



by JAMES M. SHWAYDER, MD, JD

Health care fraud exposed

The penalties of deception can be much worse than medical negligence.

The Federal Bureau of Investigation (FBI) initiated an investigation of a solo ob-gyn physician in 2018. Ultimately, the United States Department of Justice (DOJ) filed an indictment against the physician for submitting tens of thousands of fraudulent claims to various health care benefit programs, including Medicaid, Medicare, and TRICARE, for unnecessary, uninformed, and/or fraudulent gynecologic procedures. Between 2010 and 2019, private and government payors experienced \$21 million in losses for unnecessary surgeries and procedures. The FBI concluded that the physician knowingly and willfully executed a scheme to defraud Medicaid and Medicare. Further, he made materially false statements in connection with submissions to Medicaid and Medicare. As such, he was charged with 26 counts of health care fraud in violation of title 18 US Code, sections 1347 and 1349 (18 USC §1347 and §1349) and 32 counts of making false statements relating to health care matters in violation of 18 USC §1035. He was alleged to have executed a scheme for enrichment through

submission of claims for services that were: “(a) not medically necessary and contrary to the medical standard of care; (b) based upon fraudulent and falsified purported patient statements, diagnoses, and diagnostic procedures; (c) not, in fact, performed; and (d) based upon altered and fraudulent sterilization consent forms.”¹ The investigation found numerous fraudulent claims for ob-gyn care. In obstetrics, he altered due dates to be earlier than they actually were. For example, he would conduct elective induction of labor at “39 weeks of gestation” when he was already in the hospital performing gynecologic surgery. By altering the due date, he would comply with the standard of care and subvert hospital policies against the elective induction of labor in late preterm patients. Further, insurers would not reimburse for elective inductions prior to 39 weeks. For example, 1 patient, based on her last menstrual period and ultrasound, had an estimated date of delivery (EDD) of March 12. Without medical indication, he changed her EDD to March 7 and performed an elective induction of labor on March 1. Over

a 2-year period the physician billed more than \$102,000 to Medicaid and TRICARE for patients who were actually less than 39 weeks of gestation at the time of elective induction of labor. Gynecologic findings were more dramatic. He performed as many as 30 surgeries in 1 day. From 2014 to 2018, the physician performed surgical procedures on 40% of the practice’s Medicaid beneficiaries—about 510 patients—with 42% having 2 or more surgeries. He often performed bundled procedures, such as dilation and curettage (D&C), laparoscopy, and lysis of adhesions. Claims of unnecessary surgeries were rampant. Patients were frequently told they had cancer and required a hysterectomy. Such patients would undergo a total vaginal hysterectomy and colporrhaphy, with the diagnosis submitted to insurance stating that the patient had complaints of pelvic and back pain and felt something in her vagina, with symptoms of uterine prolapse. When questioned, patients denied any symptoms related to uterine prolapse, and no such symptoms were documented in the office chart. Patients with fibroids were told they

Shwayder is an adjunct professor at the University of Florida at the Gainesville Medical Center. He is a graduate of the University of Colorado School of Medicine and the University of Denver College of Law. As a nationally and internationally recognized expert in gynecology ultrasound and minimally invasive surgery, he actively consults on legal matters in medicine, including liability in ultrasound and gynecologic surgery, as well as issues surrounding privileging and insurance fraud.

were at an increased risk of cancer and were submitted to a total abdominal hysterectomy and bilateral salpingo-oophorectomy. Pathology did not reveal any precancerous cells, at times failing to demonstrate any fibroids. The diagnosis submitted to insurance would include frequent, prolonged, and extremely heavy vaginal bleeding with pelvic pain. Interviewed patients denied such symptoms. Further, the medical record and laboratory studies failed to support such diagnoses.

In several cases, an ultrasound revealed a simple cyst. No repeat ultrasound was recommended, but the patient would be told that there was an increased risk of cancer. To justify surgery, the ultrasound report would be changed to reflect the presence of a complex ovarian cyst, with surgical pathology being benign.

Numerous patients underwent unnecessary testing and procedures. One patient who presented with an abnormal Papanicolaou test underwent 2 colposcopies, a cold knife cone, a hysteroscopy, a D&C, multiple ultrasounds, and a laparoscopic bilateral salpingo-oophorectomy. The patient was told the procedures showed abnormal cells that could lead to cancer. She ultimately had a total vaginal hysterectomy with anterior and posterior colporrhaphy, with a diagnosis of symptomatic uterine prolapse. Pathology was negative for any premalignant findings. The patient was asymptomatic.

In violation of Federal Code 42 CFR §50.205, this physician would perform sterilization procedures without waiting the 30-day period required by Medicaid after the patient initially consents to the procedure. Instead,

the physician would insert a false date to satisfy the 30-day waiting period.

He routinely billed health care benefit programs for hysteroscopies and colposcopies that were not actually performed. The investigation found that the physician performed more than 12 times the number of

hysteroscopies and colposcopies.

To obtain surgical preauthorization from Medicaid, it was found, the physician used boilerplate language to describe a patient's symptoms. The physician routinely noted, "enlarged uterus, bleeding for 8+ days, frequent menstruation every 3 weeks, cyclic

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office hysteroscopies than the next leading provider in the insurance panel. Further, it was discovered that the physician's only hysteroscope was often inoperable and had been sent for repair, even while billing for such procedures. It also was discovered that the physician performed office hysteroscopy without using any type of distension. It was estimated that over a 9-year period, he had billed health care benefit programs about \$620,856 for false and fraudulent diagnostic hysteroscopies.² The physician performed colposcopies without using any solution to augment the presence of cellular abnormalities. In fact, the physician rarely performed biopsies at the time of the colposcopies, documenting that the patients refused a biopsy. The physician billed health care benefit programs \$137,806 over the 9-year period. During this time, the physician billed the benefit programs \$2,338,106 for gynecologic procedures and surgeries based on, at least in part, never-performed

pelvic pain, perineal pain, painful periods, no relief from NSAIDs [nonsteroidal anti-inflammatory drugs], unable to take hormones due to high blood pressure, unable to examine uterus—see weight, tender adnexa, and history of anemia."³

After a 4 ½-week trial, he was found guilty on 51 counts and sentenced to 59 years in prison. In addition, he was forced to forfeit to the United States any property, real or personal, derived from gross proceeds traceable to the violations. This included \$1,461,445 obtained as a result of the fraud scheme, the physician's personal residence, both medical offices, and the physician's interest in a surgical center.⁴

Discussion

This case, although an extreme example, demonstrates the reach of federal statutes enacted to prevent and punish those who commit health care fraud. Sanctions include civil penalties (fines that can now be up

to \$15,000 for each item or service), imprisonment, and forfeiture of offices and assets obtained or improved as a result of the fraud.

Summarizing several concepts can reinforce best practices.

1 Providers should submit claims only for medically necessary services they render and maintain patient records to verify that the services were provided. By submitting a claim, a provider certifies under penalty of perjury that the services were medically indicated and performed by the provider.

a. Elective induction of labor prior to 39 weeks of gestation results in higher neonatal morbidity compared with babies delivered at 39 weeks of gestation.⁵ Falsifying an EDD to subvert rules against elective induction of labor constitutes fraud, which, in addition to criminal charges, may result in nonpayment for the global obstetrical care for the provider and, occasionally, the facility.

b. Fraudulently reporting symptoms or investigational findings to obtain surgical preauthorization and subsequent reimbursement is a violation of various statutes. Such violations may result in steep fines and criminal penalties. In addition, facilities and providers found to participate in a scheme to defraud health care benefit programs can be excluded from Medicaid and Medicare for 3 to 5 years. Defrauding government programs (eg, Medicaid, Medicare, and TRICARE) triggers a coordinated response from various federal agencies, including the DOJ, the Office of the Inspector General (OIG), and the FBI. Further, Medicare has established 5 Recovery Audit Contractors

to detect and correct (recoup) improper payments so that actions can be implemented to prevent future improper payments.

c. It is recommended to establish a compliance program to prevent, detect, and correct any erroneous billing.⁶ Efforts to establish a compliance program may mitigate the penalties that would otherwise be levied. The 7 components recommended by the OIG include the following:

- i.** Conduct internal monitoring through period audits.
- ii.** Implement compliance and practice standards with written standards and procedures.
- iii.** Designate a compliance officer to monitor compliance efforts and enforce practice standards.
- iv.** Conduct appropriate training and education on practice standards and procedures.
- v.** Respond appropriately to detected violations through investigation and disclosure of the incidents to the appropriate governmental entities.
- vi.** Develop open lines of communication, such as discussions at staff meetings and bulletin boards regarding compliance activities.
- vii.** Enforce disciplinary standards through well-publicized guidelines.

2 Medicaid requires a valid consent form for all sterilization procedures.⁷ At least 30 days must pass between the date of the patient's signature on the consent form and the date of the sterilization procedure for reimbursement. This requirement was instituted to provide protection for vulnerable populations from coerced sterilization.⁸ Altering the dates to meet the 30-day waiting period constitutes fraud. The waiting

period is reduced to 72 hours if the patient delivers prematurely. However, the definition of what constitutes a premature delivery varies dramatically. A 2018 study found that 8% of physicians used more than 38 weeks of gestation as the definition of preterm labor (3.2% used 38 weeks, 1.6% used 39 weeks, and 3.2% used 40 weeks).⁹

a. Performing a postpartum sterilization that does not comply with the requirements for informed consent (42 CFR, part 441, subpart F) will result in denial of payment of both the physician and the hospital costs related to the sterilization. Although presumably not allowed by federal policy, findings from a recent study showed that 12% of respondents reported that a rejected sterilization consent form resulted in loss of the entire obstetrical global payment for both the provider and the facility.¹⁰

3 Some physicians opine that the alternative is to not file an insurance claim for the sterilization procedure. There are potential consequences of this practice.

a. Not charging patients for their sterilization may violate the Anti-Kickback Statute (42 USC §1320a-7b), which prohibits the exchange of anything of value in an effort to induce the referral of patients or generation of business reimbursable by federal health care programs.

The provision of quality care requires that it is performed, appropriately documented, and properly billed. Attempts to subvert any of these tenets can result in devastating consequences to patients, providers, and our health care facilities. ■

FOR REFERENCES VISIT
contemporaryobgyn.net/fraud