Insurance Fraud

Upon returning home from an out of town trip, my wife found a telephone message from the fraud division of her credit card company. Apparently, when she used her credit card at a restaurant, someone had copied it and used the copy to make large purchases in various parts of the country. Understandably, anyone would feel outraged and hope that the perpetrator would be caught and jailed for this blatantly fraudulent behavior. Yet, do we respond similarly to instances of a different type of fraud, one perpetrated by healthcare professionals upon insurance companies?

It was at a state dental meeting during which attendees were discussing various practice management issues, that I was dismayed to hear the comment, “We never place fissure sealants in our office, only composite restorations.” The practitioner explained that restorations were placed because that was what insurance companies covered, whereas some did not provide coverage for fissure sealants. I wondered how frequently practitioners misrepresented their treatment and whether that misinterpretation constituted fraudulent behavior which differed from the use of my wife’s stolen credit card.

That question led me to call the fraud division of a large dental insurance company. I learned that for insurance companies fraud is a major concern, not simply an isolated event. Insurance fraud is not limited to a particular type of practitioner. It occurs just as frequently in practices that are large and small, urban and suburban, solo and group, and new as well as long-standing. It seems that no type of practitioner is immune to fraudulent behavior and, consequently, this is a concern which needs to be addressed.

According to an insurance industry spokesperson, fraud is defined as “a practice in which a person knowingly and intentionally altered information provided to the insurance company”. Many examples were provided, such as changing dates on insurance forms so that a service would fall at a time within the patient’s coverage period to guarantee reimbursement; the undisclosed waiver of patient co-payment and acceptance for private payment of only the amount reimbursed by the insurance company; the existence of two fee schedules, one for paying patients and one for patients covered by a third party. Most troubling is the submission of a bill for one procedure when, in fact, another was actually performed, such as stating that a surgical extraction rather than a simple extraction was performed, or stating that a composite restoration was placed rather than a filled fissure sealant. Two different motives could explain why practitioners fudge the information, either benefit for the patient or financial gain for the practitioner. In either case, the behavior is wrong, though one might be more sympathetic to the motivations of the former as opposed to the latter.

Though it is clearly improper, fraudulent behavior by healthcare providers is a complex issue. In a study appearing in the April 2000 Journal of the American Medical Association, titled “Physician Manipulation of Reimbursement Rules for Patients, Between a Rock and a Hard Place”, researchers reported the extent to which physicians manipulate rules of reimbursement by insurance companies in order to obtain coverage to benefit patients. 720 practicing physicians responded to a survey asking how frequently they exaggerated the severity of a patient’s condition, or changed the billing diagnosis, or reported non-existent signs or symptoms, in order that patients receive needed but uncovered medical care. Surprisingly, 39% of the respondents reported that during 1998 they had occasionally or even more often used some sort of deception to “game the system” in order that patients might benefit. Discussion with other medical colleagues indicated that this kind of behavior is widespread and longstanding. Yet, while this behavior might be rationalized, it is nevertheless still considered by society to be fraudulent and, consequently, inappropriate. The January 10, 2001 New York Times reported under a bold headline “Doctor Convicted of Insurance Fraud in Fertility Procedures”, that “a Manhattan obstetrician with a celebrity clientele was convicted of defrauding insurance companies to have them pay for expensive fertility procedures... The doctor...was convicted of something that many in his profession have quietly done for years: billing insurance companies for covered gynecological procedures to mask the uncovered fertility procedures he was performing.” While that physician might have claimed that his behavior benefitted his patients, nevertheless, he was found guilty of fraud and unless he wins an appeal, he will be spending many years in jail.

A large part of the problem stems from the manner in which insurance companies have set up the rules for health care programs. In many instances, they are arbitrary and do not consider the welfare of the patient first and foremost. Practitioners report that insurance companies do not always follow the rules, often losing some claims, delaying payment for others or even changing the rules without appropriate notification to patient or practitioners. Often unnecessary hurdles, such as extensive paperwork, make the process onerous.

Clearly, there is a problem which must be addressed by healthcare professionals, the insurance industry, and the public which is served by both, so that patients are treated fairly and insurance companies are not defrauded. It is inappropriate for any healthcare worker to feel compelled to “game the system” in order to help a patient in need, and the insurance industry must take responsibility for its part in this problem.