

Health Care Fraud: Physicians as White Collar Criminals?

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White collar crimes are characterized by “deceit, concealment, or violation of trust and are not dependent upon the application or threat of physical force or violence. Such acts are committed by individuals and organizations to obtain personal or business advantage” (Ref. 1, p 3). Health care fraud is a form of white collar crime that may be committed by health care providers, consumers, companies providing medical supplies or services, and health care organizations. There is a trend toward increased participation by organized crime groups in complex health care fraud schemes.² There are many different types of illegal and unethical schemes that constitute health care fraud. The common types of fraud committed by physicians include billing for services that were never rendered, providing unnecessary treatments or tests, upcoding (billing for a more expensive diagnosis or procedure), falsifying or exaggerating the severity of the medical illness to justify coding, and accepting kickbacks for referral.^{3–7}

Health care fraud has failed to capture the attention of the public or the media. The scandals at Enron, WorldCom, and Adelphi have heightened public awareness of the serious consequences of corporate white collar crime, but there has not been a comparable response to health care fraud prosecutions. For a comprehensive review of corporate white collar crime see Price and Norris.⁸ There has been renewed interest by political leaders and prominent

government officials in raising public awareness of the enormity of the problem. In addition, investigation of health care fraud is fast becoming one of law enforcement’s major priorities.

With the Obama administration’s commitment to health care reform and extending benefits to those currently uninsured, there has been a rigorous effort to curtail the waste due to health care fraud. Attorney General Eric Holder succinctly summarized the salient concerns when he pledged:

Every year we lose tens of billions of dollars in Medicare and Medicaid funds to fraud. Those billions represent health care dollars that could be spent on medicine, elder care or emergency room visits, but instead are wasted on greed. This is unacceptable, and the Justice Department is committed to working with the Department of Health and Human Services to eradicate it [Ref. 9].

Health care fraud is not a victimless crime. The diversion of funds due to fraud drives up the costs of providing a full range of legitimate medical services and may foster mechanisms designed to recoup these losses. These efforts may result in reduced benefit coverage, changes in eligibility for programs such as Medicaid, higher premiums for individuals or their employers, or higher copays. Physicians may perform unnecessary procedures to increase reimbursement, compromising patient safety. When medical providers bill for services never rendered, they create a false medical history for patients that may later cause them difficulty in obtaining disability or life insurance policies. An inaccurate medical history may also influence treatment decisions and allow some insurance companies to deny coverage based on a previous medical condition. Health care fraud also tarnishes the reputation of the medical profession and raises

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questions about the ethics governing the conduct of all physicians.²⁻⁴

The Centers for Medicare and Medicaid Services (CMS) projected the total health care expenditures for Fiscal Year 2008 at \$2.4 trillion. With the changing demographics and escalating costs of medical treatment by 2018, CMS expects that total health care spending will increase to \$4.14 trillion and account for an even higher percentage of the gross domestic product (20.3 percent). The National Health Care Anti-Fraud Association estimated that health care fraud accounted for 3 percent of the health care expenditures, or \$68 billion, in 2007, while the Federal Bureau of Investigation (FBI) estimated losses due to health care fraud at 3 to 10 percent. At 10 percent, the losses would surge to \$226 billion for 2007.^{2,10}

There are several government agencies that play a role in health care fraud. The Department of Justice (DOJ) and the Department of Health and Human Services have a role in monitoring and enforcing health care regulations.¹¹ The FBI has functioned as the primary investigative agency for health care fraud in both the public and private health systems. The Financial Crimes Section of the FBI was created in the 1980s. It comprises three units, one of which is devoted to health care fraud. A 2007 FBI report explained that health care fraud had been identified as a priority based on information from field office crime surveys and trend analyses and input by the President, the Attorney General, the FBI Director, and the Criminal Investigative Division.²

Persons can be subject to both criminal and civil actions for health care fraud.¹¹ The Medicaid False Claims Statute criminalizes false statements or representation in relation with any application for claim of benefits or payment or disposal of assets under a federal health care program that are knowingly and willfully made. The accused must know that the statements are untrue.¹² The Medicaid Anti-Kickback Statute prohibits knowingly and willfully paying or receiving any remuneration directly or indirectly, overtly or covertly, in cash or in kind in exchange for or to induce referrals of program-related business including prescribing, purchasing, or recommending any service, treatment, or item for which payment will be made by Medicare, Medicaid, or any other federally funded health care program. There are exceptions in the form of safe harbors.^{11,13}

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided funds to attack health care fraud, expanded the definition of a kickback so that the Anti-Kickback statute could be applied to all federal health care programs, and expanded the prosecution of health care fraud.¹⁴ HIPAA, under United States Code, Title 18 § 1347, made health care fraud a federal crime punishable by fines and a prison sentence of up to 5 years. When the fraud results in serious bodily injury, the maximum sentence is a prison term of 20 years. When the violation results in a patient's death, the perpetrator may face a life sentence. HIPAA also provided for civil penalties.

Increasingly, the FBI has been part of a coordinated effort involving various agencies, including the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG), the Department of Justice (DOJ), the Food and Drug Administration (FDA), Drug Enforcement Agency (DEA), Defense Criminal Investigative Service, Office of Personnel Management, Internal Revenue Service-Criminal Investigative Division, and various state and local agencies. In tackling health care fraud in the private sector, the FBI has also formed alliances with the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, the Blue Cross and Blue Shield Association, the American Association of Retired Persons, and the Coalition Against Insurance Fraud.²

At the headquarters level, the FBI was one of the agencies involved in a Senior Level Working Group that included representatives from CMS, DOJ, HHS-OIG, and other agencies and was formed to assess vulnerabilities and make recommendations to prevent losses from health care fraud. In addition FBI field offices contributed to health care fraud working groups, which formed across the country and involved local law enforcement agencies and other stakeholders.²

The FBI has developed several national initiatives including the Internet Pharmacy Fraud Initiative, the Auto Accident Insurance Fraud Initiative, and the Outpatient Surgery Center Initiative. There has been evidence of organized criminal activity in the operation of a variety of health care facilities. In addition, there have been technology-based schemes resulting in medical data theft.²

The FBI has emphasized the investigation of medical professionals who engage in schemes that can

directly harm patients. Such schemes include performing unnecessary surgeries, diluting medication for profit, and inappropriate prescribing practices.² Recently, a California physician was accused of diluting medications such as Epogen, interferon, and intravenous immune globulin. He pleaded guilty in February 2009 to only four counts, with numerous additional counts being dismissed as part of the plea bargain. He admitted to having replaced a patient's medication with saline and vitamins and to having fraudulently billed for medication that he did not administer to another patient.¹⁵

The Internet Pharmacy Fraud Initiative has targeted Internet websites that provide illegal prescription drugs and controlled substances. Physicians who have participated in these schemes by prescribing medications for no legitimate medical purpose have been apprehended. Another area of active investigation involves the sale of counterfeit and diverted pharmaceuticals on the Internet.² Since its inception in 2005, the Auto Accident Insurance Fraud Initiative has concentrated on organized staged accident rings that submit fraudulent claims.² The implementation of the Medicare Prescription Drug Program (Part D) in 2006 led to the development of a working group to promote cooperation among agencies to prevent and detect fraud.²

In 2007, the FBI announced its concern about health care fraud involving durable medical equipment, hospitals, physicians, home health agencies, beneficiary-sharing, chiropractors, possible drug diversion in pain management, physical therapists, prescription drugs, and identity theft.² The FBI had cooperated with investigations by the DOJ and U.S. Attorney's Offices across the country. Through Fiscal Year 2007, FBI investigations led to 839 indictments and 635 convictions of perpetrators of health care fraud, with many cases still pending. There were \$1.12 billion in restitutions, \$4.4 million in recoveries, \$34 million in fines, and 308 seizures valued at \$61.2 million.²

The Obama administration has been advocating further coordinated efforts to promote health care fraud prevention and detection. On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Holder jointly announced a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), tasked with combating Medicare fraud. They also revealed that the joint DOJ-HHS Medicare Fraud Strike Forces that had

already been employed effectively in South Florida since 2007 and in Los Angeles since May 2008 were going to expand their investigations into the Detroit and Houston areas.⁹

Secretary Sebelius warned, "Today, we are turning up the heat on perpetrators who steal from the taxpayers and threaten the future of Medicare and Medicaid." She noted,

Most providers are doing the right thing and providing care with integrity. But we cannot and will not allow billions of dollars to be stolen from Medicare and Medicaid through fraud, waste and serious abuse of the system. It's time to bring the fight against fraud into the 21st century and put the resources on the streets and out into the community to protect the American taxpayers and lower the cost of health care [Ref. 9].

As an indication of the Obama administration's commitment, the HEAT team is to include senior officials from DOJ and HHS. There is also a plan to invest in technology that would enhance a data-driven strategy to spot unusual billing patterns. Preventive measures are to be implemented, and there is to be greater interagency cooperation.⁹

Just a month after this announcement, FBI Director Robert Mueller joined with Attorney General Holder and Secretary Sebelius to announce indictments against 53 persons in Detroit and Miami accused of conspiring to submit more than \$50 million in false Medicare claims. It was alleged that at least nine Medicare provider companies as well as company executives, doctors, therapists, medical recruiters, medical assistants, and Medicare consumers participated in these schemes, which involved billing for physical therapy, occupational therapy, and infusion therapy that had not been provided.¹⁶

President Obama's proposed Fiscal Year 2010 budget indicates a commitment to fighting health care fraud. It provides \$311 million, a 50 percent increase from 2009 funding, for integrity assurance activities within the Medicare and Medicaid programs. The expectation is that this additional funding would produce a saving of \$2.7 billion over five years by improving oversight and thus containing fraud in the Medicare and Medicaid system.⁹

In many ways it is much easier for those in the medical profession to imagine that well-respected, successful corporate managers could engage in white collar crime. After all, corporate officers work in an environment that rewards financial success with recognition, promotions, and bonuses. In a for-profit business environment, there can be strong organiza-

tional pressures contributing to the decision to abandon ethics for the benefit of the individual or the corporation.

As physicians, our main focus is on providing compassionate medical care to our patients without unethical deviation from the prime mission. Nevertheless, health care fraud is a reality, and there is evidence of an increase in cases in which there is direct harm to patients, a particularly reprehensible form of health care fraud.

The next generation of physicians not only should enter the profession armed with the requisite clinical knowledge and surgical techniques but also should be educated more completely about the ethics-based framework on which they build their practices. We may have to reassess how medical school applicants are screened and what attributes are given more weight in admission decisions. Evidence of commitment to patient care may be more important than test scores. Given the number of physicians engaging in fraudulent behavior, there is clearly a need for formal training during which there is frank discussion about the ethics governing patient care and the consequences to the individual and profession when there is deviation.

Law enforcement is beginning to use technology to monitor discrepancies in billing as a means of preventing and identifying health care fraud.¹⁷ However, this deterrence should not replace an education in ethics. Mentors of our young physicians must instill an appreciation of ethical conduct, and they should show no tolerance of behavior that compromises health care delivery.

References

1. U.S. Department of Justice, Federal Bureau of Investigation: White collar crime: a report to the public. Washington, DC: Government Printing Office, 1989, p 3
2. Federal Bureau of Investigation: Financial crimes report to the public, fiscal year 2007. Available at: http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm. Accessed June 4, 2009
3. National Health Care Anti-Fraud Association: Fighting health care fraud: an integral part of health care reform. Washington, DC: NHCAA, June 2009. Available at: http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/Fighting%20Health%20Care%20Fraud_NHCAAJune2009.pdf. Accessed June 29, 2009
4. National Health Care Anti-Fraud Association: The problem of health care fraud. Washington, DC: NHCAA, June 2009. Available at: http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_cent&wpscode=TheProblemOfHCFraud. Accessed June 29, 2009
5. Cobuzzi BJ: Anatomy of a fraud indictment and acquittal. *J Med Pract Manage* 24:237–40, 2009
6. Simborg DW: Health care fraud: whose problem is it anyway? *J Am Med Informatics Assoc* 3:278–80, 2008
7. Taryn V: Review of corruption in health care sector: theories methods and interventions. *Health Policy Planning* 23:83–94, 2008
8. Price M, Norris DM: White collar crime: corporate and security and commodities fraud. *J Am Acad Psychiatry Law*, in press
9. Department of Health and Human Services: Press release: Attorney General Holder and HHS Secretary Sebelius announce new interagency health care fraud prevention and enforcement action team. Washington, DC: Department of Health and Human Services, May 20, 2009. Available at <http://www.hhs.gov/news/press/2009pres/05/20090520a.html>. Accessed June 4, 2009
10. Centers for Medicare and Medicaid Services, Office of the Actuary: National health expenditure projections 2008–2018. Washington, DC: CMS. Available at: <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/proj2008.pdf>. Accessed August 5, 2009
11. Altshuler M, Creekpaum JK, Fang J: Health care fraud. *Am Crim L Rev* 45:607–66, 2008
12. Medicaid False Claims Statute, 42 U.S.C. § 1320-7(a) (2000)
13. Medicaid Anti-Kickback Statute, 42 U.S.C. § 1370-7(b) (2000)
14. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-91, 110 Stat. 1936 (1996) (codified in scattered section of Titles 18, 26, 29, and 42 of the U.S. Code)
15. Chong J-R: AIDS doctor pleads guilty to health care fraud. *Los Angeles Times*. February 27, 2009, California/Local Section p 1
16. Federal Bureau of Investigation: Headline archives: a major crackdown on health care fraud. June 24, 2009. Available at: http://www.fbi.gov/page2/june09/healthcare_062409.html. Accessed June 29, 2009
17. Parente ST, Mandelbaum K, Hanson SP, *et al*: Crime and punishment: can the National Health Information Network reduce the cost of health care? *J Healthcare Information Manage* 22:42–51, 2008