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Principles of Medical Fraud Investigations, Part I: What's the Problem and What Does it Look Like?

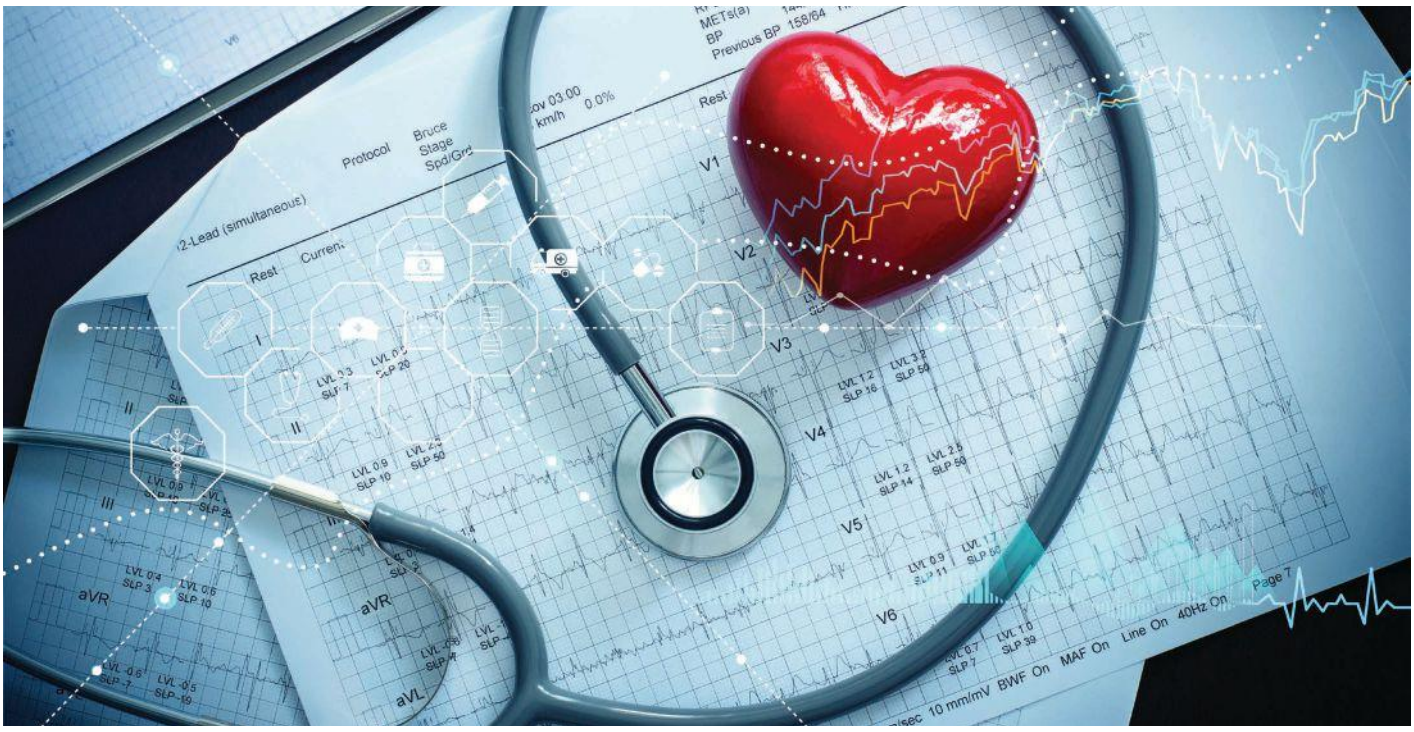
Within the SIU field, we often hear that organized medical fraud is a scourge, that it is everywhere and that it is costing the insurance industry billions annually. Is it true? What does it look like? How do we investigate and defend against it? Those of us who serve the SIU industry as legal counsel are fluent in this language, but we know that some of the most prominent national insurers, not to mention less affluent regional carriers, do not necessarily know what to look for or what to do with organized medical fraud if they encounter it.

Although I have written extensively about medical fraud in previous columns, I thought now would be a good time to offer a basic survey of the subject for those who are unfamiliar with it and a refresher for those who are. Over my next two columns, I will offer an overview of this important topic so that, hopefully, insurers can head into 2025 with a renewed and clearer focus on fighting back and keeping the perpetrators at bay.

ORGANIZED MEDICAL FRAUD: THE SCOPE OF THE PROBLEM

The first principle to recognize is that, yes, organized medical fraud is indeed real, it is indeed a financial scourge, and it is in fact costing the insurance industry and its policy holders (that is to say, *all of us*) billions annually. According to the Coalition Against Insurance Fraud's comprehensive 2022 study, insurance fraud in the U.S. costs $308 billion annually. This figure includes all claims, but of that total, a huge portion is organized medical fraud. Workers' compensation fraud alone costs $25 billion annually. The largest cities, such as Chicago where I spend so much of my time, are always hot zones for this multi-billion-dollar industry.

Who pays for all that fraud? We all do. Every time we receive the unwelcome news that our home and auto premiums have increased, we can thank medical fraud perpetrators for that price increase.



WHERE IS THE SCOURGE OF ORGANIZED MEDICAL FRAUD MOST PROMINENT?

Large cities and major metropolitan areas happen to double as the largest and major hotspots for organized medical fraud. There are several socioeconomic reasons for this, but two reasons stand out as the most significant. Both have to do with the presence of willing medical patient claimants.

The largest U.S. cities tend to feature the largest disparities in income levels amongst communities. Some communities are truly depressed economically. People of limited financial means who struggle to make ends meet, consequently, are the target zone bullseye of chasers and recruiters for medical fraud schemes and their get-rich-quick promises. Most medical fraud schemes feature economically disadvantaged people as their patients simply because some of these people are so desperate for the money that they agree to take part. It is cynical exploitation of human suffering at its worst.

Second, the three largest cities at any given time: L.A., New York, Chicago, for instance, always seem to have the highest populations of undocumented migrant workers. To be clear, this is not a political observation; it is a demographic one. These folks have often spent years in the trades or in other physically demanding occupations and they may have all sorts of pre-existing physical maladies, but if SIU investigators cannot locate any prior medical records in their countries of origin (always a very challenging endeavor) then the first dubious physician who produces an MRI of an allegedly injured portion of the anatomy after an alleged accident gets to claim that the injury is the result of the subject accident. Additionally, undocumented workers who wish to remain in the U.S. can be pressured to play along with fraud schemes or risk being deported. Fraud scheme organizers do not hesitate to prey upon the vulnerable while in pursuit of claims dollars. Many of us SIU attorneys have experienced the scenario in which we have a large settlement check, in hand from the insurer and are simply waiting on plaintiff's counsel to provide a signed release which ultimately does not and never will arrive. The plaintiff, who pretty obviously was not a legal resident, is gone, never to be seen again.

THE THRESHOLD CONSIDERATION: UNDERSTANDING THE MEDICINE (NOT ALL AGGRESSIVE TREATMENT IS FRAUD)

In order to correctly identify a procedure or pattern of treatment as fraudulent, we must first understand the relevant medicine and governing standard of care. To be clear, in the SIU field we do not defend injury claims on the basis that the treating physician breached a standard of care. We are not medical malpractice practitioners. However, standards of care are illuminating in helping us understand when certain treatment is necessary and how it should look on the records.

Yes, interventional pain relief injections of the discs and facets of the spine are a frequent target of medical fraud investigations, but they are also an effective treatment of chronic pain that enjoy wide use in the pain management field. The first step, therefore, is educating ourselves about these procedures so we know how they work, when they are and are not medically necessary, how much they should cost in any given geographical region and what the medical records of these procedures should contain.

Do not go it alone in this critical step. If you are not certain, reach out to experienced SIU counsel. I and other attorneys who service the SIU industry are always happy to take your call and discuss your questions free of charge. Enlist the aid of medical experts as well. Who better to comment on the proper use of any given medical procedure than a board-certified physician who practices in the same field? We experienced SIU counsel work with medical experts often enough that we can reach out to them and track down answers that we may not immediately know ourselves.

Understand as well that the standard of care applicable to any medical procedure contains necessary elasticity so that doctors can safely use their professional judgment to treat their patients aggressively if need be. Nine out of ten doctors might not perform a radiofrequency ablation of a damaged nerve root in the spine within the first three weeks of pain symptoms, but that does not mean that the one doctor who would has committed fraud. He or she is just exercising their professional judgment and understanding of their patient's condition in service of making that patient well as soon as possible. Standards of care allow for that. Merely being aggressive in the treatment of symptoms is rarely fraud.

In my next installment of this project, I will explore what medical fraud looks like, once we understand what the underlying medicine entails. I will share actual medical record exemplars, scrubbed of all identifying information in order to comply with HIPPA, to help illustrate the point. Spoiler alert: you are likely to miss it at first glance. And that, dear readers, is the perpetrators' goal. See you then!

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