Medical Jurisprudence

Behavioral Sciences Term
St. Georges University
School of Medicine

Visiting Professor
Thaddeus Pope, JD, PhD

Segment 6 of 8

Liability

Licensing

Objectives

1. When can medical malpractice be established through *res ipsa loquitor*
2. What are theories of liability other than medical malpractice (breach of contract, IIED, elder abuse)

3. What are the major initiatives in med mal reform

4. What are the main types of discipline meted by state medical boards

5. What sorts of conduct create liability under the False Claims Act

Alternative Theories of Liability

We already examined

- Abandonment
- Battery
- Informed consent
- Medical malpractice

Res ipsa loquitor

Normally in medical malpractice need an **expert witness** to establish the standard of care

Sometimes, rarely, there is no need for an expert witness

Res ipsa loquitor

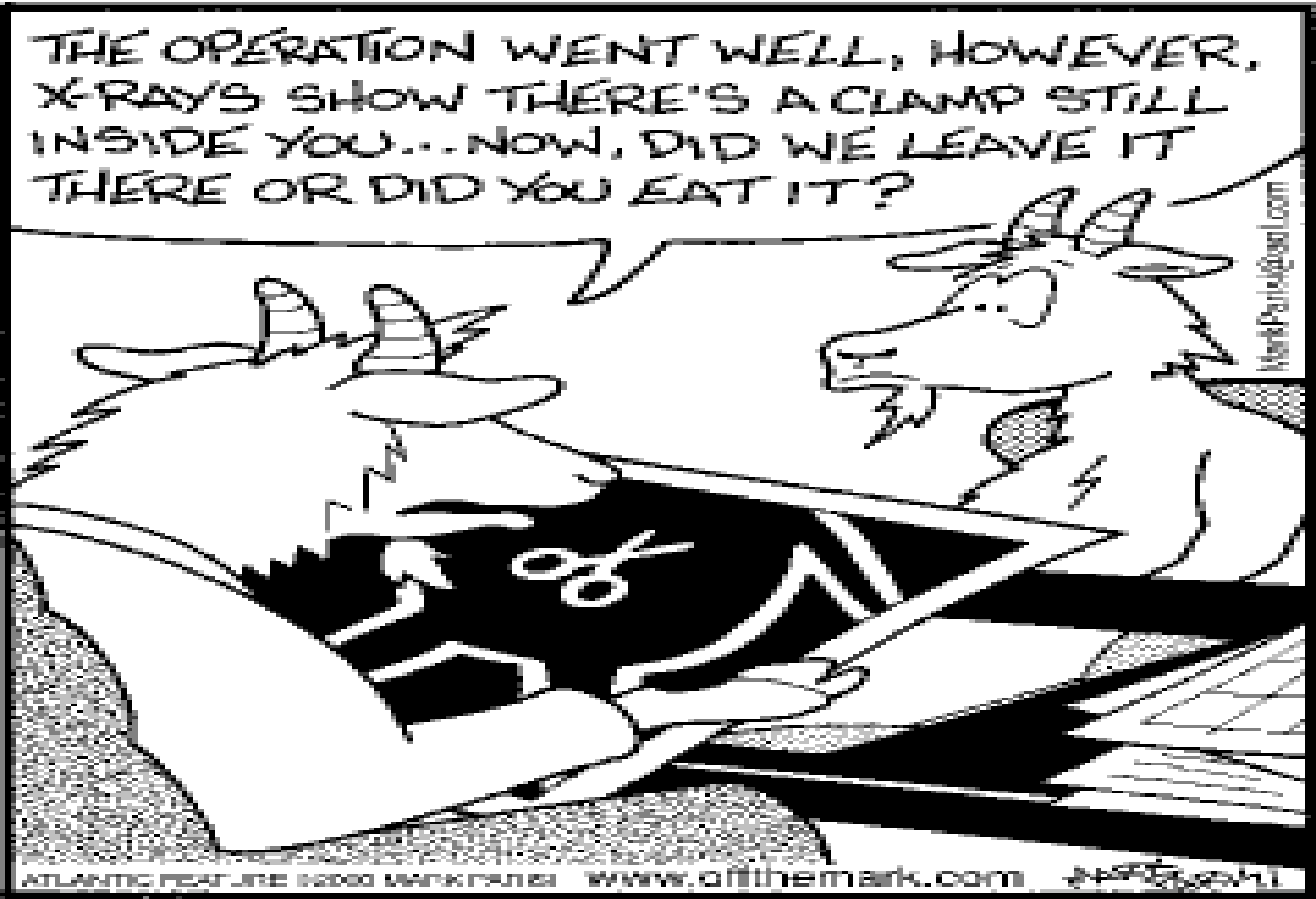
Thing speaks for itself

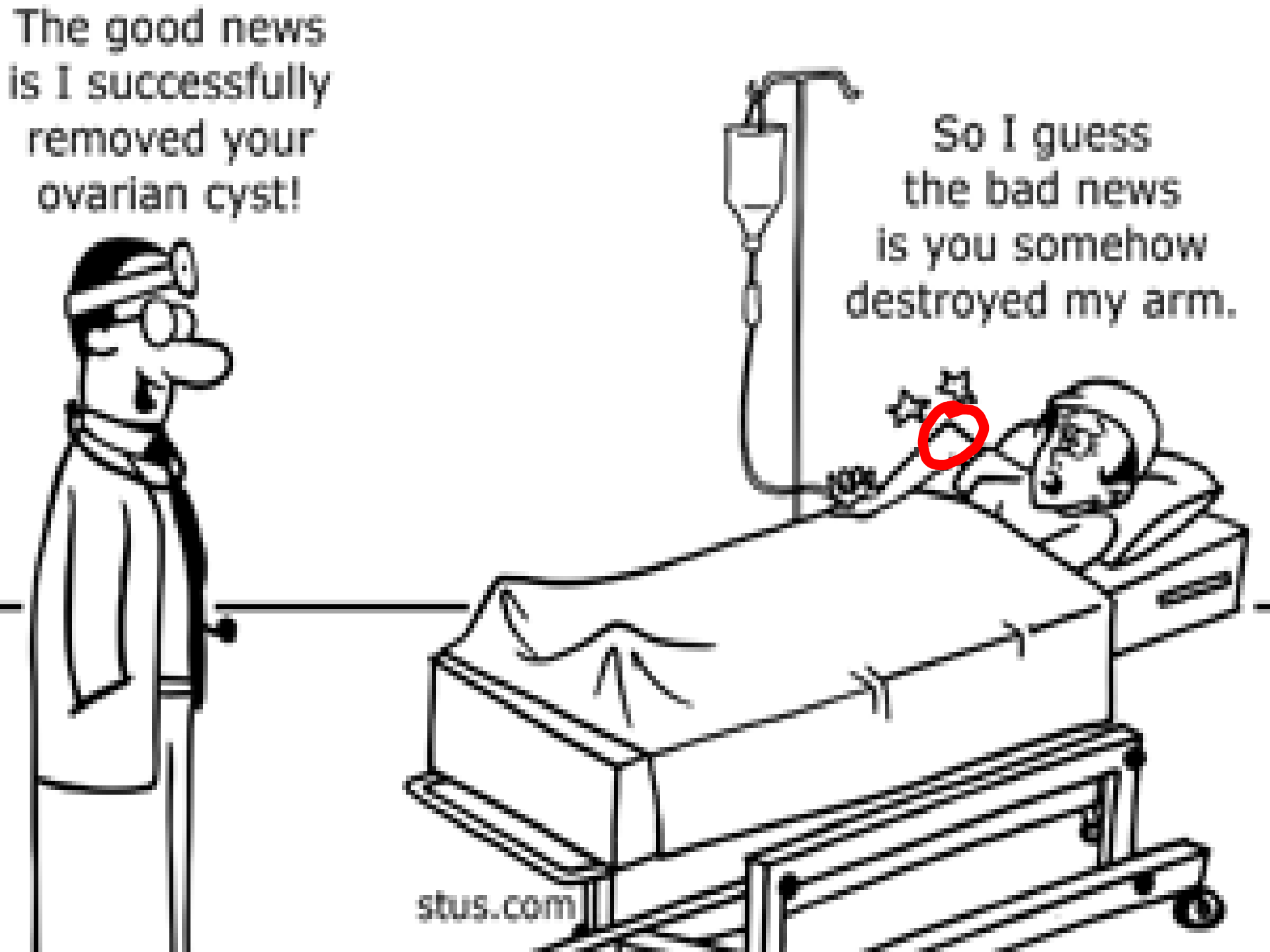
Lay jury can just **infer** there was malpractice

1. Event of type that ordinarily does not occur without negligence

2. That event probably caused by DEF

2 paradigm cases for res ipsa loquitor


THE OPERATION WENT WELL, HOWEVER, X-RAYS SHOW THERE'S A CLAMP STILL INSIDE YOU...NOW, DID WE LEAVE IT THERE OR DID YOU EAT IT?
ATLANTIC FEATURE SYND. MARK PARISI
www.offthemark.com

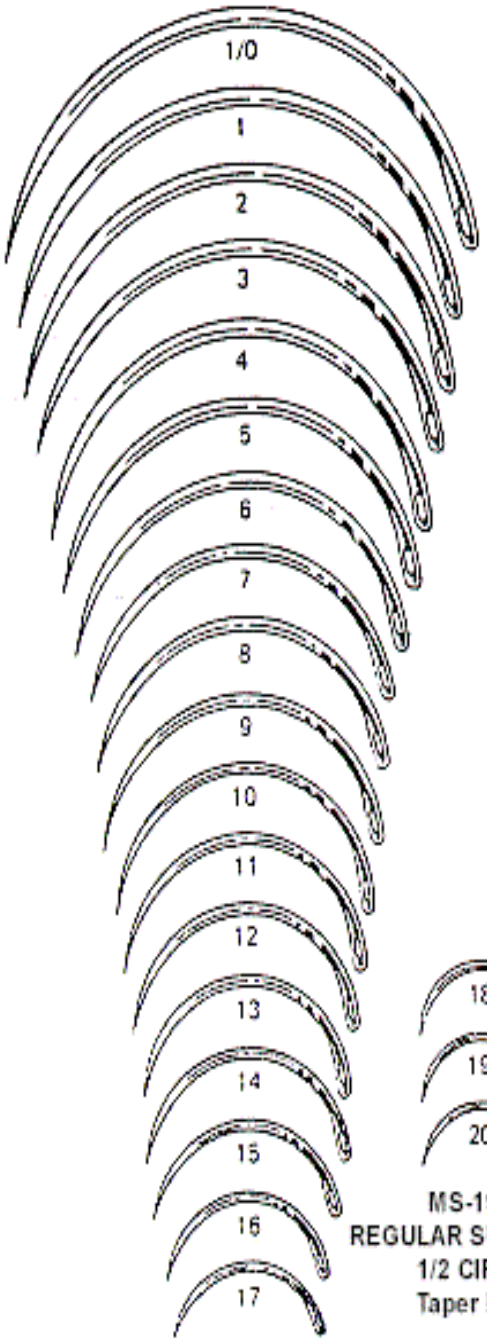

The good news is I successfully removed your ovarian cyst!
So I guess the bad news is you somehow destroyed my arm.
stus.com

Not always easy to establish first requirement

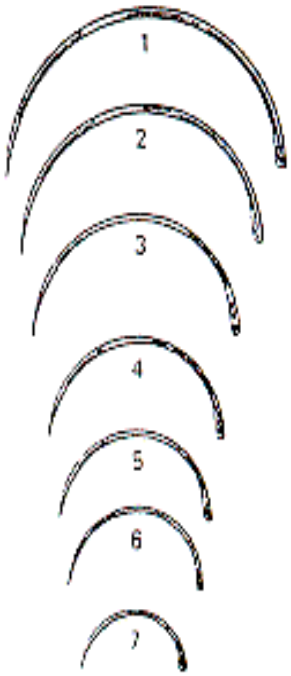
Event of type that ordinarily does not occur without negligence

SPECTRUM
Surgical Instruments, Repairs, Instrument Accessories

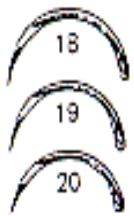
STAINLESS STEEL reusable SURGICAL NEEDLES



MS-192A
REGULAR SURGEON'S
1/2 CIRCLE
Taper Point



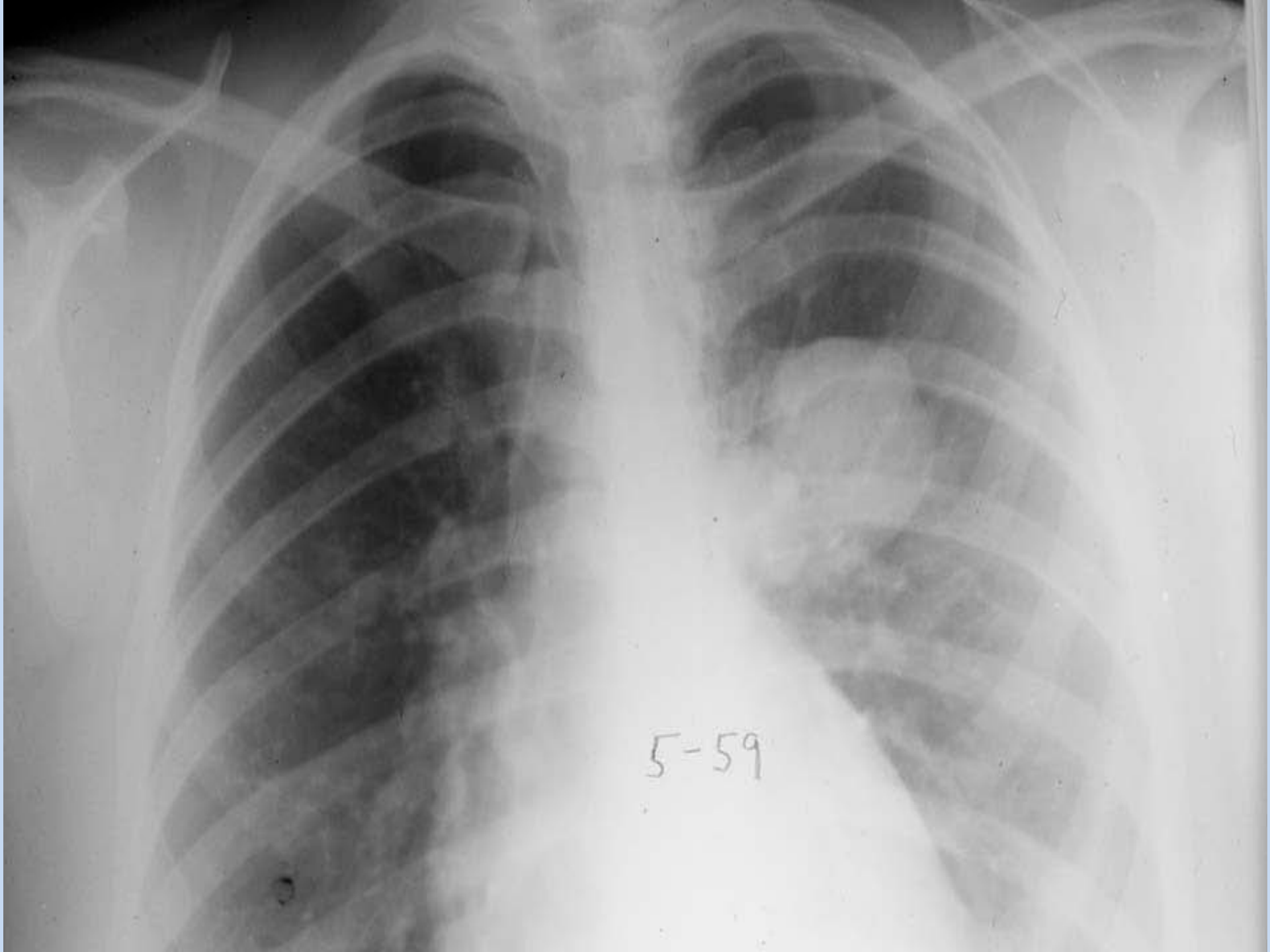
MS-150
ROUND BODIED
1/2 CIRCLE
Taper Point



MS-192
REGULAR SURGEON'S
1/2 CIRCLE
Cutting Edge

INCHES

MILLIMETERS


5-59

Do these things not happen unless there was negligence?

We often need an expert to tell us that

Breach of contract

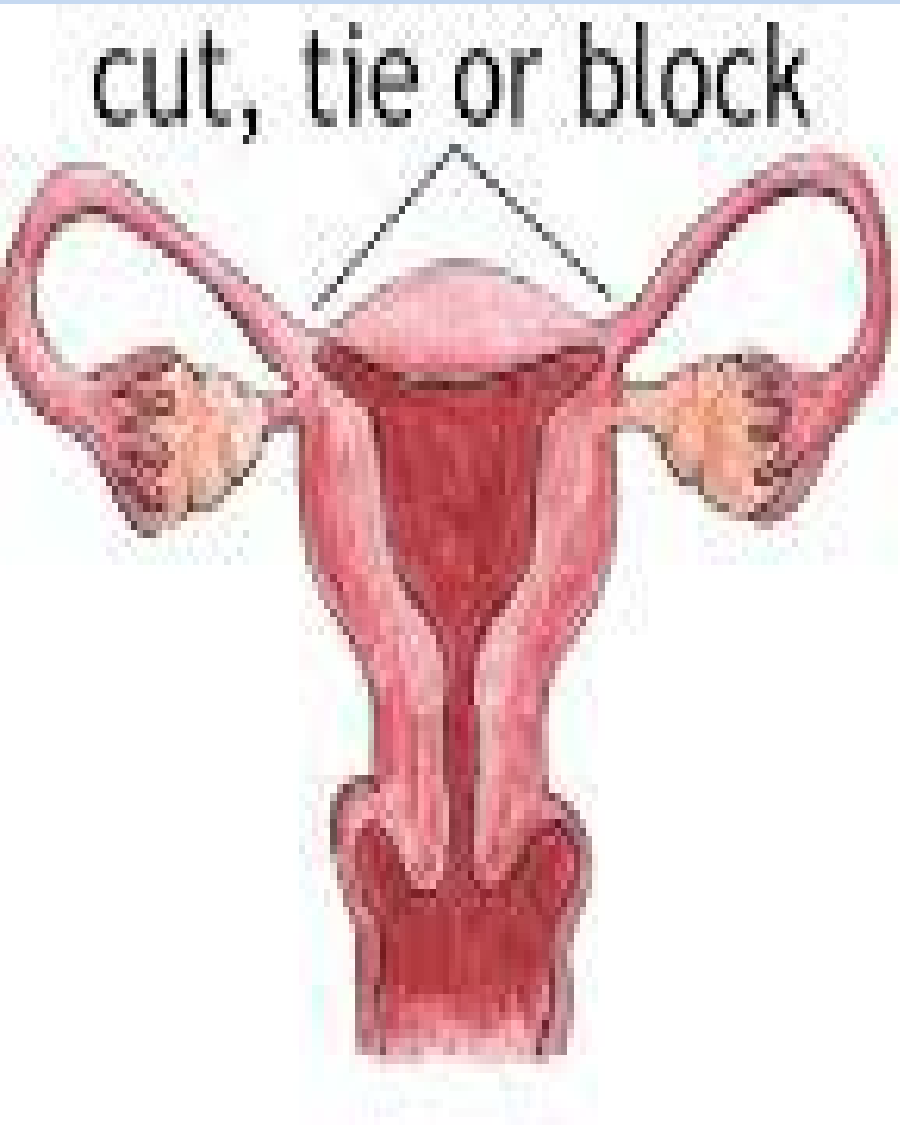
Rare claim

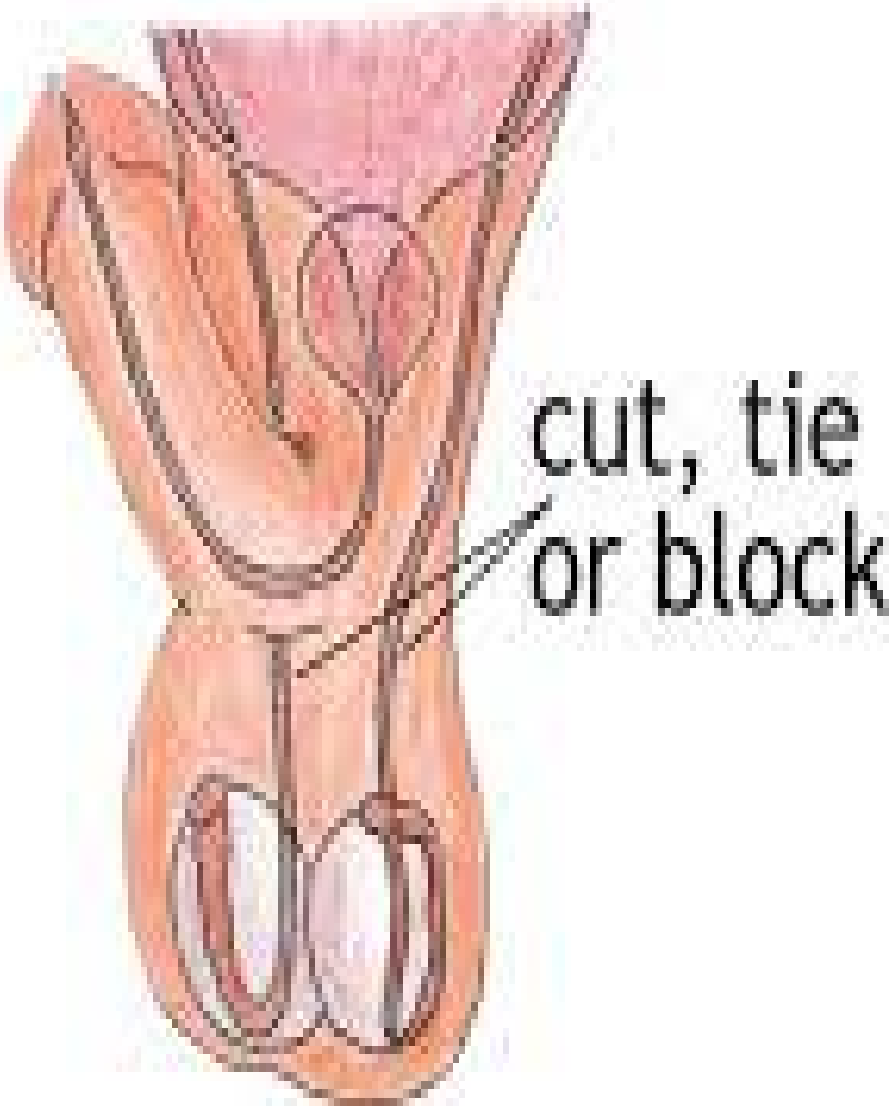
More common among cosmetic clinicians

Promise to confirm cancer **before** Whipple

Need a specific guarantee

Usually in writing


cut, tie or block


cut, tie
or block

Puffery okay

Reassurance okay

Inadequate Pain Control

Current standard of care in most jurisdictions requires that physicians adequately treat pain.

In many states, inadequate pain management of elderly patients is "**elder abuse**"

Elder abuse may expose a physician to liabilities that do not arise in a normal medical malpractice suit

May not be covered by a physician’s malpractice insurance policy

Vicarious Liability

Physician may have done **nothing** wrong

Someone **else** committed malpractice

Patient can always sue the person who committed malpractice

Can **also** sue physician if exercises “control” over person who committed malpractice

Masters liable for torts of servants

Employers liable for torts of employees

Surgeons often like temporary employers over staff (temporary employees)

No double recovery

If $50,000 in damages, can recover from **either** culpable clinician or supervising physician

Hospitals & entities liable for all torts of **employees**

Hospitals & entities also liable for torts of ostensible agents (non-employees who **look** like employees)

IIED

1. Extreme and outrageous conduct
2. Intentional or reckless
3. That causes
4. Severe emotional distress

Extreme & outrageous conduct	Not just rude Not just insult, offense Outside the bounds
Intentional or reckless	(1) DEF wants, or (2) knows, or (3) very likely should know
Severe emotional distress	Must be severe Best show with physical symptoms

Egregiously insensitive & deceptive withdrawal of life support

NOTE: Liability for battery, IIED, breach contract may **not** be covered by insurance

Also, longer SOL, attorney fees

Med Mal Reform

2 main objectives of **liability**

Compensation

Deterrence

Total payouts

$3.6 billion

and dropping

65% dropped, dismissed

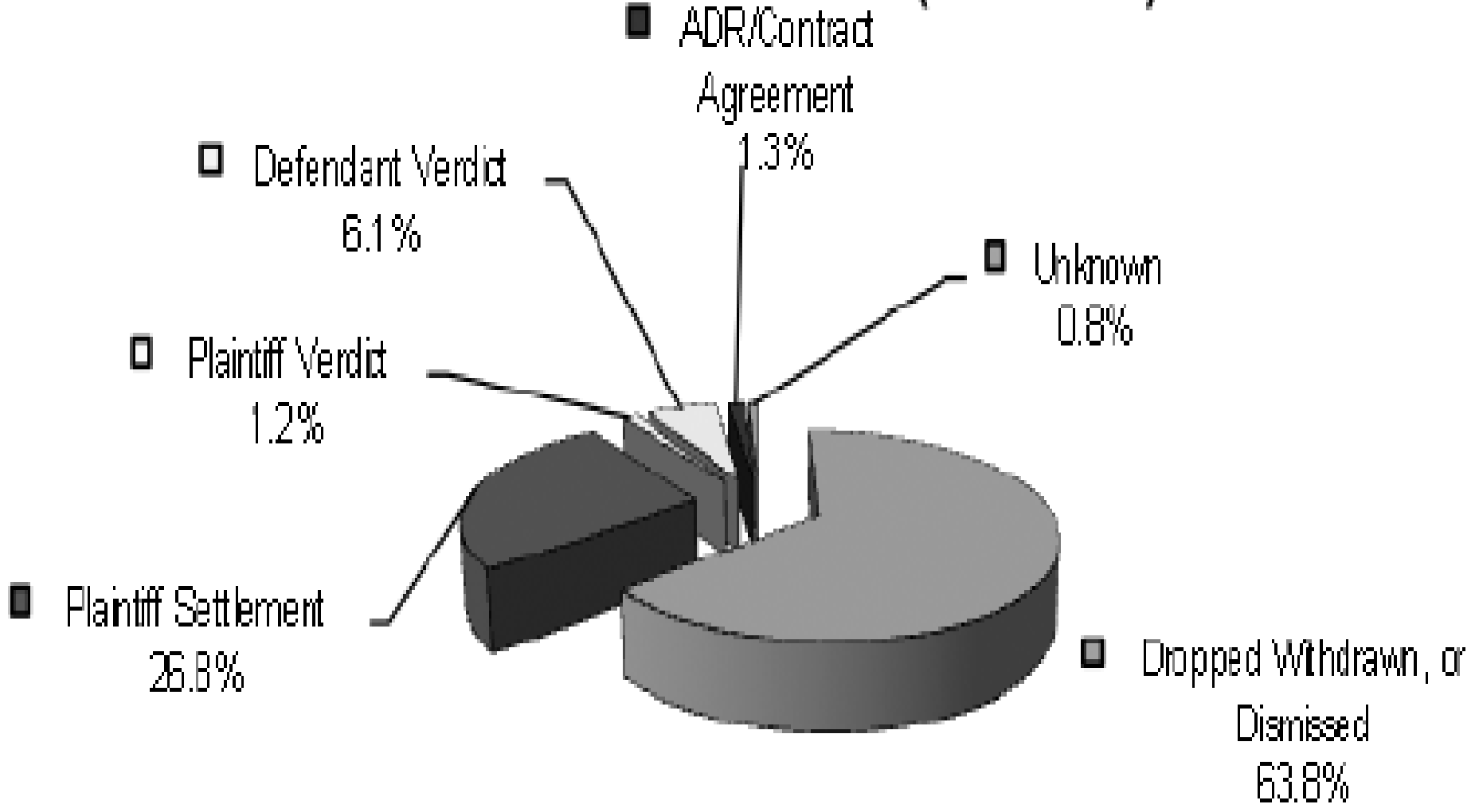
24% settled

7% verdict

(90% for DEF)

Figure 10

Figure 10. PERCENTAGE OF CLOSED CLAIMS BY ADJUDICATION STATUS (1985-2012)



Malpractice litigation very inefficient

If goal = better compensation for injured patients

Reform whole system

Not fault based

- Florida Neurological Injury Compensation Association
- Virginia Birth-Related Injury Compensation Program
- National Vaccine Injury Compensation Program

But **most** efforts focused on tinkering with malpractice system

3 main objectives of **reform**

Expand access

Improve quality

Reduce cost

Expand Access

The alleged **problem** with med mal liability

The Philadelphia Inquirer

Posted on Thu, Oct. 25, 2007

Rendell: Medical-malpractice crisis is over

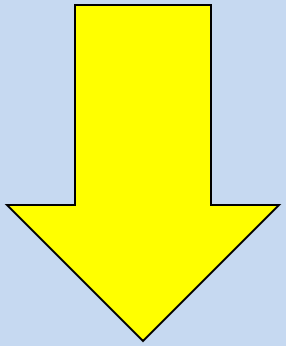
By Stacey Burling
Inquirer Staff Writer

Gov. Rendell yesterday declared Pennsylvania's medical-malpractice crisis over.

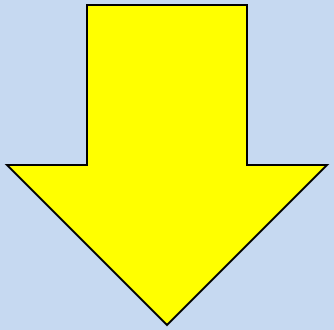
Reforms in the state, he said, have led to fewer malpractice suits, lower payouts, and lower insurance rates for doctors and hospitals.

"The results are almost phenomenal," Rendell said at a news conference at the College of Physicians of Philadelphia building. "It is a problem that has, for all intents and purposes, been resolved."

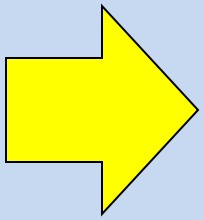
Tort liability



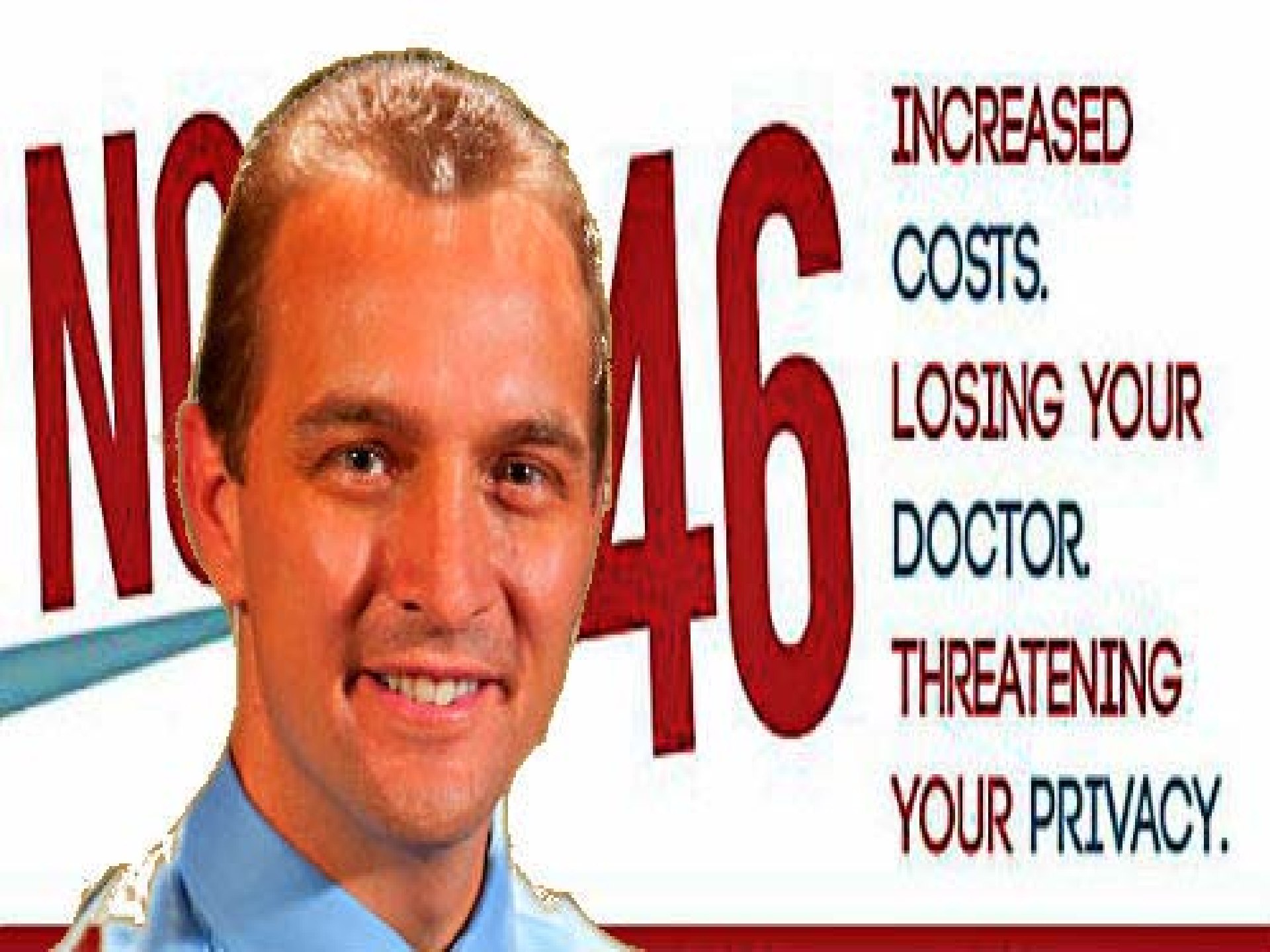
Higher malpractice premiums



Physicians leave

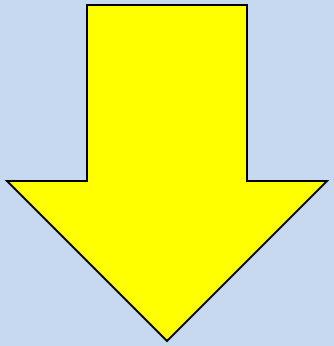


less access

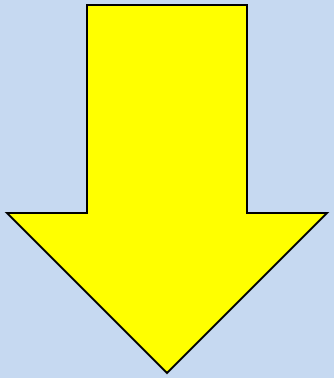

NO
46
INCREASED
COSTS.
LOSING YOUR
DOCTOR.
THREATENING
YOUR PRIVACY.

If that is the problem, then this is the **solution**

Less liability



Lower premiums



More access

Focus is on the med mal insurance **premium**

3 factors determine premium amounts

1. **Claim frequency**
2. **Claim severity**
3. **Certainty** of frequency & severity

FREQUENCY

How **many** lawsuits brought

SEVERITY

How **large** are recoveries

CERTAINTY

How well insurers **predict**

Malpractice premiums need not be connected to these 3 factors

Also affected by INS’s investment performance

DOI can just **control** rates to keep them attractive

1. **Claim frequency**
2. **Claim severity**
3. **Certainty** of frequency & severity

Measures to reduce claim frequency

1. Statutes of limitations

2. Statutes of repose

Less **time** for PTF to bring lawsuit

More will be barred

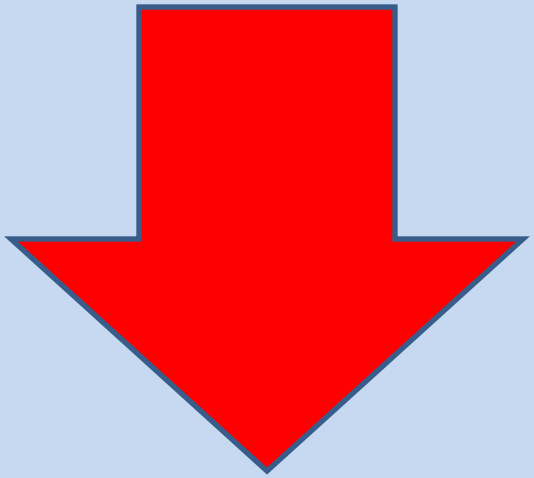
56

Impact = modest

3. Limit contingency fees

40%	$0 → $150k
33.3%	$150k → $300k
30%	$300k → $500k
25%	$500k →

Attorney makes less



Harder for PTF to find attorney

16

Impact = 0

4. Pretrial screening panels

Review case before lawsuit, to see whether has merit

1. Preclude claim from advancing
2. Evidence panel decision admissible
3. PTF post bond

Impact = 0

5. Certificate of merit

Like a screening panel, but no tribunal

Just requires PTF to consult with an expert and submit affidavit

Impact = 0

6. Expert witness requirements

Experts must be from contiguous state

Experts must be from **same** specialty

Narrow pool of available experts

Like old “locality” rule (e.g. Idaho)

Impact = 0

7. Amend substantive law

Claim against ED clinician require **willfulness**

Mere negligence not sufficient

Impact = 0

8. Damage caps

Obviously affects **severity** of claims

How does this affect **frequency** of claims and

Figure 12. AVERAGE INDEMNITY AND PAID-TO-CLOSED RATIO FOR COMBINED SPECIALTIES BY SEVERITY (1985-2012)

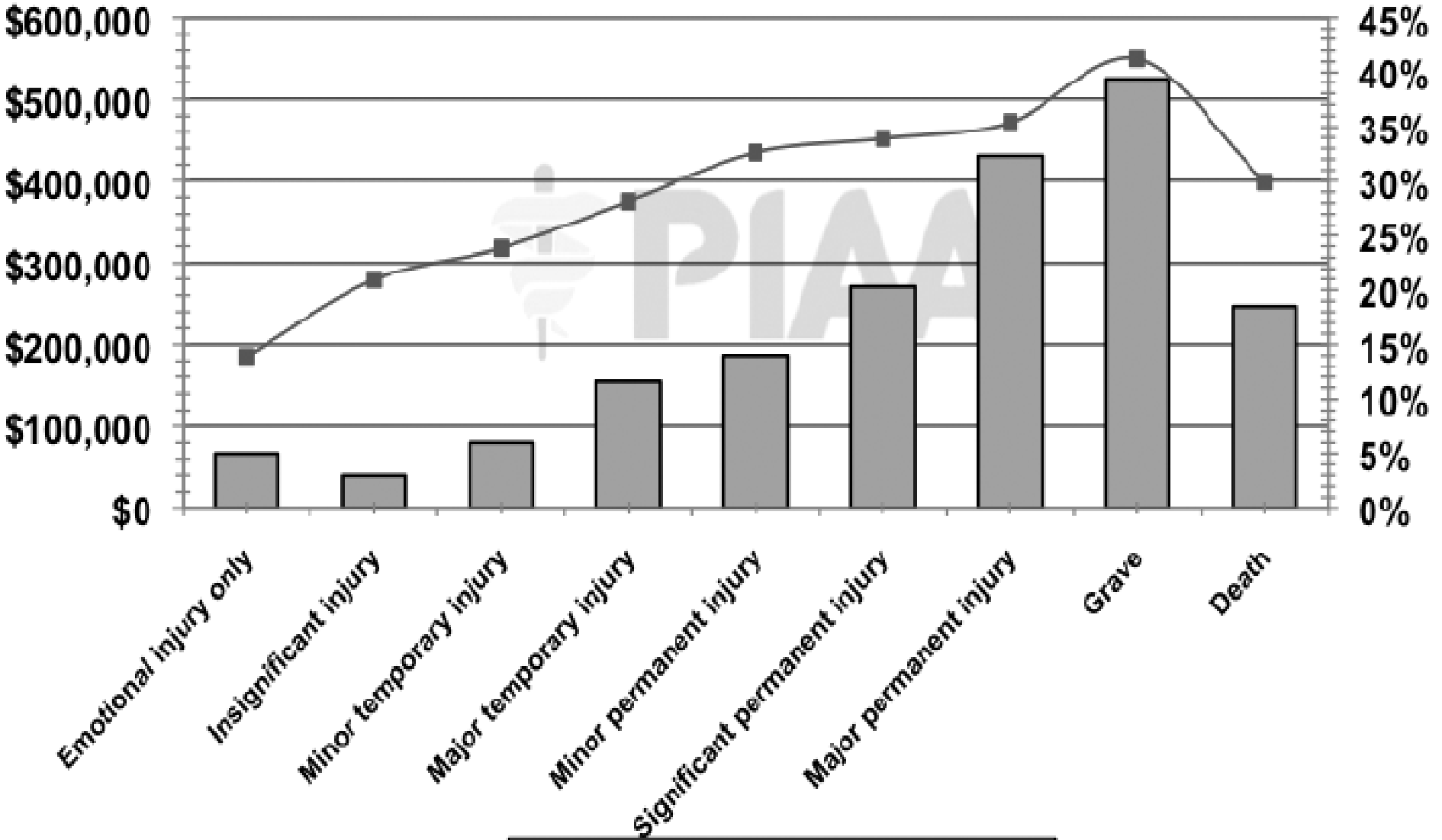


Figure 12

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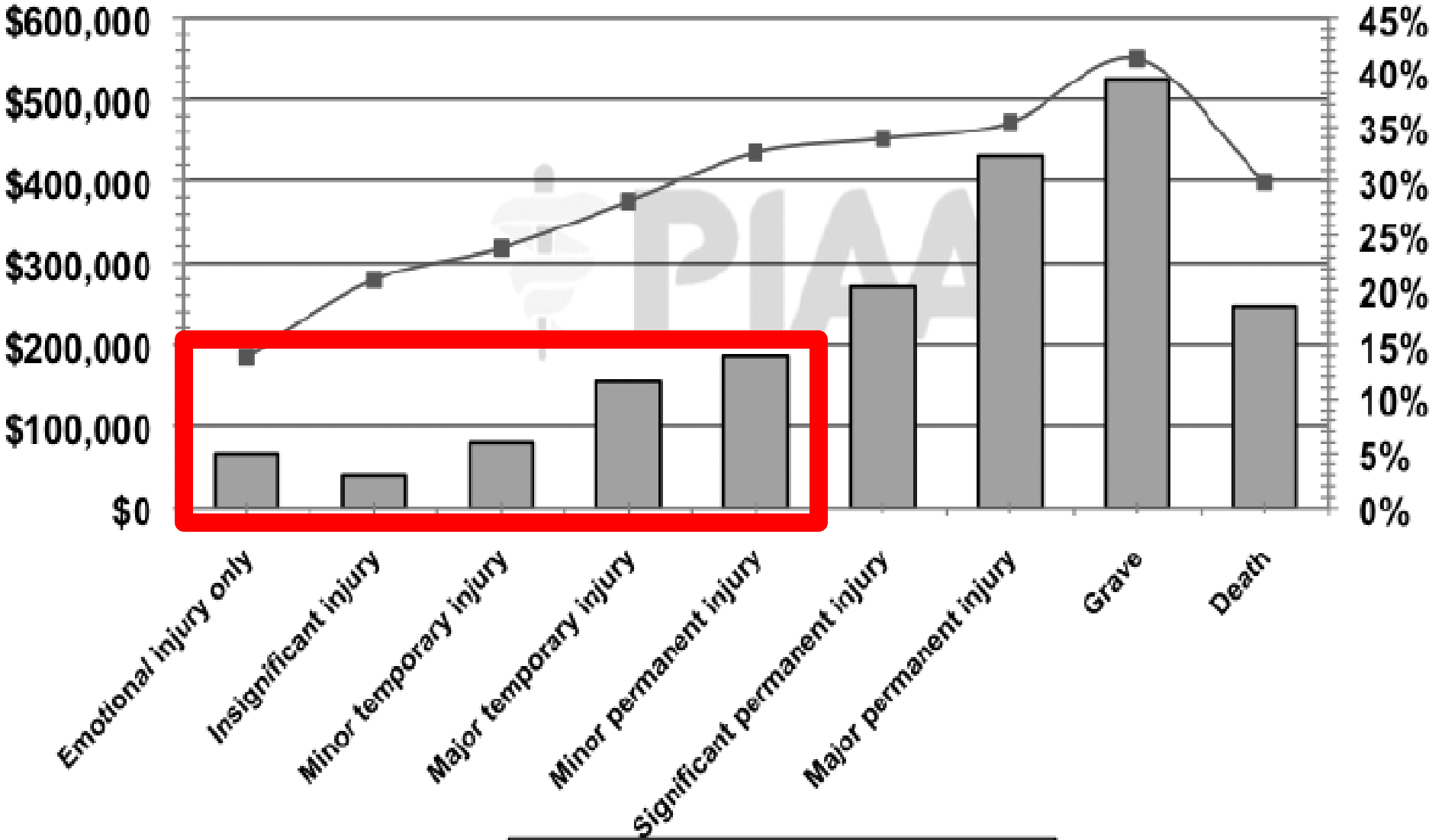

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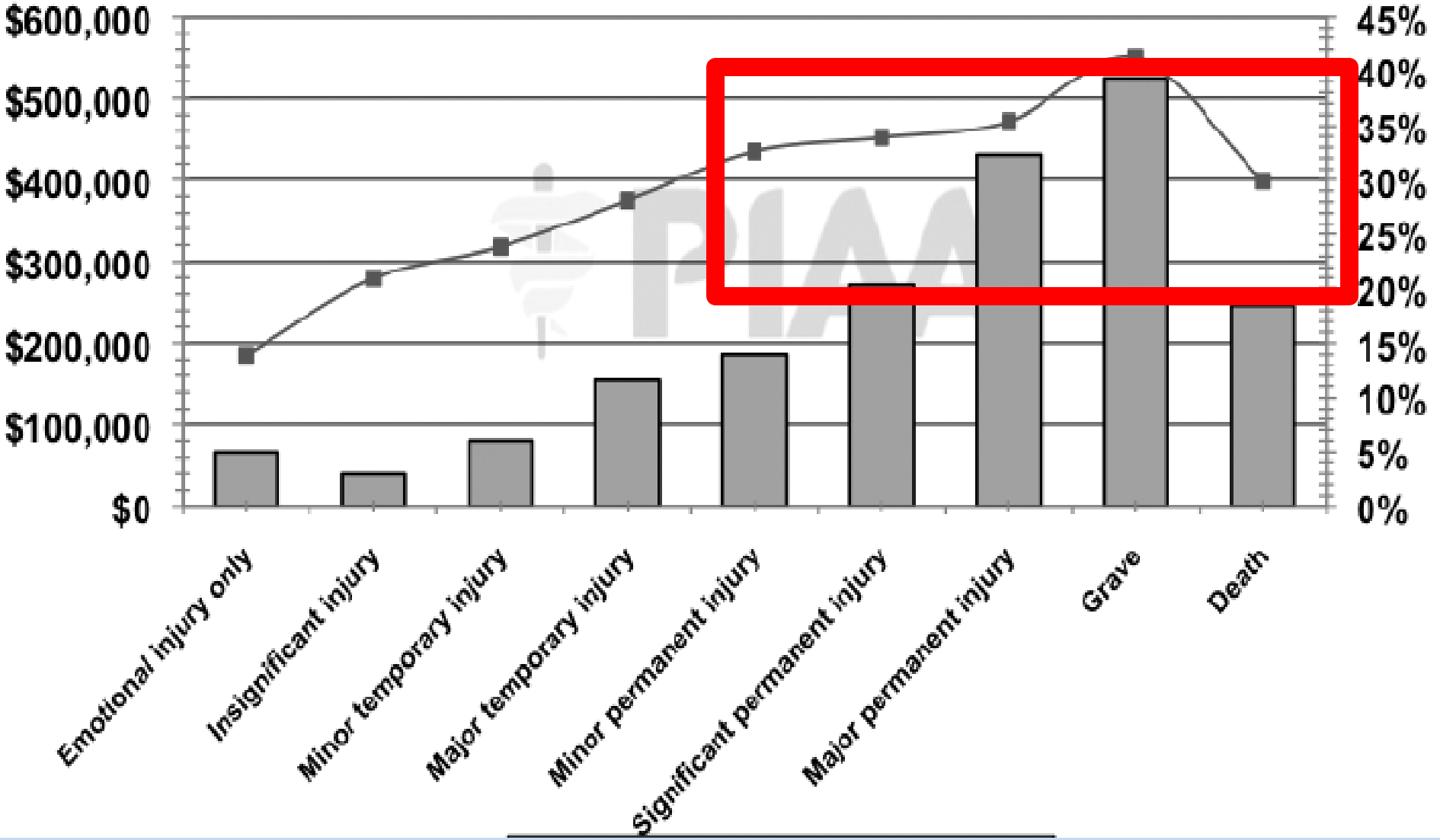
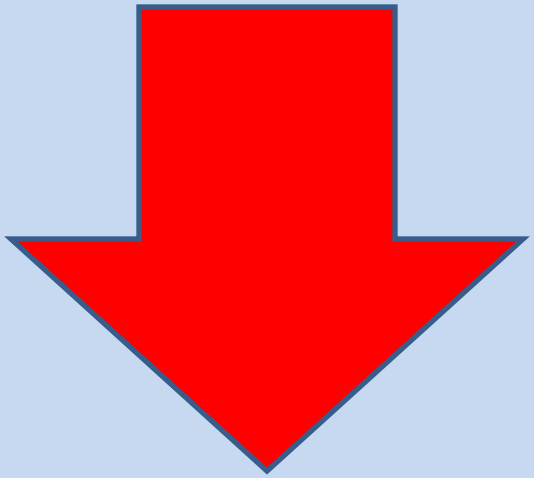


Attorney makes less



Harder for PTF to find attorney

29

Impact = yes

9. Pre-suit mediation

Traditional approach

Deny & Defend

Once a family's need for information is satisfied, and they feel an institution has responded with improvements so the problem doesn't occur again, they are **less likely** to sue

“I’m Sorry” Laws

30+ states

Protect statements, gestures showing sympathy commiseration from being used against you

Ohio Supreme Court

Complications in the gall bladder surgery of Jeanette Johnson.

Month after surgery, returned to hospital

Johnson upset and emotional over her predicament, MD took her hand and attempted to calm her by saying, “I take full responsibility for this. Everything will be OK.”

Trial Court

MD faced with distressed patient who was upset and made a statement that was designed to comfort his patient

Type of evidence the medical apology statute was designed to exclude as evidence of liability

"Something that says I'm sorry without admitting liability."

Bad: “mistake” “error” “we screwed up”

Good: convey that you are both honest and sorry for what happened

“We failed you.”

“This shouldn’t have happened”

"It may have gone better had I done something else, but I made a decision as best as I can with the information I had on hand and I'm sorry this happened."

Combine with cooling off period laws

No suit for 90 days after notify intent to sue

DRP

Disclosure & Resolution Program

1. Disclose unanticipated outcomes
2. Investigate & explain what caused them
3. Apologize
4. Offer compensation without waiting for patient to sue

University of Michigan
Health System

Monthly rate of claims (per 100,000 patient encounters) dropped

$7 \rightarrow 4.5$

Number of lawsuits per year dropped

39 → 17

Annual legal defense spending at the U-M health system **decreased** 61%

Measures to reduce claims severity

1. Damage caps

Usually just **non-economic**

Usually $250,000

Sometimes **total** damages (economic + non-economic)

e.g. VA $2m

Hurts patients with the **most agonizing injuries** (e.g. brain damage, permanent disfigurement)

Burdens the **disadvantaged** (elderly, impoverished) without high wages to recover as economic damages

2. Collateral source offset

Common law allows double recovery

Admissible: Lost wages, extra medical care paid by health or disability insurance

De facto **already** the rule because of subrogation

Impact = 0

3. Periodic payments

No one lump sum – spread out like lottery winnings

If paying for future medical care and PTF dies, can stop making payments

31

Impact = 0

4. Limit joint & several

$5m against 2 physicians but one judgment proof over $1m, can collect $4m from other

Now, liability each DEF **limited** to % fault

Impact = 0

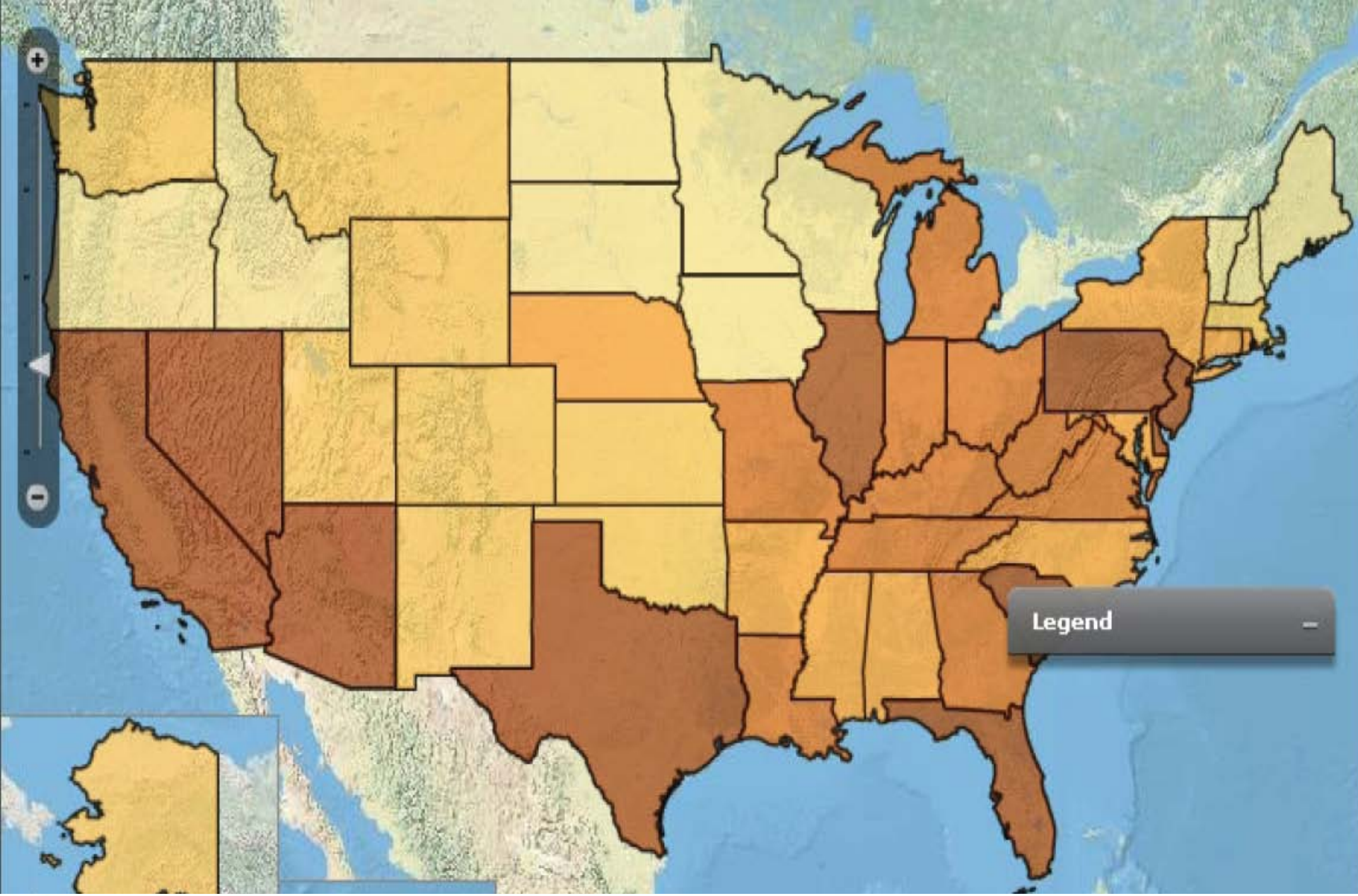
Reform	Considered	Validated	Invalidated	% Invalidate
All reforms	228	167	61	27%
Periodic payment	15	8	7	47%
Statute of limitations (and statute of limitations concerning minors)	52	30	22	42%
Statute of repose	25	17	8	32%
Collateral-source offset	22	15	7	32%
Expert pretrial affidavit / pre-notification	21	16	5	24%
Attorney fee limits	10	8	2	20%
Expert credentials / other evidence limitations	10	8	2	20%
Joint-and-several liability rule reform	17	14	3	18%
Pretrial mediation or arbitration	30	27	3	10%
Pretrial screening panel	26	24	2	8%

Measures to increase certainty

Damage caps & tight statutes of limitations – better predict claims exposure

Reduce Cost

Med Mal reform not only about **access** but also about **cost**



THE DARTMOUTH ATLAS OF HEALTH CARE

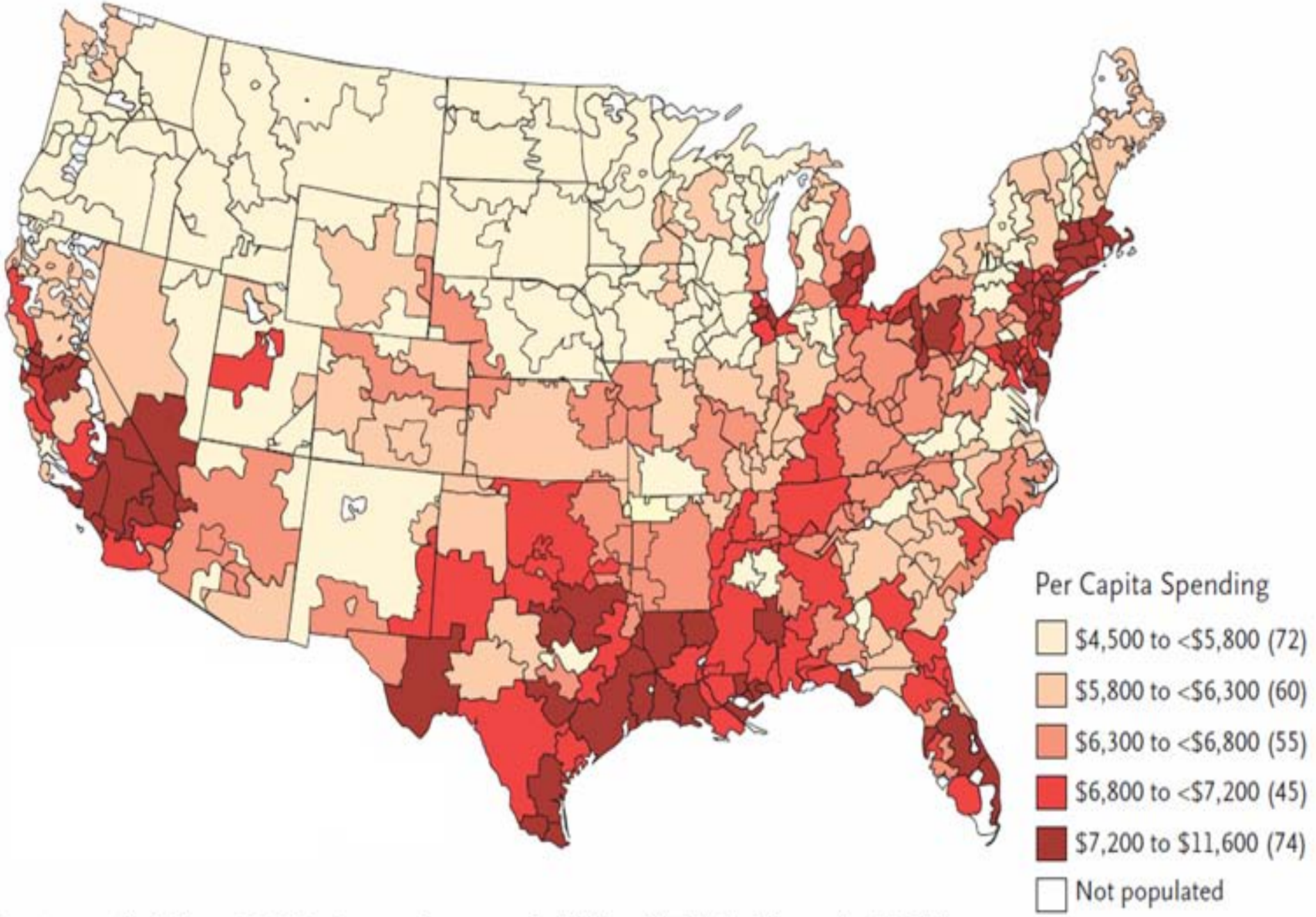
Offensive medicine

v.

Defensive medicine

Offensive Medicine


FFS



Dartmouth Atlas 2003, from Orszag & Ellis, NEJM, Nov. 1, 2007

Defensive Medicine

Defensive medicine

Do less

Do more

Defensive medicine

“avoidance tactics”

Do less

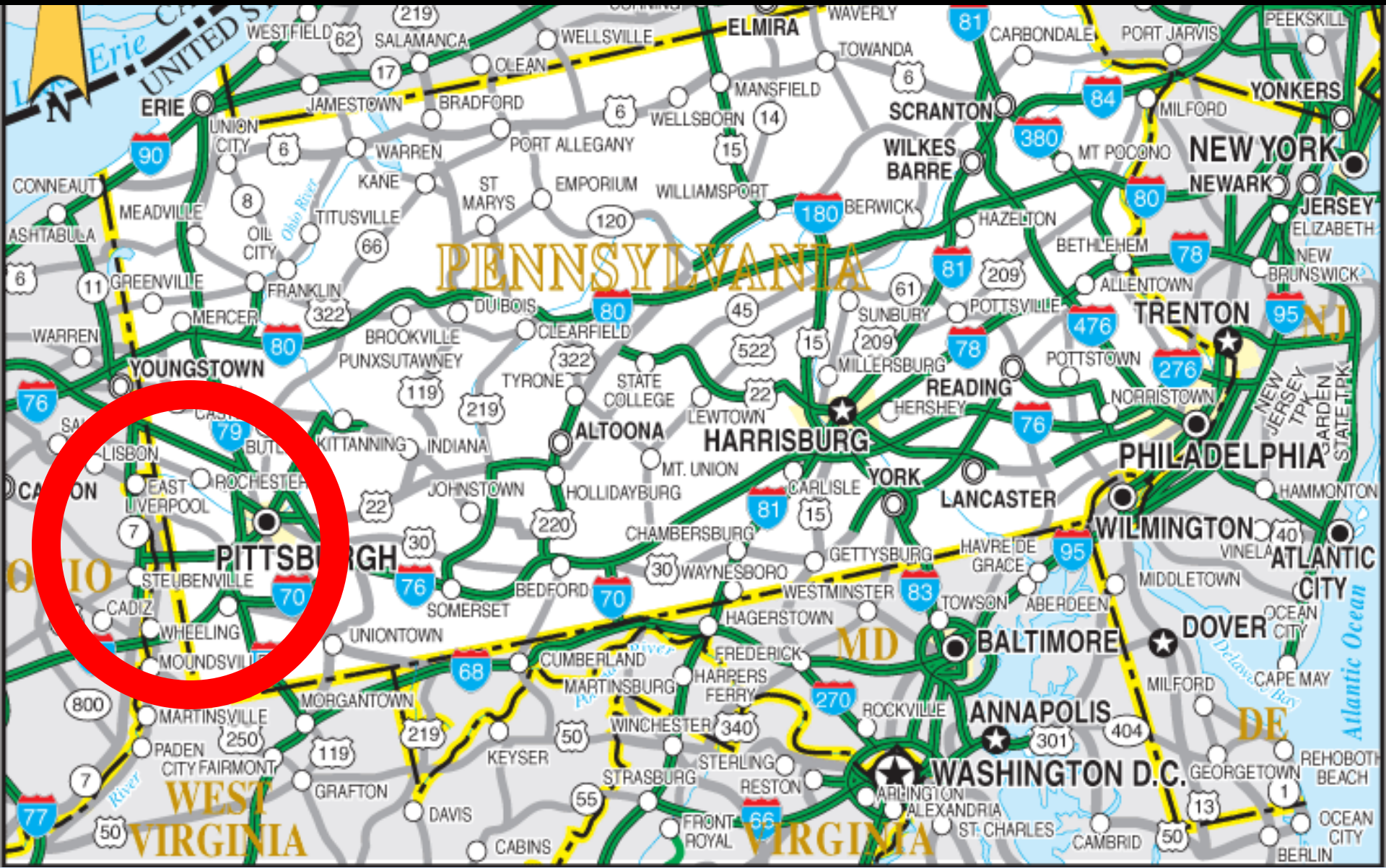
Physicians do not

- Perform some procedures
- Treat some patients
- Treat in some geographic areas

2000s

1 in 11 obstetricians in the USA stopped delivering babies

All Wheeling WV neurosurgeons left.
Trauma patients airlifted to Pittsburgh



Defensive medicine

“assurance tactics”

Do more

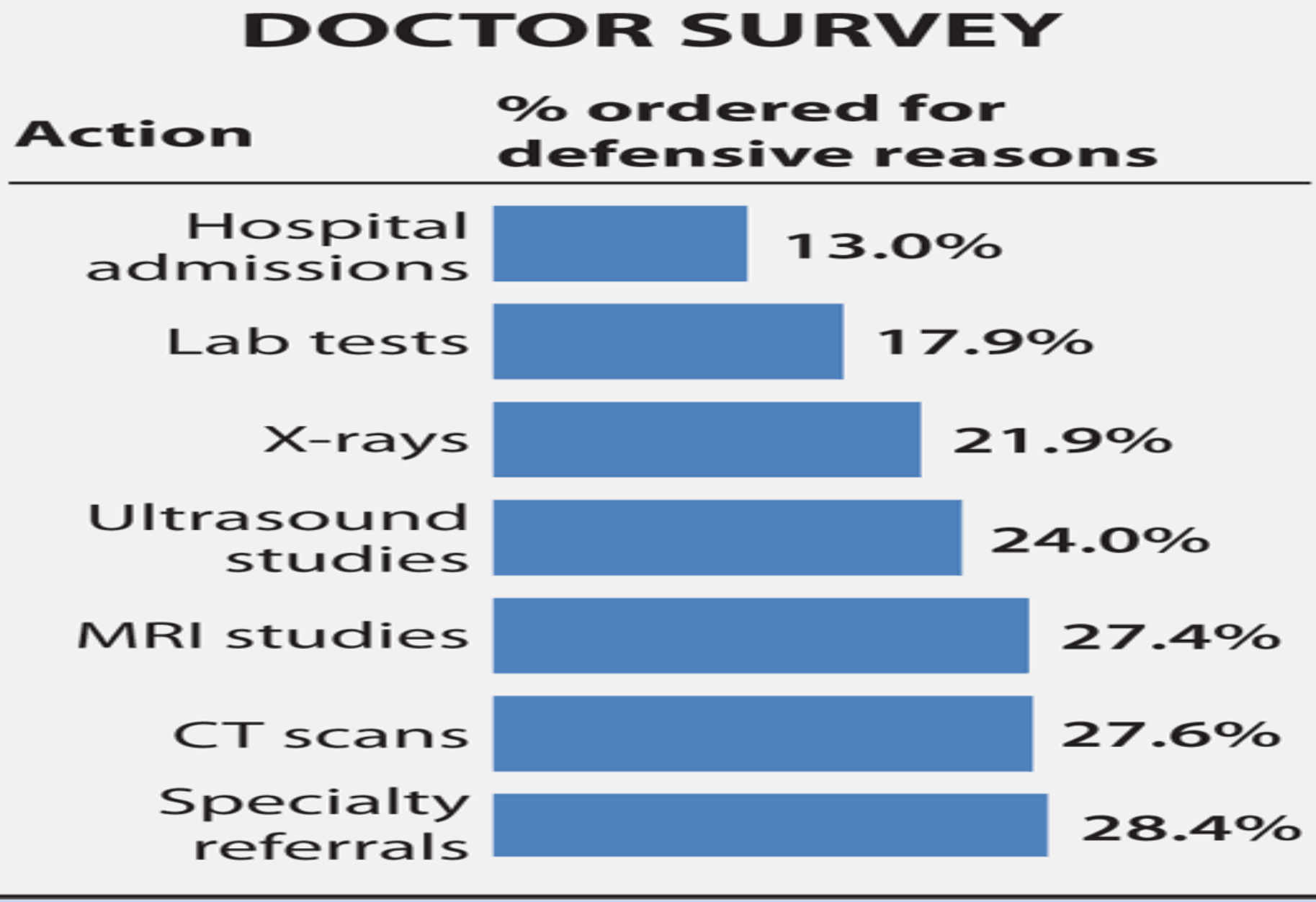
Physicians do

Unnecessary procedures

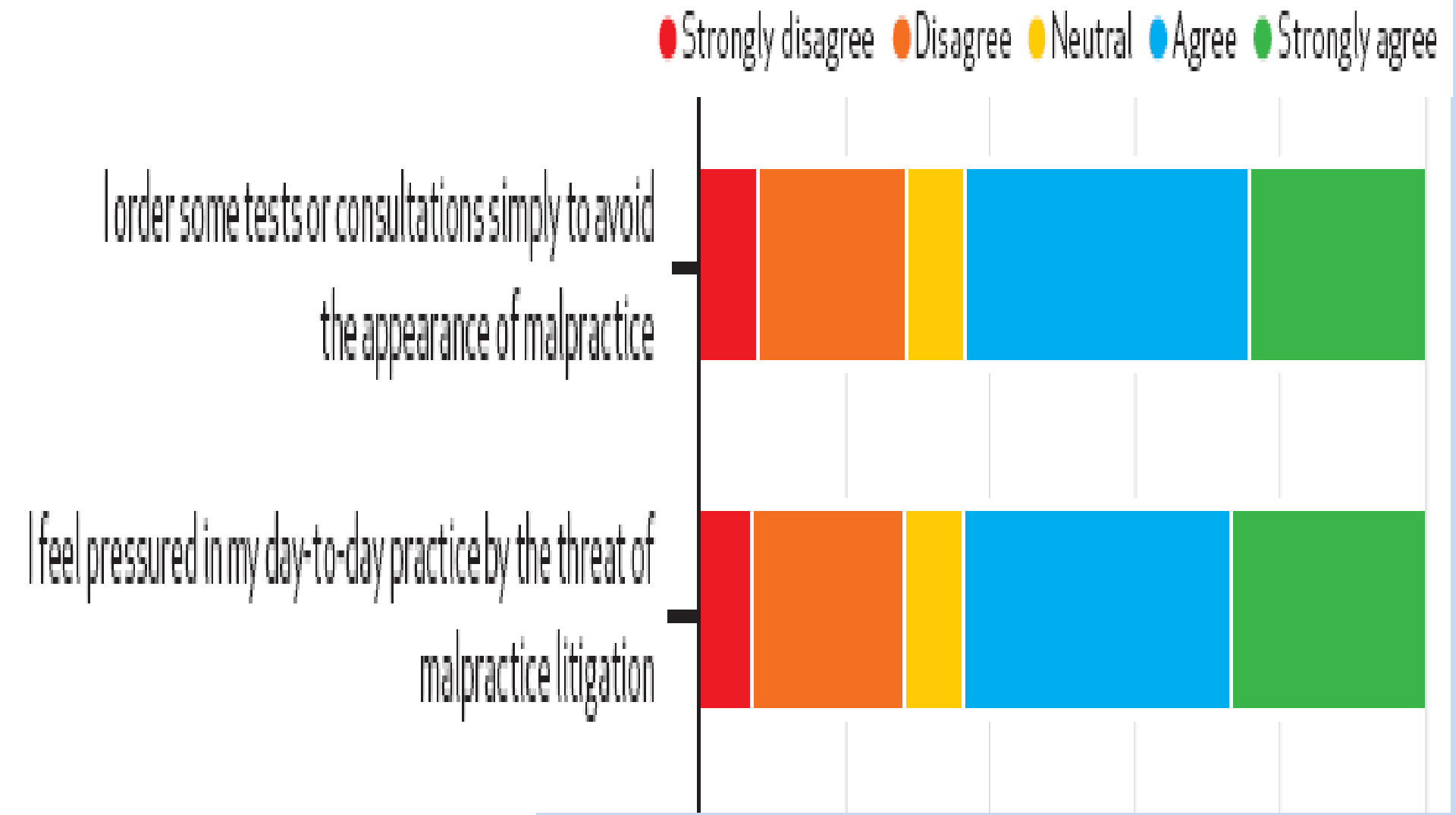
Unnecessary tests

Interventions for legal, not for medical reasons

Mass. Med. Society (Nov. 2008)



Physicians' Level Of Agreement With Items In The Malpractice Concerns Scale, 2008



HEALTH AFFAIRS 29,
NO. 9 (2010): 1585–1592

J Am Geriatr Soc 58:533–538, 2010.

Factor	Extremely or Very Important	Most Important of All Factors Listed
Patient's prognosis	98.5	12.0
What was best for the patient overall	98.1	33.2
Respecting the patient as a person	96.6	5.4
Patient's pain and suffering	94.6	12.5
What the patient would have wanted you to do	81.8	29.4
Providing the standard of care	81.5	2.2
Respecting the wishes of the family or surrogate(s)	80.9	3.3
Following the law	68.6	1.1
The burden on the family	44.8	0
Religious beliefs of the patient	35.3	0
Religious beliefs of the family or surrogate(s)	28.6	0
Cost to society of caring for the patient	14.2	0
Physician's religious beliefs	10.7	0
Concems about paying for medical care	9.3	0
Concem that the surrogate(s) might sue	8.4	1.1

Perceptions of "futile care" among caregivers in intensive care units

Robert Sibbald MSc, James Downar MD, Laura Hawryluck MD MSc

CMAJ 2007;177(10):1201-8

"Why they follow the instructions of SDMs instead of doing what they feel is appropriate, almost all cited a **lack of legal support.**"

Resolution 505-08

TITLE: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD;
William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

Reference Committee **E**

October 4-6, 2008

This resolution constitutes a proposal for consideration by the California Medical Association House of Delegates and does not represent official CMA policy.

WHEREAS, it is still common for physicians who feel non-beneficial or futile treatments are being provided or considered to feel threatened by legal action by the patient's family or other surrogates, and thus continue to provide such care against their best medical judgment; and

- In what ways is medical practice regulated other than through liability
- For what types of conduct do medical boards exert discipline

- What are the two main functions of medical licensure
- What types of conduct trigger liability under the False Claims Act

Regulation of quality OTHER than through tort liability

We spent a long time on **malpractice** liability

But that is **just one** legal tool to help ensure quality

3 other tools

Private regulation

Market forces

Licensing

1. Private regulation

Hospital credentialing

Granting, revoking, & restricting staff privileges

MCO Credentialing

Listing, delisting in networks

2. Market Forces

"It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest."

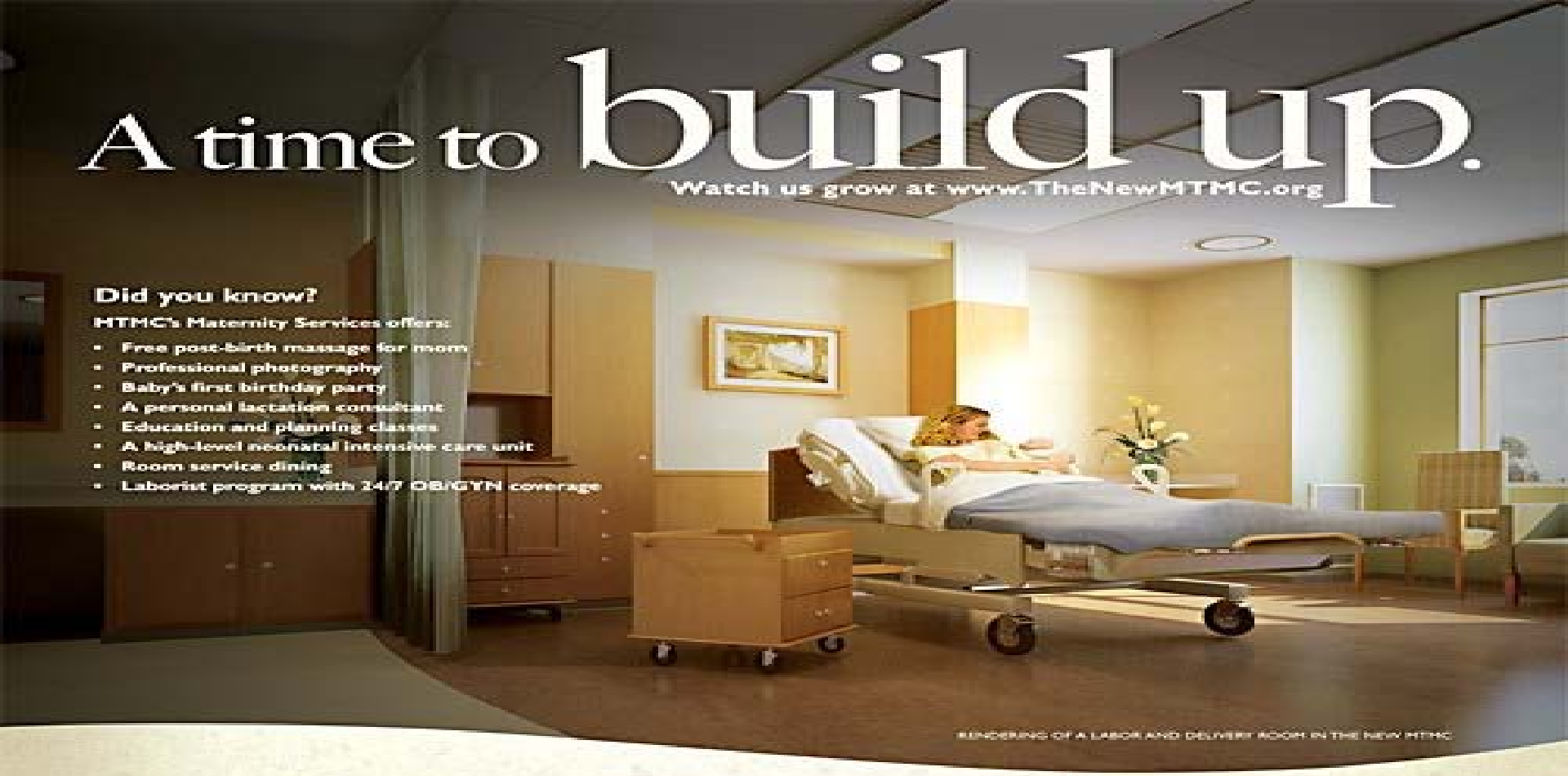
-Adam Smith-

Intellectual TAKEOUT

Brag about services

A time to build up.

Watch us grow at www.TheNewMTMC.org



Did you know?

MTMC's Maternity Services offers:

- Free post-birth massage for mom
- Professional photography
- Baby's first birthday party
- A personal lactation consultant
- Education and planning classes
- A high-level neonatal intensive care unit
- Room service dining
- Laborist program with 24/7 OB/GYN coverage

RENDERING OF A LABOR AND DELIVERY ROOM IN THE NEW MTMC

MTMC offers a safe, compassionate environment for you and your new baby. After 81 years of health care service, we look forward to providing continued care for you and your growing family as we grow with ours.

The new MTMC will provide larger patient rooms, 27 post-partum rooms, 16 neonatal intensive care beds and 11 labor and delivery rooms. With this state-of-the-art medical center, MTMC can take care of Middle Tennesseans better than ever before and for many years to come.

Middle Tennessee Medical Center

We're here for life.

Brag about outcomes


TOP 1%
IN THE NATION
BEST HOSPITALS HONOR ROLL
BEST HOSPITALS
U.S.News
HONOR ROLL
2013-14
Jefferson
University Hospital

Meet Dr. Tom Kucharchik, Family Medicine

Hampton [illegible]l Medical Center & Coastal Plains Primary Care

[illegible] to welcome **Dr. Tom Kucharchik**

He is a board certified family physician who has been practicing for more than 25 years.

Medical School: Columbia University
Residency: Medical University of South Carolina
Certifications: American Board of Family Medicine

Now Scheduling Appointments
for the week of June 24th

Call: 803.943.7612

Public reporting on quality

ZocDoc
Get well sooner.

Consumer Reports®

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vitals℠

3. Licensing

2 functions of licensing

Gatekeeper

Discipline

Gatekeeper function of licensing

Governed by state statutes

Strictly **required**

You may NOT practice profession without license

Medical school

Graduate medical education

Residency, Fellowship

USLME

Compare Accreditation

Not state government

Private sector body sets standards, gives designation

Voluntary, not mandatory like licensing

Unlike licensure, does not create an absolute barrier

Consumer can choose

You may distinguish yourself with other credentials

But still have licensure requirement

(“minimum floor”)

Harmonizes with standard of care in liability context

You can be outstanding (with great outcomes).

But must at least comply with SOC

Assume public is **incapable** of evaluating quality

Assumes accreditation not sufficient

State

v.

Miller

Charge:

Practicing medicine without license

A crime

Not just money damages

Jail

Minn. Stat. 147.081(1)

"It is **unlawful** for any person to practice medicine . . . unless . . . the person holds a valid license"

Minn. Stat. 147.081(2)

"Any person violating the provisions of subdivision 1 is guilty of a **gross misdemeanor**."

Minn. Stat. 609.02

(1) "Crime" means conduct which is prohibited by statute and for which the actor may be sentenced to imprisonment . . .

(3) "**Gross Misdemeanor**" . . . sentence [91 to 364 days]

Minn. Stat. 147.081(3)

"A person . . . is '**practicing medicine**' or engaged in the 'practice of medicine' if the person does any of the following:"

6

alternative definitions

“offers or undertakes to perform any **surgical operation** . . .”

“offers to undertake to use **hypnosis** for the treatment or relief . . . ”

“uses . . . the designation . . . medical doctor . . . **MD DO** . . .”

“**advertises, holds out** to the public, or represents in any manner that the person is authorized to practice medicine in this state”

“offers or undertakes to prescribe, give, or administer any **drug or medicine** for the use of another”

“offers or undertakes to **prevent or to diagnose, correct, or treat** in any manner or by any means, methods, devices, or instrumentalities, any disease, illness, pain, wound, fracture, infirmity, deformity or defect of any person”

Were Miller’s “patients” harmed

Defenses for Miller (unsuccessful)

Patient consent

Patient constitutional rights

Current Cases

CAM advocates

Robert Oldham Young

Internationally known proponent of alternative medicine went beyond advocating dietary changes and used intravenous “treatments” on people

Arraignment - Nov. 20, 2014

Pure greed & fraud

Keith Barton

Promised to cure cancer, HIV

Took $10k, $20k from patients

Convicted 10 felony counts
Jan. 2014

Fun


ABC NEWS

Matthew Scheidt, 18, was sentenced in Nov. 2012 to a year in jail for impersonating a physician assistant at a Florida hospital where he dressed wounds, examined disrobed patients and performed CPR.

Sex


Phillip Winikoff – door to door breast exams

Tele-medicine

MD LIVE CARE®

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24h Toll Free (1-888-632-2738)

Member Login

E-mail:

Password:

Log In

Forgot Password? | Sign-up

or

Sign-in with your Google Account

Click Here

Services | About Us | How it Works | Group Programs | Providers | HealthWatch | News & Media | Contact Us

The doctor will see you now

See a doctor or therapist when you need to, 24/7/365 from anywhere by video, phone or e-mail.

Get Started

Doctor gets jail time for online, out-of-state prescribing

The decision could give prosecutors broader reach in pursuing criminal charges in such cases.

By AMY LYNN SORREL, amednews staff. *Posted June 1, 2009.*

In a case that could have ramifications for online prescribing, a Colorado physician was sentenced to nine months in jail for prescribing an antidepressant over the Internet to a California teenager who later committed suicide.

San Mateo County prosecutors charged psychiatrist Christian Hageseth III, MD, of Fort Collins, Colo., with a single felony count of practicing medicine without a valid California license.

Scope of Practice

Miller – unlicensed for **any** health profession

Another type case is where licensed for **one** health profession but practice **another**

Medical practice act **excepts** conduct performed under another license

Nurse not practice medicine if doing nursing services - in scope of nursing practice

Tattooing

Magnetism

Faith healing

Electric hair removal

Hypnotism

Massage

Reflexology

Competition OR consumer protection

Licensing is not just about protecting patients

It is also about establishing economic domains

Hundreds of bills

APN - anesthesia

Psychologist – prescribe

Pharmacist – prescribe

Midwifery

Chiropractor - inject

Pharmacists provide more direct care

Convicted: Emily Hyatt Medwin

NC only allows certified nurse midwives, not Certified Professional Midwives

North Carolina Board of Dental Examiners

vs.

Federal Trade Commission


VICTORIA'S SECRET
BleachBright
www.bleachbright.com


SONY

Board

Teeth whitening is **part** of dentistry

Therefore **off-limits** to rival kiosks

Board sent **cease-and-desist** letters to several dozen non-dentists, ordering them to **stop** offering cosmetic teeth-whitening services

Discipline function of licensing

Not only assure competence at **front** end

But also weed out bad apples **after** already licensed

Bases for discipline

STATE OF WISCONSIN

DEPARTMENT OF SAFETY & PROFESSIONAL SERVICES

MEDICAL EXAMINING BOARD
FINAL DECISIONS and ORDERS HISTORICAL DATA ANALYSIS

(Based on data from January 1, 2003 – December 31, 2013)

Med 10.03(2) Direct Patient Care Violations

Med 10.03(2)(d) Performing or attempting to perform any surgical or invasive procedure on the wrong patient, or at the wrong anatomical site, or performing the wrong procedure on any patient.

Disciplinary

- Maximum: Surrender
- Minimum: Reprimand

Total	Discipline	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003
2	Reprimand								1			1
1	Reprimand*		1									
2	Reprimand; Limitation requiring education/testing*				1			1				
2	Surrender*	1					1					
1	Suspension (Stayed); Limitation requiring education/testing, mentor/supervision, reports, restricting practice*		1									
1	Suspension (Stayed); Limitation requiring treatment*							1				
9	Total	1	2	0	1	0	1	2	1	0	0	1

Med 10.03(2)(b) Departing from or failing to conform to the standard of **minimally competent medical practice** which creates an unacceptable risk of harm


Dr. Michael Kamrava

Medical board “triggers” from **other** legal obligations

Malpractice

Abandonment

Alcohol/drug

Aiding unlicensed practice

Incompetence

Fail to report (crim, malpr, priv)

Character

Reciprocal

Character

Arthur K. Zilberstein - sexting during surgery

Quack, greed, money


Stanislaw Burzynski, M.D., Ph.D.
Burzynski Research Institute, Inc., Burzynski Clinic

Stanislaw Burzynski claims to have much better results treating deadly brain cancers than conventional oncology, even though he is not an oncologist

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-12-1342
LICENSE NO. D-9377

IN THE MATTER OF THE	BEFORE THE
COMPLAINT AGAINST:	
STANISLAW R. BURZYNSKI, M.D.	TEXAS MEDICAL BOARD

FIRST AMENDED COMPLAINT

TO THE HONORABLE TEXAS STATE MEDICAL BOARD AND THE HONORABLE ADMINISTRATIVE LAW JUDGE TO BE ASSIGNED:

COMES NOW, the Staff of the Texas Medical Board (Board staff), and files this Complaint against Stanislaw R. Burzynski, M.D., (Respondent), based on Respondent's alleged violations of the Medical Practice Act (Act), Title 3, Subtitle B, Texas Occupations Code, and would show the following:

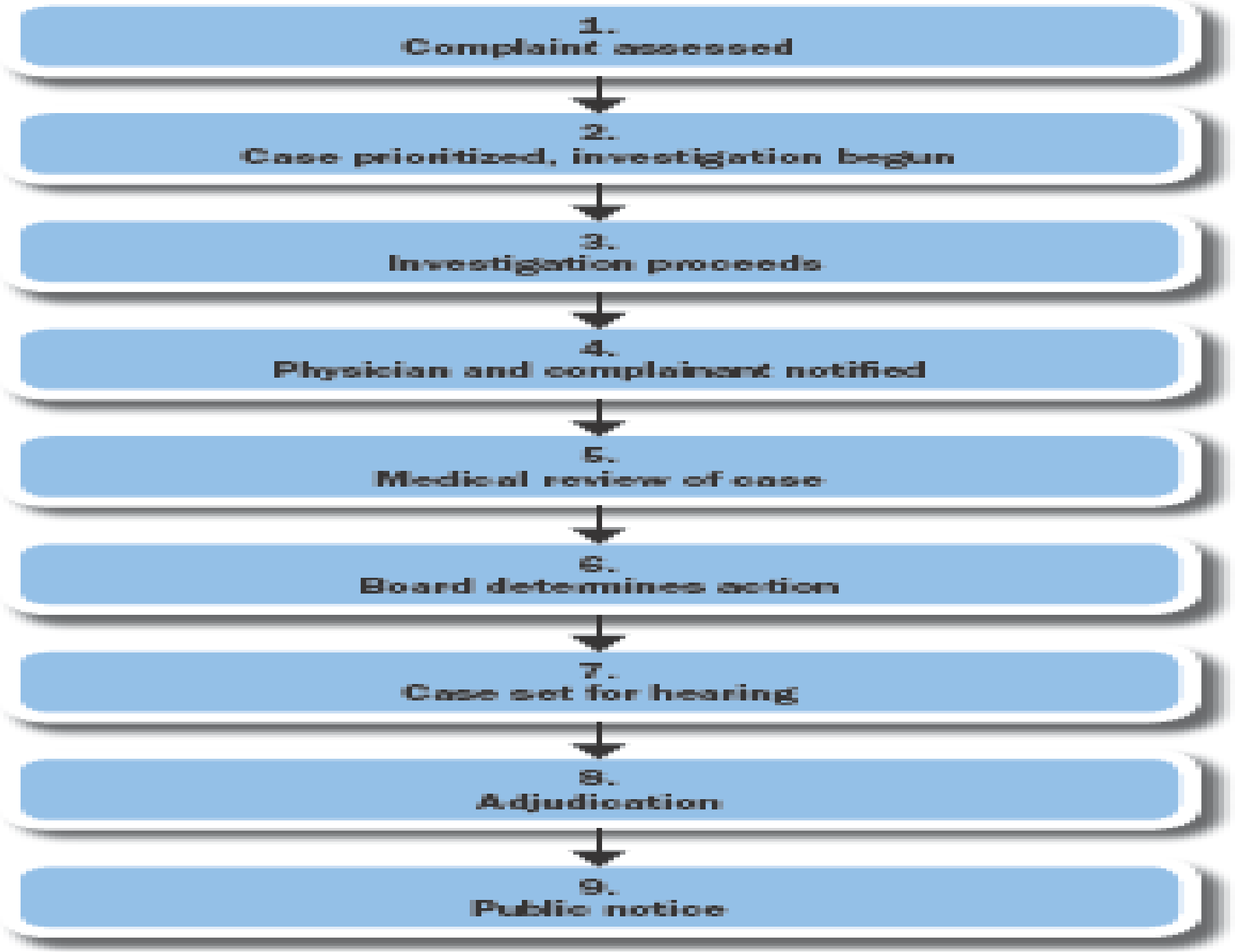
Crimes


Earl Bradley (Del. 2010)

Joshua Baron

“Need Addreall or Xanax? Let me know what you are willing to do in exchange… please send a pic.”

Convicted Chicago Aug. 2014


1.
Complaint assessed
2.
Case prioritized, investigation begun
3.
Investigation proceeds
4.
Physician and complainant notified
5.
Medical review of case
6.
Board determines action
7.
Case set for hearing
8.
Adjudication
9.
Public notice

Types of discipline

Federation of STATE MEDICAL BOARDS

U.S. Medical Regulatory Trends and Actions

May 2014

Physicians with an Active License to Practice Medicine in the United States and the District of Columbia, 2010 and 2012	2010		2012	
	Counts	Percentages	Counts	Percentages
Total	850,085	100.0%	878,194	100.0%
Degree Type				
Doctor of Medicine (MD)	789,788	92.9%	812,019	92.5%
Doctor of Osteopathic Medicine (DO)	58,329	6.9%	63,045	7.2%
Unknown	1,968	0.2%	3,130	0.4%
Gender				
Male	568,501	66.9%	578,478	65.9%
Female	246,314	29.0%	264,846	30.2%
Unknown	35,270	4.1%	34,870	4.0%
Certified by an ABMS Specialty Board				
Yes	633,733	74.5%	671,755	76.5%
No	216,352	25.5%	206,439	23.5%

State Medical Board Actions	2012
Total state medical board actions	9,219
Board actions by category*	
License restricted	1,480
Reprimand	1,224
Fine	995
Administrative action	949
Probation	913
License suspended	907
CME required	819
License surrendered	511
Conditions imposed	465
License revoked	299
License denied	170
Other	487

CMS mandatory & discretionary exclusions

Separate from license under state law

Decision about whether physician may participate in **federal healthcare programs**

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

November 4, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Tavenner:

We are writing to express our concerns that the Centers for Medicare & Medicaid Services (CMS) has not taken sufficient steps to screen Medicare providers who pose a risk to beneficiaries and taxpayers.

The Social Security Act requires CMS to exclude individuals from participation in any federal health care program, including removal from the list of authorized Medicare providers, if they have been convicted of Medicare-related crimes, patient neglect or abuse, or felonies related to health care fraud or controlled substances.[1] Yet, disturbingly, it appears that at least some individuals convicted of such offenses may continue to remain on the list of eligible providers.

We know that you share with us a strong commitment to reduce waste and fraud in the Medicare system. CMS has taken strides to improve its screening of its list of providers, including physicians, authorized to charge Medicare for health care services. However, some recent analysis performed by our offices raises serious questions as to whether current provider screening is adequate. We are concerned, moreover, that the examples identified by our analysis may be illustrative of a larger problem.

Specifically, we were able to readily identify at least 16 physicians who are enrolled in the Medicare program, and who have been convicted of a crime that requires CMS to exclude the individual from participation in Medicare or any other federal health care program (see Attachment). These examples were not the result of a complete analysis of every provider, but do represent cases easily identified using open sources.

To enable Congress to better understand CMS's current efforts to take action against providers who are convicted of crimes that are supposed to result in mandatory exclusion from Medicare, please provide our offices with the following answers and information:

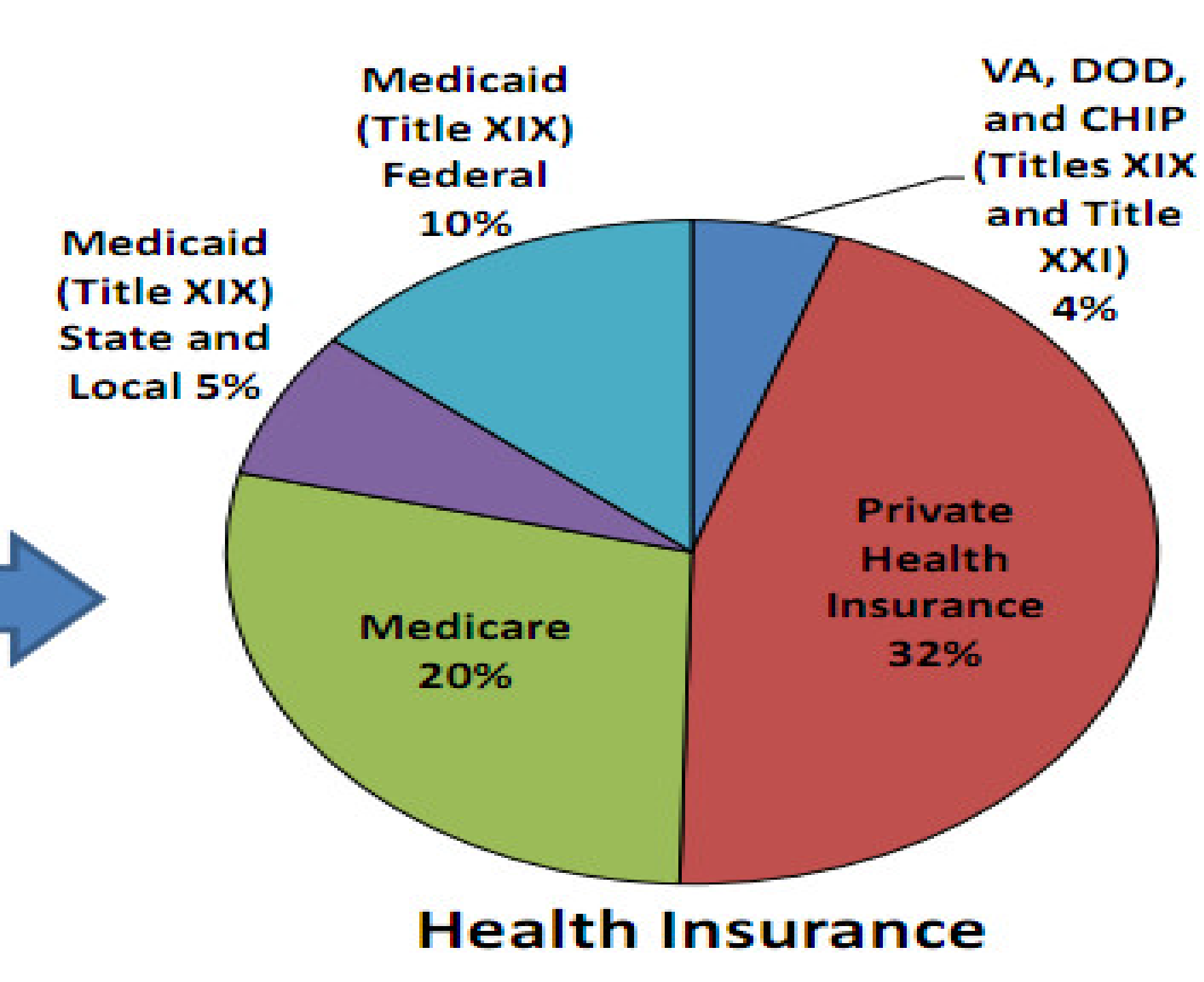
1) Describe the criteria, process, and timeframes for disenrolling such providers (i.e., who is disenrolled from the program, who is not, and why)?

2) Has CMS established interagency agreements with other federal and state agencies to ensure that it receives felony conviction information in a timely manner?

Fraud & Abuse

So far, we have focused on liability relating to **patient care**

Liability relating to billing the USGOV



Health Insurance

False Claims Act

Defense contractors billing Union Army

- Dead mules
- Boots with soles glued on, rather than stitched (and coming apart in the rain and mud)
- Gunpowder salted down with sawdust

Type of fraud alleged
Health care
Procurement
Miscellaneous[1]
Grant program
Subsidy program
Housing
Student loan
Welfare program
Scientific
Other bribery
Non-housing loan
Highway
Veterans benefits
Overseas bribery

HHS and DOD Agencies More Frequently Named as Allegedly Defrauded

HHS and DOD agencies were more frequently named than other agencies as allegedly defrauded in qui tam cases DOJ received. HHS agencies were named 54 percent of the time and DOD agencies were named 29 percent of the time of the total 5,129 qui tam cases DOJ received from fiscal year 1987 through 2005.

Number of Qui Tam Cases Listed by Allegedly Defrauded Agency, Fiscal Years 1987 through 2005

Fiscal year	HHS	DOD	Other agencies
1987	4	18	12
1988	9	36	20
1989	15	40	46
1990	12	45	33
1991	13	50	38
1992	17	64	57
1993	39	55	66
1994	80	96	105
1995	94	103	134
1996	204	135	163
1997	298	146	366
1998	287	78	168
1999	310	109	153
2000	223	77	165
2001	180	74	134
2002	197	72	122
2003	217	78	136
2004	276	99	180
2005	270	97	184
Total	**2,745**	**1,472**	**2,282**

Any federal program

- Medicare
- Medicaid
- CHAMPUS (Tricare)
- FEHBP

Penalties

Civil penalty not less than $5,000, not more than **$11,000**

Plus **3 times** the amount of damages which the Government sustains

You submit a false claim for $200 procedure

Treble damages = $600

Penalty = $11,000

TOTAL = $11,600

Possible Medicare **exclusion**

Domino cascade effect of sanctions

Criminal

Civil

Federal

State

Administrative/regulatory

Private

State licensure board

Big GOV priority

Over $30 billion and counting

High penalties

Easy proof

Who prosecutes

DOJ

CMS OIG

State AG

Private whistleblower

FIVE HUNDRED DOLLARS

REWARD!

WELLS, FARGO & CO.

WILL PAY

FIVE HUNDRED DOLLARS,

For the arrest and conviction of the robber who stopped the Quincy Stage and demanded the Treasury Box, on Tuesday afternoon, August 17th, near the old Live Yankee Ranch, about 17 miles above Oroville. By order of

J. J. VALENTINE, Gen'l Supt.

Oroville, August 18, 1875.

RIDEOUT, SMITH & CO., Agents.

GOV lacks resources to ferret out all the fraud

FCA often enforced by

Insiders

Spouses

Former business partners

Former (esp. **disgruntled**) employees

Recovering **on behalf of** GOV

But get a “reward”

Qui Tam Recoveries

Mean: $10,028,482

Median: $784,597

Qui Tam Recoveries, Fiscal Years 1987 through 2005

Settlement and judgment amounts[1]	Number
under $50,000	77
$50,000 to $100,000	54
$100,001 to $500,000	187
$500,001 to $1,000,000	87
$1,000,001 to $5,000,000	182
$5,000,001 to $10,000,000	57
$10,000,001 to $50,000,000	63
$50,000,001 to $100,000,000	15
$100,000,001 to $1,000,000,000	18
Total	**740**

Relator Share of Qui Tam Recoveries

Mean: $1,700,153

Median: $123,885

Total Relator Share Amounts of Qui Tam Recoveries, Fiscal Years 1987 through 2005

Relator share of settlement or judgment amounts[1]	Number
0	36
$1 to $10,000	65
$10,001 to $50,000	153
$50,001 to $100,000	82
$100,001 to $500,000	200
$500,001 to $1,000,000	71
$1,000,001 to $5,000,000	97
$5,000,001 to $10,000,000	19
$10,000,001 to $50,000,000	23
$50,000,001 to $100,000,000	4
Total	**740**

Recovery Audit Contractors

www.cms.hhs.gov/RAC

What's prohibited

31 U.S.C. § 3729(a)(1)(A)

Any person who — knowingly presents, or causes to be presented, to . . . a false or fraudulent claim for payment or approval . . . is liable to the United States Government

3 basic elements

1. **Claim** – submitted for payment by USGOV

2. **False** or fraudulent

3. Person "**knew**" (probably) false

Falsification

Overutilization

Falsification

Basically, care that was never even provided

Overutilization

Basically, care that may have been provided but was not medically warranted

Falsification

Billing for services **never** performed

Billing for brand-named drugs when generic drugs used

Physician billing for service provided by RN, PA

Upcoding – code for 45 min when saw for 30

14. DATE OF CURRENT: MM | DD | YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM — TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM — TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . __
2. ____ . __
3. ____ . __
4. ____ . __

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 18 11								90844								
1 19 11								90844								

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

PHYSICIAN OR SUPPLIER INFORMATION

Overutilization

Procedures were provided

Were billed under correct code

BUT procedures were not medically necessary

Unnecessary procedures, including removing teeth, x-rays, pulpotomies

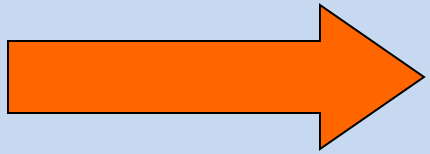
→ $24 million settlement

Small Smiles illustrates that while the primary FCA objectives are

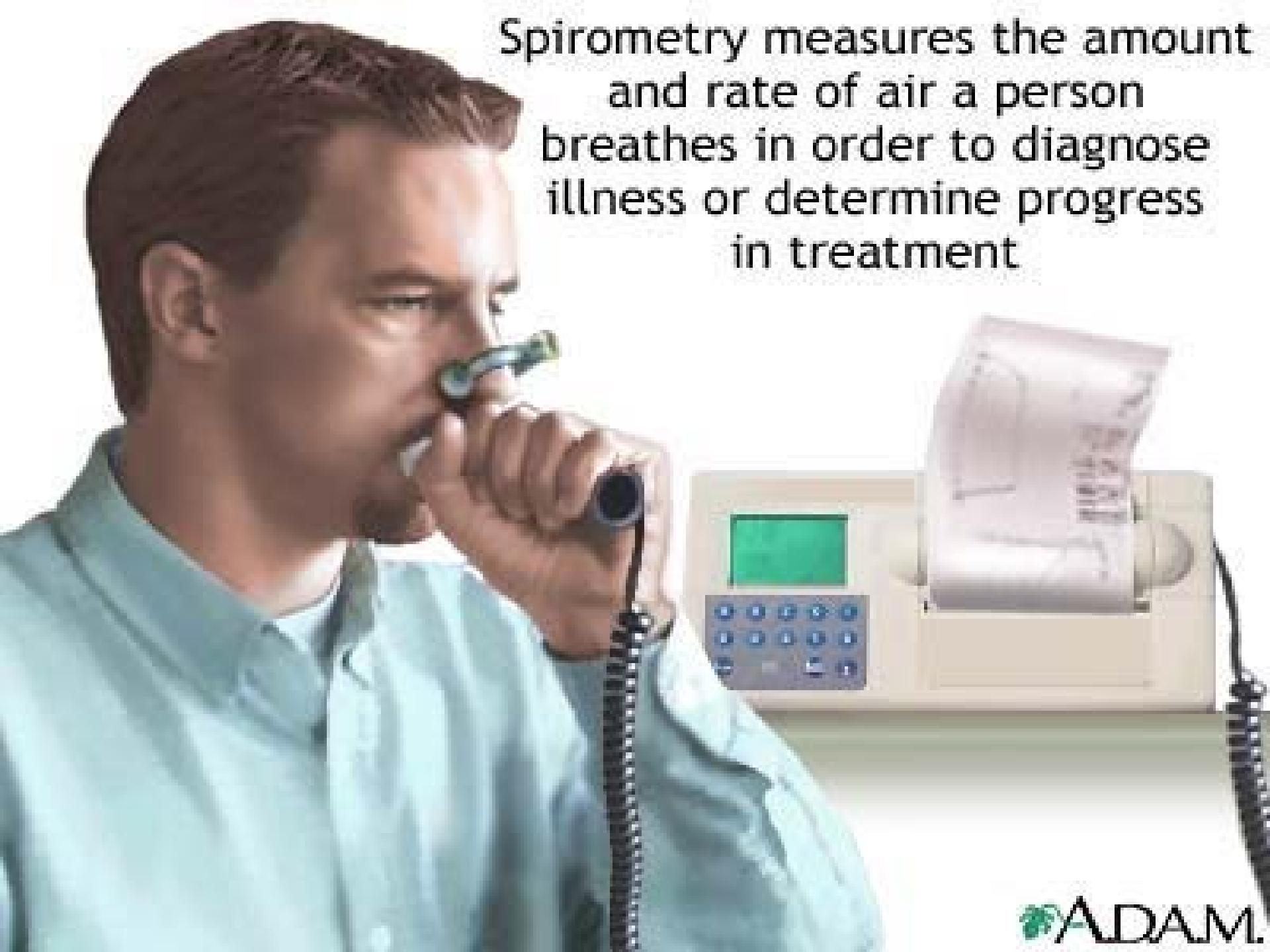
(1) to recover money and

(2) to deter fraud

a byproduct is deterrence of bad medicine

Quality  Falsity

If healthcare is of really low quality, then not “really” provided


Spirometry measures the amount and rate of air a person breathes in order to diagnose illness or determine progress in treatment
A.D.A.M.