Healthcare Fraud - A Practice Solution Approach

Dr. Fedora and South Valley Hospital

After completion of this discussion you should be able to:

1. Recognize healthcare fraud.
2. Identify specific types of fraud.
3. Interpret healthcare fraud facts and findings.
4. Recognize how to prevent fraud.

- This is the location - Southern California.
- Medical professionals work to help others, while a few also work to fraudulently help themselves.
- The story you are about to learn is fact based, the names and information have been changed to protect the innocent.
- Your assignment, if you choose to accept it, is to be able to learn how to catch and prevent healthcare fraud.

American Board of Forensic Accounting (www.abfa.us)
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Types of Healthcare Fraud Explored

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There are various types of healthcare fraud. Some are easy to perpetrate, while other schemes take a lot of work to implement.

Dr. Fedora as an individual practitioner, and possibly in cahoots with South Valley Hospital, he may have committed the following healthcare fraudulent acts:

Billing for unnecessary medical services and upcoding.

Prescription drug usage.

Lack of Doctor Supervision

Stark Violations

Let's refresh ourselves on these areas of healthcare fraud.

Billing for Unnecessary Medical Services

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A common type of fraudulent billing is charging for services that are not performed. This fraud is committed when health care providers bill insurance for services that are different from the services actually rendered, or they bill for services not provided, or they include falsified records to show delivery of items or services.

Some examples of billing for services or procedures not rendered include, but are not limited to:

- Bill for a chest x-ray when an x-ray was not taken
- Bill Medicaid for a mouth x-ray when an x-ray was not taken, or for a cleaning that was not performed (Dentistry)
- Bill for office visits when no appointment is made
- Bill for podiatry services when no services were provided
- A home health agency billing for more services than were actually provided (e.g., bath, when no bath was given)
- Providing fewer pills than prescribed, but billing for the entire number of medications prescribed
- Billing for substance abuse counseling sessions not provided (OAG, 2016).

Source: Office of the Attorney General. (2016). Examples of medicare provider fraud. State of Michigan
Retrieved from: www.michigan.gov/ag/0,4534,7-164-18156_18152-46063--,00.html

Billing for Unnecessary Medical Services (cont.)

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“Unnecessary medical billing can take many forms. In some cases, a physician will bill for a service never provided or upcode a service as a more expensive test or procedure in order to obtain further compensation.

In other cases, the healthcare provider will intentionally misdiagnose a patient, knowing this diagnosis will enable them to bill for costlier tests and procedures the patient never needed.

Another example of unnecessary medical billing occurs when a patient is provided a service or supply they never needed because the healthcare provider is hoping to receive additional funds.”

Source: http://whistleblowerlaw.com/unnecessary-medical-billing/

Prescription Drug Usage

Government Forensic Accountant

"Drug diversion" is best defined as the diversion of licit drugs for illicit purposes. It involves the diversion of drugs from legal and medically necessary uses toward uses that are illegal and typically not medically authorized or necessary. While drug diversion is not a new phenomenon, States are reporting a significant increase in the problem. In fact, according to the 2010 National Drug Threat Assessment report, "The threat posed by the diversion and abuse of controlled prescription drugs (CPDs), primarily pain relievers, is increasing, as evidenced by the sharp rise in the percentage (4.6 percent in 2007, 9.8 percent in 2009) of state and local law enforcement agencies reporting CPDs as the greatest drug threat in their area." Increased abuse of CPDs has led to elevated numbers of deaths related to prescription opioids, which increased 98 percent from 2002 to 2006.

Source: www.cms.gov/Medicare-Medicaid-Coordination/Fraud.../drugdiversion.pdf

Here are some examples of people who could be prosecuted for prescription fraud or doctor shopping in California:

1. A man who is addicted to Vicodin has his girlfriend see a doctor and pretend to be suffering from chronic back pain in order to get a prescription for Vicodin—which she then gives to him.
2. An elderly woman becomes addicted to codeine while recovering from surgery; she then sees several doctors at once and obtains prescriptions for more codeine from all of them.
3. A doctor develops a reputation among prescription drug addicts for writing prescriptions "no questions asked," for a flat fee per prescription.

Source: http://www.shouselaw.com/doctor-shopping.html

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Lack of Doctor Supervision

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Due to increases in healthcare costs and lack of Physician availability, medical facilities are using mid-level positions more to help treat patients. Nurses, Nurse Practitioners, Physician Assistants, and other staff members are taking on larger roles in the healthcare delivery system. Although this is a solution to rising healthcare costs and provides continuity of patient care, non-physicians need to be properly supervised. This patient care model fails when Physicians do not properly supervise mid-level staff. In some cases, Physicians take advantage of the system and do not perform their duties, but still get paid. (ABFA)

"So what do we know?"

1. We know that the OIG is clearly on a direct path to rectifying the alarming issue of unqualified personnel providing services to CMS/Medicaid members and reducing the number of errors they feel are associated with these services.
2. We know the OIG is putting CMS through its paces by having CMS scrutinize Incident-To claims and will be reviewing encounter data moving forward to ensure that services were not only billed correctly, but were provided by the appropriate personnel.
3. Rest assured, at the end of the day, the OIG is looking to recover overpayments and if you have been billing Incident-To services incorrectly, be prepared to answer and refund monies when they come knocking at your door."

Source: http://health-information.advanceweb.com/Article/OIG-to-Focus-on-Billing-for-Incident-To-Services.aspx

Stark Violations

Licensed Healthcare Auditor

The Stark Law and the Anti-Kickback Statute prohibit hospitals from paying physicians to get their referrals. A third law, the federal False Claims Act, allows whistleblowers and the government to sue hospitals for damages when claims are submitted to federal healthcare programs in violation of the Stark or Anti-Kickback Statute. Hospitals that violate the FCA can face treble damages plus fines.

Both the Stark Law and the Anti-Kickback Statute permit hospitals to pay salaries and sometimes bonuses to physicians who are legitimate employees of the hospital. However, those exceptions cover situations where the employed doctor is paid for performing patient care and other similar services. The doctors cannot be paid to refer patients to the hospital.

Two key questions that are useful guidelines when evaluating whether physician compensation agreements violate the law are:

1. Is the physician paid more if or because he or she sends business to the hospital?
2. Is the payment arrangement with the physician commercially reasonable or considered “fair market value” if you exclude the value of the referrals the hospital will receive from the physician?

Source: http://www.healthcarefinancenews.com/blog/lurking-risks-hospital-employed-physicians-stark-anti-kickback-and-false-claims-act-compliance

Profile - Dr. Fedora

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Dr. Fedora is a 64 year male physician who has been practicing as a surgeon and also a clinician for over 30 years.

He is well liked by his staff at his clinic and the staff at South Valley Hospital, though fellow physicians do not consider Dr. Fedora to be an esteemed medical doctor.

Dr. Fedora has been married twice and has six children. Four with his first marriage and two with his last. His younger children are in high school and two are in college and two have started their own families.

Dr. Fedora makes a lot of money but always seems to be living from paycheck to paycheck.

He likes to gamble and has a younger girlfriend. He likes to party and drives a very nice car.

Dr. Fedora has issues with creditors and owes the government a lot of money in back taxes.

Dr. Fedora likes going to sporting events, and is known to place bets.

Most people like Dr. Fedora including his patients, who really love him.

Profile - South Valley Hospital

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South Valley Hospital is a small medical surgical hospital with 75 beds, located in a semi-rural area.

Most of the hospital’s patients are Medi-cal or Medicare.

The hospital has six ICU beds and two larger surgery suites.

There is an Urgent Care Center located on the hospital’s property which is commonly owned.

The hospital averages 55 patients a day.

Dr. Fedora admits and cares for 45 of the 55 patients the hospital averages each day.

Dr. Fedora is Chief of Staff and serves on various hospital committees and boards.

Without Dr. Fedora, the hospital would not survive.

The owner of the hospital is a businessman and a friend of Dr. Fedora.

Stage 1

Potential Fraudulent Action Pattern - Billing for unnecessary service

Here are some examples of patient encounters and the recommended treatment plans from Dr. Fedora.

Patient 1 visits Dr. Fedora's clinic for a week long cough and received the following treatment:

- Full physical and blood panel
- Chest X-Ray
- Breathalyzer
- Ultrasound
- Is prescribed multiple medications
- Is referred to South Valley's Urgent Care Center and then admitted to South Valley Hospital for pneumonia with a three day length of stay.

Patient 2 visits Dr. Fedora's clinic for light chest pains:

- Full physical and blood panel
- Chest X-Ray
- Breathalyzer
- Ultrasound
- Cardiogram
- Is prescribed multiple medications
- Admitted to South Valley Hospital for possible heart condition. Has a pacemaker installed.

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Stage 2

Potential Fraudulent Action Pattern - Prescription Drug Usage

Dr. Fedora prescribed the following medications as presented below:

- Patient 1 visits Dr. Fedora clinic for back pain and receives vicodin.
- Patient 2 visits Dr. Fedora for a sore foot and receives vicodin.
- Patient 3 visits Dr. Fedora for a sore shoulder and receives vicodin.
- Patient 4 visits Dr. Fedora for extreme neck pain and is admitted to South Valley Hospital to receive a morphine injection. Patient 4 is discharged two days later and receives a prescription for vicodin.

Stage 3

Potential Fraudulent Action Pattern - Lack of Doctor Supervision

Dr. Fedora has on the average 65 inpatients at two to three different Hospitals, of which 75% of whom are at South Valley Hospital. Dr. Fedora utilizes the other Hospitals due to the fact that South Valley can not admit higher acute patients. Dr. Fedora also works two days a week at the South Valley Hospital's Urgent Care Center. He also maintains his clinic.

With 65 inpatient and around 30 clinical patients, Dr. Fedora makes his Hospital rounds late at night and even as late as 2:00 am.

For his lower acute patients at South Valley, he relies heavily on the nursing staff. At his clinic, he spends around 10 minutes with each of his patients.

Here are some comments made by South Valley nursing staff, patients, and others:

- Nurse 1 states, I hardly ever see Dr. Fedora at the Hospital except the first day when the patient is admitted.
- Nurse 2 states, Dr. Fedora likes me and I keep him abreast of the patient's progress and he provides me with orders over the phone.
- Nurse 3 states, Dr. Fedora comes in late at night, spends around 5 minutes looking at the chart and the patient and then goes to the next one.
- Patient 1 states, after my clinic visit and being admitted to South Valley, I never saw my Doctor again.
- Urgent Care Nurse states that Dr. Fedora spends time at the Urgent Care sleeping in the back office.

Stage 4

Potential Fraudulent Action Pattern - Stark Violations

Dr. Fedora provides South Valley Hospital with a lot of patient referrals.

The following are some ways Dr. Fedora receives remuneration from South Valley for his hard work:

- The Hospital pays Dr. Fedora a board director's fee of $5,000 per month.
- The Hospital also pays Dr. Fedora a fee for being Chief of Staff, at $10,000 per month and $5,000 per month for Surgery Director.
- Dr. Fedora is in charge of the Hospital’s Urgent Care and receives a fee of $5,000 per month.
- Dr. Fedora receives $200 per hour for seeing patients in the Urgent Care Center.
- The Hospital pays for the rent and other costs associated with Dr. Fedora’s clinic.
- Due to the amount of travel Dr. Fedora spends between his clinic, the Urgent Care Center, and the Hospital, the Hospital leases a BMW for him.
- The Hospital pays for Dr. Fedora’s insurance costs.
- The Doctor attends conferences and meetings locally and abroad at the Hospital’s expense. Some in Las Vegas, the coast, and other nice places.

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LEVEL 1

Credible Allegation of Fraud

Defined

Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

(1) Fraud hotline complaints.

(2) Claims data mining. – Discuss

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Source: https://www.law.cornell.edu/cfr/text/42/455.23

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LEVEL 1

Credible Allegation of Fraud Research 1

Billing for unnecessary services

Based on the examples provided, it appears that Dr. Fedora billed for services that were not necessary for the treatment of his patients.

There is a pattern in these examples where the same types of tests which may be allowed and paid for by insurance providers are performed with different kinds of illness and level of acuity of his patients.

In both examples, the patients were referred to a higher level of care, which resulted in more revenue for Dr. Fedora, the Urgent Care Center, and South Valley Hospital.

Billing for unnecessary services is a violation of Medicare guidelines and other insurance providers who have implemented CMS rules.

"When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying you earned the payment requested and complied with the billing requirements. If you knew or should have known the submitted claim was false, then the attempt to collect payment constitutes a violation."

Source: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf

Credible Allegations of Fraud Research 2

Prescription drug usage

Dr. Fedora is very popular with his patients. Most of the patient surveys received from his clinical patients and also the patients he sees at the Urgent Care Center along with the Hospital, rate his service as excellent.

On an average there are 10 patients a day that stop by his clinic and when he is on duty at the Urgent Care Center to see him for treatment. They do not mind waiting, sometimes for hours.

Most of these encounters result in the prescription of pain medication (Vicodin or Percocet) – Expand to patient committing fraud

Prescribing prescription drug medication without proper medical necessity is a violation of Medicare guidelines and other insurance providers' rules who have implemented CMS guidelines.

The most common violation in this section of the law is in the area of pain medication.

The National Drug Threat Assessment report further states that, "The most commonly diverted CPDs are opioid pain relievers, according to Drug Enforcement Administration (DEA) and the National Survey of Drug Use and Health (NSDUH) data. Opioid pain relievers are popular among drug abusers because of the euphoria they induce."

Source:
http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/drugdiversion.pdf

Credible Allegation of Fraud Research 3

Lack of Doctor Supervision

Over the years Dr. Fedora relies more and more on his support staff and team at the South Valley Hospital. With the reduction in physician reimbursement and the demand of providing proper patient care documentation, it is hard for Dr. Fedora to keep up and still have time to enjoy life.

Dr. Fedora sees a lot of patients every day at his clinic, in the Urgent Care Center, and at South Valley Hospital. A lot of patient care is now provided by non-physicians.

There are guidelines and rules that require Physicians to properly supervise staff.

“The bottom line—which all physicians who supervise midlevel practitioners would do well to keep in mind—is that the physician is ultimately responsible for ensuring that high quality medical care is provided to each patient. Physicians also should understand that they may be held accountable if they fail to provide adequate oversight or if PAs or NPs under their supervision make errors or exhibit poor clinical judgment.”

Source:
http://www.ncmedboard.org/images/uploads/publications_uploads/no308.pdf

Credible Allegation of Fraud Research 4

Stark Violations

Physician patient referrals are a main source of revenue for a hospital. When physicians receive reimbursement from hospitals for sending/steering patients to their facility, this may result in a violation of law, which is commonly referred to as a "Stark Violation".

We have seen that Dr. Fedora receives a lot of compensation from South Valley Hospital. It appears to be excessive.

The Anti-Kickback Statute (AKS)
"The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward referrals of items or services reimbursable by a Federal health care program. Where a provider offers, pays, solicits, or receives unlawful remuneration, the provider violates the AKS. NOTE: Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies."

Source:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf

Investigation 1

Billing for unnecessary services

Objective:
To determine if Dr. Fedora has billed for unnecessary medical services.

Source:
Patient charts and medical records.
Patient history with Dr. Fedora.
Inquiry of clinical staff.
Statistical data for like-kind patient encounters.
Prior issues with Dr. Fedora.

Scope:
Review a scientific sample of patient charts and medical records to determine if the physician's diagnosis is properly supported. Expand sample based on exceptions and standard deviation.
Determine if physician has had multiple encounters with patients and for what type of illness.
Perform inquiry of medical staff about patient encounters. Document feedback.
Analyze statistical data for the occurrence rate of patient illness, the frequency of recurring, and resources used for treatment. Review Dr. Fedora's treatment plans.
Research to see if Dr. Fedora has prior issues and complaints on record.

Conclusion:
Based on the information presented and reviewed, it appears that Dr. Fedora has over-utilized clinical and hospital resources and billed for unnecessary medical services for the treatment of the sampled patient base.

Investigation 2

Prescription Drug usage

Objective:
To determine if Dr. Fedora over-prescribes opioids to certain patients.

Source:
Patient charts and medical records.
Patient history with Dr. Fedora.
Inquiry of clinical staff.
Statistical data for number of prescriptions issued for opioids.
History of doctor shopping with Dr. Fedora. Check national registry.

Scope:
Select a scientific sample of patients from Dr. Fedora's prescription records and determine if the medication meets prescribed patterns. Expand sample based on exceptions and standard deviation.
Check refill rates from sample patients. Verify dosage and usage within norms.
Verify patients are receiving proper follow-up examinations.
Determine acuity level for sample patients.

Conclusion:
Based on the information examined, Dr. Fedora prescribes opioids to 78% of his patients on a recurring basis. Some of the patients have medical necessity to receive pain medication, but 54% do not have proper documentation in their medical records to substantiate the medication received.

Investigation 3

Lack of Doctor Supervision

Objective:
To determine if Dr. Fedora properly supervises the medical staff and mid-level positions that help care for the patients under his responsibility.
Source:
Patient charts and medical records.
Payroll records and timesheets.
Medical observation notes. Nursing Notes.
Inquiry of clinical staff.
Patient complaints.
Surveillance information of physician at all locations. (Clinic, UCC, Hospital)
Patient discharge documents.
Scope:
Review a haphazard sample of patient charts and medical records, cross check against payroll records to determine if mid-level staff was onsite as documented.
Determine the amount of involvement of mid-level staff and physician.
Discover when physician was onsite.
Develop a time study based on physician patient census and documented practice patterns.
Conclusion:
Based on the information analyzed, Dr. Fedora's direct patient care measured in time averaged 7 minutes. This excludes surgeries. Based on the patient's diagnosis (RV), the average time spent with patients should be 25 minutes. There were three documented instances where Dr. Fedora spent over four hours in his office at the UCC reviewing charts. There was one documented case where Dr. Fedora was found sleeping in an empty patient room.

Investigation 4

Stark Violations

Objective:
To determine if there were any Stark Violations between Dr. Fedora and South Valley Hospital.

Source:
Hospital admission records.
Accounting records for the Hospital, UCC, and Dr. Fedora and his clinic.
Time spent by Dr. Fedora on hospital boards and committees.
Payroll records for the Urgent Care Center.
Inquiry of hospital and UCC employees.
Stark guidelines and exceptions.

Scope:
Determine the average number of patients admitted by Dr. Fedora per day.
Verify how much compensation Dr. Fedora received from South Valley Hospital and the UCC.
Review compensation and apply a reasonable test.
Determine what other forms of compensation Dr. Fedora has received from South Valley and the UCC.
Check for conflict of interest and related party transactions between Dr. Fedora's clinic and the Hospital and UCC.

Conclusion:
Based on an analysis of hospital and UCC records, Dr. Fedora spends an average of 12 hours a month serving as Chief of Staff and Surgery Director and receives $15,000 per month. He also receives $5,000 per month to serve on the board of directors which meet once a month for 3 hours. In addition, he receives $5,000 per month to manage the UCC, while he is also paid to see patients. All of these compensation arrangements appear to be excessive. Dr. Fedora patients represent most of the hospital's census. The hospital pays for Dr. Fedora's insurance, some clinic expenses, travel, and leases a car for him.

FRFC - (Finding, Recommendation, File, Control) 1

Billing for unnecessary services

Finding:
Based on the information examined in the sample, Dr. Fedora has billed for medical services that were not necessary for the care of his patients.

Recommendation:
An accusation be filed with the Medical Board of California stating Dr. Fedora has billed MediCal and Medicare for medical services that were not necessary for the care of his patients.

File the following charges:
Committing healthcare fraud
Submitting False Claims

Control Implementation:
Dr. Fedora be required to have a second physician review his patient's records on a weekly basis and the reviewing physician forward to the Medical Board of California and the Department of Healthcare Services any noncompliance with standard medical practice methods.

Follow up on a quarterly basis with a sample selection of Dr. Fedora's practice records and note any exceptions. If an exception is found, recommend suspension of Dr. Fedora's medical license and his ability to participate in the MediCal and Medicare systems. Determine why reviewing physician did not report findings.

FRFC 2

Prescription drug usage

Finding:
Based on the information and documentation examined in the sample, Dr. Fedora has prescribed medication to patients that was not necessary for their care and treatment .

Recommendation:
Amended accusation filed with the Medical Board of California state that Dr. Fedora has billed MediCal and Medicare for medical services that were not necessary for the care of his patients, to add that prescription medication was provided to his patients without medical necessity.

File the following additional charges:
Four counts of intentional failure to maintain adequate records, a gross misdemeanor.

Control Implementation:
Require that a second physician review and initial Dr. Fedora's scripts for Schedule 1, 2, and 3 drugs prescribed for the next two years.

FRFC 3

Lack of Doctor Supervision

Finding:
Based on the information and documentation examined in the sample, observations made, and other evidence, Dr. Fedora does not properly supervise his medical staff and spend enough time caring for his patients.

Recommendation:
Add a second amendment to the accusation filed with the Medical Board of California stating Dr. Fedora has billed MediCal and Medicare for medical services that were not necessary for the care of his patients, and prescription medication was provided to his patients without medical necessity, to add lack of doctor supervision.

File the following additional charges:
One count of Medicaid provider fraud, a first-degree felony, and one count of scheme to defraud, a first-degree felony.

Control Implementation:
Limit Dr. Fedora's medical services to his clinic only until the completion of the investigations.

FRFC 4

Stark Violations

Finding:
Based on hospital and UCC information analyzed, calculations and testing conducted, and other evidence, Dr. Fedora has received compensation for referring patients to the facilities and excess remunerations for services to the hospital and UCC which has resulted in multiple Stark Violations.

Recommendation:
Add a third amendment to the accusation filed with the Medical Board of California stating Dr. Fedora has billed MediCal and Medicare for medical services that were not necessary for the care of his patients, prescription medication was provided to his patients without medical necessity, lack of doctor supervision, to add Stark Violations have been committed.

File the following additional charges:
Fifteen counts of conspiracy to solicit and receive remuneration in return for the referral of Medicare patients, and twelve counts of soliciting and receiving remuneration in return for the referral of Medicare patients. Each count is punishable by up to five years in prison. Fifteen counts of conspiracy to defraud the United States, and seven counts of illegally soliciting or receiving benefits in return for referrals of patients covered under a federal or state healthcare program.

Control Implementation:
Suspend Dr. Fedora’s practice of medicine and seek for an arrest warrant from the AG. Possible immediate jeopardy situation and flight risk.

Debriefing

American Board of Forensic Accounting

When auditing healthcare organizations, with one fraud finding, there are probably many more. As we have seen with Dr. Fedora, he orchestrated multiple healthcare fraud schemes to maintain his lifestyle and standard of living. Most individuals and organizations don't just commit one type of fraud.

Past healthcare prosecution history shows most fraudulent actors are sentenced to multiple counts of the same type of healthcare fraud, such as billing for services not rendered, or prescription drug fraud, but we know "where there is smoke, there is probably fire."

The **American Board of Forensic Accounting** recommends *when healthcare fraud is discovered, the scope of the examination be immediately expanded to include all other types of fraudulent activity and broad based forensic accounting principles be utilized to help recover additional losses and stop fraudsters.*

Healthcare fraudsters are some of the smartest and most educated and trusted by the public. The amount of losses and damage they commit is huge. **Join the ABFA to help fight healthcare fraud (www.abfa.us)**. The ABFA now offers a Licensed Healthcare Auditor credentialing program.