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Health Care Law

# Physician Billing Returns to the Medicare Fraud Spotlight

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October 20, 2016

Two recent Department of Justice settlements with health care providers shine a new spotlight on a long-standing risk for health care fraud and abuse.

## Background

Thirty years ago, coding and billing for physician services was a headline topic in Medicare and Medicaid fraud. Numerous academic medical centers such as the University of Pennsylvania (Penn) were forced to reimburse the federal government for claims that systematically misrepresented the physician services actually provided. In 1995, Penn agreed to pay $10 million as reimbursement to Medicare for paid services and an additional $20 million as a penalty under provisions of the False Claims Act (FCA) that allow for tripling of damages.

At the time, the chief auditor in the Philadelphia Office of the Inspector General (OIG) of the Department of Health and Human Services said a detailed audit of Penn turned up two rampant billing problems. The first involved billing for services actually performed by residents, without adequate attending supervision. Payments for these services are normally made to hospitals through special allowances for graduate medical education, under Part A of Medicare. The second problem was billing for a higher level of service than that actually performed.

The Penn settlement kicked off of a nationwide effort by the OIG, called Physicians at Teaching Hospitals, or PATH, to investigate coding and billing at other academic medical centers.

## Recent Developments

In September, the U.S. Attorney's Office for the District of Connecticut announced a civil settlement with the University of Connecticut Health Center for $184,984 to resolve allegations that it overbilled the Medicare program. The government alleged that UConn Health improperly submitted claims for wound closure procedures. Specifically, the government said UConn Health

was guilty of upcoding for wound procedures by submitting codes for more complex procedures than the ones performed. The conduct persisted for more than five years, from Jan. 1, 2011 to June 2, 2016.

In July, the University of Pittsburgh Medical Center and three related physician organizations agreed to pay the United States $2,520,429 to settle FCA allegations in a whistleblower (qui tam) suit. The complaint alleged that neurosurgeons employed by UPMC submitted claims for assisting with or supervising surgical procedures performed by other surgeons, residents, fellows or physician assistants when those individuals did not actually participate in surgeries to the degree required. The settlement also resolved allegations of upcoding by a neurosurgeon for spinal decompression procedures.

These new cases demonstrate the ingrained and persistent nature of certain problematic coding and billing practices. They open the door for health care attorneys to remind their clients that coding and billing remain a high-risk area and an important element in their compliance programs. Equally important, they point out the need for ongoing billing monitoring and auditing processes.

# The Old is New Again

The OIG's PATH initiative catapulted coding compliance to the forefront in physician organizations. Since then, many tools and mechanisms have been developed to help ensure coding and claims submission compliance with Medicare and private payer requirements. The tools range from software packages in computerized billing systems to elaborate monitoring programs directed by compliance officers.

One danger in provider organizations, however, is that billing compliance may be viewed as being under control. Providers may be overlooking the potential risk of both inadvertent and intentional billing errors.

Today's larger physician billing departments, those resulting from the merger of private practices or created by health systems that own multiple practices, are inherently at risk for overlooking billing problems. Tasks and responsibilities in these larger billing departments tend to be highly fragmented, with each staff member assigned narrow responsibility and inadequate resources devoted to a comprehensive view of potential problems. This is particularly true when there are many geographically disparate practice sites and a centralized billing department. Communication and coordination challenges are very common.

Many providers have hired certified coders as a key tactic to minimize billing problems, but our operational audits have found that the coding process in the revenue cycle may not work as intended. The workflow may not facilitate accurate coding; coders may not have adequate interaction with doctors and practice staff, and doctors may not be adequately trained on their charge capture and documentation responsibilities. Our billing department reviews have also identified broader billing problems such as delays in charge submission, claim production inaccuracies and lack of timely billing system maintenance.

# CMS Marches On

While some providers may have shifted attention away from billing risk areas, billing fraud remains a high priority for the OIG and the Department of Justice, simply because deceitful providers continue to develop "new and improved" fraudulent billing schemes. CMS continues to ramp up its efforts to ensure compliance with regulations and combat fraud. It increasingly relies on sophisticated computerized data mining to identify inadvertent errors and intentional fraud. CMS requires Medicare Administrative Contractors (MACs) to conduct a wide range of billing audits as part of its Medicare Integrity Program. These audits include a program called Medical Review, involving pre-payment and post-payment claim reviews.

The goal of medical review is to detect billing errors, but Novitas, the MAC for Pennsylvania, says another purpose is to "establish baseline data to enable Part B contractors to recognize unusual changes in utilization over time or schemes to inappropriately maximize reimbursement." Novitas further says, "At any time during the course of a review, if evidence of fraud is detected, a referral will be made for further development to the appropriate Program Safeguard Contractor."

MACs publish a list of the CPT codes for services that are the targets of prepayment reviews, and that list focuses on the services that have a history of abuse or fraud. Currently, in Pennsylvania, Novitas is targeting CPT codes 99205, a comprehensive office visit for new patients, across all provider specialties, and CPT codes 99222 and 99223, initial hospital visits, billed by the following specialists: cardiology, gastroenterology, pulmonary medicine, infectious disease, internal medicine, and family practice. MACs have the authority to conduct intensive reviews of specific services by designating them as part of a "widespread prepay probe." For example, Medicare contractor Cahabagba is conducting a probe of 99214, the code for an extended office visit, which historically has been abused by upcoding lower level, routine office visits.

The bottom line is that coding and billing fraud remains a high priority for CMS, the OIG and the DOJ, and it should not be overlooked by providers and health care attorneys. •

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