



## Fraud in Health Care

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By David J. Gibson, MD

**Despite the myth of abused doctors, fraud is a serious problem that we must address.**

DOCTORS GENERALLY FIND THEMSELVES in the crossfire of our unending cultural wars. Take almost any issue — abortion, use of narcotic analgesics, use of marijuana in the treatment of AIDS or glaucoma, class action lawsuits, gender issues — we are in the middle of the battlefield taking unfriendly fire from polarized partisans.

When "reforms" in health care in which we had little involvement — managed care, workers' compensation, entitlement benefit expansion — trigger inflationary spirals, physicians always get singled out for special blame.

No wonder then that mythological stories proliferate when doctors get together. The classic: a hard working, heroic physician makes an inadvertent mistake in billing for services and is hounded out of practice by overzealous state and federal prosecutors.

### Fraud and mythology

The myth of abused doctors gives our profession permission to ignore the elephant standing in the room. Fraud is a very serious problem.

**Medicaid:** The program is literally out of control. Its cost was \$1 billion in 1967 and will run about \$280 billion this year. By 2012, the Congressional Budget Office estimates outlays will hit \$578 billion. Fraud and abuse are a debilitating reality in all government entitlement programs. According to the US General Accounting Office and health insurance industry sources, between 3 and 10 percent of any state's Medicaid budget is lost to fraud and abuse.

In California, criminals have siphoned off billions of Medi-Cal dollars earmarked for healthcare, and have used them to finance luxurious lifestyles. Total spending on Medi-Cal in 2002 was \$25 billion, approximately \$9.2 billion of it from the state's general fund — or more than one of every eight California tax dollars. The FBI conservatively estimates that 10 percent of the Medi-Cal funds are stolen by doctors, dentists, pharmacists, durable goods vendors and others.

Fraud is most frequently found in the following areas:

- Registered Medi-Cal providers who allow others to use their billing privileges, or criminals who tap into the billing privileges of registered providers.
- Registered providers who knowingly bill for unnecessary or unperformed services, or more expensive services than they actually provide.
- Identity thieves who steal information from providers and patients, or beneficiaries who accept payment for using a particular provider or for selling their identities.

These criminals prey on the poor, the uneducated, the unsophisticated, or those lacking

English language skills. They subvert the institutions whose mission centers upon protecting the poor — local government and immigrant churches.

**Medi-Cal's Pharmacy Benefit:** The problems for Medi-Cal program are even more pronounced in the area of pharmaceutical services and durable goods. Fraud in these areas may run two to three times the over all 10 percent fraud rate.

As an example, a black market has developed among body builders for Serostim, a human growth hormone used by AIDS patients, which costs almost \$7,000 for a one-month supply. A San Diego County Grand Jury indictment in 2001 alleged that Medi-Cal was bilked of \$3.5 million by a statewide ring using stolen beneficiary numbers and physician identities to create phony prescriptions, then peddling the drug at gyms and spas. Nine individuals used more than 500 fraudulent prescriptions at more than 75 pharmacies to defraud the Medi-Cal system.

In this black market, AIDS victims are aggressively recruited, robbed of life saving medications, and bought and sold as commodities.

**Medi-Cal Durable Goods Benefit:** According to last year's annual report by the California Bureau of Audits, fraud in the Medi-Cal durable goods program is estimated to be as high as 70 percent of billings. More than \$356 million in state and federal money is spent annually on Medi-Cal supplies (hearing aids, canes, crutches, wheel-chairs, bandages, diabetic tests, gloves and water-proof sheets) for Medi-Cal patients. The most frequent type of abuse: disposable diapers for incontinent adult patients.

### State Efforts

Government's ability and will to confront fraud has been problematic and anemic. Elected officials have few incentives to deal with fraud and the disincentives are overwhelming.

- Fraud, particularly in health care, is exceedingly profitable and attracts criminals. It is far more lucrative than street crime.
- Fraudsters contribute generously, particularly at the county level, to political fund raising. The contributions buy access and influence used to limit the effectiveness of fraud detection and prevention by government agencies.
- White collar crime is difficult to investigate and prosecute — the fraudsters budget for and hire the best lawyers.
- Much fraudulent activity tends to congregate within the recently arrived, urban minority communities. Thus, attacking the problem exposes elected officials to charges of racism.
- When fraudsters are caught and convicted, any recovery is generally low. The fraudster, knowing months in advance that an indictment is coming, will move funds to off shore investors where it is virtually impossible to reclaim.

The lone exception to this record of non-performance has been the California Department of Health Services' recently-created Medi-Cal Fraud Prevention Bureau, which has developed and is using provider fraud risk assessment surveys to detect, document, and refer fraud for criminal investigation and prosecution. Efforts of this bureau have resulted in criminal charges against more than 700 people and companies in the last few years, and almost \$100 million in restitution as a result of state and federal prosecutions.

### Who Steals?

In *License to Steal*,<sup>1</sup> Malcolm K. Sparrow shows how the health care industry's defenses, which focus mostly on finding billing errors, are no match for fraudulent attacks. The maxim for thieves is simply to "bill your lies correctly." Fraudsters with any degree of sophistication steal millions of dollars with impunity. They test their payment systems carefully and spread fraudulent billings widely across patient and provider accounts to escape detection.

The highly automated, quality controlled claims processing systems in the health care industry give fraud perpetrators their favorite kind of target: rich, fast paying, transparent, utterly predictable check printing systems, with little threat of human intervention, and

with the U.S. Treasury or all state treasuries on the end of the electronic line.

The range of participants is extraordinary — from low-life hoods who sign on as Medicare or Medicaid providers, to drug trafficking organizations, organized crime syndicates, and even major hospital chains and international pharmaceutical manufacturers.

It is not difficult to find physicians who participate in fraudulent activities. They generally have some or all of the following characteristics:

- Their license to practice medicine is frequently under disciplinary review by the Department of Consumer Affairs.
- They have recently relocated into California — specifically to an inner urban ethnic community — from another state (anecdotally, many come from the South Florida, the chief exporting area for con artists and fraudsters).
- They do not have hospital privileges and do not participate in organized medical associations (CMA, AMA, and specialty societies).
- Many lack board certification.
- Their names and license numbers appear as the predominant prescribers in vendor records being investigated for fraudulent activity.
- As a direct result of their associations, they are unusually vulnerable to identity theft.

### **The health care response**

The health care industry's response to government's efforts to control fraud is frequently hostile. Physicians tend to "circle the wagons," thinking they are protecting their own. However, the profile above does not fit the hard working, honest, heroic, harassed doctor who is raided by a SWAT team for an inadvertent billing error.

The various provider associations have vociferously opposed almost every recent governmental enforcement initiative, creating the public impression that the entire health care industry is against effective fraud control. The fear of additional regulations and the mythology of the hassled honest provider lie at the core of this phenomenon.

This leaves to patients or their relatives the important task of reviewing their medical bills, and frequently find billing for non-delivered services. If patients complain, they discover that no one in the system seems to care, or that no one has the resources to do anything about it.

The California Medical Association, The California Pharmacists Association and the California Healthcare Association should be at the forefront in confronting fraud in all of its manifestations within the industry.

### **What our response should be**

Fraud is an endemic problem (and not confined to health care). It is our responsibility to patients to aggressively confront and eliminate fraud in health care. Sitting around and complaining about mythology is no longer acceptable. The Legislature is now contemplating cuts of over \$300 million for Medi-Cal — when we have evidence of over eight times, or \$2.5 billion, that amount going into fraudulent payments. These cuts hurt real people.

If the medical establishment does not step forward to lead the effort to control fraud, California taxpayers will continue to lose confidence in publicly-funded medical assistance programs. The resulting pain will be borne by our weakest and most vulnerable patients.

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