# FRAUD WASTE AND ABUSE (FWA)

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1. FRAUD (Intentional)

   This is an intentional wrongful or criminal deception intended to result in financial gain

   **Unlawfully making a misrepresentation that prejudices another**

   - **Unlawful gain** - It is an act of deception or misrepresentation
   - **Intention is to deceive:** one attempts to obtain something of value that he is not entitled to under the law or rules governing the relationship
   - It can be a collusion between a provider and a patient
   - It can be done by a doctor on his own
   - **Fraud is not a victimless crime;**
   - **It drives up the cost of care** - Members pay higher or increased premiums – this will/may lead to them being unable to afford medical aids
   - **It is a criminal offense**
   - **It is estimated that 3-5% of the claims are fraudulent; this resulting in an estimated loss of at least R22bn**
   - In 2016 there were 8.8m medical aid beneficiaries and the total contribution by members was R160bn

**How is Fraud perpetrated in the medical industry?**

**Misrepresentation** of services with incorrect ICD/CPT Codes – Upcoding/Miscoding

**Billing for services not rendered**

- Phantom billing
- Ghost claims
- Falsification of information in medical records; this includes treatment of non-members
- Billing for meds not dispensed
- Dispensing a Generic medicine, but billing for the original
- Billing for supplies not provided
- Billing for a PMB condition when it is not a PMB
- Patients who have exhausted their benefits towards the end of the year asking the doctor to claim for these services in the new year

Members of the schemes maybe in collusion with the doctor in committing this crime; or they may in fact ask the doctor for this 'favor"

2. WASTE (Duplicates; Unbundling – Accidental)

Healthcare spending that can be eliminated without reducing the quality of care. It is overutilization of resources resulting in unnecessary costs; it is not regarded as criminal, but rather misuse of resources

Examples are:

- Duplicates
- Over-servicing
- Unbundling – adding multiple claim lines
- Up-coding – using modifiers like emergencies, after hour services or travelling away from the rooms: 0146; 0147 and 0148 codes
- Overuse of Emergency units (Casualties) for non-emergencies
- Underuse of generic medicines
- Overuse or Abuse of Antibiotics, especially for URTI – viral infections

Categories of Waste

A. Failures of care Delivery – Preventive care: Not doing the following tests:
   - PAP Smear;
   - Mammograms;
   - Screening for Colon Cancer;
   - Vaccines for children and the elderly, Flu vaccines

*These delivery failures can lead to worse clinical outcomes*

B. Failure of Care Coordination - This occurs when patients experience care that is fragmented and disjointed: Example is doctor hopping –
   - In chronic care;
   - In acute care some of these patients would go to another doctor within a week of seeing one for the same ailment

C. Overtreatment
   - Patients demanding medicines where it is not indicated e.g. asking for flu treatment when they are presenting with a headache
   - On the doctor side, the doctor giving more medicines than it is necessary

Examples of overtreatment

- Defensive medicine – doing all the possible tests for fear of missing something and thereafter be sued for negligence
- Over-diagnosis leading to Overtreatment
- Use of higher priced services that have negligible or no health benefits over less expensive alternatives

D. **Unnecessary hospital admissions**

E. **Office procedures that could be done by FPs at a fractional cost** being done in hospitals by Specialists. When done in FP/GP office, schemes pay for these from acute benefits or the Medical Savings Account (MSA) thus disadvantaging patients. We can draft a list of procedures that can be done by FPs in their office; **and to incentivize them, schemes should pay a higher rate as they will be saving on hospital costs.**

**Examples –** PAP smear: GPs not paid a fee for it; but expected to do them and being marked negatively if they don't. Schemes must consider that FP is a business that is time based and all these services must be remunerated.

**Challenges to Reduce Waste**

- **Third Party Payment System** drives these costs, as patients are insensitive to the cost of care at the point of service
- **The Fee for Service (FFS)** system promoted overutilization
- **Benefit Structure** where there are unlimited visits promotes over-utilisation and wastage. Examples are Low Cost Benefit Options (LCBO) where members have unlimited visits

3. ABUSE (Entitlement)

**Providing services that fail to meet professionally recognized standard of care. It results in unnecessary costs**

- Medically unnecessary procedures: Abuse or Over-utilisation of Ultrasound;
- Dispensing medicines that are unnecessary based on the patients' medical condition
- Dispensing meds in quantities above the medically necessary quantity

**It is Entitlement** - somebody recklessly or negligently attempts to obtain something of value that the party is not entitled to under the statutory or contractual rules that govern the relationship.

4. HPCSA ETHICAL RULES

ACCESS TO CONFIDENTIAL INFORMATION

By a third party requires informed consent by the patient or legal guardian

One should guard against the right of the individual being corroded by the possibility of payment being withheld on the basis on non-disclosure.

Providers must inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage

Undesirable Business Practice

Financial incentives should only be used to promote quality and cost-effective care and not to encourage the withholding of medically necessary care. Providers should not allow financial incentives to influence their judgements of appropriate.

Incentives may not be used to encourage either over or under servicing of patients. Appropriate care should be provided at all times.

Rights to Confidentiality

- It is a fundamental human right
- It is in the Ethical guidelines of HPCSA (Booklet number 5)

A doctor may divulge information regarding a patient only if this is done

- In terms of the statutory Provision
- At the Instruction of a Court
- In the Public Interest
- With the expressed Written Consent of the patient
- With the written consent of the parent or guardian of a minor
- In case of the deceased patient – his next of kin who is in charge of the estate

Risk Sharing – Capitation

Inherently in these prepayment arrangements is the risk of underservicing. Therefore, utilisation reviews; practice profiles and peer reviews should be a prerequisite.

Fraud Investigations

**IPAF is against any form of Fraud, Waste and Abuse** of medical resources as this leads to increased cost of care, which leads to lots of people being unable to afford private care. ***We urge our members to exercise care and caution when providing medical services and claiming from schemes for services rendered.***

In terms of SA Laws, any person is presumed innocent until found guilty. Therefore, when investigating fraud, this right has to be recognized and respected at all times

**Investigators must be in possession of a Section 41 (a)** warranty requested from the HPCSA and issued by a magistrate before they can search premises. Without this warrant, the doctor is within his/her right to request the investigators to leave the premises. Failure to comply constitutes trespassing.

They need to have an expressed written consent from the member to access clinical records

We, as IPAF are against:

- Attempts at entrapment by probes – inducements to commit a crime
- Any form of recording of the consultation – video/tape

Section 34 of Prevention and Combating of Corrupt Activities Act 2004

A practitioner involved in a fraudulent activity that involves an amount of R100 000 or more, should be reported to SAPS. Failure to comply constitutes an offense under the Act. Secondly, ethical matters have to be reported to the HPCSA.

## 5. General

### Restriction of Choice

It is advisable that a point of service option is offered to patients, even at an additional cost to allow the patient to consult a provider of his choice. This means all the schemes should allow Balance Billing to ensure that patients see providers of their choice.

### Sechaba judgment

Section 59(2) of the medical Schemes Act does not afford schemes discretion regards whether they can pay the member directly and not the doctor for services rendered. The judge summed up this matter this way - ***When a member utilizes medical services and arranges for the provider to submit a claim to the scheme, they are authorizing the scheme to pay the doctor directly and not the member.***

### Acknowledgment of debt (AOD)

Doctors are often coerced into signing it – withhold of payment that affects doctor financially. They have to be careful and think the matter through before signing any AOD (Admission of guilt)

**Section 59(3) of the MSA** empowers the medical aid to recover any amount paid to practitioner wrongfully – misconduct by a practitioner

**Practitioners should report to the CMS schemes that unlawfully withhold or delay payments**

Written By: IPAF Director – Dr Elijah Nkosi – May 2018