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Stormy Weather

by Brad S. Linder

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As I write this op-editorial and introduction, I notice significant turmoil around us all. OK, massive turmoil is the proper label for the oil spill in the Gulf of Mexico. No dispute there! Iran and Afghanistan? Status quo turmoil, but at a high level too. On the home scene, we've had a number of changes in federal regulations affecting the insurance and financial industry. I doubt Congress is done with legislation, but we're at that very bad time for getting further accomplishments in this session of Congress. It's considered a bad time because of the political posturing for the upcoming elections. Whoever wins this election sets the legislative tone for the next two years.

Did you know that turmoil continues to touch the Medicare system? A recent broadcast appeared on the TV show "60 Minutes" concerning fraud perpetrated under the Medicare system. For reference, that broadcast aired in early September 2010. In my opinion, it was a very good report – highly disturbing when one considers the extent of fraud is estimated to be costing us taxpayers ***billions*** in dollars. Not only are the amounts staggering, but the ease with which it demonstrably occurred in that investigative television report is shocking.

It was informative to learn that the Medicare facilitation of payment was defined by Congress to overcome the perception that reviewing Medicare claim payments would be a long, drawn-out affair. Hence, the required payments on submitted claims must occur within a defined time period (in days). As the television report clearly and strongly asserted, it's a "pay-now, chase-the-money-later" method which hopes that fraud amounts or wrong payments could be clawed back (recovered) into the Medicare coffers. It is unfortunate that this claim payment design actually facilitates the "take-the-money-and-run" approach to a particular type of fraud. The report demonstrated the ease at setting up bogus medical supply companies approved as a Medicare provider. Did I mention that Medicare was ***not*** running background checks as a procedure? By the time that Medicare or FBI officials start an investigation, the fake medical supply company has disappeared and set up shop somewhere else as a new fake company. Too late; easily tens of thousands of dollars already laundered. Background checks on the health care providers on a nationwide scale does cost time, a lot of effort, as well as money. The report asserted the cost is well worth the benefits.

The interview with the now former director of Anti-Fraud Efforts for Medicare was helpful. Efforts to detect, control, prosecute and recover on fraud were reported as limited by Congressional funding levels. The implication from the report is that understaffing and lack of resources to combat the fraud is political in nature. Further, it was noted at the time of airing of the report that that director had resigned without further commentary.

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Fortunately, we have a new director seated. In late September, I found a *USA Today* front-page article reporting that the new director of Anti-Fraud Efforts was instituting a fingerprinting effort on health care providers as one new protocol for background checking. Known criminals, with or without an alias, setting up medical supply companies that bill Medicare should be a permanent red-flag reality check. Glad to see we have a captain at the helm of this ship as we sail through stormy seas. Clearly a vacancy in this job is unacceptable.

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Further, the television report identified still-active types or methods of highlighted fraud including:

- **Lack of proper** destruction for records, particularly including medical records from hospitals, doctor's offices and clinics. Records include patient name, patient address and Social Security number. Records may include medical procedures or similar sensitive information providing criminals easy targets for billing and what to bill for. A common method to obtain the patient information is by "dumpster-diving." Criminals hire youths to do the diving, paying them per bag from the targeted dumpsters.

- **Identity theft** of the seniors including obtaining name, address and Social Security numbers from financial institutions or employers that do not properly safeguard or destroy such sensitive information.

- **Hiring** (paying with cash or cash equivalents) of the poor or vagrants in order to submit bogus information and claims under a legitimate name with a willing signature. [Be forewarned that they sometimes hire the not so poor!]

The fraud did not exist solely with Medicare claimants. Fraud examples existed for seniors who had not made a Medicare claim yet.

The report identified two case examples where the seniors reported back to Medicare officials of the fraud apparent in the statements sent to the seniors. The first senior has been reporting the instances of problems for the past six years without apparent resolution. It is clear that if the subject seniors are reporting that fraud is occurring on their accounts, then a red-flag reality check should occur.

Even though the insurance industry trains employees about appropriate data handling and privacy under HIPAA requirements, the television report highlighted that not all doctor's offices practice safeguarding client information well enough. The proper maintenance and disposal of the client's information appears to be problematic still.

To contrast with Medicare, the insurance industry keeps moving forward with improvements. We are in the process of trying to simplify our health records. This includes reporting standardizations, moving more towards electronic management of insurance data including the claim reporting documents, improving on HIPPA privacy, all the while trying to deter fraud. The insurance industry has been moving steadily forward for years. Perhaps the new director of Anti-Fraud Efforts at Medicare would welcome our collective experiences, insights and advice. I am certain that our industry would benefit by the advice of the director as well.

In this issue, we have evidence of advice and direction we are taking into our future. Our Chairperson's Corner written by Mark Costello will give you a sense of direction with encouragement to be an active part of our journey. "Straight Through Processing" may be an unfamiliar term to many. Therefore, I would like to introduce Sandra Latham as the author to educate us. I would like to introduce another article, "Independent Review of Long-Term Care Benefit Trigger Decisions" that has been written by Barbara Rothermel. It is timely in the context of claims. I hope to raise more discussion on each of these topics.

Many thanks go to each of our esteemed authors. ■