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Medical fraud north of the 49th

When it comes to health care fraud, it may be safe to conclude that Canadian physicians have a cleaner bill of health than many of their American counterparts.

Certainly there have been no eye-popping cases of physician fraud on the order of the multibillion dollar cases seen in the United States in recent years (www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4346).

But it would entirely erroneous for Canadians to smugly assume that every doctor is squeaky clean, or that the problem of health care fraud is non-existent north of the 49th parallel, as the aggregate level of fraud by physicians, pharmacies and patients probably doesn't differ much, whether it's the US, Canada or any other nation on the planet, according to the Canadian Health Care Anti-fraud Association (CHCAA).

Moreover, the extent of fraud in Canada may be more difficult to detect and investigate because there is no federal oversight in the area, says Joel Alleyne, executive director of the CHCAA, a nonprofit organization created in the year 2000 to "give a voice to the public and private sector health care organizations interested in preventing fraud in the Canadian health care environment."

Alleyne says it's long been held that between 2% to 10% of every health care dollar in North America is lost to fraud and "I don't believe it's any less prevalent than it is in the US or in Europe." With the Canadian Institute for Health Information projecting outlays in Canada at $207 billion this year, that could translate into upwards of $20 billion per year being funneled inappropriately into someone's pockets. But a precise breakdown of how much of that is respectively attributable to physicians, or to other health professionals, pharmacies or patients is entirely unknown, as there is no standardized reporting of cases of fraud in Canada or sharing of information between jurisdictions.

"Our goal is to eliminate fraud. Will we ever do that? We have as much chance in reaching that end goal as eliminating cockroaches from the earth. They were here before us and they are here after us. But we're going to do our best to shut down the different things that we see people doing and the different fraudsters. We believe it's in the interest of the profession and, in this particular case, the physicians."

What most people don't realize is that fraudulent activity by health care providers can put patients' lives at risk, or have a detrimental impact on their future insurability and employability, Alleyne says, adding that fraud extends well beyond overbilling health insurance plans to include such things as the performance of unnecessary surgeries or the distribution of counterfeit chemotherapy drugs.

Broadly speaking, though, the nature of the fraud undertaken by physicians doesn't differ much, whatever the nation or jurisdiction, he adds. "We see people billing for services that weren't performed. We see people upcoding or doing one thing but billing another. We see them allowing unlicensed people to treat and we see them accepting briberies and kickbacks."

Among other types of health care fraud that the CHCAA has identified are the performance of medically unnecessary services, misrepresentation of services as being medically necessary, unbundling of services for separate billing, theft or misrepresentation of identity, exaggeration of identity, exaggeration of illness or injury, shopping for medications from multiple physicians, and misrepresenting eligible dependents, (www.chcaa.org/education/cost_of_fraud.php).

Although punishable under the Criminal Code of Canada to a maximum 14 years in prison, medical fraud isn't as aggressively prosecuted in Canada, in comparison with the US, Alleyne says. "Government in the US has got a number of task forces and they're looking at people in a number of areas and they're making examples of these people. They're probably being more aggressive in terms of taking people to court. … We deal with this on a province by province basis, so not all provincial ministries have the same level of attention on them."

As a consequence, only the "tip of the iceberg" is being caught, he adds.

But Health Canada scotches the notion that there is a need for some manner of federal involvement or federal mechanism to crack down on health care fraud, arguing that would be an intrusion into provincial jurisdiction over health.

In areas of health over which the federal government has jurisdiction, such as the provision of Aboriginal health, the incidence of health care fraud has been minimal, Health Canada spokesman Christelle Legault writes in an email. "Since 2006, five pharmacy cases have been referred to Health Canada's Audit and Accountability Bureau (AAB) to investigate and the Department of Justice to recover potential loss of funds due to possible fraud amounting to approximately $5.5 million."

"The five pharmacy cases related to potential fraud represent approximately 0.8% of the 650 pharmacy audits. Similarly, the $5.5 million related to possible fraud represents approximately 0.2% of the $2.5 billion in total pharmacy spending in the same period," she added, noting that four of the cases remain under investigation or are before the courts. "In rare cases where potential fraud is detected, Health Canada takes action as quickly as possible to put a stop to it."

Others similarly claim that the problem is all but non-existent within their jurisdictional domain. "It is believed that the incidence of health care fraud in Manitoba is very low in terms of total cost to the system," Doug Agnew, audit investigations officer for Manitoba Health, writes in an email. "There is no evidence that the problem is growing. The province has not seen any new trends with respect to health care fraud."

While there have been cases involving improper billing by a physician, that has typically resulted "either from misunderstanding of the Rules of Application or liberal interpretation of same" and has not led to prosecution, Agnew adds. There've been "approximately three or four prosecutions of health care fraud" and they've been related to the use of a false identity to obtain a medication.

"The province has also had upcoding and unbundling of services but have not treated them as fraudulent. Rather, these are considered errors by the physicians and have made recoveries of monies," Agnew writes, adding that in 2010 and 2011, Manitoba Health recovered $334 000 and $198 000 respectively for inappropriate billings.

Agnew argues that existing checks and balances within Manitoba's system serve to constrain fraud, including random audits of health care providers, a prescription drug

monitoring network, and a committee that reviews the files of patients who are users of the system to determine if they are prescription shopping.

Alberta similarly argues that its annual review of more than 200 physicians is a major constraint on the incidence and growth rate of fraud, as is the existence of a branch of Alberta Health that reviews practitioner billings and tries to track down fraud through tools like data mining.

"When investigations identify inappropriate claims resulting in overpayments, the branch works with the physicians to recover these amounts and educates the physicians on the correct use and applications of health service codes," Howard May, a spokesperson for Alberta Health, writes in an email.

Recoveries have risen over the past three fiscal years from $752 000 in 2010/11, to $1.03 million in 2011/12 and $1.61 million through October of the current fiscal year, but May argues those figures are misleading because of reporting overlaps.

Ontario also says it has constrained the level of health care fraud through "key fraud control measures."

"These include the Provider Payment Unit, which analyzes and reviews fee-for-services claim submissions to ensure providers are billing OHIP [Ontario Health Insurance Plan] appropriately, and the Drug Program Services, which coordinates and supports province-wide post-payment verification of Ontario Drug Benefit (ODB) Program prescription claims submitted by pharmacies," Zita Astravas, a spokesperson for the Ontario Ministry of Health and Long-Term Care, writes in an email.

The province also provides a toll-free fraud hotline to the public and health care providers to report potential OHIP fraud to the ministry, issues verification letters to select consumers to confirm that services were provided and correctly billed, regularly analyzes its claim payment system to detect patterns of activity that may indicate fraud and contracts with a special health fraud unit within the Ontario Provincial Police (OPP) to investigate fraud involving OHIP or inappropriate drug diversions and payouts under the province's drug benefits program.

The OPP says it can't put a number on the extent of fraud but notes that "fraud is not confined to borders."

"Things that happen in the US happen in Canada, happen in Europe, and happen anywhere, and in any kind of fraud where there is a way for people to exploit a service or a system – people will do that," adds Scott James, detective staff sergeant and unit commander of health fraud investigations at the OPP's Anti-Rackets Branch.

The unit, which was formed in 1998 and is funded by the Ontario Ministry of Health and Long Term Care, utilizes a number of techniques to hunt down fraud, James adds. "One is obviously going out to interview people, accessing data from the ministry, sharing the billing records that they're concerned about. And we interview patients and staff and other people who might have some information to support either an allegation of fraud or to refute an allegation of fraud."

Since its formation, it has laid 10 023 Criminal Code charges (through August), resulting in 1800 convictions to date (some cases remain before the courts), as well as 128 violations of provincial law, resulting in 57 convictions and $9 million in restitution and forfeitures, James adds.

How indicative might that be of the level of health care fraud in Canada and its cost to Canadians?

There's no way of knowing that, even on a province-by-province basis, James says. "We don't quantify it. We really don't track that. What we know is that there's sufficient work out there for our unit to keep going every year with referrals from the ministry and referrals from other sources to justify the fact that we're here. I think there's a deterrent effect as well when our unit lays charges … But obviously I don't have that crystal ball to be able to quantify it." — Adam Miller, *CMAJ*

Editor's note: second of a three-part series.
Part I: **White coats and white collar crime**
(www.cmaj.ca/lookup/doi/10.1503/cmaj.109-4346).
Next: **Medical fraud: "one of the last taboos in society"**

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