

Health Care Law: Fraud and Abuse of Payment

Posted on April 14, 2018

Introduction:

The healthcare service industry has become a marketplace now, where healthcare providers are businessmen seeking to make high profits instead of serving the public's interest. Healthcare has become significantly expensive in recent times. People depend on health insurance provided by the government or private firms, which has resulted in fraudulent and abusive payment behaviour. The costs caused by fraud and abuse take up to 10% of the \$100 billion spent annually on US healthcare; hence, it is a significant issue for the country that must be catered (Wan-shiou Yang n.d.). While most physicians and doctors perform according to the Federal healthcare program and serve the public's benefit and interest, many healthcare providers and physicians manipulate their powers and expertise and take advantage of the innocence of their patients.

Fraud and Abuse Laws

Medicare fraud includes giving and receiving bribes, soliciting, submitting false claims to achieve Federal healthcare payments, and making referrals for specific designated health services in full awareness and consciousness. Abuse in health care refers to billing for unnecessary medical services and charging overly for all services and supplies, misusing the healthcare codes for the personal benefits of the organization.

The government has made many efforts to address the problem through various laws. However, detecting such fraud and abuse requires intensive medical knowledge. Computer systems alone can't function without human expertise in the field. Therefore, the process is very time-consuming and costly.

Federal laws covering [healthcare fraud](#) and abuse include the False Claim Act (FCA) which protects the government from being wrongly charged for false claims by any person who seeks payments for his healthcare services. Violation of FCA will result in fines, imprisonment or both.

Furthermore, the Anti-Kickback Statute (AKS) declares willfully paying, soliciting or receiving any compensation for rewarding referrals of items refundable by the government. Heavy fines and imprisonment are charged with the violation of AKS. Other than FCA and AKS, the Stark Law (Physician Self-Referral Law) also prohibits physicians from referring certain appointed health services payable by Medicare to an entity or organization of the physician's personal interest.

Other laws and penalties include the Civil Monetary Penalties Law (CMPL) which authorizes fines three times the damages caused by false claims of abuse in healthcare services, and violation of the AKS, FCA and Stark law.

While the mentioned laws and approaches to reduce fraud and abuse in healthcare are successful to some extent, the issue needs to be dealt with with a more permanent approach targeting the roots of the problem.

Types of Fraud and Abuse

The concept of fraud is clear and straightforward. Medical care providers often commit fraud when they misuse the nature of their services to increase their remuneration or when they bill consumers for services never performed or required by the patients. The act of billing for unfurnished services is an intentional crime by healthcare professionals. It is very common among abusers of the healthcare system. Consumers often have little or no knowledge about the medical terms used for different procedures; hence, they are looted by hospitals and charged for unredeemed services.

One of the most common types of fraud in healthcare is the concept of “upcoding,” which includes using more complex, unnecessary and expensive medical procedures on patients that can be treated through cheaper and more suitable methods.

Similarly, the practice of “unbundling” describes the charging of services in an order that increases the overall cost of the procedure. For example, the hospital usually performs tests on a patient at different times and increased rates that can be performed simultaneously at much lower costs.

For their financial benefit and excessive charges, [healthcare providers offer and perform unnecessary services on patients](#) who do not need it. It is reported that in 2015, a doctor received 45 years of imprisonment for performing cancer treatment on patients who weren’t diagnosed with cancer (CNN n.d.). Such practices occur due to the misinformation and lack of knowledge about medical procedures of the patients and consumers of healthcare providers.

How healthcare providers abuse their code of conduct is limitless. This includes suggesting multiple visits when one or two are enough for the patient and prescribing tests and medicines that do not help the patient but add up to the doctor’s financial benefit.

On the other hand, consumer’s abuse of healthcare services follows a similar pattern. The occurrence of “doctor shopping” is caused by the proliferation of prescription pain medication in the United States. Patients visit multiple doctors to receive multiple [prescriptions and collect drugs](#) that are illegally distributed further. An overdose of opioids killed more than 33,000 people, half of whom were prescribed opioids. The blame is shared by both patients and careless physicians who prescribe such drugs without consideration.

Patients often purchase prescription analgesics since they are covered by healthcare insurance and inflate the medical costs abusively when they are aware of cheaper and just as effective options. Other healthcare consumers transfer assets or limit their working hours to maintain Medicaid benefits. These consumers are also a part of the abusive system (Mashaw, 1994).

There has also been an increase in medical identity theft. People misuse the medical profiles of other individuals to obtain medical goods and services or funds. About 21% of the US population has experienced the theft of their medical identity.

Such fraud and abuse of healthcare are increasing as the industry becomes more commercialized and expensive for an average person.

Medicare Payment System

Introducing the Medicare prospective payment system (PPS) for hospitals has significantly changed the healthcare industry, influencing how physicians and patients use services. However, some payment methods exploit consumers such as fee-for-service. In this model of payment services are unbundled and paid for separately. Under fee-for-service payment, the **primary care** physician (PCP) is reimbursed for each item of service provided, and the fee is charged individually for each service depending on its type. This incentivises the physician to provide more services not required by the patient and extra costs that can be avoided.

Hence, FFS is an attraction for fraudulent and abusive healthcare providers. It encourages fraud and exploitation of consumers. This method of increasing costs is also called unbundling as mentioned earlier. FFS increases supplier-induced demand for services, which the patient would have avoided if he had more knowledge about his condition and the medical field (Gosden 2006).

Other methods of allocating patient costs and payments include the Diagnosis-related group (DRG). DRG is a system that classifies hospital patients into different groups based on their medical state. Costs are allocated to these groups according to the resources they use, such as labour wages, location costs, power and maintenance.

Ambulatory Payment Classification (APC) is a government method of paying and facilitating outpatients.

Healthcare providers and consumers exploit these payment methods and facilities the government provides for their personal benefits and interests. This has resulted in a \$272 billion fraud across the healthcare system.

On 7th Feb 2018, a New York doctor was sentenced to thirteen years of imprisonment for committing fraud of millions of dollars with Medicare (New York Doctor Sentenced to 13 Years in Prison for Multi-Million Dollar Health Care Fraud n.d.). He is reported to have stolen over \$7.2 million through

fraudulent claims for medical procedures he had never performed. He pleaded guilty after an 11-day trial (Omayra Pereira-Estrada Arrested for Health Care Fraud and Aggravated Identity Theft n.d.).

One of the hundreds and thousands of healthcare [fraud cases](#) is Omayra Pereira-Estrada, who committed fraud 11 times and stole someone's medical identity. In December 2016, she was arrested for violating U.S. laws.

Similarly, Floyd Benko was sentenced to 15 months for incorrectly diagnosing 124 cancer patients and producing false tests for his financial gain (Former Hershey Medical Center Research Technologist Sentenced For Making False Statements About Cancer Tests n.d.).

Avoiding Fraud and Abuse

Most healthcare providers and doctors strive to work ethically, provide high-quality healthcare, and submit legitimate payment claims. Trust is the core of a doctor-patient relationship. Our government and society puts high trust in doctors and respect their profession. However, the presence of dishonest and greedy physicians who exploit healthcare laws for their financial interest. The problem can be addressed in various ways, and such frauds can be avoided with the right knowledge and skills to detect them when they happen in your surroundings.

Third-party payers are the major contributors to medical bills. These include private and commercial [healthcare insurance providers](#) and the government. Payers trust physicians and medical care providers to charge reasonably for good quality care that caters to the necessary requirements of the patient and does not waste resources on tests and medical procedures that do not benefit the patient.

Medical care professionals are advised to maintain patients' medical records with better accuracy and completion of every important data. Proper documentation helps address any challenges or claims regarding the medical procedures and their billing.

Physicians usually invest in healthcare business ventures with other parties for example laboratories, pharmacies, equipment vendors and physical therapy centers. Doctors recommend these investments to patients for personal gain and financial interest. This affects their judgment and can result in dishonest and manipulated steering of the patient towards the doctor's benefit. This poor decision-making includes suggesting extra tests irrelevant to the patient's illness or prescribing an expensive alternative.

Doctors should avoid ventures that can affect their ethics and morality as healthcare providers, or question their character and personality before making such investments.

Hospitals provide financial incentives to doctors to work in that area to fill a clinical gap in geographical areas with a [shortage of healthcare services and physicians](#). On the other hand, in areas with strong competition between hospitals, hospitals adopt similar strategies to attract physicians.

This affects the physicians' decisions and ethically challenges their judgments. The job of a healthcare provider should be strictly focused on serving the public instead of gaining financial gain, which corrupts the concept of medicine.

Physician relationships with pharmaceutical vendors affect the healthcare industry in various ways since they provide a financial incentive for physicians who also seek to make a profit one way or the other. Doctors are not allowed to sell free samples provided by vendors. These industries usually ask physicians to refer their products to patients and receive a satisfying share of the profit which corrupts the physician-patient relationship. Additionally, physicians are bound to maintain their state licensure, hospital privileges and board certification through Continuing Medical Education (CME).

To avoid fraudulent claims and abuse of healthcare services, physicians are required to follow some basic practices. These include conducting internal auditing and monitoring of billing, implementing compliance and practice standards, conducting appropriate training and education, improving communication with employees, keeping a check on the whole organizational structure that works under the doctor, and enforcing disciplinary standards according to guidelines. Doctors are bound to respond to any illegal activity around them and correct mistakes their juniors commit.

Most physician relationships with other parties such as patients, third-party payers, and vendors have a conflict of interest, which influences the medical care provided and hence creates crimes of fraudulent claims and abuse of healthcare services.

Conclusion

The problem of fraud and abuse in the medical care industry is due to the lack of knowledge and poor education. Patients who are unaware of their rights, their medical condition and what treatments they require fall into the illegal charges of physicians. On the other hand, financial difficulties lead to such crimes committed by healthcare providers and patients. It is crucial to target the base of these issues and try their best to spread awareness about the kinds of fraud existing in our surroundings.

Physicians are advised to update their ways of detecting such frauds and illegal [practices since the evolution of healthcare](#) services is at a peak, as is the increasing greediness and commercialization of these industries.

The healthcare industry is now a market for people with greedy financial incentives. They seek pleasure and profits in the pain of others. The profession of a doctor is a respected and honoured position in our society; however, the misuse of such status by some individuals has corrupted the whole industry. Today's commercialization and unlimited wants have led to major crimes that affect thousands.

References

CNN, Sonia Moghe

N.d. Michigan Cancer Doctor Gets 45 Years in Prison. CNN.

<https://www.cnn.com/2015/07/10/us/michigan-cancer-doctor-sentenced/index.html>, accessed February 12, 2018.

Former Hershey Medical Center Research Technologist Sentenced For Making False Statements About Cancer Tests

N.d.

<https://www.justice.gov/usao-mdpa/pr/former-hershey-medical-center-research-technologist-sentence-d-making-false-statements>, accessed February 12, 2018.

New York Doctor Sentenced to 13 Years in Prison for Multi-Million Dollar Health Care Fraud

N.d.

<https://www.justice.gov/usao-edny/pr/new-york-doctor-sentenced-13-years-prison-multi-million-dollar-health-care-fraud>, accessed February 12, 2018.

Omayra Pereira-Estrada Arrested for Health Care Fraud and Aggravated Identity Theft

N.d. Press Release. Federal Bureau of Investigation.

<https://www.fbi.gov/contact-us/field-offices/sanjuan/news/press-releases/omayra-pereira-estrada-arrested-for-health-care-fraud-and-aggravated-identity-theft>, accessed February 12, 2018.

Wan-shiou Yang

N.d. A Process-Mining Framework for the Detection of Healthcare Fraud and Abuse.

Mashaw, J. L., & Marmor, T. R. (1994). Conceptualizing, Estimating, and Reforming Fraud, Waste, and Abuse in Healthcare Spending. *Yale J. on Reg.*, 11, 455. Retrieved from:

http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=2165&context=fss_papers

Gosden, T., Forland, F., Kristiansen, I., Sutton, M., Leese, B., Giuffrida, A., ... & Pedersen, L. (2000). Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. *The Cochrane Library*. Retrieved from:

https://s3.amazonaws.com/academia.edu.documents/45819727/Capitation_salary_fee-for-service_and_mi20160520-7558-dzbj6s.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1518429597&Signature=j4DAWpj2TDYo7%2FQ9uowSWQ7rF54%3D&response-content-disposition=inline%3B%20filename%3DCapitation_salary_fee-for-service_and_mi.pdf