Common Examples of Medicare, Medicaid Fraud

Medicare, Medicaid Fraud Examples and Steps to Ensure You Don't Commit It

- ***A medical doctor invoiced his patient's Medicare insurance for both the services he actually delivered and for services that were not delivered. He fabricated his patient's medical records to indicate office visits and treatments that never took place.***
- ***A gerontologist obtained the outcomes of medical testing executed by a diagnostic firm for her interpretation of the results. She billed the patient's Medicare insurance as if she performed both the testing and interpretation of the tests.***
- ***A family physician worked at a medical center where low-income and needy patients were enlisted to submit to needless exams. While he consulted with few patients, medical records were forged by a physician's assistant to support the billing of Medicaid for medical procedures never performed.***
- ***Patients with Alzheimer's disease were sitting unsupervised inside a small room of a medical psychological care facility watching the movie "Forrest Gump" for the umpteenth time. Granted, it's a great movie, but each time the patients sat in front of the tube watching it, the facility submitted insurance claims to Medicare for providing "group therapy."***

*These are examples of fraud as it relates to Medicare and Medicaid.

Medical fraud is the intentional deception or misrepresentation of healthcare transactions by the provider for the sake of receiving unauthorized benefits or financial gain. Healthcare fraud is committed when a dishonest provider intentionally submits, or causes someone else to

submit, false or misleading information for use in determining the amount of healthcare benefits payable by an insurer. Many leading, medical groups calculate fraud to amount up to 10% of all healthcare costs.

Most healthcare fraud today is being committed against Medicare and Medicaid, both funded with U.S tax payer dollars. Medicare pays out over $800 billion a year for claims. Medicaid also has enormous budget, providing $615 billion a year. Their sheer size makes these goliaths a target for those groups committing fraud. Plus with such volume, the U.S. Government is unable to police fraudulent claims. They rely on whistleblower. However, a ton, if not most goes undetected.

These programs process millions of claims per day, but it's estimated that an extremely small percentage of them are audited. They are vulnerable to fraud due to underfunding and lack of oversight. Put simply, there just aren't enough people on staff to check things out regularly.

Some of the More Common Examples of Medicare or Medicaid Fraud include the following:

1. **Paying "kickbacks" in exchange for referring business**
   "Kickbacks" are customary in healthcare fraud cases. State and federal laws by and large ban payments to individuals who refer patients to a particular hospital or medical provider. **Medicaid fraud prosecutions have been brought, for example, against unethical physicians for splitting fees in return for rent, demanding cash payments for Medicaid patients or taking money in exchange for patient referrals.**
2. **Phantom services**
   Itemized medical bills are long and contain dozens of items the patient may not recognize. **It's tempting to throw an extra procedure onto the bill, while charging Medicare or Medicaid for services not rendered**. The longer the bill, the simpler it is to slip in a fraudulent charge. Phantom charges also spread to durable medical equipment covered by Medicare Part B. Medicare is often charged for new DME even when the patient accepts used equipment. Some doctors even charge for equipment that was never supplied to the patient. **Fraudulent providers also "upcode" various medical procedures.** For example, when a patient sees a doctor, they may be unmindful of the scope of services that were delivered. If payment is made by units of time, the time can be extended. A minor service could also be **"upcoded"** to a more labor intensive or expensive service through fraudulent means. Another example, a bill sent for a healthcare service could be priced higher than it normally would be, based on the service that was performed.
3. **Purposely misdiagnosing a patient**
   Here practitioners **purposely misdiagnose patients**, generally claiming their illness or injuries are more severe than they actually are, **so they can bill for more costly treatments and procedures.** Regrettably, the elderly and mentally disabled make easy targets for these schemes as they are less likely to have reservations about a physician's diagnosis.
4. **Unbundling**
   Physicians and hospitals often bundle services as a way to offer patient savings. **Fraud occurs when the healthcare provider bills each item separately**. Under Medicare and Medicaid guidelines, certain mandatory procedures are meant to be bundled together, but by separating them, physicians earn hundreds of extra dollars per patient. Here's a prime

example. A patient has an appendectomy that costs $2400 total. Instead of billing Medicaid for the entire bundle, the hospital bills for each individual step of the procedure resulting in a medical bill of $4300.

5. **Billing for a non-covered service as a covered service**
   An allergy physician was providing a treatment that was considered experimental and therefore not approved by Medicare. **With a few taps on a keyboard, the allergy doctor presented claim forms and still got paid for utilizing the experimental treatment.** This was accomplished by calling (and coding) something else that was covered by Medicare.
6. **Overutilization of services**
   This usually includes billing for services that aren't necessary. Unprincipled providers might use this scheme on hypochondriac patients. Tests and exams can go on indefinitely or at least as long as a patient still has coverage. **Alcohol and drug rehabilitation facilities are ripe for such overutilization.**

There are other examples, but you get the point.

Charges of **Medicare and Medicaid fraud** can create serious legal headaches including massive fines, loss of healthcare licenses and even prison time. **Even mere allegations of fraud can do considerable damage to the professional reputation of a healthcare practice.**

Such **fraud (or perceived fraud)** is not always premeditated. However, it can arise as a result of negligence, sloppiness, mistake or oversight.

What steps can you take to ensure that you and your staff do not unintentionally cross the lines of Medicare and / or Medicaid fraud?

1. **Understand healthcare laws and regulations**
   As a prime example**, the False Claims Act bars medical practitioners from submitting insurance claims for substandard and overpriced goods and services,** identifying individuals who do not report their knowledge of such claims as perpetrating fraud. The federal government may fine offenders up to three times the disbursements, plus $11,000+ for each false claim.
2. **Ensure accurate billing**
   To avoid inadvertent fraud, healthcare providers must maintain accurate billing practices **to steer clear of inaccuracies** such as overcharges or claims for undocumented or undelivered services.
3. **Maintain updated and proper documentation**
   Medical providers need to **maintain accurate records** to help assure that future treatments deliver the best possible patient outcomes. Detailed records can also assist providers in defending themselves against malpractice suits.
4. **Keep track of your licenses**
   Check regularly to ensure your licenses and your staff licenses are up to date. If your license was expired at the time you performed medical treatment, then **you may actually be charged with fraud, regardless of the fact you actually performed the procedure billed.**
5. **Create and follow a compliance plan**
   Medical providers can avoid fraudulent activity by **creating and observing a compliance plan, a practice that the Affordable Care Act mandates to remain Medicare and**

Medicaid eligible. The Office of the Inspector General publishes the *Compliance Program Guidance for Individual and Small Group Physician Practices* to assist medical providers in establishing such plans.

Medwave is committed in assisting medical providers with their **Medicare and / or Medicaid billing**. Medwave helps avoid inadvertent fraudulent claims in **medical billing**. Contact us for complete details and pricing.