

Root Cause Analysis of Medicare Fraud Case

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Introduction

Medicare is a national health insurance program by the federal government, launched in 1965 (Medicare, 2000). The Center for Medicare & Medicaid Services is in-charge of its administration (Medicare, 2000). Intentional and accidental acts of fraud are commonplace in the healthcare industry in the U.S (Bauder & Khoshgoftaar, 2020). This brief research essay presents the root cause analysis of the Medicare Fraud Case using the 5-WHYs model and finds that workers who get regular compliance training may be better able to uphold the law, but it is still unclear whether or not employees were aware of the protections afforded by current legislation if they report wrongdoing.

Charges have been filed against 243 individuals due to a statewide investigation undertaken by the Medicare Fraud Strike Force. These individuals are suspected of submitting false Medicare invoices totaling \$712m in 2015 (Dyer, 2015). The losses have now grown into billions of dollars, and the problem has become more complex due to state and federal involvement, as seen by the arrests and convictions. The healthcare business loses billions of dollars annually due to fraud and abuse, despite the severe penalties for those responsible (Bauder & Khoshgoftaar, 2020). Alpha Diagnostics' former owner, Rafael Chikvashvili, was found guilty of healthcare fraud leading to patient fatalities and given a 10-year federal jail term (McCarthy, 2016). False claims submitted by Rafael Chikvashvili to the Medicare and Medicaid systems resulted in almost a \$6 million recovery. In addition, he abandoned people who desperately needed medical care. Vice President of Operations and licensed radiologist Timothy Emeigh also played a role in the scam by submitting false insurance claims based on fabricated cardiology, ultrasound, and radiology studies (McCarthy, 2016). Two patients died because of their carelessness.

The case against Alpha Diagnostics may be better understood, and Timothy Emeigh's involvement in the scheme can be better explained if we apply the five whys framework. Using the five WHYs, the essay analyzes the underlying cause of the fraud case and identifies why Rafael Chikvashvili committed Medicare, Medicaid, and insurance fraud. To begin, the issue at hand must be identified as healthcare fraud, which ultimately resulted in the deaths of two patients.

Why did two patients die?

Rafael Chikvashvili is not a qualified medical professional who can interpret x-rays, draw accurate diagnoses, or treat patients. He also failed to staff Alpha Diagnostic with anyone properly qualified to issue medical diagnoses. So, the workers who looked at the photographs missed two patients' congestive heart failure, ultimately leading to their deaths. One patient did not get the timely transfer

to an emergency room to receive life-saving care. The second patient was given the all-clear for an elective operation, which resulted in serious bleeding (a risk factor for patients with CHF) that could have been avoided if the x-ray had been correctly interpreted. Because Alpha Diagnostics was operating unethically and submitting false claims for many years before being caught, two innocent patients lost their lives.

Why did it take patients dying before starting an investigation?

Although death is inevitable in the healthcare sector, it is especially tragic when it results from fraudulent claims, as in this instance. Although Alpha Diagnostic had submitted fraudulent claims for years before being found, the radiologic results' fabrication ultimately resulted in two patients' deaths before the authorities initiated an inquiry. This highlights the need for increased regulation and scrutiny of claims made to government programs like Medicare and Medicaid. Multiple fatalities of an identical nature raised government suspicions and brought attention to the likelihood of malpractice; both were tied to Alpha Diagnostic further heightened those concerns. Thus, if the deaths had not occurred, more than likely, Alpha Diagnostic would still be committing false claims.

Why did healthcare fraud occur with Alpha Diagnostics?

Rafael's major motivation for fabricating x-ray, ultrasound, and cardiology examination results was financial gain. People like Rafael target Medicare and Medicaid because of the systems' complexity, making it more difficult for authorities to catch them stealing hundreds of millions of dollars. Although he did not have a valid medical license, he and his staff worked together to submit bogus reports and forged signatures for payment. Due to his position as Alpha Diagnostic's owner, he was able to order his staff to engage in unethical practices for the sake of his financial advantage.

Why did Timothy Emeigh and other employees comply with submitting false claims?

As Alpha Diagnostics' VP of Operations, Timothy Emeigh reported directly to Rafael Chikvashvili. He has more training and experience than Rafael Chikvashvili since he is a qualified radiology technologist. Even if he has his RT license, without the supervision of a radiologist doctor, he cannot read x-rays or make diagnoses (S., 2020). While on vacation in Jamaica, Timothy did as his employer Rafael ordered and viewed medical photographs to make up fake doctor interpretations. He is fully aware of his legal obligations as a licensed radiologic technician and could have refused compliance,

but instead, he decided to help his employer perpetrate fraud and should have an equal share of responsibility for the resulting harm. Timothy was most certainly benefiting monetarily from the plan with his employer in ways that went beyond his base wage. Sadly, he lacked the good judgment to put the welfare of the patients they were treating above that of his employment and financial benefit.

Why was it so easy for Alpha Diagnostics to submit false claims for many years?

Because the government had no reason to suspect fraud and abuse on the part of Alpha Diagnostics until after their patients had died, the company could submit bogus claims for a long time. Alpha Diagnostics' owner, Rafael Chikvashvili, falsified a doctor's signature or applied a fake seal to make the paper seem official (Department of Justice, 2016). This highlighted the inadequacy of controls to ensure that submitted papers are legitimate and to immediately raise red flags for fraud detection. Furthermore, according to the news statement, Alpha Diagnostics earned \$8.87 and \$218.36 for the two deceased patients' cases, respectively (Department of Justice, 2016). Because the payments per patient needed to be larger to worry the U.S. Department of Justice, such reimbursement levels may imply that Alpha Diagnostics went undiscovered for many years. The government was defrauded of over \$6 million by Alpha Diagnostic, a company whose employees submitted thousands of false claims over several years (Department of Justice, 2016).

Potential Measures to Prevent Future Fraud Cases

Alpha Diagnostics was able to conduct fraud for a long period without being discovered in part because the current system cannot differentiate between genuine and fictitious billing entries. Therefore, implementing a verification code or method before submitting invoices for radiology, ultrasound, and cardiology interpretations is a feasible solution that must be introduced to avoid future fraud incidents. It is similar to how prescriptions work, where doctors have to input a special code before sending them to the pharmacy (Office of Inspector General. (2021). For this kind of system to work, doctors would need to be credentialed to get a code to use when sending in their radiology, ultrasound, and cardiology reports for payment. A higher level of trust in the authenticity and legitimacy of reports may be achieved if they must first pass muster with a registered medical professional. Staff members may undergo appropriate training on compliance and reporting obligations to guarantee that fraud is avoided and reported. Stricter sanctions for fraudsters are another method of discouraging the practice. Rafael, the proprietor of Alpha Diagnostic, was given a 10-year sentence, which appears too little given that his deception caused the deaths of two people. The U.S. government must ultimately take the lead in implementing stronger protections in their billing system, regulation, and monitoring to further avoid future fraud instances that might lead to the deaths of innocent individuals.

Conclusion

To conclude, it may be inferred that the lack of control and monitoring of the Medicare/Medicaid billing system was at the heart of the healthcare fraud committed by Rafael Chikvashvili. Alpha Diagnostic's submission of fake reports with forged signatures suggests that the system cannot detect the most fraudulent submissions. As a result, the two fatalities in this instance may have been avoided by implementing a verification mechanism that guarantees a licensed physician is evaluating and interpreting the radiology, ultrasound, and cardiology tests. The staff at Alpha Diagnostics might have been more watchful and reported their manager's unlawful and immoral behavior. Regular training on compliance may keep workers abreast of rules and laws and their obligation to enforce them, but it still needs to be determined whether or not personnel were aware of the laws and regulations that are in place, which may include protecting them as whistleblowers.

References

- Bauder, R. A., & Khoshgoftaar, T. M. (2020). A study on rare fraud predictions with big Medicare claims fraud data. *Intelligent Data Analysis*, 24(1), 141-161. <https://doi.org/10.3233/ida-184415>
- Department of Justice. (2016). Maryland Health Care Provider Sentenced to 10 Years in Federal Prison for Health Care Fraud Resulting in Patient Deaths. www.justice.gov.
<https://www.justice.gov/usao-md/pr/maryland-health-care-provider-sentenced-10-years-federal-prison-health-care-fraud>
- Dyer, O. (2015). Hundreds are arrested for Medicare fraud totalling \$712m. *BMJ*, 350(jun23 12), h3425-h3425. <https://doi.org/10.1136/bmj.h3425>
- McCarthy, M. (2016). Three are charged in \$1bn US Medicare fraud case. *BMJ*, 354.
<https://doi.org/10.1136/bmj.i4139>
- Medicare. (2000). Medicare.gov: the official U.S. government site for Medicare | Medicare. Medicare.gov. <https://www.medicare.gov/>
- Office of Inspector General. (2021). Maryland Health Care Provider Sentenced to 10 Years in Federal Prison for Health Care Fraud Resulting in Patient Deaths. Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services.
<https://oig.hhs.gov/fraud/enforcement/maryland-health-care-provider-sentenced-to-10-years-in-federal-prison-for-health-care-fraud-resulting-in-patient-deaths/>
- S., M. (2020). Survey Paper on Fraud Detection in Medicare Using Machine Learning. *International Journal of Psychosocial Rehabilitation*, 24(5), 4170-4174.
<https://doi.org/10.37200/ijpr/v24i5/pr2020130>