



**Department of
Financial Services**

**Investigating and Combating
Health Insurance Fraud**

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Introduction

This report, required under Section 409(c) of the Financial Services Law, summarizes the 2016 activities of the Department of Financial Services in combating health insurance fraud.

2016 Highlights

The Department's Insurance Frauds Bureau (the Bureau) investigates and combats health care fraud, which affects three major types of insurance: accident and health, private disability, and no-fault. The Bureau is headquartered in New York City, with an office in Garden City and five offices across upstate New York: Albany, Syracuse, Rochester, Buffalo, and Oneonta. The Bureau, working with DFS regulated entities, has a longstanding commitment to combating insurance fraud and strives to serve the people of New York State. Highlights of the Department's efforts in combating healthcare fraud in 2016 include the following:

- The Bureau opened 114 healthcare fraud investigations in 2016 that resulted in 133 arrests;
- The Bureau received 14,141 reports of suspected healthcare fraud: 12,339 no-fault reports, 1,535 accident and health insurance reports, and 267 disability insurance reports;¹
- Reports of suspected no-fault fraud accounted for 53% of the 23,472 suspected insurance fraud reports received.

Overview of Healthcare Fraud in New York State

The High Cost of Healthcare Fraud

Healthcare fraud is a costly and pervasive drain on the national healthcare system. Experts agree that the costs of healthcare fraud are exorbitant: the National Health Care Anti-Fraud Association estimates that losses due to healthcare fraud are in the tens of billions of dollars each year. Combating fraud and abuse helps reduce the escalating costs of healthcare in the United States.

Types of Healthcare Fraud

Healthcare fraud affects three major types of insurance: accident and health, private disability, and no-fault. The more common types of healthcare fraud include:

- Prescription drug diversion and misuse;
- Medical identity fraud;
- Billing for services that were never rendered and products that were not provided;

¹ Section 405 of the New York Insurance Law requires insurers to report suspected fraud to the Department.

- Billing for more expensive procedures or services than were actually provided, commonly known as upcoding;
- Performing medically unnecessary treatments and expensive diagnostic tests for the sole purpose of generating insurance payments;
- Misrepresenting non-covered treatments as medically necessary covered treatments, for example billing a cosmetic nose surgery as a deviated septum repair, to obtain insurance payments;
- Unbundling billing as if each step of a procedure were a separate procedure;
- Staging or causing auto accidents;
- Filing no-fault claims for nonexistent injuries;
- Filing false or exaggerated medical disability claims;
- Staging slip-and-fall accidents;
- Accepting kickbacks for patient referrals.

In 2016, the Department received numerous allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. In addition, reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

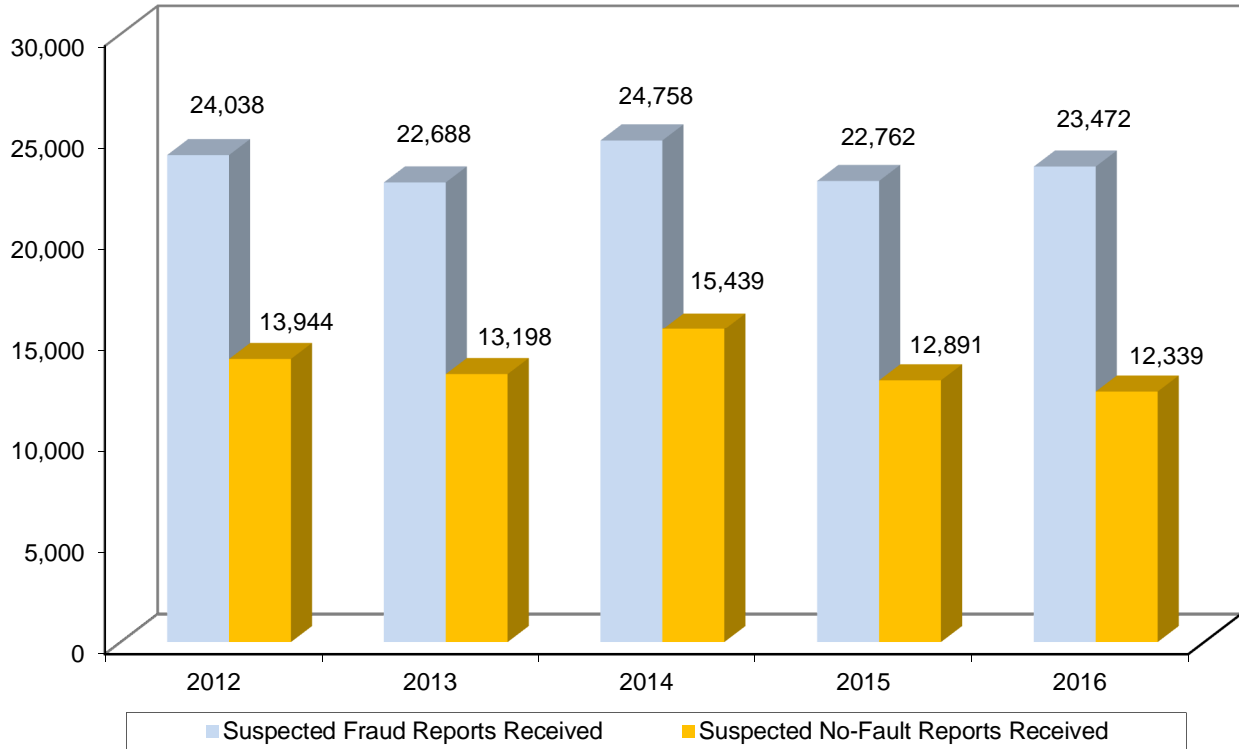
No-Fault Fraud

No-fault fraud accounts for the majority of healthcare fraud reported, and combating no-fault fraud is one of the Department's highest priorities. In 2016, the Bureau continued to work with the insurance industry, prosecutors, and law enforcement on investigations ranging from small, non-organized staged accidents, to complex investigations involving medical mills and unscrupulous healthcare providers who fraudulently billed insurers under the no-fault system. These large-scale investigations require the use of sophisticated investigative techniques, including court-ordered wiretaps, as well as undercover officers to infiltrate highly organized no-fault rings.

No-Fault Fraud by the Numbers

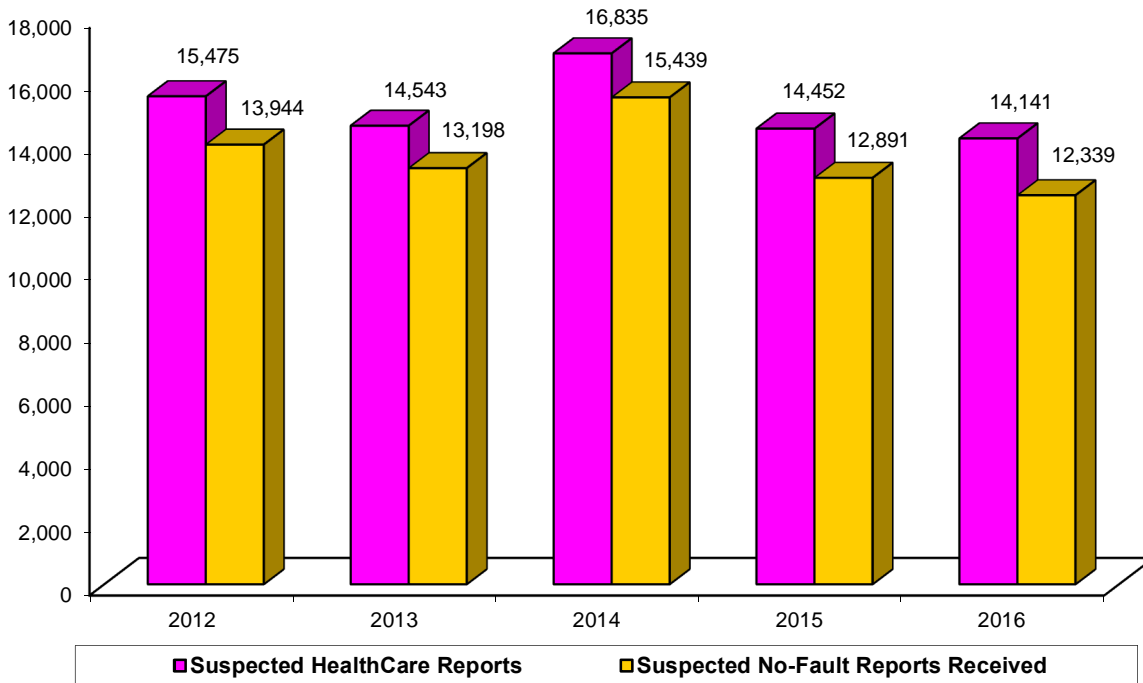
As shown in Figure 1 below, suspected no-fault fraud reports accounted for 53% of all fraud reports received by the Department in 2016.

Figure 1. Number of All Suspected Insurance Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2012-2016



As shown in Figure 2 below, the number of suspected no-fault fraud reports accounted for 87% of all healthcare fraud reports received in 2016 and at least 85% of all healthcare fraud reports received since 2008.

Figure 2. Number of All Suspected Healthcare Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2012 - 2016



Collaborative Efforts to Combat Healthcare Fraud

Department investigators work closely with the insurance industry and law enforcement agencies at the federal, state and local levels to combat healthcare fraud schemes. The Department is a member of 10 task forces and working groups designed to foster cooperation and communication among the many law enforcement agencies involved in combating healthcare fraud. Those task forces and working groups include the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- Rochester Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force/Medicare Fraud Strike Force
- New York Anti Car Theft and Fraud Association
- National Insurance Crime Bureau Working Group
- High Intensity Drug Trafficking Area

- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney's Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

Participation provides the opportunity for joint investigations, intelligence gathering, effective use of resources and the study of trends. Several of the Department's investigators have been assigned to groups and task forces, and partner with other members investigating cases involving healthcare fraud. One example of successful collaborations is the Drug Enforcement Administration Tactical Diversion Task Force, which investigates organized drug diversion schemes, "doctor shopping," and forgery of controlled-substance prescriptions. Successful investigations by the combined Upstate/Downstate Task Force resulted in 26 arrests in 2016. The Department assigns one investigator full time to each of the Upstate and Downstate offices of the Task Force. For example, in 2016 a Queens doctor and his female accomplice were arrested and charged with Title 21 USC 846 conspiracy to distribute and distribution of the pharmaceutical drug Oxycodone. An investigation by the DEA Tactical Diversion Unit, which includes the Bureau, found that the doctor and others were illegally dispersing large quantities of prescription medication in the New York Metropolitan area as well as committing healthcare fraud by billing for services not rendered.

Reporting and Preventing Healthcare Fraud

Insurance Company Reporting

Under Section 405 of the New York Insurance Law, insurers are required to report suspected insurance fraud to the Department. The Department has a web-based case management system, known as the Fraud Case Management System ("FCMS"), which allows insurers to submit reports of suspected fraud electronically. In 2016, insurers electronically submitted approximately 94 percent of the 23,472 fraud reports that the Department received.

The benefits of the FCMS to insurers include automatic acknowledgment of receipt of fraud reports and notification of case assignments and eventual case disposition. Insurers also benefit from online help screens and an online manual of operations, as well as search and cross-reference features.

Consumer Reporting

The Department encourages consumers to report suspected fraud and maintains a toll-free hotline to facilitate reporting. The Department recorded an average of 13 calls per week in 2016. The "Consumers" section of the Department's website includes a link to a fraud report form and instructions for how to report fraud to the Department.

Compliance with Section 409 of the New York Insurance Law

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 individual accident and health, workers' compensation, or automobile policies, or group policies that cover at least 3,000 individuals issued in or issued for delivery annually in New York, to submit to the

Department a Fraud Prevention Plan for the detection, investigation, and prevention of insurance fraud. Licensed health maintenance organizations (HMOs) with at least 60,000 enrollees also must submit a Fraud Prevention Plan. Plans must provide for a full-time Special Investigations Unit (SIU), as well as specific staffing levels within the SIU.

Fraud Prevention Plan Requirements

Section 409 specifies information that must be included in Fraud Prevention Plans. For example, a Plan must provide for an SIU separate from claims and underwriting, and must include details regarding the staffing and other resources dedicated to the SIU. To be designated an SIU investigator, individuals must meet certain educational and/or professional experience criteria enumerated in Section 409 and Department Regulation 95.

Section 409 and Regulation 95 also require the following information and/or procedures to be included in all Fraud Prevention Plans:

- Interface or interaction of SIU with law enforcement and prosecutorial agencies;
- Coordination with other units of the insurer for the investigation and initiation of civil actions based on information received by or through the SIU;
- Development of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity;
- Objective criteria for the level of staffing and resources devoted to the SIU;
- In-service training of investigative, claims, and underwriting personnel in identification and evaluation of insurance fraud;
- Development of a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud.

In 2016, there were 64 insurer SIUs committed to investigating health fraud in New York State that were housed within accident and health insurers, HMOs, life insurers, nonprofit medical, and dental indemnity and health service corporations. In addition, 19 property and casualty insurers writing accident and health insurance had approved SIUs during 2016.

Health and life insurers reported \$268 million in savings resulting from SIU investigations in 2015 (the most recent year for which data are available). Health and life insurers reported \$36 million in recoveries from SIU investigations. In addition, two property and casualty insurers writing accident and health insurance reported \$978,209 in savings.

The Department monitors insurer compliance with Section 409 through the analysis of data provided by insurers in annual SIU Reports. The Department may perform field examinations of insurer SIUs to assess compliance with Section 409, other sections of Article 4 of the New York Insurance Law, and Regulation 95.

2016 Healthcare Fraud Reports Received and Arrests Made

The Department received 14,141 reports of suspected healthcare fraud during 2016 ÷ 1,535 involved accident and health insurance, 267 involved disability insurance, and 12,339 involved no-fault. The Department opened 114 healthcare fraud cases for investigation. Of those, 43 involved accident and health insurance, 13 involved disability insurance, and 58 involved no-fault insurance. Department investigations resulted in 133 arrests in 2016.

Public Awareness Programs

New York Insurance Law requires that Fraud Prevention Plans address insurers' efforts to increase public awareness of the cost and frequency of fraudulent activities and the methods of preventing fraud. The New York Alliance Against Insurance Fraud and the National Health Care Anti-Fraud Association carry out advertising campaigns via newspapers, radio, television, and billboards targeting insurance consumers on behalf of HMOs and insurers of health products. The National Health Care Anti-Fraud Association conducted public awareness programs for HMOs and insurers of health products on behalf of 18 entities with Fraud Prevention Plans on file. There were 39 HMOs, health insurers, or health insurer groups (an organization comprising affiliated insurers) with Fraud Prevention Plans on file that participated in the New York Alliance Against Insurance Fraud program. In addition, several individual insurance companies have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers each year.

The Year in Review

Some of the major healthcare fraud investigations conducted by the Bureau during the past year, to the extent public, are summarized below. The Department has pending numerous other confidential investigations of healthcare fraud.

- A Manhattan doctor was convicted of one count of conspiracy to distribute Oxycodone and two counts of unlawful distribution of Oxycodone. Ten other conspirators had previously pleaded guilty. The over-prescription of opioids, such as Oxycodone, is a priority for the Department. From October of 2012 to December of 2014, the doctor wrote more than 13,000 medically unnecessary prescriptions for nearly 1.2 million Oxycodone tablets with a street value estimated at least \$36 million. He received more than \$2.4 million in fees during the two-year scheme. More than \$1.75 million in cash was recovered at the time of his arrest in December 2014. The doctor generally charged \$200 in cash for "patient visits" that involved few, if any, actual examinations but typically resulted in his issuing prescriptions for large quantities of Oxycodone. The doctor falsely documented the need for prescriptions by creating fake MRI and urinalysis reports. Most "patients" were recruited and paid by drug traffickers to pose as patients for the purpose of obtaining the illegal prescriptions. The traffickers in turn arranged for the prescriptions to be filled at various pharmacies and the drugs resold on the streets of New York City. In September 2016, the doctor was sentenced to 13 ½ years in prison and a forfeiture of \$2,046,600 for unlawful distribution of Oxycodone and healthcare fraud. The investigation was conducted by the Drug Enforcement Administration Tactical Diversion Task Force, of which the Bureau is a member.

- The Rochester Police Department requested the Bureau's assistance with an identity-theft complaint it had received. The complainant discovered that someone had used her identity to order prescriptions after she had received a call from her pharmacy informing her that her prescription was ready. During the course of the investigation, three other victims were found, all of whom had the same physician. Using surveillance videos, investigators identified an employee of the doctor as a suspect, as well as the employee's cousin. An audit of the doctor's records showed multiple prescriptions written in the name of the employee. The cousin admitted to picking up the prescriptions at the request of the suspect. The suspect subsequently turned herself in to the Rochester police department and confessed, stating that the doctor had given her access to his patients' electronic records, and that she used the information to submit prescriptions electronically to local pharmacies to obtain Percocet, which is a combination of acetaminophen and Oxycodone, for her personal use and to pay off a debt. The subject was arrested and charged with identity theft and forgery.
- A doctor was sentenced to a conditional discharge after pleading guilty in April 2016 to insurance fraud in the 3rd degree, following an investigation by the Insurance Frauds Bureau that led to the doctor's arrest. Aetna Insurance Company referred the case to the Bureau based on a report from one of its insureds that a medical service for which Aetna had been billed had not been provided. The doctor's claims history showed the doctor had filed numerous claims for one particular medical billing code. The Department's investigation revealed that 13 patients in whose names the doctor had filed claims for having received the procedure, in fact, had not received the service. Another patient provided evidence that the doctor filed a false claim reporting that emergency room services had been performed in an emergency room. The claims history showed that the doctor had submitted an unusually high number of claims for emergency room treatments compared with treatments provided in the office. A search warrant executed at the doctor's office resulted in records being confiscated that supported the patients' allegations. Further investigation revealed that Cigna, Health Plus and Affinity Health Plan had also been the victims of fraudulent claims submitted by the doctor. The claims resulted in billings totaling \$56,520, \$20,160 of which had been paid by the insurance companies. The doctor was also ordered to pay restitution.
- In December 2016, the Department's Insurance Frauds Bureau and the New York City Police Department's Fraudulent Investigation Squad arrested four New York City residents and charged them with grand larceny, insurance fraud, and falsifying business records. The subjects, who resided in Queens and Brooklyn, were involved in a no-fault insurance scheme in which they staged car collisions, exaggerated injuries, and received benefits from insurance companies in excess of \$88,000 during 2015 and 2016. The subjects face 7 to 15 years in prison if convicted. The case is being prosecuted by the Manhattan District Attorney's Office.
- An investigation conducted by the DEA Tactical Diversion Task Force, of which the Insurance Frauds Bureau is a member, led to the April 2016 arrest of three alleged members of an organized ring moving large amounts of Oxycodone throughout the New York Metropolitan area. The ring members were charged with violating Title 21 U.S. Code 841 and 843. In November 2015, five other suspects and the alleged ringleader were arrested. The ringleader allegedly billed insurers for fraudulent prescriptions she had filled, and the pills were distributed by other ring members.

- In August 2016, a doctor pleaded guilty to misdemeanor charges of falsifying a business record and his corporation pleaded guilty to the felony of grand larceny in the third degree after a joint investigation by the Department's Insurance Frauds Bureau and the New York State Attorney General's Medicaid Fraud Control Unit, based on a referral from the Excellus Blue Cross Blue Shield Special Investigations Unit. Excellus identified the Monroe County doctor for suspicion of billing for services not rendered. A search warrant executed in 2014 and subsequent interviews substantiated the allegations and led to the filing of grand larceny and false business record charges against the doctor and his corporation. The doctor was sentenced to three years' probation and 200 hours of community service. Along with the criminal pleas, a civil settlement required the doctor to pay more than \$500,000 to resolve claims of overbilling services and/or procedures relating to clinical testing services, billing for counseling services provided by ineligible staff, and improper billing of prescription pickups and medication refills.

Conclusion

The problem of healthcare fraud continues and is a major focus of the Insurance Frauds Bureau's work. The Bureau will continue to aggressively combat healthcare fraud in the year ahead.