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Not the Last Word

Defending Waste, Fraud, and Abuse

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Medicine may be a noble profession, but its members do not always act nobly. In Maryland, a cardiologist was convicted for "documenting" coronary artery disease that did not exist, inserting stents into vessels that did not need them, and submitting fraudulent medical bills for that effort [15]. In New York, an orthopaedic surgeon was sentenced to 8 years in prison for using his medical practice as a disability mill [16].

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There is a shortage of these ignoble doctors, however, from at least this perspective: If one aims to limit healthcare spending by limiting "waste, fraud, and abuse," and if one's definition of waste, fraud, and abuse comprises only egregious criminal behavior, there is not enough of it to go around. Elimination of overtly abusive practice decreases total spending by only a negligible amount.

Accordingly, when politicians promise to balance budgets by eliminating medical waste, fraud, and abuse, either they are spouting nonsense, or they are selling something far more comprehensive than weeding out the random rogue. To have any meaningful effect, these programs must attack violations so pedestrian that they do not seem like violations at all.

This broader definition should worry the orthopaedic community because the tentacles of an ordinary waste, fraud, and abuse reduction program, taken just a bit further, could easily wrap around ordinary orthopaedic practice. Here's why.

Waste

While it is difficult to define "waste" precisely, the state of Oregon has tried. The Medicaid program in Oregon "ranks health care condition and treatment pairs in order of clinical effectiveness and cost-effectiveness" and allows payment for only for the top 498 treatments. Implicitly, treatments 499 and up are considered an extravagance. On the Oregon list, only two orthopaedic procedures made the top 100 [13] and many operations that are popular among both patients and surgeons (for example, rotator cuff repair [No. 443]) are awfully close to the pay line. The fundamental logic implicit in the Oregon plan — that medical value is conferred by life extension — can easily be used to impugn life-enhancing (but not necessarily life-extending) orthopaedic surgical practices.

Fraud

Fraud is a charge that is a little tougher to stick, but if an accuser is willing to lump even inadvertent behavior in this category, the allegation of fraud can be made as well. Consider the orthopedist examining a patient with buttock pain. The encounter includes a detailed examination of the hip, the back, and the entire leg. The clinician diligently studies the plain x-rays of the lumbar spine and hip. He scrutinizes MRIs and CT scans, and then spends 20 minutes of the 45 minute encounter on patient counseling. Yet, if

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the surgeon then codes the encounter as described as a new patient visit of moderate complexity (CPT 99203), he is open to the charge of fraud. That's because the rules say that a visit of moderate complexity must include the documentation of at least three vital signs. If but two vital signs are recorded, the encounter is by definition not a visit of moderate complexity; and when a surgeon bills for performing a visit of moderate complexity when such a visit was not documented to have taken place, that's a lapse some would label as fraud.

Abuse

Orthopaedic billing practices can also be maligned as abusive all too quickly. Many orthopaedic surgeons have an x-ray machine in their office, and owning such a device is associated with greater utilization. To critics, owning an x-ray machine "increases the likelihood that inappropriate scans might be done because of the economic benefit to the physician" [8]. The same has been said about providing physical therapy, or distributing durable medical equipment — even if the increased availability of services increases patient satisfaction and compliance.

In short, orthopaedic surgery is a ripe target for the "waste, fraud, and abuse" crowd. Because most of orthopaedic surgery does not improve life expectancy, it may be perceived as wasteful. Because it is not uncommon for orthopaedic surgeons to participate in the sale of ancillary goods and services, their billing practices can be perceived as abusive. And last, because the rules of coding office visits are more in step with the practice of internal medicine, it is all too easy for an orthopaedic surgeon to engage without intent in what some might denounce as billing fraud.

Orthopaedic surgeons must not be lulled into thinking that waste, fraud, and abuse reform is limited to merely corralling the criminals of medicine. To have any effectiveness at all, waste, fraud, and abuse reform might very well have them in mind.

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In my more than 30 years of advising healthcare providers on matters pertaining to fraud, including government investigation defense, I have witnessed the increasing criminalization of unintentional behaviors. What used to be simple overpayment now is frequently considered a federal civil fraud case.

There will always be "real fraud" — deliberate falsification of information to obtain government program payments. But this is not what typically occurs when providers settle so-called "fraud" cases. Today, fraud is more likely considered activities described by Dr. Bernstein: Lack of documentation for services provided, second-guessing of physician judgment regarding medical necessity, or financial relationships regarding referral services that may implicate the Stark or antikickback laws. There often is a disconnect between what physicians believe constitutes healthcare fraud and what the government prosecutes.

How does inadvertent conduct become a fraud case? Again, there is a disconnect between what providers view as unlawful intent and what the law provides. The False Claims Act, the usual basis for government civil fraud cases, has a very low intent threshold — "reckless disregard" for the truth or falsity of claims. If there is a recognized documentation standard, such as evaluation and management criteria for office visits, and the physician falls short in a pattern of visits, the government may view this as improper "upcoding."

As Dr. Bernstein notes, the government has heightened expectations regarding documentation, and criteria are not always compatible with orthopaedic services. In the latest government cases [5], even the technology designed to assist physicians with this complexity by enabling

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documentation of services at the touch of a screen has become vulnerable to fraud claims.

Similarly, furnishing so-called "designated health services," such as imaging services, in a physician office setting, while currently permitted under the Stark Law, is subject to a multitude of regulatory requirements, as well as a pervasive government suspicion of overutilization. As such, the government is moving to scale back permissible in-office services. In the meantime, suspicion of office-based services remains, although patients enjoy convenient one-stop shopping, and are more apt to obtain needed services when they are proximately located.

Add to this the substantial financial rewards available to whistleblowers who can bring cases on behalf of the government and share in the proceeds under the False Claims Act, and one arrives at a situation in which the threshold for pursuing these cases is indeed quite low.

Orthopaedic surgeons are not the only target of these government inquiries, but, as Dr. Bernstein and I noted, they may be especially vulnerable. What can physicians do to protect their practices from a fraud inquiry? Recognize these areas of disconnect. Take any government inquiries, communications and/or issues seriously before government concern escalates. Consider establishing a compliance program, which can reveal and resolve issues before they come to government attention, as well as reduce the likelihood of a whistleblower action from within the practice.

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The United States spends more on healthcare than any other country by virtually any measure [10, 14]. Whether US spending is too high, unsustainable, and/or wasteful is open to debate.

When thinking about this issue, I often turn to the field of cardiology where I might argue the data are most robust and the methodologies well established. The parallels to orthopaedics are relatively straightforward.

The United States appears to perform far more noninvasive testing (stress testing) than other nations; noninvasive testing leads to invasive testing (coronary angiography) and interventions (percutaneous coronary intervention [PCI]). If every PCI performed in the United States were life-saving, then one could be comforted that while high rates of cardiac procedures were expensive, we were truly saving lives. Sadly, abundant data now demonstrate [1, 3] that most of the excess procedures performed in the United States do not reduce mortality, but rather reduce chest pain and enhance quality of life; this raises difficult questions about what value these procedures provide.

As Dr. Bernstein articulates in his column, defining waste is difficult, but at some point I think we need to be bold and acknowledge the painful realities. In the case of cardiology, the American Heart Association estimates 1 million cardiac catheterizations are performed annually [7]. Assuming (boldly) that 20% of these procedures are wasteful, there are 200,000 procedures performed each year with little or no benefit to the patient.

Of course, procedures that provide little mortality benefit for individual patients still generate economic activity. The healthcare sector is a major source of high-paying jobs [12]. Revenue generated from patient care translates into income not just for those involved directly in patient care, but for numerous other professions whose skills and products are required to keep the healthcare sector humming. This economic activity results in tax revenue for federal, state, and local governments.

That said, in an era where Medicare, Medicaid, and private insurers are paying for 70% to 80% of all healthcare spending, payers (and the businesses they represent) are entitled to question the value of a certain

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procedure. Orthopaedics has reason to be concerned. Orthopaedic procedures are often discretionary and costs are enormous [4]. There is indisputable evidence that many orthopaedic procedures enhance quality of life, but they do not reduce mortality save for the rarest cases. Additionally, orthopaedics has been late in developing "appropriate use criteria" that can provide an evidence-based starting point for policymakers and payers struggling to differentiate appropriate surgeries from waste [2, 6, 11].

Like Dr. Bernstein, I fear that if orthopaedic surgeons and like-minded individuals do not take the lead in finding innovative ways to reduce waste, fraud, and abuse solutions will be imposed that are much less appealing [9].

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