Investigating and Combating Health Insurance Fraud

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Maria T. Vullo
Superintendent
New York State Department of Financial Services

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Introduction

This report, required under Section 409(c) of the Financial Services Law, summarizes the 2017 activities of the Department of Financial Services (ñDFSò) in combating health insurance fraud.

2017 Highlights

DFSôs Insurance Frauds Bureau (ñBureauò) investigates and combats healthcare 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 located in 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 Departmentôs efforts in combating healthcare fraud in 2017 include the following:

- The Bureau opened 116 healthcare fraud investigations in that resulted in 105 arrests;
- The Bureau received 14,622 reports of suspected healthcare fraud: 12,887 no-fault reports, 1,500 accident and health insurance reports, and 235 disability insurance reports;[1]
- Reports of suspected no-fault fraud accounted for 54% of the 23,876 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

As mentioned above, 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 rhinoplasty (cosmetic nose surgery) as a deviated septum repair to obtain insurance payments;

- Unbundlingð 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 2017, DFS received numerous reports of suspected fraud containing allegations of medical providers billing for services not rendered and prescribing unnecessary durable medical equipment. Reports of prescription drug diversion and misuse, as well as allegations of disability fraud, remained persistent issues.

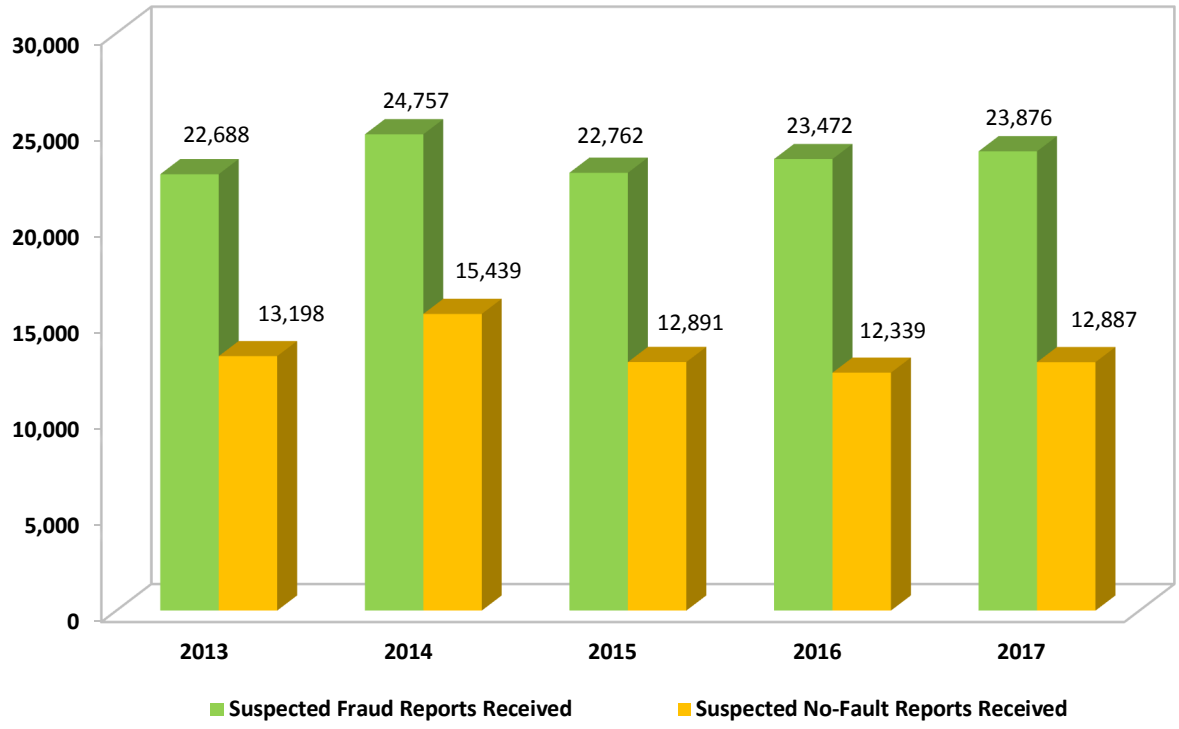
No-Fault Fraud

DFS conducted several no-fault investigations in 2017 with other law enforcement agencies, prosecutorsô offices, and the National Insurance Crime Bureau (ñNICBò) that led to the prosecution of a wide range of defendants who, in an organized fashion, are exploiting the no-fault system for personal gain. These cases have involved ñrunnersò who stage accidents and refer the phony accident victims to unscrupulous medical clinics and corrupt law firms in exchange for monetary payments. In certain investigations, the defendants used two different scenarios in staging accidents: in the first, drivers intentionally crash into one another and, in the second, the driver of one vehicle causes an accident with an unsuspecting driver. Other no-fault investigations have involved runners who solicited victims of motor vehicle accidents at accident scenes to steer them to corrupt medical clinics and coached them to exaggerate and fabricate injuries. Other no-fault investigations involve individuals adding themselves to accident reports when they were not involved in the accident that was the subject of the report.

No-Fault Fraud by the Numbers

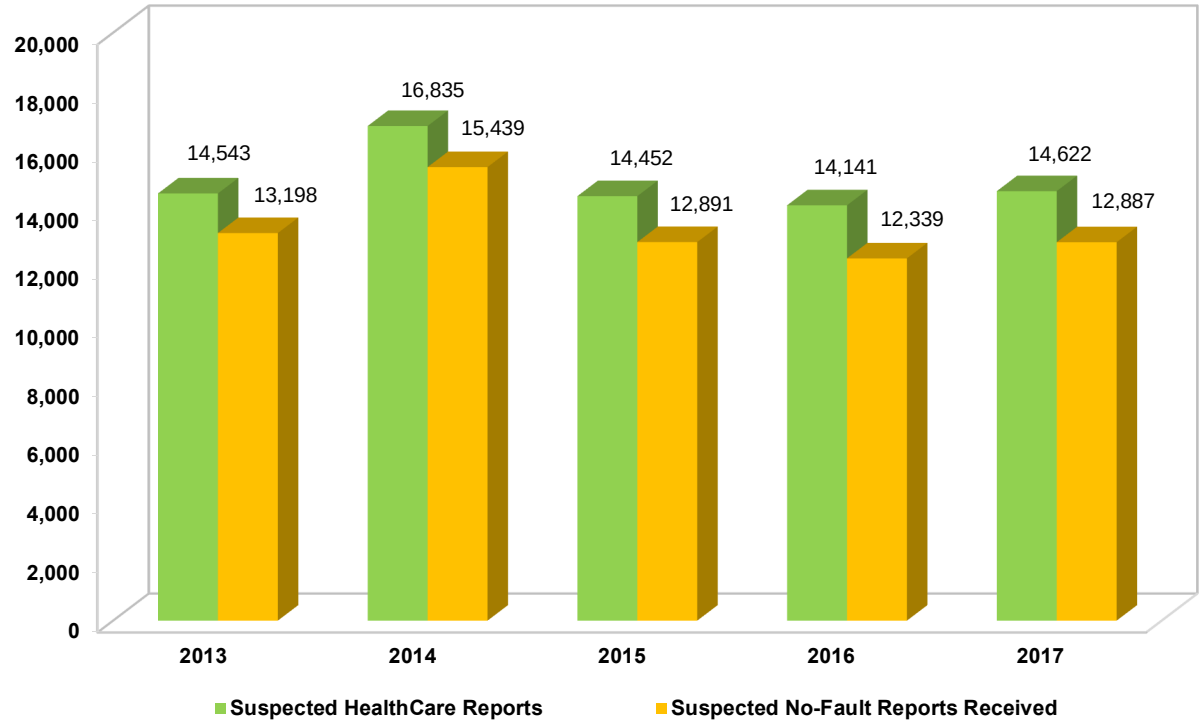
As shown in Figure 1, suspected no-fault fraud reports accounted for 54% of all fraud reports received by DFS in 2017.

Figure 1. Number of All Suspected Insurance Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2013–2017



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 88% of all healthcare fraud reports received in 2017 and at least 87% of all healthcare fraud reports received since 2013.

Figure 2. Number of All Suspected HealthCare Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2013–2017



Collaborative Efforts to Combat Healthcare Fraud

DFS investigators work closely with the insurance industry and law enforcement agencies at the federal, state, and local levels to combat healthcare fraud schemes. DFS 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 Attorneyôs Office Insurance Crime Bureau

- New York Alliance Against Insurance Fraud

The Bureauôs participation in working groups and task forces provides the opportunity for joint investigations, intelligence gathering, effective use of resources, and the study of trends. Several DFS investigators have been assigned to groups and task forces, and partner with other members investigating cases involving healthcare fraud. An example of successful collaboration is the DFSôs participation in the Drug Enforcement Administration Tactical Diversion Task Force (ñDiversion Task Forceò), which investigates organized drug diversion schemes.

One case investigated by the Diversion Task Force resulted in the indictment of a New York-licensed doctor and two others for distribution of oxycodone in June 2017. The indictment alleges the doctor wrote medically unnecessary prescriptions for oxycodone over a five-year period. Another investigation by the Diversion Task Force resulted in the arrest of a New York-licensed doctor who, while operating out of clinics in Manhattan, Queens, and Nassau County, wrote thousands of medically unnecessary prescriptions for oxycodone and fentanyl patches over a three-year period in exchange for cash. The doctor allegedly provided prescriptions with little or no physical examination and received an estimated $2 million in fees. A nurse practitioner who allegedly wrote medically unnecessary prescriptions for oxycodone was also arrested, as was an employee at one of the doctorôs offices who assisted the doctor in the diversion scheme. All three defendants were charged in November 2017.

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 DFS. DFS has a web-based case management system, known as the Fraud Case Management System (ñFCMSò), which allows insurers to submit reports of suspected fraud electronically. In 2017, insurers electronically submitted approximately 96% of the 23,876 fraud reports that DFS 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

DFS encourages consumers to report suspected fraud and maintains a toll-free hotline to facilitate reporting. DFS recorded an average of 44 calls per week in 2017. The ñConsumersò section of DFSôs website includes a link to a fraud report form and instructions for how to report fraud.

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, workersô 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 DFS a Fraud Prevention Plan for the detection, investigation, and prevention of insurance fraud. Licensed health maintenance organizations (ñHMOsò) 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 that is 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 that all Fraud Prevention Plans include the following information and/or procedures:

- 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 ñfraud detection and proceduresò 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 2017, there were 67 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, 13 property and casualty insurers writing accident and health insurance had approved SIUs during 2017.

Health and life insurers reported $363 million in savings resulting from SIU investigations in 2016 (the most recent year for which data are available). Health and life insurers reported $41 million in recoveries from SIU investigations. In addition, two property and casualty insurers writing accident and health insurance reported $76,850 in savings.

DFS monitors insurer compliance with Section 409 through the analysis of data provided by insurers in annual SIU Reports. DFS 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.

2017 Healthcare Fraud Reports Received and Arrests Made

DFS received 14,622 reports of suspected healthcare fraud during 2017: 1,500 involved accident and health insurance, 235 involved disability insurance, and 12,887 involved no-fault. DFS opened 116 healthcare fraud cases for investigation. Of those, 39 involved accident and health insurance, 10 involved disability insurance, and 67 involved no-fault insurance. DFS investigations resulted in 105 arrests in 2017.

Public Awareness Programs

New York Insurance Law requires that Fraud Prevention Plans address insurersô 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 16 entities with Fraud Prevention Plans on file. There were 40 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.

- In March of 2017, an FBI Health Care Task Force investigation led to the arrest and indictment of a cardiologist, a neurologist, and four other defendants in connection with a 12-year scheme to defraud Medicaid, Medicare, and private health insurance out of more than $50 million. Among other illegal acts, defendants are alleged to have submitted claims to insurers for medical tests that were not performed or that were medically unnecessary. Certain defendants were alleged to have used various unlawful means to obtain and maintain a high volume of patients for use in the scheme, which included paying kickbacks in exchange for referrals of patients to the clinic, and repeatedly violating healthcare privacy laws to identify and recruit patients.
- Another FBI Health Care Task Force investigation that DFS participated in led to the arrest in March of a licensed psychiatrist who was employed by the Veterans Administration in Canandaigua on charges of healthcare fraud, money laundering, and tax fraud. The doctor allegedly improperly billed healthcare benefits programs for services he did not provide, deposited proceeds from the scheme into multiple personal accounts, demanded cash payments from his patients and took actions to avoid currency reporting requirements, and submitted false tax returns.

- In November, as the result of an investigation in which DFS participated as part of the FBI Health Care Fraud Task Force, five individuals pled guilty in federal court to healthcare fraud and conspiring to commit health care fraud, mail fraud and wire fraud. The individuals are alleged members of a ring that fraudulently billed Medicaid, Medicare, and private insurance carriers more than $30 million. Five alleged members of the ring remain under indictment. Three of the defendants were doctors who allegedly signed medical charts for patients they never treated and prescribed unnecessary medications, procedures, and supplies. The scheme involved the operation of eight fraudulent medical clinics in Brooklyn, as well as the operation of related suppliers of medical equipment, tests, and services. As part of the scheme, the ring allegedly paid cash kickbacks to elderly and financially disadvantaged patients who were insured by Medicare and/or Medicaid, and then billed Medicare and Medicaid for unnecessary medical services, tests, and supplies.
- DFS partnered with the Brooklyn District Attorneyôs Office and other state, federal and local agencies in an investigation of 20 individuals, including four doctors and 14 corporations, that were named in an 878-count indictment in December alleging they participated in a massive three-year scheme to defraud Medicaid, Medicare, and other publicly funded insurance providers of approximately $146 million. According to the indictment, the defendants diverted millions of dollars from the publicly funded insurance programs relied upon by vulnerable individuals and used stolen funds to purchase expensive real estate, designer goods and jewelry. As part of the scheme, individuals allegedly were recruited on the street and paid $30 to $40 to go to medical clinics where they received no medical treatment but were given lab tests, after which the defendants would fraudulently bill Medicaid or Medicare. The defendants were charged with enterprise corruption, scheme to defraud, money laundering, healthcare fraud, falsifying business records, offering a false instrument for filing, grand larceny, and scheme to defraud.

Conclusion

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