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Investigating Physicians Billing for Services Not Rendered: Fraud Detection, Interviewing and Referral to Law Enforcement

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ABSTRACT

This qualitative study examines the role of healthcare insurance investigators related to medical fraud among physicians billing for services not rendered. Grounded in academic scholarship, industry case studies and first-hand knowledge, this study introduces methods identifying fraudulent activities, fraud detection practices and implications from discovering fraud among physicians, patients, and health insurance companies. The three types of methodologies employed provide a lens into determining misappropriation of healthcare insurance and patient monetary funds.

Healthcare fraud falls within the arena of white-collar crime. It consists of filing dishonest healthcare claims to receive a profit. Fraudulent healthcare schemes come in many forms. The public is not aware of white collar crimes committed by medical professionals, and is not well informed of what security measures organizations exercise to prevent these occurrences from happening, (Price & Norris, 2009). This paper will focus on physicians' fraudulent billing schemes for services not rendered and the process a private healthcare insurance company undergoes to investigate healthcare fraud. The paper discusses fraud detection, interviews and referrals to law enforcement. Each method will introduce a different phase within the investigation process.

Introduction

Healthcare fraud is a form of white collar crime that may be committed by doctors, chiropractors, pharmacists, other health providers, consumers, brokers, private organizations, hospitals, and pharmacies. Not many people view healthcare frauds as a serious crime because it gives the appearance that no one was being hurt or no one lost anything except for the health insurance companies. These same medical professionals that took an oath to help people in medical need are also robbing these same people through their health insurance company.

Medical professionals today are using different types of illegal and unethical schemes to get over on and to defraud the healthcare insurance companies. Some of the frauds committed by these medical professionals include billing for services that were not rendered, providing unnecessary treatments or tests, upcoding (billing the insurance company for a more expensive diagnosis or procedure), falsifying or exaggerating the severity of the medical illness to justify bill coding, and accepting kickbacks for referrals.

The unnecessary procedures physicians may bill are done to increase their reimbursement and can compromise the patient's safety. When billing for services not rendered, these physicians create a false medical history for the patients that causes problems for them in the future when obtaining disability or life insurance policies. A medical history may influence treatment decisions and allow some insurance companies to deny coverage based on a previous falsely reported medical condition.

Health insurance companies can't overlook crimes that are committed by these trusted medical providers. Healthcare fraud is fast becoming one of law enforcement's major priorities.

(Price & Norris, 2009) This paper will focus on the process of a health insurance company investigating a healthcare fraud.

The healthcare fraud discussed will focus on a physician billing for services that were never rendered. A case study of a physician billing for services will first be introduced and later examined after each investigative process. The investigation process will include how to effectively and efficiently investigate a healthcare fraud case through; fraud detection, interviewing, and referral to law enforcement.

Case Study

Look at a case study that involves a chiropractor, by the name of Dr. William Stearns residing in Marietta, Georgia, and his two partners and fellow chiropractors, Steven Levine and Christopher Topel, (HT Digital Streams Limited, 2009). All three were being charged for billing patients for services not rendered. Per United States Attorney David E. Nahmias, "Dr. Stearns and his two partners operated three clinics around the Atlanta area using the name Comprehensive Care Medical Group (CCMG). They fraudulently billed Blue Cross/Blue Shield (BCBS) of Georgia for two separate back pain procedures, which cost approximately $2 million in total, (HT Digital Streams Limited, 2009)." The fraud occurred over the course of nearly three years, from 2004 to 2007. Dr. Stearns and his partners were performing a procedure known as Vertebral Axial Decompression (VAX-D), which is a non-invasive back pain procedure that utilizes a mechanical table to stretch the patient's spine. However, they were billing BCBS with a different billing code, which pertained to a surgical nerve decompression procedure. The reason Dr. Stearns and his partners used a different billing code to bill BCBS is they knew the VAX-D was

considered investigational and not medically necessary, so BCBS would not pay for the procedure if they were billed under the VAX-D procedure code.

In addition to the VAX-D procedure, Dr. Steams and his partners were also giving patients an "electrical stimulation procedure, which delivers low-level electrical signals to the spinal cord or specific nerves to block the pain signals from reaching the brain" (WebMD). Nevertheless, they were billing BCBS for an electrical stimulation procedure using a device known as "Hako-Med". They indicated they were performing surgical procedures known as nerve block injections. Billing BCBS for the "Hako-Med" procedure allowed them to bill ten times higher than if they had billed for the electrical stimulation (HT Digital Streams Limited, 2009)

Section One: Fraud Detection

The first step in the process of initiating an investigation into healthcare fraud is fraud detection. Billing for services not rendered is usually hidden and committed by a small number of offenders, the result of this type of fraud can "cost a private healthcare insurance company members and employees millions in losses every year (NHCAA, n.d.)". For a private insurance company to stay ahead of healthcare fraud they should invest in software systems which will assist with data mining tasks. The insurance company must have a dedicated team of internal investigators responsible for conducting investigations of potential fraud, waste and abuse (FWA). The internal investigation department is referred to as a Special Investigations Unit (SIU) who will monitor and detect fraudulent activity. This will protect the integrity of the healthcare system. SIU fraud detection software tools allow investigators to review claims, decipher analytics, isolate suspicious patterns and anomalies in claims for possible fraud before

the company makes any payments. Each insurance company has their own SIU, but they also collaborate with other SIU units allowing healthcare fraud investigators to learn from each other. This will enhance their experience, knowledge and exposure to the issues effecting their profession. For health insurance companies to combat fraud effectively, health insurers must identify current fraudulent schemes, as well as predict future trends. Collaborating with other SIUs through round table discussions allows for access to up-to-date information, trending schemes, and new ways to FWA.

Healthcare fraud occurs when an intentional act is committed for one's own financial benefit (Legal Information Institute, n.d.). Waste and abuse involve mismanagement or misuse of resources, and abuse includes individuals using their position of authority for personal gain. This paper will be concentrating on proving fraud has occurred rather than abuse, as a focus on physicians' fraudulent billing schemes for services not rendered. "A physician must bill for services not rendered over a period and across many patients, for the act to be considered fraud, (Rudman, Pierce, Eberhardt, & Hart-Hester, 2009)." Below are examples of healthcare fraud schemes:

- Upcoding
- Cloning
- Phantom Billing
- Inflated Hospital Bills
- Service Unbundling or Fragmentation
- Self-Referrals
- Repeat Billing
- Length of Stay

- Correct charge for type of room
- Time in Operating Room
- Keystroke Mistake
- Cancelled Service
- No Medical Value
- Standard of Care
- Unnecessary Treatment

(PayerFusion Holdings LLC, 2018).

Certified Public Accountant and Certified Financial Forensic expert Tracy Coenen's book, Expert Fraud Investigation, A step-by-step guide; outlines steps for an investigation. When engaging in healthcare fraud detection, four essential steps must be followed; finding fraud, beginning the investigation, searching for additional occurrences of fraud, and interviewing. The first step is finding the fraud, which transitions into beginning an investigation. The primary purpose of the investigation is to search for additional fraud. The last step is to interview all parties involved, (Coenen, 2009).

There are two standard mechanisms for a fraud investigation to commence. The first entails an act of fraud where a perpetrator or perpetrators are accused of multiple acts of wrongdoing. The second is based on a strong suspicion of fraud, with or without proof. It is also common to engage in the act of investigating the probability of fraud. Fraud exists in many arenas. With our nation's high demand for healthcare insurance, healthcare providers are abusing and exploiting the need, by increasingly participating in fraudulent behavior, (Piper, 2013). "Insurance companies for example, benefit from educating their staff. They are taught red flags, and can identify warning signs, which may indicate an act of fraud. Insurance companies agree

tips from employees are one of the most common ways fraud is exposed" (Beaulieu-Volk, 2012). Therefore, it is important for businesses such as insurance companies, to acknowledge tips from their employees, members, vendors, and contractors. Weaknesses within an insurance company's regulations and policies are a fraudsters loophole. If an insurance company does not review and update company policies as needed and does not enforce regulations, exposure to fraudulent activity will grow.

Insurance companies conduct random audits, and during these audits, they will generally encounter missing information such as medical records, notes, charts, and treatment plans. Missing information is a red flag. Occasionally documents may be misplaced for a variety of reasons which may not be fraudulent. Yet missing member enrollment applications and provider billing forms may carry deceptive undertones. Fraudsters go through great lengths to conceal information, alter documents, or otherwise engage in behavior designed to mislead professionals attempting to locate factual and original data.

The fraud department relies heavily on tips of questionable behavior from employees, customers, vendors, or other outside. Some people will report false information to cause trouble for an enemy, spouse, or a disliked coworker. Investigators must evaluate the potential motivation of a tipster when reviewing their information. Tips made to an anonymous hotline, may require an investigator sense of intuition.

When beginning a fraud investigation, one must first determine what information and resources are available. It is important to understand what information has been gathered to date and what is at the investigator's disposal. The investigator must be able to ask the right questions when extracting valuable information and determining the direction of the investigation. Areas

that an investigator may want to focus on include: what happened, what evidence has been collected, and who is the suspect of the investigation. Are there any outside parties involved, who are the key players, who know about the fraud, what has already happened, and what are the goals for the investigation. The focus is to lead the investigation with precision. The investigation may be conducted for local or federal law enforcement. Referrals can include civil litigation, criminal prosecution, or monetary recovery. An investigator may be asked to make recommendations for a company's policy, regulations and/or internal controls. The investigator must be knowledgeable enough to provide expert guidance to mitigate and prevent fraud in the future.

Investigative software is the final step to beginning the investigation. There are several computer systems and software fraud detection systems that enable health insurance companies to track and analyze data on providers, members, and claims. An example of this product would be, Healthcare Fraud Shield. 'Healthcare Fraud Shield offers the insurance companies a fully integrated FWA software solution platform called FWAShield'. (Healthcare Fraud Shield , n.d.) Investigators can track documents, analyze relationships between people and entities, and identify vulnerabilities in the insurance company's policies. Software detection is helpful when it comes to analyzing large quantities of data, looking for unusual relationships between patients, providers, hospitals, pharmacies, doctors, procedure codes, healthcare claims, or unexpected charges. The investigator provides the technical skills, intuition and experience when analyzing the data and utilizing the software fraud detection systems.

Looking into member claims and billing can often be done digitally with the assistance of software, depending on the complexity of the company's records and auditing software available to the investigator. Having an advanced software system in place is beneficial for it has the

capability to quickly analyze thousands of patients' claims and billing and provide results for further analysis by the fraud investigator. Analytical review, known as data mining is essential. Data mining helps investigators to extract thousands of claims and identify a lesser subset of the claims or claimants for additional assessment, (Schiller, 2018). Analytical review involves comparing billings, claim patterns and relationships between providers. In healthcare, electronic health records have been growing and the use of computerized systems has led to newly developed opportunities to better detect fraud and abuse using data mining.

Medical records auditing is another way to search for fraudulent claims and incorrect billing activity (Gregory, Van Horn, & Kaprielian, 2008). When medical records are audited by the insurance company, the auditor must ensure that quality health care was provided. Reviewing and auditing medical records is a way for the investigator to check for accurate and complete clinical documentation in the medical records provided by the physician. Insurance companies have contracts with in-network providers which allows an audit to be conducted anytime. If medical records are requested for an audit, the provider must produce them. Insurance companies put this mechanism in place as part of a fraud control program combined with predictive modeling and detection analytics with clinical review of medical claims and medical records. Requesting and reviewing medical records helps spot suspicious medical claims and rule out false positives making automated prevention and detection of healthcare fraud more efficient. When reviewing medical records, and finding suspicious analytic or clinical information, the next step is to take a closer examination. There are several red flags for fraud and abuse that can be found by reviewing medical records. A few examples of these red flags include: provider notes which are exactly the same for multiple patients, medical charting which is considerably changed after the date of treatment, charting alleging treatment(s) on unlikely day(s) (such as

holidays), charting notes which are inconsistent with x-ray, lab or pharmacy data, medical records alleging the same patient was in two places at the same time. Investigators must use the patient recollection of care. This must match what is listed in the medical records. Medical records may reveal treatment protocols that do not coincide with best practices or prevailing standards of care, or exhibit non-FDA approved treatments, (Avoiding Medicare Fraud & Abuse, 2017).

Surveillance is the final step when investigating for fraud. Depending on the case, surveillance of people can be a great way of gathering information. Surveillance allows an investigator to observe people, places, and movements, and allows the investigator to take notes and put recorded surveillance on tape. Surveillance includes going undercover. Once all these steps are followed, the next step will be to conduct interviews.

Healthcare Fraud Investigators are trained to check their internal medical billing system (detection technology) to look for abnormal billing practices from a physician's organization or from the physician him/herself. An example of this would be a data run for physicians in general medicine. A sample size of one hundred physicians is selected; data analysis is run, and out of the one-hundred billing records which came back, there are a few physicians which stand out when looking over billing statements, in comparison to the remaining physicians. These are the investigator's red flags, physician's outliers and this is where the fraud detection begins. The investigator will run the data analysis just for these outliers and determine why the identified physician's billing statements are higher than their peers. It could be something as simple as a doctor is covering for another doctor who is on vacation, the practice could have expanded and grown, or a doctor could be moonlighting; the last option you are left with once valid reasons have been ruled out, maybe fraud. Looking over this data is just an initial step for an investigator

to concentrate on the physicians that still fall into the unexplained outliner. Investigators must refrain from using the F word, i.e. FRAUD, early in the investigation.

Next, the investigator might want to isolate the patients who were billed. The investigator should focus on the highest dollar amounts and consider contacting patients to seek their help in determining whether the services rendered from the doctor are legitimate. Normally, investigators will try to narrow the search, such as selecting the top ten patients as the highest billed and contact them. Speaking with them is conversational. After the investigator speaks with the patients, they will either agree to the services which were billed or they will tell the investigator differently. If the latter, the investigator will request medical records of the patients believed to be potential victims of healthcare fraud. To keep the physicians from questioning the investigators motives the investigator must add to the request for medical records of other patients who have not experienced issues with the physician's billing practice. This way it looks as if a random audit is being conducted, and the investigator has randomly selected patients with different billing patterns to not arouse suspicion or show the focus of the investigation.

Once these medical records are produced by the provider, the medical records should match up to what the provider billed the insurance company. There are physicians who will try to add other medical service(s) that were not rendered to the patient's medical records and that can cause other problems. Physicians may add these extra medical services to cover themselves to ensure that the billings match up to the patient's medical records. This type of practice can be problematic for the patient. If another medical professional who is not aware of the fraudulent practice, reviews the patient's medical record and sees medical service(s) were recorded in the patient's record, that can lead the reviewing physician to treat the patient for a false diagnosis, causing injury or even death. Another example would include a patient applies for life insurance

and gets denied because of the false medical documentation the physician put into the patient's medical records.

Now, if the medical records do not match up and the investigator finds the services billed are not in the medical records, the investigator at that point may want to increase the date range to a starting point further into the past.

Case Study Relevance: Fraud Detection

The investigation into Dr. Stearns and CCMG was sparked by BCBS of Georgia investigators. Their investigators were conducting fraud detection and noticed the excessive billing and extended treatment times from numerous chiropractic offices. These chiropractic offices were all from the CCMG group. This red flag had caused the investigators to take a deeper look into Dr. Stearns, his two partners and CCMG. The investigator's data analysis had shown excessive billing. "What stood out were the protracted treatment times for their members and their families for a particular employer group, (PR Newswire, 2011)." The BCBS of Georgia SIU started a large-scale investigation, which included investigators going undercover as patients. Going undercover allowed the SIU investigators to determine what Dr. Stearns, his two partners and CCMG were billing the insurance company for and compare that to what services that were rendered.

When the SIU investigators went undercover, they received treatment from Dr. Stearns, his two partners and CCMG. The SIU investigators went to all three locations and received treatment. Then they waited for CCMG to bill BCBS for services rendered to the undercover SIU investigator patients. The hard work and determination from the SIU investigators resulted in a successful discovery of evidence and the intent to defraud BCBS. Working in collaboration with

customers and law enforcement, the BCBS investigators were able to prove there were kickback arrangements clearly established. “The scheme resulted in harm to the BCBS members through depletion of their group benefits; the court ordered $4 million in restitution, (PR Newswire, 2011).”

Section Two: Interviewing

The second step health insurance companies execute in an investigation in healthcare fraud is interviewing. Interviewing is an art and sometimes the one and only chance an investigator gets with the interviewee. When interviewing a witness or suspect in a fraud investigation, the answers an investigator receives can lead straight to the truth or to a web of lies and deception. A good investigator knows how to apply a variety of interviewing skills to make sure the interview leads to the truth. An investigator must use open-ended questions and be non-accusatory. Next, the investigator needs to move from general questions to more specific ones as the interview progresses. This establishes a rapport with interviewee and then the investigator can start probing more. Once the investigator tackles the general questions, he/she will then approach asking: who, what, when, where, why and how questions. The interview progresses by locking the interviewee into their answers by asking for more detail and more specifics.

An interview is the planned questioning and the most important phase of the investigation. The investigator must have specific questions and information that needs to be confirmed, written down before the interview begins. The investigator must be aware of all the facts and have experts available if something unexpected is revealed. Your interviewee may be a witness, victim, informant, co-conspirator, or anyone with information that relates to an incident or the case. Planning to conduct an interview means remembering its importance, the key issues

and the objectives. Interviews can enable investigators to gain pertinent information to the case, obtain the interviewee's collaboration as a source or witness, determine the relationship between the interviewee and the subject of the investigation, and establish the underlying motives the interviewee has for providing information. The investigator interviews can help locate and collect copies of any pertinent documents that are needed for the investigation and in some cases, find other sources of information which may include people or things.

Planning an interview requires a few steps; pinpointing the purpose, reviewing the facts, establishing background information on the interviewee, producing an outline of potential interview questions, and setting up the interview in a place where the investigator can allow plenty of time without interruptions. Outlining questions and setting up the interview are key factors. The outline of questions must be tailored to each investigation, and that will change with each case. When developing questions tailored to each investigation an investigator needs to consider the following. Keep all questions clear and free from any type of jargon. Questions should be concise. Reframe from asking any two-part questions. Ask each question to reduce any confusion or erroneous answers. Save the close-ended questions (yes or no type answer) for when you just need to verify something. Always use open-ended questions. To help the interviewee to open up and talk longer. Be aware of the implications of specific words and avoid emotionally charged words. Make sure the list of questions covers the purpose of the interview and finally, ask the three closing questions: is there anything else I have not asked you about, is there any other person you think I should talk to, and is there anything else you would like to say? (College of Policing , 2016)

Setting up the interview(s) should be done soon after the discovery of the crime. A person's memory is fresh and essential documents may still be available. However, when it

comes to suspects, an interview would be best conducted only after gathering enough evidence. Investigators must set up interviews in advance to ensure they are well-planned and comprehensive. The method of the interview may be done in person or over the phone. Table 1 shows the advantages and disadvantages of conducting an interview in person and over the telephone.

Table 1: Advantages and Disadvantages of In Person and Over the Telephone Interviews

	In Person	**Over the Telephone**
Advantages	Can observe interviewee's body language Investigator can use body language to set a tone Collect any physical evidence Interviewee can sign a statement if needed	Interviewee may be more open Time may be easier to arrange
Disadvantages	Interviewee being less open Interviewee answers being constrained by others presence The time being difficult to arrange	Will not be able to observe body language Unable to use body language to set a tone The physical evidence will not be readily available Interviewee is not immediately available to sign statements Interviewee can simply hang up to end the interview

Source: (College of Policing, 2016)

When choosing a location for the interview, options that are common include the interviewee's home or office, or the investigator's office. Table 2 shows the advantages and disadvantages of choosing these locations.

Table 2: Advantages and Disadvantages of Choosing the Locations of the Interviews

	Interviewee's Home/Office	**Investigator's Office**
Advantages	The interviewee being more open The ability to obtain copies of any pertinent documents	Distractions can be limited Freedom from observation of others Investigators control the situation
Disadvantages	Presence of everyday distractions and interruptions Others presence may inhibit interviewee responses	The physical evidence will not be readily available Risk of interviewee feeling intimidated

Source: (College of Policing , 2016)

General guidelines for conducting an interview includes are:

- The investigator should not talk down to the interviewee
- The investigator should convey a sense of trustworthiness
- The investigator should try not to interrupt the interviewee when speaking
- The investigator should ask the interviewee if they are comfortable with recording the conversation. Lack of permission may be a violation of the law in some states
- The investigator should always introduce themselves to the interviewee and explain why they are being interviewed
- The investigator should show credentials and introduce any other investigators accompanied

- The investigator should always have an outline of questions available to expedite the interview and should listen carefully to prepare to add or remove questions while also taking notes
- The investigator should also ask the interviewee to clarify something when necessary, to repeat key details, and in their own words repeat back to the interviewee the details of the interview to verify their understanding
- The investigator also should ask the interviewee if there is anything to add or if there are any questions they might have
- They should ask for the names of others that may be relevant to the case, and gather any pertinent documents and physical evidence. If there is a confession involved, the investigator should obtain a handwritten signed statement from the interviewee or have the interviewee sign a written statement made by the investigator.

When following up after interviews, the investigator prepares a case report promptly. Any handwritten notes should be saved because they may be subject to subpoena or discovery. Finally, the investigator needs to follow the company's procedure to correctly file notes.

Case Study Relevance: Interviewing

BSBC investigators conducted interviews with their members that lead to the interviewing of employees of Dr. Stearns. Several of Dr. Stearns's former employees helped with the investigation by willingly providing interviews to BCBS investigators. This led investigators to gathering much needed information on the healthcare fraud scheme by Dr. Stearns, Levine, and Topel.

During the trial, these former employees' testimonies explicitly stated they received instruction by Dr. Stearns, to not refer to the procedure, "VAX-D" in the patient's' medical records.

All three chiropractors were charged in an indictment on March 2007 by the Federal Bureau of Investigation (FBI). Dr. Levine and Dr. Topel, plead guilty and both received a sentence of almost three years in federal prison. Dr. Stearns received a total of five years in federal prison with monetary judgments.

Section Three: Referral to Law Enforcement

The third step health insurance companies execute in an investigation in healthcare fraud is referral to law enforcement if warranted. Healthcare fraud investigators do not have policing powers. No Miranda warnings are required. 'Private healthcare companies understand that fraud has a real effect on everyone in the healthcare system. Fraud as we know it increases the cost of medical benefits and reduces the quality of care received (NHCAA, n.d.).' Fraud impacts employers by increasing the cost of providing benefits and the cost of doing business. Fraud often results in unsafe medical procedures as a result of falsified medical records which can have overwhelming effects on patient lives. Fraud is a serious crime and can affect everyone's healthcare and its cost. Not all healthcare fraud cases are referred to law enforcement. The investigator can recommend a case to be considered for settlement, or referred to the corporate legal department for civil and/or administrative actions. Cases often recommended for settlement include those which might be considered difficult for a jury to follow, or those that the providers openly admit occurred, depending on the severity of the fraud. Civil actions are recommended when the insurance company can take legal action to recover funds that should not have been

paid to the provider. Lastly, administrative actions should be considered when gross misconduct has been uncovered. In that type of situation, the action would seek to remove the provider from the insurance company network and/or have their medical license revoked. These final decisions are left to the corporate legal department and to the Director of Investigations with the interests of the insurance company in mind.

Healthcare fraud investigators fight against FWA. They detect and investigate potential areas of FWA. They identify, investigate and seek prosecution on internal and external fraud by partnering with state and federal law enforcement and regulatory agencies. Once sufficient evidence has been obtained the investigator makes a referral to law enforcement. Healthcare fraud is a violation of state and/or federal law and is a felony offense (18 USC 1347), punishable by a fine of up to $250,000 and/or up to ten years' imprisonment, (Eldridge M. & Thomas Dillard, 1994).

When an investigator refers a healthcare fraud case to law enforcement, there are several tasks the investigator should do. The investigator should compile the paperwork of the case to prove that a fraud has been committed. The paperwork must also be clear, concise and complete so anyone who reviews the case can quickly read and understand the fraud. The major points that the paperwork must cover are:

- Specific details about the healthcare fraud that occurred
    - What actions were taken by the investigator
    - What did the investigators find
    - What laws were broken
    - What evidence does the investigator have
- Identify the fraudulent behavior

    - How fraud was detected
    - Outcomes of interviews
- All relevant information
    - Assemble all the facts
    - Make a strong case

Case Study Relevance: Referral to Law Enforcement

Dr. Stearns, Dr. Levine, Dr. Topel and CCMG were billing for services not rendered. For the healthcare investigator to make a referral to law enforcement, a detailed case packet must be completed. The packet must show all the facts and prove every aspect of the referral. Every assertion made by healthcare investigators must be explained thoroughly for law enforcement to understand.

The BCBS investigators presented the case of Dr. Stearns to law enforcement for referral as a case of physicians billing for services not rendered. The investigators begun the referral by presenting three years of BCBS data, from 2004 to 2007 for Dr. Stearns, Dr. Levine, Dr. Topel and CCMG. The three years of data included the billing for services not rendered to the members of BCBS. The investigators elaborated about the extended treatment times members and their family members were billed, which all happened to be in the same employer group.

The investigators explained the excessive billing and extended treatments from their sting operation on the chiropractic offices, and showed BCBS paid $4 million for those bills. The story explained the procedure Vertebral Axial Decompression (VAX-D), which the chiropractor was performing and compared that with the surgical nerve decompression procedure that was billed. It compared the cost and procedural differences. The investigator explained the company policy

and why BCBS did not pay for the VAX-D procedure because it is considered investigational and not medically necessary.

The investigators then covered the fraudulent billing procedure for the electrical stimulation medical procedure where the chiropractors stated they were using a device known as 'Hako-Med' to perform a surgical procedure known as nerve block injection. The investigator showed that BCBS payed for that procedure, which is five to ten times higher than if they correctly billed for the procedure which was actually performed, the electrical stimulation.

Next, the investigators shared the results from the undercover investigation where the undercover investigators received treatment from all three chiropractor locations, and from all three doctors. The investigators explained what services the chiropractors performed on their undercover partners, and what services were billed for their visits. BCBS investigators include all interview transcripts in the report. The contact information of all parties interviewed, including addresses, phone numbers, along with preference time brackets to discuss medical procedures. Finally, once the details are assembled, the case packet is shared with law enforcement.

The law enforcement agency gives the investigator a request for information (RFI). This is just a referral form saying that the law enforcement agency is now investigating the criminal matter. This starts the investigation by the law enforcement agency into the BCBS case and it would be considered successfully referred to law enforcement. A RFI by the agency receiving the referral is given to the BCBS investigators. This is important in case the defense tries to assert a HIPAA violation.

Conclusion

In concluding the presentation to law enforcement, the case is now being investigated as a criminal matter. This shows that the law enforcement agency has control of the case and the evidence presented. During their investigation the enforcement agency may ask for additional documents from BCBS. The BCBS investigators must comply with these requests however if the law enforcement agency requires more interviews they will be done by the agents and not by the BCBS investigators. If the case goes to trial the BCBS investigators work continues. If a verdict is given and restitution ordered then the BCBS investigator may be called to determine which claims will comprise the amount of restitution. Also, additional reports will be prepared as needed. The BCBS investigators has resources available to them, which includes data mining analysts, management and legal to help prepare the case before referring and also after its referred.

Summary

Detecting fraud in healthcare is not a simple task. Fraud detection is an art. The investigator is attempting to understand and uncover a fraud as swiftly as possible once it has been understood that a fraud has been committed. Insurance companies protect the integrity of the healthcare system by fighting against FWA. However, it's imperative to have mechanism in place for fraud detection. It does not end there, highly trained and knowledgeable healthcare fraud investigators are needed. Knowledgeable data mining investigators are essential. They help the insurance company make informed decisions involving well-designed detection polices, and educate how one may adapt to new fraud trends and prevention measures.

Completing healthcare fraud interviews is another not so easy task. There are several key items that can make an interview strong or weak. The advantages and disadvantages of in person interview/over the phone interview and choosing the location of the interview. All needing to take in consideration when interviewing.

Overall, the fraudulent action of the medical professionals costs consumers because it can result in reduced benefit coverage, changes in the eligibility for programs like Medicaid, higher medical premiums for individual or employee healthcare, or higher copays. Consumers do not have to be a healthcare fraud victim. Consider the following suggestions below.

- Actively review statements after every doctor visit to maintain accuracy.
- Ask the doctor to explain service(s) provided and their relevance.
- Safeguard insurance member ID cards If it is compromised, request a new one.
- Do not allow fear to consume questions. Address any and all discrepancies discovered and make sure the health insurance plan reflects accordingly.

- Do not provide insurance card numbers to marketers, solicitors or any irrelevant individual.

Following simple steps and practicing personal auditing of healthcare procedures can be very effective when attempting to reduce healthcare fraud related to services not rendered.

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