The recent events surrounding the incidences of heparin contamination from China1 that was possibly willful in intent, as well as the dramatic increase in the estimated cases of deaths associated with heparin, point to a very troubling matter of terrorist elements in the medical product chain security.1 Vital records, financial accounts, and personal health records continue to be compromised at the nation’s largest data warehouses.2-6 The massive loss of personal data and customers’ transaction files that have been aligned for marketing purposes poses not only an identity loss risk, but also raises concerns about the healthcare delivery system’s ability to protect personal health information and institute fraud-related prevention activities.

In addition, new projects, such as the Medicare Part D program, may feed the opportunity for unwarranted graft and corruption, because of the novelty of the product and the lack of process controls for claim payments needed to establish adequate loss prevention techniques (ie, “audits”). Programs and tools used to audit services were not adopted early in the program by many health plan sponsors and participants in reimbursement projects, because of the novelty of the program, as well as the frequent changes requested by the Centers for Medicare & Medicaid Services. Society must have a baseline degree of trust in its systems to ensure that the identity of the individual requesting medical services is indeed that of the legitimate person who is receiving the service.

Scope of the Problem

Data contained in electronic warehouses include all aspects of a person’s life—age, sex, credit, personal shopping habits, financial worth, legal actions, health status, social security numbers, license numbers, educational status, and many other parameters. These data also contain insurance reports, examination results, past medical payments to various healthcare providers, preexisting medical conditions, and possibly the details of current medical benefit coverage. These are all gleaned from multiple sources and are nicely aligned for use in sales prospecting.

These data may be sorted, filtered, and aligned to target potential customers with razor-edge accuracy for marketing purposes. These data are for sale to telemarketers, mass mailers and catalog providers, insurance companies, and other prospectors with elements needed to focus success in the sales process. These data are also neatly arranged for marketing and sales purposes to provide new companies the tools to target-market their products.

Mr Kaye is Senior Pharmacy Director, Passport Health Plan, a Medicaid Managed Program, AmeriHealth Mercy Administrators, Louisville, KY.
With escalating medical costs and increasing resistance of payors to higher premiums, routine fraud cases occurring in payor plans and in supply and manufacturing chains contribute to rising healthcare costs.

Health plans are aware of narcotic diversion but not of diversion of nonaddictive prescription drugs or that their databases are often compromised.

In a recent survey of 750 physicians, many admitted to “gaming” the system for what they see as the benefit of their patients. And many cases of fraudulent service billings and diversion of provider reimbursements have been documented.

Counterfeit medications are being promoted unknowingly by the supply chain, with catastrophic results, leading to recalls and FDA alerts.

Implementing the preventive steps outlined in this article can minimize cost to payors.

The true scope of the data loss (or theft) is far broader than is being reported. This situation could become catastrophic in terms of payment for services and the overall integrity of our healthcare delivery process if the current trends of fraud continue. Significant problems can be expected from wrongful details being inserted into a claim history from fraudulent use of personal health services; this may unknowingly occur by the legitimate person for whom the benefits are intended and may continue until the member seeks renewal of benefits or until that member’s policy is being rejected as a result of preexisting stipulations that have entered into the health record from the fraudulent users who have accessed the services.

Today’s robust embrace of the electronic world has unwittingly made it easier to perpetrate many of the opportunities for theft, diversion, and fraud. In the years before the widespread electronic medical records (EMRs), automated call centers, and detached services, plans and providers had more live people processing and reviewing claims, but that is rare today.

The “tricks,” diversion, and fraud may go unrecognized today because of our sophisticated automated processing methods. Although some may consider this unimportant, or the value of the loss may be seen as unimportant because of the ability to increase premiums to cover the costs of the loss, this is little comfort to the individual whose health records have been compromised. (And yet, individuals who may suffer more than corporations, may at least have legal recourse if the health sponsor failed to protect personal health data.)

With medical costs now the highest in history and the increasing resistance to higher premium costs from payors, it is only sensible to recognize that fraud is taking place routinely in payor plans, supply chains, and, even in manufacturing processes. This adds to the cost burden of the employer as the payor attempts to maintain financial goals.

Abuse of Prescription Drug Benefits

In 1999, fraud specialist D.M. Disney and associates noted that the amount of dishonesty, fraud, loss, and theft in our healthcare system had reached $100 billion. With the healthcare portion of the gross domestic product now exceeding 16%, the next few years will become critical years for prevention efforts to reduce fraud, diversion, and theft, which are drivers of higher healthcare costs. The importance of loss reduction is even more critical with the massive change in Medicare Part D. The 2005 Deficit Reduction Act includes goals to reduce and prevent losses from intentional and erroneous wrongful deeds.

Pharmacy and managed care organizations are acutely aware of the existence of narcotic diversion, perpetrated by skilled professionals who use benefits to obtain medications, then resell them on the gray market to unsavory pharmacy dispensers or on the streets for high profits. The acknowledged problem with diversion of narcotics is also a problem for nonnarcotic prescription drugs, because of the high cost of popular prescription medications. It has recently been noted that the greatest number of people in the United States are now consuming pharmaceuticals at the highest level ever, and the United States is leading the world in consumption of these products. However, nonaddictive drugs are rarely seen as a potential concern for diversion by health plans. This oversight has resulted in many undiscovered diversion issues of medications and devices being sold at flea markets, on eBay, and in the shadow (gray) markets.

The term “wayward prescription” was coined to raise awareness to the intentional misuse of prescription drug benefits, using techniques for defrauding health plans, supply chains, or manufacturers.

Gaming the system

As the cost of prescription drugs rises, so does the ingenuity of perpetrators to convert these opportunities into fast cash. Complicating the issues of overall healthcare fraud and abuse is the admitted participation of some providers in wrongful, even illegal, acts. Health plans have recognized that some providers...
admit to intentionally misleading health plans to gain approval of benefits for their patients. In a 2000 survey published in the Journal of the American Medical Association, 39% of the 720 responding physicians said they sometimes, often, or very often manipulated reports to their patients’ health plan to help their patients gain coverage for needed medical care. These “manipulations” consisted of:
1. Exaggerating the severity of their patients’ conditions
2. Changing the patients’ billing diagnoses
3. Reporting signs or symptoms that the patients did not have.

A full 72% of the surveyed physicians admitted to using at least 1 of these 3 tactics in the preceding year. Furthermore, 28.5% of the physicians agreed with the statement, “Today it is necessary to game the system to provide high-quality care.” And 15.3% agreed that it is ethical to do so.

Simply stated, if the benefit terms to the members are less than the actual cost of the services or goods, and if the payment process for medical services continues to be surrounded by lack of consumer knowledge, then the opportunity presents itself for profiteering and diversion. As prescription drug costs escalate, the chances of reselling the medications, bartering, or diversion of services for financial gain increase.

Shadow (gray) market activities

Today’s injectables may be accessed by using prescription drug benefits; with costs of dosing for injectables often amounting to $1000 per treatment, this creates an incentive for profiteering. And with drug prices exceeding the cost of gold per ounce, the shadow markets for Epogen, Neupogen, growth hormone, and other injectable medications have developed with intensity. In addition to loss, these practices are also contributing to the high costs of the healthcare delivery system overall and possibly for errors in the delivery of care. Counterfeit medications are now being promoted unknowingly by the supply chain, with catastrophic results, leading to recalls and alerts from the US Food and Drug Administration.

Ironically, with the widespread electronic connectivity, it is not difficult to find willing purchasers of diverted medications or other outlets that participate in shadow market activities. These high-cost medications are easily peddled and are prime targets for profiteering. Theft from manufacturing, distribution channels, transportation, prescription drug fraud, or end-users occurs frequently. Because theft from many of these sources is unreported, except for the financial loss, it is difficult to assess the magnitude of the problem.

The penalties for these diversions and thefts range from none-to-moderate jail time, mostly based on the amount of dollars involved. Enforcement resources for prescription diversion are difficult to obtain because of the demands of competing needs. It is well known that clandestine laboratories making substances for illicit sale often take precedence in resources from law enforcement; legal drugs may seem a minor problem compared with the large dollar amounts needed to deal with illegal drug trade.

The resources needed for prosecution of prescription drug crimes are significant as a result of the intertwined police relations, jurisdictional boundaries, and surveillance needs for evidence gathering. Because of the large numbers of participants in illegal behaviors, the combined loss is significant. The variability of the schemes and the diversity of the perpetrators are contributing factors adding to the scope of the problem.

As prescription drug costs escalate, the chances of reselling the medications, bartering, or diversion of services for financial gain increase.

Diversion of prescription drugs

Diverting legal prescription medications takes various forms. Prescriptions are gained by multiple presentations of forged documents, the use of prescription drug benefit cards for other than the rightful owner of the benefit, the use of the benefit card to supply medications to a relative, a friend, or to buy favors with. Prescription drugs do not need to have a street value or a narcotic value, but a prescription has a price per unit that makes the resale appealing to the perpetrator.

In the prescription drug diversion world, a 100-count bottle of the powerful prescription pain medication OxyContin 80 mg has an average street value of about $8000, or $80 per tablet; the generic, oxycodone, is valued at 50% of this. A 500-count bottle of another pain medication, Vicodin, has a value of about $2500, or $5 per tablet; the generic form, hydrocodone/acetaminophen 5/500, is again valued at 50% of this price. Even in a dishonest process, the brand-name drug has a premium price based on the perception of a higher-quality medication.
**Procurement**

Once a thief has data elements on hand, it remains a simple task to call the health insurance provider and say that the benefit card has been lost. Most insurers have instituted policies to comply with the Health Insurance Portability and Accountability Act (HIPAA); however, HIPAA requirements may offer a false sense of confidence that the person on the phone is indeed the rightful owner of the identity. By answering a few simple questions for authentication, which may also be in the stolen data, a replacement card is easily obtained from the health plan. Often complicating the issue is that the insurer's demographic files may be out of date; even if the customer service agent questions the caller stating that this is a different address, the reply is easily covered by the thief by saying, “I’ve moved,” or by making a preliminary call that may be preceded by a call to change the mailing address. Once the health cards are in hand, the opportunities are boundless.

Taking this example further, the cards can then be used or sold with additional identification to provide a “package deal,” supporting a “total identity makeover.” Not only are members being targeted, but providers as well are targets for these fraud rings. Many cases of provider identity thefts resulting in fraudulent service billings and diversion of provider reimbursements have been documented. The following examples are ample evidence:

- On February 10, 2005, a Hunterdon County, New Jersey, healthcare worker pleaded guilty to claim fraud after submitting more than 40 fraudulent health insurance claims totaling $13,900.19

- In February 2005, 6 people were arrested in connection with a prescription drug and welfare fraud ring in Boone County, West Virginia. State troopers said a ringleader impersonated her coworkers while working at Madison Healthcare so she could call in false prescriptions for the painkiller hydrocodone.19

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- The Office of the Inspector General reported in January 2005 that scammers were getting identity information so they could file false claims with Medicare.21

- Nearly $18 million worth of reduced-price HIV drugs intended for patients in Africa were reported in October 2002 to have been intercepted by profiteers and shipped back to Europe to be sold at marked-up prices.22

- Nearly 200,000 tablets of Lipitor, the world’s bestselling cholesterol-lowering medication, “was found to be counterfeit and recalled by a small Missouri wholesaler in May 2004. Some of the pills had already reached Rite Aid and CVS pharmacies”23 by the time the report was issued.

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- In February 2005, 6 people were arrested in connection with a prescription drug and welfare fraud ring in Boone County, West Virginia. State troopers said a ringleader impersonated her coworkers while working at Madison Healthcare so she could call in false prescriptions for the painkiller hydrocodone.19

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- The Office of the Inspector General reported in January 2005 that scammers were getting identity information so they could file false claims with Medicare.21

- Nearly $18 million worth of reduced-price HIV drugs intended for patients in Africa were reported in October 2002 to have been intercepted by profiteers and shipped back to Europe to be sold at marked-up prices.22

- Nearly 200,000 tablets of Lipitor, the world’s bestselling cholesterol-lowering medication, “was found to be counterfeit and recalled by a small Missouri wholesaler in May 2004. Some of the pills had already reached Rite Aid and CVS pharmacies”23 by the time the report was issued.

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- In February 2005, 6 people were arrested in connection with a prescription drug and welfare fraud ring in Boone County, West Virginia. State troopers said a ringleader impersonated her coworkers while working at Madison Healthcare so she could call in false prescriptions for the painkiller hydrocodone.19

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- The Office of the Inspector General reported in January 2005 that scammers were getting identity information so they could file false claims with Medicare.21

- Nearly $18 million worth of reduced-price HIV drugs intended for patients in Africa were reported in October 2002 to have been intercepted by profiteers and shipped back to Europe to be sold at marked-up prices.22

- Nearly 200,000 tablets of Lipitor, the world’s bestselling cholesterol-lowering medication, “was found to be counterfeit and recalled by a small Missouri wholesaler in May 2004. Some of the pills had already reached Rite Aid and CVS pharmacies”23 by the time the report was issued.

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- In February 2005, 6 people were arrested in connection with a prescription drug and welfare fraud ring in Boone County, West Virginia. State troopers said a ringleader impersonated her coworkers while working at Madison Healthcare so she could call in false prescriptions for the painkiller hydrocodone.19

- Two former employees of major New Jersey pharmaceutical companies were sentenced in February 2005 for the illegal sale of nearly $300,000 in prescription drug samples to pharmacies in New Jersey and Florida, and for a separate scheme to defraud Schering-Plough of more than $500,000, according to US Attorney Christopher J. Christie.19

- The Office of the Inspector General reported in January 2005 that scammers were getting identity information so they could file false claims with Medicare.21

- Nearly $18 million worth of reduced-price HIV drugs intended for patients in Africa were reported in October 2002 to have been intercepted by profiteers and shipped back to Europe to be sold at marked-up prices.22

- Nearly 200,000 tablets of Lipitor, the world’s bestselling cholesterol-lowering medication, “was found to be counterfeit and recalled by a small Missouri wholesaler in May 2004. Some of the pills had already reached Rite Aid and CVS pharmacies”23 by the time the report was issued.
Wayward Prescriptions

Estimated Cost Burden of Medical Fraud

The current number of prescriptions dispensed annually in the United States is estimated to exceed $240 billion in 2008.24 This cost is staggering, but it has been increasing every year, at an average of about 7%. Previous year's pharmaceutical price increases have raised the ingredient cost of the prescription by a minimum of 5% per year. This makes the present value of nonnarcotic, nonstimulant, and nonhypnotic drugs a significant cost burden. In its 2008 Drug Trend Report, Medco reported that, for the first time ever, more than 50% of Americans are now using prescription drugs.25

This article does not attempt to detail all forms of fraud in our medical services but merely to highlight examples of the exposure of all members—plan participants as well as government agencies—to fraud and theft as a result of EMR, auto-adjudication, and failings of human oversight (Table).

Implementing Preventive Steps

To prevent or minimize the theft and abuse of prescription drugs described above, health plans should become aware of certain fraud practices and institute mechanisms to detect and prevent it.

1. Managed care plans, both commercial and Medicaid plans, often suffer from not providing tools to their members to assist the managed care organization in detecting fraud. The simple process of providing an EOB to members for prescription encounters greatly reduces prescription-dispensing fraud. Phantom prescriptions are prescriptions adjudicated using a member's identity at a pharmacy for a member who is unaware that the pharmacy is being paid for the drug as listed on the EOB. Often the driving force in phantom prescriptions presented for plan payment is the belief that the plan is unjust in its reimbursement practices. The issuance of an EOB allows the members to detect fraud in our medical services but merely to highlight examples of the exposure of all members—plan participants as well as government agencies—to fraud and theft as a result of EMR, auto-adjudication, and failings of human oversight (Table).

2. Plans often use resources while designing benefits but fail to complete the circle to ensure that if a drug is dispensed, the member receives the drug and the pharmacy is appropriately paid for it. One example is the design to track total out-of-pocket cost. Many plans have the provision for prescriptions to be called in to a pharmacy, and adjudication then takes place before the member picks up the prescription, to minimize the wait time for the member. In this scenario, the claim is processed and member accounting is done on the backside. If the member has a policy that accumulates payments to reach a deductible, the practice of calling in prescriptions and not picking them up by the member may add to reaching the deductible. To resolve this problem, if a claim has been voided or reversed, there should be a provision that the claim cost should also be removed from the accumulated totals for that member. The prescription that was not picked up may not be reversed and the dispensed drug returned to stock without a reversal of the paid charges to the dispensing pharmacy, thus allowing it to be placed back into stock. The result is a double gain for the pharmacy, which sells the drug twice. Plans should have auditing systems to look for a percentage of claim reversals and be on the alert for underutilization of a claim reversal feature.

The simple process of providing an EOB to members for prescription encounters greatly reduces prescription-dispensing fraud. Without an EOB, tracking one’s drug charges is a cat and mouse game.

3. Careful oversight should be provided to independent pharmacies that have health contracts with the provider payor. It is much too easy to fill family prescriptions for gain. Because most audits entail looking at the signature log, this can be easily addressed by audits.

4. High-cost injectables are prime targets for fraud, diversion, and theft because of the high drug ingredient cost and the low copayment often in proportion to the drug cost. Medicaid copayment is often less than $5, which buys a month’s supply of growth hormone that costs $1500; a month’s supply of injectable arthritis medication (Enbrel) that costs $1400; and other injectables that cost more than $1000 per month. Organized groups around the country are trying to get as many medications as possible. Medications are often requested for a patient’s disease states but are not being taken by the person for whom they were intended. Instituting prior authorization can prevent this practice.

5. Good accounting practices used by the pharmacy can limit thefts by employees. Purchasing accountability as well as integrated systems for accounting of amounts purchased versus those dispensed in the clinic reduce loss from theft by alerting for misaligned accounting. The awareness of all forms of surveillance is also a significant deterrent to impulsive theft.
## Estimated Costs of Fraud and Abuse in US Healthcare

<table>
<thead>
<tr>
<th>Category</th>
<th>Typical description, estimated annual costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (general):</td>
<td>False claims filed with Medicare for expensive services and devices (durable medical equipment, pharmacy supplies, and phantom drug billings from providers’ offices)</td>
</tr>
<tr>
<td>Drugs</td>
<td>Stipulated estimate by the 2005 Deficit Reduction Act for fraud/abuse recovery</td>
</tr>
<tr>
<td>Devices</td>
<td>Law enforcement authorities estimate healthcare fraud costs taxpayers &gt;$60 billion annually&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Billing</td>
<td></td>
</tr>
<tr>
<td><strong>Studies on the total cost of identity theft:</strong></td>
<td>Identity theft cost US businesses and consumers $56.6 billion in 2005&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td>Credit cards</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
<td></td>
</tr>
<tr>
<td>Personal assets</td>
<td></td>
</tr>
<tr>
<td><strong>Physicians manipulation of reimbursement rules to obtain coverage:</strong></td>
<td>A sizable minority of physicians report manipulating reimbursement rules so patients could receive care that physicians perceive necessary; of those reporting using these tactics, 54% did so more often now than 5 years ago&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Upcoding</td>
<td>Cost estimates vary considerably and cannot be verified</td>
</tr>
<tr>
<td>Unbundling</td>
<td></td>
</tr>
<tr>
<td>Phantom claims submission</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmaceutical prescription fraud:</strong></td>
<td>According to some experts, losses from Medicare fraud in 2004 were $20 billion&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Physicians billing and coding fictitious filings</td>
<td>Loss from phishing attacks was $137 million in 2004; $2.8 billion in 2006&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Inflated claims</td>
<td></td>
</tr>
<tr>
<td>Other types of improper actions</td>
<td></td>
</tr>
<tr>
<td><strong>False Claims Act (qui tam) lawsuits against pharma:</strong></td>
<td>Paying $3 billion resulting from False Claims Act (qui tam) lawsuits&lt;sup&gt;6&lt;/sup&gt; • Paying kickbacks and inducements to physicians, hospitals, and pharmacists to prescribe or otherwise favor their drugs • “Off-label” marketing practices; misreporting the “best price,” the “federal ceiling price,” or other benchmark prices reported to Medicare and Medicaid programs • Overcharging for “340B” program drugs; manufacturing or diverting substandard or tainted drugs • Providing false data to, or withholding negative data from, the FDA about efficacy of a drug/medical device in clinical trials to get FDA approval for the drug/medical device, including: Serono S.A. and its US subsidiaries paid $704 million; AstraZeneca paid $355 million; Bayer paid the federal government more than $250 million; GlaxoSmithKline paid $87.6 million; Medtronic Spine paid $75 million; Doctors buying illegally imported cancer drugs paid $275,000</td>
</tr>
<tr>
<td>Pharmaceutical companies pay federal government and individual states for Medicare and Medicaid False Claims Act (qui tam) lawsuits originating from whistleblowers</td>
<td></td>
</tr>
<tr>
<td>Nearly 600,000 of the nation’s 1.4 million drug-related emergency department visits in 2005 involved prescription drugs&lt;sup&gt;7&lt;/sup&gt;</td>
<td>Drug diversion drains health insurers of $24.9 billion-$72.5 billion annually&lt;sup&gt;8&lt;/sup&gt;; losses include insurance schemes and large hidden costs of treating patients with serious conditions from abusing addictive narcotics they obtained through the swindles</td>
</tr>
<tr>
<td>More than 20 million Americans—nearly 7% of the population—abused prescription drugs in 2007&lt;sup&gt;9&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- FDA indicates US Food and Drug Administration.
6. In almost all these cases, however, unless the medical provider personally knows the member, identity fraud is easy to perpetrate. Without photo identification, clinicians have little to go by to validate the member’s identity. Implementing radio frequency identification, smart cards, or, at the very least, photo enrollment cards, is recommended.

7. Your plan should partner with a claim administrator that can combine medical and pharmacy claims, using analytic tools and programs to statistically review claim encounters:
   - Evaluate the reversal rate for prescriptions based on regional or state rates; if your plan rate is excessively low, further investigation should be done on individual pharmacies
   - Use an internal algorithm that looks for prescription claim reversals after 5 days
   - If the brand or injectable drug cost exceeds the local average, or if the brand or injectable utilization percent is high, this is another clue for fraud
   - Use appropriate age edits for drug suspensions and liquids for patients younger than 6 years or older than 65 years (especially for antibiotics); look for out-of-the-ordinary refill transactions
   - Review dental/medical records for duplicate claims; the first alert often comes from dental extractions and procedures (it is unique to have the same tooth pulled more than once)
   - Evaluate usual distribution of prescriptions from multiple prescribers or provider stores
   - Require National Drug Code codes for J-coding for all drug classes, this is a tantalizing chance for high profits by the profiteer at the expense of our healthcare delivery system and patient safety and wellness.

Appropriate restrictions, edits, and authorization must be put in place to deter such risks and prevent continued waste of healthcare dollars.

Conclusion

The current evidence of crime using current processes and systems is staggering, with no end in sight. Payors, distributors, end-users, and members all have a part to play in limiting this growth, as well as proactively attempting to reduce the incidence of fraud, diversion, and theft of medical services. Such diversion was often thought of as occurring exclusively with narcotics, but with the current high cost of medications in

References

Stakeholder Perspective

Procedures Needed to Prevent Prescription Fraud

PAYORS: We know that fraud contributes to the high cost of US healthcare, and prescription drugs are no exception. Thomas Kaye exemplifies, however, that the scope of the problem is far greater than most of us imagine. For instance, although the government strictly controls addictive drugs, nonaddictive drugs are not subject to similar oversight; Americans without health insurance sometimes purchase prescription drugs using false identification (ID); and doctors misreport diagnoses to qualify patients for reimbursement. Although healthcare fraud is not new, the online maintenance of medical data makes it easier than ever to obtain prescription drugs fraudulently. Payors and purchasers will do well to implement Kaye’s simple suggestions on how to improve prescription drugs oversight.

Mr Kaye’s article could not be more timely. Despite the escalating healthcare costs, little effort is devoted to oversee cost as a way of reducing fraud. In a July 9, 2008, front-page article in the New York Times, titled “Report links dead doctors to payments by Medicare,” Robert Pear cited a congressional investigation that had uncovered that “from 2000 to 2007, Medicare paid 478,500 claims containing identification numbers that were assigned to deceased physicians….The total amount paid for these claims is estimated between $60 million and $92 million.” Some 16,548 to 18,240 ID numbers of deceased physicians were involved in these claims; claims made with one ID amounted to nearly $8 million, and some “2,500 doctors who died before 2003 still had active ID numbers” in May 2008, according to the report.

When such extreme examples of fraud, waste, and abuse are exposed, the federal government routinely promises to implement procedures to prevent them. Yet such retroactive responses are usually minimal; even when procedures are implemented, rarely is sufficient staff being hired to oversee the changes. Moreover, defrauders are always developing new methods to “beat the system.” Prescription fraud enables other forms of ID theft and healthcare abuse, which cost at minimum tens of billions of dollars annually. With a problem of that magnitude, it is necessary for the government to scale the response to the scope of the problem.

Susan Sarnoff, DSW
Associate Professor and Chair
Ohio University Department of Social Work,
Athens, Ohio