

Dealing with fraud in health care organizations institutions



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Introduction

According to the Department of Justice (DOJ), Health Care fraud has come to dominate its resources and time through an increase in cases (Qui Tam) over the years. Through its principal avenue of prosecution of cases of fraud, is the 1863 (31 U. S. C sec. 3729-3733) Federal False Claims Act (FCA).

Through provision of data, relators are provided with a share of recovered monies, in addition to secure tenure the place of employment. Through the ' False Claims Act, relators, need not be suffering from direct individual illness or injury as a result of such fraudulent acts, so as to bring such errors to legal redress.

Initially concentrated on the presence of false claims in the Defense Department contracting procedures, the growth of federal disbursements towards Health Care has in turn increased the likelihood of more qui tam opportunities. This may entail irregularities in the service-delivery and reimbursement programs as administered by Federal Health Care Financing Administration (both Medicaid and Medicare); the Department of Defense and Veteran affairs in military hospitals; the Bureau of Prisons facilities; the Office of Personnel Management (in charge of health insurance for America's civil service) and the Indian Health Service reservation clinics.

How the Healthcare Qui Tam affects health care organizations

Qui Tam refers to instances where a private individual assists through a writ, prosecution on cases of fraudulent activities as pertaining to different sectors under Federal Government. The individual, known as a ' whistleblower', files actions against contractors of Federal Government, in this case

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whistleblower stores the Health Care organization through the False Claims Act (known as the Lincoln Law). Under the act, individuals who report such cases, are entitled to receiving a portion (averaging between 15-25%) of damages recovered (Hsia, 1993).

Through the Act, legal avenues are provided with the information through which mitigation measures are taken against falsified billing to the Federal government especially so in cases where such individuals often possess extra knowledge as to the activities of the organization. As a 'relator', an individual is legally recognized as suing the defendant on behalf of the government as a 'partial assignment following such alleged fraudulent activities. The Department of Justice through the attorney usually intervenes in such cases through its notification of the sued company by informing them that there exists a filed claim against them.

Under the above, the presence of filed suits under seal prevents the defendant from informing anyone about any details as pertaining to the case and, thus, going against the defendant's obligation as found under the 'Securities & Exchange Commission.' Under this obligation, the defendant is required to disclose any filed lawsuits because they could potentially affect the company.

With such aforementioned action it has the effects on healthcare organizations. Not only are there economic impacts, but also the company may have reduced number of customers, or in the article's case, may lack the patient's confidence. Settlements often run into the millions of dollars effectively touching on an entity's overall capital and profit base. With

present fraudulent cases a decline in the organization's efficiency and effectiveness is imminent as proper filling of data is compromised (Rogers, 2007).

Four (4) examples of Qui Tam cases that exist in a variety of health care organizations

There are four cases affecting the variant of healthcare organizations in the U. S.

The largest healthcare fraud case in America's history was the GlaxoSmithKline case (2010), which resulted in the pharmaceutical giant paying a \$3 billion dollar settlement from both criminal and civil charges filed against it. Because of two different qui tam cases filed, the giant company pleaded guilty to a number of fraudulent activities such as Medicaid fraud, false price reporting procedures, the illegal payment of kickbacks to physicians. Others include the promotion of using drugs other than that commended by the FDA (Federal Drug Agency), referred to as ' off-label' marketing and its failure to making public vital safety data in regards to a specific product. \$2 billion was for the settlement of civil cases, while the other \$1 billion going towards criminal damages.

The second example is the LifeWatch Services Inc. case (2011), which involved a payment of \$18. 5 million to determine the company's allegations to having presented falsified declarations to American Federal Health Care programs. Stemming from two separate qui tam lawsuits, there were allegations that the company had inappropriately billed Federal Medicare on

its ACT ambulatory cardiac telemetry services, which Medicare reimbursed back at high price value.

Another case would be the 2012 AmMed Direct LLC case, which resulted in an \$18 million settlement to both the state of Tennessee and the U. S. government in addition to extra interest, because of its falsification of claims towards the Tennessee Medicaid agency and Federal Medicare. These falsified claims touched the heating pads, vacuum erection instruments and diabetes testing equipment that had been returned due to a number of reasons. In its entity, it correctly informed the contractors of ' Medicare Administration' of its failures, and effectively initiated payment of refunds to both TennCare (Tennessee Medicaid) and Medicare (Walker, 2007).

Fourth is the Pfizer Inc. case of 2004, in which the company was charged with bad marketing practices as pertaining to the drug ' Bextra.' Pleading guilty to a variant of criminal and civil charges, the company was forced to pay a fine of \$2. 3 billion inclusive of the largest fines based on criminal charges (at \$1. 2 billion) and civil fraud in America. It is alleged that Pfizer Inc. violated on a systematic order the existent federal Anti-Kickback Statute 42(b), in addition to the provision of ' off-label' marketing as entailed in the FDCA,(the Federal Food, Drug and Cosmetic Act). This was because of unwarranted reimbursement through both State and Federal Government programs of monies for the drug Bextra.

A procedure for admission into a health care facility that upholds the law about the required number of Medicare and Medicaid referrals

A set of rules have been developed to honor the variant of prerequisite requirements concerning the health care centre. Different centers have been crucial in the development of different law practices pertaining to health care. An example is Erickson/Sederstrom since 1967, a centre that continues to provide legal services to providers of healthcare in America. Such laws include the Physician Self-Referral Laws (Stark Law) and Anti-Kickback Statute, the State and Federal Confidentiality laws, the Health Insurance Portability and Accountability Act (HIPAA), the Emergency Medical Treatment and Active Labors Act (EMTALA) among others.

Consequently, as the Chief Nursing Officer, the first issue when considering admissions would be to delve more on the ' Stark Law'. As a law, it restricts the referral of both Medicaid and Medicare patients to health care institutions/ facilities in which the referral physician has relationships of a financial nature. It is especially applicable if a physician refers beneficiaries of the above to a health care entity for one of the 10 designated categories of health services. If as an institution it is financially affiliated, then it would be criminal to refer patients to such institutions. The aforementioned laws are also critical as they ensure proper measures that are taken to safeguard not only patients' health, but also Federal funding measures (John C., 2013).

Following the Health Care (Consent) and Care Facility (Admission) Act of 1996, has no issues as pertaining to the Stark Law. Then, I would distribute the patients into two avenues named ' major' or ' minor' healthcare as there is a substantial difference between them. The procurement of necessary documents would follow it and other agreements from either family relations or representatives such as photocopies of valid CGHS cards, request letters
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and permission letters for admittance purposes. This required the receiving of consent from an adult in case of child referral, or personal consent if the patient was an adult. There would be the execution of advanced directive and the representative agreement. With the directive advance of been executed, the final step of admittance of the patient follows when he receives the proper health care.

Recommend a corporate integrity program that will mitigate incidents of fraud and assess how the recommendation will affect issues of reproduction and birth.

The use of Corporate Integrity Agreements (CIAs) is on an increase to stem the increasing cases of health care fraud. Ranging from mandates of appointing by compliance officers to the requirement of employee training and the implementation of a hotline for communication purpose CIAs are vital to the institution/ facilities because they provide an official with high responsibility at a personal level and, therefore, get the necessary attention of the top management. Through the appointment of compliance officers, health care facilities will be able to effectively and efficiently deal with the increases of fraudulent cases.

In terms of birth and reproduction issues, compliance officers generally assert a standardized level of health care services, products and materials used in conformity with the set rules and regulations as provided in both Medicaid and Medicare, as per Federal Health care statutes. Through government and private industry dialogue, the addressing of prerequisite operational and implementation challenges as pertaining to CIAs is better-

enhanced and, thus, providing avenues for the safeguarding of patient health also including issues of birth and reproduction (Health Law, 1967).

Devise a plan to protect patient information that complies with all necessary laws.

Patient-doctor privacy policies are crucial as espoused in the Hypocritical Oath, which is a requirement for the medical profession. However, there exists law that permits the disclosure of a patient's health information without any consent from the patient. This may be for reasons of payment, healthcare operations and treatment purposes. Other reasons pertain to activities touching on Public Health; for purposes of reporting abuses, domestic violence and neglect; for administrative and judicial proceedings purposes; disclosure to avert serious threats to both client safety and health and for purposes of specialized Government functions among others.

Patients are protected by individual rights, such as the right to request restrictions on disclosure, to receive confidential information, to copy and inspect protected information pertaining to health, to receive an account of all disclosures as pertaining to individual health information and the right to a copy of the notice provided. Through patient-doctor privacy, all information is protected unless as stated above in compliance with prerequisite laws (Barry, 2012).

Conclusion

In conclusion, the presence of Legal policies as pertaining to the Health Care arena are a welcome mitigation measure that ensure the presence of a

safety ways pertaining to the presence of increased fraudulent activities in health care facilities/ institutions. The Stark law provides the best avenue, in ensuring a reduction of fraud cases, though on the other hand, such health facilities face damaging impacts on both economic and professional viewpoints.