
# The Fight Against Fraud:

## A Comprehensive Program To Combat Health Care Fraud

### The Governor's Task Force on Health Care Fraud

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# Forward

Ever upwardly-spiraling health care costs pose a major threat to America's economic well-being. Last year, the equivalent of 14% of this country's gross national product was consumed by health care costs and that percentage -- already the highest in the world -- is projected to rise to 19% by century's end unless reform measures are quickly and effectively introduced. While health care costs have undoubtedly continued to escalate for a number of reasons, estimates suggest that more than $50 billion of our vital health dollars are lost each year to fraud. Health care fraud takes various forms, including: unreliable billing practices, false claims, fraudulent subcontracts, excessive salaries, bribery, tax evasion, and kickbacks. At a time when unprecedented attention is being focused on how the nation can best allocate scarce health care resources and achieve access to quality care for all, we cannot afford to allow fraud to be perpetuated. While honesty generally prevails, health care is big business and big business without regulatory and legal controls invites fraud.

While many major reforms are now being debated on the national level, New Jersey can also play an important role by taking steps to reduce health care fraud at the state level. With that goal in mind, in 1992 Governor Jim Florio directed New Jersey Attorney General Robert J. Del Tufo to establish an inter-departmental Health Care Fraud Task Force to tackle problems of fraud in the delivery of and payment for health care services. Representatives from the Department of Law and Public Safety - the Office of the Attorney General and the Divisions of Consumer Affairs, Criminal Justice and Law participated, as did representatives from the Departments of Insurance, Health and Human Services, as well as a number of individuals from the private sector, each of whom brought to the discussion a unique perspective on how the systems upon which we all rely for the delivery of health care services are flawed. Through the diverse expertise of the participants, the Task Force has recognized the commonality of the issues facing a number of the agencies involved and the need for both multi-faceted "systemic" approaches and greater coordination of enforcement efforts. Participants are listed in Appendix A.

Initially, the Task Force split into four working groups, one focusing on consumer issues, another on issues of criminal laws, another on hospitals and health care facilities and one on insurance issues. After identifying the types of fraud which are plaguing the health marketplace, the Task Force began to craft specific proposals for both the legislative and regulatory arenas. The Task Force has also considered the development of reform strategies to create disincentives for fraud, to develop enhanced strategies to detect fraudulent activity and to facilitate a coordinated enforcement effort to achieve meaningful deterrents.

The Task Force participants have recognized that winning the fight against health care fraud can only be achieved through a multi-faceted approach. Even with the specific reforms proposed, it is recognized that government agencies can not combat insurance fraud alone. Insurers, patients and practitioners must all be enlisted in the effort to prevent and detect fraud and abuse. In this regard, the Task Force has made proposals which will allow the other players to assist government in detecting health care fraud. Efforts must be pursued to address the troubling public perception that insurance fraud is a victimless crime and that it is only the deep pocket of the insurance industry which will be affected. Public education is vital in any campaign to prevent and deter fraud. Not only must we foster an understanding that fraudulent behavior will be detected and punished, we must foreclose the opportunities to engage in fraud and challenge the social acceptance of such conduct. Changing public attitudes and reducing opportunities for private gain will ultimately have a more lasting and beneficial impact than punitive strategies that react to fraud already committed, but both are necessary components of any strategy to combat health care fraud.

Its work is not yet done, but in little more than a year the Task Force has proceeded far enough with its research and policy review to now be ready to propose a comprehensive statutory and regulatory package. Although the Task Force is recommending a number of concrete proposals to assist in the effort to combat health insurance fraud, this report does not, however, represent the Task Force's final effort. In many instances, problems have been identified that require additional study and review. The package is designed to achieve reforms reducing fraud and thus it will aid both individual consumers and New Jersey's effort to address health care costs. The measures recommended today are meant to counteract such fraud through a number of specific statutory amendments designed to alter the systems that allow fraud to occur. These measures will ensure that State agencies with responsibility to prosecute fraud are well equipped to wage that fight. In addition, a model regulation proposed here could ideally be by all of the State professional licensing boards which regulate health care professionals, establishing clear standards of professional conduct and fostering uniformity among health care providers. Some measures send a signal, a demonstration of a get-tough policy for those who commit fraud with health care dollars. But whatever its implications, every measure intensively studied and prepared by the Health Care Fraud Task Force seeks to alleviate the spiraling health care costs confronting our society.

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# Executive Summary

## Proposed Reforms and Long Term Goals

1. ***Change Public Attitudes and Empower Consumers***

A public education campaign -- using a variety of media strategies and publicity generated by high profile prosecutions -- must be launched to inform consumers of the link between fraud and increases in insurance premiums. Incomprehensible medical bills can often mask fraud and costly errors. Through the use of standardized plain language bills and claim forms patients can serve a vital watchdog role.

2. ***Stop Prescription Forgeries***

To combat the growing and costly problem of forged prescriptions, being submitted to governmental programs and insurers for payment, a Prescription Control Program needs to be created. Under the program, all prescribers will be required to use serialized, non-reproducible prescription forms. These forms will be available through a State-approved vendor, capable of providing security measures that will enable the tracing of fake and altered prescriptions. Those trading in altered prescriptions or stealing prescription pads will be vigorously prosecuted.

3. ***Enlist Industry Involvement***

- Facilitate the Development of Anti-Fraud Plans by Health Insurers

Through legislation, like proposed S-1008, health insurers would file anti-fraud plans with the Commissioner of Insurance detailing how they will apply greater scrutiny to suspect claims.

- Require Notice of Treatment and Timely Bills

Legislation amending N.J.S.A 17:33B-46 would encourage health care providers to give timely notice to a health insurance carrier within 30 days of the onset of treatment in PIP cases by allowing carriers to decline payment where no notice was provided.

- Create Incentives for ASO Detection

Many health insurance plans are administered by entities engaged by insurance companies to process claims. These entities, known

in the health field as ASO's, are not now subject to the jurisdiction of the Commissioner of Insurance and are often paid on the basis of the number of payments processed and thus have little incentive to question claims. The Task Force hopes to create an incentive mechanism that will apply heightened scrutiny to claims handled by ASO.

4. ***Bring Accountability to Health Care Facility Management***

The Task Force will continue to study methods to establish either clear standards or a code of ethics for health care facility administrators and trustees in order to guard against self-dealing in the procurement of goods and services.

5. ***Detect Fraud through Health Care Practitioner Reporting***

N.J.S.A. 45:9-19.5 would be amended and a new section created which would require all health care practitioners to report to the State fraudulent conduct committed by their colleagues.

6. ***Impose Practitioner Accountability through Regulatory Standards***

A model regulation will be presented to each of the professional licensing boards responsible for the regulation of health care practitioners containing ten specific reforms, intended not only to make professionals more accountable for their conduct, but also to enable patients to better serve as watchdogs.

- Establish standards for the maintenance of claim forms and treatment and billing records which are truthful and accurate.

  In accordance with this proposed regulation, a licensee's failure to maintain an accurate and truthful record could result in disciplinary action.

- Specify the information to be provided on billing records.

  To assure that patients can serve as a vital check against fraud, licensees would be required to provide clear, complete and comprehensible bills.

- Recognize licensee responsibility for all billings bearing his/her signature or stamp.

The proposed regulation would place licensees on notice that they will be held responsible for the content of billings and claim forms that bear their name.

- Provide that bills be submitted within thirty days of the onset of treatment.

  This complements the statutory reform proposed regarding PIP payments, for it requires providers to submit timely bills so that utilization patterns can be reviewed before months of expensive treatment have already been rendered.

- Prohibit excessive fees and delineate the factors to be considered in determining whether a fee is excessive.

  This model regulation, like one already applicable to physicians, provides standards by which fees may be judged and licensure action pursued when fees are considered "unconscionable."

- Require disclosure of fees, except in emergent circumstances.

  Licensees should be required to disclose fees to patients prior to treatment so that potential patients may make informed decisions about their health care options.

- Delineate specifically prohibited pricing practices.

  Double-tiered fee schedules and fee waivers without disclosure to third party payers would be recognized as fraudulent.

- Bar acceptance of referral fees and referrals to "interested" attorneys or their agents.

  The exchange of referral fees must be expressly prohibited, and referrals to attorneys for the purpose of representation in litigation must be proscribed.

- Compel licensees to disclose financial interests in health care services, in those circumstances where the providers refer the patient.

  In those limited circumstances where self-referral is still permitted, a disclosure of financial interests in health care services to which a practitioner refers would be required, as is already true of doctors, pursuant to N.J.S.A. 45:9-22.4 et seq.

- Require that prescribing licensees use the New Jersey Prescription Blank, when available.

This provision provides an enforcement mechanism that would implement the Prescription Control Program by requiring prescribers to use the specified prescription pads.

7. ***Bar Self-Referral by "Grandfathered" Practitioners***

The statute allowing a practitioner who held a financial interest in a health care service prior to July 31, 1991 to continue to refer patients, subject to a disclosure requirement should be revisited. Legislation should be considered which will close the "grandfather" loophole, while allowing health care practitioners to respond with flexibility to the movement towards managed care.

8. ***Expand the Bases for Professional Discipline***

An amendment to N.J.S.A. 45:1-21 will be sought authorizing the health care boards to take disciplinary action against a licensee based on a determination by a governmental reimbursement program that the practitioner engaged in fraudulent conduct or disciplinary action short of suspension in another state.

9. ***Authorize Emergent Licensure Action for Fraud***

N.J.S.A. 45:1-22 should be amended to enable a health care board or its president, upon notice to the licensee, to temporarily suspend a license where there is proof of fraud as evidenced by a conviction, administrative action or indictment.

10. ***Raise the Criminal Stakes***

Together these reforms serve as legislative recognition that health care fraud is deserving of harsh treatment under the law and that prison terms are likely.

- Add health care fraud to the list of "aggravating factors" at sentencing and remove the presumption of non-incarceration.

By allowing a judge to consider the theft of health care dollars to be an aggravating factor at sentencing, there is a greater likelihood that those convicted will serve prison terms and that their colleagues may be deterred from engaging in similar conduct. Another amendment to N.J.S.A. 2C:44-1 would remove the current presumption of non-incarceration which is now often accorded to "white-jacket" criminals who do not have a prior record and who can often muster "compelling" character references.

- Target "runners" and "steerers"

  An amendment to N.J.S.A. 2A:170-85 would increase the penalty -- from a "disorderly person" charge to a "crime of the fourth degree" -- for those individuals convicted of steering patients to health care providers.

- Penalize those who tamper with billing records

  By means of an amendment to N.J.S.A. 2C:21-20, the scope of the statute that bars tampering with medical records should be expressly clarified to encompass billing records.

**11.** ***Crack Down on Unlicensed Practice***

Consumers in New Jersey pay thousands of dollars each year for goods and services offered by unlicensed persons to treat medical conditions. N.J.S.A. 2C:21-20, which currently makes practicing medicine without a license a crime, should be extended to bar the unlicensed practice of other health care professions.

**12.** ***Coordinate Enforcement Efforts***

While efforts have been made to coordinate the investigation and prosecution of those who commit health care fraud, more can be done. Fragmented and disjointed enforcement efforts only aid those intent on ripping off the system.

- Regularized meetings of departmental representatives

  A comprehensive strategy to facilitate information sharing should be developed. In furtherance of that goal, a committee should be constituted to discuss overlapping policy issues as well as cases of mutual interest.

- Create and tap into databases

  Technology needs to be evaluated which permits the sharing of information concerning those who have been the targets of investigation as well as those who may be submitting suspect claims. Existing national databases, run by private industry should be utilized in order to ensure that the fight against fraud employs every weapon available.

- **Remove the Cloak of Secrecy**

  This amendment would modify N.J.S.A. 45:9-19.3, which presently bars the Board of Medical Examiners from sharing information concerning its investigations with other agencies of government in the absence of a court order. Other agencies should be alert to reforms which enhance the sharing of information.

# Proposed Reforms and Long Term Goals

## 1. Change Public Attitudes and Empower Consumers

Any successful strategy to combat health insurance fraud must reach out to the broadest cross-section of our society and enlist the participation of the public. Consumers need to be informed of the impact that fraud has on insurance premiums and the public's access to health care services. Consumers must be alerted to the vital role that they can play in the fight against fraud.

Traditionally, health care has been one of the few commodities where cost is often not a key determinant for the consumer. While each patient understandably wants and expects that his or her health care will be the best, until recently there has been little incentive for the insured patient to economize since a third party payer -- generally, the insurance company to whom he or his employer has paid the premium -- will foot the bill. With managed care on the horizon, this equation may change. But much will need to be done to assure that patients are in a position to assess the value that they are receiving for their health care dollars.

Consumers must be sensitized to abuses. Sometimes patients may be in collusion with their providers to engage in fraudulent activity (i.e., such as seeking unnecessary care to reach a PIP threshold or asking that prescriptions be written in the name of a family member who may have a prescription plan). More often, however, consumers may lack an appreciation of the impact of fraudulent conduct.

The present complexity of medical billing serves to undercut the ability of consumers to play a watchdog role, causing some patients to become unwitting accomplices to fraud. Medical bills —especially hospital bills—are often incomprehensible, even to highly educated patients. Confusing bills can mask costly errors and effectively limit the patient's ability to serve as a check on costs. Hence, the Task Force is actively pursuing reforms designed to require providers and hospitals to adopt standardized, plain language bills so that patients will be in a position to serve as a check.

The development of a Uniform Patient Bill Form -- like those now required by the Medicaid and Medicare programs -- should include plain-language descriptions of the services rendered in order to better enable patients to compare services. A universal dictionary of terms needs to be required of hospitals to ensure that the medical bills that they submit to patients are readily comprehensible. Standardized terms that come complete with definitions will help to greatly reduce patient confusion and thereby enable patients to guard against either redundant or excessive charges. In the wake of the passage of the Health Care Reform Act of 1992 last year, the need for patients to scrutinize their bills becomes even more

important as competition enters the hospital marketplace. Indeed, that legislation provides a variety of new challenges to those committed to deterring fraudulent conduct. One of the obvious intentions of the law is to foster competition amongst hospitals. Thus the need for patient consumers to have advance notice of the anticipated charges in a non-emergent hospital stay and to understand their bills is critical to the exercise of patient choice.

In addition, some consumers believe that pursuit of extra benefits is appropriate. A 1991 study conducted by the Insurance Research Council revealed that more than 20% of those questioned thought "it was all right" to inflate the amount of an insurance claim to make up for premiums paid or to compensate for a deductible. Social resistance of insurance fraud—and those who commit fraud—must be fostered by a vigorous public affairs campaign that instills in consumers a renewed sense of the unacceptability of intentionally erroneous health care claims. The message can be delivered by a variety of means, including: 1) radio, newspaper and television advertisements; 2) outreach programs encouraging consumers to report suspected fraud; and 3) coordinated press coverage of highly visible prosecutions. Public understanding is essential to the achievement of meaningful long term reforms.

## 2. Stop Prescription Forgeries

The Task Force is recommending a first-in-the-nation prescription control program designed to address the problem of forged prescriptions. In recent years, New Jersey has fallen victim to a pervasive type of fraud that is affecting citizens at every level of society. The Prescription Control Program proposed by the Task Force is intended to reduce -- or hopefully eliminate -- forged prescriptions in New Jersey. It is an uncomplicated program that is designed to avoid placing any additional burdens on patients, pharmacists or prescribers, while saving taxpayers millions of dollars. Most importantly, the program will reduce the supply of addictive prescription drugs finding their way to illegal markets.

This fraud involves the obtaining and distribution of prescription drugs without the consent of a legitimate prescriber. Perpetrators of these crimes are forging prescriptions on prescription blanks that are obtained by various illegal means, with the most common method being to "white out" the handwriting on a legitimate prescription before making multiple photocopies of the blank prescription in order to produce forgeries. This practice is known "on the street" as "whiting and blanking." As a result, millions of prescription pills are being illegally obtained and redistributed in various markets. These drugs include many that are used to support addictive habits as well as expensive brand name medications with black market value.

It is estimated that the savings experienced by instituting the Prescription Control Program in the State of New Jersey will be in the millions of dollars per year. The New Jersey Medicaid Program pays for prescriptions presented to a

pharmacy for a Medicaid recipient. Each forged prescription usually averages between $100 and $500 paid by the Medicaid Program. For every illegitimate prescription presented to a pharmacy that is paid for by the Medicaid Program, the taxpayers have to foot the bill. Just imagine that one illegitimate prescription photocopied and forged 100 times will cost the taxpayers $30,000.

Other states have adopted similar prescription control programs and have experienced significant dollar savings. For example, in 1989 New York introduced a prescription control program for certain classes of controlled prescription drugs, predominantly for minor tranquilizers such as Valium (Diazepam), Xanax (Alpraxolam) and Ativan (Lorazepam). This resulted in a $27,000,000 savings to the New York Medicaid Program over the course of two years.

Not only will the program result in direct savings to both public and private prescription reimbursement programs, there will be savings experienced by law enforcement agencies, the courts and the jails. The cost to the criminal justice system to investigate and prosecute these crimes is enormous, and made still worse by the cost of incarceration for those convicted. Investigators of these crimes often hear comments from substance-addicted individuals such as, "The first thing that I learned when I started to do drugs was to forge prescriptions," or "We all know how to do it," or "You make it too easy for us."

There are also the intangible savings experienced by the reduction of unauthorized prescription drugs that are being distributed in illegal markets and which are contributing to the substance abuse problem in the State of New Jersey. As the forging of prescriptions reaches epidemic proportions, it jeopardizes the health and safety of New Jersey citizens. The dangers associated with taking prescription drugs without the consent and supervision of a legitimate prescriber are obvious.

One of the best assets of the New Jersey Prescription Control Program lies in its simplicity. We expect to experience the significant cost savings described above, while placing no additional burdens on patients, prescribers or pharmacists. The program's only aim is to target those individuals who seek to illegally obtain and distribute prescription drugs, while draining the scarce taxpayer dollars needed to pay for quality health care in New Jersey.

All prescribers in New Jersey will use one uniform prescription blank -- the NJPB -- which will be serialized, like a check book, and printed on non-reproducible and non-erasable paper. Each prescriber will be provided with a unique prescriber number, as will hospitals. A finite group of vendors will bid for State approval to print the blanks. Those printers who are selected will be required to provide security assurances and have prescription-tracking capability. The basic concept behind the program is that a prescription blank should be easily recognizable, extremely difficult to counterfeit, and safeguarded against loss or theft. With the cost of prescription drugs as high as it is these days, each prescription is

essentially like a "blank check." Forgeries cost taxpayers and insurers millions of dollars per year. At present, it is estimated that thousands of forged prescriptions either for drugs with high abuse potential or for high priced medications enter the marketplace each year at an estimated cost of millions to the New Jersey Medicaid program alone. Under this program, the alteration of a prescription will be deemed a forgery of a writing within the meaning of the criminal code. Theft of prescriptions will be treated as theft of other valuable property. Both offenses will be third degree crimes, subjecting those convicted to $7500 in penalties and up to five years in prison. A summary of the proposal, a draft bill, and a sample prescription are provided at Appendix B.

## 3. Enlist Industry Involvement

### a. Facilitate the Development of Anti-Fraud Plans by Health Insurers

The Task Force has reviewed pending legislation, S-1008, which would call upon all companies which write health insurance policies in this state, to devise and implement anti-fraud programs by which the claims submitted would be subjected to greater scrutiny and referrals of suspect bills could be brought to the attention of the State. A comparable provision - applicable to automobile insurers - was implemented as part of the FAIR Act and has resulted in double the number of referrals to the Division of Insurance Fraud. S-1008 would require those insurers writing health insurance to file comparable plans. This statute would allow the Commissioner to impose penalties on those insurers that fail to comply. It is hoped that this legislation, when enacted, will provide a basis for a closer working relationship between the carriers and state agencies to minimize and detect fraudulent claims. Under this proposal, the Commissioner could promulgate regulations which would delineate specific investigative efforts which should be undertaken.

### b. Require Notice of Treatment and Timely Bills

The Task Force has also recommended that measures be enacted to ensure that medical bills are submitted promptly after the initiation of treatment so that they can be scrutinized before extended treatment become excessive. Once the treatment has been rendered and months have elapsed, it may be impossible to establish that a given treatment was not justified. Accordingly, it is recommended that a regulatory initiative be pursued to require health care providers to submit bills to carriers, health care benefit plans, and third-party administrators within 30 days of the onset of treatment. This reform will have particular importance in those areas where extended treatment is often contemplated, i.e., physical therapy, chiropractic treatment, pain management treatment, and personal injury protection claims.

To complement this reform, the Task Force is recommending an amendment

to N.J.S.A. 17:33B-46, allowing insurers to decline payment of medical bills in PIP cases for which the provider has failed to provide notice within 30 days of the initiation of treatment. A new section -- (d) would be added:

> **d. All claims for payment for medical services and related benefits made by medical service providers, which services represent Personal Injury Protection (PIP) benefits to be paid pursuant to a policy of insurance issued within this State (excluding the amount of any applicable deductible or co-payment to be paid by the patient or insured party), may be declined by any insurer, or insurance carrier licensed to transact business within the State, unless notice of the commencement of the provision of medical services is provided, in the form determined by the Commissioner of Insurance, to the insurer or insurance carrier licensed to transact business in this State, not later than 30 days after the initial provision of medical services to include any initial treatment, diagnosis, tests, or consultation. If proper notification has been made and the name, address and policy and/or claim number of the insurer or insurance carrier licensed to transact business within this State has been properly made available, the medical service provider shall not pursue the patient or insured party for payment of such benefits. Where multiple insurers, insurance carriers or concurrent coverage exist, the medical service provider must notify each known insurer or insurance carrier of the commencement of medical services. If at 60 days from the commencement of medical services there is no known insurer or insurance carrier, the medical service provider shall have the patient execute a form determined by the Commissioner of Insurance showing good faith attempt to uncover an applicable policy of insurance.**

A complete bill proposal appears at Appendix C.

### c. Create Incentives for ASO Fraud Detection

While the Task Force supports the enactment of measures requiring insurers to devise anti-fraud plans, it also encourages an expanded focus which will require comparable plans to be filed by third party administrators who are not now subject to the jurisdiction of the Commissioner of Insurance. Indeed, the Task Force recommends that further study with regard to these third party administrators be undertaken since it appears that from a systemic perspective this industry is unlikely to be interested in rooting out fraud. Very few claims are actually reviewed in detail, with most simply processed for payment. With many plans, the task of

processing claims is "farmed out" to an ASO (Administrative Service Only, i.e. a third party paper processor). Since the ASO is not the entity ultimately responsible for the payment of the bill, it lacks an incentive to scrutinize the legitimacy of the claim. Indeed, internal systems may actually provide a disincentive to review those claims for accuracy, since payment to the ASO may be based on the number of claims processed. It is the understanding of the Task Force members that third party administrators are generally paid for each claim processed. If a claim is rejected, those performing the processing stand to lose their fee; processors have little to gain, and much to lose, by performing a critical review of the claims submitted. Thus the Task Force will continue to study ways in which the state could alter the current systemic disincentive to detect and deter fraud.

## 4. Bring Accountability to Health Care Facility Management.

Under the present regulatory system, members of the Board of Trustees of health care facilities and Chief Executive Officers are not accountable to shareholders as corporate trustee boards would be. Indeed, members of hospital boards may not even be aware of the responsibilities which they possess. Of particular concern to Task Force members is the issue of self-dealing, whereby trustee members may be in a position to direct the business of a hospital to firms or companies in which they have an interest. This practice may result in the hospital's procurement of goods and services at costs which may not be competitive with those which could be obtained in the open market, and thus may be one factor driving health care costs ever upward. Clearly, the education and training of hospital board members ought to be pursued. With respect to hospital administrators, a licensure scheme akin to that applicable to nursing home administrators should be considered. The establishment of clear standards of conduct or a code of ethics should also be studied. Although those standards ought not be made so onerous as to dissuade qualified people from serving on boards, standards would assist in alerting responsible trustees to appropriate conduct. Before designing a specific regulatory initiative it would be valuable to elicit the views of those responsible for hospital management.

## 5. Detect Fraud through Health Care Practitioner Reporting

Health care providers can also serve as a check in preventing and detecting fraud and abuse. At present, nurses are required to report any misconduct by their colleagues (N.J.A.C. 13:37-1.4). N.J.S.A. 45:9-19.5 currently requires physicians and podiatrists to report those whose unprofessional actions present a danger to the public. Colleagues should be encouraged to bring patterns of fraudulent behavior to the attention of appropriate regulatory bodies. It is recommended that N.J.S.A. 45:9-19.5 be amended to also require notice of fraudulent activities:

**a. A physician or medical resident or intern, or podiatrist or bioanalytical laboratory director or physician assistant or acupuncturist, hereinafter referred to as a "practitioner,"**

**shall promptly notify the State Board of Medical Examiners if that practitioner is in possession of information which reasonably indicates that another practitioner has demonstrated an impairment, gross incompetence or unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety and welfare. A practitioner shall promptly notify the State Board of Medical Examiners if that practitioner is in possession of information which reasonably indicates that another practitioner has engaged in fraudulent conduct in connection with the rendition of or billing for medical or psychiatric services. A practitioner who fails to so notify the board is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).**

A comparable provision has been provided relating to other health care practitioners, such as chiropractors, dentists, and physical therapists. Through these two provisions all cross-reporting by health care professionals is required. (See Appendix D).

## 6. Impose Practitioner Accountability through Regulatory Standards

Vigilant enforcement of those found to have engaged in fraudulent activity is obviously a necessity. In order to enhance the ability of all interested agencies to discharge their obligations, the clear codification of health care professional standards is proposed. Specifically, a model regulation is proposed, which could be presented to each of the boards that regulate health care professionals. Some of these provisions have already been implemented by some of the boards, others may require minor technical amendments to enabling laws; but if these measures were adopted "across the boards," there would be a uniformity in approach. The complete model regulation is attached hereto as Appendix E. It includes specific measures to:

1. Establishes standards for the maintenance of accurate and truthful treatment and billing records, claim forms and reports. The section requires billing record retention for 7 years, consistent with the time period applicable to the retention of office treatment records.

2. Specify the information be provided on billing records. With respect to the requirement that bills reflect costs incurred by the licensee in providing goods and drugs, there is a corresponding responsibility to maintain records as to the costs associated with such dispensing, i.e. acquisition invoices, inventory costs, etc. If standardized forms are

developed, their use will be required.

3. Recognize licensee responsibility for all billings bearing his/her signature or stamp.

4. Provide that bills (with the exception of Medicaid bills) be submitted within thirty days of the onset of treatment.

5. Prohibit excessive fees and delineate the factors to be considered in determining whether a fee is excessive.

6. Require disclosure of fees, except in emergent circumstances.

7. Delineate specifically prohibited pricing practices, such as double-tiered fee schedules and fee waivers without disclosure to third party payers.

8. Bar acceptance of referral fees and referrals from and to "interested" attorneys or their agents.

9. Compel licensee disclosure of significant beneficial interests in health care services in those circumstances where the provider may refer. This requirement is already in place regarding doctors and podiatrists; it should be applied to an expanded group of health care providers.

10. Mandate that prescribing licensees use the New Jersey Prescription Blank, when they become available.

The Director of the Division of Consumer Affairs will present this model regulation to each of the boards responsible for the regulation of health care professionals. If adopted by each board, these standards will assist all agencies charged with the duty to investigate and prosecute those committing health care fraud.

## 7. Bar Self-Referral by "Grandfathered" Practitioners

At present N.J.S.A. 45:9-22.4 et seq allows physicians, chiropractors and podiatrists who held a financial interest in a health care service prior to July 31, 1991 to refer their own patients to those entities, so long as the patient is advised of the interest. The statute prohibits practitioners from self-referring if they did not hold an ownership on that date. The Task Force recognizes a certain illogic in foreclosing self-referrals to newly created health care services at the same time that the "grandfathered" practitioners are allowed to continue to refer. If the abuse potential exists as to the first group, disclosure of the interest seems to be an insufficient remedy.

The Task Force recognizes, however, that this statute has fostered the establishment of a variety of practice configurations which may be crucial as

managed care models become more prevalent in the health marketplace. Accordingly, additional study should be undertaken to determine what statutory amendment will best address the abuse potential, without generating unintended ramifications on the ability of New Jersey group practices to compete in a managed care environment.

## 8. Expand the Bases for Professional Discipline

The Task Force is recommending several specific statutory amendments to strengthen the ability of the professional licensing boards to respond decisively to fraudulent conduct by their licensees. An amendment to N.J.S.A. 45:1-21 would give the health care boards the authority to impose disciplinary action based on a determination by a governmental reimbursement plan to terminate or limit a licensee's participation (i.e. Medicaid or Medicare). Specifically, a new subsection would be added, allowing for a suspension or revocation if the licensee:

> **k. Has had his authority to participate in a reimbursement program administered by a state or federal agency terminated or otherwise limited provided that the underlying basis for the action was for reasons consistent with this section or the pertinent professional practice act.**

In addition, it is recommended that boards be given authority to take action based on action in other jurisdictions which may fall short of a suspension or revocation. The current subsection (g) could thus be amended to provide the basis for disciplinary action against a licensee:

> **g. Has had his [authority to engage in the activity regulated by the board revoked or suspended by any other state, agency or authority] license, certificate, or registration to practice the profession or occupation regulated by the board suspended or revoked or otherwise limited by another state or has been subjected to disciplinary action in another state, or has surrendered his license, certificate or registration in the face of disciplinary charges or an investigation into professional misconduct in another state.**

A legislative proposal appears at Appendix F.

## 9. Authorize Emergent Licensure Action for Fraud

A measure is also suggested that would allow a board or its President to act quickly and decisively in response to proof of fraud by providing a mechanism for the temporary suspension of professional licenses without awaiting a full plenary hearing or concurrent conviction. This measure would provide the boards with an authority similar to that now possessed by the Medicaid program. Specifically, it is recommended that an additional subsection be added to N.J.S.A. 45:1-22:

**A board may, upon a duly verified application of the Attorney General alleging an act or practice violating any provision of an act or regulation administered by such board, enter a temporary order suspending or limiting any license issued by the board pending plenary hearing on an administrative complaint; provided, however, no such temporary order shall be entered unless the application made to the board palpably demonstrates a clear and imminent danger to the public health, safety and welfare and notice of such application is given to the licensee affected by such order.**

**A board, upon a duly verified application of the Attorney General which establishes that there is good cause to conclude that a licensee has engaged in the employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense in connection with health care funds or services, enter a temporary order suspending or limiting the license of the health care professional pending plenary hearing on an administrative complaint; provided, however that no such temporary order shall be entered unless notice of such application is given to the licensee affected by such order. Good cause may be established by a judgment or order of a court of competent jurisdiction, a plea of guilty, non-vult, nolo contendere entered before a court of competent jurisdiction, a judgment or order of an administrative agency, a grand jury indictment or by other evidence that such violations of civil or criminal law did, in fact, occur.**

**The board may delegate to its chairman or president the responsibility of considering an application on an emergent basis, provided that the board considers and reviews the disposition of the application at its next regularly scheduled meeting.**

These statutory reforms appear in Appendix F. Health care professional as used here would include all those previously identified in the colleague reporting provision appearing in Appendix D (page 40).

## 10. Raise the Criminal Stakes

Prosecution of those who engage in fraudulent conduct is often hampered by the ostensible "respectability" of the perpetrators, the difficulty in developing

patterns extensive enough to reach the $75,000 threshold for a second degree crime of theft, and the accurate perception that prison terms are unlikely to be meted out even in the face of a conviction. The Task Force is recommending the enactment of several specific reforms to enable the criminal system to adequately respond to fraudulent conduct, both so that those committing fraud will be punished and those considering such action will be deterred. A complete legislative proposal appears at Appendix G.

### a. Expand "Aggravating Factors" at Sentencing and Remove the Presumption of Non-Incarceration

The Task Force is recommending two amendments that establish criteria to be considered by the judge at the time of sentencing. Both amendments are designed to demonstrate the unacceptability of misuse of health care dollars by strengthening the institutional response to a conviction for health care fraud. The first amendment would add two criteria to the list of aggravating factors to be considered at the time of sentencing. Based on criteria #13 and #14, the theft of health care dollars would be deemed an aggravating factor, as would criminal activity undertaken in the course of employment as a health care administrator. The inclusion of these criteria might result in stiffer sanctions and thus would serve as a deterrent. The Task Force is recommending that N.J.S.A. 2C:44-1 be amended so that the court "shall consider" the following at sentencing:

> **(13) The offense involved theft of health care funds or services or fraudulent practices involving funds intended for the payment of health care costs or the delivery of health care services.**
>
> **(14) The defendant is an administrator in a health care facility, whether public or private, offering health-related services to the public and the crime involved acts or omissions arising in the course of his or her employment as a health care administrator.**

The Task Force favors an additional amendment to N.J.S.A. 2C:44-1, which would add a sentence to provide an exception to the presumption of non-incarceration for theft of health care dollars or services. The new section would read:

> **e. The court shall deal with a person convicted of an offense other than a crime of the first or second degree, who has not previously been convicted of an offense, without imposing sentence of imprisonment unless, having regard to the nature and circumstances of the offense and the history, character and condition of the defendant, it is of**

**the opinion that his imprisonment is necessary for the protection of the public under the criteria set forth in subsection a.; except that this subsection shall not apply if the person is convicted of third or fourth degree crime of theft or fraud as delineated in chapters 20 and 21 of Title 2C of the New Jersey Statutes involving health care funds or the delivery of health care services.**

### b. Target Runners and Steerers

The Task Force recommends that N.J.S.A. 2A:170-85 be amended to heighten the penalties associated with the steering of accident victims by upgrading the penalty from a disorderly person to a crime of the fourth degree. Evidence suggest that there now exists a cottage industry composed of individuals engaged in the direct solicitation of persons involved in motor vehicle accidents. These so-called "runners" or "steerers" obtain the identities of "accident victims" from news articles, police records, hospital emergency rooms and via the in person solicitation of individuals who visit police record rooms to pick up copies of accident reports. These steerers offer to show the victims how to profit from an accident and then refer them to, and often provide free transportation to the offices of certain attorneys and health care providers who reportedly pay a sum for each referral. Although this reform measure, like the section which it amends, may be infrequently used, the Task Force believes that heightening the penalty will focus attention on the abuses inherent in steering. The following amendment is suggested:

**Any person shall be guilty of a crime of the fourth degree, who, for pecuniary gain, solicits any person or corporation to engage, employ or retain either himself, any lawyer or any other person to manage, adjust or prosecute any claim, cause of action or action at law, against any person or corporation, for damages for negligence, or who, for pecuniary gain, directly or indirectly solicits other persons to begin actions at law to recover damages for personal injuries or death [, is a disorderly person].**

### c. Penalize Those Who Tamper with Billing Records

This goal can be achieved by amending N.J.S.A. 2C:21-4.1 to expressly expand the scope of the criminal prohibition on record tampering and falsification to **all** types of health care records, including billing records and claim forms prepared for submission to insurers, governmental benefit programs, health benefit plans or third party administrators. The revision also makes it clear that the reference is applicable to records submitted to governmental health benefit programs. The revised section would read:

**A person is guilty of a crime of the fourth degree if he purposefully destroys, alters or falsifies record relating to**

**the health care of [a medical or surgical or podiatric] any patient in order to deceive or mislead any person as to information, including, but not limited to, a diagnosis, test, medication, treatment or medical or psychological history, concerning the patient or the billings related to treatment.**

This revision appears at Appendix G.

**d. Expand the Definition of Forgery to include alteration of prescriptions**

In order to implement the Prescription Control Program recommended by the Task Force, a revision of the criminal code is also proposed. The definition of "writing" with the forgery statute would be expanded to expressly include New Jersey Prescription Blanks. This alteration of a prescription would be classified as a crime of the third degree. See the revision appearing at Appendix B.

## 11. Crack Down on Unlicensed Practice

The prevalence of unlicensed practitioners and the availability of questionable products represents yet another way in which health dollars are being misdirected. New Jersey consumers spend thousands of dollars each year for cures and remedies for medical conditions offered by unlicensed practices - often believing that the individual providing them with health care advice or hands-on services is a licensed provider. While practicing medicine without a license subjects a person to criminal sanction, enforcement efforts could be facilitated through the adoption of comparable criminal measures in the other health care fields. The public has the right to expect that those offering dental, chiropractic and psychological services are bona fide licensed practitioners. To facilitate vigilant enforcement the Task Force is recommending that N.J.S.A. 2C:21-20 be revised so that the scope of the statute, which presently makes practicing medicine without a license a crime, will be expanded to encompass other health care professions.

**A person is guilty of a crime of the third degree if he knowingly does not possess a license or permit to practice [medicine and surgery or podiatry] a health care profession requiring licensure or permitting in this State, or knowingly has had the license or permit suspended, revoked or otherwise limited by an order entered by the [State Board of Medical Examiners] agency responsible for the regulation of that practice, and he:**

**a. engages in that practice;**

**b. exceeds the scope of practice permitted by the board order;**

**c. holds himself out to the public or any person as being eligible to engage in that practice;**

**d. engages in any activity for which such license or permit is a necessary prerequisite, including, but not limited to, the ordering of controlled dangerous substances or prescription legend drugs from a distributor or manufacturer; or**

**e. practices [medicine or surgery or podiatry] a health care profession under a false or assumed name or falsely impersonates another person licensed by the board.**

This reform appears in Appendix G. Again health care profession would include all the fields reflected in the colleague reporting provision appearing in Appendix D (page 40).

## 12. Coordinate Enforcement Efforts

As awareness of the health care fraud problem has increased, State agencies have intensified their efforts to combat the problem within their areas of responsibility. This awareness has brought with it the recognition that coordination among agencies with related areas of responsibility and overlapping interests is necessary to maximize efforts to address the health care fraud problem and avoid the fragmentation which can only serve to benefit those intent on defrauding the system. A comprehensive description of each agency of State government responsible for enforcement activities as they relate to health care fraud enforcement is attached as Appendix H. Not only should the activities of this Task Force in developing policy initiative reforms be continued, but formalized information sharing should be expanded.

### a. Regularize meetings between departmental representatives.

A number of responsible State agencies have established close working relationships which have had a significant impact on the State's ability to combat fraud. For example, the Division of Medical Assistance and Health Services in the Department of Human Services meets regularly with attorneys from the Division of Criminal Justice Medicaid Fraud Unit and the Division of Law to review numerous medicaid fraud referrals with the potential for criminal and/or civil action. The Division of Criminal Justice and the Division of Law also meet regularly with the Division of Insurance Fraud Prevention in the Department of Insurance to identify and act on insurance fraud cases warranting civil and/or criminal action; the Division of Criminal Justice and Division of Insurance Fraud Prevention jointly investigate insurance fraud cases of significance. Similarly, the Division of Law works closely with the numerous Professional Boards and the

Enforcement Bureau in the Division of Consumer Affairs to determine whether administrative action is warranted against particular licensed professionals in the health care field.

Notwithstanding the significant efforts of various State agencies to increase their coordination, the Task Force recognizes a need for broader and more comprehensive coordination among all State agencies having responsibility in the health care field. The Task Force recommends that to better coordinate enforcement activities the Attorney General should establish and chair a multi-departmental committee to include representatives of the Department of Law and Public Safety, Division of Criminal Justice, Law, Consumer Affairs, Department of Human Services, Divisions of Medical Assistance and Health Services, Department of Insurance, Divisions of Insurance Fraud Prevention and Enforcement, and the Department of Health. This permanent committee will consider policy issues involving health care fraud enforcement as well as cases of mutual interest (to the extent legally permitted by each agency.) The pursuit of civil, criminal and/or administrative remedies will be better coordinated with the result that the limited resources of each agency will be maximized.

### b. Create Databases within New Jersey

Advances in technology now enable the State to generate necessary databases to insure that the State, health institutions, and insurance companies have access to the information resources that will expedite the payment of legitimate claims and combat fraudulent claims. Those with access to the databases will be able to research file claims in order to identify a claimant's prior claims, possible overlapping coverages, pattern of claims, pre-existing conditions and possibly suspicious claims. Such identification will help to reduce redundant or excessive claims and should in general be an effective means of curtailing insurance claim abuse. Preliminary research has revealed that there are a number of existing national databases to which the State might subscribe. Exploration of those opportunities should continue.

### c. Remove the Cloak of Secrecy

The professional licensing boards, and their investigative office, and the Enforcement Bureau in the Division of Consumer Affairs, strive to cooperate with other state agencies responsible for investigating health care fraud. To more effectively accomplish this goal, it is important that the Board be permitted to share investigative information. N.J.S.A. 45:9-19.3 presently impedes the release of information to both private parties and government agencies. That section was originally designed to encourage individuals to come forward with information concerning misconduct by physicians by affording informants good faith immunity and assuring that the information provided would be "confidential pending final disposition of the inquiry or investigation by the Board." In 1989, pursuant to the Professional Medical Conduct Reform Act, N.J.S.A. 45:9-19.3 was amended allowing the release of investigative materials, where their is a finding of no basis

for disciplinary action by the board, only "upon an order of the Superior Court after notice to the physician or surgeon who is the subject of the information and an opportunity to be heard."

With this addition, the original focus of the confidentiality protection has been redirected. The Task Force recommends that this section be amended to recognize that the Board has the discretion to share investigative product with other governmental agencies:

> **Any information concerning the conduct of a physician or surgeon provided to the State Board of Medical Examiners pursuant to section 1 of P.L.1983, c. 248 (C.45:9-19.1), section 5 of P.L.1978, c. 73 (C.45:1-18) or any other provision of law, is confidential pending final disposition of the inquiry or investigation by the board. If the result of the inquiry or investigation is a finding of no basis for disciplinary action by the board, the information shall remain confidential, except that the board may release the information in its investigative file to [a] another governmental agency [, for good cause shown, upon an order of the Superior Court after notice to the physician or surgeon who is the subject of the information and an opportunity to be heard. The application for the court order shall be placed under seal [.] in furtherance of that agency's statutory or regulatory responsibilities.**

A bill is proposed at Appendix I.

*APPENDIX A:*

# Health Care Fraud Task Force Participants

## TASK FORCE CO-CHAIRS

**Emma Byrne**
*Director of Consumer Affairs*

**Edward Dauber, Esq.**
*Former Executive Assistant Attorney General*

**Task Force Co-ordinator**
**Sharon M. Joyce**
*Deputy Attorney General*

## DEPARTMENT OF HEALTH

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|---|---|
| Paul Langevin | Assistant Commissioner |
| Eileen O'Donnell | Legal Specialist |
| Ann Weiss | Director of Hospital Reimbursement |
| Robert Fogg | Director of Licensing, Certification and Standards |
| Catherine Morris | Director of Inspection Services |

## DEPARTMENT OF HUMAN SERVICES/DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

| | |
|---|---|
| Saul M. Kilstein | Former Director |
| Robert Popkin | Assistant Director |
| Leon Bartol | Chief, Bureau of Adminstrative Control |
| Peter Amato | Supervising Medical Review Analyst |
| Robert Checchi | Acting Chief, Bureau of Medical Care Surveillance |
| Cecelia Dombowski | Supervising Medical Review Analyst |

## DEPARTMENT OF LAW AND PUBLIC SAFETY

### DIVISION OF CONSUMER AFFAIRS

| | |
|---|---|
| Edward Tumminello | Chief of Enforcement Bureau |

### DIVISION OF LAW

| | |
|---|---|
| Don Palombi | Deputy Attorney General |
| Todd Wigder | Deputy Attorney General |
| Lauren Carlton | Deputy Attorney General |
| Dan DiLella | Deputy Attorney General |
| Lee Barry | Deputy Attorney General |

### DIVISION OF CRIMINAL JUSTICE

| | |
|---|---|
| Robert Winter | Former Director |
| Nancy L. Singer | Assistant Attorney General |
| John J. Smith | Senior Deputy Attorney General |
| Harry Brett | Senior Deputy Attorney General |
| Greta Gooden-Brown | Senior Deputy Attorney General |

## DEPARTMENT OF INSURANCE

| | |
|---|---|
| Louis Parisi | Director of Insurance Fraud Division |
| Richard Koch | Chief of Insurance Fraud Division |
| Kevin McCabe | Supervising Investigator |

## PRIVATE SECTOR

| | |
|---|---|
| Edwin H. Stier, Esq. | Attorney<br>Stier, Anderson & Malone |
| Willian Morrison | Morrison and Company<br>Certified Public Accountant |
| Ellen Kaplan | Fund Administrator<br>Teamsters Local 560<br>Benefits Funds |

# Appendix B:

## A PLAN TO CREATE A PRESCRIPTION CONTROL PROGRAM

### A Summary of the Request for Proposal "RFP"

### Purpose and Intent

The purpose of this Request for Proposal (RFP) is to engage the services of a qualified organization to print New Jersey Prescription Blanks (NJPBs), to provide for delivery of NJPBs to prescribers and hospitals in New Jersey, to provide for appropriate security to prevent unauthorized access to NJPBs during printing and delivery, and to provide a management information system (MIS) capable of storing, retrieving and transmitting data identifying which serialized NJPBs have been distributed to a particular prescriber or hospital.

Contractors will be selected by the state through a bidding process to perform the following tasks:

1. **Printing of New Jersey Prescription Blanks (NJPBs)**
   Prescriptions will be printed in such a manner that makes them uniquely distinctive, serialized and contain an identification number for each prescriber or hospital.
2. **Maintaining a computerized database**
   The contractor will maintain a computerized database capable of interfacing with insurers and government agencies.
3. **Verifying the identity of prescribers.**
   The contractor will verify the identity of the prescriber or hospital prior to printing or delivering any NJPB.
4. **Delivery of NJPBs**
   The contractor will be responsible to assure a safe and secure delivery process for NJPBs.
5. **Invoice and collection**
   The contractor will be solely responsible for invoice to and payment from prescribers and hospitals.
6. **Ordering procedures for NJPBs**
   The contractor will assure that there is a system which allows for quick and efficient orders and re-orders of NJPBs.
7. **Security of NJPBs**
   The contractor will assure that there is a security system which protects against theft of NJPBs at the printing site and during delivery.

## A Bill Proposal

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey

1. (New Section)

The Legislature finds and declares that the welfare of the citizens of this State and the financial integrity of the governmental reimbursement programs administered for their benefit are threatened by the growing problem of prescription drug abuse, particularly the widespread trafficking in forged and altered prescriptions for oral drugs and items. The submission of these forged prescriptions for payment by State and Federal funds through the Medicaid and PAAD programs and by private health insurers serve to drive the cost of health care up for all citizens of New Jersey. To reduce the ease with which such forgeries can be accomplished and to deter drug abuse, requires the implementation of a program by which prescriptions would be on a uniform prescription blank, printed on non-photocopiable, non-erasable safety paper, issued in a serialized, bound fashion, subject to stringent security controls. The requirements for the use of these prescriptions are set forth and criminal sanctions prescribed.

2. Section 2 of P.L. 1952, c. 351 (C45:14-14) is amended to read as follows:

The term prescription as used in Sections 45:14-13, 45:14-15 to 45:14-17 of this title means an order for drugs or medications or combinations or mixtures thereof, written or signed by a duly licensed physician, dentist, veterinarian, or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease in man or animals, and includes orders for drugs or medicines or combinations or mixtures thereof <u>on a New Jersey Prescription Blank (NJPB), obtained from a vendor approved by the Office of Drug Control,</u> transmitted to pharmacist through word of mouth, telephone, telegraph or other means of communication by a duly licensed physician, dentist, veterinarian or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease in man or animals, and such prescriptions received by word of mouth, telephone, telegraph or other means of communication shall be recorded in writing by the pharmacist and the records shall be made by the pharmacist shall constitute the original prescription to be filed by the pharmacist, as provided for in Section 45:14-15 of this title but no prescription, for any narcotic drug, except as provided in Section 24:18-7 of the revised statute shall be given or transmitted to pharmacists, in any other manner, than in writing signed by the physician, dentist, veterinarian or other practitioner giving or transmitting the same, nor shall such prescription be renewed or refilled.

3. Section 5 of P.L. 1987, c. 106 (C.2C:20-2) is amended to read as follows:

Consolidation of theft offenses; grading; provisions applicable to theft generally:

a. Consolidation of theft offenses. Conduct denominated theft in this chapter constitutes a single offenses, but each episode or transaction may be the subject of a separate prosecution and conviction. A charge of theft may be supported by evidence that it was committed in any manner that would be theft under this chapter, notwithstanding the specification of a different manner in the indictment or accusation, subject only to the power of the court to ensure fair trial by granting a bill of particulars, discovery, a continuance, or other appropriate relief where the conduct of the defense would be prejudiced by lack of fair notice or by surprise.

b. Grading of theft offenses.

(1) Theft constitutes a crime of the second degree if:

(a) The amount involved is $75,000.00 or more;

(b) The property is taken by extortion; or

(c) The property stolen is a controlled dangerous substance or controlled substance analog as defined in N.J.S.A. 2C:35-2 and the quantity is in excess of one kilogram.

(2) Theft constitutes a crime of the third degree if:

(a) The amount involved exceeds $500.00 but is less than $75,000,00;

(b) The property stolen is a firearm, automobile, boat, horse or airplane;

(c) The property stolen is a controlled dangerous substance or controlled substances analog as defined in N.J.S.A. 2C:35-2 and the amount involved is less than $75,000.00 or is undetermined and the quantity is one kilogram or less.

(d) It is from the person of the victim.

(e) It is in breach of an obligation by a person in his capacity as a fiduciary;

(f) It is by threat not amounting to extortion; or

(g) It is of a public record, writing or instrument kept, filed or deposited according to law with or in the keeping of any public office or public servant;

(h) The property stolen is a New Jersey Prescription Blank as referred to in N.J.S.A. 45:14-14,

(3) Theft constitutes a crime of fourth degree if the amount involved is at least $200.00 but does not exceed $500.00. If the amount involved was less than $200.00 the offense constitutes a disorderly persons offense.

(4) The amount involved in a theft shall be determined by the trier of fact. The amount shall include, but shall not be limited to, the amount of any State tax avoided, evaded or otherwise unpaid, improperly retained or disposed of. Amounts involved in thefts committed pursuant to one scheme or course of conduct, whether from the same person or several persons, may be aggregated in determining the grade of the offense.

c. Claim of right. It is an affirmative defense to prosecution for theft that the actor:

(1) Was unaware that the property or service was that of another;

(2) Acted under an honest claim of right to the property or service involved or that he had a right to acquire or dispose of it as he did; or

(3) Took property exposed for sale, intending to purchase and pay for it promptly, or reasonably believing that the owner, if present, would have consented.

d. Theft from spouse. It is no defense that theft was from the actor's spouse, except that misappropriation of household and personal effects, or other property normally accessible to both spouses, is theft only if it occurs after the parties have ceased living together.

5. Section 20 of P.L.1981, c. 290 (C.2C:21-1) is amended to read as follows:

2C:21-1. Forgery and related offenses.

a. Forgery. A person is guilty of forgery if, with purpose to defraud or injure anyone, or with knowledge that he is facilitating a fraud or injury to be perpetrated by anyone, the actor:

(1) Alters or changes any writing of another without his authorization;

(2) Makes, completes, executes, authenticates, issues or transfers any writing so that it purports to be the act of another who did not authorize that act or of a fictitious person, or to have been executed at a time or place or in a numbered sequence other than was in fact the case, or to be a copy of an original when no such original existed; or

(3) Utters any writing which he knows to be forged in a manner specified in paragraph (1) or (2).

"Writing" includes printing or any other method of recording information, money, coins, tokens, stamps, seals, credit cards, badges, trademarks, and other symbols of value, right, privilege, or identification.

b. Grading of forgery. Forgery is a crime of the third degree if the writing is or purports to be part of an issue of money, securities, postage or revenue stamps, or other instruments, certificates or licenses issued by the government, New Jersey Prescription Blanks as referred to in N.J.S.A. 45:14-14, or part of an issue of stock, bonds or other instruments representing interest in or claims against any property or enterprise.

Otherwise forgery is a crime of the fourth degree.

c. Possession of forgery devices. A person is guilty of possession of forgery devices, a crime of the third degree, when with purpose to use, or to aid or permit another to use the same for purposes of forging written instruments, he makes or possesses any device, apparatus, equipment or article specially designed or adapted to such use.

5. (New Section)

All duly licensed prescribers shall maintain a record of receipt of New Jersey Prescription Blanks and shall notify the Office of Drug Control within the Division of Consumer Affairs within 24 hours of being made aware that any New Jersey Prescription Blank in his or her possession has been lost or stolen.

6. (New Section)

After the effective date of this act, all duly authorized prescribers shall utilize serialized, non-photocopiable, non-erasable New Jersey Prescription Blanks bearing that prescriber's license number, secured by a vendor, approved by the New Jersey Office of Drug Control whenever issuing prescriptions for Controlled Dangerous Substances, prescription legend drugs or other prescription items.

7. (New Section)

After the effective date of this Act, prescriptions issued by a licensed health care facility shall utilize serialized, non-photocopiable, non-erasable New Jersey Prescription Blanks bearing a unique provider number assigned to that health care facility whenever issuing prescriptions for controlled dangerous substances, prescription legend drugs or other prescription items.

8. (New Section)

After the effective date of this Act, no prescription issued by an authorized New Jersey prescriber shall be filled by a pharmacist, drug store or drug department unless issued on a New Jersey Prescription Blank, bearing a prescriber license number or a unique provider number assigned to a health care facility.

9. (New Section)

Nothing herein shall preclude a duly authorized prescriber from telephoning or electronically transmitting to a pharmacy, drug store or drug department a prescription, as otherwise authorized by law, provided that prescriber shall provide verification to the pharmacist at the time of issuance, as to prescriptions of schedule II controlled dangerous substances, and shall subsequently provide a written memorialization of that prescription.

*Sample Prescription Form "NJPB"*

**State of New Jersey Official Prescription Form**
USE A SEPARATE FORM FOR EACH PRESCRIPTION
PHARMACIST: DO NOT ACCEPT IF PHOTOCOPIED OR THE WORD "VOID" APPEARS

Very Good FootCare
Dr. William Bunion, D.P.M.
Podiatric Medicine and Surgery
42 Digit Road
Metatarsal, N.J. 07055
(201) 123-0987

DEA NO: AH123456 CDS LIC NO. 7890 LIC NO. MD-6543

PATIENT_____ AGE_____

ADDRESS_____ DATE_____

Rx

| REFILLS | DO NOT LABEL |
|---|---|
| SUBSTITUTION PERMISSIBLE | DO NOT SUBSTITUTE |
| CONTROL NUMBER 0064 | SIGNATURE |

# APPENDIX C:

## A PROPOSAL TO REQUIRE TIMELY MEDICAL BILLS

AN ACT revising parts of statutory law and requiring the timely submission of medical bills and allowing for non payment of claims for late bills.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. Section 50 of P.L. 1990, c. 8 (C.17:33B-46) is amended to read as follows:

a. Every insurer writing private passenger automobile insurance in this State shall, within 360 days of the effective date of this act, file with the commissioner a plan for the prevention of fraudulent insurance applications and claims and for the prevention of automobile theft. The plan shall be deemed approved by the commissioner if not affirmatively approved or disapproved by the commissioner within 90 days of the date of filing. The commissioner may call upon the expertise of the Director of the Division of Insurance Fraud Prevention in his review of plans filed pursuant to this subsection. During the 90 day approval period the commissioner may request such amendments to the plan as he deems necessary. Any subsequent amendments to a plan filed with and approved by the commissioner shall be submitted for filing and deemed approved if not affirmatively approved or disapproved within 90 days from the date of filing.

b. The implementation of plans filed and approved pursuant to subsection a. of this section shall be monitored by the Division of Insurance Fraud Prevention in the Department of Insurance. Each insurer writing private passenger automobile insurance in this State shall report to the director on an annual basis, beginning January 1, 1992, on its experience in implementing its fraud and theft prevention plan.

c. Upon reasonable notice, the commissioner shall order a reduction of up to 20 percent in the automobile physical damage base rates of any insurer for failure to submit a plan, failure to submit any amendments to an approved plan, failure to properly implement an approved plan in a reasonable manner and within a reasonable time period, failure to provide a report required pursuant to subsection b. of this section or for any other violation of the provisions of this section. The rate reduction shall continue in effect until the insurer is in compliance with the requirements of this section.

d. All claims for payment for medical services and related benefits made

by medical service providers, which services represent Personal Injury Protection (PIP) benefits to be paid pursuant to a policy of insurance issued within this State, (excluding the amount of any applicable deductible or copayment to be paid by the patient or insured party) may be declined by any insurer, or insurance carrier licensed to transact business within the State, unless notice of the commencement of the provision of medical services is provided, in the form determined by the Commissioner of Insurance, to the insurer or insurance carrier licensed to transact business in this State, not later than 30 days after the initial provision of medical services to include any initial treatment, diagnosis, tests, or consultation. If proper notification has been made and the name, address and policy and/or claim number of the insurer or insurance carrier licensed to transact business within this State has been properly made available, the medical service provider shall not pursue the patient or insured party for payment of such benefits. Where multiple insurers, insurance carriers or concurrent coverage exist, the medical service provider must notify each known insurer or insurance carrier of the commencement of medical services. If at 60 days from the commencement of medical services there is no known insurer or insurance carrier, the medical service provider shall have the patient execute a form determined by the Commissioner of Insurance showing good faith attempt to uncover an applicable policy of insurance.

# APPENDIX D:

## A BILL TO REQUIRE PROFESSIONALS TO REPORT FRAUD BY COLLEAGUES

AN ACT revising part of the Medical Practice Act and creating a colleague reporting provision applicable to other health care professionals.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. Section 5 of P.L. 1989, c.300 (C.45:9-19.5) is amended to read as follows:

a. A physician or medical resident or intern, or podiatrist or bioanalytical laboratory director or physician assistant or acupuncturist, hereinafter referred to as a "practitioner," shall promptly notify the State Board of Medical Examiners if that practitioner is in possession of information which reasonably indicates that another practitioner has demonstrated an impairment, gross incompetence or unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety and welfare. A practitioner shall promptly notify the State Board of Medical Examiners if that practitioner is in possession of information which reasonably indicates that another practitioner has engaged in fraudulent conduct in connection with the rendition of or billing for medical or psychiatric services. A practitioner who fails to so notify the board is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

b. There shall be no private right of action against a practitioner for failure to comply with the reporting requirements of this section.

c. A practitioner who notifies the board about a practitioner who is impaired or grossly incompetent or who has demonstrated unprofessional or fraudulent conduct pursuant to this section is not liable for damages to any person for notifying the board unless the practitioner knowingly provided false information to the board.

d. Notwithstanding the provisions of this section to the contrary, a practitioner is not required to notify the board about an impaired or incompetent practitioner if he has knowledge of the practitioner's impairment or incompetence as a result of rendering treatment to the practitioner.

2. (New Section)

a. A physician or medical resident or intern, or podiatrist or bioanalytical laboratory director or physician assistant or acupuncturist or dentist or chiropractor or psychologist or physical therapist or pharmacist or nurse or social worker or marriage counselor or respiratory therapist or ophthalmic dispenser or audiologist or speech language pathologist or hearing aid dispenser or orthotist or prosthetists, hereinafter referred to as a "health care professional" shall promptly notify the Division of Consumer Affairs if that professional is in possession of information which reasonably indicates that another health care professional has demonstrated an impairment, gross incompetence or unprofessional conduct which would present an imminent danger to an individual patient or to the public health, safety and welfare. A health care professional shall promptly notify the Division of Consumer Affairs if that health care professional is in possession of information which reasonably indicates that another health care professional has engaged in fraudulent conduct in connection with the rendition of or billing for medical or psychiatric services. A professional who fails to so notify the Division is subject to disciplinary action and civil penalties pursuant to sections 8, 9 and 12 of P.L.1978, c.73 (C.45:1-21 to 22 and 45:1-25).

b. There shall be no private right of action against a health care professional for failure to comply with the reporting requirements of this section.

c. A health care professional who notifies the Division about another who is impaired or grossly incompetent or who has demonstrated unprofessional or fraudulent conduct pursuant to this section is not liable for damages to any person for notifying the board unless the professional knowingly provided false information to the board.

d. Notwithstanding the provisions of this section to the contrary, a professional is not required to notify the Division about an impaired or incompetent health care professional if he has knowledge of the professional's impairment or incompetence as a result of rendering treatment to the professional.

e. If the health care professional is a practitioner within the meaning of section 5 of P.L. 1989 c. 300, (C. 45:919.5) and has filed a report with the State Board of Medical Examiners in accordance with that section, no additional report shall be required to be filed with the Division of Consumer Affairs pursuant to this section.

# APPENDIX E:

## A MODEL REGULATION ESTABLISHING PROFESSIONAL ACCOUNTABILITY

### RECORD MAINTENANCE

Licensees shall prepare and maintain permanent records relating to billings made to patients, carriers, health benefit plans or third party administrators for professional services. All treatment records, bills and claim forms shall accurately reflect treatment and services rendered and, if required, a diagnosis. Billing records shall be maintained for a period of 7 years from the delivery of the service. A licensee's assessment of the health status of a patient related to insurability, disability or medical necessity for a service shall accurately reflect the licensee's best professional judgment. An estimate offered by a licensee as to the likely duration of a disability, the number of treatments expected, or the duration of treatment shall accurately reflect the licensee's best professional judgment. Licensee billings for goods and drugs shall be obligated to retain records relating to the actual acquisition costs for those goods or drugs.

### BILLING CONTENT

Billing records shall reflect:

1. The identity of the patient to whom the service was delivered.

2. The date that the treatment or service was rendered and the time of the delivery if an extra charge is made for the rendition of services during other than customary times .

3. A plain language description of the treatment or service rendered, in addition to any codes that may be used.

4. The identity and license category of the treatment provider who actually delivered the service if the service is rendered in a setting in which more than one health care provider practices. If the service is delivered by an unlicensed person, the billing record and claim form shall so reflect.

5. The location of the delivery of the service if not at the office premise of the licensee who performed the service.

6. With respect to billings wherein there is a separate charge for goods or drugs, the bill shall reflect the cost incurred by the licensee to provide that good or drug.

Licensees shall utilize the New Jersey Uniform Health Care Provider bill form, utilizing the assigned uniform provider number, and a plain language description of all references to codes.

## LICENSEE ACCOUNTABILITY

A licensee shall be held responsible for all bills, claim forms and reports bearing his or her name whether:

1. signed personally, or
2. signed in the licensee's name, by authorized office personnel, or
3. submitted electronically through computer or facsimile transmission or through a billing service.

Any bill, claim form or report which does not bear the signature of the licensee shall be initialled by the preparer. Licensees shall be presumed to have authorized all bills, claim forms and reports bearing their names even if not personally signed. Licensees may not authorize office personnel to utilize a signature stamp in the preparation of bills, claim forms or reports.

## TIMELY BILLING

Licensees shall submit bills for services within thirty (30) days from the onset of treatment for injuries sustained in an accident reimbursable under the PIP program. Subsequent bills shall be submitted not later than every thirty (30) days thereafter after each subsequent treatment.

## LICENSEE FEES

Licensees shall not charge an excessive fee for services rendered. Factors which may be considered in determining whether a fee is excessive include but are not limited to the following:

1. The time and effort required;
2. The novelty and difficulty of the procedure or treatment;
3. The skill required to perform the procedure or treatment properly;
4. Any requirements or conditions imposed by the patient or by circumstances;
5. The nature and length of the professional relationship with the patient;
6. The experience, reputation and ability of the licensee or other person performing the services;
7. The nature and circumstances under which the services were provided.

## FEE DISCLOSURE

Licensees shall prepare and maintain a written list of current fees for standard services, which list shall be available to patients, carriers, health care benefit plans, and third party administrators upon request. Licensees shall post in a conspicuous place a notice stating "Information on Professional Fees is Available to You on Request." Except in emergency circumstances or where the nature of the licensee-patient relationship will preclude or render infeasible discussion in advance of providing a service, licensees shall apprise patients of all components of a likely fee, including anticipated testing and follow-up. To the extent that there are significant variables typically associated with the provision of a particular service, the licensee shall so advise the patient.

## FEE LIMITATION

Licensees shall not charge a patient a fee for services rendered in connection with completion of a basic medical claim form for a carrier, health care benefit plan, third party administrator. Where a licensee supervises the services rendered by another health care provider (whether licensed or unlicensed) the supervising licensee's fee shall reasonably reflect the nature of service personally rendered by the licensee. The licensee shall certify that the charge is not in excess of an applicable standard fee schedule. On any claim form submitted to a carrier, governmental health benefit program, health care benefit plan, or third party administrator the licensee shall disclose if there has been an agreement to waive a portion of the charge. Nothing herein is intended to preclude a licensee from reducing the standard fee or waiving a portion of a standard charge in accordance with a contract with a carrier, governmental health benefit program, health care benefit plan, preferred provider agreement or health maintenance organization. Nothing herein shall preclude a licensee from reducing or waiving a fee or allowing for an installation payment schedule for charitable purposes or individual need or in satisfaction of community service obligations.

## REFERRAL LIMITATIONS

A licensee shall not offer or accept any fee, commission, rebate, gift or any other form of compensation for the referral of a patient. A licensee shall not refer any patient, either directly or indirectly, to an attorney for the purpose of representation in a matter wherein the medical condition of the patient is at issue.

## DISCLOSURE OF SIGNIFICANT BENEFICIAL INTEREST

A licensee having a significant beneficial interest in a health care service, including a professional service corporation or general business corporation (where permitted) shall notify the Board on the biennial renewal form of the name and address of each such service and principals. Notice is not required for a service conducted under the licensee's own name.

## PRESCRIPTION REQUIREMENTS

A licensee shall issue written prescriptions in this state only on New Jersey prescription blanks (NJPB) which shall be prepared by a vendor authorized by the New Jersey Office of Drug Control, in consultation with the Division of Purchase. New Jersey prescription blanks shall be non-photocopiable, non-erasable and serialized. The prescribing licensee shall retain a copy of the NJPB; the original is to be provided to the patient for presentation to a pharmacist. All prescriptions shall be dated on the day issued and written in the name of the individual for whom the medication is intended.

## VIOLATIONS

Failure by a licensee to comply with the requirements of this rule shall be deemed to be professional misconduct in violation of N.J.S.A. 45:1-21(e). Issuance of a prescription in the name of an individual for whom medication is not intended shall be deemed professional misconduct in violation of N.J.S.A. 45:1-21(e) and may be deemed to be fraudulent conduct in violation of N.J.S.A. 45:1-21(b). Completion of a claim form misrepresenting any information as required by subsection (b) shall be deemed professional misconduct in violation of N.J.S.A. 45:1-21(e) and may be deemed to be fraudulent conduct in violation of N.J.S.A. 45:1-21(b).

# APPENDIX F:

## A BILL TO ENHANCE PROFESSIONAL BOARD ENFORCEMENT

AN ACT revising parts of statutory law and providing for enhanced penalties for professionals engaging in misconduct.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. Section 8 of P.L. 1978, c. 73 (C.45:1-21 et seq.) is amended to read as follows:

A board may refuse to admit a person to an examination or may refuse to issue or may suspend or revoke any certificate, registration or license issued by the board upon proof that the applicant or holder of such certificate, registration or license:

a. Has obtained a certificate, registration, license or authorization to sit for an examination, as the case may be, through fraud, deception, or misrepresentation;

b. Has engaged in the use or employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense;

c. Has engaged in gross negligence, gross malpractice or gross incompetence;

d. Has engaged in repeated acts of negligence, malpractice or incompetence;

e. Has engaged in professional or occupational misconduct as may be determined by the board;

f. Has been convicted of any crime involving moral turpitude or any crime relating adversely to the activity regulated by the board. For the purpose of this subsection a plea of guilty, non vult, nolo contendere or any other such disposition of alleged criminal activity shall be deemed a conviction;

g. Has had his [authority to engage in the activity regulated by the board revoked or suspended by any other state, agency or authority] <u>license, certificate, or registration to practice the profession or occupation regulated by the board suspended or revoked or otherwise limited by another state or has been subjected to disciplinary action in another state, or has surrendered his license, certificate or registration in the face of disciplinary charges or an investigation into professional misconduct in another state;</u>

h. Has violated or failed to comply with the provisions of any act or regulation administered by the board;

i. Is in capable, for medical or any other good cause, of discharging the functions of a licensee in a manner consistent with the public's health, safety and welfare;

j. Has repeatedly failed to submit completed applications, or parts of, or documentation submitted in conjunction with, such applications, required to be filed with the Department of Environmental Protection.

For the purpose of this act:

"Completed application" means the submission of all the information designated on the checklist, adopted pursuant to section 1 of P.L. 191, c. 421 (C. 13:1D-101), for the class or category of permit for which application is made.

"Permit" has the same meaning as defined in section 1 of P.L. 191, c.421 (C. 13:1D-101).

k. Has had his authority to participate in a reimbursement program administered by a state or federal agency terminated or otherwise limited provided that the underlying basis for the action was for reasons consistent with this section or the pertinent professional practice act.

2. Section 9 of P.L. 1978, c. 73 (C.45:1-22) is amended to read as follows:

In addition or as an alternative, as the case may be, to revoking, suspending or refusing to renew any license, registration or certificate issued by it, a board may, after affording an opportunity to be heard:

a. Issue a letter of warning, reprimand, or censure with regard to any act, conduct or practice which in the judgment of the board upon consideration of all relevant facts and circumstances does not warrant the initiation of formal action;

b. Assess civil penalties in accordance with this act;

c. Order any person violating any provision of an act or regulation administered by such board cease and desist from future violations thereof or to take such affirmative corrective action as may be necessary with regard to any act or practice found unlawful by the board;

d. Order any person found to have violated any provision of an act or regulation administered by such board to restore to any person aggrieved by an unlawful act or practice, any moneys or property, real or personal, acquired by means of such act or practice; provided, however, no board shall order restoration in a dollar amount greater than those moneys received by a licensee or his agent or any other person violating the act or regulation administered by the board;

e. Order any person, as a condition for continued, reinstated or renewed licensure, to secure medical or such other professional treatment as may be necessary to properly discharge licensee functions.

A board may, upon a duly verified application of the Attorney General alleging an act or practice violating any provision of an act or regulation administered by such board, enter a temporary order suspending or limiting any license issued by the board pending plenary hearing on an administrative complaint; provided, however, no such temporary order shall be entered unless the application made to the board palpably demonstrates a clear and imminent danger to the public health, safety and welfare and notice of such application is given to the licensee affected by such order.

A board, upon a duly verified application of the Attorney General which establishes that there is good cause to conclude that a licensee has engaged in the employment of dishonesty, fraud, deception, misrepresentation, false promise or false pretense in connection with health care funds or services, may enter a temporary order suspending or limiting the license of the health care professional pending plenary hearing on an administrative complaint; provided, however that no such temporary order shall be entered unless notice of such application is given to the licensee affected by such orders. Good cause may be established by a judgment or order of a court of competent jurisdiction, a plea of guilty, non vult, nolo contendere entered before a court of competent jurisdiction, a judgment or order of an administrative agency, a grand jury indictment or by other evidence that such violations of civil or criminal law did, in fact, occur.

The board may delegate to its chairman or president the responsibility of considering an application on an emergent basis, provided that the board considers and reviews the depositing of the application at its next regularly scheduled meeting.

In any administrative proceeding commenced on a complaint alleging a violation of an act or regulation administered by a board, such board may issue subpoenas to compel the attendance of witnesses or the production of books, records, or documents at the hearing on the complaint.

# APPENDIX G:

## A BILL TO RAISE THE CRIMINAL STAKES

AN ACT revising parts of statutory law and providing for enhanced penalties for professionals engaging in misconduct.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. Section 1 of P.L. 1930, c. 85 (C.2A:170-85) is amended to read as follows:

Any person shall be guilty of a crime of the fourth degree, who, for pecuniary gain, solicits any person or corporation to engage, employ or retain either himself, any lawyer or any other person to manage, adjust or prosecute any claim, cause of action or action at law, against any person or corporation, for damages for negligence, or who, for pecuniary gain, directly or indirectly solicits other persons to begin actions at law to recover damages for personal injuries or death [, is a disorderly person].

2. Section 15 of P.L. 1989, c. 300 (C.2C:21-4.1) is amended to read as follows:

A person is guilty of a crime of the fourth degree if he purposefully destroys, alters or falsifies any record relating to the health care of [a medical or surgical or podiatric] any patient in order to deceive or mislead any person as to information, including, but not limited to, a diagnosis, test, medication, treatment or medical or psychological history, concerning the patient or the billings related to treatment.

3. Section 14 of P.L. 1989, c. 300 (C.2C:21-20) is amended to read as follows:

A person is guilty of a crime of the third degree if he knowingly does not possess a license or permit to practice [medicine and surgery or podiatry] a health care profession requiring a license or a permit in this State, or knowingly has had the license or permit suspended, revoked or otherwise limited by an order entered by the [State Board of Medical Examiners] agency responsible for the regulation of that practice, and he:

a. engages in that practice;

b. exceeds the scope of practice permitted by the board order;

c. holds himself out to the public or any person as being eligible to engage in that practice;

d. engages in any activity for which such license or permit is a necessary prerequisite, including, but not limited to, the ordering of controlled dangerous substances or prescription legend drugs from a distributor or manufacturer; or

e. practices [medicine or surgery or podiatry] a health care profession under a false or assumed name or falsely impersonates another person licensed by the board.

4. Section 4 of P.L. 1989, c.23 (C.2C:44-1)

Criteria for Withholding or Imposing Sentence of Imprisonment.

a. In determining the appropriate sentence to be imposed on a person who has been convicted of an offense, the court shall consider the following aggravating circumstances:

(1) The nature and circumstances of the offense, and the role of the actor therein, including whether or not it was committed in an especially heinous, cruel, or depraved manner;

(2) The gravity and seriousness of harm inflicted on the victim, including whether or not the defendant knew or reasonably should have known that the victim of the offense was particularly vulnerable or incapable of resistance due to advanced age, ill-health, or extreme youth, or was for any other reason substantially incapable of exercising normal physical or mental power of resistance;

(3) The risk that the defendant will commit another offense;

(4) A lesser sentence will depreciate the seriousness of the defendant's offense because it involved a breach of the public trust under chapters 27 and 30, or the defendant took advantage of a position of trust or confidence to commit the offense;

(5) There is a substantial likelihood that the defendant is involved in organized criminal activity;

(6) The extent of the defendant's prior criminal record and the seriousness of the offenses of which he has been convicted;

(7) The defendant committed the offense pursuant to an agreement that he either pay or be paid for the commission of the offense and the pecuniary incentive was beyond that inherent in the offense itself;

(8) The defendant committed the offense against a police or other law enforcement officer, correctional employee or fireman, acting in the performance of his duties while in uniform or exhibiting evidence of his authority, or the defendant committed the offense because of the status of the victim as a public servant;

(9) The need for deterring the defendant and others from violating the law;

(10) The offense involved fraudulent or deceptive practices committed against any department or division of State government;

(11) The imposition of a fine, penalty or order of restitution without also imposing a term of imprisonment would be perceived by the defendant or others merely as part of the cost of doing business, or as an acceptable contingent business or operating expense associated with the initial decision to resort to unlawful practices;

(12) The defendant committed the offense against a person who he knew or should have known was 60 years of age or older, or disabled.

(13) The offense involved theft of health care funds or services or fraudulent practices involving funds intended for the payment of health care costs or the delivery of health care services.

(14) The defendant is an administrator in a health care facility, whether public or private, offering health-related services to the public and the crime involved acts or omissions arising in the course of his or her employment as a health care administrator.

b. In determining the appropriate sentence to be imposed on a person who has been convicted of an offense, the court may

properly consider the following mitigating circumstances:

(1) The defendant's conduct neither caused nor threatened serious harm;

(2) The defendant did not contemplate that his conduct would cause or threaten serious harm;

(3) The defendant acted under a strong provocation;

(4) There were substantial grounds tending to excuse or justify the defendant's conduct, though failing to establish a defense;

(5) The victim of the defendant's conduct induced or facilitated its commission;

(6) The defendant has compensated or will compensate the victim of his conduct for the damage or injury that he sustained, or will participate in a program of community service;

(7) The defendant has no history of prior delinquency or criminal activity or has led a law-abiding life for a substantial period of time before the commission of the present offense;

(8) The defendant's conduct was the result of circumstances unlikely to recur;

(9) The character and attitude of the defendant indicate that he is unlikely to commit another offense;

(10) The defendant is particularly likely to respond affirmatively to probationary treatment;

(11) The imprisonment of the defendant would entail excessive hardship to himself or his dependents;

(12) The willingness of the defendant to cooperate with law enforcement authorities;

(13) The conduct of a youthful defendant was substantially influenced by another person more mature than the defendant.

c. (1) A plea of guilty by a defendant or failure to so plead shall not be considered in withholding or imposing a sentence of imprisonment.

(2) When imposing a sentence of imprisonment the court shall consider the defendant's eligibility for release under the law governing parole, including time credits awarded pursuant to Title 30 of the Revised Statutes, in determining the appropriate term of imprisonment.

d. Presumption of imprisonment. The court shall deal with a person who has been convicted of a crime of the first or second degree by imposing a sentence of imprisonment unless, having regard to the character and condition of the defendant, it is of the opinion that his imprisonment would be a serious injustice which overrides the need to deter such conduct by others.

e. The court shall deal with a person convicted of an offense other than a crime of the first or second degree, who has not previously been convicted of an offense, without imposing sentence of imprisonment unless, having regard to the nature and circumstances of the offense and the history, character and condition of the defendant, it is of the opinion that his imprisonment is necessary for the protection of the public under the criteria set forth in subsection a.; except that this subsection shall not apply if the person is convicted of any third or fourth degree crime of theft or fraud as delineated in chapters 20 and 21 of Title 2C of the New Jersey Statutes involving health care funds or the delivery of health care services.

f. Presumptive Sentences. (1) Except for the crime of murder, unless the preponderance of aggravating or mitigating factors, as set forth in subsections a. and b., weighs in favor of a higher or lower term within the limits provided in N.J.S.A.. 2C:43-6, when a court determines that a sentence of imprisonment is warranted, it shall impose sentence as follows:

(a) To a term of 20 years for aggravated manslaughter or kidnapping pursuant to paragraph (1) of subsection c. of N.J.S.A.. 2C:13-1 when the offense constitutes a crime of the first degree;

(b) Except as provided in paragraph (a) of this subsection to a term of 15 years for a crime of the first degree;

(c) To a term of seven years for a crime of the second degree;

(d) To a term of four years for a crime of the third degree; and

(e) To a term of nine months for a crime of the fourth degree.

In imposing a minimum term pursuant to 2C:43-6b., the sentencing court shall specifically place on the record the aggravating factors set forth in this section which justify the imposition of a minimum term.

Unless the preponderance of mitigating factors set forth in subsection b. weighs in favor of a lower term within the limits authorized, sentences imposed pursuant to 2C:43-7a. (1) shall have a presumptive term of life imprisonment. Unless the preponderance of aggravating and mitigating factors set forth in subsections a. and b. weighs in favor of a higher or lower term within the limits authorized, sentences imposed pursuant to 2C:43-7a. (2) shall have a presumptive term of 50 years' imprisonment; sentences imposed pursuant to 2C:43-7a. (3) shall have a presumptive term of 15 years' imprisonment; and sentences imposed pursuant to 2C:43-7a. (4) shall have a presumptive term of seven years' imprisonment.

In imposing a minimum term pursuant to 2C:43-7b., the sentencing court shall specifically place on the record the aggravating factors set forth in this section which justify the imposition of a minimum term.

(2) In cases of convictions for crimes of the first or second degree where the court is clearly convinced that the mitigating factors substantially outweigh the aggravating factors and where the interest of justice demands, the court may sentence the defendant to a term appropriate to a crime of one degree lower than that of the crime for which he was convicted. if the court does impose sentence pursuant to this paragraph, or if the court imposes a noncustodial or probationary sentence upon conviction for a crime of the first or second degree, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by prosecution.

g. Imposition of Noncustodial Sentences in Certain Cases. If the court, in considering the aggravating factors set forth in subsection a., finds the aggravating factor in paragraph a.(2) or a.(12) and does not impose a custodial sentence, the court shall specifically place on the record the mitigating factors which justify the imposition of a noncustodial sentence.

# APPENDIX H:

## STATE AGENCIES FIGHTING HEALTH FRAUD

### a. Department of Law and Public Safety - Division of Criminal Justice

#### i. Medicaid Fraud Section/Fraud Bureau

The Medicaid Fraud Section is responsible for investigating and prosecuting health care providers who commit fraud under the State Medicaid Program as well as violations of any state laws in the administration of the State Medicaid Program. In addition to the Section's responsibility to investigate and prosecute Medicaid provider fraud and fraud in the administration of the Medicaid program, the section is also required to review complaints of patient abuse or neglect in all residential health care facilities that receive Medicaid funds. In this endeavor, the Medicaid Fraud Section receives funding from the Federal Government, pursuant to Federal enabling legislation and corresponding regulations designed to strengthen the capability of the government to detect, prosecute and punish health care fraud within the nearly three billion dollar State Medicaid Program. See Medicare-Medicaid Anti-Fraud and Abuse Amendment of 1977 (P.L. 95-142).

#### ii. Insurance Fraud Section/Fraud Bureau

The Insurance Fraud Unit is responsible for investigating and prosecuting health care fraud committed against private insurance carriers and the Market Transition Facility (the successor to the JUA). The targets of these health care insurance related cases generally include health care providers who bill for treatments, services or equipment not rendered or provided; health care insurance benefit recipients who elect the direct pay method of health care cost reimbursement and submit phony medical service related bills to the insurance carriers for reimbursement; health insurance carrier employees who steal money from the health insurance carrier usually through paying phony claims and benefits to other conspiring individuals; individuals who submit bills to insurance carriers for professional services that were not, in fact, rendered by the appropriate licensed professional; conspiring doctors and lawyers who submit questionable medical bills to inflate recoveries on insurance claims primarily from purported auto related injuries; and insurance agents who misappropriate insurance premiums.

#### iii. Major Fraud Section/Fraud Bureau

The Major Fraud Section is responsible for investigating and prosecuting other areas of fraud in the health care industry where the source of the stolen funds cannot be directly traced or attributed to either private insurance carriers or the State Medicaid Program. These cases frequently arise in a hospital setting and may implicate a health care professional, an executive officer of the hospital, or any employee of the hospital in criminal activity.

iv. **Drug Diversion Unit/Narcotics Bureau**

The Drug Diversion Unit, located in the Narcotics Bureau, conducts pro-active and reactive criminal investigations and prosecutions on illicit pharmaceutical diversions by health care professionals or others having access to the illicit drugs through the health care industry. The Unit is funded by a Narcotics Block Grant, as well as licensing agencies and forfeiture funds.

**b. Division of Consumer Affairs**

At present there are more than 30 professional licensing boards or committees -- half of which regulate health care providers -- established within the Division of Consumer Affairs. Each Board is empowered to investigate violations of the relevant practice acts by licensees and unlicensed persons. Investigations can be conducted by the board itself, a committee of the board at an investigative hearing, by the Attorney General or by the investigative arm of the boards, the Enforcement Bureau. The Enforcement Bureau services all of the professional licensing boards and is divided into five sections. While each section may have a primary focus, cases developed in all sections often demonstrate an overlay of fraud.

i. **Drug Diversion Section**
This section is primarily responsible for investigating matters involving the unlawful distribution of or diversion of CDS - whether by physicians, pharmacies, podiatrists, nurses, veterinarians.

ii. **Medical Malpractice Section**
Matters involving quality of care are generally investigated by the Medical Malpractice section which employs a number of investigators who are registered nurses. These investigations often involve the retrieval and review of patient records. While the impetus for an investigation may be an initial concern with the quality of care, often times, fraudulent activities are revealed in the course of reviewing these records. This section might also be assigned the responsibility for conducting an inspection at a health care provider's office since trained personnel within this section are knowledgeable concerning the standards to which office practice is held.

iii. **Investigation Section**
The investigation section handles a variety of matters - although not those involving the unlawful distribution of a diversion of controlled dangerous substances. Again, inspections and undercover investigations are often launched by the investigators within this section.

iv. **Inspection Section**
Personnel within the inspection section are responsible for the conduct

of routine inspections of pharmacies (retail and institutional, schools of cosmetology and hairstyling, beauty shops, barber shops, funeral homes, and establishments which prepare and dispense prescription lenses). The routine inspections of pharmacies in particular often provides information which requires additional investigation by another section of the Enforcement Bureau.

v. **Southern Investigations Unit**

This section is responsible for all investigations including those involving the unlawful distribution of a diversion of CDS which arise out of the southern counties of the state.

The Enforcement Bureau prepares written investigative reports which are transmitted to the Boards and the Division of Law for further handling. Where preliminary investigation reveals conduct which may place the public at risk, early coordination with the Division of Law is undertaken and, where necessary, temporary suspension proceedings are initiated. The Boards are also authorized to conduct hearings in quasi-judicial capacity in determine what penalty, if any, ought to be meted out to a licensee. Penalties can range from a reprimand, fines, reimbursement to patients or third party insurers, practice limitations, suspension or revocation. Matters are prosecuted before the professional boards by an assigned prosecuting deputy attorney general.

**c. Department of Insurance - Insurance Fraud Division**

The Insurance Fraud Division is sub-divided into 12 Bureaus:

(1) North (2) South (3) Central (4) Training and Prevention (5) Special Investigative (6) Trial Preparation (7) Collections (8) Administrative (9) Intelligence (l0) Compliance (ll) Workers Comp. (12) Health Care. While there may be health care fraud cases that are handled by any of the above sections, those that have been received from a referral from a health insurer - Blue Cross/Blue Shield, Prudential, etc., are referred to the Health Care Bureau. Eighty percent of the cases handled by the Division of Insurance Fraud arise in the context of private passengerautomobile insurance.

**d. Department of Human Services - Division of Medical Assistance and Health Services. Office of Program Integrity Administration, (OPIA)**

OPIA's functions include the detection and investigation of providers and recipients involved in fraudulent or abusive activity and referral of such cases to other state and federal agencies for appropriate civil, criminal or administrative action. Also included are the recovery of correct, incorrect, and illegal payments from providers, recipients and other parties, recoupment of funds expended where a third party is or may be liable for payment, and correct payment recoveries from estates.

i. **SURS Review Unit**

The SURS Review Unit is responsible for utilizing the Surveillance and Utilization Review Subsystem (SURS). SURS is a statistical review system that is retrospective to claims processing. Its goal is to provide a manageable approach to gathering and displaying data regarding medical care and service delivery. Information generated by this system can be used to point out possible instances of program fraud and abuse for subsequent case development, administrative findings and legal action. In addition, SURS is required to contain program costs, assure quality of care, and to provide input to management to identify needs for program improvements. The Unit is responsible for meeting quotas set by the federal Systems Performance Review for states operating a certified Medicaid Management Information System (MMIS). This Unit is responsible for the design, development, and implementation of new SURS strategies and procedures. This Unit designs system parameter changes, evaluates resulting SURS output, and maintains the Control File on an ongoing basis while enhancing the system. All requests for information by other DMAHS units are coordinated and implemented in SURS. This Unit trains new users; coordinates the ordering, compilation and distribution of data; coordinates the completion of quarterly and annual quotas of recipient and provider reviews (including SURS cases referred to other OPIA units, DMAHS units, Professional Boards, etc.). This Unit is responsible for maintaining a tracking system of providers and recipients under current investigation to avoid duplication of effort, and so as not to interfere with any pending investigations. The Unit is also responsible for reviewing providers and recipients while continuously testing and upgrading the system.

### ii. Bureau of Medical Care Surveillance

The Bureau of Medical Care Surveillance is responsible for monitoring and reviewing providers and recipients participating in, or serviced by, the programs administered by DMAHS.

**A. Provider Unit**

The Provider Unit is responsible for monitoring, through the MMIS computer-generated reports and other sources, the utilization activities of providers to identify and investigate potential fraud and abuse in the Medicaid, PAAD, and other programs administered by DMAHS.

**B. Recipient Monitoring Unit**

The Recipient Monitoring Unit consists of the Investigative Section and the Special Status Section, which assure that services rendered to Medicaid recipients and PAAD beneficiaries are monitored for appropriateness. The Investigative Section is responsible for monitoring Medicaid recipient and PAAD beneficiary utilization of services to

identify and investigate potential fraud and abuse, and to pursue appropriate sanctions, including the filing of criminal and disorderly persons complaints. The Special Status Section restricts the utilization activities of Medicaid recipients and PAAD beneficiaries who defraud or abuse the Medicaid or PAAD programs through the issuance of special status Medicaid Eligibility Identification (MEI) cards. These special status MEI cards either restrict Medicaid recipients or PAAD beneficiaries to one specific provider, or they warn providers that an MEI card has been used by an unauthorized person or persons or for an unauthorized purpose.

### iii. Bureau of Quality Control

The Bureau of Quality Control (BQC) is responsible for the administration of the federally mandated Medicaid Eligibility Quality Control (MEQC) system. The MEQC System is based on a monthly review of Medicaid recipients identified through statistically reliable statewide samples of cases selected from the eligibles' files. These reviews are conducted to determine whether or not the sampled cases meet applicable eligibility requirements and that the amounts paid to provide Medicaid services for these cases are correct. The information gathered from these reviews provides the basis for planning corrective action to reduce erroneous Medicaid payments. Any errors discovered are classified according to type and are compared to national averages. If the error rates are above the national average, the Medicaid Program will have until the next reporting period to reduce its error rates or face fiscal sanctions in the amount of the excess percentage of errors.

#### A. Medicaid Quality Control Units I & II

The Medicaid Quality Control Units are responsible for conducting federally mandated program eligibility reviews on random statewide monthly samples of Medicaid recipients. Gathered information is used for identifying eligibility errors, computing payment error rates, and for developing and/or monitoring corrective actions.

#### B. Information Processing Unit

The Information Processing Unit (IPU) is primarily responsible for the operation of the National Integrated Quality Control System (NIQCS). The NIQCS is a Federal reporting and processing system used by states to officially store and transmit data, and to generate reports pertaining to the MEQC System. Other critical functions include conducting the Claims Payment Review for MEQC cases, providing Medicaid database inquiry or retrieval support to MEQC staff, and screening the MEQC sample against the Internal Revenue Service 1099 match. The IPU Supervisor serves as the Security Officer/Liaison for database inquiry

systems accessed by BQC staff, and conducts Systematic Alien Verification for Entitlements (SAVE) inquiries.

### iv. Bureau of Third Party Liability

The Bureau of Third Party Liability (BTPL) is responsible for the identification of recipients' other health insurance of maximize DMAHS's cost avoidance and recovery activities. The BTPL is organized into five (5) units: PAAD Intake Unit, PAAD Recovery Unit, Medicaid Intake Unit, Medicaid Recovery Unit, and Buy-In Unit.

**A. PAAD Intake Unit**
The PAAD Intake Unit determines the TPL of PAAD beneficiaries. Activities include the identification of TPL and the maintenance of the TPL Insurer file for the submission of recovery billing.

**B. PAAD Recovery Unit**
The PAAD Recovery Unit is responsible for the submission of and accounting for recovery billing and subsequent follow-up.

**C. Medicaid Intake Unit**
The Medicaid Intake Unit determine the TPL of Medicaid recipients. Activities include the maintenance of the TPL Resource File and the daily intake of TPL-1's and SSA 8019's from MDO's, CWA's, and SSA and ISS offices.

**D. Medicaid Recovery Unit**
The Medicaid Recovery Unit is responsible for the submission of and accounting for recovery billing and subsequent follow-up. Activities include monitoring the TPL contractor.

**E. Buy-In Unit**
The Buy-In Unit is responsible for the payment of Medicare premiums for Medicaid recipients. Activities include the maintenance of Buy-In records and the Automated Benefits Information Exchange (ABIE) system.

### v. Bureau of Administrative Control

The Bureau of Administrative Control is responsible for taking administrative action against Medicaid and PAAD providers, and Medicaid recipients or PAAD beneficiaries who have engaged in fraud and abuse in the Medicaid and PAAD programs, and for seeking recovery from liable third parties, estates and others.

**A. Recovery Units I & II**
The Recovery Units are responsible for the presentation of claims and recovery of payments in matters involving liable third parties, estates, recipient incorrect payments related to eligibility and fraud, and other recipient-related payments including recipients'

other resources.

**B. Administrative Action Unit**

The Administrative Action Unit is responsible for recommending, initiating and coordinating corrective action against providers and recipients involved in fraudulent or abusive activities. These actions includes suspension, recovery, and referral to other state and federal agencies for appropriate civil, criminal or administrative action.

**vi. Data Retrieval Unit**

The Data Retrieval Unit maintains microfilm/microfiche provider and recipient utilization reports and copies of claims submitted for payment by providers. This unit also provides DMAHS, county welfare agencies and other State and Federal agencies with copies of such documents upon request.

**e. Department of Health**

All fraud, whether it be with respect to the provision of service to individuals, institutions, or financial fraud such as price fixing, kick-backs and the like, is referred directly to the Division of Criminal Justice in the Department of Law and Public Safety. The Health Department's responsibility in investigating fraud has been very limited in the past because there are no specific statutory authorizations for the Department to take on such a role. In the past some consideration has been given to conducting undercover investigations of health care facilities, through the placement of investigators as employees in facilities at various levels for short periods of time in an attempt to identify systemic fraud. Traditional inspections conducted by nurses, pharmacists and other health professionals provide limited benefit in ferreting out fraud, in consultation with the Divisions of Law and Criminal Justice, it was conducted that use of undercover investigators in this manner would be inappropriate.

# APPENDIX I:

## A BILL TO FACILITATING THE SHARING OF INFORMATION

AN ACT revising part of the Medical Practice Act, allowing for the release of investigative materials to other state agencies charged with the responsibility to investigate health insurance fraud.

BE IT ENACTED by the Senate and the General Assembly of the State of New Jersey:

1. Section 3 of P.L.1983, c.248, as amended by section 21 of P.L. 1989, c.300 (C.45:9-19.3), is amended to read as follows:

Any information concerning the conduct of a physician or surgeon provided to the State Board of Medical Examiners pursuant to section 1 of P.L.1983, c. 248 (C.45:9-19.1), section 5 of P.L.1978, c. 73 (C.45:1-18) or any other provision of law, is confidential pending final disposition of the inquiry or investigation by the board. If the result of the inquiry or investigation is a finding of no basis for disciplinary action by the board, the information shall remain confidential, except that the board may release the information in its investigative file to [a] another governmental agency [, for good cause shown, upon an order of the Superior Court after notice to the physician or surgeon who is the subject of the information and an opportunity to be heard. The application for the court order shall be placed under seal [.] in furtherance of that agency's statutory or regulatory responsibilities.