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Prevention the best medicine to curb fraud

GUEST COLUMN
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The United States' health care system is hemorrhaging billions of dollars. On average, a staggering $700 billion in annual waste occurs year after year, with "fraud and abuse" representing the extreme end of the waste continuum. The National Healthcare Anti-Fraud Association, an organization of about 100 private insurers and public agencies, estimates that some $60 billion, or about 3 percent of total annual health care spending, is lost to fraud every year and that figure is actually considered conservative.

Health care fraud is more prevalent and the costs more damaging than you probably imagine. While fraud in the system is actually perpetrated by a very small percentage of people, it ultimately affects every patient, doctor and hospital in the country and results in damaged reputations for hospitals and medical professionals, and distrust between insurance companies, doctors and patients.

If suspected of health care fraud, hospitals, doctors, rehabilitation specialists and other providers often face simultaneous civil and criminal investigations, which consume much- needed funds for a painstaking legal process. If charged, either civilly or criminally – or both – the costs mount exponentially, and if an entity or employee(s) is found responsible, or guilty of violations, hefty fines, public embarrassment, loss of reputation, suspensions and/or loss of professional licenses and, in some cases, jail, are the unfortunate consequences.

Unfortunately, we have had to help too many "triage clients" – those that have already sustained damage, which then must be contained. That is why it is important for the health care industry to get out in front of this issue in order to prevent being an easy target for unscrupulous or misguided individuals or vendors who are looking to profit from fraud in the guise of "saving costs."

Health care fraud is generally defined as any deliberate and dishonest act committed with the knowledge that it could result in an unauthorized benefit to the person committing the act or to some other person or entity who is similarly not entitled to the benefit.

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Examples of health care fraud include misrepresentation of the type or level of health care service provided, misrepresentation of the professional rendering service, billing for items and services that have not been rendered, billing for services that have not been properly documented, and billing for items and services that are not medically necessary.

Criminals who devise health care fraud schemes, which are increasingly more sophisticated, often fit the legal definition of organized criminal enterprises. These organizations prey upon both providers and patients by illegally obtaining their provider or enrollment information and using it to submit fraudulent billings to Medicare and Medicaid. Recognizing the critical, fiscal state of our health care system, federal and state law enforcement have established strike forces to aggressively pursue these criminal organizations and individuals.

In 2010, Congress passed the Health Care Fraud and Abuse Control Act and devoted approximately $250 million to coordinate federal, state and local law enforcement efforts to combat health care fraud and abuse. So far during this fiscal year, "the federal government won or negotiated approximately $2.5 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings," according to a joint release issued by the Department of Health and Human Services, and The Department of Justice, entitled "Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2010."

It is clear that the U.S. Department of Justice has made health care fraud a high priority. Cases that used to be handled civilly, through administrative enforcement procedures, are now increasingly travelling down parallel tracks of civil enforcement and criminal prosecution. The government is not the only entity dealing with the high cost of health care. It costs U.S. employers substantially more to provide health care for employees, their families, and retirees than their foreign competitors and health care fraud only adds to these costs.

The best, proven practice to protect against being a victim of health care fraud is to have a proactive compliance program. An effective compliance program helps both the institutional administration and staff to navigate through the maze of complex regulations to avoid inadvertent mistakes, which are sometimes the result of the organization's lack of regulatory awareness but may still expose the institution to significant administrative penalties.

Any compliance program should include comprehensive training at all levels of the organization.

To support compliance efforts, we recommend that our clients draft a comprehensive program and then train all personnel, at least on an annual basis, on their rights and duties to uphold the highest standards when addressing compliance-related matters.

Lastly, conducting regular audits is strongly recommended to constantly test institutional procedures and to uncover improper conduct or discrepancies that should be investigated and corrected. Effective compliance programs must be proactive and thorough if they are to be considered "real" and potentially serve as a mitigating factor in any enforcement action.

A dust-collecting "paper program" will not deter violations, and its ineffectiveness will be easily recognized by any competent investigator. ■

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