ANTHONY
MEDICAL & CHIROPRACTIC CENTER

Healthcare Fraud

Annual Training Review

Healthcare Fraud in the United States

Healthcare fraud is growing at an accelerated rate in the United States. Traditional schemes include false claim submissions, care that lacks medical necessity, controlled substance abuse, **upcoding** (billing for more expensive procedures), employee-plan fraud, staged-accident rings, **routine waiver of copayments and deductibles**, billing experimental treatments as nonexperimental ones, agent—broker fraud relationships, premium fraud, bad-faith claim payment activities, quackery, overutilization (rendering more services than are necessary), and **kickbacks**.

The *Merriam- Webster Dictionary of Law* defines fraud as:

Any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage; specifically: a **misrepresentation or concealment with reference to some fact material to a transaction** that is made with knowledge of its falsity or in reckless disregard of its truth or falsity and with the intent to deceive another and that is reasonably relied on by the other who is injured thereby.

The legal elements of fraud, according to this definition, are:

- **Misrepresentation of a material fact**
- Knowledge of the falsity of the misrepresentation or ignorance of its truth
- **Intent**
- A victim acting on the misrepresentation
- **Damage to the victim**

Definitions of healthcare fraud contain similar elements.

The CMS website, for example, defines fraud as the:

Intentional deception or misrepresentation that an individual knows, or should know, to be false*, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).*

Healthcare fraud differs from healthcare abuse. *Abuse* refers to:

- **Incidents or practices that are not consistent with the standard of care** (substandard care)
- Unnecessary costs to a program, caused either directly or indirectly
- Improper payment or payment for services that fail to meet professional standards
- **Medically unnecessary services**
- Substandard quality of care (e.g., in nursing homes)
- Failure to meet coverage requirements

Healthcare fraud, in comparison, typically takes one or more of these forms:

False statements or claims
Elaborate schemes
Cover-up strategies
Misrepresentations of value
Misrepresentations of service

** Most Common*

What does healthcare fraud look like from the patient's perspective?

- The patient may submit a false claim with no participation from any other party. **The patient may exaggerate a workers' compensation claim or allege that an injury took place at work when in fact it occurred outside of work.**
- The patient may participate in collusive fraudulent behavior with other parties. A second party may be a physician who fabricates a service for liability compensation.
- The patient may be involved in an established crime ring that involves extensive collusive behavior, such as staging an auto accident. The schemes repeat themselves as well as evolve in their creativity.

What does healthcare fraud look like from the provider's perspective?

- The fraud schemes can vary from simple false claims to complex financial arrangements.
- **The traditional scheme of submitting false claims for services not rendered continues to be a problem.**
- Other activities, such as submitting duplicate claims or not acknowledging duplicate payments, are issues as well.

What does healthcare fraud look like from the payer's perspective?

- The fraud schemes in this group tend to be pursued mostly in response to transactions between the payer and a government plan sponsor.
- They include misrepresentations of performance guarantees, not answering beneficiary questions on claims status, bad-faith claim transactions, and financial transactions that are not contractually based.
- Other fraudulent activities **include altering or reassigning the diagnosis or procedure codes** submitted by the provider.

What does healthcare fraud look like from the employer's perspective?

- **Schemes include underreporting the number of employees, employee classifications, and payroll information**; failing to pay insurance premiums, which results in no coverage; creating infrastructures that make employees pay for coverage via payroll deductions; engaging in management activities that discourage employees from seeking medical treatment; and referring employees to a medical facility and in turn receiving compensation for the referrals.

Overall, healthcare fraud schemes will always target one of the following:

- **Pursuit of money**
- Avoidance of liability
- Malicious harm
- **Competitive advantage**
- Research and product market advantage
- Addiction
- Theft of personal effects
- Theft of individual and/or corporate identity

** Most Common*

Who is the most important person to help stop Healthcare Fraud?

YOU