Virtual Mentor
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CLINICAL CASE 3
Securing Diagnostic Services within System Constraints
Commentary by Bruce Patsner, MD, JD

Dr. Simpson was performing ultrasound-guided amniocentesis on Mrs. Clark, a 36-year-old woman in her 16th week of pregnancy. She had been trying for several years to conceive a child but had had two previous miscarriages, both during the first trimester. Due to her age and a remote history of trisomy 18 in her family, she had undergone amniocentesis with each pregnancy to assess chromosomal abnormalities.

While using ultrasound to guide the amniotic fluid collection needle, Dr. Simpson thought he saw a complex lesion behind Mrs. Clark's uterus. With ultrasound, he could see that the mass was approximately 11cm; it was predominately cystic but had some debris, septations, and possibly a solid component. Further evaluation was needed to determine the composition of the mass with certainty.

Normally, Dr. Simpson would have sent his patient for Doppler ultrasound to help distinguish an inflammatory from a malignant process. He knew that the hospital he was affiliated with did not provide radiology services to patients on Medicaid for workup of asymptomatic conditions. If he referred Mrs. Clark to a public hospital where she would not be responsible for the cost of the test, the wait time could be months. Dr. Simpson was concerned that, if his patient had to wait that long, her condition would be significantly more advanced and far more likely to threaten her health and her pregnancy. Furthermore, if surgical resection ultimately were required, the delay would put that surgery in the third trimester of pregnancy when it would be technically more difficult due to the size of the uterus. The ideal time to resect a pelvic mass during pregnancy is in the second trimester, when the uterus is not too big and the threat of spontaneous abortion is much lower than in the first trimester.

Dr. Simpson was aware that, if the patient were complaining of symptoms caused by this condition, the test would be given a different procedure code. Because the state Medicaid program offered satisfactory reimbursement for therapeutic radiology procedures, his hospital would accept Mrs. Clark for the procedure. Dr. Simpson asked Mrs. Clark if she had any pain in her pelvis, lower back, or bladder. She replied, "A little pressure around my pelvis and lower back from time to time, and I definitely have to urinate more often than normal." Dr. Simpson reasoned that Mrs. Clark's description could well apply to the normal symptoms associated with pregnancy. Yet if he did not categorize her as having symptoms that qualified her for the higher-level ultrasound at his hospital, she might go untreated for months. He was concerned that the lesion he saw could be either an infectious or neoplastic

process, and either case could have potentially dangerous consequences for Mrs. Clarke's pregnancy and her general health. He thought about how he could get the radiology department in his hospital to perform the procedure.

Commentary

As a physician, Dr. Simpson is under no legal obligation to provide care to a particular patient unless he has agreed to do so [1]. But once treatment has been initiated, indicated by entering into a patient-physician relationship, Dr. Simpson's ethical and legal responsibilities are clear: he has a duty to preserve and protect the health of his pregnant patient, Mrs. Clark, and her unborn child. This fiduciary relationship is characterized by the highest duty of care towards both patients. The same duty—and the same standard of care—bind the physician, even if payment is going to be reduced or services provided free of charge [2].

Because Dr. Simpson has discovered a condition that might compromise the health of his patient, her fetus, or both, he is obligated to investigate further. He has two clear legal responsibilities here. One is to practice medicine that complies with national standards of care, i.e., to not commit medical malpractice. The second is to comply with federal and state law. He might break these laws if he were to bill Medicaid for a higher level of services than actually provided, a practice known as "upcoding." Another way in which Dr. Simpson could break the law would be to misrepresent the patient's condition as one for which Medicaid provides reimbursement when, in fact, it does not. Both actions have the potential to produce more profit, and, although the latter appears to be in the patient's best interest, both actions are illegal and unethical.

Medicaid Coverage

Medicaid is a combined state-federal health coverage program for low-income individuals enacted in 1965 as Title XIX of the Social Security Act. At the present time, Medicaid covers 1 in 7 Americans, more than any other public or private insurer in the United States, including Medicare [3].

Maternity costs, particularly for inpatient medical care, comprise a significant percentage of Medicaid charges. Medicaid pays for routine prenatal visits, prenatal vitamins, ultrasound and amniocentesis screening, delivery services, and two months of post-partum care. Most state Medicaid programs outline in great detail which obstetrical and ancillary services are covered, which conditions might be compensated at a higher rate, and the proper coding for services and procedures.

Unlike Medicare, which is one large system, Medicaid is actually 50 different state systems and thus more vulnerable to fraud. According to the Government Accountability Office, up to $20 billion worth of fraud against Medicaid programs occurs annually [4]. Medicaid fraud can take many forms, including but not limited to billing for services not rendered or products not delivered, performing and billing for unnecessary medical services, double billing, or upcoding.

Submission of a fraudulent bill for Medicaid services is a violation of the False Claims Act. Individual states and the federal government have Medicaid Fraud Control Units to investigate and prosecute illegal acts related to Medicaid funds.

Medicaid fraud has potentially serious consequences for both physicians and hospitals. Depending on the severity of the infraction and the amount of money defrauded from state and federal funds, penalties may range from civil fines to exclusion from participation in Medicare and Medicaid. Penalties also include possible imprisonment [5]. For hospitals or hospital systems, a criminal conviction for Medicaid fraud can lead to collapse due to loss of revenue, funding for medical education loans, and operating licenses [6]. In lieu of costly corporate criminal trials, prosecutors have begun using Deferred Prosecution Agreements [7], which may impose far-reaching penalties and obligations on health care organizations in exchange for avoiding loss of Medicaid eligibility.

Dr. Simpson's Choices

Dr. Simpson's financial responsibilities are undefined in the present clinical scenario. We do not know about his contractual relationship with the hospital. He should disclose to all patients any financial interests he has in the radiology unit where Mrs. Clark is being seen and in any radiology center to which she might be referred. Dr. Simpson must be familiar with anti-kickback regulations and hospital and medical staff bylaws that might subject him to disciplinary action. These concerns aside, Dr. Simpson must do what is medically appropriate and necessary to properly evaluate his patient and face the financial consequences of his decision later. To send Mrs. Clark to the public hospital, thus delaying necessary, time-sensitive services (in this case the work-up of a suspicious pelvic mass) simply to minimize financial loss for himself or the hospital is malpractice and unethical.

Dr. Simpson must find a legal, ethically acceptable way to get Mrs. Clark the more advanced radiological services she needs at his private hospital rather than risk complicating any treatment because of the certain delay at the public hospital. In the case scenario as written, Dr. Simpson has two acceptable options. First, because he cannot know definitely that Mrs. Clark's symptoms are *not* due to the unsuspected retro-uterine mass, he can legitimately refer her as a symptomatic patient; he need not misrepresent her condition in order to obtain Medicaid payment. Second, Dr. Simpson might be able to refer her to the private hospital without financial penalty because she has an unrelated, new medical condition that was found incidentally at the time of planned amniocentesis and requires further evaluation. In some states this is sufficient indication for more advanced radiological evaluation, different coding, and higher payment, depending on the options available for Medicaid obstetrical patients. Both options avoid either upcoding a lesser service or performing a more expensive service that is not indicated and therefore not reimbursable.

In light of the possible serious consequences of delaying Mrs. Clark's work-up, Dr. Simpson should accurately report his secondary finding and the patient's symptoms on the Medicaid bill and schedule the Doppler ultrasound at the private hospital.

Doing anything less than securing the timely and appropriate care for his patient would be an ethical, and possibly legal, failing on Dr. Simpson's part.

Notes and References

1. American Medical Association. Opinion 1.02 The relation of law and ethics. *Code of Medical Ethics*. Chicago, IL: American Medical Association; 2006. http://www.ama-assn.org/ama/pub/category/8312.html. Accessed January 24, 2008. "Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties." The absence of a legal duty to treat aside, physicians have greater ethical obligations to treat, for example in emergency situations.
2. Hall MA, Bobinski MA, Orentlicher D. *Medical Liability and Treatment Relationships*. New York, NY: Aspen Publishers, Inc; 2005:72-176.
3. Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer*. Washington, DC: Henry J. Kaiser Family Foundation; 2005. http://www.kff.org/medicaid/upload/7334%20Medicaid%20Primer_Final%20for%20posting-3.pdf. Accessed April 1, 2008.
4. *Hearing Before the Committee on Finance, U.S. Senate*, 109th Congress, 1st Sess (2005) (testimony of Leslie G. Aronovitz, director, health care, GAO). http://www.gao.gov/new.items/d05855t.pdf. Accessed April 1, 2008.
5. False, fictitious, or fraudulent claims. 18 USC sec 287. http://www.law.cornell.edu/uscode/18/usc_sec_18_00000287----000-.html. Accessed April 1, 2008.
6. See, for example, *United States v. The University of Medicine and Dentistry of New Jersey* No 050CR-3134 (D NJ 2005).
7. Shaw PW, Welch BM. The use of deferred prosecution agreements in healthcare fraud cases. *Health Lawyers News*. November 2007:27-34.

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