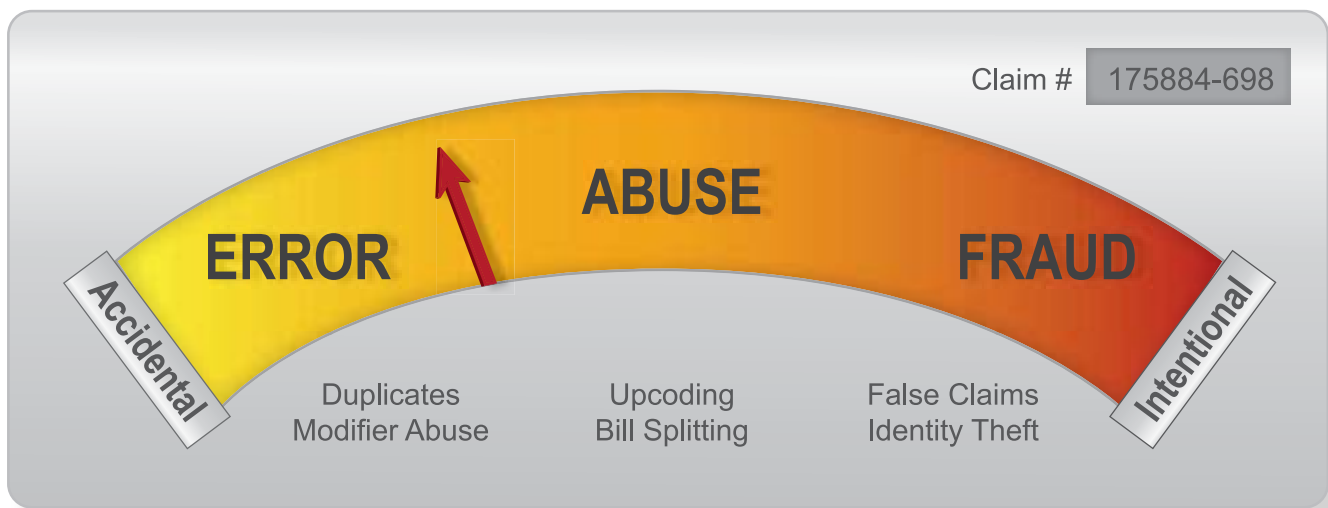


Targeting the Fraud Continuum

by Jeff Young



Health care fraud and abuse occurs at varying levels, from the most basic errors, to the most complex level of intentional fraud. An effective fraud and abuse program will monitor all aspects of the fraud and abuse continuum in an effort to control unnecessary and inappropriate costs.

Health care fraud is defined as intentionally submitting false claims for the purpose of obtaining unentitled funds. Individuals and organizations deeply involved in committing fraud are always evolving and altering their complex schemes to remain undetected and invisible. Examples of fraud include billing for services not rendered, stealing identities (provider or member), exposing patients to unnecessary invasive procedures, and misrepresenting a non-covered service as a covered service. It is imperative that commercial and public payors implement controls and processes aimed at detecting, stopping, and preventing these intricate schemes.

Equally important is the detection and prevention of abusive patterns. There is still some intent that exists with abuse. Some providers believe that because they provide superior service, have sicker patients, and are unjustly compensated, they are entitled to additional reimbursement. Examples of abuse include up-coding of office visits or procedures rendered, unbundling, billing for services within the global service period, and modifier abuse. It is equally important to monitor this

type of behavior because in many instances, abuse is the precursor to intentional fraud.

Among the most basic areas of the fraud and abuse continuum is that of error. The health care coding system is complex and can lead to billing errors. These errors are usually unintentional and provide an opportunity to educate and bring awareness to the provider.

The difference between fraud and abuse can often appear ambiguous. Ultimately, a court of law establishes if fraud occurred and if a provider or individual intentionally filed false claims or information. This can include any of the previously discussed examples of fraud and abuse. In 2007, the FBI investigated 2,493 cases of health care fraud, resulting in 635 convictions. According to the FBI, the most common health care fraud schemes are billing for services not rendered, upcoding, duplicate claims, unbundling, excessive services, medically unnecessary services, and kickbacks.

A comprehensive anti-fraud and abuse program needs to focus on the nuances of fraudulent behavior and abusive practices so as to deploy technical and clinical detection capabilities that recognize the differences. Acts of fraud and abuse contribute to significant losses in the health care industry. To effectively prevent the collective damages, payors need to demand their program capture and dispose of all forms of fraudulent claims submissions. ■