Busting Bad Medicine: a Call to Action Addressing Healthcare, Fraud, Waste, and Abuse

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Incidents involving healthcare fraud, waste, and abuse take place all around the United States, emerging periodically on the front page of numerous newspapers and magazine covers. Such was the case in July 2017 when the US Department of Health and Human Services (HHS) announced its largest ever healthcare fraud sting, charging 412 individuals in 41 federal districts across the country with committing $1.3 billion in false billings to Medicare and Medicaid. According to the announcement by HHS' Office of Inspector General (OIG), the agency also issued exclusion notices to 57 doctors, 162 nurses, and 36 pharmacists.[1]

"This year's takedown features a large-scale federal and state partnership to combat health care fraud and the opioid epidemic," stated a fact sheet OIG issued about the raid. "Enforcement activities took place nationwide, from Washington to Puerto Rico. This multi-agency enforcement operation is the largest in history, both in terms of the number of defendants charged and loss amount."

Healthcare fraud, waste, and abuse are national problems that affect everyone in the United States either directly or indirectly. The United States loses $60 billion due to healthcare fraud, waste, and abuse on an annual basis.[2] Losses this large can pose real problems for patients, the healthcare community, and the economy as a whole—most easily seen through increased costs for insurance coverage.

Stopping healthcare fraud, waste, and abuse is everyone's responsibility. This article identifies healthcare fraud, waste, and abuse practices that have been the focus of the US Department of Justice (DOJ) during completed fiscal years 2015 and 2016 and partially completed fiscal year 2017. While not an exhaustive list, the practices identified in this article occur more frequently than they should, costing taxpayers, insurers, healthcare providers, and patients themselves tremendous sums of money. In fiscal years 2015 and 2016, the DOJ recovered $2.4 billion[3] and $4.7 billion[4] as a result of healthcare fraud judgments, settlements, and administrative impositions. As this article shows, fraud, waste, and abuse are prevalent throughout the US—and the DOJ, healthcare organizations, and patients should not turn a blind eye toward this criminal behavior.

Healthcare Fraud, Waste, and Abuse Defined

With all the attention given to healthcare fraud, waste, and abuse, it is important to understand what these terms actually mean. Fraud refers to the intentional deception of another person to that person's detriment.[5] Said in plain English, it is intentionally deceiving another person, resulting in an authorized benefit to the person who is the deceiver or to someone else. An example of healthcare fraud is seen when healthcare personnel file dishonest care claims in order to turn a profit. In this example, the healthcare personnel acted intentionally, knowing that their actions were improper at best and illegal at worst.

By contrast, waste and abuse do not require showing that an individual intended to deceive anyone. Waste and abuse are closely related concepts, sometimes referred to as two sides of the same coin. Waste refers to the squandering of resources or the use of resources without gain or advantage or incurring unnecessary costs as a result of deficient management, practices, or controls.[6] Waste occurs when services are overused, resulting in unnecessary costs to healthcare programs. Abuse refers to a pattern of practices or customs that are unsound or inconsistent with ethical business, fiscal, or healthcare practices or customs.[7] Healthcare abuse is present when physicians or healthcare personnel take actions that are inappropriate outside acceptable standards of professional conduct or medically unnecessary that result in greater reimbursement for the healthcare facility. For example, a physician may follow an outdated protocol for the treatment of a given disease or disorder that involves more tests than what an updated treatment protocol would require. These additional tests would be considered medically unnecessary under the updated treatment protocol; nonetheless, the physician would seek reimbursement for those tests.

As this example indicates, the physician's actions don't necessarily involve an intention to deceive; rather, the ordering of unnecessary tests is taken as though it is appropriate, even when accepted professional standards would indicate those actions are not appropriate.[8] Healthcare fraud, waste, and abuse manifest in many forms, some of which are listed in Table 1 below.

Table 1: Common Examples of Healthcare Fraud, Waste, and Abuse

Healthcare fraud, waste, and abuse manifest in many forms, including the following common examples:

- Knowingly submitting false statements to obtain federal healthcare payments to which the specific healthcare provider is not entitled
- Knowingly soliciting, paying, or accepting remuneration to induce or reward referrals for services reimbursed by federal healthcare programs
- Making prohibited referrals for certain designated health services
- Billing for services that were not medically necessary
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes

Examples of Healthcare Fraud

Billing for services that were not provided is a crime under the False Claims Act and one of the leading problems under healthcare fraud. The False Claims Act,[9] also known as the "Lincoln Law," places liability on individuals and companies who defraud government programs. When a medical provider submits a form to a specific government healthcare plan or an insurance company for services or care that were never provided, they are committing healthcare fraud. This can occur when they bill for services that were not provided or submit a duplicate claim for the same service. This type of fraudulent claim would not have a patient health record that corresponds with the supporting documentation sent to the government healthcare plan or insurance company.

Another type of false billing occurs when medical personnel submit a claim for a different type of drug that is at a higher price than what the patient received. For example, if Drug A costs $12 and Drug B costs $25, medical personnel give the patient Drug A but charge for Drug B. This can be accomplished by coding Drug A as Drug B, and sending the bill for Drug B to the patient's specified insurance company or government healthcare program.

Three occurrences that took place in the US in 2015 help illustrate the issues. As reported by the DOJ, a false billing issue occurred at the Medical College of Wisconsin. Usually, Medicare pays for teaching physician services if the procedure is furnished by a resident when a teaching physician is present during the service. Medicare pays for teaching physician services when a resident is present because less problems arise under that arrangement and the service is also a learning experience for the resident. The DOJ alleged the Medical College of Wisconsin billed Medicare for several services from 2006 to 2013 for procedures that were performed by residents with a teaching physician present, even though evidence showed a physician was never actually present as claimed.[10] The Medical College of Wisconsin settled the case, paying $840,000 to resolve the accusations against them.

Another example of a false billing issue took place with the co-chair of the Safe Practice Committee of the National Quality Forum, Dr. Charles Denham. Safe Practice reviews, endorses, and recommends standardized healthcare performance measures and practices. The DOJ claimed Denham solicited and accepted kickbacks by receiving monthly payments from CareFusion Corporation while serving as the co-chair of the Safe Practices Committee. The DOJ also claimed Denham solicited and received payments in exchange for influencing recommendations of the National Quality Forum and for recommending, promoting, or buying CareFusion's product, the ChlorPrep. Denham did not tell other committee members he was receiving payments from CareFusion.[11] Denham agreed to pay $1 million to settle the allegations.

A final example: A jury found three individuals associated with the firm Medicall, including its medical director and primary biller, guilty of both conspiracy to commit healthcare fraud and multiple counts of healthcare fraud.[12] The jury found that Medicall billed Medicare for services never provided, including to patients who were dead, for services by medical

professionals no longer employed by Medicall, and for services by professionals who—based on billing records—worked more than 24 hours in a day. All three individuals received prison sentences for their role in the conspiracy.

Examples of Healthcare Waste and Abuse

Healthcare waste and abuse can be seen in multiple referral cases, the most common form being referrals made by physicians to a specific healthcare organization or facility. In federal healthcare programs, paying for referrals is a crime. The Anti-Kickback Statute, commonly referred to as the Stark Law, is a criminal law that prohibits the knowing or willful payment or remuneration to induce or reward patient referrals.[13] Remuneration is anything of value that can take any form besides cash. For example, remuneration can be free rent, expensive hotel stays and meals, and excessive compensation for medical consultations. Kickbacks in the healthcare industry can lead to corruption of medical decision-making, patient steering, and unfair competition with others who are not taking part in kickbacks for referrals. Physicians are the main targets for kickback schemes, because they are the source of the referral. Physicians are the ones who decide what drugs patients use, what specialists patients see, and what healthcare services and suppliers they receive or use.

One prime example of the DOJ's effort to combat healthcare abuse involved HMA's Walton Regional Medical Center, a hospital in Georgia.[14] The obstetric clinic paid kickbacks for patient referrals from outside its market to funnel into its facility; the goal was to increase Medicaid profit the hospital could claim. HMA's Walton Regional Medical Center paid kickbacks to Hispanic Medical Management doing business as Clinica de La Mama (Clinica). Clinica sent pregnant women to HMA's Walton Regional Medical Center for deliveries paid by Medicaid. HMA's Walton Regional Medical Center violated the Anti-Kickback Statute that prohibits payments intended to influence a physician's ordering or prescribing decisions. The statute's purpose is to ensure that physicians' medical judgment is not impaired by improper payments and gifts from other healthcare providers. Kickbacks undermine the integrity of medical decisions. The DOJ said HMA's Walton Regional Medical Center asked Clinica for referrals and gave Clinica kickbacks in return for their patients.[15] HMA settled the lawsuit for $595,155.

Another example of healthcare abuse took place at the Health Diagnostic Laboratory (HDL).[16] HDL paid compensation to physicians in exchange for patient referrals. HDL billed federal healthcare programs for medically unnecessary testing. A similar lawsuit took place against Berkeley Health Lab and Singulex.[17] HDL, Berkeley, and Singulex referred patients for medically unnecessary tests, and then billed the federal healthcare programs. These facilities induced physicians to refer patients to them for blood tests. The processing fee for each blood test ranged from $10 to $17 per person. The facilities also waived all patient co-pays/deductibles. HDL, Berkeley, and Singulex violated the Stark Law. Under the Stark Law, the government will not pay for certain health services prescribed by physicians who have improper financial relationships with entities to whom they refer patients. HDL, Berkeley, and Singulex referred patients to receive medically unnecessary blood tests, and charged the government for the tests.

In another case from early 2017, the DOJ settled with Walgreens Pharmacies on claims of violating the Anti-Kickback Statute.[18] Walgreens admitted responsibility for inducing patients who received government benefits to enroll in its Pharmacy Savings Club (PSC) program by offering discounts and other monetary incentives if those patients would use the Walgreens PSC program exclusively for all their prescription drug needs. It also provided bonuses to its employees for each individual the employee enrolled in the PSC program. Both of these actions constituted illegal kickbacks and Walgreens agreed to pay $50 million as part of the settlement.

Table 2: Case Examples of Fraud and Abuse

Name of Case/Fine	Where It Took Place	Fraud or Abuse Allegations	What Happened?
Daiichi Sankyo Inc. Agrees to Pay $39 Million to Settle Kickback Allegations Under the False Claims Act[19]	New Jersey	Fraud: Daichii cheated Medicare and Medicaid out of millions of dollars and threatened programs that elderly and disabled Americans rely upon	Daiichi paid physicians improper kickbacks in the form of speaker's fees. Daiichi paid for dinners that exceeded $140 a person for those who spoke at Daiichi-sponsored dinners.

Medtronic Inc. Paid $4.41 Million to Resolve False Claims Act Allegations Related to "SubQ Stimulation" Procedures[20]	Minnesota	Fraud: Medicare and Medicaid financial fraud	Medtronic knowingly caused dozens of physicians located throughout more than 20 states to submit claims to Medicare and Tricare for investigational medical procedures known as SubQ Stimulation that were not reimbursable.
Texas-Based Citizens Medical Center Paid US Government $21.75 Million to Settle Alleged False Claims Act Violations[21]	Texas	Fraud and Abuse: Violations of False Claims Act and Anti-Kickback Statute	Engaged in improper financial relationships with referring physicians. Referral sources can alter the physician's judgment about patient's healthcare need. Paid compensation to physicians that exceeded fair market value.
South Shore Physicians Hospital Organization Pays $1.8 Million for Alleged Kickbacks for Patient Referrals[22]	Massachusetts	Abuse: Unlawful kickbacks for patient referrals	Allegations of operating recruitment grant programs through which it paid kickbacks to its physician members in exchange for patient referrals. It caused participating providers who received referrals from grant recipients to submit false claims for payments to the Medicare program.
Chiropractor Pleads Guilty to Health Care Fraud for False Claims Act Violations[23]	Louisville, Kentucky	Fraud: Violations of False Claims Act	Submitted claims for services never performed.
Physical Therapist Pleads Guilty in a $4 Million Scheme Alleged False Claims Act Violations[24]	Detroit, Michigan	Abuse: Unlawful kickbacks for patient referrals Fraud: Violations of False Claims Act	Created fake patient files to indicate need for home health care and paid physicians and recruiters to refer Medicare patients for unnecessary or unprovided services.
Hospitalists Agree to Pay $60 Million to Settle Claims Alleging False Claims Violations[25]	Illinois	Fraud: False Claims Act	Hospitalists with lower billing levels were pressured to catch up to their peers by upcoding for higher services than were actually performed.

Healthcare fraud, waste, and abuse do not end with the five examples listed above. It is an ongoing problem and it does not appear that it will cease any time soon. Listed in Table 2, above, are additional fraud and abuse examples and cases that have taken place all around the United States.

Help Defeat Fraud and Abuse

The Department of Justice helps combat the overall scheme of healthcare fraud, waste, and abuse and fights Medicare financial fraud through cooperation from healthcare organizations. One DOJ team that helps combat healthcare fraud is the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The team has focused efforts to reduce and prevent Medicare and Medicaid financial fraud through enhanced cooperation and training. The DOJ and HEAT cannot defeat healthcare fraud and abuse by themselves. They need the integrity and honesty of consumers/patients and healthcare organizations as well.

Healthcare fraud, waste, and abuse can be controlled in a healthcare facility. Consumers can help control healthcare fraud, waste, and abuse by protecting their insurance card and personal information at all times. They can also review every visit to a healthcare facility, the date of their service, name of their provider, and the type of service that was conducted for them.

Consumers can also count their pills each time they pick up a prescription, research their providers with state medical boards, and report suspected fraud, waste, or abuse.

A healthcare facility can help control fraud by fostering an environment where individuals are dedicated to the integrity of the services offered at the organization. A facility should gain, strengthen, and stress the need for trust and honesty with their employees and start and sustain a companywide anti-fraud training effort. For example, most healthcare organizations operate companywide HIPAA training programs; just as importantly, there could also be companywide anti-fraud training programs. Such programs can help prevent honest mistakes and stop potential fraud before it happens.

Individual healthcare employees can also take action to prevent fraud, waste, and abuse by completing their work in the most diligent and ethical manner. One way to minimize false billings is to check the patient's health record for documentation concerning the date of treatment, the type of treatment, and if there was a nurse/physician signature. If a medical staff member has seen the patient on the day that their procedure was performed, there should be written or electronic documentation of that certain procedure. Fraud examiners and investigators will not just stop at documentation alone. They will ask for trustworthy witnesses who can tell them what they know about the fraud.

Individuals can also report incidences of fraud, waste, and abuse to the appropriate authorities. Healthcare employees can initiate action within their own institutions as well when they suspect criminal activity, reporting their concerns to those tasked with ensuring quality healthcare, ranging from their supervisor to the institution's compliance officer to the executive staff or, if warranted, an organizations' board of directors. Individuals may also consider reporting incidences of fraud, waste, or abuse to the appropriate governmental authorities. For example, both the Centers for Medicare and Medicaid Services and OIG operate hotlines and websites where suspected incidences may be reported. Such reports can be made on an anonymous basis if desired; however, the lack of contact information may prevent comprehensive review of an individual complaint.

Controlling healthcare fraud, waste, and abuse will help create trust within the medical field and with all healthcare consumers. Healthcare fraud, waste, and abuse can be stopped if the right measures are taken. If fraud is suspected, take action and contact the right person either in a healthcare facility or the appropriate governmental authority. Combating and putting a stop to healthcare fraud, waste, and abuse can start with citizens themselves, but it is also up to healthcare organizations to train their employees and make sure that their employees know what the proper procedures are to combat crime. Combating and preventing healthcare fraud, waste, and abuse is the first step in saving patients, healthcare organizations, and the economy as a whole from the loss of tremendous sums of money.

Notes

[1] Department of Health and Human Services Office of Inspector General. "Media Materials: 2017 National Health Care Fraud Takedown." July 2017.

[2] Senior Medicare Patrol. "Dollars Lost to Fraud." 2015.

[3] US Department of Justice. "Fact Sheet: The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud." Press Release. February 26, 2016.

[4] US Department of Justice. "Justice Department Recovers over $4.7 Billion From False Claims Act Cases in Fiscal Year 2016: Third Highest Recovery in FCA History." Press Release. December 14, 2016.

[5] McWay, Dana C. *Today's Health Information Management: An Integrated Approach, Second Edition*. Clifton Park, NY: Cengage Learning, 2014.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] US House of Representatives. "False Claims: 31 U.S.C § 3729-3733." August 16, 2017.

[10] US Attorney's Office, Eastern District of Wisconsin. "Medical College of Wisconsin, Inc. Pays $840,000 to Settle Alleged False Claims for Neurosurgeries." January 9, 2015.

[11] US Department of Justice. "United States Settles False Claims Act Allegations Against Patient Safety Consultant and His Companies." Press Release. March 2, 2015.

[12] US Department of Justice. "Medical Biller Sentenced to 45 Months in Prison for Role in $4 Million Health Care Fraud Scheme. " Press Release. September 18, 2015.

[13] US House of Representatives. "42 U.S.C § 1320a-7d: Guidance regarding application of health care fraud and abuse sanctions." August 16, 2017.

[14] US Department of Justice Office of Public Affairs. "United States settles kickback allegations with Georgia Hospital." June 4, 2015.

[15] Ibid.

[16] US Department of Justice. "Two Cardiovascular Disease Testing Laboratories to Pay $48.5 Million to Settle Claims of Paying Kickbacks and Conducting Unnecessary Testing." Press Release. April 9, 2015.

[17] Ibid.

[18] US Attorney's Office, Southern District of New York. "Manhattan U.S. Attorney Announces $50 Million Settlement With Walgreens For Paying Kickbacks To Induce Beneficiaries Of Government Healthcare Programs To Fill Their Prescriptions At Walgreens' Pharmacies." Press Release. January 19, 2017.

[19] US Department of Justice. "Daiichi Sankyo Inc. Agrees to Pay $39 Million to Settle Kickback Allegations Under the False Claims Act." Press Release. January 9, 2015.

[20] US Department of Justice. "Medtronic to Pay $4.41 Million to Resolve Allegations that it Unlawfully Sold Medical Devices Manufactured Overseas." Press Release. April 2, 2015.

[21] US Department of Justice. "Texas-Based Citizens Medical Center Agrees to Pay United States $21.75 Million to Settle Alleged False Claims Act Violations." Press Release. April 21, 2015.

[22] US Department of Justice. "South Shore Physicians Hospital Organization to Pay $1.775 Million for Alleged Kickbacks for Patient Referrals." Press Release. January 20, 2015.

[23] US Attorney's Office, Western District of Kentucky. "Louisville Chiropractor Guilty of Health Care Fraud." Press Release. February 23, 2016.

[24] US Department of Justice. "Home Health Care Agency Owner Pleads Guilty in $4 Million Detriot-Area Medicare Fraud Scheme." Press Release. April 11, 2016.

[25] Tycko & Zavareei Whistleblower Practice Group. "IPC Healthcare Agrees to Settle Qui Tam Lawsuit Alleging Company Engaged in Fraudulent Medicaid and Medicare Billing Scheme; Agrees to Pay $60 Million." National *Law Review*. February 9, 2017.

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