

Healthcare Fraud and the Law

Posted on December 22, 2024

Introduction

Fraud and abuse in healthcare refer to knowingly executing a well-organized scheme to illegally obtain money, property, or any other luxury that is owned by any medical benefit program, such as Medicare or Medicaid, in the healthcare sector. While it is impossible for the government and the stakeholders to stop an individual or a certain care facility that is intentionally committing fraud and abuse, the healthcare sector and the regulatory bodies have implemented several internal and external processes and systems to detect and reduce fraud. These processes and systems are implemented under the “Federal [Fraud and Abuse Laws](#)” that are aggressively and swiftly imposed by the government. These laws and regulations allow care providers as well as consumers to address fraudulent attempts, provide appropriate documentation, and take an ethical stand against abuse issues in the care facilities or environment.

Implications of the Federal Fraud and Abuse Laws

1. False Claims Act

“False Claims Act” (FCA) is one of the most important Federal fraud and abuse laws that prevents the individuals or organizations from selling shoddy services or goods to consumers. It also prohibits the submission of fraudulent or false claims and conspiracy to commit violations. For instance, it is unethical to assert payment claims to Medicaid or Medicare that an individual knows are false and fraudulent. Under the FCA, filing fraudulent claims may consequently lead to up to a penalty of three times the loss that the system or medical program bears. Moreover, the convicted individual has to pay the additional amount of \$11,000 per claim filed.

1. Stark Law

“Stark Law” is also known as “Physician Self-Referral Law” which prevents financial incentives from influencing critical decision-making in the medical field. This law is intended to prohibit referring patients to entities by the physicians in case they show an ownership interest or have a financial relationship with the entities for certain designated healthcare services. The law penalizes individuals who commit fraud and abuse in a systemic manner with up to 3 times the claims arising from prohibited arrangements and also the exclusion from federal health programs.

1. Anti-Kickback Statute

“Anti-Kickback Statute” or AKS is a penal legislation under the Federal Fraud and Abuse Laws that prohibits the willful demand or claim of the payment of remuneration payable by Federal healthcare programs. It also prohibits rewarding or inducing patient referrals. Remuneration can include anything of value other than money or property such as expensive meals, free rent, compensation for medical consultancies, or expensive hotel stays. Violation of AKS law results in up to 10 years of imprisonment and \$100,000 per violation (Klein & Campbell, 2006).

Example – An Actual Case of False Act Claims

Michael Rosin, a former dermatologist, in Sarasota, Florida performed numerous needless surgeries on elderly patients’ skin and defrauded the system of Medicare over a period of six years. He was convicted of thirty-five counts of making false statements related to healthcare matters under the False Claims Act (FCA). He approximately performed 3086 unnecessary surgeries on 865 Medicare beneficiaries from the Sarasota area to which he was sentenced to 22 years of imprisonment in federal prison under federal sentencing guidelines. Rosin must also pay \$3.7 million to the federal government, \$3.6 million to the trust fund of Medicare in restitution, and \$48,866 to patients (Rudman et al., 2009). Rosin could have been sentenced to 24 years in prison, for putting 865 patients under his surgical knife, but Judge William Castagna did not go easy on Rosin because he caused serious bodily injuries to the elderly victims and lied on the stand, so he was ordered to pay millions in fine.

Solution

In order to adequately address fraud and abuse issues, healthcare organizations and providers must invest in providing educational programs and training to educate and train individuals who are working in care facilities across the United States about how to detect, prevent, and reduce fraud and abuse problems. Finally, federal agencies and the government must actively offer their share in prosecuting organizations, care providers, retailers, and manufacturers if they try to execute fraudulent attempts at their workforce.

Summary

In conclusion, Federal fraud and abuse laws or regulations in the healthcare space exist to safeguard patients, medical benefit programs such as Medicaid and Medicare, and the healthcare system from criminal and unethical actions. Laws such as FCA, AKS, or Stark Law are enforced by government and regulatory agencies to prohibit the knowing or willful fraudulent attempts of physicians and healthcare providers in a systemic manner. Violating these [Federal laws](#) can lead to exclusion from the health care programs owned by Federal regulatory bodies, penalties, loss of medical license, or civil fine from the medical board at the state level.

References

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Rudman, W. J., Eberhardt, J. S., Pierce, W., & Hart-Hester, S. (2009). Healthcare Fraud and Abuse. *Perspectives in Health Information Management / AHIMA, American Health Information Management Association*, 6(Fall), 1g.