

Fraud

In General

Health care fraud is a multibillion dollar operation, and this does not take into account workers' compensation, disability or life insurance. It has been estimated that approximately 10% of the health care costs are used to pay for fraud.

Types of Fraud and Abuse

Five types of fraud and abuse have been identified:

1. Billing for procedures and/or services that were not performed
2. Shading or outright falsifying the diagnosis
3. Miscoding, upcoding, multiplecoding to gain greater benefits
4. Provider-involved rebates or kickbacks
5. Inaccurate treatment plans where such preauthorization is needed.

Examples of Health Care Fraud

Some examples of health care fraud by types of providers or services are as follows:

- 1. Chiropractic**
 - Unneeded physical therapy
 - Overtreatment (long regimens of *every Tuesday* visits)
 - Unsupportable vitamin therapy
 - Excessive number of x-rays
 - Extending unneeded treatments to family members.
- 2. Cosmetic Surgery**
 - *Tummy tuck* called a hernia repair
 - *Nose job* called nasal injury
 - *Eyelid lift* called ptosis with impaired visual acuity.
- 3. Foreign Providers with U.S. Billing Addresses**
 - Tijuana hospital with a San Diego PO Box
 - Outright quackery is practiced (laetrile for cancer, coffee enemas, cobra venom, liver juice, etc.).
- 4. Laboratories**
 - Billing by test and not by panel
 - Test not correlating with diagnosis.
- 5. Durable Medical Equipment**
 - Motorized scooter instead of wheelchair
 - Orthotics for items that may be purchased in retail stores.
- 6. Psychiatric Care**
 - Weight loss vacations
 - Unnecessary anti-stress trips.
- 7. Outpatient Surgeries**

- Facility is extension of physician's office.
- 8. Procedures That Add to Billed Amount**
- Daily physician visits
 - Physician visits on weekends/holiday
 - Physician-directed Rx administration
 - Vital sign monitoring.

Fraud Alerts

There are numerous red flags which may signal fraud:

- Receipts that are consequently numbered
- Significant increase in the number of claims filed
- Withdrawal of a claim that is challenged
- Lack of patient cooperation
- Patient stalling
- Large claims billed directly to patient
- Provider and patient PO boxes
- Frequent address changes – especially PO boxes
- Copies, not originals, of bills
- Unusual features of bills (alterations, erasures, misspellings, wrong codes, not signed, billings on Sundays/holidays)
- Unusually high or uneven claim amounts
- Provider not in data base.

Response to Suspected Fraud

These are the various actions that a plan supervisor may take to combat fraud:

1. Within the Plan Supervisor Organization

- Establish/train/develop a person (or persons) who have skills needed to spot fraud.
- Conduct in-house training.
- Join with outside anti-fraud organizations.
- Tie on to existing anti-fraud information sources.

2. Anti-Fraud Organizations

a. Federal

- FBI
- U.S. Postal Service
- IRS
- DOJ
- DOL
- HHS

b. State

- Attorney general
- Insurance fraud units
- Medicare/Medicaid
- Local authorities

There are numerous such organizations easily accessed by a Web search for fraud (medical, insurance, etc.).