Common Fraud Waste Abuse Enumeration in Healthcare

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This document is a draft outline of a standardized list of medicaid fraud, waste, and abuse types and definitions. The methodology and sources associated with creating the Fraud Waste Abuse Common Fraud Enumerated can be found at the end of the document.

Enumerated list of fraud, waste, and abuse

The following is an overview of the Fraud Waste Abuse enumerated list. 21 types of fraud, waste, and abuse were identified (with percentage frequencies at the far right). Some sources noted false cost reports, obvious errors, and misleading enrollees as types of fraud waste and abuse in Medicaid. However these were not included as these are indirectly related to fraud waste abuse.

- 1.000 No service was provided but a charge was submitted (18.9% total)
  - 1.001 Billing for services not provided
  - 1.002 Billing for phantom visits
- 2.000 A service was provided but it was not necessary (10.8% total)
  - 2.001 Billing for unnecessary services (overutilization)
  - 2.002 Obtaining and selling medications using medicaid
  - 2.003 Excessive use or overuse of medicaid
  - 2.004 Simultaneously receiving benefits in multiple states
  - 2.005 Doctor shopping
- 3.000 A service was provided but a kickback was involved (9.1% total)
  - 3.001 Paying providers for patient referrals (kickbacks)
- 4.000 A service was provided but the actor was not eligible (7.6% total)
  - 4.001 (provider) Falsifying credentials (5%)
  - 4.002 (patient) Using another person's insurance card (1.5%)
  - 4.003 (patient) Providing false information to apply for services (1.1%)
- 5.000 A service was provided but an overcharge was submitted
  - 5.001 Billing for more hours than there are in a day
  - 5.002 Billing for expensive procedures (upcoding) (7.7%)
  - 5.003 Double billing
  - 5.004 Substitution of generic drugs
  - 5.005 Using multiple billing codes instead of just one (unbundling) (1.9%)
- 6.000 A service was provided but the payment was denied
  - 6.001 Denying valid claims
  - 6.002 Undervaluing amounts owed
  - 6.003 Overstating the insurer's cost in paying claims
- 7.000 A service was provided but it was not covered
  - 7.001 Billing for a noncovered service
  - 7.002 (abusing transportation benefits)

Enumerated list of fraud, waste, and abuse (detail)

The following is an expanded list of the enumerated list of fraud waste and abuse. When possible/available, each type includes an example, the type (fraud, waste, or abuse), the relative stage of the healthcare encounter (medicaid enrollment, patient onboarding, diagnosis/treatment, claims or post-treatment), the primary actors involved (provider, payer, other), and the frequency and impact of the type of fraud waste abuse. The [citations] in the headers refer to the FWA definitions section.

1.001 Billing for services not provided [1, 14, 33, 38, 49]

Example: Patient was billed for 30 tablets of Oxycontin but half of this amount was given to the patient.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.6% - 1.9% of medicaid | 18.9% of all fraud** [Appendix A.1]
- Impact (MA): **$97M - $323M** [Appendix A.2]

1.002 Billing for phantom visits [3, 42]

Example: A provider deliberately falsely bills the medicaid program for patient visits that never take place.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

2.001 Billing for unnecessary services (overutilization) [7, 12, 13, 20, 21, 32, 44, 47, 50, 54]

Example: A provider orders an MRI for a sprained ankle.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.3% - 1.1% of medicaid | 10.8% of all fraud** [Appendix A.3]
- Impact (MA): **$55M - $185M** [Appendix A.4]

2.002 Obtaining and selling medications using medicaid [24]

Example: A patient asks an individual to get drugs for them using their medicaid coverage.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency:, N/A
- Impact: N.A.

2.003 Excessive use or overuse of medicaid [57]

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

2.004 Simultaneously receiving benefits in multiple states [61]

Example: Visiting multiple providers in order to gain multiple prescriptions.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

2.005 Doctor shopping [26]

Example: Visiting multiple providers in order to gain a medical opinion the patient wants to hear.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (MA): N/A
- Impact (MA): N/A

3.001 Paying providers for patient referrals (kickbacks) [9, 18, 39, 48, 55]

Example: A nursing home owner or operator requires another provider, such as a laboratory, ambulance company, or pharmacy, to pay owner/operator a certain portion of the money received for rendering services to patients in the nursing home.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.3% - 0.9% of medicaid | 9.1% of all fraud** [Appendix A.5]
- Impact (MA): **$46M - $156M** [Appendix A.6]

4.001 Falsifying credentials [5]

Example: A physician allows a non-physician to impersonate a licensed doctor who medically treats patients and prescribes drugs and then bills the medicaid program.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.2% - 0.5% of medicaid | 5% of all fraud** [Appendix A.9]
- Impact (MA): **$26M - $86M** [Appendix A.10]

4.002 Using another person's insurance card [27, 40, 58, 59, 60]

Example: A patient uses a neighbor's Medicaid card in order to receive Medicaid services.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.04% - 0.14% of medicaid | 1.5% of all fraud** [Appendix A.13]
- Impact (MA): **$7M - $24M** [Appendix A.14]

4.003 Providing false information to apply for services [25]

Example: False information is used to enroll in Medicaid and then receive Medicaid services.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.03% - 0.1% of medicaid | 1.1% of all fraud** [Appendix A.13]
- Impact (MA): **$5M - $19M** [Appendix A.14]

5.001 Billing for more hours than there are in a day [4]

Example: A psychiatrist bills for more than 24 hours of psychotherapy treatment in a day.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

5.002 Billing for expensive procedures (upcoding) [8, 17, 35, 45, 51]

Example: Coding for the excision of a 5 cm skin lesion when the actual skin lesion was 1 cm.

- Fraud Waste Abuse
- Medicaid enrollment → patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.2% - 0.8% of medicaid | 7.7% of all fraud** [Appendix A.7]
- Impact (MA): **$39M - $132M** [Appendix A.8]

5.003 Double billing [2, 15, 23, 43]

Full definition: A provider bills both medicaid and a private insurance company for a treatment, or two providers request payment on the same recipient for the same procedure on the same date.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

5.004 Substitution of generic drugs [6]

Example: A lower cost drug is provided to a patient after Medicaid was billed for a brand name prescription.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

5.005 Using multiple billing codes instead of just one (unbundling) [34, 46]

Example: A common panel of tests, normally billed using a single code, is aplit up into individual tests and billed as if they were performed separately.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency (US): **0.1% - 0.2% of medicaid | 1.9% of all fraud** [Appendix A.11]
- Impact (MA): **$10M - $32M** [Appendix A.12]

6.001 Denying valid claims [31]

Example: A provider submits a valid claim but it is denied by the payer.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

6.002 Undervaluing amounts owed [30]

Example: Undervaluing the amount owed by the insurer to a healthcare provider under the terms of its contract.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

6.003 Overstating the insurer's cost in paying claims [28]

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

7.001 Billing for a noncovered service [19]

Example: A patient receives cosmetic dental work and the provider bills it as a similar procedure that is covered by Medicaid.

- Fraud Waste Abuse
- Medicaid enrollment → Patient onboarding → Diagnosis / Treatment → Claims → Post-treatment
- Provider Patient Payer Other
- Frequency: N/A
- Impact: N/A

Methodology

1. A list of FWA types/examples were pulled from primary sources listed in the **References** section. Medicaid centric government or sources from established health care organizations were used as references. All of these pulled examples are listed in the **All Fraud Waste Abuse Definitions** section**.** The citations in this section [ ] refer to **References**.
2. Similar groupings of types/examples from the **All Fraud Waste Abuse Definitions** section were condensed into the following format, which can be found in the **Enumerated list of Fraud, Waste, and Abuse (detail)** section:

   [CFE number] Definition of the type of fraud waste or abuse [citations refer to the **All Fraud Waste Abuse Definitions** section. Citations found outside the 'definition' header refer to Appendix A.
   - Real world example of the type of fraud waste or abuse.
   - (fraud/waste/or abuse)
   - (stage in the medical encounter process: Medicaid enrollment → Patient onboarding → Diagnosis / treatment → Claims → Post treatment)
   - (actors associated with this type of FWA: provider, patient, payer, third-party, other)
   - Frequency of occurrence
   - Total impact ($) in MA

3. The methodology used for calculating estimated frequency and total impact are as follows:
   a. Table 6 of the US GAO health care fraud report was used as a primary source for the estimates of frequency and total impact. Out of the 739 fraud cases analyzed (2010 cases. Includes only cases adjudicated favorably for the US. Private and federal healthcare program fraud cases), there were a total of 1,671 FWA schemes present. The # of times the particular scheme was used was divided by the total # of FWA schemes present (1,671) in order to find the percentage. This is the national frequency of occurrence. Label for frequency of occurrence is as follows: % of medicaid | % within fraud types.
   b. The national frequency of occurrence was multiplied by the US medicaid fraud estimates of a minimum of 3% and a maximum of 10% in order to gain the total range of % frequency of occurrence within the US medicaid system.
   c. The range of total impact was found by multiplying the total minimum and maximum % of the frequency of occurrence with 2016 MA medicaid spending ($17.1B). Label for total impact is as follows: $minimum estimate - $maximum estimate. Detailed calculations can be found in appendix A.
   d. Calculation of impact was calculated solely based on % occurrence of the particular type of FWA paired with the total MA medicaid budget. Therefore, the methodology does not take into account factors such as a particular type of fraud costing more to the medicaid system compared to other types.

All Fraud Waste Abuse definitions

(the citations [ ] *in this section refer to the* **references** *section)*

1. **Billing for services not provided** - A provider bills for services not performed, such as blood tests or x-rays that were not taken, full denture plates when only partial ones are supplied, or a nursing home or hospital that continues to bill for services rendered to a patient who is no longer at the facility either because of a death or transfer. [1]
2. **Double billing** - A provider bills both Medicaid and a private insurance company (or recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date. [1]
3. **Billing for Phantom visits** - A provider falsely bills the Medicaid program for patient visits that never take place. [1]
4. **Billing for More Hours Than There Are In A Day** - Inflating the amount of time a provider spends with patients, for example a psychiatrist that bills for more than 24 hours of psychotherapy treatment on a day. [1]
5. **Falsifying Credentials** - Misrepresenting the qualifications of a licensed provider in order to defraud Medicaid. For example, a physician who allows a non-physician to impersonate a licensed doctor who medically treats patients and prescribes drugs and then bills the Medicaid program. [1]
6. **Substitution of Generic Drugs** - A pharmacy bills Medicaid for the cost of a brand-name prescription when, in fact, a generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy. [1]
7. **Billing for Unnecessary Services or Tests** - A provider falsifies the diagnosis and symptoms on recipient records and billings to obtain payments for unnecessary laboratory tests or equipment. [1]
8. **Billing for More Expensive Procedures than were Performed** - A provider bills for a comprehensive procedure when only a limited one was administered or billing for expensive equipment and actually furnishing cheap substitutes. [1]
9. **Kickbacks** - A nursing home owner or operator requires another provider, such as a laboratory, ambulance company, or pharmacy, to pay owner/operator a certain portion of the money received for rendering services to patients in the nursing home. Examples of this type of payment include vacation trips, personal services and merchandise, leased vehicles, and cost payments. This practice usually results in unnecessary services being performed to generate additional income to pay the kickbacks. [1]
10. **False Cost Reports** - A nursing home owner or operator includes personal expenses in its Medicaid claims. These expenses often include the cost of personal items. [1]
11. Obvious errors - claims filed before birth or after death, or bills for hysterectomies performed on men [2]
12. Filing claims for children's braces that were not medically necessary and should not have been covered by medicaid [2]

13. Private contractor that Texas hired to process pre-authorization applications gave approvals without appropriate medical review [2]
14. Provider fraud: billing for services not performed [3]
15. Provider fraud: Billing duplicate times for one service [3]
16. Provider fraud: falsifying a diagnosis [3]
17. Provider fraud: billing for a more costly service than performed [3]
18. Provider fraud: accepting kickbacks for patient referrals [3]
19. Provider fraud: billing for a covered service when a noncovered service was provided [3]
20. Provider fraud: ordering excessive or inappropriate tests [3]
21. Provider fraud: prescribing medicines that are not medically necessary or for use by people other than the patient [3]
22. Patient fraud: filing a claim for services or products not received [3]
23. Patient fraud: forging or altering receipts [3]
24. Patient fraud: obtaining medications or products that are not needed and selling them on the black market [3]
25. Patient fraud: providing false information to apply for services [3]
26. Patient fraud: doctor shopping to get multiple prescriptions [3]
27. Patient fraud: using someone else's insurance coverage for services [3]
28. Insurer fraud: overstating the insurer's cost in paying claims [3]
29. Insurer fraud: misleading enrollees about health plan benefits [3]
30. Insurer fraud: undervaluing the amount owed by the insurer to a health care provider under the terms of its contract [3]
31. Insurer fraud: denying valid claims [3]
32. Billing for unnecessary services or items. Intentionally billing for unnecessary medical services or items. [4]
33. Billing for services or items not provided. Intentionally billing for services or items not provided. [4]
34. Unbundling. Billing for multiple codes for a group of procedures that are covered in a single global billing code. [4]
35. Upcoding. Billing for services at a higher level of complexity than provided. [4]
36. Card sharing. Knowingly treating and claiming reimbursement for someone other than the eligible beneficiary. [4]
37. Collusion. Knowingly collaborating with beneficiaries to file false claims for reimbursement. [4]
38. Drug diversion. Writing unnecessary prescriptions, or altering prescriptions, to obtain drugs for personal use or to sell them. [4]
39. Kickbacks. Offering, soliciting, or paying for beneficiary referrals for medical services or items. [4]
40. Multiple cards. Knowingly accepting multiple medicaid ID cards from a beneficiary to claim reimbursement. [4]
41. Program eligibility. Knowingly billing for an ineligible beneficiary. [4]
42. Phantom billing. Submitting claims for services not provided. [5]
43. Duplicate billing. Submitting similar claims more than once [5]

44. Bill padding. Submitting claims for unneeded ancillary services to medicaid [5]
45. Upcoding. Billing for a service with a higher reimbursement rate than the service provided. [5]
46. Unbundling. Submitting several claims for various services that should only billed as one service. [5]
47. Excessive or unnecessary services. Provides medically excessive or unnecessary services to a patient. [5]
48. Kickbacks. A kickback is a form of negotiated bribery in which a commission is paid to the bribe-taker (provider or patient) as a quid pro quo for services rendered [5]
49. (provider) Billing for services not rendered [6]
50. (provider) Billing for services not medically necessary [6]
51. (provider) “Upcoding” or inappropriate billing that results in a loss to the medicaid program [6]
52. (provider) Inappropriate or lack of documentation to support services billed [6]
53. (provider) Quality of care issues that fail to meet professionally recognized health care standards [6]
54. (provider) Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment [6]
55. (provider) Soliciting or receiving kickbacks [6]
56. (provider) Violating medicaid policies, procedures, rules, regulations, and/or statutes [6]
57. (beneficiary) Excessive use or overuse of medicaid [6]
58. (beneficiary) Using another’s medicaid identified card [6]
59. (beneficiary) Lending, altering or duplicating a medicaid ID [6]
60. (beneficiary) Providing incorrect eligibility or false information to a provider to obtain treatment [6]
61. (beneficiary) Simultaneously receiving benefits in Mississippi and another state [6]
62. (beneficiary) Knowingly assisting providers in rendering services to defraud the Medicaid program [6]
63. (beneficiary) Prescription fraud [6]

References

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Appendix A (frequency + impact calculations based on GAO [7])

1. 315 ÷ 1,671 = 18.85%. 3% x 18.85% = 0.57%. 10% x 18.85% = 1.89%. Range = 0.6% - 1.9%
2. 0.57% x $17.1B = $97M. 1.89% x $17.1B = $323M. Range = $97M - $323M
3. 181 ÷ 1,671 = 10.83%. 3% x 10.83% = 0.32%. 10% x 10.83% = 1.08%. Range = 0.3% - 1.1%
4. 0.32% x $17.1B = $55M. 1.08% x $17.1B = $185M. Range = $55M - $185M
5. 152 ÷ 1,671 = 9.09%. 3% x 9.09% = 0.27%. 10% x 9.09% = 0.9%. Range = 0.27% - 0.9%
6. 0.27% x $17.1B = $46M. 0.91% x $17.1B = $156M. Range = $46M - $156M
7. 129 ÷ 1,671 = 7.72%. 3% x 7.72% = 0.23%. 10% x 7.72% = 0.77%. Range = 0.2% - 0.8%
8. 0.23% x $17.1B = $39M. 0.77% x $17.1B = $132M. Range = $39M - $132M
9. 83 ÷ 1,671 = 4.97%. 3% x 4.97% = 0.15%. 10% x 4.97% = 0.50%. Range = 0.2% - 0.5%
10. 0.15% x $17.1B = $26M. 0.5% x $17.1B = $86M. Range = $26M - $86M
11. 31 ÷ 1,671 = 1.86%. 3% x 1.86% = 0.06%. 10% x 1.86% = 0.19%. Range = 0.1% - 0.2%
12. 0.06% x $17.1B = $10M. 0.19% x $17.1B = $32M. Range = $10M - $32M
13. 24 ÷ 1,671 = 1.44%. 3% x 1.44% = 0.04%. 10% x 1.44% = 0.14%. Range = 0.04% - 0.14%
14. 0.04% x $17.1B = $7M. 0.14% x $17.1B = $24M. Range = $7M - $24M
15. 19 ÷ 1,671 = 1.14%. 3% x 1.14% = 0.03%. 10% x 1.14% = 0.11%. Range = 0.03% - 0.11%
16. 0.03% x $17.1B = $5M. 0.11% x $17.1B = $19M