Health care fraud

Any discussion on physician fraud is unpopular, especially among physicians. Try talking about it in a hospital dining room or a scientific meeting and you will soon lose your audience. That is because doctors and hospitals work on an honour system. Even though the Hippocratic oath is not taken by all graduating doctors, it remains etched in most minds as the standard to uphold in the practice of medicine. Who would dare question the amorality of robbing the poor, the sick and the compromised, especially since the cost of health care remains prohibitive and unaffordable for the pockets, even of the rich?

However, it seems that some health care workers including doctors do not feel guilty about cheating the government as well as the faceless insurance companies. Getting caught is unlikely and being made to repay the ill-gotten gains is, more often than not, impossible. The Federal Bureau of Investigation (FBI) developed a health fraud investigation group in the early 1970s, but in the 1980s its activities were overshadowed by other white-collar crimes dealing with drugs and fraud in the savings and loan industries. At the start of the 1990s, because of the enormous impact that health care costs have had on the whole economy, and because of the pressure for health care reform, the spectre of...
health care fraud has risen again. In a major 'sting' called 'Operation Goldpill', 150 FBI agents arrested more than 100 people and seized more than $6 million in drugs and cash. Most of those arrested were pharmacists who allegedly sold drugs to Medicaid patients, bought them back at a fraction of their real price and resold them to other patients. One FBI official estimates that fraud ranges from 3% to 10% of the total health care budget—between $24 and $80 billion from a total of an $800 billion expenditure. The role of physicians in dealing with fraud is not clearly defined. They were often uncertain about how to report it; the American Medical Association (AMA) has a network of medical county and state societies that could be used to identify cases and bring them to the attention of authorities. One estimate of physician involvement puts it to be 1% of the criminally fraudulent activity. Considering that there are about 600,000 practising doctors in the USA this is a fairly large number. However, most believe that doctors are less likely than other health care providers to be directly involved in such schemes. Encouraging physicians to report illegal activity is vital to the FBI's success. Though officials will not divulge the specific type of cases being pursued they admit to using every technique, including undercover operations, consensual monitoring and electronic surveillance.

Reports of large-scale fraudulent activity are increasing. In 1991, a $1 billion rip-off was carried out by thieves operating on mobile clinics. These clinics offered patients free tests and examinations, then used insurance information to generate a huge number of fake bills. In New York City, a doctor billed Medicaid for $50,000 worth of laboratory tests for a single patient. Under the guise of circumventing bureaucracy, innumerable small crimes are committed in laboratories, doctors' offices and hospitals. Some doctors and dentists give their patients inflated bills in exchange for higher than normal fees. Patients get a kickback in the form of bigger insurance refunds. In a survey by one large insurance company, 4 out of 10 consumers said their doctors had cheated insurance companies. Conflict of interest situations contribute to much waste. A study released in August 1991, reported that Florida doctors owned 93% of the radiation therapy centres, 60% of the clinical laboratories and 38% of the physical therapy and rehabilitation centres. The number of magnetic resonance imaging scanners and laboratory tests ordered in Miami are twice those ordered in Baltimore—where very few doctors own such facilities.

In an ever-changing spectrum of health care delivery and facilities, federal officials are looking closely at the sale of physician practices to hospitals. The question of 'fair market value' has been addressed by a comprehensive government definition of what is permissible for practice sales. Seeking more efficient health care delivery, hospitals and foundations usually purchase physicians' practices with large upfront payments that can total hundreds of thousands of dollars. These physicians then become employees of the organization, or contract to provide services to patients. Any amount paid in excess of the fair market value of the hard assets of a physician practice is deemed questionable. However, intangible assets such as the reputation of the physician, and 'goodwill' can vitally affect the practice, and arguably the price. Clearly, financial incentives can affect a doctor's medical judgment and according to one official communication, 'many of these arrangements are merely sophisticated disguises to share the profits of business at a hospital with referring physicians, in order to induce the physician to steer referrals to the hospital.' It has been suggested that the Inland Revenue Service study physicians referral patterns after purchase agreements to determine whether sellers become increasingly 'loyal' to the hospital.

The latest legislative attention to doctors' charging practices is now here in the form of a bill entitled the National Health Care Anti-Fraud and Abuse Act of 1993. The intent is to establish a national programme to control health fraud and abuse. The bill was drafted in part as a response to the US Government's General Accounting Office health fraud investigation. The estimate was that abuse made up roughly 10% of the country's annual health tab of more than $800 billion. Doctors now file claims under as many as 600 provider numbers. The maze of paper work associated with the process leads to frequent unintentional billing errors. There is general agreement that large-scale fraud is able to flourish under this type of system, making it virtually impossible to track a single abuser's activities. When defrauders get caught by one insurer, they continue billing others. A recent landmark case was cited during hearings on the bill. A major private insurance company spent $1 million in suing an abuser, 'won' an $18 million verdict, but was able to collect nothing. The bill has the potential of rooting out fraudulent practitioners but it must be fair to those who might make billing errors, according to an AMA official.

The legislator proposing the bill says 'we aren't going to do it unless the docs go along with it. It can't happen without them'. Given the complexity of the entire process, the specifics of the bill, which range from application to all payers—public and private, data-sharing between law enforcement agencies and the payers, mandates to publish adverse actions against offenders and set both criminal and civil monetary penalties, all point to the need for careful design and stringent enforcement.

This is clearly one of the many issues coming to the fore in health care reform as the country awaits the Clinton administration's somewhat tardy proposals to clean the current mess.

REFERENCES


YVAN J. DAS DORES SILVA