Healthcare's toothache:

Inappropriate billing in dentistry

EHFCN

European Healthcare Fraud & Corruption Network

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By Paul Vincke - Managing Director, EHFCN

Lone wolf vs organised crime?

Over the past decade, OECD has continuously repeated how important it is to stop healthcare expenses from absorbing an ever increasing percentage of GDPs in order to avert budgetary calamities in Europe.

The European Healthcare Fraud and Corruption Network, for it's part, has not stopped insisting that fighting fraud, waste and corruption in healthcare is an important and effective step for governments and for private insurers setting up cost cutting strategies in order to stop financial losses without reducing access to quality care.

One might wonder how effective counter fraud activity in healthcare really is.

Do special investigation units (SIU) in public and private health insurance really generate the desired effect in terms of considerable losses detected and monies recovered in line with what fraud loss measurement exercises 'predict'?

In Europe, healthcare fraud is often mistakenly seen as an occasional offense committed only by individual perpetrators and with low financial impact.

Evidence of healthcare fraud revealed in a report recently published by the Belgian Medical Evaluation and Inspection Department (or MEID – the government healthcare fraud watchdog) does not support this assumption.

Two of MEID's investigations demonstrate that healthcare fraud can also be large-scale malpractice by reputable hospitals or common practice amongst a large group of home nurses. The scale of the fraud detected by MEID was considerable and well planned, both in home nursing and medical imaging.

- In 105 Belgian **hospitals** targeted by MEID, 13 medical imaging departments wrongly billed 75% of their petrosal CT scans: between 1 March 2013 and 31 August 2014 protocols showed evidence of cheaper scull CT scans or the cheaper facial massif CT scans actually carried out instead of the more expensive petrosal CT scan.
  - This systematic misrepresentation, totaling €2,849,000 was judged to be intentional.
  - 12 out of the 13 hospitals admitted the fraud.
- An annual turnover exceeding €200,000 is considered to be practically impossible in Belgian **home nursing**.
  - Nevertheless the number of home nurses generating a revenue exceeding this amount has been increasing: 136 in 2013 and 187 in 2014 of which 39 generated an implausible turnover of €300,000.
- MEID started an investigation of revenues between 1 January 2012 and 31 May 2015 and targeted 87 home nurses with a turnover exceeding €200,000.

- Evidence showed that 62 home nurses billed health insurance in excess of €3,000,000 in total.
- 58% of them over-scored for more than €25,000, 25% for less than €10,000.
- 26% of the infringements detected related to care that was not provided: plain fraud.
- Other important anomalies detected related to inappropriate billing for complex wound care and performing acts without the proper qualification.

Fraud in dentistry: Common practice?

Both cases demonstrate how the same kind of fraud is perpetrated by a considerable number of healthcare providers as if it were 'common practice' in a particular area of care delivery.

In both cases the group of fraudulent outliers showed explicitly on the MEID radar when anomalies were screened in the 'risk areas' of CT scanning and home nursing.

Detecting anomalies becomes extremely difficult when, in a particular area of interest, the cluster of fraudulent outliers blends with the whole group of practitioners.

This is in particular the case in **dentistry** where, for example, inappropriate billing practices related to dental fillings and coronal restorations seem to be common practice for a particular number of dentists.

Recent reports published in Germany (Health Insurer Barmer Gek – Zahnreport 2015) and Belgium (MEID – Restorative dental care 2015) demonstrate how billing for non-delivered care has become standard procedure in dentistry.

This hampers effective screening for fraudulent overconsumption, as indicators for non-delivered care will not reveal a group of outliers within the targeted sample of practitioners.

Additionally, investigators are confronted with the difficulty of producing tangible proof of fraud; in most cases examination of the patients' mouth is the only way to show evidence.

Nonetheless, the challenge remains to stop health insurance budgets from bleeding when reimbursing for dental fillings and coronal restorations.

Methodology to stop the bleeding

In the referred-to MEID report on inappropriate billing in dentistry, two specific investigative approaches have been used to determine the nature of the fraud.

These methods have also allowed the creation of specific indicators to determine the extent of the fraud.

Both the nature and the extent of the fraudulent billing can thus be established without having to demonstrate the material proof with dental photography or other time consuming techniques that sometimes appear to be useless such as the extraction of teeth. Composites and GIC glass ionomer cement are often radiolucent and not visible to the eye or even on X-rays, or patients do not recall the dental care received.

The methods deployed were the following:

Investigative method 1: Restorative Dental Care: Repeated billing for interventions on the same tooth.

A population of 7,176 Belgian dentists has been screened on how they applied conserving dental care between 2007 and 2009, in particular dental fillings and coronal restoration applied on the same tooth of ambulatory patients over 15 years old, with repeated billing in 1 year (by the same dentist).

The 'repetition rate' (RR) was defined as:

- The number of interventions for the same tooth, repeatedly billed in the period of reference and within 1 year (numerator).

- The number of all the interventions billed in the period of reference (denominator).

In the Barmer 'Zahnreport 2015' (as referred to earlier) an average repetition rate of 8.5% was thus concluded for 17 million dental restorations analysed between 2010 and 2013. These restorations had a lifespan between 8.7 and 10.5 years but one third of these restorations were repeated within 4 years.

The Belgian MEID 'Restorative dental care 2015 report' concluded, after excluding social, economic and geographic factors, that a repetition rate of **more than 10%** was to be considered as **inacceptable**:

- Or the dental care is not actually provided (incorrect billing).

- Or the restorations are of very low quality (overconsumption or unnecessary expensive care).

Subsequently MEID started a campaign informing **1,000 dentists with a >10% restoration rate** of the fact that they were considered to be outliers.

This resulted in an important change of attitude within the targeted group after an observation period of 1 year: 80% of all dentists with initially >10% restorations reduced their restoration rate to <10%.

The impact on the budget was a €8,500,000 reduction or 4.7% of the total budget for conserving dental care.

After a second period of observation 174 hardliners were requested to repay amounts up to €15,500 individually and were sanctioned to a fine up to 200% of the amount repaid.

Investigative method 2: Determining a minimum duration for types of care and the maximum amount of reimbursable care.

Apart from the repetition rate, the time spent by the dentist on specific dental care such as restorations and root canals is also considered to be a relevant indicator for fraud and unnecessary expensive care (overconsumption).

- In a first phase academic referents and court experts have determined the minimum time required for restoration of a 1/2/3 surface cavity (1S/2S/3S).

- In a second phase the time as indicated in the dentist diary was set against the expert opinion.

  - This resulted in for instance the following finding:

	Time as in Dentist diary	**Minimum Time as set by Expert**
1S	3 minutes	24 minutes
2S	5 minutes	30 minutes
3S	5 minutes	39 minutes
Crown	7 minutes	55 minutes

- In this particular case these time differences generated a fraudulent surplus billing for not provided dental care of €360,000 over a period of 2 years.

- In a third phase the technical dental board (mainly composed of representatives of dentists) has elaborated a ceiling system for billing in a fixed period, creating the value 'P':

  - P-value reflects the minimum (expert) time and complexity of the dental care concerned.

  - P-value also reflects the cost of the disposable equipment used.

- Finally it was decided that P values will concern only the extreme outliers exceeding the ceiling **P200**.

  - As a result, all dental care billed in excess of the P200 ceiling during a period of at least 30 days, with a minimum of 6 reimbursed acts a day, is considered to be non compliant with this new billing rule as explicated in a piece of new legislation.

This new monitoring system will eliminate the requirement of demonstrating evidence of fraudulent intention in every single suspicious case and will stop 100 out of the 7,200 Belgian dentists from eating 5% of the dental care budget.

[Off the record: according to Jeremy Hetherington-Gore (Tax-News.com, London 29 November 2000) before the financial crisis it was traditionally Belgian dentists who were the mainstay of the Eurobond markets – wealthy professionals in a high-taxing country who kept their money in lock-boxes under the bed and used it to buy bearer bonds which paid interest gross into offshore bank accounts, no questions asked.]

By Paul Vincke

About EHFCN
https://ehfcn-powerhouse.org/welcome

EHFCN was formally established in 2005 as a not-for-profit international association by Belgian law.

The Network is membership based. The 16 members from 14 European countries represent public and private healthcare insurers, health financers and payers who all have the countering of fraud, waste and corruption in healthcare as their core business or as part of their mission.

The aim of EHFCN is to improve European healthcare systems by reducing losses to fraud, waste and corruption, and its objective is to help members to be more efficient and effective in their work of prevention, detection, investigation, sanctioning and redress of healthcare fraud, waste and corruption, with the ultimate goal of preventing money being lost and returning money to healthcare services for the benefit of every patient.

EHFCN provides its members with high quality information, tools, training, global links and access to professional consultancy. It also promotes the share of good practice, joint work, bilateral agreements and the development of common working standards.

The real cost of healthcare fraud

Jim Gee, Partner and Head of Forensic and Counter Fraud Services at PKF Littlejohn sheds light on the impact of fraud on the healthcare sector...

Fraud is a challenging problem no matter what sector it impacts on. Its economic effects are clear – worse public services, less financially stable and profitable companies, diminished levels of disposable income for all of us, charities deprived of resources needed for charitable purposes. In every sector of every country, fraud has a pernicious impact.

However, in the healthcare sector there is a direct, negative impact on human life. Whatever country we live in what we all have in common is that our people want and need to be healthy. There are healthy people who fear ill health, sick people who yearn to be well, older people who want to enjoy their later years and young people who need the foundations of lifelong good health.

At present we have a fraudulent or corrupt minority who are prepared to divert the funds which are intended to keep us all well. That minority exists in all countries – and even in the UK's National Health Service (NHS). Every penny lost to fraud and corruption drains the lifeblood from our healthcare systems and undermines their capacity to provide essential treatment.

PKF Littlejohn and the Centre for Counter Fraud Studies at University of Portsmouth have published the latest global (and UK) research concerning the extent to which this happens – 'The Financial Cost of Healthcare Fraud Report 2015'.

The Report doesn't just look at detected fraud or the individual cases which have come to light and been prosecuted. Because there is no crime which has a 100% detection rate, adding together detected fraud significantly under-estimates the problem. The Report also doesn't

Jim Gee, Partner and Head of Forensic and Counter Fraud Services

rely on survey-based information where those involved are asked for their opinions about the level of fraud.

Instead it considers 107 statistically valid and highly accurate loss measurement exercises looking at the total cost of fraud (and error). The data considered covers 17 years and 14 different types of healthcare expenditure in different countries, with a total value of £2.9 trillion.

Across this massive global dataset it shows average losses of 6.2% with 88% of the loss measurement exercises showing losses of greater than 3% and an increase of almost 11% in this cost since 2007.

In the UK's NHS, the report looks at losses in 6 areas of expenditure and 3 of patient charge income, using the NHS's own data where it has measured losses or global data where it has not. Total losses for the NHS (for fraud alone) are estimated to be between £3.73 and £5.74bn depending on the assumptions made – either way an enormous sum which is not being devoted to patient care.

In the context of the NHS having to make efficiency savings over coming years and the annual pressures for additional expenditure as new treatments become available, this is a cost which the NHS needs to do more to manage and minimise. The report cites the period between 1998 and 2006 when the NHS did just this – reducing the cost of fraud by up to 60% and delivering £811m of financial benefits to fund better patient care.

"At present we have a fraudulent or corrupt minority who are prepared to divert the funds which are intended to keep us all well."

So what is to be done? It is the view of the authors of the Report that there are 3 first steps for the NHS to take to reduce the cost of fraud:

1) The NHS needs to re-adopt an approach which is focussed on reducing the cost of fraud not just investigating and prosecuting individual examples (although this is important too);

2) It therefore needs to re-commence loss measurement exercises across key expenditure streams. It is only with accurate knowledge about the nature and extent of fraud that proportionate, effective action can be taken to reduce its extent; and

3) It needs to re-create a powerful, well-resourced organisation to lead this work with a remit and authority across all parts of the NHS.

This is an urgent task for those who manage the NHS. It is hoped that the report provides an evidence base for renewed action to protect it as it needs to be protected.

Jim Gee
Partner and Head of Forensic and Counter Fraud Services
PKF Littlejohn
Tel: +44 (0)20 7516 2288
jgee@pkf-littlejohn.com
www.pkf-littlejohn.com

Paul Vincke

Managing Director

European Healthcare Fraud and Corruption Network

www.ehfcn-powerhouse.org/welcome