Health Care Fraud

How employers can reduce the risk of fraud and improve their bottom line

Health care fraud costs the nation more than $200 billion a year, accounting for between 5 and 10 percent of health care expenditures.

That's about $800 a year per person with health care coverage, a cost that is reflected in increased premiums, says Howard Levinson, clinical fraud director of the Special Investigations Unit at HealthLink.

"Fraud also results in lost benefits, inaccurate medical records and increased out-of-pocket spending by patients," says Levinson.

What is health care fraud?

A small percentage of dishonest health care providers commit fraud for financial gain, using the health care delivery system to do so. Fraud can also be committed by members and insurance brokers, medical identities can be stolen, theft occurs, but much of the fraud and abuse we investigate are committed by health care providers, whether that is a single doctor, a hospital system, a pharmacy or a medical equipment company.

What are some examples of fraud?

One of the most common health care frauds is when an unscrupulous provider bills for services not rendered. With millions of claims submitted each year to insurance companies, it is impossible to ensure that every claim is accurate. The insurance industry relies on providers to be truthful. As a result, providers can submit fictitious claims or add on services that they didn't perform so that they will receive a higher payment.

Fraud can also occur when services are misrepresented. Providers may know that a particular treatment, therapy or drug won't be paid for by the insurance company, so instead of billing what they actually did for the patient, they misrepresent that service as something else, something that is payable by the insurance company.

Upcoding is another common form of fraud. When a patient visits the doctor, every service is assigned a code for billing. The fraudulent provider may submit a claim with codes that indicate the doctor rendered a more comprehensive level of care than what was done. For example, a patient may be healthy and go for a basic checkup, but the physician bills as if the patient were really sick, exaggerating about how much work he or she did in order to get paid more.

How can employers and their employees help reduce the risk of fraud?

Employers should educate their employees about the importance of paying attention to the explanation of benefits they get in the mail after they've received health care services. Look for items that might not be correct, or for services that were not performed. Tell employees to check their bills and EOBs to make sure they received the services they and their insurance company are paying for. Too often, members throw away these EOBs without reading them because they can be difficult to understand. Employers could work with the insurance company to assist their employees in deciphering the EOBs.

Employers should also educate employees about medical identity theft, in which someone steals medical ID numbers, then bills services to the insurance company. While this results in charges for services not rendered, it can also wreak havoc on the member's medical records. For example, if someone is using your medical identity to bill your insurance for HIV infusion therapy drugs, now you're saddled with a diagnosis of HIV and a record of having received hundreds of thousand of dollars worth of drugs. You may be perfectly healthy, but it can be very difficult to clear that up and get insurance somewhere else.

In addition, make sure that employees are sensitive to the fact that they shouldn't give out private health care information to anybody who doesn't have a need for it. And members should be very careful choosing a doctor that they trust and that the doctor or his or her staff are not going to do anything untoward with their health care information.

Health care fraud is a violation of your trust by your doctor, hospital or pharmacy, etc. Anything an employer can do to instill a culture of ethics among its employees can help decrease the risk of fraud.

How can fraud impact patient care?

Patients may not actually be getting the services that they need. If you're going to doctors whose primary focus is not on your health care but on how much money they can get out of your insurance company, are you getting the proper treatment? Often, when fraud is occurring, patients are not.

They're undergoing expensive diagnostic tests that they don't need. Or the doctor may not be doing the right tests because he or she is more involved with patient's insurance card than with the patient's health.

What can an employer or employee do if fraud is suspected?

Most health care insurance companies have fraud hotlines that you can call to report suspected fraud. Or if you're not comfortable calling the hotline, report your concerns to your HR department. Some significant fraud investigations have started with patients calling to say they were billed for something they didn't receive or that the doctor only spent five minutes with them and they were billed an exorbitant fee.

We need the assistance of our insured members to weed the garden of bad providers. We don't want members to be treated by fraudulent doctors. It's wasted health care dollars and dangerous to the health of members. Our investigators, often in cooperation with law enforcement, are working to identify the fraudsters, investigate, intervene and then remove them from the system. Health care fraud increases all of our costs. If you can get your employees to recognize potential fraud and abuse and pay attention to it, your company could see improvements to its bottom line and keep your employees healthy.