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Health Care Law

Insurance Fraud Prevention and PIP Disclosures: What Every PIP Attorney and Medical Provider Needs To Know

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What do "predictive modeling" and "fraud scoring" have to do with arbitrations to recover personal injury protection (PIP) benefits? In some cases, the results generated from these fraud detection techniques may result in a stay of arbitrations, an insurance fraud complaint, a referral to the Office of the Insurance Fraud Prosecutor and an inquiry by the State Board of Medical Examiners. While government resources in tandem with insurers are developing highly sophisticated and collaborative methods to detect fraud, information acquired during the course of PIP proceedings are serving up fraud fodder for protracted and costly litigation under the New Jersey Insurance Fraud Prevention Act.

Increasingly, coordinated efforts between government, personnel and technology have enhanced the ability of insurers to develop predictive models of fraud behavior. Predictive modeling involves the review of data to detect statistical patterns in previously discovered fraudulent behavior and establishes models that assign fraud scores on new claims with similar characteristics and patterns. By way of example, insurance fraud investigators may be alerted to certain treatment routines by referring providers or providers treating the same family members multiple times per week for the same chronic injury. Predictive models are then created to target similar cases that have had a high statistical propensity for fraud in the past and provide data for investigators to "flag" suspect claims that follow that pattern. At the same time, innovative technology, including predictive modeling computer software, similar to that used by banking and telecommunications companies to spot fraud, has been approved by the federal government to analyze and target potential health care fraud in real time. Julie Malida, "The Changing Face of Health Care Fraud Detection — Predictive Analysis," 15 *BNA Health Care Fraud Report* 4, p.191 (2011).

Successful deployment of fraud detection technology largely depends on the efforts of insurance investigators. To this end, regulations promulgated by the Department of Banking and Insurance require New Jersey insurance companies to create, file and implement fraud prevention and detection plans (fraud plans) outlining guidelines to handle potential fraud cases. An integral component of the fraud plan includes the development of a fraud investigative department, often referred to as the special investigations unit (SIU). Referrals to SIU personnel are made from a variety of sources, including suspect claims forwarded by claims adjusters, investigative reports and "tips" from former (often times disgruntled) employees of medical providers. With the help of predictive modeling and other fraud detection techniques, the SIU may investigate a patient, medical provider or medical practice for a variety of reasons including, but not limited to, billing irregularities, provider referrals that violate the Patient Ethics and Self Referral Act (known as the "Stark Law"), suspected staged accidents and multiple patient claims. If a claim, provider or insured is targeted in the investigation, a "block" is instituted, and all claims associated with the suspect insured or medical provider are denied pending further investigation.

While technology and investigative personnel act in concert to detect fraud patterns and highlight suspect claims, information procured during the PIP arbitration process is perhaps

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the most dangerous weapon insurers rely upon to initiate and bolster fraud litigation. Examinations under oath (EUO) taken years after an insured was treated for accident injuries provide a perfect opportunity for insurance lawyers to add material to potential fraud claims. For example, an insurance lawyer may rely upon the failing memory of a patient who was treated years prior to his EUO and who can no longer recall whether he visited the doctor twice a week, twice a month or every three days. Insurance lawyers may ask for descriptions of individuals providing care, and in response, a patient may confuse a licensed provider with an unlicensed employee, or forget the amount of time spent in the provider's office or the nature of the modality received. Confronted by leading and often confusing questions on the part of counsel, an insured's EUO record can become a catalyst for further investigation or a fraud complaint.

Similarly, requests for the EUO of providers and provider employees, accompanied by a subpoena for documents, can also serve to fuel the fraud machine. Typically, insurers seeking this type of discovery are looking for ways to support a claim that a practice is improperly structured or otherwise operating in violation of medical regulations. In an effort to create a record, insurers may seek information unrelated to the provision of medical services, opting instead to explore the structure of the practice and the referrals made to other providers. Such claims can translate into a fraud action and destroy a medical practice if a practitioner defending the EUO is without sufficient health care law knowledge to defend against this type of discovery and inquiry.

Once an insurer has developed enough "discrepancies" in connection with claims for reimbursement, it may institute an action seeking the stay of all further arbitration proceedings until the inconsistencies are resolved. On the other hand, an insurer may choose instead to file a complaint under New Jersey's most punitive civil statute, the Insurance Fraud Prevention Act, N.J.S.A. 17:33A-1 et seq (IFPA).

In an attempt to "root out fraud" in the health insurance context, insurers rely on the strong arm of IFPA to recover a wide range of remedies against fraudulent claims submitted by insureds and providers. IFPA provides for the recovery of compensatory, treble and punitive damages, investigation costs and attorneys' fees by a successful claimant who demonstrates that a defendant engaged in a pattern of violating its provisions. In addition to the significant civil penalties associated with a violation, complaints filed under IFPA must be simultaneously forwarded to the Office of the Insurance Fraud Prosecutor, thereby allowing the government to intervene in the action and exact additional penalties for violations. Special concerns arise for medical providers when an allegation under IFPA is asserted and the Board of Medical Examiners (the Board) is alerted to the action. In some cases, the Board may launch a separate inquiry of the allegations in order to determine whether regulations have been violated or patient care is at risk.

IFPA contains five primary bases pursuant to which liability may attach directly to an individual or medical provider. A person or practitioner violates the Act if he: 1) presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy; 2) prepares or makes any written or oral statement that is intended to be presented to any insurance company in support of or in opposition to any claim for payment or other benefit pursuant to an insurance policy; 3) conceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to any insurance benefit or payment; 4) prepares or makes any written or oral statement, intended to be presented to any insurance company, for the purposes of obtaining insurance; or 5) conceals or knowingly fails to disclose any evidence, written or oral, which may be relevant to a finding that a violation of the provisions has taken place.

Although the language of the IFPA suggests that it seeks redress against false claims, i.e., staged accidents or billing for services that were not rendered, insurance companies have alleged fraud in the face of seemingly innocent omissions as well. While in some cases the allegations of fraud may be amply supported, in others minor billing errors, unfounded "tips" from former employees and information procured from pre-arbitration discovery (including specific references to EUO testimony) may form the basis for a fraud action. Given the high stakes involved, careful consideration must be given to each stage of the arbitration process to defend against these allegations.

Insurers have successfully embraced the broad framework of the IFPA as a basis to support demands for a stay of pending PIP arbitrations, block payments to providers and institute unduly protracted litigation that wreaks havoc on medical practices. The threat of a parallel law-enforcement and Board action, in combination with the plethora of civil remedies afforded under the IFPA, make any allegation of fraud a serious concern to medical providers and the lawyers representing them. In light of the vast resources in the hands of insurers, including trained investigators, innovative technology and the highly punitive remedies afforded under the IFPA, it is increasingly important for PIP practitioners to be aware of the potential signs that an insurer is attempting to create a fraud record. Understanding that fraud claims come in many forms, ranging from documentation errors to Stark Law and Anti-Kickback violations, is the first step in knowing whether your experience can sufficiently prepare your client in the PIP venue or whether you need to enlist the assistance of a health care practitioner. ■