Fraud involves intentional deception or misrepresentation intended to result in an unauthorized benefit. An example would be billing for services that are not rendered. Abuse involves charging for services that are not medically necessary, do not conform to professionally recognized standards, or are unfairly priced. Type of Fraud and Abuse
False claim schemes are the most common type of health insurance fraud. The goal in these schemes is to obtain undeserved payment for a claim or series of claims. Such schemes include any of the following when done deliberately for financial gain: Billing for services, procedures, and/or supplies that were not provided.
Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.
Providing unnecessary services or ordering unnecessary tests Charging for a service that was not performed.
Unbundling of claims: Billing separately for procedures that normally are covered by a single fee. An example would be a podiatrist who operates on three toes and submits claims for three separate operations.
Double billing: Charging more than once for the same service.
Upcoding: Charging for a more complex service than was performed. This usually involves billing for longer or more complex office visits (for example, charging for a comprehensive visit when the patient was seen only briefly), but it also can involve charging for a more complex procedure than was performed or for more expensive equipment than was delivered. Medicare documentation guidelines describe what the various levels of service should involve.
Miscoding: Using a code number that does not apply to the procedure.
Kickbacks: Receiving payment or other benefit for making a referral. Indirect kickbacks can involve overpayment for something of value. For example, a supplier whose business depends on physician referrals may pay excessive rent to physicians who own the premises and refer patients. &#65533; source : www.quackwatch.org
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