Dynamic Chiropractic

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Health Fraud or "Covert Advocacy?"

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The results of an extremely interesting study on deceptive reimbursement practices have just been released.[1] The authors surveyed 1,124 MDs to determine if they had used any or all of three tactics within the past year:

1. exaggerating the severity of patients' conditions;
2. changing patients' billing diagnosis;
3. reporting signs and symptoms that patients did not have to help the patients secure coverage for needed care.

Thirty-nine percent of the MDs admitted they had "very often, often or sometimes engaged" in these deceptive practices, numbers certain to send the insurance world spinning - or perhaps the insurers already know the extent of these abuses. However, the study also revealed that these tactics are on the rise. When asked if they used "deception of third-party payers to obtain needed benefits for patients" more, or less often than they did five years ago, 54 percent responded "more often."

Even more enlightening were the comments made by the authors. As you read them, please substitute "doctors of chiropractic" or yourself where you see "physicians":

"As shown in Table 2, 28.5 percent of physicians agreed with the statement, "Today it is necessary to game the system to provide high quality care" and 15.3 percent agreed with the statement, "In general, it is ethical to game the system for your patients' benefit. These two items were strongly associated (X216 = 187.5; P<.001); among those who believed that gaming the system is necessary, 42.9 percent believed it was ethical.

"In a multivariate model, the belief that gaming the system was necessary to get patients needed care, more requests from patients to deceive payers, believing that visit lengths were too short to get everything done that they needed to do, and having more than 25 percent of one's patients covered by Medicaid were independently and significantly associated with having manipulated reimbursement rules in the last year.

"Since the financial and health-related interests of patients and physicians can coincide, it is impossible to completely separate these motivations. However, two aspects of our findings suggest that financial self-interest is not the sole motivation for most physicians who manipulate reimbursement rules. First, manipulation of reimbursement rules was most common in the situation in which an individual physician could not possibly provide free or reduced-cost care (i.e., hospitalization). Physicians may reserve gaming the system for situations in which free care cannot be offered. Second, to our surprise, we found no association between manipulation of reimbursement rules and any of the financial markers we examined, such as proportion of income at risk, principal type of reimbursement (fee for service vs capitation or salary), or recent practice-related income

losses.

"Yet, although the AMA and others have consistently opposed the manipulation of reimbursement rules, regardless of intent, and though more physicians agree with this position, some nevertheless appear to view this advice as untenable given their immediate patient care obligations. Moreover, in the face of the current crackdown on fraud and abuse, it is interesting that worry about prosecution for fraud did not seem to inhibit physicians from manipulating reimbursement rules... among physicians who see it as the only feasible way to provide high-quality care.

"Bending the rules for patients to provide a high-quality standard of care may be seen as an act of beneficence, or mercy, which is also ethically compelling. While insurance policies are contracts between patients and insurers, our findings suggest that some physicians believe that strictly enforcing these contracts is contrary to their professional role as patients' agents and caregivers.

"Physicians are thus caught in two sets of conflicting demands. Legally, physicians are contractually bound to adhere to reimbursement policies yet are also liable for failure to deliver an equally high standard of care to all patients, regardless of ability to pay. Ethically, physicians are caught between the compelling principles of social justice on the one hand and beneficence, or mercy, on the other. We can document the effects of these tensions and perhaps find ways to alleviate them, but the question no empirical study can answer is, 'When, if ever, is it 'good' for a contract to be broken in a surreptitious act of mercy?'

"Without answering this question, our findings still have several practical implications. As pressures to control health care costs increase, it is likely that manipulating reimbursement systems will increase in parallel. Efforts to more tightly control utilization will likely increase physicians' perceived need to manipulate reimbursement rules to provide high-quality care and will increase patients' requests for the services being controlled. Further attempts to reduce physician reimbursement will put pressures on physicians to increase patient volumes, necessarily reducing the time physicians and patients spend with each other. Our findings suggest that such conditions will be associated with more covert manipulation of reimbursement rules, and that enforcement of fraud and abuse statutes will not alleviate this."

It is truly refreshing to read a study in which the authors take an honest look at our health care system and can admit that it doesn't work. The only real question is, what do we do until the system is fixed, if ever?

Reference

1. Wynia MK, Cummins DS, VanGeest JB, Wilson IB. Physician manipulation of reimbursement rules for patients. *JAMA* 2000;283:1858-1865.

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