Fraud and Abuse

Fraud and abuse is a large area of health care compliance that covers multiple different types of legislation. All of the acts and laws discussed in this class play a role in fraud and abuse.

Fraud is considered an intentional tort. It is defined as willful and intentional misrepresentation that could cause harm or loss to a person. Fraud includes behaviors such as being cunning, deceptive, trying ways to circumvent laws or policies, or in any way cheating another person.

In order to prove fraud, the following must be demonstrated:

- An untrue statement is known to be untrue by the party making the statement and the statement is made with the intent to deceive another person
- There is justifiable reliance by the victim on the truth of the statement
- Damages resulted due to this situation

Fraud is seen as deceptive and self-serving. There was a case in Redding, CA surrounding a cardiology group who seemed to do more cardiac procedures than any other similar organization in the whole state. Through a long investigation, it was discovered that several of the cardiologists would inform patients that they needed immediate heart surgery. Almost all of the patients immediately went into surgery. Retrospectively, it was noted that many did not have cardiac issues at all and likely would never need surgery. The cardiologists appeared to be most interested in revenue to line their own pockets with little concern for patients who were harmed. At least two patients did die due to the surgeries.

Fraud occurs on a more micro level, too. A physical therapist claimed to be supervising two PTAs during a time when he was on vacation. The PT signed the documentation and signed the time logs for the PTAs. One of the PTAs was also later found to have charted and billed for services for two patients who were no longer in the building when the treatments were stated to have occurred. One patient had gone home. The other patient had died three days prior to the billing and documentation.

Common types of fraud and abuse may be found on this fact sheet.

Health care fraud and abuse takes many forms. The most common of these include:

Providers

- Billing for services that were not provided
- Duplicate submission of a claim for the same service
- Misrepresenting the service provided
- "Upcoding" - charging for a more complex or expensive service than was actually provided
- Billing for a covered service when the service actually provided was not covered

Members

- Using a member ID card that does not belong to that person
- Adding someone to a policy that is not eligible for coverage (i.e., grandchildren)
- Failing to remove someone from a policy when that person is no longer eligible (i.e., a former spouse)
- "Doctor shopping" - visiting several doctors to obtain multiple prescriptions.

Case Study – Occupational Therapy Clinic

California Clinic Owner Sentenced to 63 Months in Prison for Role in Occupational Therapy Fraud Scheme

A rehabilitation clinic operator in Los Angeles County was sentenced to 63 months in prison March 2017 for his role in a $3.4 million Medicare fraud scheme that involved billing for occupational therapy services that were not

medically necessary and not provided.

Simon Hong, 55, of Brea, California, was sentenced by U.S. District Judge George H. Wu of the Central District of California. Judge Wu also ordered Hong to pay $2,407,857 in restitution. Hong pleaded guilty on Dec. 15, 2016, to one count of conspiracy to commit health care fraud.

As part of that guilty plea, Hong admitted that he owned JH Physical Therapy Inc., an occupational therapy clinic in Walnut, California, but hid his ownership in the name of a “straw” or nominee owner in an effort to execute and conceal the fraudulent scheme. Hong admitted that as part of the scheme, he billed Medicare for occupational therapy services when no such services were provided to the Medicare beneficiaries. Instead, the Medicare beneficiaries received acupuncture and massage services, which were not reimbursable by Medicare. Hong further admitted that he directed co-conspirator therapists to falsify medical records to make it appear as if the services billed had been actually provided and funneled 87 percent of the proceeds from Medicare to himself.

Through this scheme, Hong admitted that he and his co-conspirators billed Medicare approximately $3,454,485 from October 2009 until December 2012 in false claims and received approximately $2,407,857.

In a separate case, Hong was convicted by a jury in October 2016 of eight counts of health care fraud, nine counts of illegal health care kickbacks and two counts of aggravated identity theft, involving a scheme to bill Medicare for physical therapy services that were never provided to beneficiaries. On Jan. 10, 2017, Hong was sentenced in that case by U.S. District Judge David O. Carter of the Central District of California to 121 months in federal prison and remanded into custody. The 63-month sentence imposed by Judge Wu will run concurrently to the sentence imposed by Judge Carter.

HHS-OIG investigated the case. The Criminal Division’s Fraud Section Trial Attorney Niall M. O’Donnell and Former Fraud Section Trial Attorney Blanca Quintero prosecuted the case.

As you read this real case, what do you think you would do if you realized this was happening in your own work environment? Would you report the issues? Would you try to become a whistleblower? Would you resign?

Though this case is large and egregious, small issues of fraud occur every day. It may seem harmless to go out for lunch with other staff members and never clock out; or to add some extra time to a bill for helping a patient to the bathroom even though that is not part of an actual treatment. Fraud is everyone’s concern. If you were faced with a case of possible fraud you should speak to your supervisor or human resources; or contact the compliance officer of the facility. In this particular case study, you could likely not work within the organization as there is a criminal intent to mislead and bill erroneously. In a case like this, you could talk to your own licensing board staff to ask about your best options to follow. You may also file a report with Medicare or any other health plan that is billed by the organization. Health plans and Medicare fiscal intermediaries do follow up on these complaints with investigations. Unfortunately, the investigations and case can drag on for three to five years. If you are caught in such a situation, resignation may be your best option to preserve your integrity and protect your own license.