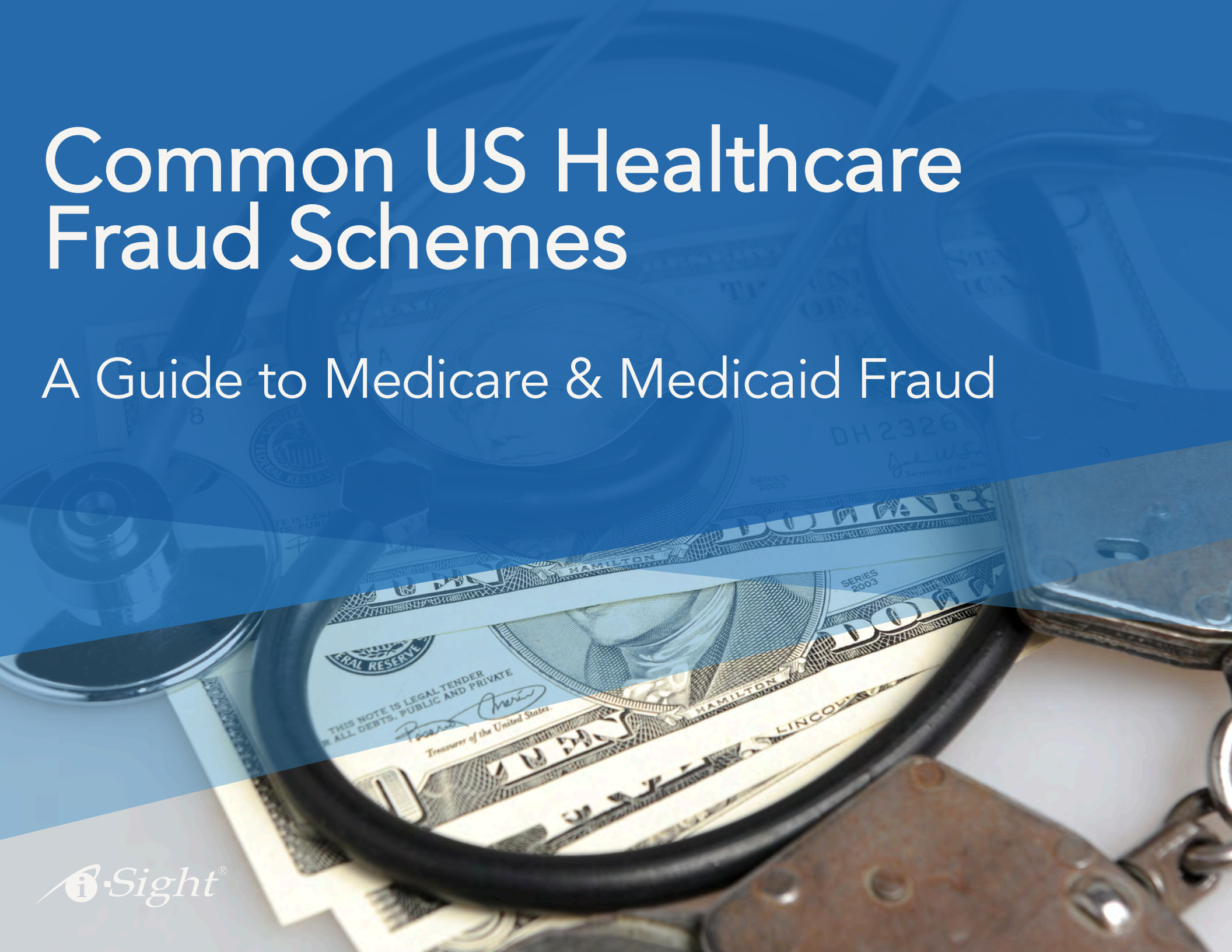
Common US Healthcare Fraud Schemes

A Guide to Medicare & Medicaid Fraud



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In 2019, The Department of Health and Human Services Office of Inspector General filed 809 criminal actions and nearly 700 civil actions for crimes against Medicare and Medicaid.

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Introduction

The US Department of Health and Human Services (HHS) healthcare programs, Medicare and Medicaid, help millions of Americans afford medical services and products. Unfortunately, fraud, waste and abuse (FWA) plague these programs, reducing the quality and availability of care. In 2019:

Regardless of who commits the act or against which program, healthcare fraud schemes violate the Federal Civil False Claims Act (FCA), a law that protects the US government from paying (or overpaying) for substandard goods and services.

This eBook outlines common Medicare and Medicaid fraud, waste and abuse schemes that cost Americans financially and physically.

Medicare Parts A & B Fraud

What it is:

Medicare Part A covers hospital and inpatient services for eligible beneficiaries. Part B covers other health insurance costs such as doctor visits, lab tests and preventive services. Together, they make healthcare affordable to seniors aged 65+, in addition to people with end-stage renal disease and certain disabilities.

Medicare Parts A & B fraud can be committed by one person or a group. In many cases, people or organizations (such as a doctor and a lab technician) work together to hide their scheme and share the profits.

Examples:

Because Medicare covers such a wide range of services and so many people interact with the program daily, this type of fraud includes an equally vast array of schemes. For instance:

- Billing for unnecessary services
- Unbundling services that are usually billed as a package
- Billing for more expensive services than those provided
- Sharing a Medicare ID card

Real-life example:

In 2018, a for-profit hospice company billed Medicare for patients with life expectancies over six months (the maximum for Medicare coverage), resulting in a $1.24 million settlement to resolve the fraudulent claims.

Medicare Part D Fraud

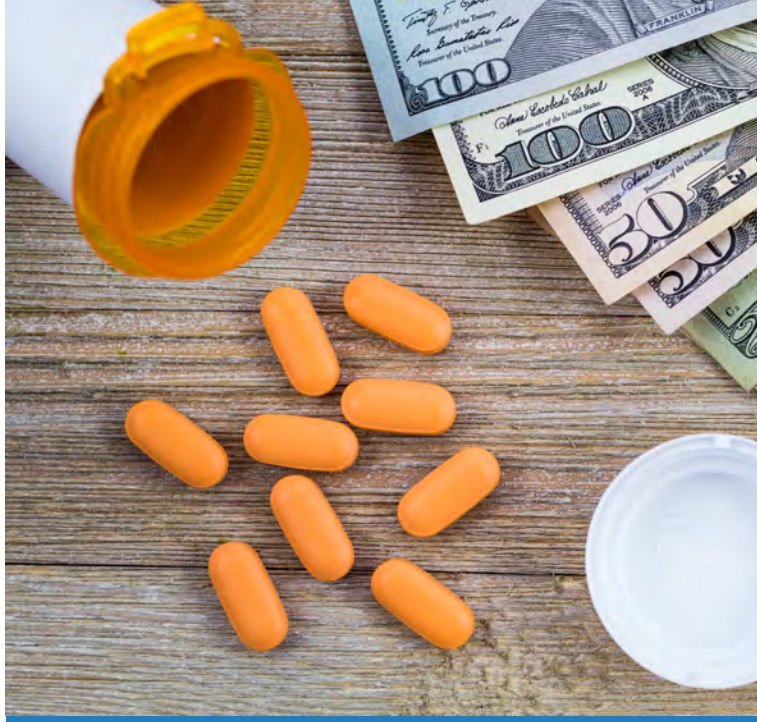
What it is:

Medicare Part D, an optional add-on to the program, covers prescription drugs and medical equipment. Part D coverage involves even more people (such as pharmacists and pharmacy benefits managers), increasing the risk of fraud.

Examples:

While Part D is defrauded in many of the same ways as Medicare Parts A & B, adding drugs to the mix makes it susceptible to a number of unique schemes as well. For instance:

- Doctor shopping (obtaining multiple identical prescriptions from different doctors)
- Selling prescription drugs obtained through Medicare coverage
- Billing for drugs not dispensed
- Charging for brand-name drugs but dispensing the generic version



Real-life example:

K-Mart agreed to pay $32.3 million in 2017 to resolve allegations that they gave cash customers a discount on prescriptions, yet billed Medicare Part D for the full prices.

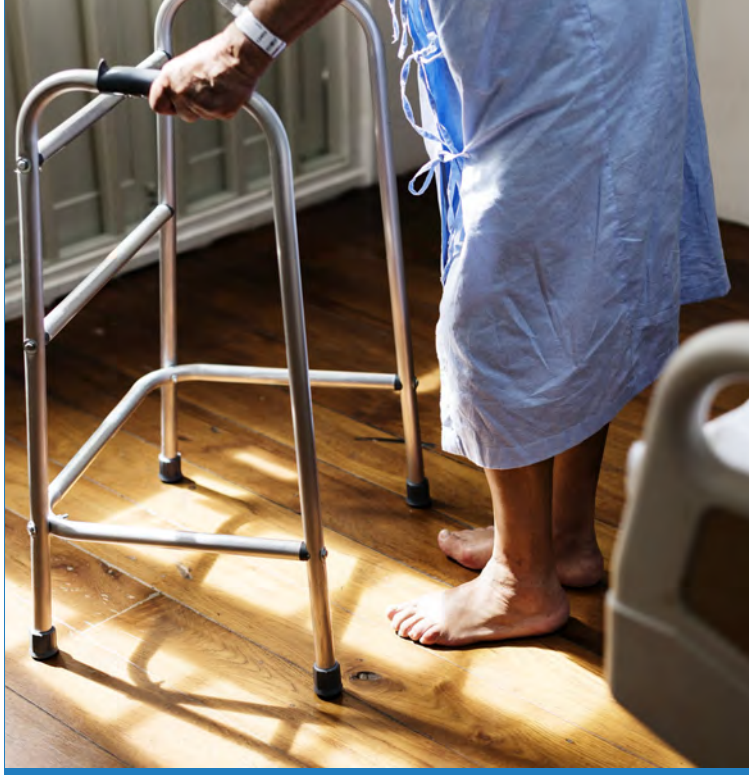
Durable Medical Equipment (DME) Fraud

What it is:
Durable Medical Equipment (DME) refers to a wide range of healthcare equipment and supplies. Wheelchairs, crutches, diabetic testing supplies, oxygen equipment and hospital beds are all examples of DME.

Because DME is already expensive and fraud increases healthcare costs, this is one of the most damaging types of healthcare fraud.

Examples:
DME fraud occurs when the provider bills for more than the equipment should cost or provides it to a person who doesn't need it. For instance:

- Charging for component parts of DME instead of a whole unit
- Providing defective or inferior DME
- Billing for DME that is ineligible under the beneficiary's plan
- Marking up DME prices above state standards



Real-life example:
The Scooter Store was fined $4 million and banned from participating in US healthcare programs after pressuring providers into prescribing their power wheelchairs for beneficiaries who didn't need them.

Fraudulent Drug Treatment Centers

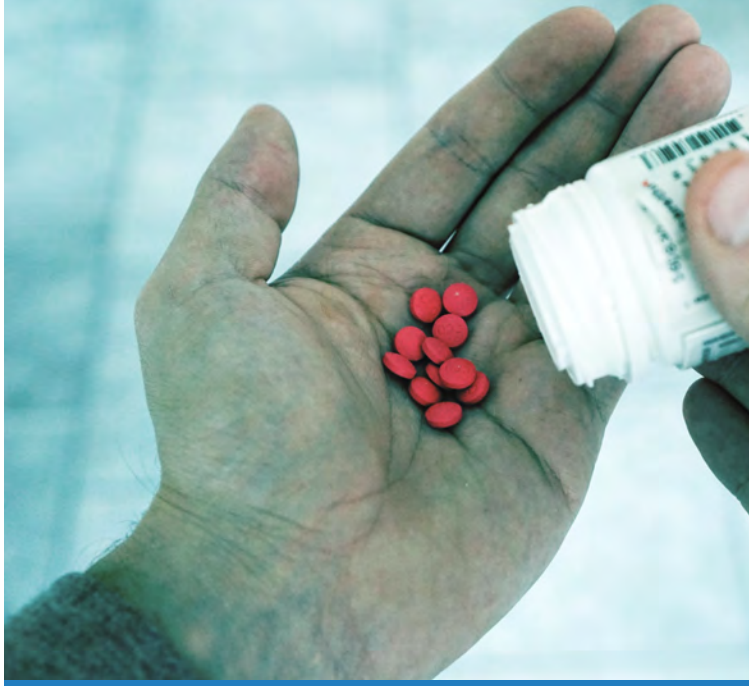
What it is:

Fraudulent drug treatment centers and sober homes pose as places to help patients recover from addiction. Instead, they trap them in a relapse cycle by encouraging drug use. Keeping beneficiaries in "treatment" longer means the facilities can bill the healthcare programs for more lab tests, therapy sessions and medicines.

Examples:

Phony treatment centers and sober homes often work together (and with labs and physicians) to conceal their fraud. Examples of this type of fraud include:

- Billing for unnecessary services (such as excessive drug tests)
- Charging for phony treatments (such as claiming a movie night as group therapy)
- Allowing drug use on site or providing drugs to patients to ensure they stay in treatment



Real-life example:

A Florida man who ran a number of fraudulent drug treatment centers was sentenced to 27 years in prison on counts of conspiracy to commit health care fraud, money laundering and sex trafficking.

Medical Identity Theft

What it is:

Medical identity theft is one of the most common healthcare fraud schemes, affecting about one in 10 Americans. It occurs when a fraudster misuses someone's medical identity to obtain healthcare goods and services (or money).

Examples:

There are three main reasons that a person commits medical identity theft. Fraudster may:

- Want or need the healthcare services for themselves but can't afford them and/or don't have the health insurance coverage they need, so they steal data from covered beneficiaries
- Need the healthcare services for themselves, so they buy or borrow a beneficiary's medical identity with the person's consent
- Use the stolen medical data to help them commit other healthcare fraud schemes, such as writing and claiming prescriptions without the beneficiary's knowledge

Real-life example:

A patient account representative for a medical billing company was sentenced to 15 years in federal prison after stealing the personal information of many patients while working with their records.

Kickbacks and Bribes

What it is:

Fraudsters often don't work alone. By committing healthcare fraud together with someone at another stage in the treatment or billing process, it's easier to hide the crimes. In some cases, one person makes payments, or kickbacks, to the other in exchange for their help. In other schemes, the coordinator of the fraud may bribe someone to take part in their scheme with money or gifts.

Examples:

Schemes that violate the Anti-Kickback Statute include:

- Bribing a patient to switch to a plan that isn't right for them or benefits the fraudster
- Paying for patient referrals
- Receiving payment for prescribing a certain manufacturer's drugs
- Accepting or providing payment for referrals to labs, hospitals or treatment centers

Real-life example:

One California health system had to pay $30 million after offering free physician assistants to a surgeons group in exchange for patient referrals.

Conflicts of Interest

What it is:

Many healthcare providers have financial interests in facilities, such as investments. However, because referring patients there would put money in their pockets, those situations are considered conflicts of interest and forbidden by the Physician Self-Referral (Stark) Law.

Examples:

Examples of healthcare fraud through conflict of interest include:

- A healthcare provider referring a patient to a treatment facility they've invested in
- A healthcare facility offering lower office rent to physicians in exchange for patient referrals
- A provider referring a patient to a member of their immediate family who also works in the medical field

Real-life example:

A Montana healthcare system paid $24 million to resolve allegations that their physicians invested in their own hospital, incentivizing the doctors to make referrals there and boosting profits.

i-Sight case management software simplifies the process of tracking and managing healthcare fraud investigations, and gives you the reports you need to analyze results, demonstrate trends and prevent losses.

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