CRACKING THE CODES

Medicare has emerged as a potent campaign issue, with both Barack Obama and Mitt Romney vowing to tame its spending growth while protecting seniors. But there's been little talk about some of the arcane factors that drive up costs, such as billing and coding practices, and what to do about them. Our 21-month investigation documents for the first time how some medical professionals have billed at sharply higher rates than their peers and collected billions of dollars of questionable fees as a result.

The Center for
Public Integrity

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A look at the reporting process behind this investigation

By The Center for Public Integrity

Published Online: September 15, 2012

THE "Cracking the Codes" stories are but the latest in a series of Center pieces that illuminate questionable Medicare practices and policies by marrying traditional shoe-leather reporting with rigorous data analysis.

The foundation of these pieces is the Center's access to about two terabytes of Medicare claims data — data that was obtained by the Center in 2010 as the result of a settlement from litigation against the Centers for Medicare and Medicaid Services.

Delving deeply into this data has now helped us expose one of medicine's dirty little secrets: medical providers garnering extra Medicare fees by "upcoding," or billing for more extensive care than had actually been delivered. But it wasn't easy. "Cracking the Codes" is the result of almost 20 months of often-tedious work.

That work began in early 2011, with preliminary analysis by data editor David Donald that summarized changes in hundreds of codes used by doctors and hospitals to bill Medicare over much of the past decade. Center investigative reporter Fred Schulte spent hours sifting those findings for story ideas, and subsequently discovered sharp spikes in higher-cost Medicare billing codes for routine patient visits to doctors.

The code patterns indicated that short office visits paying doctors modest amounts had dropped off precipitously, while lengthier and higher-paid visits were rising dramatically. The trends ran counter to much of the medical research; the differences were costing taxpayers billions of dollars.

Under Donald's direction, former Center data analyst Elizabeth Lucas then embarked on a six-month journey through millions of Medicare records to determine the extent of the billing anomalies and quantify the cost to taxpayers. The database was daunting indeed, consisting of scores of tables and thousands of columns, totaling more than 700 million claims.

As the details of the data dive began rolling in during the latter months of 2011, Schulte and reporter Joe Eaton — also a veteran of the health care beat — dove into the "nuts and bolts" report-

Key Findings:

- Thousands of medical professionals have billed Medicare at progressively higher rates over a decade's time, costing taxpayers at least $11 billion in inflated charges.

- A significant portion of the added charges is likely due to "upcoding" — charging for more extensive and costly services than actually delivered.

- Upcoding is facilitated by abuse of Medicare billing codes that reflect the range of care delivered and the time it takes. Many doctors have steadily billed the higher-level — and more lucrative — codes, while spurning those that pay less.

- Some of the most dramatic surges in higher-cost billing codes have occurred in hospital emergency rooms. Hospitals are permitted to set their own rules for billing outpatient charges and these payments are seldom audited by Medicare.

- The rise in costly coding and billing errors appears to be getting worse amid lax government oversight and the proliferation of electronic medical records systems, which critics say can facilitate abuse.

ing, interviewing health care policy and health care fraud experts, while simultaneously combing through policy papers, Medicare audits, investigative reports and litigation case files.

Data analyst Lucas departed in April for a position at Investigative Reporters and Editors, but the Center then received pro-bono help from Palantir Technologies, a Silicon Valley software company specializing in integrating, visualizing and analyzing information. Accommodating Palantir's powerful servers required modification to the Center's cooling facilities. Once those adjustments were completed, Palantir analysts Elizabeth Caudill, Daniel Tse and Lekan Wang — working at the Center and in Palo Alto — coordinated with Schulte, Eaton and Donald to marry further data analysis with more traditional reporting. Geographical analysis using the Palantir Gotham platform revealed the nationwide patterns of higher billing. Schulte then sketched the outlines of a three-part series, and the writing of the "Cracking the Codes" pieces

began in the spring. Data editor Donald completed the data analysis in August.

The significance of "Cracking the Codes" has been reflected in the honors bestowed upon it. The project received the prestigious Philip Meyer Award from Investigative Reporters and Editors Inc., which recognizes the best use of social science methods in journalism. "Cracking the Codes" also won the print journalism award from the National Institute for Health Care Management Foundation; judges called the reporting "thorough" and "impactful," remarking on the "impressive numbers" that would be "impossible from a policy-making perspective to ignore."

Additionally the project won second place for health policy in the Awards for Excellence in Health Care Journalism, and was a finalist in the Global Editors Network Data Journalism Awards. Finally, "Cracking the Codes" received a coveted "laurel' from the Columbia Journalism Review, which called the findings "startling" and said "the rest of us would do well to pay attention." ■

The Team

Lead reporters: Fred Schulte and Joe Eaton

Fred Schulte, who joined the Center in 2011, has been exposing questionable health care practices for decades. Schulte, a four-time Pulitzer prize finalist, spent much of his career at the Baltimore Sun and the South Florida Sun-Sentinel. He is the recipient of the George Polk Award, two Investigative Reporters and Editors awards, three Gerald Loeb awards for business writing and two Worth Bingham Prizes for investigative reporting.

Joe Eaton joined the Center in 2008. He previously served as a staff writer at the Washington City Paper and a reporter at The Roanoke Times.

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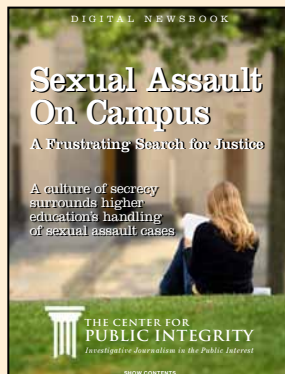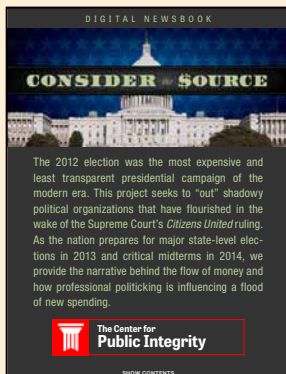
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The Center for
Public Integrity

The Center for Public Integrity was founded in 1989 by Charles Lewis. We are one of the country's oldest and largest nonpartisan, nonprofit investigative news organizations. Our mission: To enhance democracy by revealing abuses of power, corruption and betrayal of trust by powerful public and private institutions, using the tools of investigative journalism.

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How doctors and hospitals have collected billions in questionable Medicare fees

Center investigation suggests costs from upcoding and other abuses likely top $11 billion

By Fred Schulte and David Donald
Published Online: September 15, 2012

THOUSANDS of doctors and other medical professionals have steadily billed higher rates for treating elderly patients on Medicare over the last decade — adding $11 billion or more to their fees and signaling a possible rise in medical billing abuse, an investiga-tion by the Center for Public Integrity has found.

Medical groups argue that the fee hikes are justified because treating seniors has grown more complex and time-consuming, both due to new technology and declining health sta-tus. The rise in fees may also be a re-

action, they say, to years of under-charging, and reflect more accurate billing. The fees are based on a system of billing codes that is structured to make higher payments for treatments that take more time and effort.

But the Center's analysis of Medicare claims from 2001 through 2010 shows that over time, thousands of providers turned to more expensive Medicare billing codes, while spurning use of cheaper ones. They did so despite little evidence that Medicare patients as a whole are older or sicker than in past years, or that the amount of time doctors spent treating them on average was rising.

Mark McClellan, former administrator of the Centers for Medicare and Medicaid Services (CMS) Charles Dharapak/AP file

While it's impossible to know precisely why doctors and hospitals moved to better-paying codes in recent years, it's likely that the trend in part reflects "upcoding," — the practice of charging for more extensive and costly services than delivered, according to Medicare experts, analysis of the data and a review of government audits.

And Medicare regulators worry that the coding levels may be accelerating in part because of increased use of electronic health records, which make it easy to create detailed patient files with just a few mouse clicks.

Many health policy experts have long believed that billing errors and abuses, from confusion over how to pick proper payment codes to outright overcharges, are common in Medicare. But the Center's year-long examination has outlined their scope in an unprecedented manner, uncovering a range of costly medical coding mistakes and abuses that have plagued the government-paid health care plan for years and are worsening amid lax federal oversight.

"This is an urgent problem," said Dr. Mark McClellan, who directs the Engelberg Center for Health Care

Reform at the Brookings Institution in Washington. McClellan, a former director of the Centers for Medicare and Medicaid Services, or CMS, said the agency must send a message that it "won't stand by and do nothing … that they are paying attention to this."

Among the investigation's key findings:

- Doctors steadily billed Medicare for longer and more complex office visits between 2001 and the end of the decade even though there's little hard evidence they spent more time with patients or that their patients were sicker and required more complicated — and time-consuming — care. The higher codes for routine office visits alone cost taxpayers an estimated $6.6 billion over the decade.

- More than 7,500 physicians billed the two top paying codes for three out of four office visits in 2008, a sharp rise from the numbers of doctors who did so at the start of the decade. Officials said such changes in billing can signal overcharges occurring on a broad scale. Medical groups deny that.

- The most lucrative codes are billed two to three times more often in some cities than in others, costly variations government officials said they could not explain or justify. In some instances, higher billing rates appear to be associated with the burgeoning use of electronic medical records and billing software.

- Medicare administrators have struggled for more than a decade to crack down on medical coding errors and abuses, often in the face of opposition from medical groups including the American Medical Association, which helped design, and now controls the codes. Whether they make honest mistakes or engage in willful misconduct, there's little chance doctors who pad their charges will face any serious penalties.

CMS officials declined numerous interview requests. However, in an e-mail response to written questions, officials said while they believe most doctors and hospitals are "honest and try to bill Medicare correctly," the agency also "is keenly aware that certain Medicare providers and suppliers seek to defraud the program."

Dr. Robert Berenson, a former vice chairman of a federal commission that recommends Medicare payment strategies to Congress, called the Center's findings "clearly significant," and said they indicate an

urgent need to revamp the pay scales.

"It is really time to deal with this issue. There are so many perverse outcomes, including spending for taxpayers," Berenson said.

That so many doctors deviate widely from billing norms — and have done so for years with apparent impunity — spotlights Medicare's chronic vulnerability to abuse and fraud, several experts said.

Thomas Scully, an archi-

Thomas Scully, former Medicare administrator under President George W. Bush Kaiser Health News

tect of the Medicare pay scales during his White House days under the first President Bush, is now critical of the system. He said it was put in place in order to curb rising doctors' fees, but Medicare's pay hikes have been too small to match rising medical office expenses. Many doctors have responded by picking the highest codes possible, he said.

"You are going to pedal faster and code more aggressively," said Scully, also a former director of the federal Medicare agency and now a Washington lobbyist with a range of health care clients. "I'm not sure it's malicious. It's a fact a life," he said.

However, the U.S. Department of Health and Human Services inspec-

tor general in a May report stated that payments made under the doctor-visit codes rose 48 per cent between 2001 and 2010, from $22.7 billion to $33.5 billion. The report also noted that the coding system has been "vulnerable to fraud and abuse."

And agency officials acknowledge that the surge in these billings has been driven at least partly by potentially illegal "upcoding" which the government has largely failed to stamp out through the years.

"We have some people who will use any excuse to get more money for the services they do," said Jennifer Trussell, who heads the investigations unit for the HHS inspector general's office. "They don't see it as a crime."

Trending toward higher fees

Medicare pays for more than 200 million doctor visits every year, using a series of five-digit codes (99211-99215) that are supposed to reflect the complexity of the medical service and the amount of time it typically takes.

Over the past decade, more and more doctors have turned to the higher-level codes that pay more, while largely spurning those that paid less.

Established Patient Visits

Percentage of Office Visits Charged per Code

- **99211:** Minimal problem that takes five minutes or less of the doctor's time or that of an employee supervised by the doctor.
- **99212:** Minor medical problem that typically requires 10 minutes face-to-face.
- **99213:** Medical problem of low to moderate severity that typically requires 15 minutes face-to-face.
- **99124:** Medical problem of moderate to high severity that typically requires 25 minutes face-to-face.
- **99215:** Medical problem of moderate to high severity that requires medical decision making of high complexity and typically takes 40 minutes face-to-face with the patient.
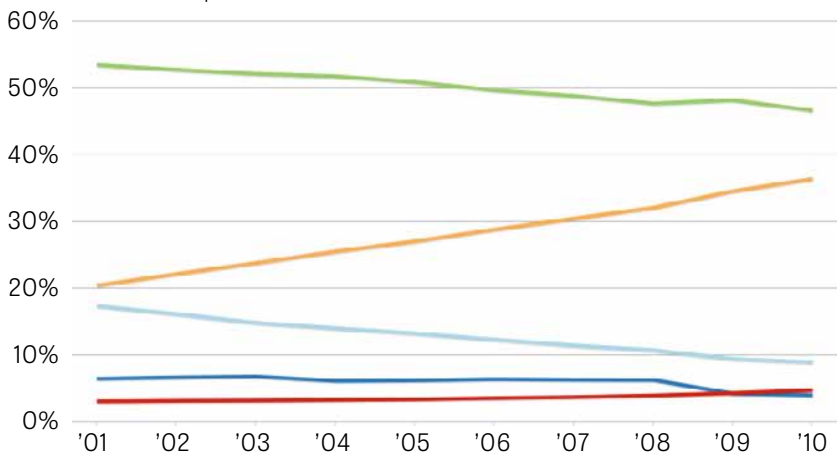
Graphic by Timothy Meko

AMA president Jeremy A. Lazarus agreed that doctors have shifted toward billing higher priced codes. But the "contributing factors are unclear," he said in a written statement. "There could be several possible reasons for this trend, but more analysis is needed," Lazarus said.

Secret Code

The current billing scales, known as Evaluation and Management codes, were unveiled in 1992 as part of an unusual and secretive arrangement between Medicare officials and the AMA, the nation's most influential doctors' group.

The AMA wanted Medicare to reward doctors for the "thinking part" of medicine, or their skill in diagnosing and treating illness, as well as the time it takes. Medicare expected the pay scales to cut down on billing abuses and to save taxpayers money by setting measurable standards that all doctors would follow.

On paper, the process seems straightforward enough: the lowest of the five coding levels for an office visit, 99211, signifies a minimal health problem and five minutes either spent treating the patient or supervising a nurse or other health worker who does so.

That simple visit pays the doctor about $20 from Medicare.

The top code, 99215, requires much more effort. Doctors must do two of three things: a comprehensive examination, a detailed history of the patient's health status, or make a medical decision of "high complexity."

That typically requires 40 minutes of face-to-face contact between doctor and patient and pays about $140.

Medicare officials expect medical professionals to bill a range of the five fee codes because some patients require more time and effort to treat than others. The government trusts them to bill correctly and medical groups say the vast majority of America's physicians follow the complex coding rules as best they can. Medicare pays for more than 200 million office visits each year.

However, doctors and hospitals have increasingly abandoned the lower-level codes for better paying ones. Medicare officials have largely failed to challenge these surges in billing across a broad spectrum of medicine, from doctors working in hospital emergency departments and nursing homes to family physicians and specialists seeing patients in their offices.

Government officials and medical data experts note that sharp spikes in billing strongly suggest some doctors and hospitals engage in "upcoding," by finding ways to bill for higher codes than justified.

Medical groups counter that most doctors charge less than they deserve. The only way to tell for sure is to review patient records that support each of the 370 million such claims Medicare pays annually, which officials say is impractical and not cost-effective.

Physician groups don't dispute that coding errors are commonplace in medicine or that a tiny fraction of doctors may exploit loose federal oversight to fatten up their fees.

But they argue that coding guidelines are vague and subjective and that just as many doctors undervalue their work by picking lower codes as might be tempted to bill too much.

The medical organizations also argue that more elderly patients over the past decade have been diagnosed with multiple health problems that require additional time and effort to treat, a contention undercut by much health care research.

And they cite growing use of computerized medical records and billing systems for enabling doctors to document the level of treatment they provide more easily than by hand, which pays off in higher codes. Federal officials are spending as much as $30 billion in economic stimulus money to help doctors and hospitals purchase the digital gear, and more than half the doctors billing Medicare are using it, with more expected to follow.

Dr. Thomas Weida, a family physician in Hershey, Pa., said that wiring up his office has boosted the amount of time spent face-to-face with a typical patient by five minutes or more, both from the amount of stored information he reviews and increased time writing and prescribing treatments. That alone could justify higher billing codes in many instances, he said.

"You're having to do a lot more than you did before," said Weida, a medical coding expert for the American Academy of Family Physicians.

But digital systems also can prompt doctors to "code at the highest possible level," said Dr. David Kibbe, who has consulted with the family physicians' group. Often, that means that with "the push of a button" doctors can create reams of documentation to support higher codes, Kibbe said.

Some doctors identified by the Center's data analysis as disproportionately billing high codes for office visits cited the poor health condition of their patients as a key justification for doing so.

"I know they are high," said Dr. Brantley B. Pace, who has practiced family medicine for more than a half century in Monticello, Miss., when asked about his billing practices, among the highest in the Medicare billing sample.

Pace said many of his longtime patients live with multiple infirmities that require his attention. "I rarely have a person who comes to me for a cold," he said.

Data experts noted that some individual doctors may in fact be justified in billing much higher than their peers. But they stressed that the sheer numbers of physicians from a range of medical specialties who do suggests some degree of manipulation of the payment scales.

Billing Norms

The Center for Public Integrity analyzed a representative 5 percent sample of Medicare patients and their claims submitted by more than 400,000 medical practitioners and 7,000 hospitals and clinics, starting in 2001. The cost analysis projected the increase in Medicare costs as more doctors picked higher codes each year over the decade.

The added fees totaled at least $11 billion, adjusted for inflation — more than half of it from higher doctor fees for office visits and the rest from other services, including treatment in nursing homes and hospitals.

The investigation identified thousands of doctors, from a broad range of specialties and locales, who adjusted their billing patterns sharply upward and netted higher fees as a result. A 1979 federal court injunction in Florida bars HHS from publicly releasing doctors' names and Medicare reimbursements.

The Center sued HHS to obtain the Medicare data but had to agree not to publish the names of individual doctors, unless they agreed to discuss their billing histories. Most who were contacted declined to do so.

From 1999 through 2008, the number of doctors who billed at least half of their office visits at one of the two most expensive codes more than doubled to at least 17,000 practitioners. Those who quit using the two least expensive codes rose 63 percent, climbing to more than 13,000 in 2008.

"Those are codes we see abused quite frequently," said Trussell, of the HHS inspector general's office.

In 2010 alone, Medicare paid for more than six million more visits at the second highest pay rate than the year before. That upsurge cost Medicare more than $1 billion, government records show.

Some doctors relied on the same code for nearly every patient visit despite Medicare guidelines calling for a balance because not all patients who see the doctor require the same degree of attention or time.

More than 750 doctors billed the two highest-paying codes exclusively for office visits, some for as long as seven years straight, for instance.

The changes in billing patterns vary sharply by region. For instance the Milwaukee area saw a steep jump in use of the two highest codes, from 19 percent at the start of the decade to 45 percent in 2008. The Phoenix and Salt Lake City areas also saw hefty jumps. By contrast, some major urban areas, including New York City and Los Angeles, decreased slightly over the decade.

Medicare has been paying for longer and more complex office visits despite annual surveys by the federal Centers for Disease Control and Prevention showing that the aver-

Top 20 counties for high coding

U.S. counties in which doctors billed the highest percentage* of the two most expensive Medicare codes for established patients in 2008.

1. Santa Rosa County, Fla. (60%)
2. Escambia County, Fla. (57%)
3. Merrimack County, N.H. (56%)
4. Strafford County, N.H. (56%)
5. Washington County, Okla. (56%)
6. Colbert County, Ala. (55%)
7. Baldwin County, Ala. (55%)
8. Cumberland County, N.C. (55%)
9. Shelby County, Ala. (54%)
10. Whatcom County, Wash. (54%)
11. Limestone County, Ala. (53%)
12. Chittenden County, Vt. (53%)
13. Warren County, Ohio (52%)
14. Hunterdon County, N.J. (51%)
15. York County, Maine (51%)
16. Clay County, Fla. (51%)
17. Arapahoe County, Colo. (50%)
18. Imperial County, Calif. (50%)
19. Adams County, Colo. (50%)
20. Duval County, Fla. (50%)

*For counties with at least 100 claims in the sample citing either or both of the top two billing codes

age time doctors spent with patients didn't change much over the years.

Jerry Cromwell, a researcher with RTI International in North Carolina, in a 2006 study found the average Medicare doctor visit lasted about 18 minutes, or less. Yet Medicare billing records show a sharp rise in services over the decade that were supposed to take 25 minutes or longer in face-to-face contact with a patient.

Cromwell said it has been a "real challenge" for Medicare officials to verify how much time doctors typically spend with patients. He identified "upcoding" as one possible explanation for the discrepancy.

The Medicare billing data do not show that patients are getting more infirm; their reasons for visiting the doctor's office were essentially unchanged over the decade. And the May report by the HHS inspector general said its review of 2010 Medicare claims found that many high-end billers tended to treat patients who were slightly younger than average.

Researchers also said there's not much evidence that elderly people on Medicare have been getting sick-

er over time — certainly not enough to justify the sharp rise in more costly billings.

Eric Seiber, an Ohio State University researcher who has studied physician billing trends, said Medicare officials have yet to conduct studies

Online Video: **'PBS NewsHour: Doctors are charging more for Medicare patients.**

to determine to what extent the pay scales are being manipulated.

"There is a lot of money there and we have almost no handle on it. It's so hard to pin down," Seiber said.

The Medicare billing data also lend little support to the argument that many doctors on average choose codes that are too low. In 2008, three times as many physicians were billing only the two top codes as picked the two lowest ones, for instance.

In addition, federal officials

projected that Medicare overpaid nearly $658 million in 2010 as a result of wrongly coded bills for office visits at the second most expensive payment level. Officials found underpayments to be a tiny fraction of that amount, or about $6.1 million, according to government records.

Malcolm Sparrow, a health care fraud expert and professor at the John F. Kennedy School of Government at Harvard University, said: "If there are changes [in billing] over time costing the public billions of dollars, there should be an explanation."

Coding Errors

Medicare manuals state that the government trusts doctors to bill accurately and pays bills "generally based solely on your representations" in the claim.

"When you submit a claim for services performed for a Medicare [patient], you are filing a bill with the federal government and certifying that you have earned the payment requested and complied with the billing requirements," the manual reads.

Yet Medicare auditors through the years have repeatedly detailed high rates of doctor billing errors, though mostly in obscure audits which captured little public notice and spurred little government action.

In June 2000, Medicare officials identified incorrect coding as Medicare's third most prominent error, triggering $1.7 billion in suspect payments. Much of the time, errors paid doctors too much, not too little.

"These improper payments, as in past years, could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud," auditors wrote.

In 2001, members of a government panel were so fed up with the payment scales that they recommended junking them. Two years later, Congress passed Medicare reform legislation that called for studies to consider alternatives to the pay scales.

But the law required Medicare officials to consult physicians' groups before making any changes, a legacy of the decision to allow the AMA to develop the codes. Medical groups have since been able to block any reform effort, according to former government official Scully and other insiders.

Scully said it was a "big mistake" for the government to give the AMA such a prominent role in creating

the doctor payment yardstick. "As a result the AMA has amassed enormous power," he said.

Medicare officials deny the AMA and other medical groups have outsized influence over the payment system. But they concede that the system has been left in place for years because they could not reach an agreement on ways to improve it.

Most patients have no idea doctor pay scales exist because Medicare and other insurers don't typically help people decipher them. As owner of the copyrights on the codes and their definitions, the AMA controls their publication and aggressively enforces its copyright.

Princeton University Professor Uwe E. Reinhardt, a prominent health care economist, said government officials could have paid the AMA a lump sum to develop the codes, simplified them and retained their ownership for taxpayers. Doing so would have opened up the process to public scrutiny and given patients a better understanding of health care finances. Other critics note that millions of seniors might help the government check on the veracity of medical bills if they knew the lingo and how to crack the codes.

"I wish I had some way to check up on the billing process," said Judy Ryden, a retired community college teacher who is on Medicare and lives in Grants Pass, Ore. "Unless I had a degree in medical coding I have no idea what all that means. I can't tell whether a charge is legitimate or not," she said.

AMA president Lazarus in his statement noted that while the AMA provides "guidance for the appropriate use" of billing codes, it "does not profit in any way if physicians bill an insurer for a complex service rather than a simple service."

Lazarus noted that the group "does not receive a single taxpayer dime" for its oversight of the codes. He said the system "saves taxpayers millions of dollars" by allowing medical information to be communicated efficiently and reliably."

Without the system, "the transfer of vital information between physicians, hospitals and health plans would break down under an even greater burden of costly paperwork," Lazarus said.

The payment system also has given rise to a cottage industry of coding experts and medical practice consultants who conduct seminars for doctors that often encourage higher coding — in some cases through Internet pitches that promise doctors significantly higher profits.

Medical organizations also teach their members ways to code at higher levels legitimately. In one 2009 article, the academy of family physicians noted that using the second-highest level for most office visits could put an additional $30,000 to $75,000 in a doctor's pocket.

As a result, the billing codes intended to hold medical fees in check have instead contributed to spiraling Medicare costs.

Error Prone

Today, startlingly high rates of billing mistakes — many of them overcharges — persist, according to Medicare audits conducted in several states.

In May 2011, Medicare contractor Palmetto GBA notified more than 11,000 California doctors that it would begin auditing their claims for office visits after concluding that too many were being billed at high-level codes.

Another Medicare contractor called Trailblazer audited patient office visits in early 2010 in Virginia and found mistakes in half the records it reviewed. A similar audit in Colorado, New Mexico, Oklahoma and Texas reported a 91% error rate for billing for office visits.

Billy Quarles, a spokesman for BlueCross BlueShield of South Carolina, which owns both companies, said "inadequate documentation" was the primary reason for the high denial rates in the Trailblazer audit.

"In some cases the documentation available did not support the level of service billed, but more often, the documentation was not sufficient to determine medical necessity or evidence of a face-to-face encounter with the patient," Quarles said.

A third Medicare contractor, WPS Medicare, conducted a similar review of doctors in Wisconsin, Illinois, Michigan and Minnesota after discovering unusually high levels of the second highest code, most of them coding errors on routine patient visits.

In both cases, the audits focused on family practice doctors and specialists in internal medicine. Doctors who failed to respond could face denials of their claims.

"Upcoding"

Deliberately inflating bills to boost profits can constitute health care fraud, but few offenders face any liability.

And chances of getting caught are

very small because Medicare rarely audits closely and typically has no way of finding out unless someone on the inside comes forward and alerts them. Federal officials have recently stepped up efforts to use computers to detect abnormal billing patterns, however.

Many of the more than 50 "upcoding" court cases reviewed by the Center for Public Integrity resulted from whistleblower lawsuits, often filed by an employee who fears retribution after alerting superiors to the billing problems. They can share in money the government recoups, and most cases are settled with no admission of wrongdoing.

Minnesota family doctor David Lang offers an example. He sued his employer, the Apple Valley Medical Clinic in suburban Minneapolis, as a whistleblower after concluding that some of the 14 doctors working there were upcoding Medicare claims.

He also took his findings to federal officials, who joined the civil case.

In his suit, Lang said that when he brought up some "extraordinarily high" doctor billings to the clinic's board, he faced threats and retaliation.

For instance, he said he was accused of seeing patients with "alcohol on his breath," an allegation Lang refuted by demanding a test, which showed no liquor in his body, according to court filings.

The Apple Valley clinic's managers denied wrongdoing, though they settled the suit by paying the government more than $180,000 in December 2010. The clinic did not respond to requests for comment. But Lang, a partner in the clinic, says it now bills properly.

"We've cleaned it up," he said.

Lang said in an interview that he believes billing irregularities are "prevalent" in medical offices. He said some doctors overbill "consciously and without remorse," while others may regard inflating a few service codes as a relatively harmless way to help defray rising office expenses — or to silently protest what they regard as stingy pay from Medicare.

According to Lang, Medicare officials should publicize these cases widely to limit what he called "robbing from the public."

But that seldom happens.

Like many others, Lang's lawsuit file was sealed by a federal court judge with only his initial allegations made public.

Even criminal prosecutions con-

ducted in open court may not bring a significant penalty. Several criminal cases reviewed were settled with a plea bargain that not only kept the doctor out of jail, but also let him continue participating in Medicare.

Billing administrator Lynne Lewis helped trigger such a case after concluding that her boss, Massachusetts pain specialist Dr. Anil Kumar, was "upcoding" some bills.

When she confronted Kumar about his billing tactics, he testily told her that he did business that way "long before you came," and would do so "while you are here" and "long after you are gone," according to her lawsuit.

The tongue lashing didn't deter Lewis. She filed a whistleblower lawsuit against the doctor and federal authorities charged Kumar with health care fraud.

Prosecutors accused Kumar of fraudulently billing every new patient visit as if it were a consultation referred by another doctor. At the time, Medicare paid more for consultations than for simple office visits.

In June 2010, Kumar agreed to pay the government $586,000 in a settlement deal in which he did not admit any wrongdoing. He still practices in Stoneham, Mass., and is in good standing with Medicare. He had no comment.

Growing Tensions

Though the Obama administration has made a significant commitment to cracking down on Medicare fraud and abuse, officials don't appear to have an aggressive strategy for cutting down on medical coding abuses.

CMS acting Administrator Marilyn Tavenner earlier this year confirmed that the agency planned to contact as many as 5,000 doctors it identified as billing outside norms, but said the effort was "not intended to be punitive or sent as an indication of fraud."

She said the agency would focus on the top ten high billers in each Medicare region as a first step, but that it might cost the agency more to investigate suspicious claims than it could collect.

The agency, Tavenner wrote in a letter published in the May IG report, "must take into account the respective return on investment of medical review activities."

It is clear that CMS is meeting resistance to fraud-control audits from doctors' groups — and threats that some physicians might dump

Medicare patients if the government doesn't back off.

In December of 2011, California Medical Association president Dr. James T. Hay fired off a letter to federal officials in Washington noting that audits of doctor billings have "created great consternation" among the state's doctors and saddled them with what he deemed an "enormous administrative burden" on their office staffs.

"Clearly, physicians want their purposefully overbilling and illegally behaving peers to be found and stopped. We also want to be paid fairly," Hay later wrote in a CMA publication.

Hay added a threat that targeting doctors for review unfairly "will only further induce physicians to decrease or stop their participation in the Medicare program."

Asked about the controversy, Medicare officials said they didn't believe the limited number of proposed audits would lead doctors to dump Medicare patients. Officials said they had responded to the letter by "conducting a telephone conference and additional discussions with [Medicare payment contractor] Palmetto," but declined to offer details.

These sorts of clashes are likely to become more common. Several provisions in the health care reform law step up penalties for doctors and hospitals who fail to return any overpayments within 60 days, for instance.

In draft regulations, Medicare officials predicted the new policies would result in about 125,000 medical providers returning from three to five overpayments each during a typical year.

Many experts also predict an even sharper clash lies ahead over electronic health records, which Medicare officials are pushing doctors and hospitals to purchase, and also are widely marketed for their power to document higher billing codes — and thus boost the bottom line. More than half of doctors billing Medicare used the devices in 2011, and more are expected to do so.

Reinhardt, the health economist, said that government must be cautious to pay health professionals properly for their work, and that under the current coding system, fees often are too low, which in turn encourages higher coding.

"If it is a dishonest payment system, doctors will be dishonest," Reinhardt said. ■

Impact Articles ▶

IMPACT

Cabinet officials signal crackdown on Medicare billing abuse

By Fred Schulte and Joe Eaton

Published Online: September 24, 2012

TOP FEDERAL officials are stepping up scrutiny for doctors and hospitals that may be cheating Medicare by using electronic health records to improperly bill the health plan for more complex and costly services than they deliver.

U.S. Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder notified five medical groups of

Health and Human Services Secretary Kathleen Sebellius, with attorney general Eric Holder. Jacquelyn Martin/AP

their intention to ramp up investigative oversight, including possible criminal prosecutions, by letter on Monday.

The government action follows The Center for Public Integrity's "Cracking the Codes" series, published last week. The year-long investigation found that thousands of medical professionals have steadily billed higher rates for treating seniors on Medicare over the last decade — adding $11 billion or more to their fees.

The Center's probe uncovered a broad range of costly billing errors and abuses that have plagued Medicare for years—from confusion over how to pick proper payment codes to outright overcharges. The findings indicated that Medicare billing problems are worsening as doctors and hospitals switch to electronic health records.

"There are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled," the letter states, adding: "There are also reports that some hospitals may be using electronic health records to facilitate 'upcoding' of the intensity of care or severity of patients' condition as a means to profit with no commensurate improvements in the quality of care."

The letter said that "false documentation of care is not just bad patient care; it's illegal." The Centers for Medicare and Medicaid Services, which oversees the program "is specifically reviewing billing through audits to identify and prevent improper billing." The letter went on to say that CMS is "initiating more extensive medical reviews to ensure that providers are coding…accurately."

The letter adds that "law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided. The Department of Justice, Department of Health and Human Services, the FBI and other law enforcement agencies are monitoring these trends and will take action where warranted."

Most of the five groups sent the letter on Monday had no comment. The American Hospital Association said it agreed that upcoding should not be tolerated, but added that "more accurate documentation and coding does not necessarily equate with fraud." The group also asked federal officials to develop national guidelines for hospital emergency department and clinic visits —a request the group said it hade made 11 times since 2001.

The group said it does not question the need for auditing to identify billing errors, but added that "the flood of new auditing programs…is drowning hospitals with a deluge of redundant audits, unmanageable

Letter from Health and Human Services and the Justice Department

September 24, 2012

American Hospital Association
Richard Umbdenstock
President and Chief Executive Officer
325 Seventh Street, N.W.
Washington, DC 20004

Federation of American Hospitals
Charles N. Kahn, III
President and Chief Executive Officer
750 9th Street, NW, Suite 600
Washington, DC 20001-4524

Association of Academic Health Centers
Steve Wartman
President and Chief Executive Officer
1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036

Association of American Medical Colleges
Darrell G. Kirch, M.D.
President and Chief Executive Officer
2450 N Street, NW
Washington, DC 20037-1126

National Association of Public Hospitals and Health Systems
Bruce Siegel, MD, MPH
President and Chief Executive Officer
1301 Pennsylvania Avenue, NW
Suite 950
Washington DC 20004

Dear Chief Executive Officers:

As leaders in the health care system, our nation's hospitals have been at the forefront of adopting electronic health records for use in coordinating care, improving quality, reducing paperwork, and eliminating duplicative tests. Over 55 percent of hospitals have already qualified for incentive payments authorized by Congress to encourage health care providers to adopt and meaningfully use this technology. Used appropriately, electronic health records have the potential to save money and save lives.

However, there are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal. These indications include potential "cloning" of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate "upcoding" of the intensity of care

Letter from Health and Human Services and the Justice Department

or severity of patients' condition as a means to profit with no commensurate improvement in the quality of care.
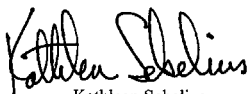
This letter underscores our resolve to ensure payment accuracy and to prevent and prosecute health care fraud. A patient's care information must be verified individually to ensure accuracy: it cannot be cut and pasted from a different record of the patient, which risks medical errors as well as overpayments. The Centers for Medicare and Medicaid Services (CMS) is specifically reviewing billing through audits to identify and prevent improperly billing. Additionally, CMS is initiating more extensive medical reviews to ensure that providers are coding evaluation and management services accurately. This includes comparative billing reports that identify outlier facilities. CMS has the authority to address inappropriate increases in coding intensity in its payment rules, and CMS will consider future payment reductions as warranted.

We will not tolerate health care fraud. The President initiated in 2009 an unprecedented Cabinet-level effort to combat heath care fraud and protect the Medicare trust fund, and we take those responsibilities very seriously.

Law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided. The Department of Justice, Department of Health and Human Services, the FBI, and other law enforcement agencies are monitoring these trends, and will take action where warranted. New tools provided by the health care law authorize CMS to stop Medicare payments upon suspicion of fraud and to mine data to detect it in the first place. These efforts have contributed to record-high collections and prosecutions. Prosecutions in 2011 were 75 percent higher than in 2008. That said, we will continue to escalate our efforts to prevent fraud and pursue it aggressively when it has occurred.

The nation's hospitals share our goal of a health system that offers high quality, affordable care. We thank you for your relentless work toward this goal which can be better achieved once all Americans have privacy-protected electronic health records. The health information technology incentive program promotes electronic health records that go beyond documentation and billing and towards meaningful use as a foundation for new payment and delivery models. The Affordable Care Act has accelerated the spread of such models like Accountable Care Organizations, patient-centered homes, and value-based purchasing which shift the incentives away from volume and towards value. As we phase-in electronic health records, though, we ask for your help in ensuring that these tools are not misused or abused.

Sincerely,

Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services

Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice

medical record requests and inappropriate payment denials."

The suggestion that digital medical gear has fueled a rise in potentially improper medical billing is a touchy one for the Obama administration, which has championed electronic health records as a means to both improve the quality of medical care and cut costs. The administration is spending more than $30 billion in economic stimulus funds to help doctors and hospitals purchase the gear. More than half the nation's hospitals have received some payments from the program, according to HHS.

But critics have also noted that digital medical and billing equipment can with the touch of a button create an exquisitely detailed medical file and thus present a challenge to government auditors concerned about preventing fraud.

The letter sent Monday was the first acknowledgment by top federal officials that the digital era may spawn more costly Medicare fraud and billing abuse. In the past, federal officials have largely accepted the explanations of doctors and hospitals that higher-level billings are mainly the result of patients on Medicare getting sicker and older and taking more time to treat—even though there's little evidence to back that view.

Sebelius and Holder took aim at the common practice of using electronic health record software to "clone" documentation from previous medical visits "in order to inflate what providers get paid."

"We will not tolerate health care fraud," the letter states. "The President initiated in 2009 an unprecedented cabinet-level effort to combat health care fraud and protect the Medicare trust fund and we take those responsibilities very seriously," the letter states.

Medicare's shaky finances also have emerged as a presidential campaign issue, with both Barack Obama and Mitt Romney promising to tame its spending growth while protecting seniors. But there's been little talk about the impact of billing and coding practices in driving up costs, and what to do about them.

Medicare pays doctors for office visits using five escalating payment

Response from American Hospital Association

American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

September 24, 2012

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Ave., S.W.
Room 445-G
Washington, DC 20201

The Honorable Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice
950 Pennsylvania Ave., N.W.
Washington, DC 20530

Dear Secretary Sebelius and Attorney General Holder:

America's hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries. Hospitals have a longstanding commitment to compliance, establishing programs and committing resources to ensure that they receive only the payment to which they are entitled. We agree that the alleged practices described in your letter, such as the so-called "cloning" of medical records and "upcoding" of the intensity of care, should not be tolerated.

Electronic health records hold great promise for improving the efficiency and effectiveness of care. Hospitals have made great strides to comply with the Administration's regulations for implementing this technology, which also enhances their ability to correctly document and code the care a patient has received.

It's critically important to recognize that more accurate documentation and coding does not necessarily equate with fraud. Medicare and Medicaid payment rules are highly complex and the complexity is increasing. We have made numerous requests to the Centers for Medicare & Medicaid Services (CMS) to develop national guidelines for the reporting of hospital emergency department (ED) and clinic visits. This is a request that the AHA has made to CMS 11 times (starting in 2001) since the outpatient prospective payment system (OPPS) was first implemented.

Since April 2000, hospitals have been using the American Medical Association's (AMA) Current Procedural Terminology (CPT®) evaluation and management (E/M) codes to report facility resources for clinic and ED visits. Recognizing that the E/M descriptors, which were designed to reflect the activities of physicians, did not adequately describe the range and mix of services provided in hospitals, CMS instructed hospitals to develop internal hospital guidelines to determine the level of clinic or ED services provided. In 2003, the AHA and the American Health Information Management Association (AHIMA) recommended that CMS implement national hospital E/M visit guidelines based on the work of an independent expert panel comprised of representatives with coding, health information management, documentation, billing, nursing, finance, auditing and medical experience.

Response from American Hospital Association

In the 2004 and 2005 OPPS rules, CMS stated it would consider national coding guidelines recommended by the panel. **However, to date, CMS has not established national hospital E/M guidelines.**

For calendar year (CY) 2013, as it has for every year since implementing OPPS, CMS proposes that, until national guidelines are established, hospitals should continue to report visits according to their own internal hospital guidelines to determine the different levels of clinic and ED visits. In the proposed rule, CMS notes its continued expectation that hospitals' internal guidelines should comport with the principles listed in the 2008 OPPS final rule. Hospitals with more specific questions related to the creation of internal guidelines are directed to contact their local fiscal intermediaries or Medicare Administrative Contractors (MACs).

The AHA has long called for national guidelines for hospital ED and clinic visits, and we stand ready to work with CMS in the development and vetting of such guidelines. Once national guidelines are developed, we recommend that a formal proposal be presented to the AMA's CPT® Editorial Panel to create unique CPT® codes for hospital reporting of ED and clinic visits based on the national guidelines. These codes then could be widely reported by hospitals to all payers.

Hospitals share the Administration's goal of a health system that offers high-quality, affordable care and work hard to ensure billing is correct the first time. What's needed is clearer guidance from CMS, not duplicative audits that divert much needed resources from patient care. In recent years, CMS has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. No one questions the need for auditors to identify billing mistakes; but the flood of new auditing programs, such as Recovery Audit Contractors, MACs and others, is drowning hospitals with a deluge of redundant audits, unmanageable medical record requests and inappropriate payment denials. For example, respondents to AHA's latest RACTrac survey are appealing more than 40 percent of denials with a success rate of 75 percent. While the payment accuracy programs may be well intentioned, they need to be streamlined with duplicative audits eliminated and inappropriate denials halted. Furthermore, investments should be made in provider education and payment system fixes to prevent payment mistakes before they occur.

Thank you for your attention to this issue. On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, we look forward to working with you and other stakeholders as we continue to improve health care for patients.

Sincerely,

Rich Umbdenstock
President and CEO

codes, which range from a minimal visit of about five minutes for about $20 to about $140 paid for more complex treatments that generally take 40 minutes or more of face-to-face time with the doctor. Federal officials expect doctors to report a range of the five codes because some patients require more time and effort to treat than others. Medicare uses the scales to pay for more than 200 million office visits each year and other doctor services that cost taxpayers more than $33 billion.

But doctors over the past decade have increasingly spurned lower-level codes for ones that pay better —even though there's little hard evidence that they spent more time with patients or that patients were sicker and required more complicated and time-consuming care. Hospitals also use the billing codes, and the Center found similar problems with billing for emergency room services.

More than 7,500 physicians billed the two top-paying codes for three out of four office visits in 2008, a sharp rise from the numbers of doctors who did so at the start of the decade, the Center's data analysis found. Officials said such changes in billing can signal that some doctors are billing for more complex services than they delivered, a practice known as "upcoding."

As the government has invested more heavily in electronic health records, hundreds of technology firms have begun marketing digital records system, often doing so by promising doctors and hospitals that they can significantly boost revenues with the devices.

Most manufacturers and the hospitals using the gear contend that the digital gear merely allows them to more efficiently bill for their services, which in the past were often done by hand.

In 2010 alone, Medicare paid for more than six million more patient visits at the second highest level code, 99214, than the year before. That upsurge cost Medicare more than $1 billion, government records show.

CMS acting Administrator Marilyn Tavenner earlier this year confirmed that the agency planned to contact as many as 5,000 doctors it identified as billing outside norms, but said the effort was "not in-

tended to be punitive or sent as an indication of fraud."

She said the agency would focus on the top ten high billers in each Medicare region as a first step, but that it might cost the agency more to investigate suspicious claims than it could collect.

The agency, Tavenner wrote in a letter published in a May Inspector General's report , "must take into account the respective return on investment of medical review activities."

The five medical groups sent the letter are: the American Hospital Association, the Association of Academic Health Centers, the National Association of Public Hospitals and Health Systems, the Federation of American Hospitals.

The association of public hospitals said in a statement that it "shares the government's goal of a health care system that offers high-quality, affordable care. Our hospitals and health systems adhere to high ethical standards and reject practices that might result in fraudulent or improper claims. We stand ready to help regulators understand fully the many aspects of electronic health record use in the hospital setting as they consider actions to ensure proper billing practices." ■

HHS IG pledges focus on Medicare billing abuse involving electronic records

By Fred Schulte

Published Online: October 24, 2012

FEDERAL OFFICIALS will focus on possible Medicare overbilling by doctors and hospitals that use electronic medical records, a top government fraud investigator said Wednesday, in announcing investigative priorities for the coming year.

"Electronic medical records can improve quality of care and efficiency and help us uncover cases of fraud and abuse. At the same

time, we must guard against the use of electronic records to cover up crime," said Daniel Levinson, the Department of Health and Human Services inspector general, in a video presentation.

The video posted on the agency's website on Wednesday summarized the inspector general's "work plan," for 2013, a listing of Medicare and Medicaid fraud fighting efforts the agency plans to emphasize.

The plan states that the agency "will identify fraud and abuse vulnerabilities in electronic health records (EHR) systems as articulated in literature and by experts to determine how certified EHR systems address these vulnerabilities." The agency did not provide further details of its review.

The economics of switching to electronic health records is receiving new scrutiny in the wake of the Center for Public Integrity's "Cracking the Codes" series, which found that thousands of medical

Daniel R. Levinson, Inspector General for the U.S. Department of Health and Human Services, at a press conference in February 2012. LM Otero/AP

professionals have steadily billed higher rates for treating seniors on Medicare over the last decade — adding $11 billion or more to their fees. The investigation suggested that Medicare billing errors and abuses are worsening as doctors and hospitals switch to electronic health records. A similar report was subsequently published by the New York Times.

Earlier this month, Dr. Farzad Mostashari, the Obama administration's National Coordinator for Health Information Technology, said he would ask a panel of policy experts to examine the billing contro-

Letter to HHS Secretary Kathleen Sebelius

United States Senate
WASHINGTON, DC 20510

October 17, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius:

We write to formally request that relevant staff from the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) meet with staff from the Senate Finance and Senate Health, Education, Labor, and Pensions Committees regarding the final rule for the Stage 2 of Meaningful Use for the adoption of electronic health records.

We appreciate the Administration's commitment to having dialogue with Congress on the issue of our nation's adoption of electronic health records; however, the recent briefing did not provide sufficient time and opportunity to fully cover the full range of questions regarding the final rule and related implementation issues, many of which have been informed by dialogue with our constituents directly impacted by this program. For example, recent media reports and independent analysis have highlighted several important questions to address:

- Does the use of taxpayer-subsidized electronic health records (EHRs), in some circumstances, actually increase the utilization of diagnostic tests rather than reduce them? What is the Administration's strategy to address what may be an unintended consequence of federal policy – higher utilization of tests and higher spending across the health system?[i]

- Have some health care providers received federal subsidies for EHR systems they already had in place prior to the adoption of federal standards and mandates? If so, what steps is the Administration taking to recoup any inappropriate payments and what additional program integrity measures have been adopted? [ii]

- Has the digitalization of records and broader adoption of EHRs increased providers' billing of Medicare and thereby increased the overall costs of the program for taxpayers?[iii]

- Since federal rule-making has largely focused on stakeholders' adoption and "meaningful use" of EHRs, what is the Administration's strategy for meaningful interoperability, since they acknowledge current interoperability standards remain insufficient and incomplete?[iv]
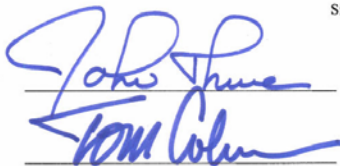
The final rule for Stage 2 of Meaningful Use affects the direction of health care delivery and the future use of health information technology across our nation. To date, more than $6.6 billion has been paid out in incentives to health care providers. Fully understanding the next steps for this significant federal investment and the decisions made in the final rule are a critical part of fulfilling our role in conducting oversight over this program and representing the concerns of our constituents as elected Members of Congress. Therefore, we respectfully request another meeting, with the objective to ensure an opportunity to fully discuss the outstanding questions and continue the productive dialogue that was started during the recent briefing, but which Administration staff did not have sufficient time to complete.
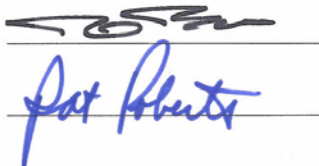
Letter to HHS Secretary Kathleen Sebelius

We believe this additional conversation will provide an important opportunity for the Department of Health and Human Services to hear from and respond to outstanding Congressional questions on this issue. To ensure the most productive and efficient meeting, we further request that the relevant staff with appropriate technical knowledge of the final rule are made available no later than October 26, 2012, for as much time as is necessary to adequately respond to the questions we have on the final rule for Stage 2.

Thank you in advance for your prompt attention to this request.

Sincerely,

[i] Abelson, Reed and Creswell, Julie. "U.S. Warning to Hospitals on Medicare Bill Abuses." The New York Times, September 24, 2012. http://www.nytimes.com/2012/09/25/business/us-warns-hospitals-on-medicare-billing.html?_r=0

[ii] iHealthBeat, "Incentives Going To Doctors Who Were Already Using Health IT," October 13, 2011. http://www.ihealthbeat.org/articles/2011/10/13/incentives-going-to-doctors-who-already-were-using-health-it.aspx?p=1#ixzz1agzC4UfH

[iii] Soumerai, Stephen and Koppel, Ross. "A Major Glitch for Digitized Health-Care Records," The Wall Street Journal, September 17, 2012. http://online.wsj.com/article/SB10000872396390443847404577627041964831020.html?mod=googlenews_wsj

[iv] Manos, Diana. "More Voices Raised Against EHR Incentives," HealthcareIT News, October 9, 2012. http://www.healthcareitnews.com/news/more-voices-raised-against-ehr-incentives?topic=,08

versy. Mostashari said he wants to find out if the digital systems are triggering higher billing codes by allowing doctors to cut and paste records from prior encounters with a patient, a practice known as "cloning."

Many experts say that this process can raise the size of a patient's bill, even though it reflects little in the way of added or necessary medical service.

Dr. Stephen R. Levinson, a Connecticut physician and expert on medical coding and billing issues, called the inspector general's focus a "warning shot across the bow" for physicians. While Medicare requires an efficient auditing effort, Levinson also criticized the "punitive nature" of the audits, which are "turning physicians off."

Other critics have noted that the software itself may encourage medical professionals to bill for more complex and costly services than they actually deliver — a practice known as "upcoding."

Republicans in Congress also are expressing concern about the government's program to spend more than $30 billion helping doctors and hospital purchase digital record keeping systems—and to use them as a means to improve the quality of medical care.

In an Oct. 17 letter [see previous two page] to HHS Secretary Kathleen Sebelius, four Republican senators raised questions about whether electronic health records are hiking the number of medical tests doctors ordered as well as boosting billing and "thereby [increasing] the overall costs of the program" to taxpayers. ■

Hospitals grab at least $1 billion in extra fees for emergency room visits

Center probe suggests facilities have taken advantage of government's failure to set billing standards

By Joe Eaton and David Donald
Published Online: September 20, 2012

JUDGING by their bills, it would appear that elderly patients treated in the emergency room at Baylor Medical Center in Irving, Texas, are among the sickest in the country — far sicker than patients at most other hospitals.

In 2008, the hospital billed Medicare for the two most expensive levels of care for eight of every 10 pa-

tients it treated and released from its emergency room — almost twice the national average, according to a Center for Public Integrity analysis. Among those claims, 64 percent of the total were for the most expensive level of care.

But the charges may have more to do with billing practices than sicker patients. A Baylor representative conceded hospital billing for emergency room care "did not align with industry trends," but said that the hospital since 2009 has reined in its charges.

The Texas hospital's billing pattern is far from unique. Between 2001 and 2008, hospitals across the country dramatically increased their Medicare billing for emergency room care, adding more than $1 billion to the cost of the program to taxpayers, a Center investigation has found. The fees are based on a system of billing codes — so-called evaluation and management codes — that makes higher payments for treatments that require more time and resources.

Use of the top two most expensive codes for emergency room care nationwide nearly doubled, from 25 percent to 45 percent of all claims, during the time period examined. In many cases, these claims were not for treating patients with life-threatening injuries. Instead, the claims the Center analyzed included only patients who were sent home from the emergency room without being admitted to the hospital. Often, they were treated for seemingly minor injuries and complaints.

While taxpayers footed most of the bill, the charges also hit elderly patients in the pocketbook, increasing the amount of their 20-percent co-payments for emergency room care.

Hospitals and federal officials say the rise has likely been caused by an increase in sicker patients seeking care in emergency rooms, more accurate billing on the part of hospitals, and an increasing number of options for patients who aren't as sick — options that include retail-based clinics and urgent care facilities. But the Center's investigation found that the surge in billing also reflects lax government oversight, confusion about proper billing standards, and widespread payment errors that have plagued Medicare for more than a decade. And the data suggest that some hospitals are working the billing system — and its flaws — to maximize payments.

Dr. Donald Berwick, the immediate past administrator of the Centers

for Medicare and Medicaid Services (CMS), which administers the Medicare program, said a small portion of the billing increase is likely caused by outright fraud, but in the majority of cases hospitals are legally boosting profits by targeting the vulnerabilities of Medicare's payment system. "They are learning how to play the game," Berwick said about the hospitals.

Hospital industry insiders say it's no secret that hospitals are pushing the limits to bill higher-priced Medicare codes, a practice known as upcoding. "There is such financial pressure to upcode," said Barbara Vandegrift, a health care consultant at Tennessee-based Quorum Health Resources. "It's 'wait until we get caught and we'll fight it at that point.'"

Few hospitals, however, are being scrutinized. Medicare officials are aware of the rising expense of emergency room billing for evaluation and management services, but the agency has downplayed the problem and done little to verify the accuracy of hospital emergency room charges. Instead, it has given hospi-

Former Medicare Administrator Dr. Donald Berwick gestures during an interview with The Associated Press. J. David Ake/AP

tals a free hand to set their own billing policies, with little agency guidance and even less auditing.

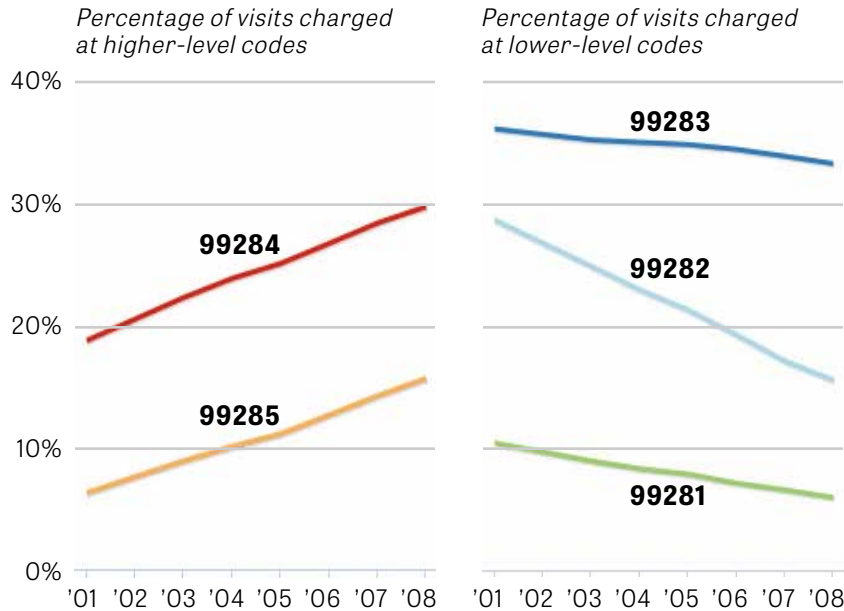## Medicare lacks rules for hospital ER billing

Since 2000, hospitals have chosen among five codes to bill Medicare and other insurers for evaluating emergency room patients and coordinating their treatment. This hospital "facility fee," which can add millions of dollars to the hospital's bottom line in the course of a year, ranges from $50 to $324, depending on which code is chosen for any given case. It comes on top of physician charges.

Rush to higher-paying codes

Hospital billing of the two most expensive emergency room codes —
99284 and 99285 — jumped while less expensive codes — 99281 through
999283 — dropped off. The billing codes represent the varying levels of
hospital resources required for different types of care; the codes call for
payments ranging from $50 to $324, and come on top of physician fees.
The codes were developed for physicians, not hospitals. Yet Medicare's
administrator has balked at implementing uniform standards governing
how hospitals determine which codes to bill. Instead, Medicare relies on
hospitals to set their own internal rules.

Emergency Room Visits
Higher-numbered codes receive higher payments from Medicare.

Percentage of visits charged at higher-level codes

Percentage of visits charged at lower-level codes

Graphic by Timothy Meko

The system dates back to a change in federal law requiring hospitals be paid a set fee for services, rather than a blanket payment based on the cost of providing care, which was meant to save the program money. Yet instead of developing specialized billing codes just for hospitals, CMS since 2000 has required hospitals to file claims using a set of codes developed and licensed for physician billing by the American Medical Association — so-called Current Procedural Terminology, or CPT, codes. The lack of specific hospital codes, or guidelines for how hospitals should use physician codes, has left the system open to broad interpretation by hospitals.

"All the hospitals looked at each other and said, 'OK, how are we going to do this?' To make a long story very short, we still have no guidelines," said Duane Abbey, a hospital billing consultant in California.

Medicare administrators acknowledge as much. Since 2000, CMS has repeatedly announced plans to develop new hospital evaluation and management codes, or at least provide national guidelines for hospital billing. But the agency has failed to deliver. Instead, CMS requires hospitals to develop their own guidelines for billing those codes designed for doctors. Some follow strict internal policies, Abbey and other hospitals billing consultants said, while others wildly inflate charges, regularly change their billing criteria, and sometimes fail to follow even their own lax internal policies.

"The whole issue of the E and M levels for the emergency department … is an absolute mess," Abbey said.

Chasing dollars

Left to develop their own billing rules, hospitals have flocked to higher paying emergency room codes. Leatrice Ford, an independent consultant in Louisville, Ky., who uses Medicare claims data to advise hospitals on their emergency room billing, said it's well known in the industry that many hospitals inflate their charges. But Ford said it's a tough sell for a consultant to convince hospitals their billing is too high. "In my experience hospitals are reluctant to give up their overpayments," Ford said. The reason, she said, is that Medicare and the contractors it employs to administer payments are not checking.

"I have never once seen or heard of anyone being audited or called on the carpet for their distribution of E and M codes," Ford said. "That's

a standard audit for physician practices, but I've never seen a hospital get in trouble for it."
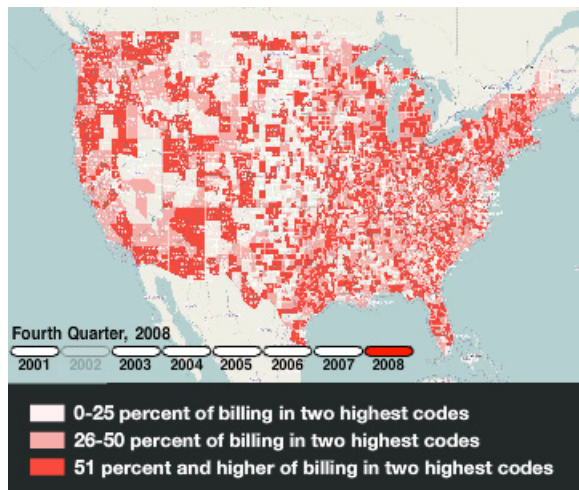
In 2008, more than 500 hospitals of the more than 2,400 in the database billed the two most expensive codes for more than 60 percent of patients. More than 100 billed the two most expensive codes for at least 70 percent of patients.

Some — like Baylor Medical Center in Irving — were even higher. In 2007, Yuma Regional Medical Center, a 369-bed nonprofit hospital in southwestern Arizona, billed the top two most expensive codes for eight of every 10 Medicare emergency room patients. Billing at the hospital made Yuma, Arizona, the nation's regional leader for the percentage of billing of the top two levels of E and M codes, far higher than metropolitan areas like New York City and Chicago.

Yuma's CEO Pat Walz, however, said the charges are accurate. When the Center first asked about the claims, Walz said elderly winter visitors have driven up the hospital's number of serious emergency room cases. Yuma claims data reviewed by the Center for Public Integrity, how-

Percentage of Medicare emergency room claims billed at the two highest levels, by county

Fourth Quarter, 2008
2001 2002 2003 2004 2005 2006 2007 **2008**

0-25 percent of billing in two highest codes
26-50 percent of billing in two highest codes
51 percent and higher of billing in two highest codes

Online Interactive Graphic: Analysis/mapping by Palantir Technologies/Graphic assistance by Timothy Meko.

ever, suggest the average age of the hospital's emergency room patients remained steady from 2001 to 2008 at around 77 years old.

Walz also conceded that the in-

stallation of Medhost, an electronic emergency department information system, was likely one of the most significant drivers of the hospital's push toward more expensive codes. Before Medhost, nurses and doctors wrote patient notes by hand, Walz said. Computerized charting captured much more of the work they actually performed, which he said resulted in higher E and M levels.

But Walz said the electronic system is not overcharging Medicare. Rather, it is simply helping the hospital make money from care that once fell through the cracks. "If you look at any industry — as it goes from human to electronic input, the same thing is going to happen," Walz said.

Walz said Medhost has paid for itself through increased billing, but he said the decision to install it was not financial. "We did it to improve the quality of patient care," he said. Medhost did not respond to requests for comment.

CMS: hospital billing increase "slight"

The Centers for Medicare and Medicaid Services has so far downplayed the spike of hospital billing. In 2011 comments published in the Federal Register, CMS said it noticed a "slight shift" toward hospital billing of more expensive evaluation and management codes. The agency said it also noticed that emergency room charges for the higher-level visits "seem to be trending upward year over year."

Presented with the Center's analysis, which shows a far more dramatic shift toward expensive codes, CMS declined interview requests. But in written responses to questions, the agency's press office said the trend is only "notable" over several years. Considered year to year, as the agency said it examined the data, the higher level codes increase at no more than 2 percent.

Further, the agency wrote that the trend may reflect more accurate coding by hospitals and physicians rather than upcoding. Indeed, the agency said its advisory panel, which is made up of physicians, hospital administrators and other hospital financial staff, told CMS that the rise in billing is a result of hospitals getting better at capturing their costs.

"They would argue that the costs were inadequately reflected in our data several years ago," the agency wrote, "so the increases we are seeing now are bringing the payment system to where it should have been all along."

Dr. Scott Manaker, a professor of medicine at the University of Pennsylvania Perelman School of Medicine, a member of the panel, said there are a number of possible causes for the rise in high-level billing, including more accurate hospital coding. Manaker said he doubts upcoding is the major cause, but said it's impossible for the panel to determine without examining individual patient charts and hospital billing records, which it has not done.

Another panel member said hospital emergency room billing has not been a critical issue during meetings. "In my four years in the panel there has not been a lot of discussion of E and M leveling on the facility side," said Judith Kelly, director of health information management at Unity Health System in Rochester, N.Y. To address the issue, Kelly said CMS should issue hospital-specific billing codes or guidelines for emergency care. "When there is ambiguity, there are problems," she said.

In response to questions, CMS said some hospitals have been audited. But the agency said the process of auditing and seeking reimbursement of overpayment is "expensive and time consuming relative to the potential return that will be realized on individual claims for rela-

tively low cost services."

But some question whether CMS contractors — who help administer Medicare payments — can effectively audit hospital billing. Without national billing guidelines, said Abbey, the hospital auditor, it would be difficult for CMS contractors to determine who is cheating the system. Indeed, he said they would need first to ask each hospital for a copy of its internal billing guidelines. "They should have one of their famous committees developing guidelines right now," Abbey said. "My sense is they aren't, but they should be."

A never-ending quest for billing guidelines

During the 12 years that CMS has allowed hospitals to set their own billing policies for E and M codes, a host of organizations have proposed national guidelines. So far, none of them have made the cut.

In 2002, the American Hospital Association (AHA) and the American Health Information Management Association, an association representing health information management professionals, formed an expert panel to develop guidelines for hospital emergency room billing at the urging of CMS. In

2003, the groups submitted detailed recommendations for a billing system that measured hospital emergency room care. The recommendations went nowhere. "It just died a slow death," said William Briggs, a nurse who represented the Emergency Nurses Association on the expert panel.

CMS has called the AHA proposal the "most appropriate and well-developed guidelines" available. Yet the agency has not required hospitals to follow them. Not long after the AHA proposed the guidelines, a CMS-funded outside study found a number of problems with the guidelines.

A separate small-scale study, however, suggested the guidelines save money. In 2009, the Ohio-based company Permedion, which reviews medical claims for state and federal agencies, found that 37 percent of a sample of Ohio Medicaid emergency room claims should have been coded at lower levels, based on the AHA guidelines. The remainder were in agreement with the guidelines.

The AHA remains one of the loudest voices pushing for guidelines, but it is discouraged over the long delay. "We keep asking them to issue national guidelines," said Nelly Leon-Chisen, the association's director of coding and classification.

Marilyn Tavenner, acting administrator of the Centers for Medicare and Medicaid Services (CMS) Steve Helber/AP file

"We do it every year and they don't do anything about it."

By 2007, though, it appears CMS had effectively given up on releasing new guidelines. The effort "was proving more challenging than we initially thought," the agency wrote in the Federal Register.

Industry insiders say there are a number of reasons why the agency never established guidelines. Some suggested a working set of rules that accurately reflects costs for all hospitals may be impossible to develop. Others say CMS is reticent to sign off on an outside group's system, as it has with the American Medical

Association, which licenses the use of the CPT codes it owns and administers.

In written responses to questions submitted by the Center, CMS said "it seems unlikely that one set of straightforward national guidelines could apply to the reporting of visits in all hospitals and specialty clinics." It also said the agency believes that "as a whole, hospitals have worked diligently and carefully to develop and implement their own internal guidelines that reflect the scope and type of services they provide."

Asked about the hospital shift toward billing more expensive codes, Roslyne Schulman, the hospital association's director of policy development, said she was unaware billing had risen at the rate revealed by the Center's data analysis, and could only speculate on the reasons without comparing billing to patient charts. Asked if hospitals were simply billing for levels of care they did not provide, Schulman said, "I would hope that would not be an issue."

Hospitals say patients are "sicker and older"

In 2008, Sentara Virginia Beach General Hospital, a 276-bed hospital a few miles from the Atlantic Ocean, billed the top two emergency room codes for 80 percent of all patients, up from about 29 percent in 2001. Hospital spokeswoman Amy Sandoval said the hospital since 2001 has used the electronic charge system Optum Lynx to determine evaluation and management billing levels.

In a written response to questions about the hospital's billing, Sandoval said Optum reviewed the hospital's billing and found it within acceptable limits. Sandoval said "possible" reasons for the high level of billing include an older and sicker patient population, the intensive resources required to treat psychiatric patients before transfer, and a trend of less sick patients seeking care outside of emergency rooms to avoid long waits and high co-pays. The hospital, she added, is a level III trauma center, located within a mile of seven assisted-living centers and nursing homes.

Representatives from small-town hospitals and major urban trauma centers generally offered the same justification for their rising charges. These explanations could be accurate for individual hospitals, but they are not borne out in the national Medicare billing data analyzed by the Center. The average age of emergency room patients in data examined

by the Center was 77 and remained constant from 2001 to 2008. The total number of emergency room claims rose 31 percent during that time, however, as compared to a less than 10 percent increase in Medicare beneficiaries, which suggests urgent care clinics have not sapped overall business levels.

Some of the rise could be accounted for by emergency room care advances. In the eight years from 2001 to 2008, advances in medical care allowed emergency rooms to treat patients without later admitting them to the hospital. Since the Medicare data the Center for Public Integrity examined includes only treat-and-release patients, these sicker patients would be included in the data more often in 2008 than in 2001. But some experts strongly doubt this accounts for the extent of the rapid rise.

Moreover, the ten most common "primary diagnoses" — the chief complaints for why patients seek care in emergency rooms — remained unchanged during the time period of the data reviewed by the Center. Although those top diagnoses including dangerous symptoms like chest pain and loss of consciousness, the list also included seemingly minor complaints like lower-back discomfort, urinary tract infections and limb pain.

But while the most common diagnoses remained constant, billing of the most expensive codes surged. Take the case of emergency room headaches. From 2001 to 2008, hospital billing of the top two evaluation and management codes for headache patients more than doubled to 43 percent. The number of tests and procedures doctors performed on headache patients also rose. In 2001, hospital emergency rooms billed an average of six revenue codes (which represent areas of the hospital where costs occur, including imaging, labs, and supplies) for headache patients, according to Medicare billing data. In 2008, they billed an average of nine.

In addition to changes in standards of care over those eight years, hospitals say they simply are seeing sicker Medicare patients than in the past. But some disagree.

Berwick, the former CMS head, said patients haven't changed. What's changed is the aggressiveness of how hospitals bill. "They are smart," Berwick said. "If you create a payment system in which there is a premium for increasing the number of things you do or the recording of what you do, well, that's what you'll get."

Dr. Stephen Pitts, an emergency physician and associate professor in the Emory University School of Medicine, examined data from the Centers for Disease Control and Prevention's National Hospital Ambulatory Medical Care Survey, a well-established nationally representative survey of emergency department visits. Pitts found that between 2001 and 2008 emergency patients did not appear to be getting sicker.

"It's total nonsense," Pitts said of hospital claims that sicker patients have led to higher charges.

Emergency physician billing also rises

A more likely cause, Pitts said, is the pressure hospitals put on emergency room physicians to bill every patient at the highest rates possible. Emergency room salaries at many hospitals are tied in part to how much profit doctors generate per patient, Pitts said. From the business side, this makes sense. "If you don't bill maximally, your ER is going to die," Pitts said. But from a patient perspective, it means doctors perform more tests and procedures than they did in the past, which increases the costs of care.

Although hospital facility charges are separate from physician charges, billing and coding experts say the two are linked. And like hospital charges, emergency room physician charges for evaluation and management services are soaring. In 2008, emergency room physicians billed the most expensive code for 44 percent of patients, up from 27 percent in 2001, according to Center analysis of Medicare claims data.

The cost associated with this rise is substantial. In 2010, the top level physical evaluation and management code for emergency care cost the program nearly $1.6 billion, up 21 percent form 2008.

Unlike hospital billing, CMS requires that physicians follow American Medical Association criteria for billing emergency room evaluation and management services. The top level code 99285, for example, requires doctors to perform a comprehensive medical history, a comprehensive exam and engage in highly complex medical decision making.

Yet a number of probes have found physicians are over-billing the top-level code. A 2012 probe of physician billing of 99285 in Iowa, Kansas, Missouri, and Nebraska found an error rate of almost 50 percent. The probe, performed by Medicare contractor Wisconsin Physicians

Service Insurance Corporation, found that physician documentation did not support the 99285 level.

David McKenzie, the reimbursement director of the American College of Emergency Physicians, said upcoding is not to blame for the rise in physician charges. Emergency room doctors are simply getting better at documenting their work, and Medicare patients in general are getting sicker, McKenzie said. In addition, nurse practitioners and physician assistants are treating less sick patients who in the past would have been treated by doctors, which is skewing their numbers.

Evaluation and management of health care in seniors takes time, McKenzie said. "A broken leg in a 17-year-old football player is not the same as a broken leg in an 88-year-old diabetic."

CMS says rise unlikely caused by upcoding

In written comments, CMS said upcoding is unlikely to account for the rapid rise in hospital emergency room billing since the trend appears "to be consistent across hospitals and physicians." But billing at some hospitals is rising much faster than at others. Asked if the agency is monitoring hospitals, like Baylor Medical Center in Irving, Texas, with rates that were nearly twice the national average, CMS said it is inappropriate for the agency to discuss audits involving specific hospitals.

But Baylor Irving's president, Cindy Schamp, said CMS never questioned the hospital's 2008 evaluation and management code billing. In 2009, Schamp said, the hospital instituted new billing rules that led to fewer claims for the top two codes. She said the change was voluntary.

Asked if the hospital returned Medicare overpayments, Schamp said it has not. "To date, we have not made any payments back to Medicare," Schamp wrote in response to questions. "However, continuing to work to do the right thing, we feel it is appropriate to review."

Four months later, a Baylor spokeswoman said the review was complete. "We looked at a sample set of (emergency room) charges made at Baylor Irving during that time period to see if they were accurate in the context of the billing guidelines at that time," Nikki Mitchell wrote. "That is the appropriate way to review charges. In the review, no overcharges were found." ◼

Billing complexity spawns new industry

Thousands now employed as professional coders, but oversight is lacking

By Fred Schulte
Published Online: September 20, 2012

ELEVEN YEARS AGO, Dr. Kathryn Locatell's testimony at a U.S. Senate hearing on alleged Medicare billing abuses generated a rush of media coverage, but little lasting reform.

Locatell, a California physician, helped expose medical billing consultants who made a living teaching doctors how to use the billing system to reel in higher fees.

The techniques ranged from billing for medical treatments that weren't needed to packing a patient's file with irrelevant details as a means to justify higher, more lucrative, Medicare billing codes.

"The information presented to us at the seminars did not include any method of … ensuring that the services billed for were medically necessary," Locatell testified at the June 2001 Senate Finance Committee hearing.

Despite much legislative hand-wringing and media attention — CBS Evening News told her story prominently — little changed in the aftermath of the congressional probe.

More than a decade later, federal officials are still struggling to make sure doctors code accurately and charge Medicare only for treatments that are medically necessary, a Center for Public Integrity investigation has found.

The Center's analysis of Medicare billing records found that more than 7,500 doctors billed the two top paying codes for three out of four office visits, a sharp rise from the start of the decade. Government records also show medical professionals billing billions of dollars in suspect payments in recent years through coding errors.

The Center also examined more than a dozen recent Medicare audits that revealed medical care which auditors said was not necessary, properly documented or correctly coded in a strikingly high percentage of patient files sampled — sometimes half or more. Medicare officials projected overcharges of more than $1.4 billion due to coding errors for office visits during 2010 alone.

Locatell, a geriatric medicine specialist in Sacramento, said doctors today face even more financial pressure to chase dollars than a decade ago.

"It's so easy to pad your documentation so you can meet the requirements" for higher billing codes, she said in an interview. "Until we get enough movement of people clamoring for something different … it will not change, and vested interests won't allow it to change."

Medical groups deny that their members "upcode" patient visits. Most doctors, they say, bill less than they deserve, often because they aren't exacting in writing down all the work they do, or out of fear of being audited.

But the American Medical Association, which wrote the billing codes and controls their use, also has raised the specter of increased upcoding tied to the explosion in use of electronic health records. In May, the AMA urged tighter government controls to assure that the digital devices don't prompt upcoding by, among other things, facilitating "documentation of irrelevant services."

'Codetalkers'

Medicare and other health insurers use the AMA's fee scales to pay doctors for routine medical services, such as office visits and other care provided in hospitals and nursing homes.

The five-digit scales, called "Evaluation and Management" codes, reflect the complexity of the service and the time it usually takes. Medicare paid out more than $33 billion in 2010 using the codes, which are the bread and butter for many medical practices.

Yet from the early 1990s, when the current system was established, coding has bewildered many doctors. Dr. Stephen Levinson, a coding expert and physician, notes that doctors aren't taught much in medical school about how to code correctly — even though it's essential to getting paid. Many doctors would rather focus on treating patients than wading through arcane billing tracts, he said.

It's widely accepted in medicine that coding is more art than science and that two experts often will disagree over which code to assign.

"Doctors want to focus on patients. They're not policy wonks," noted Michael Miscoe, a Pennsylvania health care lawyer and medical coding specialist.

The need for coding assistance has spawned a multi-billion dollar industry that employs tens of thousands of professional coders. Some work in doctors' offices and hospitals, while others sift through computerized records at home or at billing companies. An estimated 2,000 companies nationwide handle billing for doctors and hospitals, according to the Healthcare Billing and Management Association

By all accounts, demand is rising. Courses on how to code are a staple of online universities and training programs. The U.S. Department of Labor has forecast medical coding to grow faster than most other occupations and create 37,700 new jobs by 2020.

Two national groups have set curriculum and accreditation standards for coders. The American Association of Professional Coders, founded in 1988, boasts more than 117,000 members. The American Health Information Management Association, which has advocated for accurate medical record keeping since 1928, has 64,000 members. Both groups have written ethics canons to which members must adhere.

Raemarie Jimenez, the director of education for the coders' association, said doctors aren't trained in the "business of medicine" and using a professional offers them a "safeguard."

Yet it's widely accepted in medicine that coding is more art than science and that two experts often will disagree over which code to assign. And despite years of government campaigns to foster correct coding, errors are common and show signs of worsening with electronic billing systems.

Federal officials concede they have no idea how much tax money is lost through simple coding mistakes and disagreements, and how much

occurs from deliberate overcharging. It's also not clear who is making the mistakes. The Medicare billing records analyzed by the Center for Public Integrity don't indicate whether high-billing doctors coded their own bills, hired professional coders or billing companies, or took advice from consultants.

The system's shortcomings were evident after investigators, with Locatell's help, went undercover in 2001 and sat in on sessions conducted by "revenue maximization" consultants.

At the ensuing hearing, U.S. Sen. Charles Grassley, R-Iowa, lamented that officials had no way to know how many doctors were turning to billing consultants — let alone how many handed out dubious advice.

"There is no mandatory accreditation or certification of health care consultants. Anyone can put out a shingle and call themselves a health care consultant," Grassley said at the time.

Robert Hast, a GAO investigator involved in the 2001 undercover operation, testified that certain advice dispensed at the seminars was "inconsistent" with federal Medicare law.

One example cited: a patient with a sore throat for whom the doctor collected "extraneous information" that once entered into the medical file was used to justify a higher billing code. Another consultant had advocated diagnostic tests such as heart monitoring tests for all cardiac patients, whether needed or not, according to testimony.

One consultant's website promised to boost a doctor's earnings by $10,000 per month, with the consultant pocketing 40 percent of the money, witnesses said. Though federal officials said at the time and still believe that these "percentage billing arrangements" can create an incentive to overcharge, they remain in wide use. But the Healthcare Billing and Management Association contends these deals are "appropriate and reasonable," according to executive director Brad Lund.

Though most don't provide precise financial details, a range of billing and coding consultants promise doctors their methods and products will boost revenue. One website, for instance, promises its coding methods will stay on the right side of the law and generate a "10%-15% increase in revenue."

There's still little oversight of consultants who offer billing advice, even though their numbers appear to be increasing with a decision by the federal government to spend

as much as $30 billion in stimulus funds helping doctors and hospitals purchase electronic health records.

For instance, some online advertisements for electronic records and billing software assure doctors they can profit from higher coding once they get wired up.
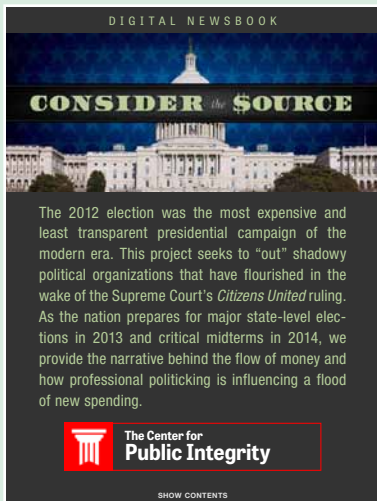
Many billing consultants argue that doctors are simply getting their just due after years of understating the work they perform. Still, several said that coding controversies will not go away so long as doctors are paid by the number of services they provide.

Florida consultant Frank Cohen, for instance, believes that little will change unless the government scraps the billing codes and find new methods for paying doctors.

Cohen, who advises physicians on proper coding, said "nebulous" coding guidelines assure "there's going to be a wide range of errors."

Health lawyer and coding expert Miscoe agreed. "Fundamentally, we need to change the reimbursement system so doctors can go back to being doctors," he said. "There's got to be something wrong when they [doctors] need coding experts to get through a regular day." ■

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Growth of electronic medical records eases path to inflated bills

Billing software helps medical professionals document higher fees

By Fred Schulte
Published Online: September 19, 2012

ELECTRONIC medical records, long touted by government officials as a critical tool for cutting health care costs, appear to be prompting some doctors and hospitals to bill higher fees to Medicare for treating seniors.

The federal government's campaign to wire up medicine started under President George W. Bush.

But the initiative hit warp drive with a February 2009 decision by Congress and the Obama administration to spend as much as $30 billion in economic stimulus money to help doctors and hospitals buy the equipment needed to convert medical record-keeping from paper files.

In the rush to get the program off the ground, though, federal officials failed to impose strict controls over billing software, despite warnings from several prominent medical fraud authorities. Now that decision could come back to haunt policy makers and taxpayers alike, a Center for Public Integrity investigation has found.

Experts say digital medical records may prove — as promised — to be cost-effective, allowing smoother information sharing that helps cut down on wasteful spending and medical errors.

Yet Medicare regulators also acknowledge they are struggling to rein in a surge of aggressive — and potentially expensive — billing by doctors and hospitals that they have linked, at least anecdotally, to the rapid proliferation of the billing software and electronic medical records. A variety of federal reports and whistleblower suits reflect these concerns.

Regulators may lack the auditing tools to verify the legitimacy of millions of medical bills spit out by computerized records programs, which can create exquisitely detailed patient files with just a few mouse clicks.

"This is a new era for investigators," said Jennifer Trussell, who directs the investigations unit of the U.S. Department of Health and Human Services Office of Inspector General.

"We are all excited about the many benefits of electronic health records, but we need to be on the lookout for unscrupulous providers who take advantage of this new technology," she said.

The Center for Public Integrity has recently documented how some health professionals have seemingly manipulated Medicare billing codes to gain higher fees. The investigation unmasked thousands of doctors consistently billing higher-paying treatment codes than their peers, despite little evidence in many cases that they provided more care.

Some of the sharpest surges in more costly coding have occurred in hospital emergency rooms, according to the Center's data analysis, where billing software has been widely used.

Interviews with hospital administrators, doctors and health in-

formation technology professionals confirmed that digital billing gear often prompts higher coding, though many in the medical field argue that they are simply recouping money that they previously failed to collect.

For example, Holy Name Medical Center in Teaneck, N.J., saw a spike in billing codes after wiring up its emergency room in 2007, according to hospital CEO Joe Lemaire.

Coding 'Slam Dunk'

Electronic medical records can influence pay scales known as "Evaluation and Management" codes. Medicare spent more than $33.5 billion in 2010 using these numeric codes for services ranging from routine doctor office visits to outpatient hospital or nursing home care. More than half the doctors billing Medicare were using electronic records in 2011, and more are expected to follow.

For an office visit, a doctor must choose one of five escalating payment codes that best reflects the amount of time spent with a patient as well as the complexity of the care. The lowest-level code for a minor problem, 99211, pays about $20. But the doctor can bill roughly $100

more for the top level. Hospitals use similar codes for billing emergency room and outpatient services.

The subjective nature of the coding process has left the medical community and those who pay its bills in constant conflict. Many doctors and billing consultants argue that most practitioners habitually charge too little because they neglect to put down on paper all of the work they do, which if done more diligently would justify higher codes and fees.

The HHS Agency for Healthcare Research and Quality, an advocate for pressing ahead with electronic health records, accepted that view when it wrote in September 2009 that doctors may choose billing codes that are too low. The agency suggested that converting to digital systems would enable doctors to bill higher fees, "translating into enhanced revenue."

By contrast, government auditors and many private insurance investigators see evidence that some doctors pick higher codes to inflate their bills — a practice known in medical circles as "upcoding."

The rapid expansion of electronic health records is adding a whole new dimension to that quarrel. Government officials, however, have yet to

step in and settle whether the hundreds of software products on the market consistently prompt doctors and hospitals to bill at higher levels than they did prior to going electronic — and if the higher fees are merited.

Doctor Backlash

Warnings that digital billing equipment could unleash a torrent of inflated charges date back to the administration of President George W. Bush.

In July 2005, the American Health Information Management Association identified an "unintended incentive for fraud because healthcare organizations and software developers need to prove a return on investment for the coding products," reads the report, which was commissioned by HHS officials.

Two months later, a second American Health Information Management Association panel stated that "without a deliberate effort to build fraud management" into networks of digital medical records "health care payers and consumers will be exposed to new and potentially increased vulnerability to electronically-enabled healthcare fraud."

Dr. Donald W. Simborg, a California physician who co-chaired that panel, said its findings were dismissed out of fear that doctors would shun the digital devices if they thought buying one might lead the government to second-guess their fees, and perhaps even accuse them of impropriety.

Simborg also headed up an executive team HHS turned to in 2007 to recommend fraud controls in digital gear certified for sale to doctors and hospitals.

In a May 2007 report, the 23-member group, which included representatives from medical groups, health insurers and government, warned against approving software that assisted doctors in selecting billing codes. It is "not appropriate to suggest to the provider that certain additional data, if entered, would increase the level" of the billing code, according to the report.

"Our report was totally ignored for fear of a physician backlash," said Simborg. The report saw print under the bland title "Recommended Requirements for Enhancing Data Quality in Electronic Health Records" that gave little hint it dealt with the sensitive fraud issue, he said.

The billing tools that the study panel panned have been trumpeted

in recent years by electronic health record manufacturers hoping to persuade doctors and hospitals to shell out thousands of dollars — millions in the case of a hospital — to computerize.

"This is the big elephant right now and we aren't touching it," said Simborg.

Dr. Robert Kolodner, a physician who headed the federal push for electronic medical records in 2007, acknowledged that billing abuse took a backseat to steps likely to entice the medical community to embrace the new technology.

Kolodner said officials were certain the savings achieved by computerizing medicine would be so great that billing abuse, "while needing to be monitored, was not something that should be put as the primary issue at that time."

That view didn't change much with the 2009 arrival of the Obama team, which was sympathetic to some of the tech companies that stood to benefit handsomely from the conversion.

For instance, giant tech vendor McKesson submitted to the Obama-Biden Transition Team its vision for the rollout, which recommended "significant start-up funds" to get the ball rolling.

Since 2009, the Obama administration has held dozens of public meetings on electronic health record policies and standards, but none that focused primarily on fraud control and billing integrity.

The administration's Office of National Coordinator for Health Information Technology, which is spearheading the drive, declined to discuss the billing controversy.

But on April 27 of this year that office asked the HHS Office of Inspector General to study the issue. Spokesman Peter Ashkenaz said that ONC "will review any recommendations that are made in the report and will address those at that time."

Donald White, a spokesman for the inspector general's office, said that the issue "is on the radar" and the office will be "looking into these codes and how electronic health records may be affecting them."

But government officials admit they lack a system to monitor the hundreds of billing and medical software packages in use across the country. That shortcoming caught the eye of the American Medical Association, which helped develop the billing codes and favors stricter government standards. In May, the doctors' group urged officials to require testing that assures digital devices

bill accurately and "do not facilitate upcoding."

'Improper Payments'

Connecticut doctor Stephen R. Levinson, who authored a major textbook on medical coding published by the AMA, strongly believes that many electronic medical records systems improperly raise coding levels.

He said the units are programmed to easily allow doctors to cut and paste records from prior encounters with a patient so that "records of every visit read almost word for word the same except for minor variations confined almost exclusively to the chief complaint."

That extra documentation often triggers the software to raise the billing level and the size of the patient's bill. But Levinson said information from previous visits is often not "medically necessary" to treat a current problem — and thus not a legitimate factor in charges.

Levinson said "cloned documentation" in a patient's file often "doesn't make sense clinically," but it steps up billing and rewards the doctors with a "slam dunk" higher billing level, even though it takes 30 seconds to copy and paste.

"This is done in the wrong way and doesn't satisfy the patient's needs," he said.

These "cut and paste" features produce voluminous files that are difficult for auditors to challenge, even when they suspect that the doctor did very little to warrant the higher fees.

That's starting to change, however, greatly raising the stakes for doctors and hospitals that could face a demand for repayment from the government on behalf of patients.

Insurance auditors criticized "over documentation" as a billing ploy as far back as 2006. That year Medicare contractor First Coast Service Options chided Connecticut doctors who "frequently over-documented" to justify higher billing codes.

The Department of Health and Human Services Office of Inspector General late last year announced it would ratchet up audits of "potentially improper payments" linked to electronic medical records. The office also advised doctors they could be held accountable if the codes they used didn't "accurately reflect the services they provide."

Electronic health records figured prominently in a critical Medicare audit of Texas and Oklahoma hospital emergency rooms in March. The audit concluded that $45.14 of every

$100 billed for emergency room care "was paid in error."

Auditors said that billing codes were "higher than was reasonable and necessary to adequately care for the patient's needs or treat the presenting problem."

One unidentified hospital billed Medicare for the highest level code, 99285, for treating a woman who arrived at the emergency room complaining of mild to moderate abdominal pain. The code is generally reserved for conditions of "high severity" that "pose an immediate significant threat to life and limb," auditors wrote.

After a battery of tests, including a CT scan, and intravenous antibiotics and morphine, the doctor diagnosed a urinary tract infection, sent the woman home and told her to follow up with her regular doctor.

Auditors said the woman's case should have been coded two rungs lower based on the degree of medical decision-making required.

They also criticized the electronic record system for generating "testis and penile assessment findings" for a female, noting "coding at a higher level based on clinically unnecessary (or anatomically incorrect) systems examined is not acceptable."

Hospitals have faced scrutiny over their use of electronic billing in emergency rooms from other quarters as well.

Dr. Alan Gravett, an Illinois emergency physician, argues in a federal "whistleblower" lawsuit that hospitals have jacked up emergency room bills with the help of aggressive billing software.

The doctor filed suit under seal in the U.S. District Court for Northern Illinois in January 2007. He alleges Methodist Medical Center in Peoria, Ill., where he worked for six years, installed a McKesson Corporation digital records system in March 2006 "specifically to increase its billings and recovery from government funded health insurance programs."

Gravett alleges that the billing system had a "tendency to inflate nearly every" emergency room code. This happened "despite the physicians' belief that lower … codes were warranted based on the degree of care they provided," according to the suit.

The lawsuit alleged that patients who were treated in the emergency room for many seemingly simple conditions were "as a matter of course" coded at high levels. The diagnoses included toe injury, sprained ankle and toothache.

The software, according to Gravett, prompted charges for condi-

tions such as "alcoholic intoxication" or "psychiatric cases" to a code four or five, "even when such patients are treated and released, or released with no treatment."

The screen also prompts doctors to add documentation to reach a higher coding level, according to Gravett's court filings.

To pressure doctors to go along, the hospital distributed a monthly report called a "lost charge analysis," which ranked doctors by how much revenue they produced, according to the suit.

"This was done to pressure the physicians to out-bill one another, and weed out physicians that were not generating as much income as those willing to upcode," according to the court filing.

Methodist hospital spokesman Duane Funk said the hospital has yet to be served with the suit and would have no comment. McKesson did not respond to requests for comment.

A second "whistleblower" lawsuit filed in the state of Washington in 2006 alleged that Health Management Associates, a Florida-based hospital chain, used software called Pro-Med Clinical Systems that prompted questionable billing.

The suit was brought by two emergency room physicians at one of the company's hospitals, Yakima Regional Medical and Heart Center. The doctors alleged that using Pro-Med led to "misleading medical charts," including "examinations which had not occurred and physical observations which had not been noted by the physician."

The software "automatically ordered a series of expensive and unnecessary tests," according to the suit, which was dismissed in February 2009.

Pro-Med, based in Coral Springs, Fla., was not named as a defendant. Pro-Med CEO Thomas Grossjung said the hospital, not the software company, set the treatment protocols.

Maryann Hodge, vice president of marketing for Health Management Associates, said the hospital chain was never served with a copy of the suit, though it had cooperated with federal officials investigating the matter.

The hospital chain's use of Pro-Med has come under review in a more recent federal investigation of emergency room billing, records show.

Health Management Associates, which owns or leases more than 60 hospitals in 15 states, disclosed in a May Securities and Exchange Commission filing that the HHS inspector general's office was investigating

it's business operations, including whether "Pro-Med software has led to any medically unnecessary tests or admissions." Hodge said the company could not comment further on the investigation.

A second hospital chain that has used Pro-Med also has been served with a subpoena from federal investigators.

Community Health Systems, Inc., which owns and operates some 130 hospitals in more than two-dozen states, told investors in April 2011 that HHS was investigating "possible improper claims." The subpoena requested documents concerning use of the Pro-Med software in emergency rooms, according to the SEC filing. Tomi Galin, Community Health Systems' vice-president for corporate communications, said at the chain's hospitals the software does not order tests or "make any recommendation to physicians about whether to admit patients, place patients in observation or discharge patients."

Both hospital chains said in SEC filings that they are cooperating with investigators. Pro-Med CEO Grossjung said his firm also had met with federal investigators, but the probe had "nothing to do with the software itself."

Doctors' groups also are report-ing higher fees associated with electronic records, though they argue that the systems merely allow them to catch up with billing practices that for years did not pay them enough.

Robert Tennant, a Washington lobbyist with the Medical Group Management Association, which represents large medical practices, said the software simply helps doctors pick the correct code. "With a paper based system there's a little bit of concern from providers that they don't have sufficient documentation to support a particular" coding level, he said. Electronic systems, however, can quickly retrieve a patient's documented history.

"I don't use the term 'upcode.' I use 'correct code.' I see it more as physicians being reimbursed more appropriately for the work that they're doing," he said.

After the Gold Rush

Judging from their marketing strategies, there's little doubt among the makers of electronic health records that their products will pay for themselves — and then some — through higher coding of patient bills.

Sales literature touts features such as "charge capture," highlighting the computer's skill at never

missing a billable item that a human might overlook.

Many companies stress that the software can pay for itself through more lucrative codes, a benefit called "ROI," short for return on investment. That pitch suggests a doctor who collects stimulus payments over time will cover the purchase costs and eventually turn a nice profit as a result of higher fees from higher coding.

For instance, one manufacturer predicts a rise of one coding level for each patient visit, which it said could add up to $225,000 over the course of a year. Another cites a medical journal report that a medical practice in Utah "produced an average billable gain of $26 per patient visit."

Ross Koppel, a sociology professor at the University of Pennsylvania who has studied design weaknesses in the software, said that sales agents stress how the machines help doctors document the work they do.

"That presumably is fair and good, but everybody knows there is a 'wink, wink' behind that indicating it will help … make the patient's visit look more involved than it is." That "generates additional revenue" for doctors, Koppel said.

The industry's trade association, the Healthcare Information and Management Systems Society, has published a guide for doctors to use in estimating how much new revenue they can expect by going electronic. It cites as one key benefit, "increased coding due to elimination of lost charges and using appropriate coding levels based on services delivered."

But some others note that doctors may initially lose money from wiring up their practices, mainly due to the time it takes them and their staffs to learn how to use the equipment and its high upfront cost.

'Unintended Consequences'

The emphasis on improving the bottom line, rather than the quality of medical care, has disappointed some longtime health policy hands.

The Obama administration's foray into digital medicine "has backfired at this point," said Dr. Robert Berenson, a former vice chairman of MedPac, a commission that advises Congress on Medicare payment issues.

Berenson said that the current crop of electronic medical records encourage too much medical documentation "for the purposes of billing" and not better patient care.

The software helps doctors sub-

mit bills for "a higher level code than was performed," said Berenson, who served as a member of the 2008 Obama transition team on health policy. "It's a lot of money and the money goes right to the bottom line," he said.

The criticisms are not just about money. The American College of Physicians, which represents more than 100,000 internists, considered the threat to patient safety serious enough that in May it announced a class for doctors in "potential problems associated with the use" of electronic medical records and "strategies to overcome these problems."

Some doctors grumble about slogging through pages of redundant information that appears to be in a patient's file simply to satisfy requirements for stepped up billing codes.

Just like in the days of poor physician handwriting, the voluminous computer generated files can prove tough for doctors to quickly decipher and decide how to treat a patient's illness.

"We're getting a whole generation of records that are not illegible, they are largely un-interpretable. It's a horrific problem," said Dr. Bob Elson, a former health information technology specialist, now a physician at the Cleveland Clinic.

These criticisms aside, many in the medical community regard the switchover not only as inevitable, but also as an opportunity to revolutionize medicine. For starters, researchers hope to be able to mine data from millions of patients to discover better ways to treat disease and improve the nation's overall health.

The initiative continues to pick up speed behind a broad coalition of political players, from an elite corps of technology experts to organized labor groups that support moving medicine into the 21st century with dispatch.

Tennant, whose group represents medical practices, noted that Congress and the Obama administration have sent a "clear message" that they want physicians to adopt electronic health records.

He said "a slight uptick" in codes would be more than offset by savings on duplicative tests and other waste associated with paper records systems, and by higher quality care.

So far, the government has shelled out about $5 billion in incentive payments to doctors and hospitals that have adopted the technology, according to the Government Accounting Office.

How much Medicare has paid out in higher codes related to digital

billing is trickier to assess. In 2011, 57% of Medicare doctors were using an electronic health record, most for three years or less, according to an HHS survey. Officials expect those numbers to climb as doctors scramble to avoid Medicare payment cuts to those who fail to adopt the technology starting in 2015.

But Elson, the Cleveland clinic doctor, said that government officials may have oversold the benefits to Congress by failing to account for health care costs to rise from higher coding, at least in the short term.

"That's a huge oversight if that whole issue wasn't factored into the strategy," Elson said. ◼

IMPACT

Top House Republicans demand suspension of electronic medical records program

By Fred Schulte
Published Online: October 5, 2012

FOUR REPUBLICAN House leaders want federal officials to suspend payments to hospitals and doctors who switch from paper to electronic health records, arguing the program may be wasting billions of tax dollars and doing little to improve the quality of medical care.

In an Oct. 4 letter to Health and Human Services Secretary Kathleen Sebilius, they suggested that $10 billion spent so far on the program has failed to ensure that the digital systems can share medical information, a key goal. Linking health systems by computer is expected to help doctors do a better job treating the sick by avoiding costly waste, medical errors and duplication of tests.

The letter urges Sebilius to "change the course of direction" of the incentive program to require that doctors and hospitals receiving tax

money get digital systems that can "talk with one another." Failure to do so, the letter says, will result in a "less efficient system that squanders taxpayer dollars and does little, if anything, to improve outcomes for Medicare." The letter urges Sebelius to suspend payments under the program until rules are written requiring that the systems share information.

The letter is signed by Ways and Means chairman Dave Camp, R-Mich., Energy and Commerce Chairman Fred Upton, D-Mich., Ways and Means health subcommittee chairman Joe Pitts, R-Pa. and energy health subcommittee chair Wally Herger, R-Calif.

The Office of National Coordinator for Health Information Technology, which runs the incentive program, did not respond to a request for comment on the letter on Friday.

The harsh criticism from Congress is unusual given the strong support that digitizing medicine has received from both political parties in recent years.

Rep. Dave Camp, R-Mich. chairman of the House Ways and Means Committee.
Pablo Martinez Monsivais/AP

President George W. Bush in 2004 first set the goal of creating a digital medical record for every American within ten years. But in early 2009 the Obama administration championed using stimulus money to achieve the goal, hoping electronic health records would both enhance the quality of medical care and hold costs in check.

In all, the Obama administration expects to spend more than $30 billion to help doctors and hospitals purchase the gear and use it to

improve health care. More than half the nation's hospitals have received some payments from the program, and so far more than $10 billion has been spent. About half the doctors now billing Medicare are using digital records.

Many medical leaders also hope digital records revolutionize the nation's health care delivery. For starters, researchers hope to be able to mine data from millions of patients to discover better ways to treat disease and improve the nation's overall health, which requires computers to link to each other. The initiative also is backed by a broad coalition of groups, from an elite corps of technology experts to organized labor.

But the congressmen also noted emerging concerns that so far the digital medical revolution has prompted doctors and hospitals to bill higher charges to Medicare.

The Center for Public Integrity's "Cracking the Codes" series, published last month, found that thousands of medical professionals have steadily billed higher rates for treating seniors on Medicare over the last decade — adding $11 billion or more to their fees.

The Center's year-long investigation strongly suggested that Medicare billing errors and abuses are worsening as doctors and hospitals switch to electronic health records. A similar report was subsequently published by the New York Times.

"Recent reports revealed that the EHR (electronic health records) program may be leading to higher Medicare spending and greater inefficiencies while doing little if anything to improve health outcomes," the House Ways and Means Committee said in a statement.

Obama administration officials acknowledged the problem for the first time last month, asserting that some doctors and hospitals may be cheating Medicare by using electronic health records to improperly bill the health plan for more complex and costly services than they actually deliver — a practice known as "upcoding."

HHS Secretary Sebelius and Attorney General Eric Holder on Sept. 24 warned five hospital and medical groups of their intention

to ramp up investigative oversight, including possible criminal prosecutions, of upcoding.

The Center for Public Integrity investigation found that digital medical and billing equipment can with the touch of a button create an exquisitely detailed medical file and thus present a challenge to government auditors concerned about preventing billing abuse and fraud.

But in the rush to get the program off the ground federal officials failed to impose strict controls over billing software, despite warnings from several prominent medical fraud authorities to do so. Now officials admit they lack a system to monitor the hundreds of billing and medical software packages in use across the country to prevent overbilling.

Most manufacturers and medical professionals using the gear contend that it merely allows them to more efficiently bill for their services, which in the past was often done by hand.

Medicare's shaky finances also have emerged as a presidential campaign issue, with both Barack Obama and Mitt Romney promising to tame its spending growth while protecting seniors. But there's been little talk about the impact of billing and coding practices in driving up costs, and what to do about them. ■

Administration official asks for Medicare billing review

By Fred Schulte

Published Online: October 16, 2012

THE NATION'S top health information technology official has launched an internal review to determine if electronic health records are prompting some doctors and hospitals to overbill Medicare.

Dr. Farzad Mostashari, the Obama administration's National Coordinator for Health Information Technology, said in an interview Monday afternoon that his policy-setting committee of experts would

examine the issue and make recommendations on how to address it.

It is the second government action in the wake of the Center for Public Integrity's "Cracking the Codes" series, which found that thousands of medical professionals have steadily billed higher rates for treating seniors on Medicare over the last decade — adding $11 billion or more to their fees.

The Center's year-long investigation, published in September, suggested that Medicare billing errors and abuses are worsening as doctors and hospitals switch to electronic health records. A similar report was subsequently published by the New York Times.

Mostashari said he wants to find out if the digital systems are triggering higher billing codes by allowing doctors to cut and paste records from prior encounters with a patient, a practice known as "cloning." Many experts say that this process can raise the size of a patient's bill, even though it reflects little in the way of added or necessary medical service.

"If we are just copying the same information over and over, that's not good medicine," Mostashari said. "I've asked the policy committee to provide guidance on that."

Mostshari also said that he wanted to determine if some software functions that do little more than prompt doctors to inflate the size of their bills "should be off limits."

In a Sept. 24 letter, Department of Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder warned five hospital and medical groups of their intent to ramp up investigative oversight, including possible criminal prosecutions, of doctors and hospitals that use electronic health records to improperly bill for more complex and costly services than they actually deliver — a practice known as "upcoding."

In response, the American Hospital Association and other groups that received the letter have sought to shift blame to the federal government, which the groups say has done little to set guidelines for acceptable billing tactics, particularly in hospital emergency rooms.

Meanwhile, the 64,000 member American Health Information Man-

agement Association has announced it will hold an industry summit in Chicago early next month to press for standard electronic health record guidelines that discourage billing fraud and abuse.

The group said in a statement earlier this month that "recent concerns" that electronic health records "could lead to fraud further highlights the need to establish these standards."

"We urge the government to truly investigate the depth of the recently reported problems so we can determine the scope of the issue and take steps to fix it," said Lynne Thomas Gordon, the group's chief executive officer.

Lydia Washington, an association executive who is chairing the conference, said she hopes the group's panel of experts will "suggest policy and standards that are needed" both to prevent billing fraud and assure patient safety and data integrity.

President George W. Bush in 2004 set the goal of creating a digital medical record for every American within ten years. In early 2009, the Obama administration added billions of dollars in stimulus funds in the hopes that electronic health records would both enhance the quality of medical care and hold costs in check.

In all, the Obama administration expects to spend more than $30 billion helping doctors and hospitals purchase the gear and use it to improve health care. More than half the nation's hospitals have received some payments, and so far more than $10 billion has been spent. Just over half the doctors now billing Medicare are using digital records.

In his interview with the Center, Mostashari stressed that doctors and hospitals must do more than simply buy digital systems to collect stimulus dollars. Medical professionals must gradually meet a series of medical quality standards that are designed to "keep people healthier," he said. Many medical leaders also want to use digital records to mine data from millions of patients in the hope of discovering better ways to treat disease and cut costs.

But the push for better quality medicine is facing off against an aggressive sales push by technology companies, which typically stress that their

products can significantly boost the bottom line. One company predicts an increase of one Medicare coding level for each patient visit to the doctor, potentially adding $225,000 in new revenue in a year, for instance.

Federal officials lack a system to monitor the accuracy of hundreds of billing and medical software packages in use across the country. That shortcoming caught the eye of the American Medical Association, which helped develop the billing codes and favors stricter government standards. In May, the doctors' group urged officials to require testing that assures digital devices bill accurately and "do not facilitate upcoding."

The information technology industry generally agrees that computerized medical records can lead to higher costs. But it argues that the software makes it easier for doctors and hospitals to more efficiently document all of the work they do—which they often failed to do on by hand on paper.

While the drive to digitize medicine has received strong support from both political parties in recent years, some cracks have begun to appear.

In an Oct. 4 letter, four Republican House members urged HHS Secretary Sebilius to suspend government payments to hospitals and doctors, arguing the program may be wasting tax dollars and doing little to improve the quality of medical care. They argued that tax dollars spent so far have failed to ensure that the digital systems can share medical information, a key goal. Linking health systems by computer—called interoperability—is expected to help doctors avoid costly duplication of tests and medical errors.

The letter was signed by Ways and Means chairman Dave Camp, R-Mich., Energy and Commerce Chairman Fred Upton, D-Mich., Ways and Means health subcommittee chairman Joe Pitts, R-Pa. and energy health subcommittee chair Wally Herger, R-Calif.

The Ways and Means Committee added in a statement: "Recent reports revealed that the EHR (electronic health records) program may be leading to higher Medicare spending and greater inefficiencies while doing little if anything to improve health outcomes."

The industry's trade association, the Healthcare Information and Management Systems Society, opposed the suspension. It said in a statement that "significant progress has been made" and that "widespread interoperability is within reach."

Medicare, which covers 49 million elderly and disabled people and spent more than $500 billion in 2011, has emerged as a presidential campaign issue, with both Barack Obama and Mitt Romney promising to tame its spending growth while protecting seniors. But there's been little talk about the impact of billing and coding practices in driving up costs, and what to do about them. ◾

Medicare paid $3.6 billion for electronic health records but didn't verify quality goals were met

By Fred Schulte

Published Online: November 29, 2012

IN EARLY 2009, federal officials announced they would pay billions of dollars to hospitals and doctors who agreed to buy electronic medical records and use them to improve the quality of health care.

But the Centers for Medicare and Medicaid Services has since paid out more than $3.6 billion to medical professionals who made the switch without verifying they are meeting the required quality goals, according to a new federal audit to be released today.

The Department of Health and Human Services Inspector General's audit warns that the electronic records program is "vulnerable" to abuse and that officials should immediately "strengthen" oversight to protect tax dollars from being wasted.

Many experts believe electronic health records hold great potential to keep people healthier. To achieve that goal, government officials

insisted that doctors and hospitals receiving payments meet a lengthy checklist of quality standards, ranging from writing prescriptions electronically to recording immunization and smoking histories.

Yet it's not clear if that's happening because nobody checks to make sure. In a response included in the audit report, CMS Acting Administrator Marilyn Tavenner said that requiring medical professionals to prove they are meeting the quality requirements prior to cutting them a check would be burdensome and "significantly delay payments."

Tavenner said that the agency plans to conduct some audits in the future and would then take steps to recover any improper payments. But the Inspector General opined that CMS should verify compliance first to avoid having to track down miscreants later, a much maligned practice sometimes referred to as "pay and chase."

A CMS spokesman declined to address the audit findings directly, but said: "Protecting taxpayer dollars is our top priority and we have implemented aggressive procedures to hold providers accountable."

The shift from paper to digital medical records has enjoyed strong political support in Congress, though how best to pay for it—and who deserves the money— has been controversial. Funds for the conversion are part of the nearly $800 billion economic stimulus package passed by Congress in February 2009.

Last year, the Center for Public Integrity reported that about half the first batch of federal dollars went to providers who had converted to the technology long before the stimulus program was announced. A spokesman for Sen. Tom Coburn, R-Okla., called that an "inexcusable waste of taxpayer dollars," saying it "makes no sense" for the government to "pay physicians for systems they already have."

Criticism from Republicans in Congress has mounted in the wake of the Center's "Cracking the Codes" series published in September. The investigative project documented that thousands of medical professionals have steadily billed Medicare for more complex and costly health care over the past decade — adding $11 billion or more to their fees—and strongly suggested that the rapid growth in the use of

electronic health records and billing software has contributed to the higher charges.

In an Oct. 4 letter to Health and Human Services Secretary Kathleen Sebilius, four Republican House leaders asked federal officials to suspend the payments, arguing the program may be wasting billions of tax dollars and doing little to improve the quality of medical care.

The four members wrote that the program has failed to ensure digital systems can share medical information, a key goal. Linking health systems by computer is expected to help doctors do a better job treating the sick by avoiding costly waste, medical errors and duplication of tests.

From May 2011 to August of this year, Medicare paid about $3.6 billion to 74,317 medical providers and 1,333 hospitals that made the switch to electronic records. Doctors can receive as much as $44,000 each, while hospitals get a minimum of $2 million. Costs are expected to rise to $6.6 billion over the next four years.

According to the Inspector General's audit, CMS lacks the tools to check whether many of the medical quality measures are being met. For instance, auditors said that CMS had no way to know whether doctors and hospitals were writing the required numbers of prescriptions electronically.

"CMS does not verify the accuracy of professionals' and hospitals' self-reported information prior to payment because data necessary for verifications are not readily available," auditors wrote.

The Inspector General also noted that some of the problem may stem from software systems that can't produce accurate quality assessments.

The report cited as an example a "report to customers" issued in February by GE Healthcare, a manufacturer of digital records systems. The notice said that two of its products could produce "inaccurate" quality reports and that it had notified CMS and its customers, and was working to correct the problem.

The new report said the Inspector General has audits underway to find out if some medical providers have been gaming the system. It did not say when those audits would be completed. ■

Judgment calls on billing make 'upcoding' prosecutions rare

Authorities typically settle, and doctors often continue treating Medicare patients

By Fred Schulte
Published Online: September 15, 2012

THERE SIMPLY weren't enough hours in the day to justify the fees Dr. Angel S. Martin collected from Medicare.

On fifty-three separate days, the Newton, Iowa, general surgeon billed the government health plan for the elderly and other insurers for medical services that would have taken him more than 24 hours to complete, according to federal prosecutors.

The hours made the case a slam dunk for prosecutors. But they weren't Martin's only problem. Many patients recalled the briefest of visits with the doctor, even though Martin routinely billed Medicare for long, complicated treatments.

Every year, Medicare pays doc-tors more than $30 billion for treating patients. For office visits, doctors must choose one of five escalating billing scales — called Evaluation and Management codes — that most closely reflect the complexity of the treatment and the time it takes. The fees range from about $20 to about $140.

Medical groups argue that most doctors take pains to bill accurately. If anything, doctors tend to pick codes that pay them less than they deserve out of concern that they might otherwise get audited and face financial penalties, these groups say.

But cases such as Martin's reveal what can happen when doctors are tempted to game Medicare by "upcoding" — billing for more exten-

sive care than actually delivered. Raising the code by a single level on two patients a day can increase a doctor's income by more than $15,000 over the course of a year and is not likely to raise suspicions, experts said.

Upcoding "is a big problem," said Charlene Frizzera, a consultant who spent three decades at the federal Centers for Medicare and Medicaid Services and served as its acting administrator in the early months of the Obama administration.

Indeed. A jury convicted Martin on 31 counts of health care fraud for manipulating the Medicare pay scales.

Martin, 64, spent six months in prison and was released in June. The doctor, who has surrendered his medical license, could not be reached for comment.

The Center for Public Integrity has documented widespread Medicare billing errors and abuses by doctors and hospitals that have cost taxpayers billions of dollars over the past decade. For instance, the investigation unmasked more than 7,500 doctors who were billing the top two highest codes for three out of four office visits in 2008. That's a sharp rise from the start of the

decade and significantly above the norms. Federal officials and fraud experts said the abnormally high billing patterns uncovered by the Center strongly suggest overcharges and possible upcoding.

"This has been one of the most common and garden variety fraud violations for years," said William Mahon, a Virginia health care fraud expert. "This is the first time that anyone has quantified it."

Yet unlike Martin, many doctors accused of inflating their bills don't wind up in prison, according to a review of court filings.

Prosecutors argue that proving criminal fraud is difficult given the complexity and subjective nature of the codes — and the judgment calls doctors must routinely make in picking codes, or in hiring someone to do it for them.

The government often must hire coding experts who comb through reams of patient files to confirm the overbilling. And these experts can often disagree over which code to apply, potentially weakening a fraud prosecution.

As a result, authorities typically settle these cases — civil and criminal alike — with deals that keep the doctor out of jail and still entitled to treat Medicare patients. Some doc-

"Specialists have a greater risk of over-coding because of the assumption that what they do is more complex. That couldn't be further from the truth."

tors agree to pay back suspected ill-gotten gains without admitting any wrongdoing or facing other serious consequences.

Cases such as Martin's stand out because his alleged billing pattern appeared to be so extreme as to defy reasonable explanation.

At the doctor's trial in late 2010, more than two dozen patients testified they had spent much less time at the doctor's office than was reflected in their bills. Most recalled a "very short encounter" with the doctor, even though Martin had consistently billed for codes that reflected time-consuming and complex treatments, according to court filings.

Martin's defense team argued that he had a "good faith belief that he was in fact applying the correct code," according to court records.

Several other doctors accused of "upcoding" in criminal cases managed to avoid prison, according to court filings reviewed by the Center for Public Integrity.

Orthopedic surgeon Ezzat M. Soliman, for instance, almost always billed Medicare the maximum amount for patients treated at his clinic near Buffalo, N.Y., "without any regard to the level of service he actually provided," prosecutors alleged.

Without admitting wrongdoing, Soliman agreed in December 2009 to repay the government $72,193.25 and complete a pretrial diversion program.

That ended the criminal case. He went on to practice at the Department of Veterans Affairs hospital in West Palm Beach, Fla., and retired last year, according to the hospital. He could not be reached for comment.

In some instances, highly-trained medical specialists may believe that because they treat people with serious illness any visit to the office justifies the highest fees.

"Specialists have a greater risk of over-coding because of the assumption that what they do is more com-

plex," said Lester Perling, a Florida lawyer who has represented doctors in payment disputes. "That couldn't be further from the truth."

Perling said that these risks may multiply as more doctors rely on electronic medical records and billing software to help them assign a billing code.

"Any practitioner that relies on software without a human verification is doing so at their own risk because I don't think it's that reliable yet," Perling said.

Officials at CMS, the federal agency that oversees Medicare, said that the agency can take a number of steps short of prosecution, such as suspending payments to doctors it believes are ripping off the system. The agency also said it routinely refers cases of alleged fraud to law enforcement, but declined to give specifics.

Given the complexities of these cases, it's no secret that prosecutors favor cases with a pile of highly incriminating evidence.

Jennifer Trussell, who directs investigations for the Department of Health and Human Services Office of Inspector General, discussed such a case at a Medicare Fraud Summit in Philadelphia in June 2011.

She told the audience (starting at 1:34) of discovering a psychiatrist who was billing for 12 hours of psychotherapy for 365 days a year. The prosecutor wouldn't take the case until she could document the doctor billing for more than 24 hours in a single day. She did, and the case went to trial.

In another case, prosecutors allege that Arizona pain doctor Angelo Chirban overbilled for years before he came under scrutiny.

Authorities started investigating him in May 2008 when police found a suicide note near the body of a man who had worked for Chirban as a nurse practitioner.

In his suicide note, the man accused the doctor of running a dangerous pill mill. Chirban, he alleged, only saw a few patients a week, but billed as if he had seen hundreds of them, according to a search warrant application.

As the investigation proceeded, drug enforcement agents learned that ten of Chirban's patients had died from overdoses between 2007 and 2009, the application stated. The doctor has not been charged in connection with any of these deaths.

However, Arizona health officials revoked his medical license

last December, alleging "unprofessional conduct" in the care of a woman who fatally overdosed on drugs.

A federal grand jury indicted Chirban in December 2011 on 130 counts of submitting "false and fraudulent" bills to insurers, illegal prescribing of narcotics and money laundering. His case is set for trial in Phoenix in April of next year.

The indictment alleges that Chirban billed Medicare and Medicaid, the government health plan for the poor, for tens of thousands of patient visits, almost always using the two most lucrative billing codes.

The doctor billed more than 57,000 claims to Medicaid alone between September 2006 and April 2010. Prosecutors allege that most patients never saw the doctor.

One Medicare patient who said he had visited the clinic once a month for three years was unable to identify Chirban in a photo lineup. The man said he had always been treated by a female, even though Chirban had been paid more than $2,300 for the patient's care from January 2007 to September 2009, according to the search warrant application.

Chirban's lawyer, Ashley D. Adams of Scottsdale, said the doctor "was not involved in the coding aspect of the practice."

Adams said that pain management "is a very difficult specialty area with very difficult clients," and that the doctor "has helped many addicted patients get off of drugs, and has taken good care of countless others."

She said Chirban "hopes to retire and move on with his life," adding, "We are in the process of discussing resolution with the government." ◼

Methodology for 'Cracking the Codes'

A glimpse into the data analysis for the "Cracking the Codes" investigation

By David Donald
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FOR THIS SERIES, the Center for Public Integrity and Palantir Technologies analyzed Medicare claims data obtained from the Centers for Medicare and Medicaid Services (CMS).

For privacy purposes and other reasons, the Center was limited to a 5 percent sample of national Medicare Part B data that contain claims for medical procedures, such as doctor office visits and emergency room procedures, and used mainly by researchers and consultants. Over and above the limitations of sampling, the data have only the quarter in which a procedure was performed, not actual dates. And a permanent federal injunction against the Department of Health and Human Services prevents data users from naming individual doctors who received payment for the claims. Some physicians subsequently contacted by the Center agreed to discuss their billing practices.

For the upcoding analysis, the Center and Palantir used a subset of the data submitted by physicians, hospitals and clinics from 1999 to 2008, the last year available at the time the data were acquired. The year 2002 was not included in the data, and any results for that year are imputed based on averaging 2001 and 2003 data. In addition, the Center and Palantir used CMS formulas for facility fees and co-payments, as CMS publishes formulas and modifier values to determine reimbursement amounts. Finally, Medicare Utilization reports published by CMS were used to look at specific billing codes for 2009 and 2010.

To calculate the possible taxpay-

er costs to upcoding, the Center and Palantir analyzed 14 sets of Current Procedure Terminology Evaluation and Management (E and M) codes published by the American Medical Association and used by most providers when filing their claims. Within each set are three to five billing codes requiring varying levels of Medicare reimbursement, based on the complexity of the treatment and the time spent by the doctor. We focused on a set of 84 million claims from office visits for established patients and five million emergency department visits in which E and M codes were billed, as well as 12 other E and M categories. Denied claims were excluded from the analysis.

From those data subsets, we calculated costs from 2001 through 2008 for each code and compared trends within each of the 14 E and M groups. Data from 2009 and 2010 for some E and M code groups were added from the utilization reports. Using 2001 as a baseline, a percentage for each code from the total billing in each group was calculated, giving a decade-long trend line for a code in comparison with the other codes in its group. Then the 2001 ratio was applied to each subsequent year and dollar amounts adjusted for inflation. This allowed

for comparisons of the actual trends to hypothetical trends if 2001 ratios had remained constant. The difference between the actual inflation-adjusted dollar amounts and the 2001-based projected dollar amounts were summed.

To look at trends in age among Medicare patients, the age at the time of a claim was averaged over geography, hospital or E and M code as needed. The CMS data only provided age ranges — under 65, 65-69, 70-74, 75-79, 80-84, and over 85 — in order to protect patient privacy. The under-65 age group typically represents exceptionally sick individuals with end-stage renal disease and was excluded from the analysis; the median values of the remaining age buckets (67, 72, 77, 82, and 87 for those over 85) were used to calculate the average age.

A geographical analysis revealed the nationwide trend of higher E and M billing. Claims were grouped by county and state, according to the beneficiary's residence and visualized with heat maps to show geospatial and temporal trends of billing codes. A heat scale was applied with light red indicating a low percentage and a dark red indicating a high percentage of claims billed at the highest two codes for office vis-

its emergency department visits.

In addition to the nationwide trends, hospitals, physicians, and counties with especially high rates of billing for the most expensive codes were examined in detail. E and M claims were aggregated by hospital, physician, or county, excluding those buckets that fell below a threshold for the minimum number of claims per year (50 claims per year for physicians, 100 for counties, and 100 for hospitals). Physicians who billed 50 percent, 75 percent, 90 percent, or 100 percent of claims at the highest two codes for a given year were analyzed for patterns of geography and specialty. Billing information was integrated with hospital affiliation, ownership, and electronic health-record use information to analyze patterns of billing within group practices and hospital chains.

Results from the 5 percent sample were multiplied by 20 to give a national scope to analyzed trends, an accepted survey research technique. However, even with a sample this large, it is impossible to account for all types of errors in the data. This means all calculations are estimates and rounded and must be considered imprecise. The Center and Palantir used accepted rounding practices. For analysis about specific doctors and some of their coding practices — not billing totals — sums were not multiplied by 20 and reported only as in the sample. When faced with a potential range of costs, we chose the smallest amount to keep estimates conservative. And dollar amounts were adjusted for inflation to prevent over-estimation so that the rising costs were indexed to 2001, the base year in the analysis. ■