

**A White Paper  
On  
Healthcare Fraud, Waste and Abuse  
A Follow up to the CBS 60 Minutes Special Broadcast October 25, 2009**

**The Headlines:**

- CBS 60 Minutes (*October 25, 2009*): “Medicare Fraud: one of, if not the most profitable, crimes in America” “Medicare Fraud, Is bigger than the [illegal] drug business”
- “Medicare and Medicaid fraudsters are beating U.S. taxpayers out of an estimated \$90 billion a year using a billing scam that is surprisingly easy to execute.” *FBI Special Agent Brian Waterman*
- “Drug diversion drains health insurers of up to \$72.5 billion a year, including up to \$24.9 billion annually for private insurers.” (“Prescription for Peril”, CAIF, December 2007)
- President Obama says, “Rising costs are driving huge federal budget deficits that imperil our future, and enough waste and fraud in the system to pay for healthcare reform, [if eliminated].”
- Fraud and abuse make up 19 percent of total healthcare waste, or up to \$175 billion a year in fraudulent claims, kickbacks for referrals for unnecessary services and other scams. *Thomson Reuters, October, 2009*

In the midst of these headlines, the nation is hotly debating the challenge of how to ensure that all Americans have access to quality, affordable care. President Obama and Congress report that rising costs are driving huge federal budget deficits that imperil our future, while there could be enough savings to pay for proposed healthcare reform if healthcare fraud, waste and abuse were eliminated or reduced. Unfortunately, to date, the success in stemming healthcare fraud, waste and abuse across commercial and government programs has been dismal.

The United States now spends more than \$2.3 trillion annually on healthcare (15.3% of GDP) and with the proposed reform initiatives now under debate, the number of Americans covered and the amount spent will grow dramatically. While Fraud and Abuse make up \$175 billion in unnecessary annual cost, carefully developed estimates by Thomson Reuters place the combined cost of Fraud, Abuse **and** Waste at over \$700 billion annually! These statistics are indicative of unnecessary healthcare costs that directly impact every American with higher product cost, healthcare cost, insurance premiums and taxes.

In recent years, organized crime has been drawn into healthcare fraud, because it can be more lucrative than other major crimes; the likelihood of being caught is substantially less; and the penalties are significantly less severe. Even if the perpetrator is caught, severe sentences are rare; thereby giving organized crime rings a significant incentive to commit fraud.

## **CURRENT GOVERNMENT EFFORTS AND RESULTS:**

In recent years, the government has devoted only moderate levels of resources in responding to healthcare fraud, waste and abuse. As public awareness has grown, and concern over fraud, waste and abuse has increased, the Department of Justice identified the eradication of healthcare fraud as its number two priority, right behind violent crime. The government’s enforcement efforts on Medicare and Medicaid fraud have resulted in recovery of just \$4 billion in fiscal 2009, up from \$3.2 billion in fiscal 2008, but still representing significantly less than 1% of the money spent on government healthcare programs. Unfortunately, by almost any standard, the current government sponsored recovery programs that attempt to recover money already paid out in claims, are only marginally effective.

Expert estimates that fraud, waste and abuse losses represent at least 10% to 20% of what the government pays in Medicare and Medicaid claims are probably very conservative. With total government healthcare program expenditures topping \$1 trillion, this represents \$100 billion to \$200 billion in unnecessary annual costs. Does that mean that we are letting at least an additional \$96 billion in unnecessary government healthcare expense get through the system? Unfortunately the answer is yes, and if we apply those same statistics to the entire healthcare bill for the country (commercial healthcare payers and government programs

combined) of some \$2.3 trillion, we can see from the \$4 billion recovered in FY 2009 that we are touching only the tip of an enormous iceberg.

## WHY IS IT SO TOUGH TO STOP HEALTHCARE FRAUD?

### Limited Time for Payment:

Limited time is allotted for the investigation of suspicious claims. Even when suspicious claims are identified, prompt payment laws require that Medicare claims be paid between 14 and 30 days. With Medicare claims volumes averaging 4.4 Million claims per day, many claims are paid just to meet the prompt payment laws.

### Extremely High Volumes:

Due to the high volume of claims, the Medicare program reviews only 3% of suspicious claims. If fraud is proven, the government is left to try to recover money that has already been paid out. This is known as a “retrospective pay and chase” model.

### Fraudulent Medical Claims:

Healthcare fraud is an intentional deception or misrepresentation that a person or entity makes, knowing that the misrepresentation could result in a payment to which the person or entity is not entitled. Healthcare fraud is like a chameleon; it blends in with its surroundings, making it difficult to discover. Repetitive schemes continue to be perpetrated over and over again by newcomers, who employ increasingly stealthier and discreet techniques that take many forms.

The 60 Minutes episode of October 25, 2009, pointed out the growing number of fictitious equipment suppliers, clinics, and pharmacies in business. Additionally 60 Minutes revealed in graphic detail just how claims for false orders for medical equipment are easily submitted. Other types of fraud include:

- Recruiting patients for unnecessary medical procedures.
- Claims for services not rendered, or equipment not used.
- Billing for a more expensive medical service than was provided.
- Billing for services not medically necessary.
- Billing for services by unlicensed or improperly licensed physicians and clinics.
- Misrepresenting cosmetic procedures that are not covered by insurance, as legitimate procedures that ARE covered by insurance
- Provider and recipient identity theft

Additionally, fraudulent pharmaceutical claims often follow the same pattern as the types of medical claim fraud identified above. And, healthcare payers have been slow in adopting new technologies to stem the increase in healthcare fraud, waste and abuse.

*Only one conclusion can be drawn: reviewing [or auditing] only a small portion of claims and retrospectively attempting the recovery of payment of fraudulent claims is **not effective**.*

## HOW CAN WE REDUCE HEALTHCARE FRAUD, WASTE AND ABUSE – NOW?

**We need a dramatic change in basic strategy!** Healthcare fraud, waste and abuse detection efforts must be more robust and applied PROSPECTIVELY, before payment is made! Change the strategy from a “Retrospective Pay and Chase” strategy, to a “Proactive Fraud Avoidance” strategy! And, laws must be changed to support the new strategy with more severe punitive sanctions to limit the incentive to commit healthcare fraud!

Imagine what damage could be done to your computer(s) if your available anti spyware and virus detection tools were NOT applied before the spyware or virus could damage your computer. If the fraud waste and abuse tools were applied prospectively (before payment) like the anti spyware and virus detection screens are applied in your computer, the damage (fraud, waste, abuse and other over payment) would be avoided.

**In order to be effective, we need to review 100% of all medical claims with:**

- Sophisticated analytical tools to detect fraud, BEFORE PAYMENT!
- STOP and PEND questionable claims, until they can be investigated and either paid accurately or denied;
- Trained investigators and clinical personnel who have the knowledge and expertise to recognize suspicious claims and providers must investigate and quickly resolve suspicious claims
- When pre-payment avoidance is not an option, a robust recovery program must be implemented! (These efforts must supplement the newly formed Medicare RAC {Recovery Audit Contractor} Program to identify and seek reimbursement for overpayments).

## **WHY IS A MULTI-DIMENSIONAL APPROACH NEEDED?**

It is important to implement a strong integrated and multi-dimensional pre-payment Fraud, Waste and Abuse program that uses **Education, Detection** and **Investigation**.

**Education**, focused on anti-fraud, waste and abuse awareness training for health payer employees, providers, employer groups and the public is needed.

**Detection** requires analytical software tools. **Detection** software requires a composite of analytics that include: Watch lists of past fraudulent physician; clinic and medical equipment suppliers; advanced analytics to determine sudden changes in claim submission patterns and collusive networks of physicians, patients; and client referrals; and rule-based claim edit technology.

**Investigation** of suspicious claims by trained, qualified medical and technical personnel, who aggressively pursue suspended suspicious claims, and, as needed, implement an aggressive post-payment recovery strategy is essential.

**Analytics must be applied to** 100% of professional and hospital medical claims. As Attorney General Eric Holder recently said, "Clearly more auditing needs to be done and it needs to be done in real time".

## **THESE FRAUD WASTE AND ABUSE SOLUTION TOOLS EXIST TODAY!**

Documented experience shows that by using currently available, automated cost avoidance technology to review 100% of all claims for fraud, waste and abuse before they are paid, savings ranging from 2% to 4% of total claim dollars could be realized. Considering the magnitude of the nation's annual claims payment costs, this represents a material impact on the root causes of claims overpayment that can be utilized by all healthcare payers.

**In Summary, commercially available off-the-shelf pre-payment capabilities offer healthcare payers:**

1. A cost avoidance audit strategy for performing post-adjudication pre-payment services which are transparent, defensible and supportable. With this proven approach and use of existing robust tools, audits, edits, analysis you will experience, less than 1% in medical provider appeals AND 80% of the appeals will be upheld on the original position;
2. Sophisticated data analytics tools and decision support systems with rapid (overnight) data manipulation and analysis of patterns.
3. The ability to swiftly investigate, and make decisions on suspicious cases.
4. A proven set of tools and processes for the pursuit of recoveries within the provider community.

***For more information on available pre-payment fraud, waste and abuse detection and resolution capabilities, E-mail your request to the author:***

*George J. Bregante*

*Founder*

*TC3 Health, Inc*

*19732 MacArthur Blvd, Suite 100*

*Irvine, CA 92612*

*Phone 949-943-8705*

*E-mail [gbregante@tc3health.com](mailto:gbregante@tc3health.com)*

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