PA INSURANCE FRAUD PREVENTION AUTHORITY

KNOW THE RISKS. KNOW THE PENALTIES.

HEALTH INSURANCE FRAUD

Health insurance fraud is any intentional deception made knowing it could result in an unauthorized benefit being paid to an individual, entity, or some other party. The most common kind of health insurance fraud involves a false statement, misrepresentation, or deliberate omission critical to the health insurance company's determination of benefits payable.

Insurance subscribers commit insurance fraud by:

- Allowing someone else to use their identity and insurance to obtain medical services.
- Using benefits to pay for prescription drugs not prescribed by their doctor.

Common fraudulent acts by health care providers include:

- Billing for services, procedures, and/or supplies that were never provided.
- Misrepresenting dates, locations or providers of service.
- False billing for prescription medicine.
- Billing for more expensive services than were actually provided (known as "upcoding").
- Deliberately performing medically unnecessary services for the purpose of financial gain.
- Misrepresenting non-covered treatments as medically necessary.
- Falsifying a patient's diagnosis to justify tests, surgeries, or other procedures.
- "Unbundling" — billing each step of a procedure as if it was a separate procedure.
- Billing a patient more than the co-pay agreed to under the terms of the managed care contract.

Most health insurance includes a lifetime maximum of benefits. Health insurance fraud robs consumers of these benefits.

Recent IFPA statistics on the incidence of fraud in Pennsylvania found that:

- Incoming complaints of health insurance related crimes ("referrals") from all sources in Pennsylvania were 11 percent of all referrals in 2014.
- Health insurance-related crimes accounted for 13 percent of arrests in 2014.

Typical Opportunistic Health Insurance Fraud Scenarios

SCENARIO 1
Chris was the only one in his family with health insurance, but he let his brother and cousin use his card to receive health care benefits.

SCENARIO 2
A nurse in Dr. Smith's office became addicted to painkillers. Using her access to patient records she called in forged prescriptions to a local pharmacist and posed as a patient's family member when she picked up the drugs.

SCENARIO 3
Devon was addicted to painkillers, stole and forged prescription forms from his doctor's office, passed them at a local pharmacy, and used his health care insurance to pay for the drugs.

SCENARIO 4
Dr. Talbot billed his patients' health insurance for both the services he actually provided and for services that were not provided. He falsified his patients' medical records to reflect office visits and treatments that never occurred.

SCENARIO 5
Dr. O'Neill received the results of medical testing performed by a diagnostic firm for her interpretation of the results. She billed the patient's health insurance as though she performed both the testing and interpretation of the tests.

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