Insurance Fraud: What's the Real Cost?

By: Anita Barsalou, CPC
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Working in the insurance industry for over 27 years has led me to realize just how much insurance fraud costs us as consumers and as a society. This is not a victimless crime. We're all affected by insurance fraud.

Fraud 101

The Association of Certified Fraud Examiners defines health care fraud as, "Intentional misrepresentation of a material (important) fact submitted on, or in support of a claim for payment of a health-care insurance claim, or the theft of money or property belonging to a health plan or health insurance company." Wikipedia defines it more simply as, "Any act committed with the intent to fraudulently obtain payment from an insurer."

U.S. government and law enforcement estimates place the loss due to health care fraud as high as 10 percent of our nation's health care expenditure, or approximately $226 billion each year (see "The Dollars and Cents of Health Care Fraud and Abuse," by Howard Levinson DC, CFE, AHFI). The number of cases for insurance fraud that are detected is much lower than the number of acts that actually are committed. Whether you have employer-sponsored health insurance or an individual policy, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits and coverage. For employers, health care fraud increases the cost of providing insurance benefits to employees, and in turn increases the overall cost of doing business.

There are two main categories of fraud: hard and soft.

Hard fraud occurs when someone deliberately plans or invents a loss. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars. One example is a staged slip and fall. The "victim" hires an attorney, who refers the victim to a physician. The physician submits charges to the insurance carrier, and refers the victim to a physical therapist, who also submits

charges. The accident is fake, and so are the "services" the physician and/or therapist provides. Who ultimately pays? You do.

Soft fraud—often called opportunistic fraud—is far more common. This type of fraud occurs when policyholders exaggerate an otherwise legitimate claim. It's that "little white lie" a normally honest person tells the insurance company, such as changing a legitimate date of service from 2/1 to 2/4 with a few pen strokes, and resubmitting the claim. This can be rationalized because "I pay big bucks for insurance, and they did not pay enough on my claim."

Too many consumers believe insurance fraud is justified. According to the Coalition Against Insurance Fraud, two out of five Americans want little or no punishment for insurance cheats (http://insurancefraud.org/fraud_backgrounder.htm). Consumers blame the insurance industry for its fraud problems because they believe insurers are unfair.

My personal experience suggests that fraud is both widespread and widely tolerated. To cite just one example, a family member on Medicare was charged for a service that was never rendered. When questioned, the office told the family member, "Don't worry about it. You won't be charged for the balance." In fact, the balance was charged to every one of us.

Soft fraud isn't harmless. It's a crime that contributes to higher insurance costs for everyone.

The Perpetrators of Fraud

Most commonly, the perpetrators of health care fraud are providers. One reason for this is the historically-prevailing attitude in the medical profession of fidelity to patients. This can lead to fraudulent practices, such as billing insurers for treatments that are not covered by the patient's insurance policy. In other words, a "well-meaning" provider commits fraud to "help" the patient. To do this, physicians often will bill for a different service, which is covered by the policy, rather than what was actually done. For instance, we might see charges for an abdominal hernia repair when a tummy tuck was performed. The Coalition Against Insurance Fraud cites the Journal of the American Medical Association, claiming that nearly one-third of doctors exaggerate the severity of a patient's illness to help the patient avoid early discharge from a hospital (http://insurancefraud.org/learn_about_fraud.htm).

Patients deserve their share of the blame for health care fraud, as well. A common fraud technique is to add a digit in front of a charge (e.g., $120 for a blood test that originally was billed as $20.00). Another scheme becoming more popular involves patients who design and submit their own receipts from a provider they have never seen.

On a large scale, law enforcement agencies and health insurers have witnessed the migration of some criminals from illegal drug trafficking into the safer and far more lucrative business of perpetrating health fraud schemes. According to the Anti-Fraud Resource Center of the National Health Care Anti-Fraud Association (NHCAA), in South Florida alone, government programs and private insurers have lost hundreds of millions of dollars in recent years to criminal rings. Many of these rings are located in Central and South America. These rings fabricate claims from non-existent clinics, using genuine patient insurance and provider billing information that the perpetrators have bought and/or stolen for that purpose.

Other examples of health care fraud include:

- The billing of late charges by a hospital: The hospital routinely resubmits a reimbursed hospital stay and claims that "late charges" were not added to prior billing, when in fact there were no late charges.
- False durable medical equipment (DME) claims: For example, a manual wheelchair may be billed for a quadriplegic. Although this may seem like obvious fraud, when submitted to a carrier who processes millions of claims, the chances of this slipping under the radar are great.
- Behavioral health fraud: One of the most difficult to identify and prove because of constraints surrounding patient privacy.
- Dental fraud: Commonly involves submitting for an extraction and replacement of a tooth, and then billing for a restoration on that tooth at a later time.
- Medical identity theft: For instance, your wallet is lost or stolen and the person who finds it also finds your insurance card and uses (steals) medical services with your identity. This might establish an unwanted diagnosis on your record or exhaust limited benefits. Identity theft also occurs if we give our card to a friend or relative to use because he or she doesn't have or can't afford health insurance coverage—*this is still theft*. Our medical insurance cards should be considered as precious as a charge or debit card. If the health insurance card is stolen, report it just as if it were a charge card.

The Price of Fraud

The cost of insurance fraud is built in to the premiums each of us pay, just as the cost of theft is factored into the amount we pay for consumer products. Higher insurance premiums leave us and/or our employers less money to purchase benefits. Fewer fraudulent charges reimbursed could allow lower premiums and other advantages; maybe your employer could buy a better plan, or reduce the deductable. Maybe the insurance coverage wouldn't change, but there would be more money available for salaries or to fill a position that has been open for a while.

What Can Be Done

What can be done to fight back? Federal and state governments can tighten up fraud laws and institute tougher penalties. There can be an increased sharing of information. The Federal Bureau of Investigation (FBI) does reach out to insurance carriers to work with them, enabling them to trace a claim from submission to payment. They also may notify a carrier of a current case to verify the carrier's exposure and to see if the scheme had been submitted and reimbursed by that carrier. On a state level, more fraud bureaus need to be established. There are approximately 40 state fraud bureaus now in existence. There should be one for each state.

Insurance companies also are responsible for identifying and prosecuting fraud. Most carriers currently have a fraud or special investigations department whose sole focus is to detect, recover and/or prosecute fraud. Most carriers provide information to plan sponsors, members, and their own employees on what to look for so any fraud is identified before money is paid. It is always easier to prevent fraud than to recover illegitimate payments. Insurance carriers do indeed prosecute offenders in an attempt to recoup payments.

Our Role as Coders and Consumers

As coders, we must uphold our ethics. Only code those services that are documented. If you are asked to add a code or service to a bill, politely ask the provider to add it to the patient's permanent record because it is not currently there, and you're sure that he or she would want such information to be part of the record. Don't have fingers of blame pointed in your direction, claiming you are responsible for adding an additional code. Most insurance carriers have a fraud hotline, where cases of fraud can be reported anonymously.

As a consumer, you can be powerful in the fight against fraud. Never sign a blank insurance form; read and understand all claim forms; request detailed bills; check for charges on "free services;" and always keep your insurance identification confidential. Don't be afraid to question or speak up. Remember: The money you save could be your own.

Source: The American Academy of Professional Coders

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1 comment for "Insurance Fraud: What's the Real Cost?"

Jim Harden

Posted Thursday, March 10, 2011 at 1:23:39 PM

Anita, Very good!
There are other deliberate unethical and unprofesional motivations to delivering healthcare than outright criminal fraud.
Please reply and I will send you a couple related messages:
1) My tale of four dental treatment plans.
2) Combating Waste, Abuse & Fraud
Regards, Jim