Falsifying Medical Records

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Fraud in healthcare refers to intentional deception or misrepresentation to gain unauthorized benefits, such as financial gain, to the detriment of the healthcare system or individuals involved. It involves knowingly and willfully engaging in dishonest practices. As the Compliance Officer, I received a hotline complaint alleging that Dr. Spine was falsifying medical records. Following a thorough investigation, I discovered multiple violations of policies and regulations committed by Dr. Spine. The most significant violations involve. Falsifying diagnosis codes to qualify patients for unnecessary lead-less pacemakers, owning stock in the medical device company that manufactures these pacemakers, and receiving payments from a surgical group for each referral. Further implications will be processed based on other case study rulings and the significance of fraud. Upon completing a comprehensive investigation into the allegations against Dr. Spine, it is evident that several severe violations of policies and regulations have occurred. These violations compromise the integrity of patient care and raise ethical and legal concerns within our healthcare organization.

****Violations of Policies and Regulations****

****Falsifying Medical Records:**** Falsification and tampering come in many forms. These include removing a diagnostic report, inserting information without standard documentation, rewriting, or destroying the record, omitting significant facts, or creating records for nonexistent patients or staff (McMacken, 2023). Dr. Spine's falsifying diagnosis codes to qualify patients for lead-less pacemakers severely violates medical ethics, healthcare regulations, and the organization's policies. Falsifying medical records breaches patient trust and jeopardizes patient safety by subjecting them to unnecessary medical procedures.

****Conflict of interest:**** Dr. Spine's stock ownership in the medical device company that manufactures lead-less pacemakers presents a significant conflict of interest. This conflict of interest raises concerns about the objectivity of Dr. Spine's medical decisions, as financial gains may influence patients' choice of medical treatments. Maximizing patient appointments may also be an example of a conflict of interest if it is intended to earn more money and spend less time on each patient. Sometimes, it is against the patient's autonomy of thought, decision-making, and action regarding health care (7-9) (Farhud & Zokaei, 2022).

**IMPROPER REFERRAL BONUS:** Dr. Spine's acceptance of payments from the surgical group for each referral violates anti-kickback laws and conflicts with the organization's referral policies. This practice compromises the integrity of patient referrals and may lead to unnecessary surgical procedures. The Anti-Kickback Statute targets any remunerative scheme that intends to induce or reward referrals for items or services reimbursed by federal healthcare programs (Defining "Referral" in the Anti-Kickback Statute, n.d.).

 **CORRECTIVE ACTION RECOMMENDATIONS**

**Immediate Suspension and Investigation:** Considering the severity of Dr. Spine's violations, immediate suspension from all clinical duties is recommended. An internal investigation team comprising legal, compliance, and medical experts, should thoroughly examine the extent of the violations and their potential impact on patient care.

**Report to Relevant Authorities:** As per legal requirements, the organization must report these violations to appropriate regulatory bodies, such as the state medical board and the Office of Inspector General (OIG).

**Termination of Employment:** Based on the investigation findings, the organization should take appropriate disciplinary action, including termination of Dr. Spine's employment if the violations are substantiated.

**Patient Safety Measures:** Patients who received the lead-less pacemakers without legitimate medical need should be identified and their medical conditions re-evaluated. Corrective measures, including pacemaker removal, should be discussed with the patients if necessary.

**Monetary impact:** Based on investigation findings, Dr. Spine could pay fines that adequately measures up to the crimes. Fines could be measured by the harm done to the recipients of these unneeded pacemakers paying for any future or past care they received related to the pacemaker.

 **CASE STUDIES TO SUPPORT RECOMMENDATIONS**

**Case 1**

A Pennsylvania nurse formerly employed at a senior living facility pled guilty to neglect of a care-dependent person and tampering with medical records. A patient under the nurse's care was left in the facility's lobby and died hours after suffering a fall and a severe head injury. This case is a tragic example of the serious consequences that can arise from neglect and falsification of medical records in a healthcare setting. The nurse's actions resulted in losing a patient's life and violated the trust and responsibility of caring for vulnerable individuals in senior living facilities. The patient had an unattended fall at the facility on April 12, 2018, and the evidence showed that the nurse neglected to perform eight necessary neurological checks on him. He was found dead just after 7:00 a.m. on April 13, 2018, due to a subdural hematoma (Admin, 2022).

The failure to administer required neurological checks after a fall highlights a fundamental breach of patient safety protocols. These checks are critical for assessing a patient's condition and determining appropriate interventions, especially in cases of head injuries. The fact that the nurse falsified documentation further demonstrates a disregard for the patient's well-being and an attempt to cover up her neglectful actions.

The legal consequences, while significant, also reflect the gravity of the situation. The nurse's guilty plea and subsequent sentencing, including house arrest and a prohibition from seeking reinstatement of her license or working in care facilities, clearly show that such behavior will not be tolerated. The case shows how Dr. Spine falsifying documentation could be detrimental to the patient because of falsified issues the patient did not have. Dr. Spine had no regard for the long-term implications his actions could have on his patients, that trusted him to do things in their best interest.

**Case 2**

The case involving Reliance Medical Systems LLC and its owners, Bret Berry and Adam Pike, sheds light on the importance of upholding ethical and legal standards within the healthcare industry. The resolution of this lawsuit through a $1 million settlement highlights the severity of violating the False Claims Act and the Anti-Kickback Statute.

The lawsuit alleged that the defendants used physician-owned distributorships (PODs) to provide kickbacks to physicians in exchange for using Reliance medical devices in spinal surgeries. The Anti-Kickback Statute prohibits arrangements that induce physicians to refer patients or services covered by federal healthcare programs. The case exposed how these PODs paid physicians based on referrals, made false statements, and even terminated physicians who did not refer enough patients. The offer of kickbacks and inducements to physicians compromises the integrity of medical decision-making and increases healthcare costs.

The settlement demonstrates the government's commitment to fighting healthcare fraud and upholding transparency in healthcare transactions. The case underscores that the form of an arrangement is not sufficient; the substance of the arrangement will also be scrutinized to determine if it constitutes an illegal kickback. This reiterates the need for ethical conduct in all financial relationships within the healthcare sector.

By resolving this case through a substantial settlement, the government emphasizes its stance against fraudulent practices that undermine the integrity of the healthcare system. The Department of Health and Human Services Office of Inspector General's (HHS-OIG) involvement and collaboration with law enforcement partners underscores the seriousness of investigating such schemes.

Furthermore, this case underscores the role of the False Claims Act in combating healthcare fraud. It encourages individuals to report potential fraud, waste, abuse, and mismanagement. The settlement not only results in financial penalties but also serves as a deterrent for others who might consider engaging in similar unethical practices.

Ultimately, the resolution of this case sends a clear message that healthcare fraud and kickback schemes will be investigated and penalized to protect the integrity of federal healthcare programs and ensure patient trust.

**Case 3**

The allegations involve improper billing practices and kickback violations related to healthcare services provided by Feel Well Health Center. Greene, a physician and the principal owner of the center, is accused of falsely billing Medicare, Connecticut Medicaid, and the State of Connecticut Comptroller Healthcare Programs for medical visits that were fitness-related services provided at a gym operated by the center. False medical records and diagnoses were allegedly created to support these fraudulent claims. Additionally, false claims were made for services rendered by Greene when he was not physically present and for medically unnecessary testing and procedures.

The case also involves violations of the Anti-Kickback Statute, where Greene and Feel Well Health Center allegedly received remuneration from Boston Heart Diagnostics Corp. in exchange for ordering clinical laboratory services for Medicare patients. The payments were in the form of "processing and handling" fees and "speaker" fees that exceeded fair market value.

To settle the matter, Greene and Feel Well Health Center agreed to pay $2,656,685.52 plus interest. They also entered into a three-year billing Integrity Agreement with the U.S. Department of Health and Human Services to ensure federal healthcare program requirements compliance (*Physician and Medical Office to Pay Over $2.6 Million to Settle False Claims ACT and Kickback Allegations*, 2022). The Office of Inspector General conducted the investigation for the Department of Health and Human Services, and the case was prosecuted by the U.S. Attorney's Office and the Connecticut Office of the Attorney General.

Feel Well Health Center of Southington, P.C. (formerly "Feel Well Health Center") and its owner, Kevin P. Greene, M.D., have reached a civil settlement agreement with federal and state authorities, agreeing to pay over $2.6 million to resolve allegations of violating the federal and state False Claims Acts and receiving illegal kickbacks.

Similar cases listed above detail the crimes committed similar to those of Dr.Spine. These cases involve falsifying reports and kickbacks from companies, revealing a concerning pattern of unethical and illegal behavior within the healthcare industry. Such cases of falsifying records and accepting kickbacks are not isolated incidents; they reflect a breach of trust and integrity that can have severe consequences for patient care and the healthcare system.

In each case, healthcare professionals have manipulated patient records and engaged in financial arrangements prioritizing personal gain over patient well-being. These actions undermine the quality of care and erode the public's trust in the healthcare system. Investigations into these cases are essential to uncover the extent of the wrongdoing, hold the responsible parties accountable, and implement corrective measures to prevent similar occurrences. Regulatory bodies and law enforcement agencies are crucial in ensuring justice is served, and healthcare providers adhere to ethical and legal standards. The cases also help with the precedence of punishment for these crimes, such as legal ramifications and acceptable fines given out.

**Conclusion**

Dr. Spine's violations of policies and regulations, including falsifying medical records, conflicts of interest, and improper referral incentives, are serious offenses that compromise patient care and trust. Immediate corrective actions, including suspension, investigation, and potential termination, must uphold the organization's integrity, patient safety, and compliance with healthcare regulations.

By addressing these cases head-on, healthcare organizations can demonstrate their commitment to ethical practices, patient safety, and regulatory compliance. Upholding these principles is not only essential for the well-being of patients but also for maintaining the credibility and trust that the healthcare industry relies upon.

Addressing the violations committed by Dr. Spine requires swift and decisive action to protect patients, uphold ethical standards, and maintain regulatory compliance. The organization's commitment to integrity and patient safety should guide all decisions throughout this process. Organizations can start by taking steps to recover any financial gains made by Dr. Spine through fraudulent activities, such as kickbacks or improper reimbursements. If patient harm is identified, promptly communicate with affected patients, provide the necessary support, and offer corrective actions to mitigate the impact. Communicate transparently with staff, patients, and stakeholders about the actions taken to address the violations and prevent their recurrence. Rebuilding trust is crucial for maintaining the organization's reputation and patient confidence. The healthcare organization should promptly and transparently address these violations, upholding our commitment to patient care, ethical standards, and regulatory compliance.

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