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 2018 activities of the Department of Financial Services ("DFS") in combating health insurance fraud.

2018 Highlights

DFS's Insurance Frauds Bureau ("Bureau") 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: 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 Department's efforts in combating healthcare fraud in 2018 include the following:

- The Bureau opened 75 healthcare fraud investigations that resulted in 91 arrests;
- The Bureau received 16,184 reports of suspected healthcare fraud: 14,459 no-fault reports, 1,562 accident and health insurance reports, and 163 disability insurance reports;[1]
- Reports of suspected no-fault fraud accounted for 57% of the 25,549 suspected insurance fraud reports received, which represents a 11% increase from the previous year.

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 New York and the United States.

Types of Healthcare Fraud

As discussed 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;

- 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 2018, 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.

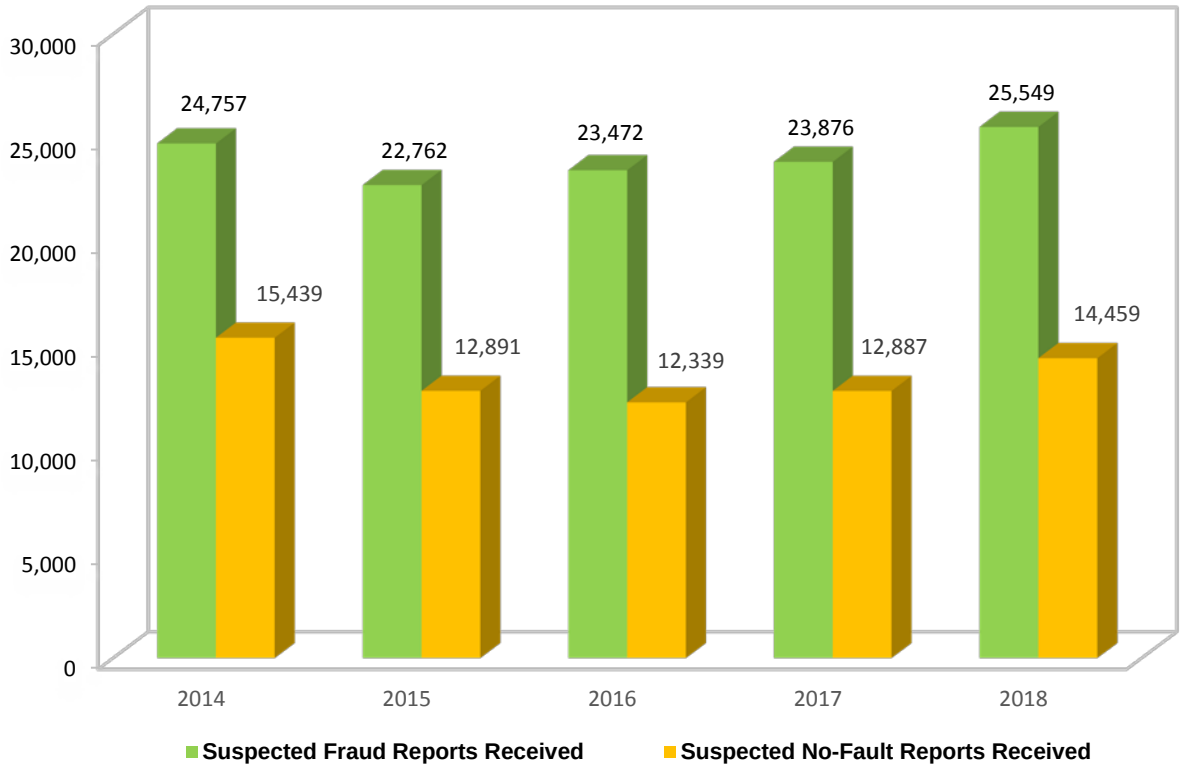
No-Fault Fraud

DFS conducted several no-fault investigations in 2018 with other law enforcement agencies, prosecutors' offices, and the National Insurance Crime Bureau ("NICB") 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 "runners" 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 involved 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

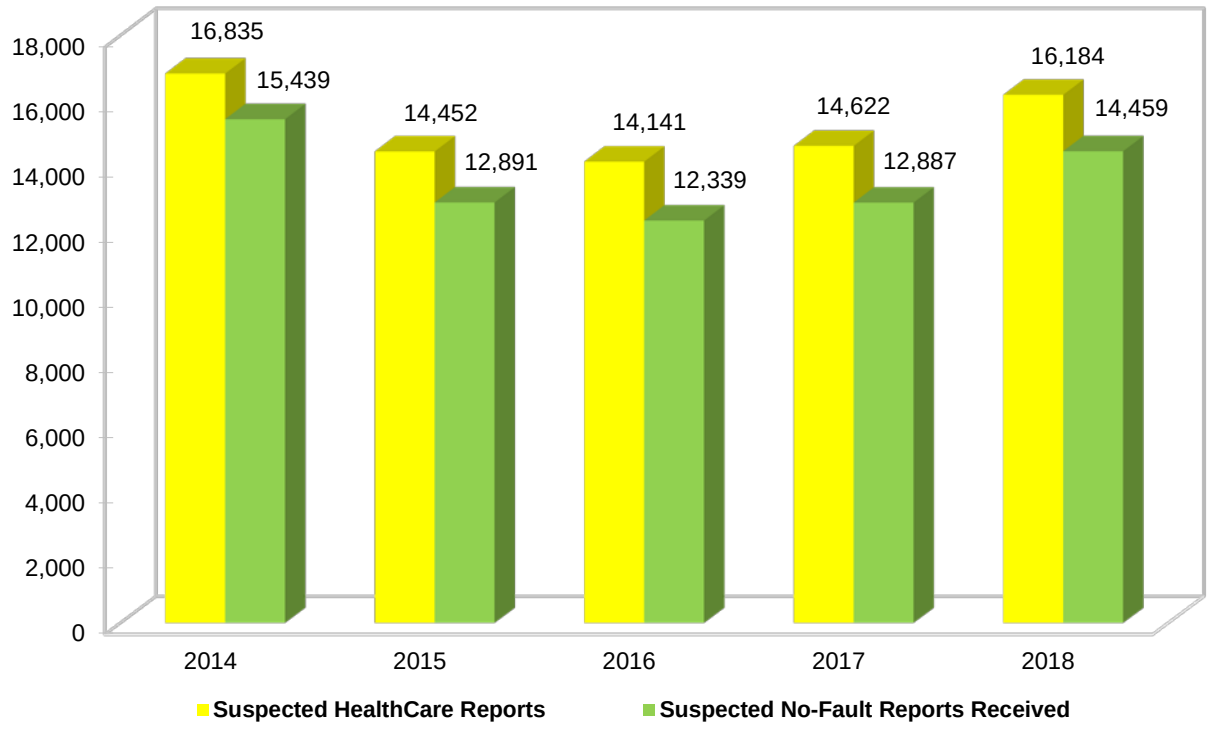
As shown in Figure 1, suspected no-fault fraud reports accounted for 57% of all fraud reports received by DFS in 2018.

Figure 1. Number of Suspected Fraud Reports Received Compared with Number of Suspected No-Fault Reports Received 2014 - 2018



As shown in Figure 2, the number of suspected no-fault fraud reports accounted for 89% of all healthcare fraud reports received in 2018 and at least 87% of all healthcare fraud reports received since 2014.

Figure 2. Number of All Suspected HealthCare Fraud Reports Received Compared with Suspected No-Fault Fraud Reports Received 2014 - 2018



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 Attorney's Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

The DFS Insurance Fraud Bureau's 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 DFS's participation in the Drug Enforcement Administration Tactical Diversion Task Force ("Diversion Task Force"), which investigates organized drug diversion schemes.

In October 2018, the DFS Insurance Frauds Bureau, as a member of the Drug Enforcement Administration's (DEA) Tactical Diversion Task Force, arrested a medical assistant and charged her with illegal distribution of a controlled substance (oxycodone) and healthcare fraud. Information was developed from DEA confidential sources that alleged the medical assistants were providing prescriptions for a controlled substance (oxycodone) without medical necessity in two locations, one in the Bronx and one in Brooklyn.

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. The Department's web-based case management system, known as the Fraud Case Management System ("FCMS"), allows insurers to submit reports of suspected fraud electronically. In 2018, insurers electronically submitted approximately 96% of the 25,549 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. Consumers may call 1-888-FRAUDNY (1-888-372-8369) for information about insurance fraud and how to report it. DFS recorded an average of 22 calls per month in 2018. The "Consumers" section of DFS's website also includes a link to a fraud reporting 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, 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 DFS 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. Health insurance providers writing 3,000 or more policies per year (the threshold number to require an SIU, an SIU Annual Report, and a Fraud Prevention Plan) are in compliance.

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 "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 2018, there were 66 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, 16 property and casualty insurers writing accident and health insurance had approved SIUs during 2018.

Health and life insurers reported $332 million in savings resulting from SIU investigations in 2017 (the most recent year for which data are available). Health and life insurers reported $31 million in recoveries from SIU investigations. In addition, two property and casualty insurers writing accident and health insurance reported $134,700 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.

2018 Healthcare Fraud Reports Received and Arrests Made

DFS received 16,184 reports of suspected healthcare fraud during 2018: 1,562 involved accident and health insurance, 163 involved disability insurance, and 14,459 involved no-fault. DFS opened 75 healthcare fraud cases for investigation. Of those, 28 involved accident and health insurance, and 47 involved no-fault insurance. DFS investigations resulted in 91 arrests in 2018.

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. In 2018, 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, two 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

Summarized below are some of the major healthcare fraud investigations conducted by the Bureau during the past year, to the extent that information is public. The Department has pending numerous other, confidential, investigations of healthcare fraud.

- The DFS Insurance Frauds Bureau, in a joint investigation with the Eastern District and the FBI, arrested a Central Islip chiropractor in September 2018, charging him with healthcare fraud. The indictment alleges that the chiropractor billed Anthem Blue Cross Blue Shield over $2 million for healthcare services that were never performed. The chiropractor hired medical doctors for part-time work and then billed Anthem Empire Blue Cross Blue Shield under the taxpayer identification numbers of those doctors for osteopathic manipulation and other services purportedly provided to beneficiaries. Between December 2003 and September 2014, the chiropractor was paid over $2 million for fraudulent claims filed with Anthem Blue Cross Blue Shield, billing for medical services that he knew the doctors had not provided. The chiropractor was arrested in Texas, and arraigned in the U.S. Attorney's Office for the Eastern District of New York.

- The DFS Insurance Frauds Bureau, in a joint investigation with the FBI, investigated a psychiatrist employed in private practice and by the Canandaigua Veterans

Administration. The psychiatrist, who operated a mainly cash business at his private practice, pled guilty in 2018 to healthcare fraud, money laundering and tax fraud. The investigation involved an undercover operation and the execution of a search warrant under which it was discovered that the psychiatrist was double billing patients and insurance carriers, selling prescriptions to patients, money laundering, and committing tax fraud.

- A psychiatrist in Pittsford, N.Y., was arrested in July 2018 and charged with healthcare fraud under Title 18 USC Section 1347 for submitting $1.8 million in fraudulent claims to Medicaid and private insurance carriers. A joint investigation by the DFS Insurance Frauds Bureau and the FBI found that the psychiatrist submitted insurance claims for services that were not rendered, up-coded office visits to the highest level, and submitted a false certificate stating he is board certified when he is not. At this time, the case is pending a plea agreement with the U.S. Attorney's Office for the Western District of New York.

- The DFS Insurance Frauds Bureau, in a joint investigation with the New York State Attorney General's Medicaid Fraud Control Unit, New York State Police, and the FBI, announced that 716 Transportation, Inc., a Medicaid medical transportation provider, and its president were sentenced for stealing $1.2 million from the Medicaid program. The Medicaid Fraud Control Unit identified multiple taxi companies that billed Medicaid for services that were not rendered. The taxi company obtained the Medicaid recipient's Medicaid card information and billed for fraudulent trips to medical providers that didn't occur. In July 2018, 716 Transportation and its president pleaded guilty to grand larceny for obtaining over $1.2 million in Medicaid payments by falsely representing that transportation services had been provided in accordance with Medicaid.

Conclusion

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