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STATEMENT OF THE



2450 N STREET, NW, WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1125

Jordan J. Cohen, M.D., President

on

DHHS Inspector General "PATH" Audits

presented to the

Subcommittee on Labor, Health and Human Services,
Education and Related Agencies
of the
Committee on Appropriations
United States Senate

by

Jordan J. Cohen, M.D.
President
Association of American Medical Colleges

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Mr. Chairman and distinguished members of the Subcommittee, I am Jordan J. Cohen, President and Chief Executive Officer of the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to participate in this special hearing to review the basis for the Physicians at Teaching Hospitals (PATH) initiative of the HHS Office of Inspector General. The Association represents all of the nation's 125 medical schools, approximately 350 major teaching hospitals which participate in the Medicare program, the 88,000 full time faculty of these institutions represented by 86 academic and professional societies, and the more than 160,000 men and women in medical education as students and residents.

On June 21, 1996, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced what it described as "a series of nationwide reviews of compliance with rules governing physicians at teaching hospitals (PATH) and other Medicare payment rules." The letter announcing the PATH initiative went on to state that, "This initiative grows out of the extensive work performed by the OIG at a major east coast university. The focus of the review was compliance with Intermediary Letter 372 (IL-372), the Medicare rule affecting payment for physician services provided by residents. We found that the institution was not complying with this rule. We also found that teaching physicians were improperly 'upcoding' the level of service provided in order to maximize Medicare reimbursement....The OIG has initiated the PATH project in order to determine whether, and to what extent, similar problems are present at other teaching institutions throughout the country." Teaching physician services for years 1990 through 1995 were selected for review. Thus, on the basis of an audit conducted at one institution, the PATH initiative was born.

From June 1996 until July 1997 the OIG initiated PATH audits at forty-nine teaching institutions. During this same time period the Department of Health and Human Services, the HHS Office of Inspector General and the Health Care Financing Administration (HCFA) were asked by medical schools, faculty practice plans, teaching hospitals, members of Congress and organizations representing medical schools and teaching hospitals to clarify the parameters that would be utilized to conduct the PATH audits. These requests for clarification and the ensuing discussions and disagreements over the standards being utilized by the OIG were an indication of the confusion which had existed for almost 30 years regarding the standards which teaching physicians must fulfill and document to support Medicare billing for their services when medical residents were involved in the care of their patients.

This confusion is reflected in a February 24, 1997 letter to Representative John Porter (R-IL) from former HHS Secretaries Otis Bowen, M.D. and Louis Sullivan, M.D.. In their letter Drs. Bowen and Sullivan stated that, "Really since the inception of the Medicare program the Department of Health and Human Services has had a difficult time in setting forth a bright line standard that could be used to separate the services provided by an attending physician that are strictly teaching in nature and those that involve care to a specific patient". Drs. Bowen and Sullivan further stated that, "Given the contorted history of this issue [IL 372] through the years, it would appear to be an unlikely candidate for an OIG investigation."

It became clear through written and oral responses to various requests for information and clarification that the OIG had adopted a standard for teaching physician billing which reflected the rules which went into effect on July 1, 1996, rather than the rules and requirements that were in effect from 1967 through June 30, 1996. With respect to the audit activity which focused on possible 'upcoding' (charging for a higher level of service than was actually provided) it also became clear that the OIG was auditing against guidelines which became effective in August 1995 -- subsequent to the date of the records generally being audited.

It is also clear from early briefing materials used by the OIG in public forums that their expectation was that institutions would be found to have violated the Federal False Claims Act (FCA) and would, presumably, owe the government money. One OIG document states that PATH has among its objectives to:

“Recover Medicare reimbursements for unallowable and inadequately documented services in amounts **imposed by the Federal False Claims Act**, or determined by settlement between the OIG/DOJ project teams and the physician group practices.”
(emphasis added)

The FCA prohibits anyone from submitting a claim to the federal government if the person: (1) knows the information is false, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. A violation of the FCA may result in an assessment of double or treble damages, plus an additional \$5-10,000 per claim. Fraud must never be tolerated, but for the OIG to begin an audit initiative under the premise that monies will be recovered under the FCA suggests that there is an underlying assumption that any errors found will be fraudulent.

On July 11, 1997 Harriet Rabb, the General Counsel for the Department of Health and Human Services, completed an exhaustive review of the PATH audits, including an examination of the history of Medicare rules governing payment to teaching physicians. Her conclusion was that **“the standards for paying teaching physicians under Part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades.”** (emphasis added). She then stated: “When HCFA policy is not unambiguously clear, carrier clarification is warranted and appropriate. Thus, where a carrier informed a teaching institution that physicians must either personally furnish a service or be present when it is furnished by an intern or resident in order to be reimbursed under Part B, that guidance would be controlling.” Ms. Rabb, whose analysis was articulated in a letter to the AAMC and AMA, then set forth new guidelines under which the PATH audits were to be conducted. It is questionable whether carriers have the authority to promulgate requirements which have the effect of rules. Yet, on the basis of the conclusions and guidelines in Ms. Rabb’s letter, the OIG ended sixteen of the forty-nine PATH audits then underway because it was determined that local carriers had not provided clear guidance.

In the succeeding months approximately twenty more institutions were notified that they had been selected for PATH audits. Additionally, in September 1997 the U.S. Attorney for the District of Massachusetts sent civil investigative demands (CIDs)--akin to subpoenas--to at least a dozen teaching hospitals and faculty practice groups in Boston, each of which had been told by the OIG, in the wake of the Rabb letter, that it was no longer being audited under the PATH initiative. The CIDs requested extensive documents covering the same issues that were the subject of the PATH audits--IL-372 and coding of physician services.

Congress is concerned about the direction of the PATH audits. In addition to numerous letters from members of Congress to the HHS Secretary and Inspector General, on July 14, 1997 Congressman Bill Thomas (R-CA), chair of the Health Subcommittee of the House Ways and Means Committee, requested that the General Accounting Office (GAO) examine this issue and report to Congress. The GAO review is ongoing. In 1986 the GAO issued a report on 'Documentation of Teaching Physician Services' that concluded that the federal rules were unclear and that HCFA needed to issue new regulations and provide physicians with unambiguous billing standards.

What Is Wrong With the PATH Audits?

There is no argument that Congress has provided the OIG with ample authority to conduct audits of Medicare payments. However, in conducting those audits the OIG by law must look to the rules promulgated by the federal agency--in this case the Health Care Financing Administration (HCFA)-- charged with implementing the relevant law to determine the audit standards. The OIG is without legal authority to create rules that differ from those promulgated by HCFA. The OIG also may not apply a new rule to services that were rendered prior to the rule's effective date. Those services must be audited under the HCFA rules in place at the time of the service.

As described by the OIG in the June 1996 letter announcing the PATH initiative, the audits would focus on two issues: (1) "compliance with Intermediary Letter 372 (IL 372), the Medicare rule affecting payment for physician services provided by residents"; and (2) whether the level of the physician service was coded properly. Therefore, to determine the standards under which the audits must be conducted it is necessary to understand the requirements of IL-372 and of coding for physician services.

IL-372

When the Medicare program began in 1965, there were no separate rules under which teaching physicians were paid for services to patients. By 1967, rules were issued which, until December 1995, underwent only minor revisions. For all services, a teaching physician could bill Medicare once an "attending physician relationship" was established between the teaching physician and the patient. The attending physician had to also "assume and fulfill the same responsibilities for this patient as for other paying patients" and be recognized by the patient as his or her personal physician.

The 1967 general rule clearly established two standards of teaching physician involvement required to bill for services that involved residents, depending upon the type of service performed. Section 405.521 (b) of the rule establishes a general standard and states:

“Payment on the basis of the physician fee schedule applies to the professional services furnished to a beneficiary by the attending physician when the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient.”

Paragraph (b) (2) establishes a higher standard for other services and reads:

“In the case of major surgical procedures and other complex and dangerous procedures or situations, the attending physician must personally supervise the residents and interns who are participating in the care of the patient.”

The 1967 rule, in its general provisions, encompasses both activities of personal service and medical direction of residents by teaching physicians providing service for payment purposes under the Medicare program. The general provision, however, makes no mention of a strict physical presence requirement in order to bill Medicare for visit and consultation services or minor procedures. The rule establishes a higher standard of physical presence of the teaching physician when performing or providing direction to a resident participating in a major surgical or complex procedure and teaching physicians generally understood that they must be present for the key component of these activities.

The rule also acknowledged that teaching physicians differ from their non-teaching counterparts in that they not only provide patient care, but they also educate and provide medical direction to recently graduated medical students, known as resident physicians. Sometimes the education occurs through traditional teaching methods - apart from patient care activities - such as lectures; many times it occurs at the patient's bedside or in the physician's office as the resident observes the teaching physician, works in collaboration with the teaching physician, or provides care under the medical direction of the teaching physician. Medical direction of a resident by a teaching physician is, in general, distinguishable from education since it is patient and service-specific and is an integral component of the overall management of the patient's care.

While recognizing the joint nature of a teaching physician's activities, Medicare payment policy attempts to distinguish between the activities of education and medical direction by paying for educational activities under Medicare Part A and the activities of medical direction of residents, under Part B. To support and guide the payment of teaching physicians under Part B, the Medicare program established specific criteria to qualify when medical direction activities are occurring and when a teaching physician's personal care to the beneficiary constituted a billable unit of service. The attending physician criteria in the 1967 rule included:

Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; ensuring that any supervision needed by the interns and residents is furnished; and making frequent reviews of the patient's progress throughout the period of care.

Even after the 1967 regulations were issued, there continued to be confusion among Medicare carriers concerning the standards for teaching physicians. Thus, in 1969, HCFA issued Intermediary Letter 372 (IL-372) to "clarify and supplement the criteria that govern reimbursement" for services rendered to patients by teaching physicians. An intermediary letter is not, as the OIG has stated on a number of occasions, a rule. It is an elucidation of a rule but it cannot change the substance of the rule. Unlike a rule, it is not subject to public comment.

IL-372 clearly states that for a teaching physician to be eligible for Medicare payment the physician must be the patient's 'attending physician.' IL-372 then lists the criteria found in the regulation discussed above, as the minimum requirements that must be fulfilled to establish the attending physician relationship. It reiterates two very distinct standards of involvement for teaching physicians---one for the medical direction activities and personal services performed relative to visit and consultation services, and another for the medical direction activities and personal services performed relative to major surgical and complex procedures.

According to IL-372, "performance of the activities referred to above [the attending physician criteria] must be demonstrated, in part, by notes and orders in the patient's records that are either **written by or countersigned by the supervising physician.**" (emphasis added) When the carrier audits physician claims, IL-372 says: "provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart."

The confusing standards set out in 1967 and "clarified" by IL-372 continued to be a problem, so in 1970 HCFA issued a second intermediary letter (IL 70-2) that "summarizes the major questions [raised about IL-372] and provides the basic policies applicable to making reimbursement." IL 70-2 continued to look toward the attending physician relationship as the keystone to teaching physician billing, and made the distinction between major surgical or other complex or dangerous procedures and all other physician services. It also states that "**if the physician countersigned the entries in the record pertaining to the patient's history and the record of examinations and tests, it would be presumed the physician reviewed these activities.**" (emphasis added). IL 70-2 goes on to say that "frequent reviews of the patient's progress by the physician would be established by the appearance in the records of the physician's signed notes and/or countersignature to notes with sufficient regularity that it could be reasonably concluded that he was personally responsible for the patient's care."

Various rules and documents were issued by HCFA in subsequent years, but none changed the criteria established by the 1967 rule and elaborated on by IL-372. It was not until HCFA issued

new teaching physician regulations in December 1995, effective July 1996, that the agency required that a teaching physician must be present to perform or observe the resident perform the 'key portion' of every unit of service billed to Medicare. In issuing the regulations HCFA described as "inappropriate" the fact that carriers (private companies, usually insurers, that contract with HCFA to process and pay Medicare bills) were inconsistently applying standards that could result in a payment of several thousand dollars for a surgical procedure in one area of the country, and a zero payment for the same procedure in another locale. Moreover, HCFA delayed its implementation of this new rule for six months to allow carriers "adequate time to educate all affected parties."

Despite what is written in IL-372, and admissions by HCFA that the rules have been inconsistently applied, the Inspector General has chosen to audit physician billings under the PATH initiative by using the following standard:

"The medical record must clearly indicate that the teaching physician personally performed the service or was present when the service was performed."

This may be considered a reasonable audit standard for those teaching physician services performed **after July 1, 1996** when the new Medicare teaching physician rules went into effect, but it does not reflect the standard in effect from 1990 through 1995, the dates covered by the PATH initiative. During that time, IL-372 and its related regulation were in effect. The OIG originally acknowledged that the PATH audits were being conducted under IL-372. This means that prior to July 1996, the standard for auditing teaching physician billings should be the 1967 regulation, IL-372, and IL-70-2. Based on these regulations, and clarifying documents, the countersignature of the record by the teaching physician should be the documentation standard applied to determine compliance with IL-372 requirements. The presence of a countersignature on the record should be viewed as compliance with the minimum audit documentation requirements unless other information indicates the teaching physician did not meet the required standards.

As noted above, it is not appropriate to rely on standards promulgated by the Medicare carriers. To rely on such standards would be a delegation of rule making authority to these agents of the Medicare program with no opportunity for application of the Administrative Procedures Act or other rule making requirements. Furthermore, the utilization of variable standards by the carrier will inevitably mean that teaching institutions will have differential standards applied relative to their compliance with a national program. To have such a system is patently unfair and inequitable

Coding of Physician Services

The PATH audits also focus on whether teaching physicians documented in accordance with AMA/HCFA guidelines for Evaluation and Management (E/M) services. E/M services are physician visit and consultation services furnished during an outpatient or inpatient visit during

which the physician evaluates and prescribes a course of treatment to manage a patient's illness or injury.

In 1992, the manual used by physicians to code their E/M (visit and consultation) services, Physicians' Current Procedural terminology (CPT), was revised substantially by the American Medical Association CPT Editorial Panel, with participation of HCFA personnel. This revision was a result of the implementation of the resource-based Medicare Fee Schedule payment system. The new coding architecture requires that physicians select from multiple levels of care for a particular E/M service category. Categories of E/M codes differ depending upon: 1) the type of service, ie. visit or consultation performed; 2) if the patient is a new or an established patient with the physician; 3) whether the service is performed in the hospital, office or other delivery setting. Consultation and office visit codes, for example, have up to five levels from which to select.

The revisions added an elaborate and complex set of criteria that a physician must determine in order to select a level of E/M code that best describes his/her visit service. For a new patient the key components of the visit service that must always be performed are: history, review of systems, physical exam, and medical decision-making. The more complex the patient, the more work and intensity of care the physician is expected to perform in order to bill at the highest level of service within an E/M category.

In 1994, HCFA and the AMA agreed upon a national standard in the form of guidelines for documentation of E/M services. The new guidelines were circulated to all physicians in November 1994 to be effective August 1995 for purposes of Medicare audits of physician services.

In 1995, the OIG reviewed the use of the new visit codes to determine whether or not physicians were using them accurately. Given the complexity of the coding system it is not surprising that the OIG found that both physicians and carriers had difficulty selecting the appropriate new codes. The OIG determined it was not going to take further action in this area aside from monitoring to see whether the newly issued HCFA/AMA guidelines would make a difference.

When Harriet Rabb conducted her review of the PATH audits, she concluded that "HCFA instructed its Regional Administrators that, during the period of training [on E/M codes] prior to August 1995, action could be taken at any time to deal with egregious cases of fraud and abuse. Thus, where OIG finds egregious cases of upcoding abuse or fraud as it audits pre-August 1995 records, such matters are appropriate for attention and resolution." The question becomes what are 'egregious cases of upcoding'.

In the absence of any definition, the OIG has indicated their intent to conduct full reviews of coding activity and to determine, at the conclusion of an expensive and lengthy audit process, if there were egregious cases of fraud and abuse.

Conclusion

The academic medical community has recognized for almost three decades that the rules governing when a teaching physician can appropriately bill Medicare when a resident is involved in the care of his or her patient have been ambiguous and has actively encouraged and supported efforts to develop revised regulations. The lack of clarity relative to these rules has been acknowledged on numerous occasions by government officials, through a GAO report, in the development of proposed regulations in 1989 and the development and issuance of regulations in 1995 which became effective on June 30, 1996. This history of confusion has recently been confirmed during a thorough review by the General Counsel for the Department of Health and Human Services.

When the PATH audits were initiated they were characterized as a review of compliance with the requirements of IL-372. The PATH audits should and must be limited to auditing teaching physicians on the national, not carrier specific, standards in effect at the time. Likewise, it is inappropriate to conduct audits of coding activity prior to August 1995 unless there is a clear definition of egregious behavior and indications prior to undertaking an audit that there was egregious behavior. As currently constituted the PATH audits are applying differential standards by carrier region and retrospectively determining what - if any - egregious coding behavior was occurring. It is also inappropriate to assume that the Federal False Claims Act penalties will be applied to these audits absent a finding of fraudulent activity. To do otherwise is inequitable, costly, and disruptive to teaching physicians and the academic medical community.

The PATH audits must be conducted under fair and just standards. To apply standards retroactively, as the OIG has done under the PATH initiative, is to engage in conduct that is outside the broad authority that Congress has granted the OIG. Fraud must be eliminated from the Medicare program. Yet, there also must be a recognition that if a physician's behavior complied with the standards in effect at the time, then fraud was not committed. The OIG is not free to change past standards nor may it determine current standards. That job has been delegated by Congress to HCFA. HCFA has now issued explicit rules about what is expected of a teaching physician if he/she is to bill Medicare. Not even the OIG can reasonably hold a physician to those rules prior to the date on which they became effective.

As the subcommittee members are aware Congressman Thomas (R-CA), Chairman, Health Subcommittee of the House Ways and Means Committee, has requested that the GAO conduct an independent review of the PATH initiative. You are also aware the House Appropriations Committee included report language requesting the OIG to suspend the audits until the GAO completes its study. Our hope, Mr. Chairman, is that the Conference Committee will also ask the OIG to suspend the audits until the GAO study is completed. We have never asked that the audits be stopped but we believe it is imperative that teaching physicians across the country be treated equitably and fairly.