LTC Claims Fraud: Hindsight is 20/20

Pamela Cathlina: Director, Long Term Care Benefits, Northwestern Mutual
Christie Conway: Director, LTC Claims Operations, Bankers Life & Casualty
Michael Gilbert: President, AssuriCare LLC
Session Overview – Key Concepts

- Undiscovered claims fraud costs the industry millions each year.
- Claims organizations necessarily need to drive efficiency – which means you can’t get every piece of information on every claimant, over-review every different type of document, medical record, visit or care notes, surveil every claimant 24x7, etc.
- Each organization needs to make choices about what tools & techniques are in place to meet the often conflicting goals of processing efficiency vs. identification of policy abuse or fraud.
- This session will discuss and review three different case studies which each resulted in substantial losses for the LTC carrier.
- With “20/20 Hindsight”, we have analyzed these cases and will suggest things we could have done earlier in the claims process to identify the fraud before it caused a big loss to the company.
Case Study Scenarios

• “The Accidental Claimant”
  ▪ Claimant accessing policy benefits after a motor vehicle accident

• “My Husband’s Double Life”
  ▪ Claimant’s spouse was agent for policy, primary caregiver and owns “agency”

• “Money for Nothing”
  ▪ Claimant accessing benefits for 5+ years while likely not receiving any care
Claims & Underwriting

The Accidental Claimant

LTCI Claims Case Study

16th Annual Intercompany Long Term Care Insurance Conference
Facts of Case

- August 2008: Policy issued at Insured age 54
  - Lifetime benefit
  - High daily limit
  - Indexing
- October 2008: Motor vehicle accident
- January 2009: Notice for LTC benefits
  - Left sided trauma, pain and dysfunction
  - Unable to brush teeth, toilet, bathe and dress
- All functional assessments suggested ADL dependency; as well as frequently changing medical conditions
- Weekly timesheets indicate insured receiving assistance with all ADLs and cognitive supervision
Facts of Case, cont’d

• The Independent Provider is a friend (no relation)
• IP provided care 18 to 20 hours a day, 7 days a week, for 5 years
• Daily IP charge increases immediately after the maximum daily limit indexes
• Questionable proof of payment
• Reimbursement demanded every Thursday
Investigative Approach

• Performed thorough claim and medical review
• Database research
  – Revealed several MVAs
  – Bankruptcy
  – Active driver’s license
• Conducted in-home interview
  – Insured represented significant decline in health and functional ability
  – Insured signed “confirmation of interview” statement
• Observed activity
  – Inconsistencies with statements from in-home interview
  – Care not observed when represented on service invoices
Outcome

- Closed claim
- Demanded return of benefits paid
- Insured obtained attorney representation
- State fraud reporting
  - State DOI referred case to State investigator and prosecutor for further investigation
  - State conducted evaluation of what steps to ensure restitution (i.e., freezing accounts pending prosecution)
- State’s investigation:
  - Multiple MVAs: Received thousands of dollars in claims - - pattern?
  - Spoke with driver of the MVA that led to this claim
- Current status: Case being staged for prosecution
Hindsight is 20/20

- Should the policy have been issued (knowing about the multiple MVA history)?
  - Likely still yes
- Obtain medical records at time of claim directly from providers
- If MVA is triggering event to cause loss of functional status:
  - Obtain police report for MVA
  - Perform database research for MVA history
- More thorough claim analysis and medical review
- Verification of hours worked and care provided
- Recognize and listen to the red flags
  - Ask questions!
  - Care >12 hours/day, 7 days/wk from one provider with no breaks
Claims & Underwriting

My Husband’s Double Life

LTCI Claims Case Study
Facts of Case

• 2 policies issued:
  – July 2009 (Contracted by agent/spouse)
    • Policyholder age 29-years old
  – November 2010 (Contracted by an agent sought out by agent/spouse)
  – Both policies had lifetime benefits with high daily benefit limits ($130k/yr)

• January 2013: Filed initial claim
  – 33-year-old at time of initial claim
  – Spouse/former agent providing care. Spouse claimed he worked for a home care agency (Title “Manager on Duty”)
  – Initial billed hours 8:00 a.m. to 8:00 p.m.
  – Billed hours changed to 8:00 p.m. to 9:00 a.m.
  – Indicated friends provide informal care

• Conducted three on-site Benefit Eligibility Assessments (March and June 2013 and July 2014)
  – Assessments suggested significant ADL dependencies; Led to approval of claim

• Frequent reimbursement demands and threats to go to DOI and media made by spouse

• Refused LTC Carrier’s telephony verification services
Investigative Approach and Outcome

• Referred case to SIU
  – Underwriting Review
    ✓ Fraudulent misrepresentation identified on 1st application based on how questions were answered on 2nd policy application.
    ✓ Underwriting missed opportunity to reject 2nd application (SSI benefits disclosed)
  – Investigated the HHC Agency
    ✓ Spouse listed as only officer, executive, business contact and resident’s address used as business address

• Conducted surveillance in 2013
  – Claimant walking outside home with a female companion – unassisted
  – When questioned claimant’s ability to move around outside unassisted, claimant stated she has “good days”

• Medical Records
  – Identified that claimant represented a “disabled” status since 2006
Outcome - Result

• Could not prove claimant wasn’t benefit eligible

• August, 2014, denied claim due to the policy’s “Immediate Family” exclusion
  – Spouse was the owner and sole employee of agency

• Recommended seven (7) eligible providers

• Insurance carrier filed fraud report with DOI and opened up an investigation
Facts of Case, the Sequel

• October 2014, received claims for new HHC provider
  – HHC provider selected was not from the list of seven (7) eligible providers
  – New HHC provider had business license that was approved 10 days after claim denied
  – Spouse is listed as formal caregiver and employee under new HHC agency
Investigative Approach and Outcome

- Second referral to SIU
- Additional surveillance conducted on Claimant
  - Was observed moving into new home – unassisted
  - Showed no signs of disability
- Conducted interview with owner of new agency
  - Referred carrier back to the spouse/managing the business
- Ordered proof of payment including bank statements
  - Documentation was incomplete
  - Records did not reflect payment in full of invoiced amounts
  - Spouse confirmed that he was a 1099 independent contractor of the agency (not an employee)
• Denied claim again due to the policy’s “Immediate Family” exclusion
• Sent letter offering to forego litigation in exchange for the policy
• Claimant responded with DOI complaint
• Carrier responded to the DOI complaint to Department’s satisfaction
• Carrier notified Claimant and spouse of possible litigation
  – Attempting to recover benefits paid to date ($269k)
• Claimant recently submitted new bills from an eligible HHC agency
  – Currently under investigation
Hindsight is 20/20

- Recognize and listen to the red flags
- Follow appropriate procedures at time of Underwriting
  - Thoroughly underwrite family members of agents
- Validate agencies and its employees
  - Especially when a family member acting as employee of an agency and is providing care
- Perform appropriate/adequate amount of surveillance
- Take advantage of the extra time provided by states for claim payment when potential fraud is identified
Claims & Underwriting

Money for Nothing

LTCI Claims Case Study

16th Annual Intercompany Long Term Care Insurance Conference
Facts of Case

• Initial claim payment date June 2005
  – 52-yr-old at time of initial claim
• $320/day MDB, Unlimited lifetime maximum, 5% compound inflation protection
  – $116,000 per year when case received
• 6 BEA’s performed from 2005-2012, all approved BE
  – Primary diagnosis: MS
• APOC approved which allowed Private Caregiver
• Same Private Caregiver from 2008-Jan 2012
  – Invoiced 16 hrs / 7 dys for 5+ yrs
  – Simple math: 16 hrs x $20/hr = 100% of MDB
Initial Warning Signs

- AssuriCare / LTCfastpay received the case in December 2011
  - Began using telephonic timecard system Feb 2012
- Claimant initially gave substantial resistance to using timecard system
  - Claimant stated no home phone line, wanted to use cell phone
- Changed caregiver prior to start of timecard system use (after years of using the same caregiver)
- Care documented after use of timecard system began much different than self-reported hours prior to timecard system use
- Telephonic timecard system entries did not match log sheets submitted
Investigative Approach and Strategy

• Placed claimant in elevated initial risk tier
• AssuriCare gathered data for initial 2-week timecard use period
  – Many missing and inconsistent timecard entries
  – Multiple verification calls: waited for caregiver to check in, then placed phone calls to claimant cell
    • Caregiver and claimant were never together
    • Many instances where caregiver did not answer when called while checked in
  – Service hours varied wildly compared to previously reported consistent 16-hrs per day
• Performed Internet search
  – Identified that caregiver had second job while supposedly providing 16 hr/day care
• Good cop / bad cop with LTCI carrier led to AssuriCare (good cop) receiving info from claimant/providers
  – Provider(s) disclosed financial side deal with claimant
• Coordinated surveillance activities with carrier
  – Surveillance confirmed no care was being received
  – Specific care check-in and check-out times from timecard system provided for days surveillance was conducted
• Re-conducted additional on-site assessment
  – Claimant demonstrated functional dependence
Outcome

- Exposed fraudulent agreement between claimant and provider(s) to split policy benefits
  - Claimant was providing caregiver with $500 per week payment for no care provided
  - Claimant was pocketing the remainder of the benefit payments ($1740/week)
  - Using the LTC policy as a revenue stream
  - Two of the newer caregivers ended up writing letters confirming relationship

- This carrier has never rescinded a policy for fraud, however:
  - Carrier denied all shifts submitted through AssuriCare based on AssuriCare data and surveillance
  - Carrier revoked APOC; must use a home care agency
    - Claimant subsequently went through 5-10 agencies who refused “service”

- Carrier referred claim to state DOI in Q2 2012
  - No known action taken by state DOI

- Claimant deceased (2015)

- Claim financials:
  - More than $600,000 in total claims paid
  - Over $350,000 in avoided claims after Feb 2002 (on unlimited lifetime benefit policy)
Hindsight is 20/20

- Earlier use of telephonic timecard system with identity and service verification could have reduced claim loss due to fraud
- Evaluate weight put on primary diagnosis of MS vs. evaluation of actual functional status
- Spot check proof of payment to verify benefits actually being paid to provider
- Recognize and listen to the red flags
  - Care >12 hours/day, 7 days/wk from one provider with no breaks
Hindsight is 20/20

COMMON THEMES AND LESSONS LEARNED
Commonalities between 3 case studies

- Claimants < 55 years old at time of claim
- Unlimited lifetime max benefit
- Maximum daily benefit > $300/day
- Presented as home care claims with friend/family caregivers
- Short time period between policy issue and notification of claim
- Multiple onsite assessments suggested functional dependence
Recognize and listen to the red flags!

- Care >12 hours/day, 7 days/wk from one provider with no breaks
- Claimants or providers “demanding” payment weekly
- Questionable or missing proof of payment
- Pushback / refusal to use enabling technology / timecard system
- Spouse/relative providing services as employee/contractor of an agency
- “Revolving door” of caregivers / agencies
- Only receiving ADL care at night

LTC Claims Fraud: Hindsight is 20/20
Parting Thoughts / Actions

• Claims evaluation process needs to be thorough AND efficient
  – Analyze claims thoroughly and ask questions – don’t take claims at face value
  – Size up the risk and take commensurate actions

• Early / consistent use of timecard system with hours and identity verification
  – Coordinate surveillance times/dates with actual hours from timecard system

• Spot checking proof of payment is useful
  – Helps identify side deals between claimants and providers

• It’s ok to be curious: Trust but Verify
LTC Claims Fraud: Hindsight is 20/20

Pamela Cathlina: Director, Long Term Care Benefits, Northwestern Mutual
Christie Conway: Director, LTC Claims Operations, Bankers Life & Casualty
Michael Gilbert: President, AssuriCare LLC