



## Fraud Prevention in Healthcare

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### ABSTRACT

Healthcare fraud is an evolving problem that fraudulently increases spending for private and public payers. Although the 'pay and chase' model has helped insurers recover some losses, the model is inefficient and incentivizes fraud. Deterrence is an alternative to 'pay and chase' that has demonstrated immense potential in curbing healthcare fraud. The model proactively detects fraud and disincentivizes fraud. This document explored healthcare fraud and how deterrence can be leveraged to mitigate the challenge.

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### Introduction

The healthcare sector is vulnerable to a myriad of fraud schemes that affect individuals and government programs. According to CMS, fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or other persons [1]. Abuse is another type of healthcare fraud. CMS describes abuse as provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Healthcare fraud can result in exaggerated health insurance premiums and unnecessary medical procedures. Consequently, relevant organizations must take action to deter healthcare fraud.

### Problem Definition

According to the National Health Care Anti-Fraud Association, about 3 percent (\$300 billion) of healthcare spending is lost to fraud annually [2]. Healthcare fraud is a complex problem that presents itself in evolving techniques. However, the most common types of healthcare fraud that affect payers include;

**Medical Identity Theft:** This involves the misuse of a person's medical identity to acquire healthcare services. The perpetrator wrongfully uses patients' identities to bill public or private payers for fraudulent services. Identity theft is usually used to enable fraudulent prescriptions, referring patients for unnecessary services or supplies, and billing for services that were never provided.

**Billing for Unnecessary Services or Items:** Section 1902(a)(30) (A) of the Social Security Act directs service providers to bill only necessary services and items. Some providers contravene this directive by intentionally billing unnecessary services and supplies.

**Billing for Services not Furnished:** Only supplies and services offered to patients should be billed. Some healthcare providers falsify documents to justify bills for services they never provided. For example, a physician may bill for tests that never occurred.

**Upcoding:** This type of fraud entails charging for superior services while the actual service delivered is inferior. For example, a healthcare provider may bill for a motorized scooter while the actual item delivered is a manual wheelchair.

**Unbundling:** This is the practice of submitting bills that should be billed as a unit in fragments to maximize income. For example, a laboratory may receive a panel of blood tests and bill it as separate tests instead of billing it as a panel.

**Kickbacks:** Kickbacks involve providers benefiting from the referral of patients or the generation of businesses where payments are settled by public or private payers. For example, physicians accept payments from medical imaging facilities in exchange for referring patients.

### Issues with 'Pay and Chase'

The aforementioned healthcare frauds are well known in the healthcare insurance sector. Federal authorities, state governments, and private players employ various methods to mitigate the vices. One of the most commonly used approaches is the 'pay and chase' model. The technique entails recovering losses after a fraud has already occurred. Issues with this model include;

**Delayed Detection:** Identifying fraudulent activities takes time. By the time fraud is detected, fraudsters may have already benefited immensely from the schemes and even disappeared.

**Limited Chance of Recovering Funds:** Recouping payments is a complex process. In some cases, perpetrators may close operations or even move offshore, making recovery impossible. The cost of recovery may also be astronomical. Audits and legal battles are not only time-consuming but also expensive.

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**Incentivize Fraud:** The model is reactive. This incentivizes perpetrators to engage in fraudulent practices as they view the risk of being discovered as low compared to the potential reward.

The 'pay and chase' model is ineffective for combating healthcare fraud. The model is reactive, and for that reason, it incentivizes fraud, complicates recovery of lost funds, and is costly. To effectively alleviate healthcare fraud, payers should switch to a proactive model that detects fraud in advance.

**Fraud Deterrence**

Fraud deterrence is a set of practices specifically designed to proactively detect and stop healthcare fraud. Public and private healthcare insurance firms unanimously agree that deterrence is effective in curbing fraud and a driver of value in anti-fraud efforts. According to a publication by the World Bank, deterrence measures can reduce healthcare fraud by as much as 80 percent [3]. Some of the effective deterrence practices in the United States include;

**Provider Enrollment and Credentialing**

This entails conducting thorough background checks on providers before allowing them to bill insurers or government programs. The process includes verifying licenses, assessing criminal records, and validating past disciplinary actions. Provider enrollment and credentialing is not a one-time exercise. Regular reevaluations should be conducted to detect providers under investigation or sanctioned.

**Advanced Claims Audits**

It is advisable for insurers to conduct random and targeted audits on claims. This can help deter fraud by creating a perception amongst healthcare providers that fraudulent activities will eventually be detected. It is also a good practice to conduct retrospective claims audits regularly. Conducting in-depth analysis of past claims can unearth patterns that can help detect fraud.

**Stiff Penalties**

Heavy penalties and fines can help deter healthcare providers from committing fraud. Hefty monetary charges and long-term imprisonments can discourage providers from attempting healthcare fraud. Aggressively pursuing civil and criminal prosecutions can act as a warning to healthcare fraudsters.

**Investing in Technology and Fraud Teams**

Investing in technology can help alleviate healthcare fraud. Investing in tech tools such as data analytics and AI can enable insurers to identify trends, anomalies, and suspicious behavior, allowing them to proactively detect fraud. Big data and AI can reveal patterns such as abnormal coding, unusual frequency of claims, and excessive billing. Investing in blockchain allows insurers to permanently store data, denying fraudsters the ability to alter patient records and claims. Fraud teams are another deterrence measure that has proved effective over time. These are specialized units whose sole mandate is to investigate and prevent healthcare fraud. They are trained to recognize and curb complex schemes before payers incur severe losses.

**Measuring the Impact of Deterrence Practices**

It is essential insurers measure the effectiveness of deterrence practices. Deterrence is measured by comparing estimated spending in the absence of an enforcement (Pre-period) to actual spending following an enforcement (Post-period) [4]. This is done using relevant data. First, spending data before enforcement of deterrence is collected. Then, spending data after enforcement is collected. The data points are extrapolated into a linear graph to visually inspect trends before and after enforcement. A spending trend decline after enforcement implies effective deterrence.

**Impact of Deterrence**

The general impact of deterrence efforts is reduced healthcare fraud, which translates to abridged spending on healthcare claims. For instance, according to a report by CMS, a lawsuit on medically unnecessary implantable cardioverter defibrillators (ICDs) resulted in a potential spending reduction from \$5.9 billion to actual spending of \$2.6 billion, as illustrated in Figure 1. Similarly, a lawsuit on spending on ICMs at the Desert Regional Medical Center saw potential spending on ICMs drop from \$2.2 million to actual expenditures of \$1.1 million, as illustrated in Figure 2. Reduced spending on healthcare costs can result in reduced premiums for policyholders or program beneficiaries. These interventions can also protect patients from unnecessary treatment procedures.

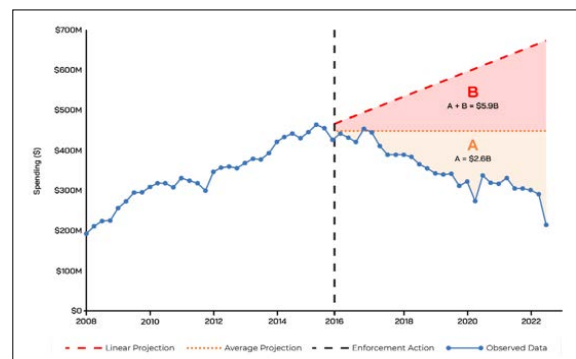


Figure 1

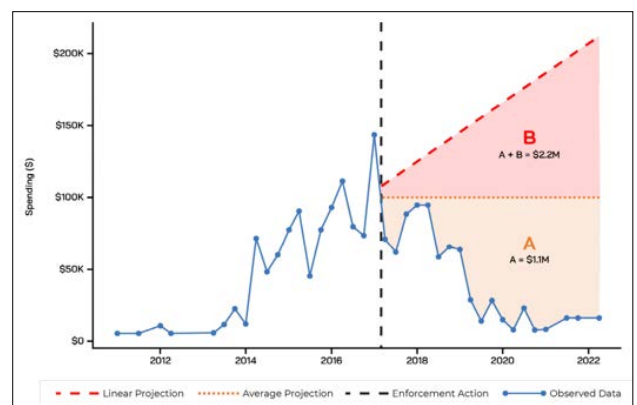


Figure 2

**Conclusion**

Healthcare fraud is an evolving problem that affects both patients and payers. Although the 'pay and chase' approach has helped minimize losses due to fraud, the model is ineffective, costly, and somehow incentivizes fraud. This document proposes

deterrence as the solution to healthcare fraud. Deterrence is quite effective in proactively preventing losses. Various case studies have found that the model efficiently discourages healthcare providers from engaging in fraudulent billing. You can leverage deterrence by embracing approaches such as provider enrollment and credentialing, carrying out advanced claims audits, imposing stiff penalties on culprits, and investing in relevant technologies and anti-fraud teams.

## References

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