FRAUD, WASTE & ABUSE SUMMIT

CMS Council for Medical Schemes

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Discussion Document

Reaching a Common Understanding – Defining Healthcare Fraud, Waste and Abuse

Introduction

Although worldwide private healthcare funding is commonly based on accepted commercial principles that apply to other insurance industries, there are a variety of additional factors that make this form of insurance funding unique.

The volume of claims in healthcare far exceed those of short-term and long-term insurance, on average at least 90% of members claim from their health insurer annually, as opposed to the only 25% of insured who claim from their general insurance over the same period. One healthcare event is associated to a multitude of individual claims. The complexity of a single claim is also distinctly complicated. The ICD-10 medical coding system has over 67,000 diagnosis codes and 87,000 procedure codes, which funders and healthcare providers need to navigate in order to determine some level of fair reimbursement.

One of the most fundamental differences is that healthcare claims are paid upfront and in good faith to ensure scheme members have access to immediate healthcare treatment when needed. Unlike general insurance, each and every individual claim is not first validated and assessed prior to payment. There is a presumption that a proper service was rendered. Therefore only retrospective claiming patterns can assist in identifying irregular or outlier claiming behaviours as payment has already occurred.

Lastly, the emotive nature of healthcare treatment makes any associated claim very personal to the person who is insured. Denial of funding has a direct impact on the quality of life of the member, and as such health insurers have a humanitarian duty to honour as many claims as possible, whilst remaining financially sustainable for the

benefit of their collective membership. It cannot be ignored that whilst the provision of private healthcare services is treated as a commodity financially, the service itself is in fact a social necessity.

All these factors combined create a structurally weakened payment process that is open to errors, abuse and potential exploitation. This environment is not unique to South Africa and internationally the losses incurred as a result of these challenges have been encompassed into the expanded term Fraud, Waste and Abuse (FWA).

Why is Waste and Abuse associated to Fraud

Healthcare funders rely on provider representations in order to process and approve claims. FWA occurs when there is a misrepresentation and that individual or entity gets a payment or insured benefit to which they are not entitled.

This misrepresentation is however not always intentional. It can often be attributed to an honest mistake due to the dense, complex billing and reimbursement system that healthcare providers need to understand. It can result from billing errors, inefficient diagnostic testing, negligent coding, improper training, administrative confusion, unintentional duplication of claims and a whole range of other causes.

The difference between Fraud and Abuse is therefore the intent behind the misrepresentation that lead to overpayment. In healthcare it is extremely difficult to prove intention behind a false, inflated or incorrect claim, and therefore the focus remains on the 'Entitlement' to payment, unless evidence exists that indicates something more sinister. Very often Abuse leads to an indication of Fraud, when ongoing billing irregularities form a pattern that cannot be justified as a simple error.

Whether classified as Fraud or Waste and Abuse, the impact is however the same to the medical scheme. Significant losses are incurred by paying claims to which, on a balance of probabilities, a healthcare service provider, pharmacy or healthcare facility was not entitled.

Unlike Fraud, Waste and Abuse is not defined as a criminal act, which places an onus on the victim to provide evidence proving the intention of the accused *beyond reasonable doubt*. Waste and Abuse however will be subject to principles of civil laws, which will require the funder to prove the losses on a *balance of probabilities*.

The biggest misperception in the industry is that funders bear the onus to prove all FWA at the criminal law standard for burden of proof. This is not incorrect and is one of the main points of contention between funders and providers.

FWA in a South African context

As recognised in the Introduction, the occurrence of FWA in private healthcare funding is not unique to South Africa. There are however a number of distinct payment controls usually available to funders that have been eroded over time, for a number of reasons that result in medical schemes being even more exposed.

The lack of proper Ethical Billing Guidelines; the removal of up-to-date National Reference Pricing; the introduction of financially unlimited benefits (PMB's) and a very regulatory prescriptive environment for funders has led to an exponentially increasing occurrence of Waste and Abuse that the industry has historically not been sufficiently equipped to deal with.

The HPCSA prohibit '*Over-servicing or Over-charging*' in their Ethical Rules, whilst the Funders refer to it as '*Waste and Abuse*'. It is however all the same conversation, ie: healthcare providers (including Pharmacies and Facilities) claiming for services that are not absolutely medically necessary. The recent Health Market Inquiry (HMI) found that '*Supplier Induced Demand*' (SID) and over-servicing is a significant contributor to escalating healthcare costs.

Defining FWA

Fraud

Although different legal systems have varying versions, the standard definition of Fraud is widely recognized as: *"Wilful misrepresentation or deception in order to obtain financial or personal gain"*.

Healthcare fraud is defined as: *"Knowingly submitting, or causing to be submitted, false claims or an intentional misrepresentation of the facts in order to access payment of a benefit to which you would otherwise not have been entitled."*

Intentionally submitting a false claim to receive a benefit is considered a criminal act in terms of the Medical Schemes Act and punishable by imprisonment. In instances where a funder can prove fraud in excess of R100 000 beyond reasonable doubt, they have a legal obligation to report it to the South African Police Service.

Waste and Abuse

Waste and Abuse is not criminal in nature as the element of intention cannot be proven. Instead it is the misrepresentation of a claim (knowingly or unknowingly), in order to get a payment to which the provider or member was not entitled. The validity of the claims in question is measured on a balance of probabilities taking into account all facts available to a funder. In healthcare it also refers to the ethical obligations of healthcare service providers not to over-service or over-charge patients. This is because of the strong element of trust and honesty required when providing medical services.

Distinguishing between Waste and Abuse is a very subjective differentiation and mainly used for academic purposes when it comes to measuring the quality of healthcare outcomes versus the cost. It is however not necessary when it comes to determining the entitlement to payment by anyone submitting a healthcare claim.

Waste and Abuse can be considered any over-charging or over-servicing that results in the overpayment of a benefit. The Guidelines for Good Practice of the HPCSA prohibits a healthcare professional from over-servicing, under-servicing or over-charging a patient. There is a similar implied expectation by the general public and funders that healthcare facilities, pharmaceutical companies and pharmacies have a similar duty to uphold these ethical obligations. Any abuse of this duty poses a risk to the sustainability of the industry, and very often the health or financial position of the vulnerable patient.

Booklet 5 of the HPCSA guidelines defines over-servicing as the provision or supply of treatment or care which is medically and clinically not indicated, unnecessary or inappropriate and without due regard to both the financial and health interests of the patient. The HMI referred to over-servicing as the rendering of treatment and services that are not absolutely medically necessary.

Internationally Abuse is defined as actions that are inconsistent with sound business, ethical or medical practices and results in unnecessary cost or reimbursement for services that are not medically necessary or that do not meet the recognized standards of healthcare. Waste is defined as the misuse or over-utilisation of resources for which no true value is received.

Recommendation

It is important to note that every case of potential FWA will need to be classified on it's own merits. There are numerous factors that play a role in determining whether the misrepresentation is intentional or not, such as the nature of the billing irregularities; the frequency of the irregularities; the evidence available; the claiming history and the degree of deviation from peer norms. These factors do not however impact the Funder's right to receive repayment of overpaid claims to which a healthcare service provider was not entitled.

In light of the above background and context, it is proposed that the industry adopts the following definitions of FWA as the industry standard for policy determination and application:

***Fraud**: Knowingly submitting, or causing to be submitted, false claims or an intentional misrepresentation of the facts in order to access payment of a benefit to which you would otherwise not have been entitled.*

***Waste and Abuse**: The claiming for healthcare treatment and services that are not absolutely medically necessary, including any form of over-servicing or over-charging of a patient, and that may objectively be considered unethical or unconscionable or contrary to best practice principles.*