

GOVERNOR'S
TASK FORCE
ON

HEALTH CARE FRAUD
INITIAL REPORT

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Governor

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1. Require the use of standardized and serialized prescription forms on non-reproducible and non-erasable paper.
2. Amend N.J.S.A. 45:9-19.3 to permit the sharing of investigative information from the State Board of Medical Examiners' files with other governmental agencies.
3. Amend the Insurance Fraud Protection Act to apply to fraud committed against the State Health Benefits Program.
4. Revise and provide for periodic review of PIP fee schedules.
5. Amend the No-Fault Statute to allow individuals to select a managed care option for personal injury protection benefits.
6. Amend the No-Fault Statute to provide for peer review of PIP claims.
7. Amend N.J.S.A. 17:33A-11 to expressly shield insurance company representatives as well as Division of Insurance Fraud Prevention (IFP) personnel from discovery during the pendency of an investigation.

The Task Force also set a course for future study:

- 1 . The development of recommendations for how to best coordinate health care fraud prevention and enforcement efforts in New Jersey among State agencies, the federal government and the private sector.
2. Exploration of technological developments in order to recommend necessary computer systems and training of investigative staff.
3. Study of proposed legislative and regulatory changes to enhance fraud prevention and enforcement efforts including:
 - Amending criminal statutes to increase the likelihood of jail sentences for the commission of Health Care Fraud related crimes.
 - Amending criminal statutes to criminalize running, the payment and receipt of kickbacks and the routine waiver of copayments.

3. Expressly criminalize "running" and the payment and receipt of kickbacks.

Discussion. Because most fraud schemes depend on a volume of "patients," fraudulent providers will often pay third parties for patients. Most commonly this occurs through "runners" who provide accident victims or alleged accident victims to health care providers and others involved in the health care field who will refer patients in return for kickbacks. Because these practices facilitate fraud and serve no legitimate purpose, it has been suggested that they be expressly criminalized.

4. Expressly criminalize the routine waiver of copayments.

Discussion. While it has been established that the waiver of copayments is fraudulent in a civil setting, the nature of the fraud is not clear enough that the existing theft by deception statute is sufficient to criminally prosecute the routine waiver of copays.

5. Amend the General Assistance statute to make the criminal and civil penalties contained in the Medicaid statutes applicable to violations involving General Assistance health care payments.

Discussion. Current statutory remedies for dealing with fraud and abuse in the General Assistance program are limited. Unlike the Medicaid and PAAD programs, which have clear provisions for civil and criminal penalties for fraud in the obtaining of health care payments, there is no similar provision in the General Assistance statute.

6. Clarify the doctor-patient privilege as it applies to health care fraud investigations.

Discussion. When a criminal prosecutor issues a subpoena to a doctor for patient files, the doctor-patient privilege is often asserted. While this is being sorted out, time is lost to the State and gained by the provider. Billing records and dates of treatment and perhaps other information should not be so "privileged."

2. Civil Enforcement

A number of suggestions were also made to enhance civil enforcement efforts against health care fraud. Among these recommendations were those intended to