ANESTHESIOLOGY NEWS

Policy & Management

SEPTEMBER 16, 2013

Physicians Recommend Forensic Health Services Research

Applying health care research to the problem of health care fraud

By Ashley Taylor

When federal officials announced in May an eight-state mass arrest of nearly 100 doctors and nurses charged with Medicare fraud, the accusations were relatively straightforward: bogus prescriptions, kickbacks for motorized wheelchairs, billed but undelivered care and other misdeeds that, officials claimed, bilked the government insurance program out of some $223 million.

But beyond these black-and-white cases is a gray area of services that, although not blatantly egregious, do not meet professional standards or are not medically necessary.

Considered health care abuse by the Centers for Medicare & Medicaid Services (CMS), which administers these federal health care programs, it is also a legal gray area. Cases of health care abuse are not necessarily taken to court, as are more obvious cases of deliberate fraud.

These cases represent an untapped area of regulation and potential savings. Medicare expenditures rose by 6.2% in 2011 according to federal data; its yearly expenditure growth has been as high as 18.8% since 2000. Abuse of national health care programs represents at least some share of that spending. Although the increases in overall health care expenditures, which have risen 3.9% each year from 2009 to 2011, have slowed since 2002, there is no doubt that cutting these costs is desirable.

To this end, internists Laurence McMahon Jr., MD, MPH, and Vineet Chopra, MD, MSc, both from the University of Michigan Health System, in Ann Arbor, have proposed using existing methods for studying trends in patient care data—health services research—to detect health care fraud and abuse. They introduced this concept, which they call forensic health services research, in a commentary in the *American Journal of Managed Care* (2013;19:e71-3).

“If we’re going to be serious about addressing the cost of health care and the value of the care we provide,” Dr. McMahon said, “we need to be fairly forthcoming in the fact that we do provide services that have little value to patients.” Many of these services, he said, represent fraud and abuse, yet are not recognized as such.

The current system for catching and prosecuting health care fraud is what many see as an inefficient collaboration among the CMS and the Office of Inspector General (OIG), both within the U.S. Department of Health and Human Services, and the Department of Justice (DOJ), including the FBI. Working together, these agencies audit health care providers, review claims and prosecute fraudulent parties using an approach known as “pay and chase”—trying to recover money paid out for fraudulent claims rather than denying the claims in the first place—which a 2012 report by the U.S. Government Accountability Office (GAO), cited by the authors, called ineffective. Less than $20 million of the $102 million spent on audits from 2008 to 2012 was recovered, according to a June report by the GAO.

During fiscal year 2012, the DOJ convicted 826 defendants of health care fraud, and the OIG excluded 3,331 providers or entities from federally funded health care programs, 912 of them for crimes related to Medicare or Medicaid.

Little to no data were available about levels of fraud within the field of anesthesiology, but it is probably no exception, Dr. McMahon said. “Every specialty has procedures currently done that haven’t been shown to be beneficial to patients,” he said.

The OIG handles settlements, fines and exclusions but would not comment on charges and convictions, citing lack of prosecutorial authority. The DOJ did not return repeated requests for comment.

Health services research has been around for 30 years, Dr. McMahon said, and investigators already are using its methods to detect cases in which Medicare and Medicaid pay for unwarranted procedures.

“This data is out there, it’s known by everyone,” Dr. McMahon said. “It’s not something we just found, it’s published leading journals. But the question is how do you look at it in the context of fraud and abuse.” The commentary gave several examples of health services research papers documenting unnecessary or unsupported procedures, from too-frequent colonoscopies to placement of defibrillators in cases where they were not proven to have a benefit. Currently, these kinds of cases are not prosecuted as fraud and abuse, Dr. McMahon said.

Hays Gorey Jr., JD, of the law firm GeyerGorey, LLP, which specializes in white-collar crime, confirmed that assessment.

“There may be conduct that is short of fraud that may fall into a category called abuse. If it involves false claims, of course, then that would be one thing, but if it falls short of being actual knowing fraud, then I don’t know of any way, either that that would be prosecutable under the law.” Mr. Gorey added that there might be other ways, such as new regulations, to deal with abuse.

The False Claims Act, a Lincoln-era statute, allows not only the government but also individuals acting on the government’s behalf to sue for restitution of payments for knowingly fraudulent claims to the government. These can include bills for worthless services, a category that may include procedures with no medical value.

“The claim, or one of the claims, could be that the services were medically not necessary, or that the services were worthless. That’s pretty close to saying the same thing,” Mr. Gorey said.

But cases of medically unnecessary procedures would not necessarily be prosecutable under the False Claims Act. For example, one could not successfully sue a doctor, based on the act, for performing colonoscopies too frequently without more information, Mr. Gorey said.

“If that’s all you do, the answer is pretty clearly no. It may be a lead to conduct further inquiry.” In order to make a case, he said, one would have to determine that the bills “amounted to knowingly false or fraudulent claims.” In other words, a doctor with best intentions in mind is not committing fraud under current laws.

James Goodwin, MD, professor of geriatric medicine at the University of Texas Medical Branch at Galveston, and lead author of the colonoscopy study cited in the commentary, said prosecuting doctors for performing unnecessary procedures is not the answer. “I assume the physicians who are performing screening colonoscopy too frequently have managed to convince themselves that they are doing the right thing. If Medicare refused reimbursement for those procedures, the problem would disappear overnight,” he said.

Overall, however, Dr. Goodwin said forensic health services research is “a good idea. The distinction between ‘fraud’ and ‘abuse’ can be debated endlessly, but there is no doubt that using administrative data to identify clinics and providers with ‘abuse-like’ profiles for further scrutiny could have a major impact on overuse of tests, procedures and treatments.”