

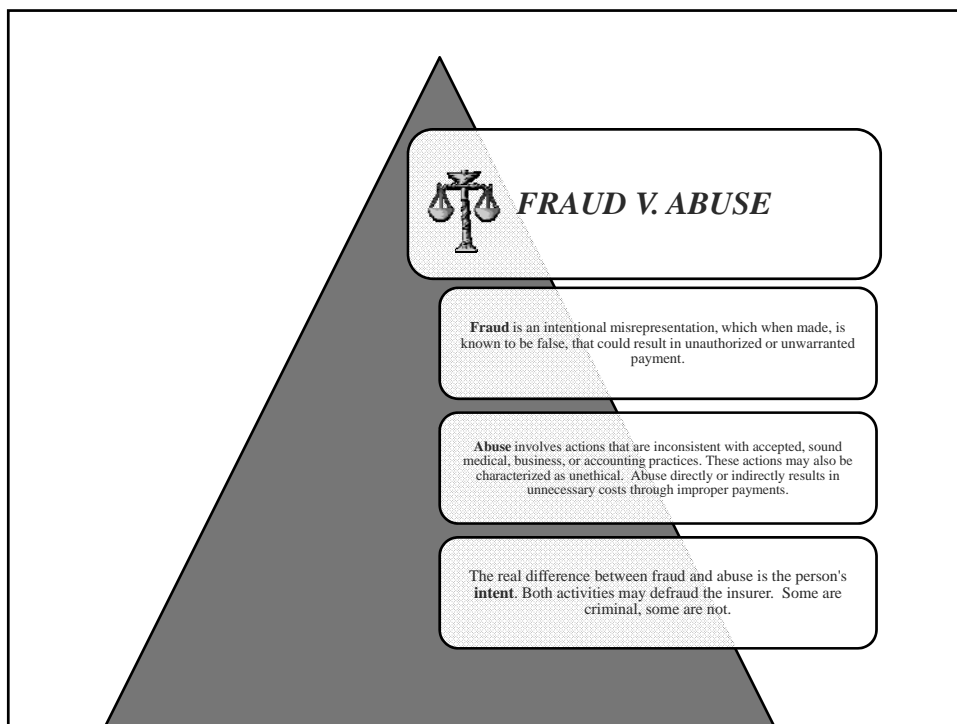
Insurance Fraud Bureau of Massachusetts

*NHCAA Institute for Health Care Fraud Prevention 2011
Annual Training Conference
Atlanta, Georgia
November 15-18, 2011*



Insurance Fraud Bureau of Massachusetts

- ☐ Public/Private investigative agency created by statute
- ☐ Established in 1991
- ☐ Authorized to investigate all lines of insurance fraud, especially auto and workers' compensation fraud
- ☐ Criminal investigations only- no civil matters handled

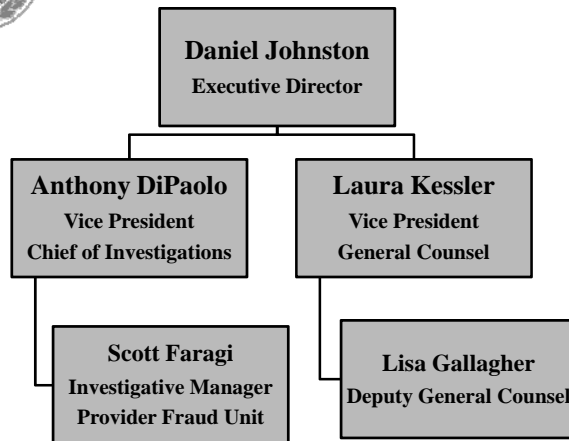


Financial Facts

❖ IFB Staff Count	56
❖ 2011 Budget	\$8.4Million
❖ Statewide P&C Premium	\$11.1Billion
❖ Cost as % of Premium	0.08%



Insurance Fraud Bureau of Massachusetts



CIFI Program

- ✦ Inception of the CIFI program launched in Lawrence.
- ✦ The formation of Community Insurance Fraud Initiatives (CIFI) throughout Massachusetts has proven to produce a positive effect on the fight against insurance fraud.
- ✦ Each CIFI is comprised of local law enforcement personnel, IFB Investigators, a designated prosecutor from the local District Attorney's office as well as the Attorney General's Office and insurance company investigators.

Claim Reduction State-wide



\$563,896,577*

** 2010 compared to 2003*

** The savings results from increased fraud fighting, as well as other factors such as yearly weather conditions, road conditions, and general driving habits.*

As of October 15, 2011:



2,688 Indictments & Complaints

791 Convictions

Workers' Compensation Insurance

Employers are required to provide benefits for illness or accidental injury arising in the course of employment regardless of fault.



Employees give up the right to privately sue their employers in return for this benefit.

TYPES OF WORKERS COMPENSATION FRAUD

- Employee Fraud
 - Working While Collecting
 - Staged Accidents
 - Prior or Non-Work Related Injuries



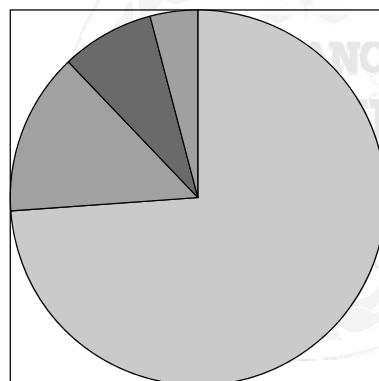
TYPES OF WORKERS COMPENSATION FRAUD

□ Employer Fraud

- Misclassification of Employees
- Understating Payroll
- Re-incorporation to Avoid Mod



Total Restitution from 01/01/1991 to 10/15/2011



□ W/C Premium Evasion
\$45,495,968
■ Automobile
\$8,625,972
■ Other Lines
\$4,945,555
■ W/C Claimant
\$2,528,405



PROSECUTIONS



- ☐ District Attorney
- ☐ Attorney General
- ☐ United States Attorney



PROSECUTIONS

- ☐ District Attorney
 - Meaningful
 - More claims = More Premium
- ☐ Attorney General
 - Resources
 - Availability
- ☐ United States Attorney
 - “Cherry Picking”



CRIMINAL CHARGES

State

- ☐ Workers' Compensation (MGL c. 152, sec. 14)
- ☐ Automobile (MGL c. 266, sec. 111B)
- ☐ Other Lines (MGL c. 266, sec. 111A)
- ☐ Conspiracy (MGL c. 274, sec. 7)
- ☐ Larceny (MGL c. 266, sec. 30)



Federal

- ☐ Mail Fraud (18 USC 1341)
- ☐ Wire Fraud (18 USC 1343)
- ☐ Conspiracy (18 USC 371)

RECENT SUCCESS

- ✦ *As a result of the revitalization of the Provider Fraud Unit, an investigation involving a 50 clinic operation resulted in a guilty plea and the closing of those clinics responsible for bilking over \$7 million related to more than 2000 fraudulent claims.*



Tu Quy Mai

The Scheme

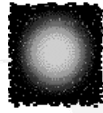
- ☐ Multi-Layered Insurance Fraud Scheme
- ☐ Involved 50 PT Clinics and Billing Companies
- ☐ Spanned 7 years and 4 Counties
- ☐ Straw Owners
- ☐ Billing for Treatments not Rendered and Not Medically Reasonable or Necessary
- ☐ Staging of Auto Accidents and Jump-In Passenger Claims by Employees of the Clinic directed by Tu Mai
- ☐ Avoided Filing Taxes and Limited use of Banks

Patterns Identified

- ☐ SIUs involvement
- ☐ Claims denied
- ☐ Clinic name changes
- ☐ Straw owner changes
- ☐ Same employees
- ☐ Same Doctor's, PTs, PTAs



End of the Day



- ❑ Over 30 different Insurance Companies found in DCD
- ❑ Over 3000 claims found
- ❑ Involving over 2000 claimants
- ❑ Over \$7 million billed
- ❑ Over \$4 million paid by insurers

FOR IMMEDIATE RELEASE
Thursday, October 15, 2009
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FORMER BOSTON MAN SENTENCED TO 10 YEARS IN PRISON FOR STAGING AUTO ACCIDENTS AND OPERATING FRAUDULENT PHYSICAL THERAPY CLINICS

BOSTON, MA - A former Boston man was sentenced today in federal court, after pleading to a 54-count Indictment, charging him with a mail fraud scheme that involved staging auto accidents and operating fraudulent physical therapy clinics and medical billing offices in several Massachusetts cities and towns.

Acting United States Attorney Michael K. Loucks, Robert Malaby, Acting Inspector In Charge of the United States Postal Inspection Service, Anthony DiPaolo, Chief of Investigations of the Massachusetts Insurance Fraud Bureau and Keith Carrough, Director of Operations of the National Insurance Crime Bureau-Area 9, announced today that

_____ was sentenced to 10 years in prison and fined \$3,758,589. He was also ordered to pay \$3,758,589 in restitution. _____, 42, of Boston, MA, pleaded guilty to the charges on December 10, 2008.

At the earlier plea hearing, the prosecutor told the Court that had the Government's evidence would have proven that from 2000 through 2006, TU QUY MAI engaged in a scheme to defraud insurance companies by means of staged auto accidents and false and fraudulent medical and physical therapy billing claims. TU QUY MAI established and operated clinics in various locations in Massachusetts, including Worcester, Quincy, Brockton, West Roxbury and at least five different locations in Dorchester. In addition to paying people to stage auto accidents, TU QUY MAI paid others to pretend to have been in auto accidents, whether real or staged, in order to seek treatment at TU QUY MAI's clinics, for which he submitted claims to insurance companies. TU QUY MAI also routinely caused physical therapists and physical therapist assistants who worked for him to prepare false records, including evaluation reports and notes of alleged treatments, when no actual evaluation or treatment had been performed. In order to avoid detection by insurance companies, TU QUY MAI routinely changed the name of his clinics and billing companies and caused others to hold themselves out as the owners. Insurance companies paid more than \$4 million in claims submitted by TU QUY MAI's clinics and billing companies.

Acting United States Attorney Michael K. Loucks said, "Not only does insurance fraud cost the industry millions of dollars, it is an affront to all of the legitimately injured individuals for whom claims are filed. We will vigorously prosecute these cases, and I believe that the Court's decision to sentence Tu Quy Mai to 10 years in prison will send a strong deterrent message that such crimes do not pay, and punishment will be severe."

Acting Inspector in Charge of the U.S. Postal Inspection Service Robert Malaby said, "Postal inspectors continue to aggressively investigate all instances where the US mails are used to commit fraud against consumers, such as insurance fraud. Violations of the Mail Fraud Statute are taken seriously by postal inspectors, and those who commit such frauds via the mail can expect to face stiff jail sentences."

Anthony DiPaolo, Chief of Investigations of the Massachusetts Insurance Fraud Bureau said, "This lengthy sentence is the result of committed efforts by several agencies on a very complicated case. This sends a clear message that committing insurance fraud has serious consequences. The Insurance Fraud Bureau continues to aggressively pursue this type of insurance fraud."

"This is an excellent example of agencies working together against the organized activities of those preying on the insurance industry and in the end the consumer. We would like to thank all involved for their extensive efforts on this case," said Keith Carrough, Director of Operations for the National Insurance Crime Bureau-Area 9.

The case was investigated by the United States Postal Inspection Service, the Massachusetts Insurance Fraud Bureau and the National Insurance Crime Bureau. It was prosecuted by Assistant U.S. Attorneys Mark J. Balthazard of Loucks' Economic Crimes Unit and Gregg D. Shapiro of Loucks' Civil Division.



- 121 months in prison
- Followed by 3 years supervised release
- Pay \$3,758,588 in restitution
- \$5,400 assessment



Examining Medical Records and Bills: CPT Coding

- ☐ *Current Procedural Terminology*
- ☐ *Published by the American Medical Association since 1966*
- ☐ *Published every year*
- ☐ *Most current publication is for 2011*
- ☐ *Provides a listing of codes and terms used for the reporting and billing of medical services and procedures performed by physicians*
- ☐ *Serves to provide a uniform and accurate means for standardized nationwide billing*

CHIROPRACTIC MANIPULATION: Codes 98940-98943



Common Codes Used in Physical Therapy and Chiropractic Clinics

- ***Physical Medicine and Rehabilitation (97001-97006)***
 - *Includes PT, OT and Athletic Training evaluations and re-evaluations*
- ***Modalities (97010-97039)***
 - *Supervised: Does not require one-on-one attendance*
 - *Examples include cold packs, mechanical traction, electrical stimulation, and whirlpool*
 - *Constant Attendance: The application of the modality requires direct one-on-one patient contact by the provider*
 - *Examples include electrical stimulation, ultrasound and Hubbard tank*

HYDROCULATOR AND PACKS (HEAT): 97010



ICE PACK (CRYOTHERAPY): 97010



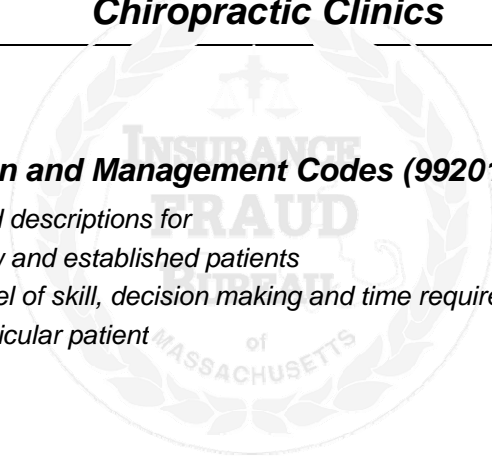
Common Codes Used in Physical Therapy and Chiropractic Clinics



Evaluation and Management Codes (99201-99215)

Detailed descriptions for

- New and established patients
- Level of skill, decision making and time required to see a particular patient



How CPT Codes Can Be Used To Commit Insurance Fraud

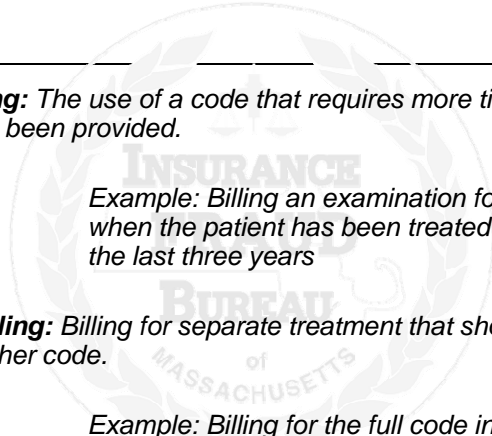


Upcoding: The use of a code that requires more time or treatment than has been provided.

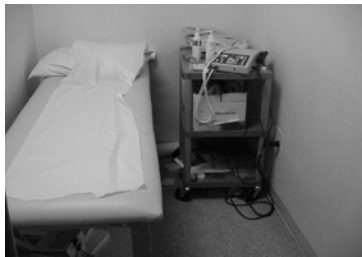
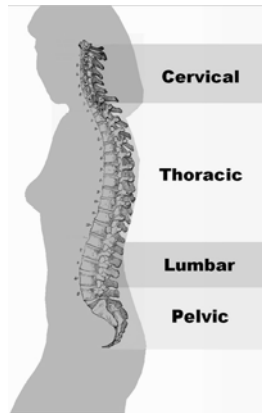
Example: Billing an examination for a new patient when the patient has been treated at the clinic within the last three years

Unbundling: Billing for separate treatment that should be billed under another code.

Example: Billing for the full code in Radiology and Imaging- once for the provider who took the x-ray, the second for the provider who read the x-ray.



SPINAL REGIONS



RED FLAGS

- ✓ Accident report inconsistent with diagnosis
- ✓ Injured worker refuses a diagnostic procedure
- ✓ *Treatment dates on Sundays, holidays or other unusual times*
- ✓ Treatment extends for lengthy time with no bills

RED FLAGS

- ✓ Clinic or treatment facility in a “less than desirable area” of the city or town
- ✓ *Physical plant of the facility too small for the type or volume of treatment being billed for inaccessible*
- ✓ Address of the clinic is not legitimate- a post office box or another type of business
- ✓ Clinic advertises free transportation or translation service

RED FLAGS

- ✓ Facility changes owners, tax ID numbers or addresses frequently
- ✓ Attorneys cards or advertisements found in clinic
- ✓ Advertises in print or on the web for boiler-plate medical reports
- ✓ *Employees of the facility cannot answer simple questions like “Who owns the clinic?” “What is the billing address?”*

RED FLAGS

- Patient was never seen at a hospital after the accident
- Long period of time passed from accident date until initial treatment
- *Treatment rendered to very young children*
- Treatment rendered more than once a day or redundant treatment- i.e. Chiropractic and Physical Therapy treatment simultaneously

RED FLAGS

- ✓ Clinic or Facility is owned by a non-medical person
- ✓ EUO and/or recorded statement of claimant indicates monetary kickbacks for treating with provider
- ✓ Medical services provided by a non-licensed employee
- ✓ *Treats patients who have to travel a great distance to the facility*

RED FLAGS

- ✓ *Same treatment on all individuals regardless of diagnosis*
- ✓ Same treatment regimen and dates on different patients
- ✓ Mistakes in spelling, name or other patient identifying characteristics
- ✓ Lab reports or physician reports appear identical in other cases by same doctor

Composition of Unit

- *4 Investigators*
- *2 Criminal Analysts*



Provider Fraud Referral Sources

- *Insurance Carriers-SIU's*
- *IFB Task Forces-CIFI's*
- *Law Enforcement-FBI, IRS, HHS, SSA*
- *Prosecutorial Agencies-OUSA, OAG, DAO*
- *Regulatory Agencies - DPL, BORIM*
- *Unsolicited Referrals-Policyholders*
- **IFB Hotline 1 800 32 FRAUD**



Provider Background Investigation

- *Sec. of State-Corporations-Link Analysis*
- *Business Certificates on File*
- *Assessors Office-Who is the Property Owner?*
- *Databases-Accurint / ISO / Google*
- *Identify TIN Numbers for TIN Run*
- *Carrier Referral Expansion*
- *Contact DPL / BORIM*



Provider Background Investigation (cont.)

- *DCD*
 - *All Closed Auto Claim Report – Assess Volume*
 - *SI report – SI involvement (EUO's, Recon, MRR, IME)*
 - *Denials by Carrier*
 - *Pairing Reports – Attorney Links*
 - *First Date of Treatment Report*



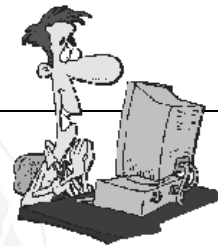
Active Provider Fraud Investigation

- *Massachusetts Department of Revenue (DOR)*
 - *Employer WR-1's – ID Quarterly Payroll Employees*
 - *Employer Corporate Tax Reporting*



Active Investigative Steps

- *CJIS / BOP / Triple III / WMS*
- *HSI (ICE) – Immigration Entry Query*
- *Accurint / Google / Assets – Property*
- *Request TIN Run Data*
- *Request Related / Relevant Claims*



Identify Employees

- *Surveillance*
- *Claim File Review*
- *Other Misc. Intelligence*



Assemble the Investigative Team

- *Multi-Agency Investigations-Utilize the TEAM Approach*
 - *Focus on the Goal*
 - *Everyone has a Role*
 - *Commitment to the Case*
 - *Best Resources*
 - *Most Experience*
 - *Delegate Responsibilities*
 - *Respect Agency Rules-IFB, FBI, IRS*
 - *Keep Personalities in Check*





Law Enforcement Partners



- ❑ *FBI*
- ❑ *IRS*
- ❑ *HSI (formerly ICE)*
- ❑ *USPIS*
- ❑ *MA State Police*
- ❑ *OIG HHS (Health & Human Services)*
- ❑ *OIG SSA (Social Security Admin.)*

Making the Case



- ❑ *Determine the Fraud Scheme*
 - *Billing for Services not Rendered*
 - *Up Coding/Unbundling*
 - *Medical Identity Theft*
 - *Unreasonable / Unnecessary and Excessive Treatment*
 - *Tax Avoidance Scheme*
- ❑ *What crime/s does the evidence support*

Advanced Investigative Techniques

- ❑ *Subpoena Records*
- ❑ *UC Operations*
- ❑ *Search Warrants*
- ❑ *Trash Runs*
- ❑ *Interviews*
- ❑ *Grand Jury*



UC Operations

- ❑ *Pros:*
 - *Critical in Provider Fraud Cases*
 - *Whenever Facts Presented Support Use*
 - *Used Mainly to Obtain Probable Cause for Future Actions.*
- ❑ *Cons:*
 - *Labor Intensive*
 - *Be Aware of UC Security Issues – Unarmed?*



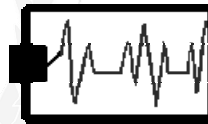
Search Warrants

- *Gather and Assemble Facts to Show Probable Cause*
- *Usually Serves as a Foundation for Further Investigation*
- *Review and Analyze all Documents*
- *Information Assembled and Used During Interviews*



Provider Fraud Trends

- *Shift from Auto to WC Carriers*
- *Diagnostic Testing Fraud*
- *Medical ID Theft*
- *Increase in Billing for Services not Rendered-(Bad Economy?)*



Lessons Learned



- *Early-On Prosecutor Introduction*
- *Multi-Agency Cooperation and Relationships*
- *Tell the Whole Story*

Questions ?

