Drilling Down on Fraud

Auto insurers can attack the big problem of fraud by paying attention to the details hidden in claims.

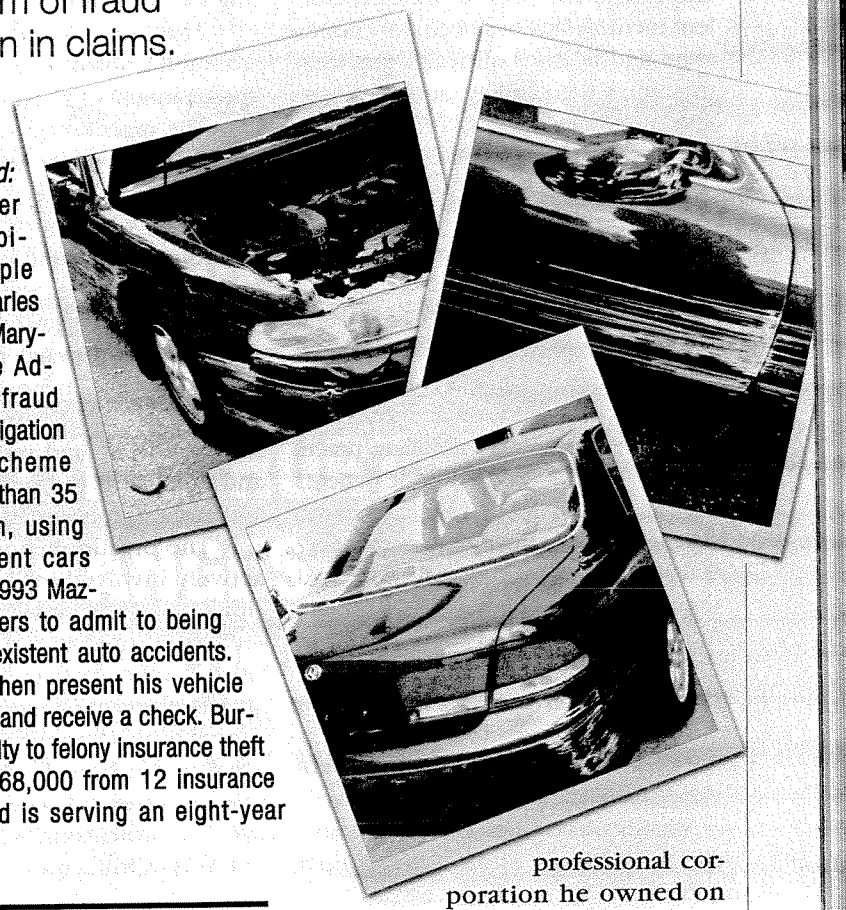
by Francis J. Serbaroli and Skip Short

When the notorious bank robber, Willie Sutton, was asked why he robbed banks, he replied, "Because that's where the money is." The Willie Suttons of today have more sophisticated methods, and today's victims are more likely to be no-fault insurers, but the motivation is the same: that's where the money is.

The scope of the fraud problem in the no-fault automobile insurance marketplace is staggering. In New York State, for example, the insurance department estimates that fraudulent claims cost insurers and the premium-paying public upward of $1 billion per year.

The figures, however, do not tell the whole story nor adequately convey the full magnitude of the problem. Increasingly, fraudulent operatives are staging car accidents in order to submit insurance claims. The medical facilities these and other victims are taken to are frequently mills created to bill no-fault and sometimes are operated by organized crime. One New York law enforcement agent said, "I don't know why anyone would rob a bank anymore when they can open a medical facility and bill no-fault."

Fortunately, as grave as the problems have become, rapidly escalating insurance premiums, combined with the brazenness of some of the schemes, have caught the attention of state legislators and law enforcement, resulting in needed reforms and prosecutions of organized no-fault fraud rings. Insurers also are filing more of their own civil suits to recoup claims that should not have been paid. As challenging as the problem may seem to be, there are significant actions that insurers can take to fight this national scourge.



Fraud Uncovered: After an insurer became suspicious of multiple claims from Charles L. Burton, the Maryland Insurance Administration's fraud division's investigation revealed a scheme involving more than 35 people. Burton, using several different cars including this 1993 Mazda, bribed drivers to admit to being at-fault in nonexistent auto accidents. Burton would then present his vehicle for an estimate and receive a check. Burton pleaded guilty to felony insurance theft for stealing $268,000 from 12 insurance companies and is serving an eight-year prison term.

Photo illustration by Karen McNamara/Photos Courtesy of Maryland Insurance Administration

Recognizing the Problem

When health facilities have been created for the sole purpose of billing no-fault, often the owners are not medical doctors and their goal is frequently the production of bills, not the quality of patient care. Understanding this, insurers should scrutinize claims for evidence of the practice of bad medicine.

One important step is to request copies of all wave forms and raw data generated from diagnostic testing. In one case, a medical doctor submitted bills for nerve conduction velocity tests. When the insurers obtained copies of the wave forms and raw data, they discovered the doctor was using the same test results for numerous patients. As a result, the doctor was convicted and sentenced to prison. A professional corporation he owned on paper subsequently settled when several insurers sued to recover their payments.

In other cases, marketers of questionable medical testing and devices sell their services to dubious medical facilities. Medical reports need to be examined carefully because providers of certain radiology services may use the same findings in patient after patient. In one case, after the results were studied by radiology experts, it was discovered that the reported findings were life-threatening and could not possibly have been reported in hundreds or thousands of patients. This information became critical in successfully opposing these claims.

Helpful Resources

Increasingly, assistance in fighting medical fraud can be found in the offices of state health departments. New York and New Jersey in particular

Francis J. Serbaroli is a partner in Cadwalader, Wickersham & Taft LLP. Skip Short is a partner in Short & Billy P.C.

have been particularly vigilant in disciplining doctors who have been involved in fraudulent schemes, especially when there is poor patient care and risk to the patients. Since fraudulent medical facilities need the cooperation and licenses of health providers to submit their billing, actions of the regulatory agencies can bring some of these schemes to an end.

Laws, including state licensing statutes that govern the practice of medicine, podiatry, chiropractic, physical therapy and other professional services, are potent weapons that can and should be deployed in the war against fraud. Insurers have the right to look behind a bill for services and ask a variety of questions. Did the billing practitioner actually see and treat the patient? Was he or she properly licensed in the state where the treatment took place? Did the practitioner accurately record the examination, diagnosis and treatment in the patient's medical record? If other practitioners also treated the patient, were they properly licensed and did they make an accurate record? Are unlicensed individuals actually providing patient care services?

Besides asking these basic questions, insurers should look into whether the practitioners involved are in compliance with state corporate practice and fee-splitting prohibitions. For example, was the practitioner's professional corporation, association or partnership properly set up under state law? Are unlicensed individuals involved in the ownership of the professional practice or do they exercise inordinate control over the practice either directly or through a contract with a management company?

Red Flags

Fee-Splitting. Most states prohibit fee-splitting by professionals. Insurers should ask if practitioners who are treating no-fault patients are splitting their fees or paying kickbacks for referrals of patients. Are payments being made to lawyers who refer their clients to practitioners for health services? Are physicians, chiropractors, podiatrists, physical therapists and so on improperly splitting fees with each other?

These are the key areas of inquiry in determining whether state laws prohibiting corporate practice or fee-splitting are being violated:

- The licensed practitioner must maintain control over the diagnosis and treatment of all patients.
- The practitioner-owner of a practice must not allow lay ownership or control over the practice, nor allow any lay interference in decisions regarding what kind of treatment is appropriate, in the practitioner-patient relationship or in any other professional aspects of the practice.
- The practitioner-owner must at all times set the fees charged for professional services, and retain ownership and control of the practice's patient and business records.
- The practitioner-owner must be actively involved in the practice by either personally providing professional services or supervising the services provided by other professional personnel.
- The practitioner-owner may outsource limited nonprofessional management functions to outside contractors, but may not cede any control over the professional side of the practice to an unlicensed outside entity such as a management company, or to any individual or group of laypersons.

Improper Referrals. Many states have enacted anti-referral laws. These laws prohibit practitioners such as physicians from referring patients for further medical services to another entity that is owned in whole or in part by the referring practitioner or that compensates the practitioner. These laws often cover referrals for the services that are most often the subject of billing abuse in no-fault programs: MRI, radiology and other imaging; physical therapy clinical laboratory services and pharmacy services. If prohibited referrals take place, these laws often provide insurers solid grounds for rejecting payment for claims for these services.

Provider Backgrounds. No-fault insurers regularly should consult the lists of providers excluded from the Medicare program and state Medicaid programs. Many of these practitioners have been barred for abusive billing practices or other misconduct, though they still have their licenses to practice. Some of those who can no longer treat Medicare or Medicaid patients simply go to work for medical mills that handle a large volume of no-fault cases, and take up a new line of work overtreating no-fault patients and overbilling no-fault carriers. (Lists of Medicare-excluded individuals and entities are available at *http:// oig.hhs.gov/fraud/exclusions.html.* States maintain their own lists of exclusions.)

No-fault insurers should pay only those claims for legitimate and necessary professional services provided by properly licensed individuals, groups or entities. Besides having proper licenses, these practitioners and their professional and business dealings should be compliant with the laws and regulations governing the proper practice of their professions.

These various laws and regulations have been around for years, and were intended to protect patients and to ensure that the practitioners treating them exercise objective medical judgments. Violations of these laws can subject the offending practitioner to disciplinary action up to and including license revocation. Medical services tainted by illegality should not have to be paid for by either the patients or their insurers.

Legislative Solutions

Given the crisis proportions of fraud, insurers should continue to work actively in two areas: legislative support for expanded law enforcement resources to fight insurance fraud, and legislative support to remove suspected fraudulent claims from prompt payment periods. The second issue arises because many claimants argue that if an insurer doesn't pay or deny a claim promptly, it cannot defend the claim. Whatever the merits of such an argument in the context of legitimate claims, it obviously should not support the payment of fraudulent claims, especially in a system that now must contend with organized criminal activity. BR