Dynamic Chiropractic

Health Care Fraud: The Costly Deception

For years, significant resources have reportedly been directed toward combating health care fraud by insurers, regulators, law enforcers and legislators. Yet despite these reported efforts, it would appear, based on the annual estimates, that the problem continues to grow and flourish. Could this indicate that health care fraud is at epidemic proportions and can't be stopped? Is our health care system infested with providers who will stop at nothing to make a buck? I think not.

My experience over two decades of working with insurers, law enforcers, regulators and health care providers, suggests that most health care providers are honest, ethical and strive to do the right thing. Additionally, my experience has provided me with the opportunity to see the fraud problem from both sides: enforcement and provider. When viewed from both perspectives, it is readily apparent that our fraud problem is caused by a number of factors, including:

- inadequate education for health care providers relative to coding and payer standards;
- deviant providers;
- inadequate training for claims handlers and claims investigators on coding and provider standards;
- inept claims handling and claims investigations by insurers prior to paying claims;
- lack of communication from insurer to provider on what is required;
- paucity of reliable training for law enforcers regarding the investigation of health care fraud - from identification to prosecution;
- tag-a-long investigators looking for organizational stats, resulting in inefficient use of law enforcement resources;
- lack of interest or commitment by prosecutors - big cases, big problems, little cases, little problems; and
- lack of accountability for all segments of the health care delivery system: provider, payer, regulator and enforcer.

The High Cost of Fraud

Insurers, the main reporter and victim of the fraud, indicate that all policyholders pay for the fraud in the form of higher premiums. According to the National Insurance Crime Bureau, the average American household will pay $200 more every year in premiums to pay for the fraud. Insurers are very aggressive in reporting how costly the problem is, revealing estimates of double-digit percentages of claims submitted that are fraudulent, and billions of dollars lost each year due to fraud. These reports and estimates weigh heavily in the minds of state insurance regulators when they allow insurers to raise premiums.

Basically, what insurers and others refer to when they reveal their estimates of the frequency and costs of health care provider fraud is billing for services not rendered, billing for services that are substandard and/or unnecessary, billing for services that misrepresent the nature of the service provided, billing for services that misrepresent the actual service provider, etc.

The sweeping nature of the attention health care providers are getting - even those not engaged in fraudulent activity - by insurers via postpayment audits is unprecedented, and may take away from your ability to do what you do best - make people better. It is unfortunate that today, health care

providers may spend more time documenting and defending their services to a multitude of sources, including insurers, regulators and law enforcers, than they do providing care to patients.

Health care fraud is a crime that should be dealt with swiftly, responsibly and severely. But it should not be used as a vehicle for one to prosper at another's expense. Insurers are in the business of making money and they are doing just that: making money - *a lot* of money. This money comes from premiums collected on the sale of policies to consumers seeking protection from future (unknown) losses.

Many insurers are in a position to limit their potential health care claims exposure, as they possess the ability to tell insureds what doctor they can see, what treatment services they can get, and how much will be paid for the services. Further, insurers may capriciously limit payment on health care claims, denying health care services reported by providers by asserting the services were illegitimate/fraudulent.

Claims Evaluations

Many insurers conduct claims evaluations, reportedly for the purpose of determining if the health care services rendered by the provider were usual, customary and/or reasonable (UCR). Consider that by definition, fraud is "the knowing and willful deception or misrepresentation of the facts with intent to receive an unauthorized payment." Wouldn't such an evaluation be considered a fraud evaluation? It is purportedly done for the purpose of determining if the health care provider misrepresented the nature of the services provided and reported.

Unfortunately, the UCR evaluation seems to have little to do with actual fraud fighting, but everything to do with cost containment and the bottom line for insurers. These evaluations typically do not identify that the health care provider did not provide the reported services, but instead report subjective opinions of consultant providers who usually do not even see the patient.

In many cases, insurers may successfully reduce the health care provider's billings using UCR evaluations - not because the evaluations were accurate, but because the health care provider did not have the knowledge or necessary resources to fight back. The effectiveness of these evaluations as a means to combat fraud is questionable and may be nonexistent. Check with your state insurance regulators and health care boards to determine if insurers refer their UCR evaluations to them for fraud investigations, and, if so, ask them how many. Ask your local law enforcers how many cases they investigate or prosecute that were based on UCR evaluations. Further, ask your insurer what percentages of their estimated losses due to health care fraud include UCR evaluations. And ask your insurer why, with their duty and ability to examine all claims, they are unable to do a better job of reducing fraudulent claim payments.

Interestingly, since the late 1980s, health care providers have had a standard coding system. This system, known as Current Procedural Terminology (CPT), is used by providers to report and bill for health care services rendered to patients. CPT was promulgated by the American Medical Association (AMA) so that all health care providers, regardless of discipline, could accurately report their services and be compensated for services rendered.

Although CPT has been around for decades, there are no standards of education and training required of health care providers for the proper use of the codes, or insurers for what the codes mean. This may lead to a systematic problem in our health care system, as an unnecessary adversarial system is created between providers and payers based on an "attack and defense" of billing codes and treatment records. Both are looking at the codes; one for the purpose of reporting services to seek compensation, and the other for determining what they will pay.

What Is the Solution?

It should be evident from the annual reports, if they are accurate, that our health care fraud problem will not be solved solely by amassing a large amount of resources to attack the problem, creating consortiums to share information and research the problem, or introducing additional laws or regulations from politicians stumping for re-election. The investigation of health care fraud for the purpose of prosecuting the offenders is needed. But also needed is a mandatory educational process for our providers, insurers and investigators on combating health care fraud.

The health care fraud problem is too complex to be battled by the few. It demands greater participation by the principals of our health care system, including health care providers. There is no stronger voice against health care fraud than that of honest and ethical health care providers - who, by the way, are also insurance and health care consumers and part of the premium-paying public. Most providers do not engage in fraud and would like to see those who do be stopped and put out of business. However, the current fraud-fighting arena has many providers - even the honest and law-abiding ones, pitted against insurers and others.

If you are not engaged in fraudulent activity, you may still endure aggressive and invasive encounters with insurers to get paid for legitimate services provided. This process has a counterproductive effect on our overall success in combating health care fraud. You may possess information and knowledge that would be useful in assisting health care fraud fighters. You could potentially assist at the street-level on the identification of health care providers who *are* engaged in fraud. You also could help establish the evidence to support prosecutions of the fraud. However, with the current adversarial system, you may have neither the opportunity nor the desire to assist fraud fighters, as you may be fighting payers for their mere financial existence.

Maybe it is time the various health care disciplines and associations formed an alliance to be the health care provider's action arm and work closely with law enforcers in attacking insurance and health care fraud, just as the insurance industry purports to do. Maybe, with such an alliance, we would actually see a drop in the annual estimates of the costs attributed to health care fraud, which currently range from $20-$60 billion, depending on the source.

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