Medical Aid Fraud

What is Fraud?

Fraud refers to an intentional deception made for personal gain or to damage another individual. Fraud is a crime and a civil law violation. The most common purpose of fraud is to defraud people or entities of money.

The Association of Certified Fraud Examiners defines healthcare fraud as a deception or misrepresentation that a person or entity makes, knowing that the misrepresentation could result in some unauthorised benefit to the individual or entity or another party. The most common fraud involves a false statement, a misrepresentation or a deliberate omission which results in benefits being granted, which would otherwise be denied.

What is the impact of fraud on members of a medical aid?

It is estimated that medical aid fraud cost the medical aid industry approximately R22 billion per year. Statistics from the South African Medical Association indicates that in 2002 R150 of a member's average contribution went to covering losses and combatting fraud as a result of fraudulent activities – this increased to R400 in 2010.

Fraud is committed by various parties including service providers, members, brokers and other parties with the main perpetrators being service providers and members. Money spent on fraud means that there is less money to spend on healthcare expenses.

Example: Peter visits his doctor who gives him cash and sends a claim through to the medical aid for a consultation and medication. This happens regularly and Peter's benefits are depleted by June. Peter's four year old daughter suffers from eczema and needs to go to the doctor for treatment, but there are no benefits. It is three weeks before payday and Peter does not have cash to pay for the consultation. Peter forgets that he has submitted fraudulent claims which have depleted his benefits.

Some other examples of medical aid fraud:

Fraud committed by members:

- Non-disclosure of previous medical conditions
- Submitting false or altered invoices
- Colluding with a service provider to submit false claims
- Membership substitution – members using their medical aid card for other people to use who are not registered dependants.
- Dual membership – belonging to two medical aids simultaneously.

Fraud committed by service providers:

- Code manipulation – charging for a more expensive procedure by billing for tariff codes with a higher monetary value, or charging for codes in respect of services not provided.
- Submitting accounts for services not rendered sometimes in return for a cash payment to the member.
- Merchandise substitution – e.g. providing a member with a nebuliser and charging for an oxygen tank.

- Generic instead of branded – provider dispenses generic medication and charges for the original medication.
- Providing services which are unnecessary
- Claiming for non-covered benefits under codes that are covered.

The direct consequences of healthcare fraud are:

- Direct financial losses to the members of the medical aid
- Investigation costs
- Management time
- Legal costs
- Reputational damage
  Ultimately all leads to increased contributions for the members

Real examples of fraud committed against medical schemes administered by PROVIDENCE Healthcare Risk Managers:

Member complained about having received a second hand hearing aid, but being charged for a new hearing aid. It is important to note that it is not illegal in itself to supply a second-hand object. It is only problematic if it was sold as new and proven subsequently to be second-hand.

A pharmacy held back a claim from December 2011 as the member's benefits were depleted and re-submitted the claim in 2012 under a 2012 service date once the member's benefits were renewed.

A dependant's mother, who is not a member of the medical aid, is claiming for services under her daughter's name (who is a member of the medical aid).

What are the consequences for members and providers who commit fraud?

The following will happen when a member is found to be guilty of committing fraud:

- Scheme membership will be terminated
- All fraudulent claims will be reversed and the member will be liable to pay them
- The member will be reported to the participating employer group where the member's contribution is subsidised by an employer
- A criminal case will be opened

The following will happen when a service provider is found to be guilty of committing fraud:

- All fraudulent claims will be reversed
- Direct payment to the provider will be stopped – all claims will be refunded to the member
- The provider will be reported to the relevant regulatory body
- A criminal case will be opened

How can you prevent fraud?

- Analyse your claims statements carefully. Check that you have received the services claimed for by the service provider.

- Keep your medical aid number and medical aid card in a safe place.
- Refrain from accepting money in exchange for a claim from your medical aid.
- Report suspicious behaviour.

Report Medical Aid Fraud

Telephone number:	(041) 395 4515
Fax number:	086 618 2806
E-mail address	forensics@providence.co.za