

## FRAUD CASE STUDY – MEDICALLY UNNECESSARY PROCEDURES

### Case

A doctor was accused of performing medically unnecessary procedures on numerous patients suspected of heart-related issues, even when the risks involved included stroke, heart attack, or death. Accusations that the doctor was participating in fraudulent activity came after several patients went to other doctors for a second opinion regarding their diagnosis, and received different views about their health problem and how to treat it.

Prosecutors for the case allege the doctor conspired to defraud Medicare and the DoD healthcare program by submitting false claims for costs associated with the unnecessary procedures. The costs were for time, labor, supplies, and facility overhead. The doctor clearly had no regard for medical guidelines which state all services provided to a Medicaid beneficiary by a practitioner must be medically necessary in order to be covered.

The investigation found the doctor specifically:

- Ordered medically unnecessary tests for patients who did not exhibit any of the requisite symptoms to necessitate the exam.
- Purposely interpreted the normal results of both medically necessary and medically unnecessary stress tests as abnormal so as to justify ordering additional medically unnecessary procedures.
- Falsified patient records and charts.

Also, the investigators found that members of the hospital staff received information and complaints about improper practices conducted by the doctor, however, the warnings were ignored and the unnecessary procedures continued. Payments the doctor received for the unnecessary procedures soared to roughly \$875,000 before they were stopped. The doctor was convicted of health care fraud and sentenced to 10 years in federal prison.

### Fraud Risks Ignored

Information provided by internal parties can be used to identify fraud risks. This may include allegations of fraud or suspected fraud reported by personnel that interact with the entity. In this case, hospital management failed to consider the fraud risks involved despite receiving multiple complaints and warnings that the doctor was performing medically unnecessary procedures. Complaints and warnings should be taken seriously and can aide in uncovering the pressure faced by the perpetrator to commit fraud, the circumstances that exist for the fraud to occur, and attitude/rationalization that allow the perpetrator to knowingly and intentionally commit a dishonest act.

## **Control Activities – Medical Practices Must Be in Compliance with Laws and Regulations**

Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. These objectives and related risks can be broadly classified into one or more of the following three categories:

- ❖ Operations - Effectiveness and efficiency of operations
- ❖ Reporting - Reliability of reporting for internal and external use
- ❖ Compliance - Compliance with applicable laws and regulations

This case can definitely be classified under compliance with applicable laws and regulations. In the medical arena, pursuant to the Federal False Claims Act, a cause of action arises when any person knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.

### *Responding to False Medical Claims for Unnecessary Procedures*

Management and entities must conduct activities in accordance with applicable laws and regulations. As part of specifying compliance objectives, the entity should determine which laws and regulations apply to the entity.

To ensure that false claims are not submitted and unnecessary procedures are not performed, there are several internal control procedures that can be designed and implemented:

- ❖ Randomly select and review medical charts for patients who undergo tests and other procedures ordered by a doctor. It might be determined that none or only a few of the patients meet the medical necessity guidelines for reimbursement.
- ❖ Notification alerts for doctors with a pattern of billing for services and care with no supporting documentation or limited explanations as to why procedures were performed – This should be considered a red flag and is unlikely to be coincidental.
- ❖ Daily Claims Audits – Determine whether medical records and claims contradict information on a patient's questionnaire (which is filled out by the patient). For example, on the questionnaire, the patient checked "NO" to questions as to whether or not they ever had symptoms associated with the doctor's diagnosis. This can help conclude the doctor falsified medical records which resulted in the patient receiving a medically unnecessary procedure and the doctor receiving reimbursement monies for the procedure.

### **What to Monitor**

- ❖ Whether patients meet the medical necessity guidelines for reimbursement.
- ❖ A pattern of billing for services and care with no supporting documentation.

## **Fraud Indicators**

- ❖ Complaints and warnings regarding fraudulent activity from internal personnel.
- ❖ Lack of documentation and limited explanations to support reasons for procedures performed.
- ❖ Falsified patient records and charts.