FEDERAL BUREAU OF INVESTIGATION

New Orleans Field Office

HEALTH CARE FRAUD

PROGRAM OVERVIEW

UNDERSTANDING THE THREAT

- Health Care Fraud (HCF) exists in nearly every segment of the health care industry and affects virtually all sectors of the economy.
- Fraud schemes are continually evolving, targeting both public, government-sponsored health care programs, including Medicare and Medicaid, and private health insurance plans of all sizes and beneficiaries.
- The FBI's HCF Program also encompasses:
  - Non-insurance Related Fraud
  - Medical Privacy Violations
  - Threats to the Public Health
    - *Prescription Drug Diversion*
    - *Internet Pharmacy Fraud*

UNDERSTANDING THE THREAT: A HISTORICAL PERSPECTIVE

- FBI initially investigated HCF as Fraud Against the Government matters
  - *Due to the significant rise in the cost of health care provided through government programs.*

- HCF caseload expanded in 1992, when the FBI began investigating fraud against private payer health care plans

- FBI established the Health Care Fraud Unit in April 1993

- In August 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which provided new criminal statutes directed at HCF occurring in both public and private health care plans

UNDERSTANDING THE THREAT: TODAY

- HCF continues to plague the U.S., with losses exceeding tens of billions annually.
- We all pay for Health Care Fraud:
  - ↑ Health insurance premiums
  - ↑ Copayments
  - ↑ Taxes
  - ↓ Benefits

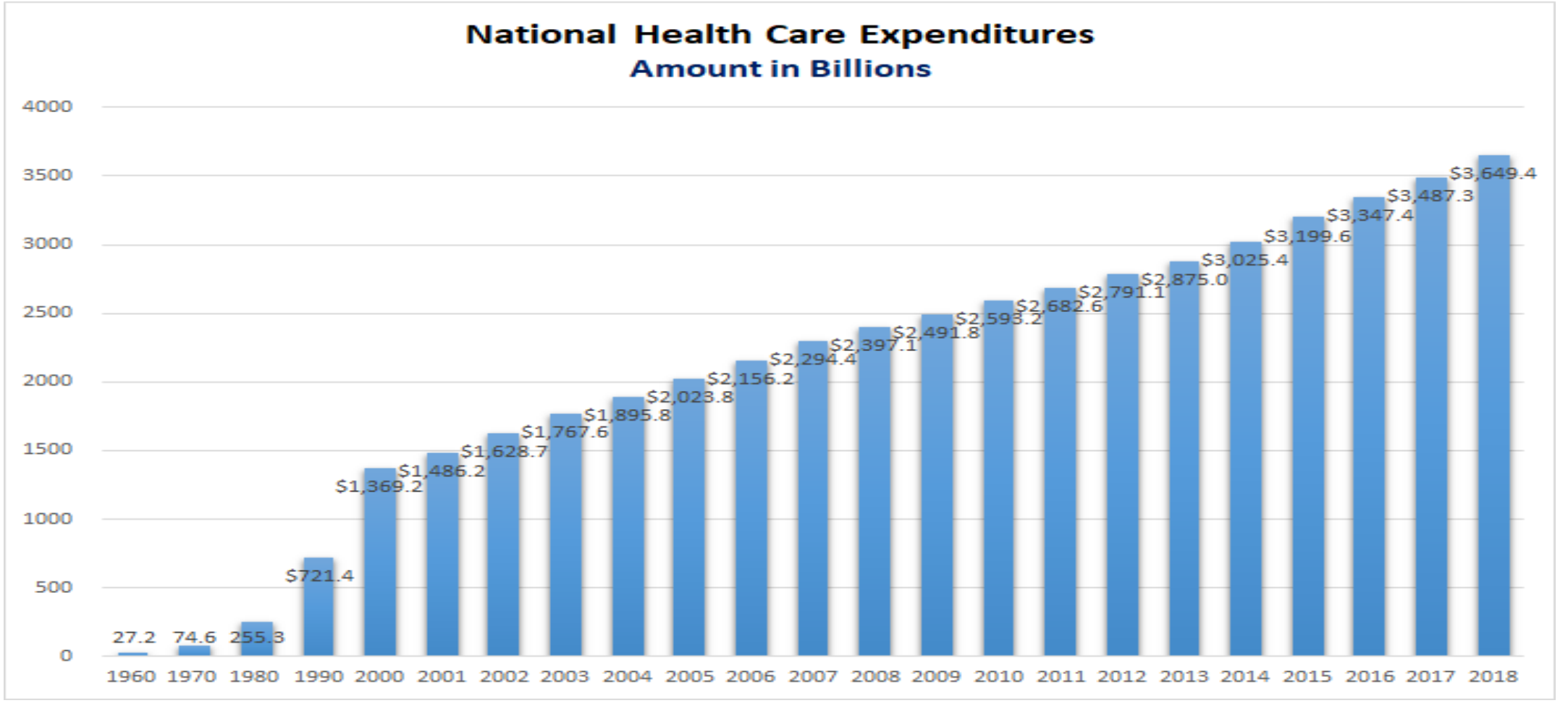
  Loss of benefits
- 2018 National Health Expenditures

  $3.6 Trillion $11,172 per person
- 2019 National Health Expenditures

  $3.86 Trillion
- Estimation of the losses due to Fraud, Waste and Abuse

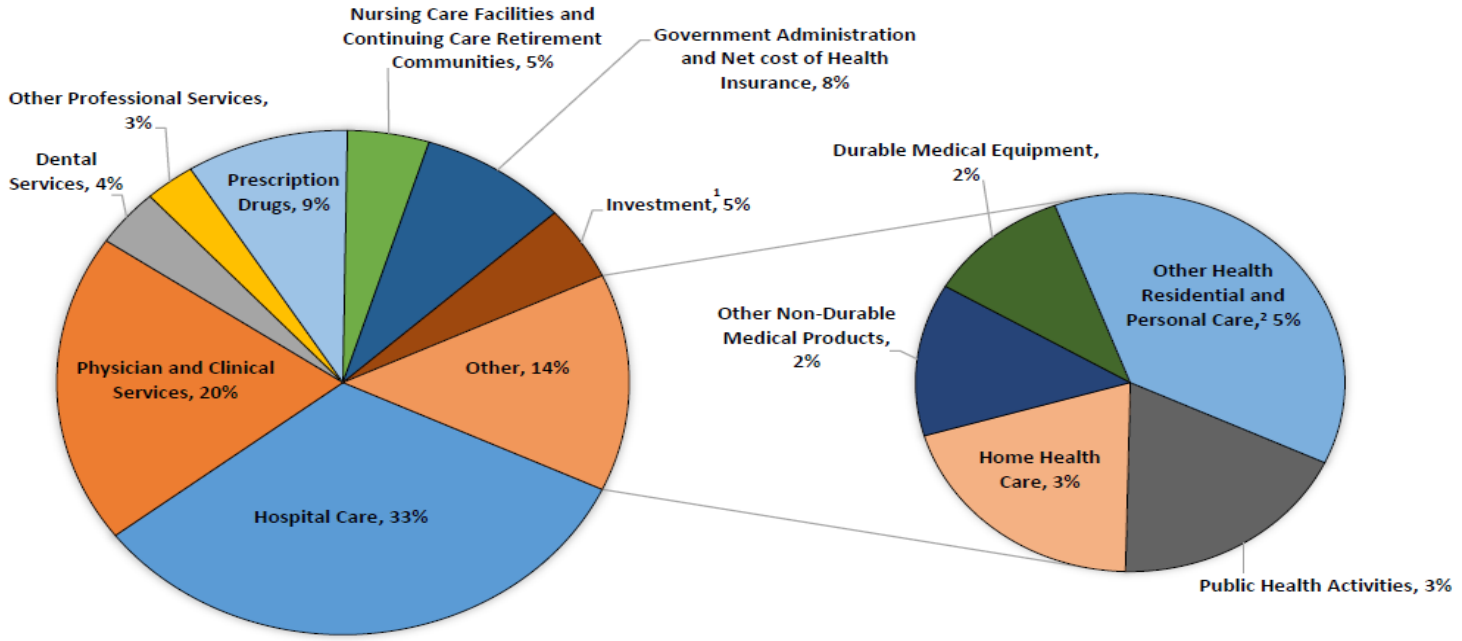
  3% to 10% of Total Expenditures ($115 billion - $386 billion)

UNDERSTANDING THE THREAT: U.S. HEALTH CARE EXPENDITURES



UNDERSTANDING THE THREAT: U.S. HEALTH CARE EXPENDITURES

THE NATION'S HEALTH DOLLAR ($3.6 TRILLION), CALENDAR YEAR 2018, WHERE IT WENT



[1] Includes Noncommercial Research and Structures and Equipment.
[2] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

FBI
HEALTH CARE FRAUD PROGRAM

Our Mission

Protect the public by investigating, reducing, and preventing significant financial crimes and harm against individuals, businesses, and industries involved in the administration of America's health care system.

OUR TEAM

- The FBI has 12,800+ Special Agents, 56 Field Offices, 400 Smaller Offices, and 60 International Offices
- Currently, approximately 435 Special Agents and 327 Professional Staff are dedicated to investigating Health Care Fraud
- 2,331 pending Health Care Fraud Cases as of November 2020.

IMPACT

- 443 HCF-related Arrests in FY2020

  October 1, 2019 – September 30, 2020

- 624 HCF-related arrests in FY2019

  October 1, 2018 – September 30, 2019

- 721 HCF-related arrests in FY2018

  October 1, 2017 – September 30, 2018

IMPACT

$3.1 Billion

https://oig.hhs.gov

Health Care Fraud and Abuse Control (HCFAC) Program

HCFAC Annual Report – provides statistics and gives case examples

FUNDING - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

- The FBI's HCF Program is completely funded by HIPAA through a reimbursable agreement between the FBI, U.S. Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services (HHS).
- Since its inception in 1996, HIPAA has provided annual funding that supports a certain number of Special Agents and Professional Staff dedicated to investigating HCF.
- The FBI is held accountable by Congress for this funding, and these funds must be used for their appropriated purpose. FY20 Funding amounts:
  - Mandatory: **$141 Million**
  - Discretionary: **$9,308,000**
  - Opioid Funds - **$400,000.00**
  - Outlook

COOPERATION & COORDINATION: PRIVATE SECTOR

- HIPPA expressed intent that the U.S. Attorney General and the Secretary of Health and Human Services establish a program to coordinate the efforts of law enforcement and private insurers to combat health care fraud.
- In response, the Attorney General promulgated a statement of principles to guide federal law enforcement agencies in carrying out this legislative objective.
  - *To the extent permitted by law and policy, investigative information will be shared with private insurers and, in addition, private health plan personnel will be included on health care fraud task forces.*

Humana
UnitedHealthcare
BlueCross BlueShield
Cigna
aetna™

COOPERATION & COORDINATION

- U.S. Department of Justice, Fraud Section
- U.S. Department of Health and Human Services - Office of Inspector General (OIG)
- U.S. Drug Enforcement Administration
- U.S. Food and Drug Administration – Office of Criminal Enforcement
- U.S. Department of Defense – OIG, Defense Criminal Investigative Service
- U.S. Centers for Medicare & Medicaid Services
- Internal Revenue Service - Criminal Investigation
- U.S. Postal Inspection Service
- United States Secret Service
- U.S. Office of Personnel Management
- State Attorneys General
- County District Attorneys
- State and Local Law Enforcement Agencies

WHAT THE FBI INVESTIGATES

The HCFU organizes HCF investigations into six (6) categories:

1. Government Sponsored Program Fraud
2. Private Insurance Program Fraud
3. Non-Insurance Fraud
4. Medical Privacy Violations
5. Internet Pharmacy Fraud
6. Opioid Investigations

WHAT TO CHARGE: FEDERAL CRIMINAL STATUTES

Prior to HIPAA

- 18 U.S.C. § 201 - Bribery of public officials and witnesses.
- 18 U.S.C. § 287 - False, fictitious, or fraudulent claims.
- 18 U.S.C. § 371 - Conspiracy to commit offense or to defraud the United States.
- 18 U.S.C. § 1001 - False statements.
- 42 U.S.C. § 1320a-7b(b) - Criminal penalties for acts involving federal health care programs (Anti kickback statute). *Statutory Maximum: 10 years*

HCF Against Private Health Insurance Companies

- 18 U.S.C. § 1341 – Mail Fraud - *Statutory Maximum: 20 years*
- 18 U.S.C. § 1343 – Wire Fraud - *Statutory Maximum: 20 years*
- 18 U.S.C. § 1956 - Laundering of monetary instruments
- 18 U.S.C. § 1957 - Engaging in money transactions in property derived from specified unlawful activity (money laundering).
- 18 U.S.C. § 1962 - Prohibited activities (Racketeer Influenced Corrupt Organization [RICO]).

WHAT TO CHARGE: FEDERAL CRIMINAL STATUTES

HIPAA Criminal Statutes:

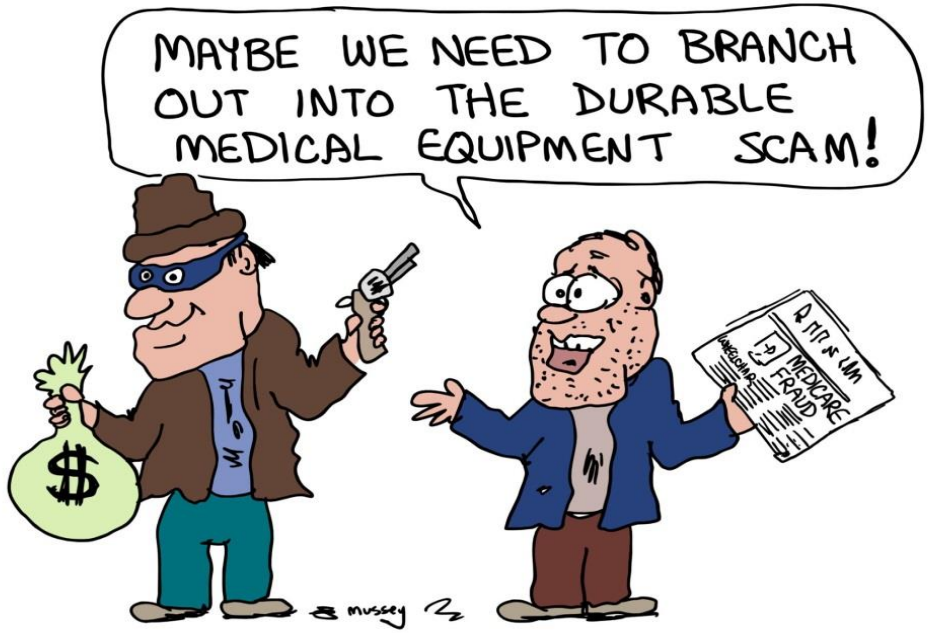
- 18 U.S.C. § 669 - Theft or embezzlement in connection with health care.
- 18 U.S.C. § 1035 - False statements relating to health care matters - *Statutory Maximum: 5 years*
- 18 U.S.C. § 1347 - Health care fraud (engage in a scheme or artifice to defraud any health care benefit program). *Statutory Maximum: 10 years; 20 years, if violation results in serious bodily injury*
- 18 U.S.C. § 1349 – Conspiracy to Commit Health Care Fraud & Wire Fraud -*Statutory Maximum: 20 years*
- 18 U.S.C. § 1518 - Obstruction of criminal investigations of federal health care fraud offenses.
- 18 U.S.C. § 3486 - Authorized investigative demand (AID) or administrative subpoenas.
- 18 U.S.C. § 220 - Eliminating Kickbacks in Recovery Act (EKRA) - *Statutory Maximum: 10 years*

COMMON SCHEMES

- Billing for Services Not Rendered
- Excessive Services
- Unbundling of Services
- Upcoding of Services
- Double Billing
- Kickbacks on Government Sponsored Programs
- Spiked Billing
- Identity Theft – Selling Beneficiary (Patient) Lists
- Billing for Medically Unnecessary Services
- False Statements

EMERGING SCHEMES

- Telehealth/Telemedicine
- Sober Homes
- Durable Medical Equipment Scheme
- Genetic Testing
- Respiratory Pathogen Panels – COVID-19
- Auto Accident Schemes



PRESCRIPTION DRUG NATIONAL INITIATIVE

- Launched in 2016 to address the fraudulent dispensing and distribution of prescription drugs, such as Hydrocodone and Oxycodone, and the powerful synthetic opioid painkiller Fentanyl, by health care professionals.
  - *Fraudulent dispensing occurs when the drugs are prescribed outside the usual course of professional practice, and when there is no legitimate medical purpose for the prescription.*
- Part of the multidisciplinary approach the FBI is employing to address the opioid crisis, as diversion of prescription opioids fuels the opioid crisis,
- The PDI also targets fraud. At the time the FBI launched the PDI, estimated national health expenditures for prescription drugs exceeded $300 billion and the associated Medicare expenditures exceeded $85 billion.

COVID-19 Anti-Fraud Initiative

- Established to address the increase in health care fraud and patient safety cases related to the COVID-19 Pandemic.
- HCFU has identified a variety of fraudulent schemes targeting both government sponsored health care programs, particularly Medicare and Medicaid, and private health insurance plans as a result of the pandemic.
  - Overbilling/Billing for Services Not Rendered/Billing for Medically Unnecessary Services
  - Expansion of "Telehealth/Telemedicine" Coverage
  - Medical Identity Theft
  - Kickback Schemes
  - Medicare Part D Schemes
  - Fake Testing Kits
  - Hoarding & Price Gouging Matters
  - General Stimulus Fraud

MAJOR PROVIDER FRAUD NATIONAL INITIATIVE

- Established to identify and target major medical providers, such as corporations, companies, and other provider groups engaging in significant medical billing fraud schemes that result in, or are intended to result in, large monetary losses to taxpayer funded, government health care benefit programs and private health care plans.
- Investigations targeting major providers are typically identified and initiated based upon data analytics, including the review of civil Qui Tam filings, and coordination with HHS-OIG and DOJ's civil and criminal components.
  - Qui Tams
  - Groups of individuals to include medical providers colluding together
  - Schemes span multiple jurisdictions

LARGE SCALE CONSPIRACY NATIONAL INITIATIVE

- Established in 2012 in response to the substantial and increasing threat associated with criminal enterprises and other groups whose schemes result in significant monetary losses, or potential losses, to government health care benefit programs and private health insurance plans.
- Focuses on organized criminal enterprises, and other groups of individuals who co-opt medical providers to collaborate in fraud schemes.
- Focused on complex schemes such as:
  - The sharing and selling of beneficiaries' identifying information and
  - Multi-tiered kickback schemes involving fraudulent referral and billing for medically unnecessary services or services never provided.

OUTREACH & LIAISON NATIONAL INITIATIVE

- Established to ensure ongoing and frequent contact with our law enforcement, regulatory, and private sector partners as well as the general public.
- Educate the public about the threat, including identifying and reporting health care fraud
- Ensure the FBI is aware of the latest intelligence and recent trends related to the threat

National Nursing Home/Elder Fraud

- Established to ensure coordination with DOJ in furtherance of DOJ's Nursing Home Initiative and Elder Fraud Initiative.
- HCF Program's focus will be on patient harm in the form of elder abuse and fraudulent billing in connection with long-term care and placement in elder care facilities of all types.
- DOJ Focus is on Nursing Homes that:
  - Consistently fail to provide adequate nursing staff to care for their residents
  - Fail to adhere to adhere to basic protocols of hygiene and infection control
  - Fail to provide their residents with enough food to eat so that they become emancipated and weak, or withhold pain medication, or use physical or chemical restraints to restrain or otherwise sedate their residents.
  - Fail to provide their Medicare and Medicaid residents with even the most basic nursing services.

DOJ Health Care Fraud Strike Force (HCFSF)

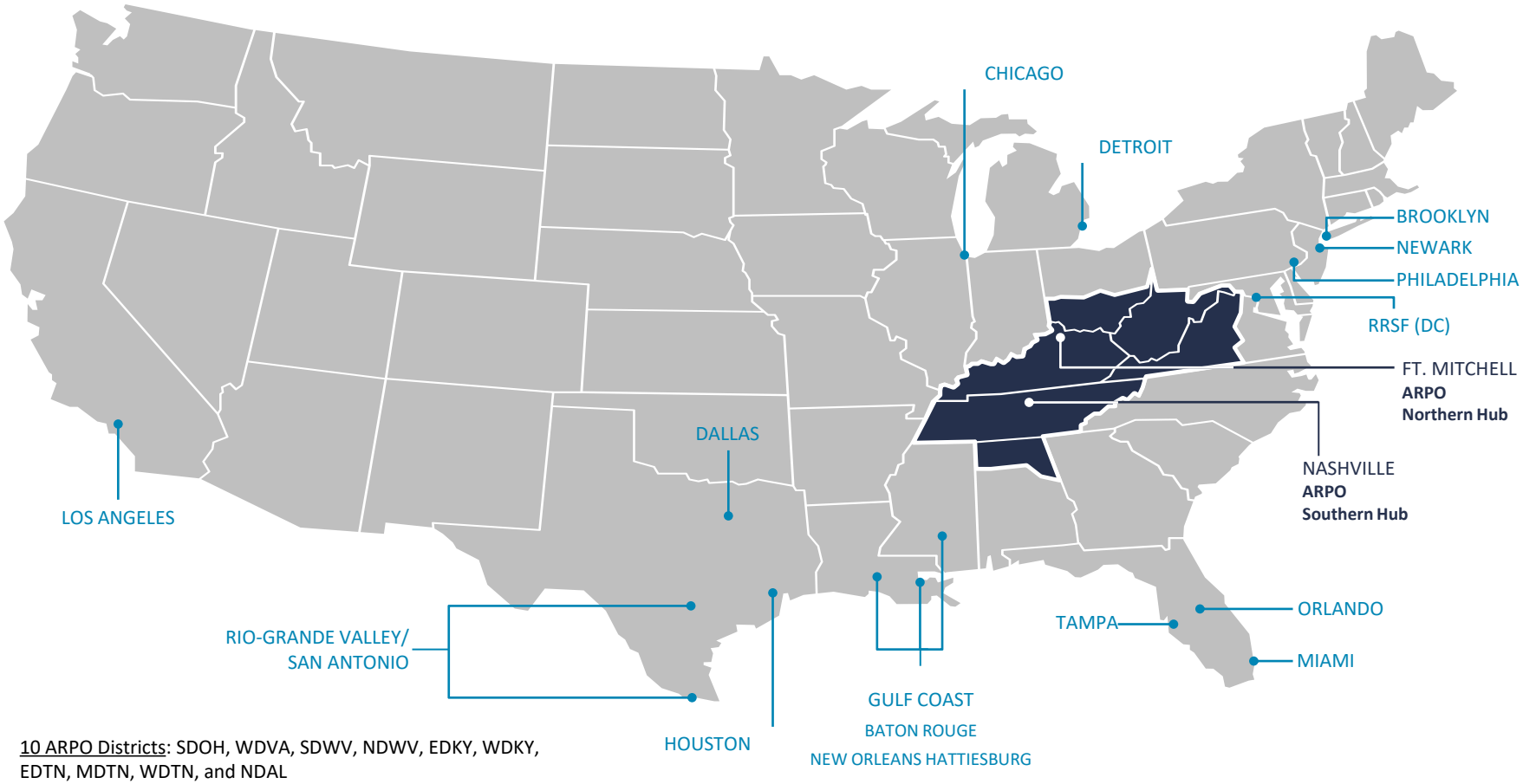
- Multi-agency team of Federal, state, and local investigators initially designed to combat Medicare fraud through the use of data analytics.
- Established in select cities with high rates of HCF
- Since its inception in March 2007, SF prosecutors have filed more than 1,400 cases charging more than 3,000 defendants who collectively billed the Medicare program more than $10 billion.

Miami – March 2007
Los Angeles – May 2008
Detroit – May 2009
Houston – May 2009
Brooklyn – December 2009
Tampa and Orlando - December 2009
Baton Rouge - December 2009
Gulf Coast
New Orleans
Chicago
Dallas
Newark – August 2018
Philadelphia – August 2018
Rio Grande Valley

APPALACHIAN REGIONAL PRESCRIPTION OPIOID (ARPO) STRIKE FORCE

- Established to identify and investigate HCF schemes in the Appalachian region and surrounding areas that have been hard-hit by the opioid crisis to investigate and prosecute medical professionals and others involved in the illegal prescription and distribution of opioids.
- Brings together the resources and expertise of DOJ's Health Care Fraud Unit, the U.S. Attorney's Offices in ten (10) federal districts in six (6) states, as well as the FBI, U.S. Department of Health and Human Services-Office of the Inspector General (HHS-OIG), and U.S. Drug Enforcement Administration (DEA).
- Operates out of two (2) hubs based in the Cincinnati/Northern Kentucky, and Nashville, Tennessee, areas.
- Also works closely with the U.S. Postal Inspection Service, IRS Criminal Investigation, and State Medicaid Fraud Control Units.

DOJ Health Care Fraud Strike Force (HCFSF) & ARPO Locations



10 ARPO Districts: SDOH, WDVA, SDWV, NDWV, EDKY, WDKY, EDTN, MDTN, WDTN, and NDAL

DOJ Sober Homes Initiative

- Nationwide initiative targeting addiction treatment fraud
- Identify Sober Homes and Addiction Treatment Centers committing fraud;
- Secure criminal charges against owners, marketers/body brokers, medical professionals, and culpable employees; and
- Identify laboratories and Medical Directors that make such fraud possible,
- Began in two locations:
  1. Southern District of Florida
  2. Central District of California

April 2019 Operation Brace Yourself

The New York Times

24 Charged in $1.2 Billion Medicare Scheme, U.S. Says

By Niraj Chokshi and Julia Jacobs

April 9, 2019

Federal officials said Tuesday that they had dismantled a $1.2 billion Medicare scheme that spanned continents and ensnared hundreds of thousands of unsuspecting elderly and disabled patients.

Under the scheme, which the authorities described as one of the largest health care frauds in United States history, doctors prescribed back, shoulder, wrist and knee braces that were not needed, prosecutors said. Twenty-four people were charged, according to the Justice Department.

"These defendants — who range from corporate executives to medical professionals — allegedly participated in an expansive and sophisticated fraud to exploit telemedicine technology meant for patients otherwise unable to access health care," Brian Benczkowski, the assistant attorney general for the department's criminal division, said in a statement.

$2 Billion in Fraudulent Medicare Reimbursements for Medically Unnecessary Durable Medical Equipment (DME)

Back, knee, shoulder, wrist, neck and elbow “braces”

Over 40,000 brace orders per week and average reimbursement per brace is over $600

Over $24 million per week

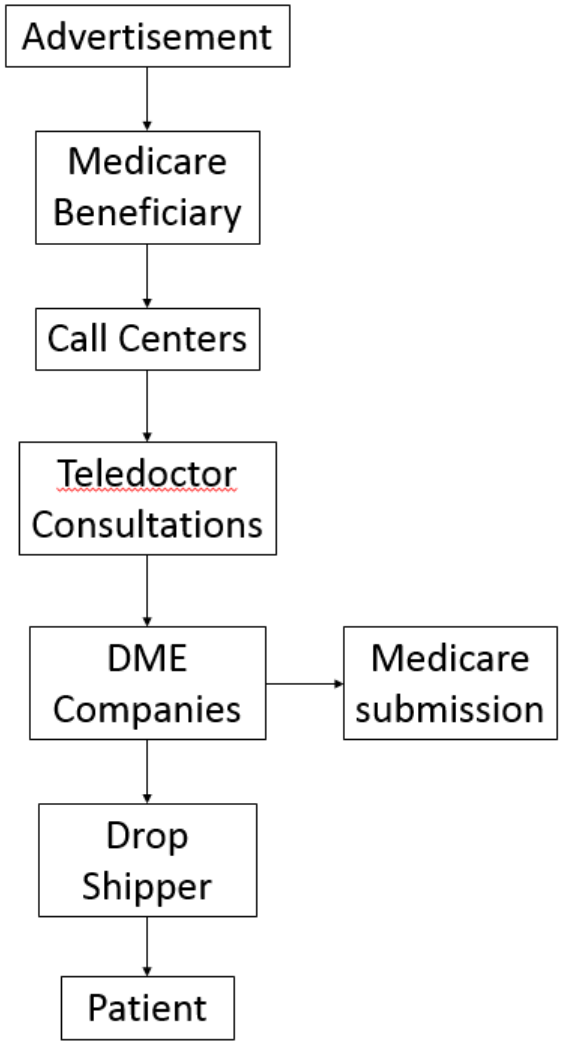
Over $1.3 Billion per year

Anti-Kickback Statute

Prohibits:

Knowingly and willfully soliciting, receiving, offering, or paying remuneration (including any kickback, bribe, or rebate) for referrals for services that are paid in whole or in part under a federal health care program (which includes the Medicare program).

42 United States Code § 1320a-7b(b)


Advertisement
Medicare Beneficiary
Call Centers
Teledoctor Consultations
DME Companies
Medicare submission
Drop Shipper
Patient

The Ironman

Scheme

- **Call Center**
- **Revenue**: $280 per Completed Doctor Order (D.O.)
- **Cost**: $80 per Doctor Script
- **Cost**: $80 Ad/Workforce Cost per D.O.
- **Profit**: $120 per Completed D.O.

Tele-Medicine Company

Revenue: $80 per Completed Prescription

Cost: $20 per Tele-Doctor Call

Profit: $60 per Completed Prescription

Tele-Doctor

Revenue: $20 per Prescription

Cost: Time

Profit: $20 per Prescription

Medical Equipment Company

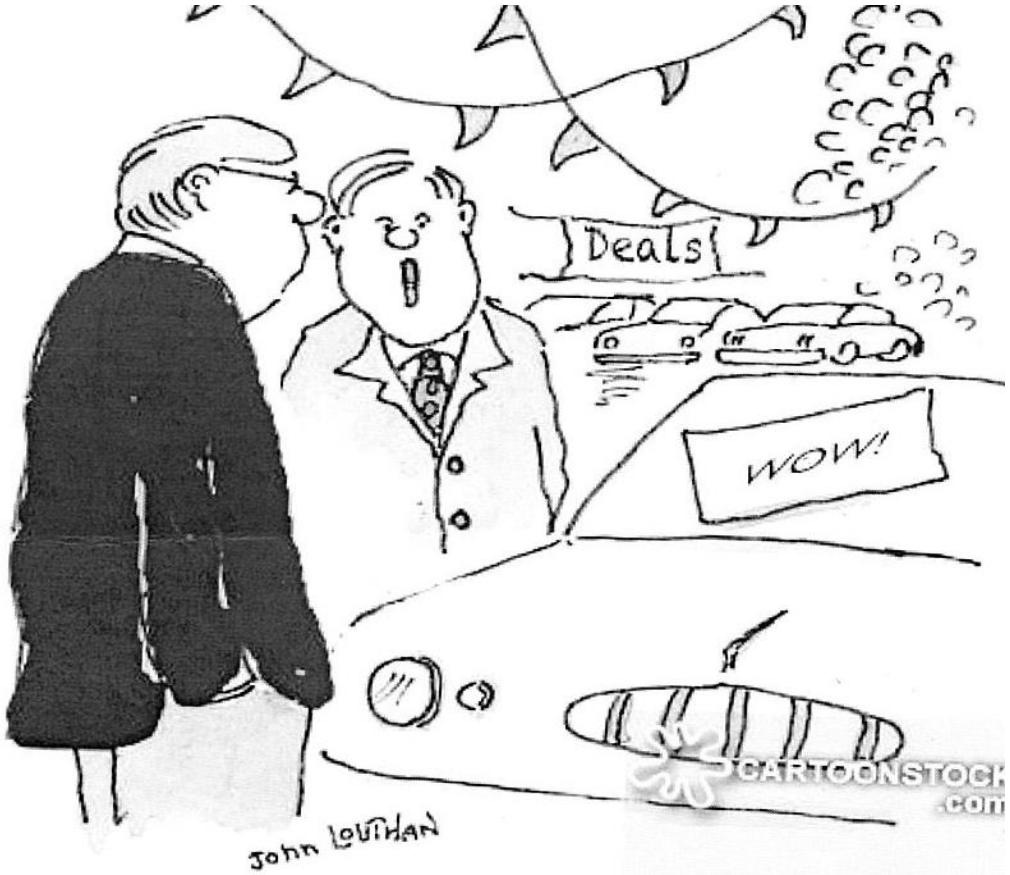
Revenue: $600 -$900 Medicare Reimbursement per Submission

Cost: $280 per Completed D.O.

Cost: $25 per Brace

Cost: $25 per Drop-Shipment

Profit: Minimum $270 per Medicare Submission



"Doctor, are you going to finance it or shall I just bill Medicare?"

SSRA Evan Patterson
New Orleans Field Office
Lafayette & Lake Charles RA
Ecpatterson@fbi.gov
337-233-2164

CRIMINAL INVESTIGATIVE DIVISION

FEDERAL BUREAU OF INVESTIGATION