Pandemic shifts healthcare fraud

Over the past 18-months, during the pandemic, new patterns of fraud and abuse have emerged in healthcare, with research revealing differing trends in the misdemeanours identified on the provider side.

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During the pre-Covid-19 period, from January 2018 to March 2020, general practitioners, pharmacies and psychologists topped the list, only to be overtaken during Covid-19 (April 2020 to June 2021) by the discipline of speech therapy and audiology, with dieticians not far behind.

This is according to statics from the Healthcare Forensic Management Unit (FMHU) of the Board of Healthcare Funders (BHF), that has been playing a major role in unifying approaches to combating fraud in the medical schemes environment.

The HFMU discovered that audiologists' rise in the reported fraud case charts, starting pre-Covid-19, was partly due to provider claims for expensive hearing aids which were charged at up to five times more than the cost of actual devices that patients were being given or where claims were wholly fictitious.

It also revealed that false claims - submitting a claim without rendering a service - still heads the list of fraudulent activities, averaging 72% of the total cases investigated since 2019.

"Although likely to be less than the 2019 estimate of R22bn, due to a reduction in consultations and utilisation in general

during Covid-19, fraud, waste and abuse (FWA) is still a huge problem," says Dr Hleli Nhlapo, chairperson of the HFMU.

A shift to organised fraud

In the detail of the false claims, there has been a big shift towards more organised fraud, such as identity theft, where fraudsters use the identities of other providers to submit claims.

"This is not only on isolated identities, but those of doctors either dead or overseas or across provinces, being used to submit significant volumes of false claims. Some cases have also included theft of members' identities," says Nhlapo.

From one or two isolated cases a year, the HFMU has reported that there have been a lot more during the last year. "It is not individual providers anymore, for example just one pharmacy committing fraud, but now it is syndicates - it's organised crime," notes Nhlapo.

"We have seen a group of organised individuals in some instances stealing 13 different doctors' details, and then submitting claims as though they originated from these specific practitioners," he says.

The HFMU has highlighted that information sharing between various medical schemes caught up in the hearing aid fraud scams ultimately curtailed the prevalence thereof.

"We need all medical schemes to utilise the HFMU as a resource to collaboratively tackle the challenges of fraud and abuse in healthcare, as it's the only way we can get ahead of these criminal activities," explains Nhlapo.

"Although FWA losses are incurred by the medical schemes directly, members ultimately bear the impact, through unavoidable increases in their scheme contributions," says Nhlapo.

He notes that, if this loss could be taken away, it could lead to as much as a 10% reduction in members' monthly contributions.

"Then, obviously, if there were no losses, there would also be a better opportunity for enhancements in the benefits available to beneficiaries," he says.