inside the clinic, the rent-a-patients are asked to sign an “informed consent” form promising to turn over all insurance claim checks to the crooked health care provider. The patients, who usually understand that their health is of no concern to those providing the “care,” receive examinations, treatments, and durable medical equipment referrals. Then either a public or private insurer is billed for the bogus services and products. Recruiters, in turn, are paid for each patient they lure into the scheme, and the patients are paid a fee for their participation.

Sometimes the rent-a-patient scheme becomes a nightmare, as this Phoenix, Arizona, newspaper story illustrates:

Julio Hernandez says he felt “healthy as a horse” before he agreed to use his body as an instrument for insurance fraud. But during a five-month stretch last year, the 36-year-old Phoenix resident endured the following medical procedures: A circumcision. Removal of his sweat glands. A nose operation. A colonoscopy. An endoscopy. Hernandez admits he needed none of these procedures. But, he says, a work associate persuaded him to travel to Southern California for the operations, again and again. The associate...moonlights as a health-care coyote—a ubiquitous middleman for...surgical clinics that are performing unnecessary, sometimes
risky medical procedures on “rent-a-patients” such as Hernandez....In return for using their bodies as mini-cottage industries, they are getting paid cash in under-the-table payments.

Mr. Hernandez, looking for quick cash, received eight hundred dollars for each medical procedure he underwent. The perpetrators made millions of dollars from this scam.75

In a bizarre variation, a South Carolina doctor recruited friends and family to serve as rent-a-patients. With the aid of an accomplice, he filed $2 million in billings for unnecessary nerve and vascular tests.76 An Indiana dentist operating out of a mobile office was sentenced to fifty-seven months in prison for Medicaid fraud. By offering free gift cards and CD players, the dentist induced parents to bring their children to his office for unnecessary treatments. He used this scheme to obtain over $2.4 million.77

Rent-a-patient schemes have several common elements. Fraudulent health care providers often target working-class minority groups. The patients are often factory workers with employer-sponsored health insurance who are recruited by runners from the same ethnic background. Although not destitute, these patients may regard several hundred dollars in tax-free cash as a small fortune. Then they are pleasantly surprised to learn that they can up the amount to several thousand dollars by enticing their family members, including children, to participate in the scam. Many of these scams are centered in Southern California, although greedy health care providers there have been known to transport patients from as far away as Florida. One such example was a California physician who was sentenced in late 2007 to fifty-eight months in prison after he billed insurance companies for unnecessary surgical procedures as part of a broad-based rent-a-patient scam.78

In another Southern California case, top executives at a medical center in Los Angeles were charged with a rent-a-patient operation that stole $4.1 million from Medicare and Medi-Cal coffers. (Medi-Cal is California’s Medicaid program.) Three persons all entered guilty pleas—a former center co-owner and board chair, a former CEO, and a recruiter who had been paid $500,000 to entice homeless people into the scam. Patients were typically paid twenty to thirty dollars to participate, and the recruiter received forty dollars for bringing in a Medicaid-eligible patient and twenty dollars for bringing in a Medi-Cal-eligible patient.79 On January 25, 2010, the United States obtained a $10 million dollar consent judgment against the former co-owner and the former CEO for Medicare and Medi-Cal fraud. According to Tony West, assistant attorney general for the Civil Division of the Department of Justice, “Performing unnecessary medical procedures just to take money from taxpayers’ pockets is bad enough, but to prey on homeless people struggling to survive day to day is particularly reprehensible.” The pair, at this writing, was also awaiting sentencing on criminal charges.90
Rent-a-patient scam artists—whose audacity seemingly knows no boundaries—often submit exaggerated claims, stating falsely that their services were provided on an emergency basis in an attempt to obtain a higher reimbursement. These so-called health care providers also have a thorough understanding of insurance policies and claims procedures. They may first target employed patients with comprehensive insurance plans before shifting to those with more restrictive plans. Once their claims are submitted, these scam artists often pursue collections aggressively. According to Steven E. Skwara, director of fraud investigation for Blue Cross Blue Shield of Massachusetts, “They’d call constantly, they write nasty letters, they write nasty letters to your boss.”

So how do “patients” fall prey to these schemes? For the indigent covered by Medicaid, it is their desperate need for quick, but not easy, cash—cash that provides them with the basic necessities or, in some cases, drugs. For the working class covered by an employer-sponsored health plan, it is the prospect of extra money that can be used to pay past-due bills or to purchase otherwise unattainable items, such as a new car or a much-wanted flat-screen television. For the elderly covered by Medicare, cash may also be the primary attraction. It is probable, however, that some elderly victims are misled into believing that they need medical attention when, in fact, they do not.

The perpetrators of these schemes are aware that many of their low-income Medicaid-eligible victims may be difficult to locate, especially if they have been transported to the clinics from distant locations. These same perpetrators also know that the elderly, if suffering from dementia, are easily confused and either will not make reliable witnesses or will be easily discredited by defense attorneys. Many of the culprits are caught, but only after they have bilked public and private insurance programs out of millions of dollars.

Some might get a dark sense of satisfaction from knowing that some rent-a-patients cheat the cheaters. Rather than signing over their insurance checks to the clinics as they agreed to do at the outset, they cut the dishonest providers out of the loop by cashing the checks and keeping the proceeds for themselves.

**Pill-Mill Schemes**

A fifty-three-year-old Brooklyn pharmacist was sentenced from one to three years in prison for his part in a scheme that funneled tens of thousands of pills, including powerful narcotics and barbiturates, to street-level drug dealers. His accomplice, a fifty-eight-year-old Brooklyn internist, supported the pharmacist by writing phony prescriptions for the painkiller Percocet and the sleeping pills Seconal and Tuinal. The physician received five years of probation, a $40,000 fine, and community service.

The pharmacist and doctor were running what is known as a “pill-mill.” Pill-mill schemes involve the fraudulent prescribing, buying, and selling of prescription
drugs. They invariably involve a “patient finder” who directs patients to designated medical clinics for unnecessary physical examinations and laboratory tests. Based on the bogus or perfunctory examinations and tests, the corrupt physician writes a prescription for the patient. Medicare, Medicaid, or other insurers are then billed for the phony services and prescriptions. Once the prescription is filled, the patient turns the drugs over to a pill buyer in exchange for cash, merchandise, or illegal drugs. The pill buyer then resells the drugs to a corrupt pharmacist at lower-than-wholesale prices. This cycle is repeated as the same drugs are bought and sold several times.

If the diverted drugs have a high value to street users, they may be sold to drug traffickers. The term “pill-mill” has also been used to describe doctors who prescribe drugs freely to patients whose medical condition does not warrant their use. A federal jury found a Naples, Florida, physician guilty of overprescribing powerful painkillers to patients. According to undercover agents, the doctor’s prescriptions were written after she gave patients a cursory medical examination by checking their blood pressure and knee reflexes and by having them extend their arms outward in front of their bodies.84

A Kansas grand jury returned a thirty-four-count indictment against a physician and his wife for conspiracy, unlawful distribution of a controlled substance, health care fraud, illegal monetary transactions, and money laundering. They allegedly wrote illicit prescriptions for painkillers, muscle relaxants, and other drugs. According to prosecutors, this scheme caused the deaths of at least four patients. The doctor’s wife also bragged to job applicants that their clinic, with its pain-management patients, prescribed more painkillers than any clinic in the state. With the monikers “the pill man” and “the candy man,” the doctor kept his clinic open eleven hours a day, scheduling patients ten minutes apart. The clinic generated $4 million in billings to health-benefit programs.85

According to a July 2010 report released by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration, “the proportion of all substance abuse treatment admissions aged 12 or older that reported any pain reliever abuse increased more than fourfold between 1998 and 2008, from 2.2 to 9.8 percent.”86 The Department of Health and Human Services has become suspicious of the growing number of small clinics that have been dispensing an unusually high volume of pain medication. Tipped off by an anonymous caller, a ring of doctors at a clinic in West Virginia was discovered to be attracting patients by writing prescriptions for an inordinate amount of pain medications. The prescriptions were funneled through two local pharmacies under common ownership. In 2006 one pharmacy sold about 3.2 million hydrocodone pills—or about one prescription per minute— an amount that was well above the national dispensing rate of 97,431 hydrocodone pills per pharmacy. One cardiology resident, working on behalf of the clinic, earned more than $250,000 by signing prescriptions for pain medications.87
Illegal drugs may also be dispensed through the practice of "doctor shopping." These shoppers visit the offices of numerous practitioners within a short amount of time to obtain more prescription medications than are clinically necessary.\textsuperscript{88} If the shopper is a drug abuser, he takes the drugs for nonmedical reasons. If the shopper is a drug trafficker, he sells the drugs to pill buyers or street traffickers. An Arizona resident obtained more than 27,000 pills (primarily Percocet and oxycodone) from fifty-one Tucson-area pharmacies. He was charged with, among other things, possession of a controlled substance with the intent to distribute.\textsuperscript{89}

Pill-mill schemes impose several costs on society. Because prescription drugs are a major portion of health care expenditures, these scams inflate health care and insurance costs. Pill-mill schemes also foster illegal drug trafficking. Painkillers are among the most common drugs used in pill-mill schemes. But recycling and trafficking prescription drugs poses a major health hazard to unwary users. The generic pain medication oxycodone is in high demand by drug abusers and addicts because it generates a euphoric state similar to that of heroin. The drug also has been abused extensively and blamed for hundreds of deaths.\textsuperscript{90}

Pill-mill schemes have also created a problem for physicians and their patients who have a legitimate need for pain medications. Physicians have become increasingly concerned that they will be arrested, lose their license to practice medicine, and face incarceration. Prosecutors even threatened one outspoken doctor, who believed in the liberal prescribing of pain medication, with the death penalty. The dilemma is in knowing where to draw the line between the legitimate management of pain and the illegal prescription of painkillers.

The defendants in the Kansas case described above appear to land squarely on the wrong side of the law. People have an enormous capacity for adjusting to life-changing circumstances, but pain is something that one never gets used to. When pain cannot be alleviated, it takes its toll on the victim's physical and mental health.

But patients have different thresholds for pain. For these reasons, doctors are hard put to know whether a patient's complaints about pain are legitimate or whether their complaints are motivated by their addiction to a painkiller. How responsible should a doctor be if his or her patient becomes addicted to a controlled substance? Some doctors take the approach of let's cure your source of pain and we will worry about your addiction to the painkiller later. Others are concerned about the legal ramifications of overprescribing pain medication. What is the doctor's liability if the patient suffers harm or dies after mixing prescribed painkillers with illegal drugs? What is the doctor's culpability if the patient sells his or her drugs to someone else? To answer these queries and more, the University of Wisconsin, in conjunction with the Drug Enforcement Administration (DEA), drafted a forty-eight-page report for physicians and law enforcement personnel that addressed frequently asked questions about the medical and legal
ramifications of prescribing opioid analgesics and other painkillers. Shortly after the guidelines were published, however, the DEA withdrew its support—a sign that the controversy over pain management will continue.

The Emerging Drug Frauds in Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a prescription-drug plan known as Medicare Part D (effective January 1, 2006). The plan is a decentralized, voluntary outpatient prescription-drug program relying heavily on the cooperation and integrity of private insurance companies, pharmacy benefit managers, retail pharmacies, and pharmaceutical firms (manufacturers).

Providers of prescription drugs, known as “sponsors,” are private insurers under contract with the Centers for Medicare and Medicaid Services. Sponsors, in turn, develop contracts with pharmacy benefit managers, and the pharmacy benefit managers are expected to negotiate with pharmaceutical manufacturers and retail pharmacies to control prescription-drug costs. Medicare beneficiaries have the option of selecting from among a number of stand-alone drug plans or from plans that are affiliated with a managed-care organization (Medicare Part C).

The Medicare Part D program pits the quality health care and cost-control interests of the Medicare program and its beneficiaries against the profit-seeking interests of the health care providers, insurance companies, pharmacies, and pharmaceutical manufacturers. Its decentralized structure, however, has created a fertile environment for fraud and abuse. Fraudulent actions may arise with regard to marketing and beneficiary enrollments, kickbacks and rebates on pharmaceuticals, manipulation of covered services, and claims processing.

The MMA antifraud provisions are directed primarily at the sponsors (private insurers). Sponsors must develop antifraud and abuse programs tailored to their operations. Furthermore, the OIG develops an annual “work plan” targeting designated forms of fraud and abuse. Knowledge of the work plan emphasis areas provides guidance to sponsors and other entities doing business with the Medicare program. The OIG’s 2008 work plan, for example, identified audit priorities such as diagnostic Medicare Part D duplicate claims and the ability of pharmacies to purchase drugs at the average manufacturer price. Sponsors must also submit to the CMS detailed quarterly reports on their program operations. Special attention is paid to the calculation of a sponsor’s pharmaceutical costs and reimbursement rates, marketing strategies, drug formulary, and management structures. A lengthy, but possibly incomplete, list of frauds directed at the Medicare Part D program is provided in table 3.1.

Persons outside the health care industry, most notably crooked telemarketers, have also taken advantage of the complex and, for many beneficiaries, seemingly
incomprehensible provisions of Medicare Part D. In the “299 scam,” telemarketers posing as Medicare sponsors with legitimate-sounding names such as the “National Medical Office” call Medicare beneficiaries. Some callers may already have personal information on their targeted elderly victims, further enhancing their credibility. Typically, the caller offers to help the victim select the best deal on a Medicare Part D plan for a one-time fee of $299—hence the name “299 scam.”\textsuperscript{95} The caller uses this subterfuge to obtain the beneficiary’s Medicare or Social Security number as well as information about his or her bank or credit card accounts. This tactic opens the door to a variety of scams, including Medicare fraud, identity theft, and credit card fraud.

The CMS may impose several sanctions on sponsors who fail to comply with Medicare Part D antifraud provisions. The most severe penalties include termination of the sponsor’s Medicare contract and civil monetary penalties ranging from $10,000 to $100,000. Errant sponsors and others are also subject to prosecution under the False Claims Act, the antikickback statute, and the Stark Law.

**Durable Medical Equipment Frauds**

Durable medical equipment frauds have recently received a great deal of attention from Congress and the CMS. DME includes wheelchairs, scooters, walkers, hospital beds, prosthetics, special seating cushions, urinary-collection devices, surgical dressings, airway-pressure machines, breathing aids, oxygen equipment, orthopedic devices, and nutritional supplies such as milk supplements.

To receive reimbursement under Medicare or Medicaid for durable medical equipment, patients must obtain a certificate of medical necessity completed jointly by a physician and the equipment provider. The CMS contracts with the National Supplier Clearinghouse to verify that suppliers meet twenty-one standards before they are permitted to bill federal programs. Unfortunately, there has been inadequate oversight of DME suppliers, a condition that has enabled the proliferation of disreputable firms and massive frauds. A September 2005 Government Accounting Office report revealed $900 million in overpayments out of the total $8.8 billion paid for durable medical equipment by Medicare in 2004.\textsuperscript{96} DME fraud operations are especially prevalent in South Florida and in Southern California. An OIG investigation discovered over half of the 1,581 South Florida DME suppliers do not meet HHS’s minimum standards. When federal agents made surprise visits to these companies, 491 of them (31%) either had no facilities or maintained no staff or operating hours. Yet, during 2006, these phantom DME supply firms managed to collect $97 million from Medicare.\textsuperscript{97}

On July 2, 2007, then Department of Health and Human Services (HHS) secretary Mike Leavitt announced a two-year plan directed at fighting DME fraud in South Florida and Southern California. All DME suppliers in these locations
were asked to reapply for certification in the Medicare program. In previous testimony, Secretary Leavitt described a visit that he made to DME suppliers in South Florida.

Just to give you a sense of this, during the time I spent there, we visited several locations. You'd walk up to a strip mall, and there would be what looked to be a business. You'd look inside and there was no one there, but you could see a chair, a little medical equipment on the wall, and what was established to look like a business....When you checked the Medicare records, you'd find that—from this essentially vacant business—that sometimes $1 million, $2 million, sometimes $3 million or more would have been billed in a relatively short period of time from this so-called business....I went to an office building in the Miami area. I would say it was 20,000 square feet, maybe two stories. Inside this office building was a marquee listing probably 60 or 70 companies....Fifty or so of these companies—my estimate—were durable equipment businesses. You'd walk down long corridors that would remind you of a dorm room, with a door roughly every 15 feet....On the door would be a marquee that would say XYZ—the name of the durable equipment dealer—the hours and the phone number. Those three things happen to be requirements to get a Medicare billing number....You'd knock on the door, try to open the door—no one there—door, after door, after door....When you would find someone there, it would be generally someone caring for small children, and waiting for a Medicare inspector to come help them get their number....It was a shocking level of fraud to me. This kind of fraud is hard to believe....And yet, when you realize that every vacant storefront represents tens, hundreds, even thousands of seniors who have been cheated, it is simply intolerable.

DME frauds take several forms. Medicare and Medicaid may be billed for undelivered equipment and supplies. Seven South Florida men were charged on seventy-nine counts, including health care fraud and money laundering, after they created a DME company and billed Medicare for equipment that beneficiaries never received.

Cheap equipment or supplies may be provided to a patient, with Medicare or Medicaid being billed for more expensive items. An Idaho DME dealer provided two-thousand-dollar scooters to his elderly clients but billed Medicare and Medicaid for six-thousand-dollar electric wheelchairs.

Patients may receive items that are of no use to them, with Medicare picking up the tab. For example, Medicare pays for oxygen concentrators if a patient has a documented need for oxygen. Illicit suppliers, however, have colluded
Table 3.1  Major Types of Fraudulent Activities, Medicare Part D

BY SPONSORS (PRIVATE INSURERS WITH CMS CONTRACTS)

- Offering cash to prospective beneficiaries to encourage their enrollment.
- “Cherry-picking” (e.g., targeting beneficiaries from high-income areas only).
- Using bait-and-switch tactics.
- Telling prospective beneficiaries the federal government prefers a particular plan.
- Using a health care provider to distribute brochures touting a preferred plan.
- Failing to provide medically necessary benefits covered by law or contract.
- Reporting improper cost calculations or fraudulent information (e.g., nondisclosure of rebates) to the CMS.
- Paying for excluded drugs or paying for the use of “off-label” drugs (drugs used for something other than their approved purpose).
- Charging excessive or duplicate premium payments or extracting higher than mandated deductibles and copayments from beneficiaries.
- Submitting multiple billings to Medicare.
- Rejecting legitimate claims by beneficiaries, “slow walking” claims, or denying beneficiaries the right to appeal a rejected claim.

BY PHARMACY BENEFIT MANAGERS

- Receiving kickbacks to switch beneficiaries from one drug plan to another.
- Placing a drug on a formulary list because of its low cost rather than because of its clinical efficacy.
- Splitting a prescription (putting one prescription into two bottles) to obtain a higher reimbursement or short-filling a prescription (not providing the beneficiary with the full prescription amount).

BY RETAIL PHARMACIES

- Dispensing generic drugs to patients and billing Medicare for a brand-name drug.
- Drug diversion through a pill-mill scheme.
- Altering or forging a prescription.
- Dispensing expired or adulterated drugs.

BY PHYSICIANS PRESCRIBING DRUGS

- Selling free sample drugs or products provided by pharmaceutical manufacturers.
- Accepting kickbacks or gratuities from pharmaceutical manufacturers in exchange for prescribing the manufacturer’s drug.
- Writing a prescription for a patient knowing the drugs will be used by another person (perhaps done by a well-intentioned doctor who wants to help an elderly couple around a deductible or copayment problem).
- Prescribing controlled substances for no medical reason (a variation of the pill-mill scam).
- Providing false prescription information to justify insurance coverage (e.g., filing a claim for a drug covered by Medicare to pay for a substitute drug not covered by Medicare).
- Submitting duplicate bills or manipulating the system by exploiting the differential copayments between Parts B and D.
FRAUD IN FEE-FOR-SERVICE AND MANAGED CARE

BY PHARMACEUTICAL MANUFACTURERS

• Reporting false cost and pricing information.
• Paying kickbacks or inducements to pharmacies, PBMs, or doctors to increase sales (e.g., lavish meals, travel and entertainment, or grants for bogus research or teaching activities).
• Concealing price concessions, discounts, or rebates.
• Entering into financial relationships or other conflicts of interest with PBMs or sponsors for formulary placements.
• Promoting drugs for illegal off-label promotions.

BY MEDICARE BENEFICIARIES

• Falsifying personal information to enroll in Medicare.
• Allowing ineligible individuals to use their Medicare card to obtain services or prescription drugs.
• Falsifying out-of-pocket costs to speed movement through Medicare coverage gaps.
• Altering or forging prescriptions.
• Selling drugs to street traffickers.
• Obtaining multiple prescriptions and drug stockpiling.


with physicians and laboratories to falsify oximetry test results. Patients are then provided with oxygen concentrators that they do not need. Similarly, suppliers may fail to pick up equipment when it is no longer used by the patient, allowing rental charges to continue. Hospitals have allowed “discharge planners” employed by DME companies to work with patients. With greed-driven flair, the planners try to provide as many pieces of equipment as possible to patients, regardless of their medical needs.

Dishonest DME suppliers may bilk Medicare by offering beneficiaries free services, supplies, food, or health screenings in exchange for their Medicare numbers. Other scam artists, posing as university or health care–institution researchers, trick beneficiaries into revealing their Medicare numbers under the pretext of conducting a survey. A South Florida DME supplier pleaded guilty to Medicare fraud after he obtained 250 Medicare numbers from beneficiaries and ten provider numbers from physicians. He used these numbers to submit 4,000 Medicare claims between January and March 2007, amounting to $2.2 million in false claims for equipment never provided to beneficiaries.

Kickbacks are a major part of DME fraud. A Texas jury convicted a Houston osteopath on thirteen counts of health care fraud. The doctor, who rarely examined the patients, was paid by DME marketers to sign certificates of medical necessity for motorized wheelchairs. The marketers then sold the signed documents to DME suppliers in Texas and elsewhere. In Florida, a licensed orthotist
and patient-recruiter provided DME suppliers with signed certificates of medi-
cal necessity and prescriptions for orthotic devices—again, without bothering
to examine the patients. The DME companies billed Medicare for expensive
custom-fitted equipment but provided patients with cheap, prefabricated de-
vices. In another Texas kickback case, the owner of a power wheelchair business,
along with the owner’s brother, hired recruiters to find Medicare beneficiaries.
They paid a crooked physician to falsify certificates of medical necessity on the
patients and then submitted fraudulent bills in excess of $12 million to Medicare.
The owner was sentenced to nearly thirteen years in prison. The brother received
sixty-six months and the physician fifty-four months behind bars.105

Health Care Frauds That Save Money

As the title to this chapter suggests, health care fraud can be viewed as a two-
sided coin: on one side, money is stolen and, on the other, money is conserved.
The most prominent frauds are based on the indemnity approach to health care.
That is, the service is provided—or allegedly provided—and a fee is paid to the
health care provider by the patient or by the patient’s insurer. Fraud arises when
the objective becomes one of generating as much money as possible rather than
one of providing optimal patient care.

A second and less-publicized fraud occurs primarily in managed-care plans.
Health maintenance organizations—a major form of managed care—provide
services on a capitation basis. Under this arrangement, members pay a flat
monthly premium entitling them to receive health care services as needed. In
theory, HMOs should both discourage fraud and encourage the cost-efficient
delivery of health care services and products. When health care providers or in-
surers become too preoccupied with slashing costs, however, patient care can
be compromised. The problem is compounded when physicians or other health
care providers are offered financial incentives to save money. Medical ethicists
Nancy S. Jecker and Clarence H. Braddock III have warned of the dangers of
placing too much emphasis on “efficiency” and controlling costs in managed-
care settings.

Most often, efficiency is maximized by increasing productivity while
fixing cost. Hence, managed care may create pressure to do more with
less: less time per patient, less costly medicines, and fewer costly diag-
nostic tests and treatments. Monetary incentives are often used to affect
physician behavior, and may include rewarding physicians who practice
medicine frugally by offering financial rewards, such as bonuses, for
those who provide the most cost-efficient care. Those who perform too
many procedures or are cost-inefficient in other ways may be penalized,
often by withholding bonuses or portions of income. Nonmonetary inducements to limit care take the form of bringing peer pressure, or pressure from superiors, to bear on those who fail to take into account the financial well being of their employer. These monetary and non-monetary incentives raise the ethical concern that physicians may compromise patient advocacy in order to achieve cost savings.106

Dr. Linda Peeno, a physician who worked for a managed-care plan, provided lengthy testimony before the U.S. House of Representatives, Committee on Commerce, Subcommittee on Health and Environment. Her testimony described the pressures she encountered as medical director at a 35,000-member HMO as well as at other health care institutions to use “my medical expertise for the financial benefit of the organization, often at great harm and potentially death, to some patients.”

Dr. Peeno identified practices such as using complex benefits restrictions and exclusions to deny treatment, developing marketing practices to attract the “best” patients to the plan but hiding the plan’s pitfalls, drafting incomprehensible language in physician contracts, threatening economic sanctions against recalcitrant physicians, rigging patient contracts so that claims could be denied based on technicalities set up by “a maze of rules for authorizations, referrals, and network availability,” and devising unorthodox definitions of “medical necessity” to deny treatment to patients.107

Because cost containment is essential to the survival and profitability of managed-care plans, some plans employ seemingly standard, but underhanded, tactics to reduce costs. These tactics include accepting only healthy enrollees—a practice known as “cherry picking”—or removing unhealthy patients from the plan (disenrollment fraud). Beneficiaries may be encouraged to leave a managed-care plan for expensive treatments elsewhere only to be reenrolled once the treatments are completed. Additional iniquitous cost-saving tactics include selecting providers with offices in distant or inconvenient locations, using providers with very limited office hours, refusing to pay for covered care such as emergency services, delaying patient referrals to specialists, pressuring providers to cut corners on patient care, using low-cost but incompetent providers, “losing” or refusing to pay claims, and manipulating and inflating Medicare administrative cost data.108

Managed-care frauds are often harder to spot and more difficult to prosecute than other health care frauds. This dilemma may be due to the government’s focus on detecting and prosecuting money-producing frauds rather than on money-saving ones. As James G. Sheehan, New York’s Medicaid inspector general, said, “We’re watching by land, and they’re coming by sea. The reality is we’ve been doing (medical) provider fraud for a hundred years; we’ve been doing managed care fraud for 10 years.”109
Another way of cheating people enrolled in managed-care programs is to force them to subsidize physician kickbacks and lucrative commissions to insurance agents. Because some plans may require patient referrals to nonplan specialists, a common fraud is for physicians to accept kickbacks for referrals. The specialists cover the costs of the kickback by charging higher rates for treatments, which ultimately come to rest in the laps of their patients in the form of higher managed-care plan premiums.

Federal officials have also become concerned about the lucrative commissions paid by Medicare Advantage plan insurers to their agents and brokers. Agents were making between $500 and $550 in 2008 for enrolling a beneficiary in one of their plans, and they stood to make an additional $500 for each year the beneficiary stayed in the plan. In expressing concern about elderly patients being lured into plans not meeting their medical needs, Senator Max Baucus (D-Montana) remarked, “Medicare Advantage plans that have nearly quadrupled agent commissions are putting profits before patients and that’s wrong. We can’t let seniors remain at risk of being targeted by predatory sales agents looking to make a quick buck.” At this writing, the CMS is promulgating regulations to curb abusive commission practices.

Insurance Companies That Dodge Their Obligations

The insurance mechanism transfers risk from the individual policyholder to the large group of policyholders of a specific insurance company; the risk is then shared by policyholders on some equitable basis. In essence, insurance represents the payment of a small, but certain, premium in exchange for protection against a large, but uncertain, loss. Underwriting by an insurance company entails selecting and classifying risks. The premiums charged to policyholders are a direct reflection of these risks.

Group insurance provides coverage for employees or union members. The underwriting process focuses on the entire group, not on any specific individual within the group. For persons working at companies offering no health insurance or for persons who are unemployed, the only alternatives are Medicare, Medicaid, or an individual health insurance policy. Medicare and Medicaid have age- and income-eligibility requirements, and purchasing a health insurance policy on an individual basis can be prohibitively expensive, or impossible, for persons in poor health.

Injured or unhealthy members of a group health insurance plan are protected from losing their coverage, and their expenses are absorbed by the larger group. Policyholders with individual plans, however, are subject to medical examinations and an underwriting process that has allowed insurance companies to select customers based on their health and preexisting conditions. It is the
individual policyholders—not those under a group health insurance plan—who have been targeted for abuse by health insurers.

Health care insurance companies could earn tremendous profits if they were allowed to drop coverage on those suffering from a serious injury or an illness, an illegal practice known as “rescission.” Rescission occurs when a health insurance carrier retroactively cancels a policy after the policyholder becomes seriously injured or ill and files expensive medical claims. Unlike a simple cancellation, rescissions treat the coverage as if it had never been approved, and it leaves the confused and distraught policyholder responsible for all medical bills dating back to the starting date of the policy. The insurance companies have justified these rescissions by accusing policyholders of omitting information on the insurance application or of failing to reveal preexisting conditions.

California has been the scene of several cases in which policyholders incurring large medical bills were dumped by health insurance companies. In 2006 one of the state’s largest health insurers was the target of thirteen lawsuits filed by former policyholders who were allegedly jilted by the insurer. One plaintiff said he was left with $15,000 in bills when the company retroactively cancelled his son’s coverage after a surgery. Policyholders complained they were dropped under the pretext of having trivial or inadvertent omissions on their health care insurance applications.

California insurance commissioner John Garamendi said that “this may be one of the reasons [the company] has such a very, very high profit margin on these products.” Less than a year later, Garamendi’s successor, insurance commissioner Steve Poizner, commented shortly after taking office, “I am very concerned about the practice of post-claims underwriting. The law does not permit a health insurer to agree to provide coverage and then wait until a claim comes in to decide whether to pay for the medical care a policyholder needs. Specifically, I am concerned about insurers rescinding coverage for small, inadvertent and innocent omissions on applications for coverage.”

Lawmakers and regulators have accused insurance companies of using confusing applications to trick consumers into making mistakes that could later be used against them. Insurers have also been accused of failing to verify the medical histories of insurance applicants before issuing a policy.

Another large insurer agreed in July 2008 to settle claims from 480 California hospitals for failing to pay the bills of patients whose coverage had been revoked. The $11.8 million settlement was triggered by allegations from scores of patients who were dropped illegally by the company after they received both emergency and authorized care. The insurer said the patients had undisclosed preexisting conditions affecting their insurability. In addition, the insurer was also fined $1 million by the California Department of Managed Care for illegal rescission practices, and it faced even more serious liability after agreeing to pay $13 million and reinstate coverage to 1,770 former policyholders whose coverage had been cancelled.
Another form of health insurance fraud involves companies that either mislead or fail to disclose important coverage limits to prospective policyholders. A health insurance company with some 612,000 policyholders in forty-four states agreed to pay $20 million to settle regulatory violations in thirty-six states. The legal problems were sparked by consumer complaints of denied health care coverage and slow payments of claims. According to USA Today, the company sold limited-coverage plans to self-employed individuals. But it was accused of improperly training its agents, who then failed to disclose policy limits to customers.\(^{117}\)

And some health insurance “plans” are outright frauds. An Oklahoma man purchased coverage from a company called the American Trade Association, and a Colorado man purchased his health insurance through the National Trade Business Alliance. Despite the legitimate-sounding names of these companies, the American Trade Association turned out to be fake, paying nothing when the Oklahoma man filed a claim for medical expenses brought on by a heart problem. The National Trade Association was little better, paying just $250 after the Colorado man was fatally injured in a hit-and-run accident. Many of these plans are classic “fly-by-night” operations that employ aggressive telemarketing, website, and email advertisements offering premiums that are too good to be true. Other phony health insurers use door-to-door sales people who claim to represent the federal government. These imposter agents pressure uninsured victims—often the elderly—into signing up for health insurance that is “required” under the Obama administration’s health care reform.\(^{118}\)

**Short-Pilling Consumers and Diluting Drug Therapies**

Some unscrupulous pharmacists have engaged in two money-saving, but highly dangerous, practices—“short-pilling” (or “short-filling”) patient prescriptions and diluting drug therapies. In the former, retail pharmacies fail to provide patients with a complete prescription, but bill Medicare or Medicaid for the full amount. The OIG has received a number of complaints about retail pharmacies—including several major retail chains—that were accused of billing Medicaid for prescription drugs that were not provided to patients. According to the OIG, this short-pilling fraud resulted in collections of more than $30 million from these pharmacy chains.\(^{119}\)

A reprehensible health care fraud is the sale of diluted or counterfeit pharmaceuticals. A Tennessee oncologist received a fifteen-year sentence for administering diluted chemotherapies and other medications to patients.\(^{120}\)

But the worst case of all—possibly the most atrocious health care fraud in history—was the Kansas City-area pharmacist who admitted that he diluted intravenous chemotherapy drugs for as many as 98,000 prescriptions that were written by 400 doctors for 4,200 patients. This astute—but depraved—entrepreneur
became one of the first pharmacists in Kansas City to dispense cancer medications in premixed bags, saving doctors the trouble of measuring and mixing the bags themselves. He was accused of diluting Taxol and Gemzar, drugs used to treat a variety of cancers. At least one of the pharmacist’s premixed bags contained less than 1 percent of the prescribed measure of Gemzar. In another instance, he provided only 450 milligrams of Gemzar instead of the prescribed 1,900 milligrams, enabling him to pocket an additional $779 profit.

The patients receiving these diluted treatments were pleasantly surprised when they suffered none of the usual side effects of chemotherapy. Their surprise turned to horror, however, when they and their families learned the sordid truth about the pharmacist’s diabolical scheme. And the unsuspecting physicians who trusted him and thought their patients were receiving a full measure of chemotherapy were equally devastated.

A son of a minister, this pharmacist-gone-bad was a Sunday school teacher and multimillionaire who pledged huge amounts of money to his church. According to a New York Times magazine article about him:

The sheer voraciousness of his dilutions suggests the compulsion of a pathological shoplifter. At times, [he] diluted conservatively; at others, he reduced medications to trace amounts, seemingly taunting their recipients: Feel anything now? Though [his] highest profits came from diluting expensive chemotherapy medication—a plaintiff’s lawyer says he pocketed as much as $50,000 in the treatments of a single cancer patient—[he] adulterated a total of 72 different drugs, including fertility drugs, antibiotics, drugs to prevent nausea and others to improve blood clotting. “Basically,” says Judy Lewis, the F.B.I. agent in charge of the….investigation, “if you could mix it or inject it, he diluted it.” In addition to shorting prescriptions and buying meds from illegal sources, the pharmacist chiseled whenever an opportunity arose. To one oncologist in the [place] where he worked, [he] dispensed generic drugs while charging them for the more expensive brand-name versions. When customers could not make their $5 or $10 copayments, the kindly pharmacist would let them slide, in exchange for taking back the supposed equivalent portion of their medications to be resold later.

This Midwestern pharmacist’s unforgivable fraud began to unravel when a sales representative for Eli Lilly and Company—who harbored a strong personal animosity against the pharmacist for his arrogant and pretentious ways—noted his chemotherapy drug purchases from Lilly were only about one third of the amount he billed to area physicians.

At this writing, the pharmacist is incarcerated at a federal prison hospital in Rochester, Minnesota. Shortly after entering the federal prison system, he
petitioned the court for a temporary release to attend his daughter's wedding. In denying his request, a judge noted: "Defendant would be unable to give his daughter away at her wedding while dressed in a prison jumpsuit and wearing leg chains and handcuffs." His release date, according to the Federal Bureau of Prisons inmate locator, is November 20, 2027.

Short-changing consumers by providing diluted or counterfeit drugs obviously poses major health hazards. Cancer patients who fail to get the full measure of their chemotherapy lose valuable time. Instead of forcing their cancer into remission, the diluted medications provided by the Kansas City pharmacist probably allowed the disease to progress to the point where further treatments were ineffective. He banked on his deceptions going undetected because cancer patients undergoing chemotherapy often have uncertain prognoses; some may not survive even when given a full dose of medication. In addition, certain bacteriological disease strains develop immunity to adulterated or diluted drugs. And contagious diseases may spread if ineffective counterfeit or diluted drugs are administered by unwitting or unscrupulous health care providers.

The cases of health care fraud and abuse described here cover a wide spectrum. Although these cases vary widely, they all contain the common elements of illicit transfer of resources, misinformation, manipulation, and—sometimes—bodily harm. The line between legal and illegal health care practices is not always clear, but the cases illustrated here either violated a law or, at a minimum, represented a serious breach of ethics. I now turn my discussion to the marquee health care fraud prosecutions that have resulted in hundreds and millions of dollars in settlements.