

# WASTING AWAY

## Sick of Throwing Money Away on Medical Provider Fraud? Here's How to Fight Back

By Matthew J. Smith, Esq.

In the 1976 movie *Network*, William Holden famously exclaims, "I'm mad as hell, and I'm not going to take this anymore!" While uttered nearly 40 years ago, this quote exemplifies the frustration that many insurance carriers feel after decades of paying for questionable, if not fraudulent, medical care and services. Finally, in this new millennium, insurance carriers and their legal counsel are realizing the strategic advantage of battling back against such improprieties by seeking recompense of payments for excessive and improper treatment on both first and third party claims.

The combination of the Great Recession, smarter business practices, including metric analysis, and recognizing the high cost of insurance fraud for innocent consumers causes insurers to no longer ignore seeking recovery for fraudulent medical care. From the federal indictment of a physician performing unnecessary spinal procedures to the arrest of a physician for more than \$2 million in false insurance billings, both public and private investigators are taking much more interest in the \$2 trillion spent annually in the U.S. on health care. Estimates show that at least \$68 billion of that figure is lost to fraud annually.

According to the Internal Revenue Service, health care fraud investigations are up 74 percent within the past two years. In 2012, the U.S. Department of Justice opened more than 1,000 new criminal health care fraud investigations involving 2,000 potential defendants. That same year, a total of 826 defendants were convicted of health care fraud related crimes. The future of the Patient Protection and Affordable Care Act, also known as "Obamacare," spells the potential for even higher amounts of health insurance

fraud. Health insurers and property and casualty carriers must understand the seriousness of these issues and also the financial impact upon their business if left unchecked.

The reasons for proceeding with affirmative medical recovery actions are myriad. Successful actions serve honest policyholders by keeping premiums low, rewarding the integrity of legitimate care providers, and ultimately saving the insurance carrier costs while recouping monies improperly paid. Such actions, however, are not without peril when conducted improperly.

One of the primary reasons for today's medical fraud crisis is the insurance industry itself. For decades, we increasingly paid higher sums as allegedly "nuisance value" for questionable injury claims and attendant medical treatment and procedures. Especially after the Great Recession, many insurers cut expenses by eliminating special investigation unit (SIU) and claims positions, limiting the ability to review medical billing and procedures properly. Even when federal or state prosecutors tried to investigate medical providers on a regional and national level, many insurers refused to cooperate, citing internal policies and procedures, or they released information only under a "guarantee" that other insurance carriers would not be allowed to gain access to their company's information. Such actions prohibit a comprehensive investigation by public sector authorities attempting to battle medical fraud.

Slowly, insurance carriers are beginning to understand the seriousness of these issues and are taking affirmative steps to cooperate with both public and private sector efforts. Since 2003, Allstate Insurance Company has filed 47 fraud lawsuits in New York alone, seeking more than \$235 million in damages. Allstate also prevailed





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in the highly publicized Racketeer Influenced and Corrupt Organization Act (RICO) action brought against a chain of chiropractic clinics in federal court in Texas, resulting in a \$6 million verdict in its favor.

Other carriers have filed actions against entities such as the 1-800-ASK-GARY referral service. In 2009, State Farm successfully secured a verdict ordering a medical provider in Florida to pay \$3.9 million in compensatory damages and \$750,000 in punitive damages for improper services billed to the insurer. Insurers are beginning to understand that they need not go solo and may work in cooperation within appropriate boundaries. In New York, three insurance carriers joined together to file the largest no-fault lawsuit in U.S. history, seeking to recoup more than \$100 million in compensatory and treble damages for fraudulent personal injury protection (PIP) payments.

While these wins represent the national trend, insurance companies

also must be cautious in making certain these cases are researched and prepared properly and assigned to skilled counsel. A successful \$6 million verdict in favor of Allstate in 2007 in Texas was reversed when a court of appeals found no trial evidence that Allstate claims professionals actually relied upon the fraudulent misrepresentations of the defendants in determining whether to pay claims. Another case recently settled in Arizona involving allegations under federal and state RICO laws where allegedly there was no good faith basis for those allegations.

While any loss is painful, there are far more victories for insurance carriers in medical recovery actions than defeats. When the insurance carrier conducts a proper investigation and compiles the right litigation team, the results of success should more than offset any fear or risk.

It is easier today for insurance carriers to track medical fraud. Many fraudulent providers no longer operate

as local clinics but instead as a larger regional or national network. Simply searching corporate ownership of clinics, magnetic resonance imaging (MRI) centers, and physical therapy providers often will disclose whether these are truly local businesses or part of a larger network. Questionable providers often change their business names every two or three years solely to seek a new tax identification number (TIN). Newer computer programs track billing and payments based not only on the TIN, but also addresses and names of specifically licensed care providers.

There also is a migration of medical fraud. Florida, long a hotbed of fraud, has undertaken more aggressive enforcement efforts. While good for Florida, states such as Kentucky, Michigan, New York, and Wisconsin are witnessing dramatic increases in claimants, medical providers, and even attorneys migrating north in search of easy insurance targets. The largest personal injury firm in Florida now operates in the Commonwealth

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No manager wants their appraisers, adjusters and estimators passing out blank checks, but if their claim-handling skills aren't sufficient, the misapplications, oversights and errors they commit could be just as costly. For example, the difference between repairing or replacing a set of kitchen cabinets when adjusting a fire loss can be anywhere from \$3,000 to \$12,000, and that's just one example of the kind of misjudgments we see both beginners and experienced professionals make all too often.

In fact, we've identified five types of weaknesses that challenge even the most efficient and profitable claims departments.

- (1) policy interpretation
- (2) basic practices
- (3) core knowledge
- (4) estimating proficiency
- (5) technology application

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of Kentucky, along with many medical providers who own clinics in Kentucky with ties to South Florida. Organizations such as Chiropractic Strategies Group Inc. out of Louisiana and Texas continue to operate clinics throughout many parts of the U.S.

Many questionable medical providers follow the same pattern of solicitation and treatment. Through the rising use of social media, both medical and legal providers are seeking lines of communication with persons involved in accidents that will much more quickly entice them to seek treatment and representation. Services such as Auto Accident App are promoting themselves as “one touch” services in which your smartphone links you with legal representation or medical services directly from the accident scene.

Once a person is involved with one of these questionable providers, they are normally asked to commit to up to eight weeks of treatment and sign up for legal representation immediately. Billing for these services may not be excessive,

often in the range of \$5,000 to \$10,000. Questionable providers and legal counsel procure millions of dollars of recovery from the insurance industry not from high-dollar claims, but from the sheer volume of these claims, which insurers are willing to pay based upon clear liability and what appears on the surface to be reasonable treatment.

Often it is years later before insurance carriers realize the magnitude of the financial impact for payment of these questionable or fraudulent services. The ability to conduct electronic media searches, share information appropriately through insurance-related organizations, compile data via metric analyses, and encourage public information and support all contribute to an environment in which insurance carriers have the ability, if they choose, to fight back through medical recovery actions.

One of our best policy tools is the requirement in first party claims for cooperation during the claims investigation. Early recorded statements address-

ing solicitation, clinical practices, and treatment lead to better identification of files requiring further investigation. Selecting counsel specifically skilled in the field of insurance fraud and experienced in conducting examinations under oath (EUOs) results in testimony more directly targeted to identifying providers against whom medical recovery actions may be appropriate and to laying the evidentiary foundation to secure successful results, even if it may be years later.

We also must partner better with state departments of insurance and legislative leaders to continue strengthening civil fraud and misrepresentation statutes and, where appropriate, seek specific insurance fraud legislation allowing for recovery actions and greater latitude in the investigation of fraud. Many insurers battling medical fraud have found state statutes already exist—such as consumer sales practice acts, deceptive trade practice acts, and even conversion actions—that provide avenues for seeking not only financial recovery, but also punitive

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damages and attorney's fees.

The majority of states also have adopted civil RICO laws in addition to the federal RICO statutes. These statutes allow for civil recovery by individuals, including insurers, where evidence is shown of a pattern and practice of improper activities for purposes of deception. RICO actions provide insurers the ability to seek treble damages and also may permit recovery from the personal assets of clinic owners, individually licensed professionals, and even attorneys.

Insurance carriers not actively considering medical recovery actions may be doing a disservice not only to their companies, but also, more importantly, to their innocent policyholders who increasingly pay the high cost of medical fraud. A proactive approach to medical recovery actions follows a simple model for success.

First, build your team correctly. This requires senior management support and the identification of specific claims and SIU personnel who are provided high-quality education, training, and support to conduct medical fraud investigations.

Second, select the right counsel, whether it's for EUOs, claims investigations, or filing of recovery litigation.

Only use counsel with the right skills to handle these investigations and the ensuing litigation. The old days of simply selecting counsel based upon geographic location are not sufficient. Insurers must have legal counsel with the requisite skills, knowledge, and experience to handle these cases correctly.

Third, identify a qualified team of medical experts. Independent medical evaluation (IME) physicians must be fair and willing to commit to conducting a thorough review of patient files and billing records. One of the pitfalls of medical recovery is failing to recognize even with the most fraudulent of medical care providers that there still will be injured individuals who truly need medical care and for whom care is appropriate. Also consider the correct mix of experts, including orthopedic, chiropractic, neurological, and physiological as well as pain management. Experts in medical billing and coding also form a strategic part of a successful team.

Finally, work in cooperation, where appropriate, with other carriers, state departments of insurance, state medical or chiropractic boards, and recognized insurance professional organizations committed to the battle against insur-

ance fraud.

The road ahead is neither paved with gold, nor is it necessarily easy to traverse. You will encounter issues such as federal privacy laws, challenges to the release of medical records under the Health Insurance Portability and Accountability Act (HIPAA), and medical providers engaging in protracted discovery battles to try to "wear down" the insurance carrier. Courts across the country are recognizing that medical fraud is a very real and prevalent problem, and with the advent of massive health care changes on the horizon, the federal courts, especially, are more willing to consider these types of actions as meritorious when insurers present the information in a rational and analytical manner.

As with any other form of litigation, we will not win every case. We already are winning more cases than we are losing, causing more insurance carriers to consider medical recovery actions and more courts to be willing to entertain these types of cases and rule in favor of insurers on key discovery issues. If we effectively educate juries on the impact of medical fraud on consumers, these types of cases will be viewed favorably by jurors. And if presented correctly, they also will reflect our industry in a much more favorable light by demonstrating that we are battling back against medical fraud to hold down the cost of insurance premiums.

While we may, in part, have contributed to today's epidemic of medical fraud, we did not cause it solely. Along with our innocent policyholders, we all should be "mad as hell" about fraudulent claims and medical services. The question now is whether we, individually and collectively as professionals, will step up and make the choice to do something to bring about a meaningful change. **CM**

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