United States General Accounting Office

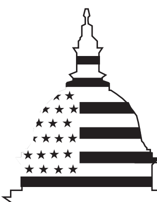
GAO

The Honorable Charles E. Grassley,
Ranking Minority Member,
Committee on Finance,
U.S. Senate

June 2001

HEALTH CARE

Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims



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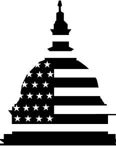

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

June 27, 2001

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Grassley:

This report responds to your request that we investigate health care consultants who conduct seminars or workshops that offer advice to health care providers on ways to enhance revenue and avoid audits or investigations. Specifically, you asked that we (1) attend seminars or workshops that these consultants offer and (2) determine whether the consultants are providing advice that could result in improper or excessive claims to Medicare, Medicaid, other federally funded health plans, and private health insurance carriers.

To assist us in identifying consultants who provide advice on billing practices and compliance programs, and to analyze the information provided by these consultants, we contracted with a licensed physician. This physician and a criminal investigator, who posed as a member of the physician's staff, attended two workshops and one seminar. The focus of our work was seminars and workshops that advertised how to enhance revenue and avoid audit, rather than on those that provide advice on coding for reimbursement. We raise issues in this report about advice given at two workshops—"How to Run a More Profitable Practice," which was sponsored by the Medical Society of the District of Columbia and "Creating a 7-Step Compliance Plan Audit/Audit-Proof Your Practice," which qualified for continuing education credits by the American Association of Medical Assistants. The same consulting company presented both workshops.[1] We raise no issues regarding the advice provided at the seminar we attended, which was sponsored by the American Academy of Physician Assistants. We conducted our investigation from July 2000 to June 2001 in accordance with investigative

[1] This company advertises that (1) it has designed, developed, and presented hundreds of workshops on behalf of many medical societies and hospitals and (2) its workshops have been attended by over 50,000 physicians and 100,000 office managers and medical assistants.

standards established by the President's Council on Integrity and Efficiency.

Results in Brief

In summary, the two workshops about which we raise issues in this report offered in-depth discussions of regulations that pertain to billing for evaluation and management health care services[2] and compliance with health care laws and regulations. During the course of discussions at those workshops, certain advice was provided that is inconsistent with guidance provided by the Department of Health and Human Services' Office of Inspector General (OIG). Such advice could result in violations of both civil and criminal statutes. Specifically, certain consultants advocated not reporting or refunding overpayments received from insurance carriers after they were discovered. The consultants also encouraged the performance of tests and procedures that are not medically necessary to generate documentation in support of bills for evaluation and management services at a higher level of complexity than actually confronted during patients' office visits. Furthermore, one consultant suggested that providers discourage patients with low-paying insurance plans, such as Medicaid, from using their services by limiting services provided to them and scheduling appointments for such patients at inconvenient times of the day.

Background

Medicare and Medicaid have consistently been targets for fraudulent conduct because of their size and complexity. Private health care insurance carriers are also vulnerable to fraud due to the immense volume of claims they receive and process. Those who commit fraud against public health insurers are also likely to engage in similar conduct against private insurers. The Coalition Against Insurance Fraud estimates that in 1997 fraud in the health care industry totaled about $54 billion nationwide,[3] with $20 billion attributable to private insurers and $34 billion to Medicare and Medicaid.

[2] Evaluation and management health care services encompass the basic services provided by physicians in diagnosing and treating patients.

[3] The Coalition used private insurance information provided by the Health Insurance Association of America and public insurance information supplied by the Health Care Financing Administration. The most current year for which statistics were available is 1997.

In addition to losses due to fraud, the Department of Health and Human Services' OIG has reported that billing errors, or mistakes, made by health care providers were significant contributors to improperly paid health care insurance claims. The OIG defined billing errors as (1) providing insufficient or no documentation, (2) reporting incorrect codes for medical services and procedures performed, and (3) billing for services that are not medically necessary or that are not covered. For fiscal year 2000, the OIG reported that an estimated $11.9 billion in improper payments were made for Medicare claims.[4]

OIG Guidance

In a March 1997 letter to health care providers, the Department of Health and Human Services' IG suggested that providers work cooperatively with the OIG to show that compliance can become a part of the provider culture. The letter emphasized that such cooperation would ensure the success of initiatives to identify and penalize dishonest providers. One cooperative effort between the IG and health care groups resulted in the publication of model compliance programs for health care providers.

The OIG encourages providers to adopt compliance principles in their practice and has published specific guidance for individual and small group physician practices[5] as well as other types of providers to help them design voluntary compliance programs. A voluntary compliance program can help providers recognize when their practice has submitted erroneous claims and ensure that the claims they submit are true and accurate. In addition, the OIG has incorporated its voluntary self-disclosure protocol[6] into the compliance program, under which sanctions may be mitigated if provider-detected violations are reported voluntarily.

Evaluation and Management Services

Evaluation and management services refer to work that does not involve a medical procedure—the thinking part of medicine. The key elements involved in evaluation and management services are (1) obtaining the patient's medical history, (2) performing a physical examination, and (3) making medical decisions. Medical decisions include determining which

[4] Department of Health and Human Services' OIG report, *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments,* A-17-00-02000, (Feb. 5, 2001).

[5] 65 F. Reg. 59434 (Oct. 5, 2000).

[6] 63F. Reg. 42410 (Aug. 7, 1998).

diagnostic tests are needed, interpreting the results of the diagnostic tests, making the diagnosis, and choosing a course of treatment after discussing the risks and benefits of various treatment options with the patient. These decisions might involve work of low, medium, or high complexity.

Each of the key elements of evaluation and management services contains components that indicate the amount of work done. For example, a comprehensive medical history would involve (1) determining a patient's chief complaint, (2) tracing the complete history of the patient's present illness, (3) questioning other observable characteristics of the patient's present condition and overall state of health (review of systems), (4) obtaining a complete medical history for the patient, (5) developing complete information on the patient's social history, and (6) recording a complete family history. A more focused medical history would involve obtaining only specific information relating directly to the patient's symptoms at the time of the visit.

Providers and their staffs use identifying codes defined in an American Medical Association publication, titled *Current Procedural Terminology* (CPT), to bill for outpatient evaluation and management services performed during office visits. The CPT is a list of descriptive terms and identifying codes for reporting all standard medical services and procedures performed by physicians. Updated annually, it is the most widely accepted nomenclature for reporting physician procedures and services under both government and private health insurance programs. The CPT codes reported to insurers are used in claims processing, and they form the basis for compensating providers commensurate with the level of work involved in treating a patient. Accordingly, the higher codes, which correspond to higher payments, are used when a patient's problems are numerous or complex or pose greater risk to the patient, or when there are more diagnostic decisions to be made or more treatment options to be evaluated.

The CPT has two series of evaluation and management codes for outpatient office visits, one series for new patient visits and another for established patient visits. Each series of CPT codes has five levels that correspond to the difficulty and complexity of the work required to address a patient's needs. The code selected by the provider to describe the services performed in turn determines the amount the provider will be paid for the visit. For example, under the current Medicare fee schedule

for the District of Columbia and surrounding suburbs,[7] a provider would be paid $39.30 for a new patient who is determined to have received services commensurate with a level 1 visit and $182.52 for a level 5 visit. Similarly, payments for level 1 and level 5 visits by an established patient are $22.34 and $128.03, respectively.

Some Advice Provided by Consultants Could Result in Violations of Law

The two workshops we attended provided certain advice that is inconsistent with the OIG guidance and that, if followed, could result in violations of criminal and civil statutes. Specifically, at one workshop the consultant suggested that when providers identify an overpayment from an insurance carrier, they should not report or refund the overpayment. Furthermore, consultants at both workshops suggested that providers attempt to receive a higher-than-earned level of compensation by making it appear, through documentation, that a patient presented more complex problems than he or she actually did. Additionally, one consultant suggested that providers limit the services offered to patients with low-paying insurance plans, such as Medicaid, and that they discourage such patients from using the provider's services by offering appointments to them only in time slots that are inconvenient to other patients.

Nondisclosure of Overpayments

One workshop focused on the merits of implementing voluntary compliance programs. The consultant who presented this particular discussion explained that a baseline self-audit to determine the level of compliance with applicable laws, rules, and regulations is a required step in creating a voluntary compliance program. Focusing on "how to audit-proof your practice" and avoid sending out "red flags," the consultant advised providers not to report or refund overpayments they identify as a result of the self-audit. The consultant claimed that reporting or refunding the overpayment would raise a red flag that could result in an audit or investigation. When asked the proper course of action to take when an overpayment is identified, the consultant responded that providers are required to report and refund overpayments. He said, however, that instead of refunding overpayments, physician practices generally fix problems in their billing systems that cause overpayments while "keeping

[7] Medicare has separate fee schedules for various geographic regions throughout the United States.

their mouths shut" and "getting on with life." Such conduct, however, could result in violations of criminal statutes.[8]

Creating Documentation to Support Higher-Than-Warranted Code Levels

According to the most recent OIG Medicare audit report, the practice of billing for services that are not medically necessary or that lack sufficient diagnostic justification is a serious problem in the health insurance system. The OIG estimated that during fiscal year 2000, $5.1 billion was billed to insurance plans for unnecessary services. Intentionally billing for services that are not medically necessary may result in violations of law.[9]

Moreover, based on advice given at workshops that we attended during this investigation, we are concerned that insurers may be paying for tests and procedures that are not medically necessary because physicians may be intentionally using such services to justify billing for evaluation and management services at higher code levels than actual circumstances warrant. Specifically, two consultants advised that documentation of evaluation and management services performed can be used to create, for purposes of an audit, the appearance that medical issues confronted at the time of a patient's office visit were of a higher level of difficulty than they actually were.

For example, a consultant at one workshop urged practitioners to enhance revenues by finding creative ways to justify bills for patient evaluation and management services at high code levels. He advised that one means of justifying bills at high code levels is to have nonphysician health professionals perform numerous procedures and tests. To illustrate his point, the consultant discussed the hypothetical case of a cardiologist who examines a patient in an emergency room where tests are performed and the patient is discharged after the cardiologist determines that the patient has a minor problem or no problem at all. To generate additional revenue, the consultant suggested that the cardiologist tell the patient to come to

[8] See, for example, 18 U.S.C. § 641 (intentional conversion of federal property to personal use), and 42 U.S.C. § 1320a-7b (duty to report changed circumstances that affect a provider's entitlement to payment).

[9] Among the criminal statutes applicable to health care fraud are 18 U.S.C. § 1347 (knowing, willful scheme to defraud federal health care programs), 42 U.S.C. § 1320a-7b (knowingly providing false statements to obtain federal benefits). The False Claims Act 31 U.S.C. § 3729 applies civil penalties plus damages for knowingly presenting to federal authorities a false claim for payment, and 42 U.S.C. § 1320a-7b also applies civil penalties to improper claims made on the federal health programs.

his office for a complete work-up, even when the cardiologist knows that the patient does not have a problem. He advised that the work-up be performed during two separate office visits and that the cardiologist not be involved in the first visit. Instead, a nurse is to perform tests, draw blood, and take a medical history. During the second visit, the cardiologist is to consult with the patient to discuss the results of the tests and issues such as life style. The consultant indicated that the cardiologist could bill for a level 4 visit, indicating that a relatively complex medical problem was encountered at the time of the visit. The consultant made clear that the cardiologist did not actually confront a complex problem during the visit because the cardiologist already knew, based on the emergency room tests and examination, that the patient did not have such a problem.

Another consultant focused on how to develop the highest code level for health care services and create documentation to avoid having an insurer change the code to a lower one. The consultant engaged in "exercises" with participants designed to suggest that coding results are "arbitrary" determinations. His emphasis was not that the code selection be correct or even that the services be performed, but rather that it is important to create a documentary basis for the codes billed in the event of an audit. He explained that in the event of an audit, the documentation created is the support for billing for services at higher code levels than warranted.

During the exercises, program participants—all were physicians except for our criminal investigator—were provided a case study of an encounter with a generally healthy 14-year-old patient with a sore throat. Participants were asked to develop the evaluation and management service code for the visit that diagnosed and treated the patient's laryngitis. The consultant suggested billing the visit as a level 4 encounter, supporting the code selection by documenting every aspect of the medical history and physical examination, and mechanically counting up the work documented to make the services performed appear more complicated than they actually were. All of the participants indicated that they would have coded the visit at a lower level than that suggested by the consultant, who stated that "documentation has its rewards." The consultant explained that in the event of an audit, the documentation created would be the basis for making it appear that a bill at a high code level was appropriate.[10]

[10] The OIG's most recent audit of Medicare claims at level 4 showed that over the last 5 years, providers on average incorrectly coded at level 4 in over 41 percent of the cases the OIG reviewed.

Limiting Services to Medicaid Patients

One workshop consultant encouraged practices to differentiate between patients based on the level of benefits paid by their insurance plans.[11] He identified the Medicaid program in particular as being the lowest and slowest payer, and urged the audience to stop accepting new Medicaid patients altogether. The consultant also suggested that the audience members limit the services they provide to established Medicaid patients and offer appointments to them only in hard-to-fill time slots.

Workshop participants were advised to offer better-insured patients follow-up services that are intended to affiliate a patient permanently with the practice. However, the consultant suggested that physicians may decide not to offer such services to Medicaid patients. He sent a clear message to his audience that a patient's level of care should be commensurate with the level of insurance benefits available to the patient. This advice raises two questions: First, are medically necessary services not being made available to Medicaid patients? Second, are better-paying insurance plans being billed for services that are not medically necessary but performed for the purpose of affiliating patients from such plans to a medical practice?

Program participants were further urged to see at least one new patient with a better-paying insurance plan each day. The consultant pointed out that, by seeing one new patient per day, a provider can increase revenue by $6,000 per year because the fee for a new patient visit is about $30 more than the fee for an established patient visit. He said that over time such measures would result in reducing the percentage of Medicaid patients seen regularly in the practice and increase the number of established patients with better-paying insurance.

The consultant also recommended that providers limit the number of scheduled appointment slots available to Medicaid patients on any given day and that Medicaid patients be offered appointments only in hard-to-fill time slots rather than in the "best," or convenient, time slots. He suggested that insurance information and new patient status be used to allocate the best time slots to the best payers. He identified this approach as "rationing," which he described as "not real discrimination," but "somewhat discrimination."

[11] The presenter recommended rating the various insurers based on the amount they allow for services, the percentage of claims collected, and the timeliness of their claims processing.

While neither the Social Security Act[12] nor Medicaid regulations require physicians to accept Medicaid patients, title VI of the Civil Rights Act of 1964[13] prohibits discrimination based upon race, color, or national origin in programs that receive federal financial assistance. The Department of Health and Human Services, which administers the Medicare and Medicaid programs, takes the position that the nondiscrimination requirement of title VI applies to doctors in private offices who treat and bill for Medicaid patients. While the conduct promoted by the consultant is not overt discrimination on the basis of race, color, or national origin, under certain circumstances, such conduct might disproportionately harm members of protected groups and raise questions about title VI compliance. Moreover, even if the conduct promoted is not unlawful, it raises serious concerns about whether it would result in depriving Medicaid patients of medically necessary services, and whether better-paying insurance plans are billed for services that are not medically necessary but performed for the purpose of affiliating patients to a particular medical practice.

Conclusion

Advice offered to providers at workshops and seminars has the potential for easing program integrity problems in the Medicare and Medicaid programs by providing guidance on billing codes for evaluation and management services. However, if followed, the advice provided at two workshops we attended would exacerbate integrity problems and result in unlawful conduct. Moreover, the advice raises concerns that some payments classified by the OIG as improperly paid health care insurance claims may stem from conscious decisions to submit inflated claims in an attempt to increase revenue. We have discussed with the Department of Health and Human Services' OIG the need to monitor workshops and seminars similar to the ones we attended.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will make copies of the report available to interested congressional committees and the Secretary of the Department of Health and Human Services.

This report will also be available at *www.gao.gov*. If you have any questions about this investigation, please call me at (202) 512-7455 or

[12] 42 U.S.C. § 1396, *et seq.* (1994).

[13] 42 U.S.C. § 2000d.

Assistant Director William Hamel at (202) 512-6722. Senior Analyst Shelia James, Assistant General Counsel Robert Cramer, and Senior Attorney Margaret Armen made key contributions to this report.

Sincerely yours,

Robert H. Hast
Managing Director
Office of Special Investigations

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