ETHICS—FRAUD!

Diane H. Schetky, M.D.

Fraud is not a term we like to associate with the practice of child psychiatry. The press reminds us that we are not above transgressing the law. Child psychiatrist, Dr. Barry Garfinkel, faces possible imprisonment for fraudulent research on Anafranil. National Medical Enterprises, one of the nation's largest hospital operators, is under investigation for improper recruitment of patients and fraud. Numerous hospital chains have been under fire for fraudulent billing and giving kickbacks to staff for recruiting patients.

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Fraud differs from malpractice in that it is an intentional rather than negligent act and it is punishable by criminal sanctions. Fraud involves deception as in intentional misrepresentation or attempts to gain advantage over others through false suggestion. Physicians who engage in fraud face not only criminal charges but possible loss of license and ethical sanctions through the American Psychiatric Association. Fraud, in contrast to negligence, is not covered by most liability policies.

Fraudulent interactions with patients and their families might involve false reassurance about the safety of a particular drug or research protocol, making unwarranted promises about a proposed treatment outcome, or practicing beyond one's area of professional competence. Concealing negligence or wrong doing may also be interpreted as fraud.

While few of us would attempt to deliberately deceive a patient, greater temptations to stretch the truth may arise when dealing with third party payers. For instance, waiving co-payments may be construed as being helpful to the patient. However, if done routinely, it is not fair to insurance companies who rely on payments to cut down on utilization. The AMA Council on Ethical and Judicial Affairs recently addressed this issue and concluded that "When copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment." Alternatively, if one decides to reduce one's fee, the amount billed to the insurance company, along with the copayment, must also be reduced.

Child psychiatrists often spend a lot of time with collateral contracts i.e., conferring with teachers and other physicians. Medicaid and often insurance companies will not pay for this time. Where I practice, inclement weather and high seas often prevent patients from getting to their appointments. I have on some of these occasions done telephone therapy only to find the insurance company would not pay for it. Nor will they pay for written reports, in most instances. If one alters the place of service in order to get paid, one enters a slippery slope. Is one then also justified in altering the diagnosis or amount of time spent with the patient? The extreme of this slope might include double billing when two family members are seen together, billing for unnecessary services, exaggerating one's usual fee beyond that which was agreed upon, and billing for non-existent sessions.

Ironically, I have encountered pressures from third party payers to be dishonest. A managed care company told me I had to stick with my original diagnosis, which had changed, when billing, otherwise the computer would reject it. Medicaid has told me to change places of service (a parent-child assessment in a park) because their computer couldn't handle that procedure code at that location. My favorite Medicaid story is when they rejected a claim on my patient, Emily, insisting Emily was a he. When I called to correct them, I was told they could not change the records and if I wanted to get paid, I should alter Emily's sex on my billing! Recently, I saw a child in renal failure awaiting a transplant for possible depression. Unfortunately for her, she was not depressed when I saw her, but in denial. She and her mother need my ongoing support, but there is no diagnostic code for denial. I will probably come up with some sort of Adjustment Disorder but wonder if I am being dishonest.

Fraudulent interactions may also arise in dealing with colleagues. Fee splitting and kickbacks are illegal. There has been much focus lately on physicians who refer patients to laboratories or hospitals in which they have a financial interest as such conflicts of interest may unduly influence decision making. Psychiatrists who work in clinics and institutions are often asked to sign off on the work of non-medical therapists for purposes of insurance reimbursement. If a supervisor has not been actively involved in the care of the patient or misrepresents his role in the patient's care when signing, this may be considered fraud. On the other hand, if a psychiatrist states he or she has reviewed and approved a treatment plan, but not examined the patient, there is no deception involved.

With the advent of managed care and health care rationing, temptations to bend the system will only increase.

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Liability Insurance Q & A

Joseph Jankowski, M.D., Chair, AACAP Task Force on Liability Insurance
Steven Brill, Director of Marketing, MedPro

Since there are so many questions being asked about liability insurance, it was decided that we would present this column in the Newsletter of the AACAP to help inform our membership about liability issues. This column will be edited jointly by the AACAP Liability Insurance Task Force and staff of MedPro.

The first series of questions are as follows:

Q. What is the difference between an occurrence and a claims made policy?

A. Occurrence coverage provides protection for claims that may arise from incidents which occurred while you had a policy in force, regardless of when a claim is reported, even if the policy is no longer in force. In the event of an incident or actual claim arising from an activity while your occurrence policy was in effect, the policy in effect at that time (time of incident) will apply, regardless of when the claim was reported. A Claims Made policy provides coverage for incidents or claims that take place and are reported during the policy period or its extended reporting period. There is no coverage for reported incidents or claims reported to the insurer after the policy has been cancelled, unless "tail coverage" is purchased.

Q. What is tail coverage and when do you need it?

A. Tail coverage is an optional extension of the reporting period available in claims made policies, usually at an additional premium charge. The tail or extended reporting coverage provides an extension of time available to report incidents or claims resulting from activities taking place during the policy period.

Q. What is Nose coverage and when do you need it?

A. Nose coverage or "Prior Acts" coverage provides for coverage of incidents taking place prior to the Claims Made policy's effective date but not before the retroactive date of the insured's prior policy. Nose coverage is an optional coverage available at an additional charge. Nose coverage only extends insurance for those incidents where there was no knowledge at the time of application by the insured to his new carrier and replaces "tail coverage."

For further information about MedPro Academy-Sponsored professional liability insurance, please call 1-800-822-8260. N

Fraud

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We can not risk jeopardizing our own standards of practice in efforts to help the patient get what we feel he or she deserves. A more constructive approach is continued lobbying for a more equitable health care system.

REFERENCES:

AMA: A report of the Council on Ethical and Judicial Affairs, June 1993.

Hyman, D. (1989), *Fraud and abuse: Setting the limits on physicians' entrepreneurship.* Editorial. NEJM Vol 320 (19), 1275–1278.

Simon, R. and Sadoff, R. (1992), *Psychiatric Malpractice.* Washington: APPI.

Diane Schetky, M.D. is in private practice in Rockport, ME., in child, adolescent and adult psychiatry with special interest in child forensic psychiatry. She is co-editor of the Handbook of Child Psychiatry and the Law (Williams & Wilkins, 1992). She is the chairperson of the Maine Psychiatric Association's Ethics Committee. N

Educational Campaigns

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Academy members in the three states are being mailed a survey to ascertain their current use of the Facts series. Press kits will also be sent to the leading newspapers and broadcast stations encouraging news interviews with local child and adolescent psychiatrists on the topic of diagnosis and treatment of children and adolescents suffering from mental illnesses.

Individuals receiving the Facts series will be able to request a child and adolescent psychiatrist to speak at a school or parent-group function. This allows Academy members to become actively involved in the campaign, and more importantly, to begin working with schools, parents, and day care centers in their communities.

The Academy gratefully acknowledges the support of The **Nathan Cummings Foundation** for the campaign.

For more information regarding the campaign, please contact the Communications department at the Central Office, 1-800-333-7636. N