

# Medical Fraud & Gambits

- Inaccurate billing (dates of service and length of treatment) reflecting a different pattern of treatment and duration of treatment than that was actually provided
- Designing bills to be confusing with overlapping days and services to encourage duplicate payments, and not reimbursing for overpayments.
- Selling receivables to collection for services, that had already been paid or adjudicated
- Billing by collection companies for services already reimbursed (i.e. balance forward on bills that were reduced to fee schedule, or legally denied by the payors)
- Billing for services, medical tests and treatment never authorized or never performed
- Falsification of medical records to facilitate billing and/or settlements
- Postdating and/or backdating of medical records to conform with policy coverage periods
- Billing in different geographic areas from where treatment took place to increase fees
- Allowing unlicensed or unqualified medical personnel to take patient history and or provide care.
- Treatment or testing provided by untrained or unlicensed persons and then billing for medical care as though treatment was provided by the physician or qualified personnel
- Clinic or doctor using multiple tax ID #'s to avoid paying taxes
- Clinic or doctor uses multiple tax ID #'s to avoid identification as denied provider
- Durable medical equipment (DME) delivered/mailed to patient's residence that was never prescribed.
- Having the employee sign sign-in sheet multiple times at first visit and then billing for services never provided.
- Medical cost shifting through billing the higher paying venue rather than the correct venue (group health vs. workers compensation) (this is particularly an Illinois issue)
- Provider billing both the workers compensation payer, and the group health provider and not reimbursing for the duplicated payments that they received.
- Capping (buying and/or selling of patient referrals)