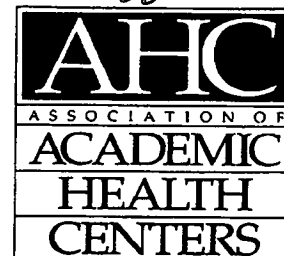




ASSOCIATION OF
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Jeanne 2/28/97 - 301



Date: January 17, 1997

To: Members of the Association of Academic Health Centers
Members of the Council of Deans
Members of the Council of Teaching Hospitals and Health Systems
Members of the Council of Academic Societies

From: Jordan J. Cohen, M.D.
Roger J. Bulger, M.D.

Subject: Background and Briefing Material: Physicians at Teaching Hospitals (PATH) Initiative

Over the past several months, our associations have attempted to keep you up to date in a variety of ways with developments in the Physician at Teaching Hospitals (PATH) initiative of the HHS Office of the Inspector General. At this time we are pleased to provide you with an important, new set of briefing materials regarding the PATH initiative. These documents were developed by the AAMC and AHC in conjunction with the law firm of Hogan & Hartson. They summarize the key features of the overall PATH initiative and outline the changes needed to rectify the numerous problems associated with its current implementation.

The position advanced by these documents can be stated briefly, as follows:

As currently implemented, the Physicians at Teaching Hospitals initiative amounts to an OIG program to coerce medical schools and teaching physicians into forfeiting millions of dollars of fees billed in good faith by threatening punitive damages if they do not settle audits based on the retroactive application of HCFA regulations. This process is fundamentally unfair. Billing practices should be audited based on clear policies in effect when patient services were provided. In no event should teaching physicians be subject to punitive financial or criminal penalties based on the OIG's retroactive application of HCFA regulations.

The documents included with this memo in support of our position are:

- Briefing Paper - Office of the Inspector General's Physicians at Teaching Hospitals Initiative
- Summary of Issues - Office of the Inspector General's Physicians at Teaching Hospitals Initiative

We have also provided an addendum of the appendix materials cited in the Briefing Paper.

In addition to providing information on the problems and issues that must, in our view, be addressed in relationship to the PATH initiative, the Briefing Paper and Summary of Issues paper also attempt to answer the question: What guidelines should the OIG utilize in conjunction with PATH audits? The AAMC and AHC are recommending that the following guidelines for the PATH audits be adopted by the OIG:

1. Countersignature by the teaching physician, in and of itself, should be adequate documentation that the physician provided a "personal and identifiable" service, as required by statute and regulation, until July 1, 1996, when a more explicit documentation requirement went into effect.

- 2 For physician visit services, HCFA's documentation guidelines for Evaluation and Management services should not be used as an audit tool except for services furnished on or after August 1, 1995, the effective date of the guidelines.
3. During an audit, examples of overcoding of services should be offset against examples of undercoding.
4. Double and treble damages, fines for each "false claim", threats of criminal prosecution of individual physicians and of exclusion from the Medicare program, cannot be justified as punishment for violation of retroactively imposed standards, and should play no role in any audit of pre- August 1, 1995 coding of Evaluation and Management services (physician visits) or pre- July 1, 1996 documentation of reimbursable services by teaching physicians.

We hope you will find these materials helpful in explaining the PATH initiative to interested parties both within your institution and in your local community. We are sure you understand how important it is for members of both associations to provide consistent information about the PATH initiative, especially about our concerns with how the program is being implemented and about the changes necessary to assure that the program's audits are conducted appropriately. These materials have been developed with that purpose in mind.

The AAMC, AHC and other organizations will be using these materials to respond to inquiries regarding the PATH initiative from members of Congress and others. In addition, we are forwarding them to Executive Branch leadership in an effort to achieve modification of the guidelines for the audit process. As you and your colleagues communicate with your state and federal representatives, we hope you also will base your comments on the arguments and recommendations contained in these briefing documents.

We will be developing background papers on specific topics relating to the PATH initiative as an adjunct to the Briefing Paper and Summary of Issues paper. We would value your advice about what additional materials might be useful. If you have any questions regarding the enclosed materials, please feel free to contact Bob Dickler, Division of Health Care Affairs, at 202-828-0490 (fax:202-828-4792; E-mail: rdickler@aamc.org).

cc: Group on Business Affairs/Principal Business Officers
Group on Faculty Practice
Group on Institutional Advancement/PR
Government Relations Representatives



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Briefing Paper
Office of the Inspector General's
Physicians at Teaching Hospitals Initiative

The Problem

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) is conducting a national audit of teaching hospitals (most of which are affiliated with medical schools and medical school faculty practice plans) to determine compliance with standards for billing by teaching physicians for patient care. During the audits the OIG is examining medical records to determine: (1) whether teaching physicians were physically present for all services provided to Medicare patients; (2) how the teaching physician documented his/her involvement in those cases; and (3) whether documentation supports the level of service billed to Medicare for physician visits. In conducting these audits the OIG is applying standards and regulations retroactively that did not go into effect until August 1, 1995 and July 1, 1996 and is disallowing millions of dollars in fees billed from 1990 through 1995. Moreover, in the two cases brought to conclusion, the Department of Justice has assessed penalties calculated as double and treble the amounts disallowed. Unless fair audit standards are established, our nation's medical schools, teaching hospitals, and faculty practice plans will be required to forfeit millions of dollars to the Federal government which will undercut their ability to fulfill their education, service and research missions.

The OIG's audit standards conflict with certain policies of the Health Care Financing Administration (HCFA), the federal agency charged with implementing the Medicare law, and disregard the government's own admission that certain other policies are unclear. That admission appears in the preamble to the new rule on teaching physician billing that went into effect on July 1, 1996, which states that:

...the [Medicare teaching physician] policy as set forth in IL-372 and related issuances specifically stated that the attending physician had to be present when a major surgical procedure or complex or dangerous procedure was performed *but was vague, perhaps necessarily, on the matter of presence of the physician during other occasions of inpatient service.* 60 Fed. Reg. at 63138 (December 8, 1995) (Emphasis added) (Attachment 1).

Since 1967 the Medicare regulations have been clear that a teaching physician must be physically present during the critical portions of major surgeries and other complex or dangerous procedures. See 42 C.F.R. §405.521(b)(2) (Attachment 2). However, in contrast to major surgeries and similar procedures, the standard for other inpatient and outpatient services clearly stated in the Medicare law is simply "personal and identifiable *direction*" to the residents by the teaching

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physician. See 42 C.F.R. §405.521(b)(1) (Attachment 2); see also Social Security Act §1842(b)(7)(A)(i)(I) (Emphasis added) (Attachment 3).

The new teaching physician rule, that was issued in accordance with the Administrative Procedure Act, significantly clarifies decades of chaos with respect to the government's requirements for teaching physicians to bill Medicare for patient care services. This new rule requires teaching physicians to be physically present for all services (with very limited exceptions) and clarifies the standards for documentation of this presence. However, these are requirements that apply from July 1, 1996 *forward*. If these requirements had always been the standard, why was a new rule needed? Further, why did HCFA delay implementing this new rule from December 8, 1995 when it was promulgated until July 1, 1996 to allow Medicare carriers "adequate time to educate all affected parties"? (See Attachment 1 at p. 63142-43.) In fact even a year after this rule was promulgated, HCFA still is conducting educational programs for its carriers and academic medical centers on these requirements.

No one in the academic medical community questions the authority or appropriateness of the OIG to conduct audits. However, the standard to which the OIG holds teaching physicians must be fair and must be the standard articulated in the Medicare statute and regulations. As described below, neither is the case in the ongoing OIG investigations.

Background

Who is Being Audited? - In June 1996, the OIG launched a nationwide review of the billing practices of teaching physicians for services provided to Medicare patients. This effort is known as the Physicians at Teaching Hospitals ("PATH") initiative. Teaching physicians typically have a medical school faculty appointment and provide patient care during the course of educating medical students and residents and conducting state-of-the-art medical research.

What Are Teaching Physicians and Hospitals? - It is important to note that teaching physicians and teaching hospitals are a small but critical group of health care providers.

- 1994 data from approximately 280 non-federal teaching hospitals, which are members of the Association of American Medical Colleges ("AAMC"), show that while teaching hospitals account for only 6% of all short-term non-federal acute care institutions, they provide 24% of all Medicaid inpatient days, 27% of all bad debt expense, and 45% of all charity care (\$5.6 billion) written off by these institutions.
- In addition, according to a 1994 AAMC survey, it is estimated that teaching physicians dedicated 28% of their income from providing patient care to support undergraduate and graduate medical research and education.

What Is Being Audited? - For these PATH audits, the OIG primarily is reviewing medical records of teaching physicians for three issues -- (1) whether a teaching physician was physically present;

(2) how a teaching physician documented his/her involvement in the care of a Medicare patient; and (3) whether the documentation supports the level of Evaluation and Management service (physician visit) billed to Medicare. **The audits do not focus on, or question, the quality of care or whether a patient received proper care.**

Audit Problems

Retroactive Application of the Physical Presence Requirement for All Services

With respect to the first issue, physical presence of the teaching physician, the OIG has stated that it is using criteria contained in HCFA's Intermediary Letter 372 ("IL-372") as its standard. ***IL-372 is a HCFA document issued in 1969 that was never subjected to public notice and comment as required under the Administrative Procedure Act.*** The OIG is not relying on Medicare law or regulations in conducting the PATH audits. Instead, the OIG is retroactively applying a standard that did not become effective until July 1, 1996.

- The Medicare statute and regulations prior to July 1, 1996 clearly establish two different degrees of teaching physician involvement required to bill for patient care involving residents. The first is a general rule, and the second is a higher standard for major surgeries and other complex and dangerous procedures. The general rule in 42 C.F.R. §405.521(b)(1) reads:

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. (Emphasis added) (Attachment 2.)

Paragraph (b)(2) establishes the higher standard for a subset of services:

In the case of major surgical procedures and other complex and dangerous procedures or situation, the attending physician must ***personally supervise the residents and interns*** who the physician involves in the care of the patient. (Emphasis added) (Attachment 2.)

- With respect to IL-372 itself, HCFA on numerous occasions has admitted that everyone, carriers, physicians, and hospitals, found it confusing. In the preamble to the new teaching physician rule that went into effect on July 1, 1996, HCFA stated that the "Intermediary Letter 372 policy left it to individual carriers to determine coverage of the [teaching physician] services based on customary practices in the area" (Attachment 1 at p. 63139). HCFA described IL-372 which was adopted in 1969 as being "controversial ever since." (Id. at 63138.) HCFA also acknowledged that IL-372 "was not applied uniformly by all Medicare

carriers," (Id. at 63137), and "might be viewed as not entirely consistent with the payment mechanism enacted in OBRA '86." (Id. at 63138.)

- There is additional evidence that the Medicare law did not require the physical presence of the teaching physician for all services until July 1996. In February of 1989, just 10 months before the beginning time period covered by the PATH audits, HCFA issued a proposed rule in this area that clearly stated an "immediately available" rather than a "physically present" standard for all outpatient services. (See Attachment 4 at p. 5968, proposed §415.178.) HCFA's preamble to this proposed rule stated it was simply issuing regulations to implement a 1980 regulatory revision and not to overturn IL-372. HCFA never repudiated this proposed rule until it published the new rule effective in July 1996. Thus, it was wholly reasonable for teaching physicians to believe that the 1989 proposed rule represented the best guess as to HCFA's current thinking. In fact, many times regulatory agencies (including FDA) take the position that a proposed rule represents current agency policy and may be relied upon by regulated entities.
- Going back to 1986, a report by the General Accounting Office ("GAO") (Attachment 5) documented that IL-372 did not articulate a clear standard for Medicare billing by teaching physicians. The GAO concluded that under IL-372, there was substantial variation of interpretation by local Medicare carriers as to what would constitute a "personal and identifiable" service provided by the teaching physician. The GAO report stated that "HCFA's instructions [IL-372] did not explicitly define what constituted appropriate and adequate documentation to support teaching physicians' claims for reimbursement." (Attachment 5 at p. 10,272.) The report concluded that "HCFA needs to establish and enforce explicit documentation requirements so that teaching physicians and hospitals know what is expected to [sic] them and understand that they are to be held accountable for not complying with Medicare requirements." (Attachment 5 at p. 10,278.) HCFA did not heed these recommendations until publication of its July 1, 1996 rule.
- It is true that in December 1992, Charles Booth, then-Director of HCFA's Office of Payment Policy, sent a memorandum (the "Booth memorandum") to the HCFA regional offices concerning resident involvement in physician visit services. As an aside in this memorandum, Mr. Booth stated that the teaching physician must be present in all cases involving residents to bill Medicare. This memorandum caused a furor in the academic medical community, because no one had understood that to be the standard in the wake of the 1989 proposed rule. This memorandum triggered the commencement of a series of meetings over a number of years between HCFA officials and representatives of the AAMC, the Medical Group Management Association ("MGMA"), and the American Medical Association ("AMA") to resolve this issue. The plain language of documents prepared by HCFA staff for these meetings contradicts the Booth memorandum. A HCFA issue paper prepared in July 1994 illustrates that HCFA was continuing to have discussions with outside groups, even at that late date, over what the true standard under IL-372 should be. Moreover, in this same issue paper, HCFA admitted again that IL-372 instructions were *ambiguous and have not been vigorously*

enforced" and that it was willing to make application of the Booth memorandum *"prospective."* (See HCFA issue paper at Attachment 6.)

- When a few carriers attempted to implement a physical presence requirement in the aftermath of the Booth memorandum, Thomas Ault, Director of HCFA's Bureau of Policy Development, instructed them *not* to institute a "physician presence" requirement until HCFA could issue a final rule on this issue. (See letter from Bob Saner, counsel to MGMA, to Thomas Ault at Attachment 7 and Ault response at Attachment 8.)

Teaching Physician Documentation of Involvement in Patient Care

- Without any statutory or regulatory authority, the OIG takes the position that a countersignature by the teaching physician of a resident's note in the medical record, in and of itself, would *not* be sufficient documentation of involvement by the teaching physician. The OIG requires the teaching physician to provide additional evidence of involvement either through explicit reference to this in the resident's note or some independent source. It is important to note that a requirement to explicitly include a statement in a medical record such as "I (or teaching physician X) was there" is contrary to the way physicians have typically been trained to document services since the beginning of the practice of medicine.
- The OIG's requirement of more than a countersignature is not supported even by the plain language of IL-372 and its progeny, IL-70-2.

Performance of the activities . . . 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. IL 372, Item A.3 (Emphasis added) (Attachment 9, p. 3).

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 personally examined the patient and determined the course of treatment to be followed. Frequent reviews of the patient's progress by the physician would be established by the appearance in the record at 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. IL 70-2, Answer to Question 22. (Emphasis added) (Attachment 10).

- Moreover, there had never been a statutory nor regulatory requirement for documentation by more than a countersignature prior to the July 1, 1996 rule. Many carriers conducted audits throughout the years reviewing teaching physicians' medical records and had required only a countersignature as sufficient documentation that a reimbursable service had been performed.
- Thus, the teaching physician was not put on notice before the July 1, 1996 rule that he/she literally must document "I was there." Absent clear regulatory requirements, the teaching

physician's countersignature in the medical record should be sufficient documentation of his/her involvement in the service provided.

Adequate Documentation of Evaluation and Management Services (Physician Visits)

- Physician visit services (clinic or hospital visits), so-called Evaluation and Management services, have various levels of billing with different descriptions and payment amounts. For example, clinic visits have five levels of service, with level 1 being a brief visit, encompassing a problem-focused patient history, a limited examination, and straightforward decision making, with a typical time of 10 minutes and the lowest reimbursement. A level 5 visit describes a complex visit, with a comprehensive history and exam, and decision making of high complexity, with a typical time of 60 minutes and the highest reimbursement.
- The OIG again is applying *retroactively* documentation guidelines that did not go into effect until August 1, 1995 for services provided from 1990-1995.
- From January 1, 1990 until August 1, 1995, HCFA had *no* uniform documentation guidelines for appropriate levels of visit services for its carriers to follow in reviewing these services or to educate physicians as to what documentation was required. Indeed, HCFA explicitly informed carriers that it should not conduct audits on level of visit services until the documentation guidelines are finished and put into effect. (See American Medical Association's CPT Assistant article at Attachment 11; see also at Attachment 8 page 61 of the article in Family Practice Management, dated January 1995, quoting Barton C. McCann, medical officer in HCFA's Bureau of Policy Development, as stating, "*Up to now there has been no yardstick for reviewing claims for E/M [Evaluation and Management] services.*")
- In May 1995 the OIG report, *Physician Use of New Visit Codes* (OEI-04-92-01060) (Attachment 12), confirmed that the carriers themselves had no idea what constituted proper coding and documentation for physician visit services. That report raised concerns about "... the ability of carriers to correctly advise physicians on coding matters . . ." (p. ii) This conclusion was reached after the OIG surveyed 8 Medicare carriers to determine how they implemented and monitored the new visit codes to be used for billing for physician services. The survey found: (1) a lack of uniform coding by carriers (p. 4) and (2) that 6 of the 8 carriers "... said the new visit codes are not clear" (p. 5). Physicians should not be held to documentation standards for services rendered from 1990 forward when HCFA's own carriers did not know how to code physician visits appropriately as late as 1995.
- HCFA was aware of the need to work with the physician community on developing visit documentation guidelines even prior to the publication of the OIG's report. The guidelines, a collaborative effort of HCFA, the AMA and other physician specialty groups, were released to carriers in November 1994. Upon instruction by HCFA, carriers were to conduct educational seminars on the guidelines from November 1994 - May 1995. Between May 1 and July 31, 1995, the carriers were to begin a "phase in" of the documentation process.

HCFA instructions to carriers were that no medical review audit should include the guidelines until after August 1, 1995. (See CPT Assistant and Family Practice Management articles at Attachment 11.)

- As noted in a September 1, 1993 memorandum of the American Society of Internal Medicine ("ASIM"), HCFA officials had orally stated that carriers "will not attempt to retroactively enforce [the documentation guidelines] during the period when guidelines were still being developed." (See ASIM memorandum at Attachment 11)

No Credit for Undercoding

- Thus far, in the OIG audits of teaching physician billing, the government has refused to use undercoding (i.e., the documentation in the medical record that would have supported the teaching physician billing for a higher level of service) as an offset against overcoding when determining overpayments and assessing penalties. Instead, although the OIG is well aware that in most instances the deadline for appeal has long since passed, the government's response is for the provider to appeal **each** instance of undercoding because, according to the government, extrapolation cannot be used to correct underpayments to physicians. Nonetheless, the government freely uses extrapolation as a technique to determine overpayments and assess penalties.

Assessment of Penalties

- Compounding the OIG's retroactive application of recently promulgated standards, the Department of Justice has imposed penalties under color of the False Claims Act amounting to double and treble the alleged and projected overpayments in the two cases settled to date. Moreover, the government is threatening institutions with the possibility of: exclusion from the Medicare program, criminal prosecution of individual academic physicians, and a fine of \$10,000 for each "false claim" being submitted, unless the institution settles.

Proposed Solution

Given the uncertainty of the billing rules concerning the documentation required to demonstrate both the adequate involvement by the teaching physician and the appropriate level of service billed from 1990-95, we recommend the following audit guidelines for the PATH initiative:

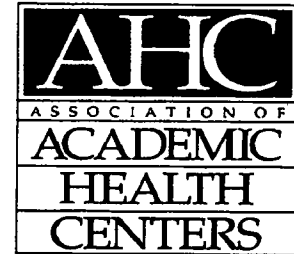
- Countersignature by the teaching physician, in and of itself, should be adequate documentation that the physician provided a "personal and identifiable" service, as required by statute and regulation, until July 1, 1996, when a more explicit documentation requirement went into effect.
- For physician visit services, HCFA's documentation guidelines for Evaluation and Management services should not be used as an audit tool except for services furnished on or after August 1, 1995, the effective date of the guidelines.
- During an audit, examples of overcoding of services should be offset against examples of undercoding.
- Double and treble damages, fines for each "false claim", threats of criminal prosecution of individual physicians and of exclusion from the Medicare program, cannot be justified as punishment for violation of retroactively imposed standards, and should play no role in any audit of pre- August 1, 1995 coding of Evaluation and Management services (physician visits) or pre- July 1, 1996 documentation of reimbursable services by teaching physicians.

Conclusion

In short, as currently implemented, the Physicians at Teaching Hospitals initiative amounts to an OIG program to coerce medical schools and teaching physicians into forfeiting millions of dollars of fees billed in good faith by threatening punitive damages if they do not settle audits based on the retroactive application of HCFA regulations. This process is fundamentally unfair. Billing practices should be audited based on clear policies in effect when patient services were provided. In no event should teaching physicians be subject to punitive financial or criminal penalties based on the OIG's retroactive application of HCFA regulations.



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**Summary of Issues
Office of the Inspector General's
Physicians at Teaching Hospitals Initiative**

- **Nationwide Audits Applying Standards Retroactively.** -- OIG currently is conducting a nationwide audit of Medicare billings by teaching physicians. In conducting this audit, the OIG is applying (for the period 1990-95) documentation guidelines for Evaluation and Management services (physician visits) that were not effective until August 1, 1995, and a uniform physical presence requirement that did not go into effect until July 1, 1996.
- **Regulations Required Teaching Physicians To Be Present for Major Surgeries and Complex Procedures; A Different Standard Applied To All Other Services.** -- Since 1967 the Medicare regulations have been clear. For major surgeries and complex procedures, a teaching physician's physical presence is required to bill Medicare for physicians' services. For all other services, the regulations required only that the teaching physician provide personal and identifiable *direction* to interns and residents who participate in the patient's care for the teaching physician to bill. See 42 C.F.R. §405.521(b)(1) & (2).
- **OIG Audit Standards Inconsistent With Standards In Effect.** -- The OIG primarily is reviewing Medicare billings by teaching physicians for three issues: (1) whether teaching physicians were physically present for all services provided to Medicare patients; (2) how the teaching physician documented his/her involvement in those cases; and (3) whether documentation supports the level of service billed to Medicare for physician visits. The academic medical community agrees that the OIG has the authority to conduct audits. However, the standard to which the OIG holds teaching physicians should be the standard articulated in the Medicare statute and regulations at the time the services were provided.

Audit Problems

Retroactive Application of the Physical Presence Requirement for All Services

- **OIG Relying on Internal HCFA Document and Not Medicare Law or Carrier Practice.** -- In conducting these audits, the OIG is relying on HCFA's Intermediary Letter 372 ("IL-372") as its audit standard. IL-372 is an internal HCFA document issued in 1969 that was never subjected to public notice and comment as required under the Administrative Procedure Act. The OIG contends that IL-372 requires the physical presence of the teaching physician for all services and deems a countersignature of a resident's notes, in and of itself, as insufficient documentation of physical presence.

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- **OIG Retroactively Applying Medicare Rules and Guidelines.** --The OIG's interpretation of IL-372 is contrary to that of HCFA and local carriers. In effect, the OIG is retroactively applying a standard that did not become effective until July 1, 1996.

Teaching Physician Documentation of Involvement in Patient Care

- **OIG Failing to Recognize Sufficiency of Countersignatures.** -- The OIG takes the position that a countersignature by the teaching physician of a resident's note in the medical record, in and of itself, would *not* be sufficient documentation of involvement by the teaching physician. The OIG requires the teaching physician to provide additional evidence of involvement either through explicit reference to this in the resident's note or some independent source. Contrary to the OIG's belief, the plain language of IL-372 and its progeny IL 70-2 deems a countersignature to be sufficient documentation. Moreover, during past audits many carriers have accepted a countersignature as sufficient.

Adequate Documentation of Evaluation and Management Services (Physician Visits)

- **Retroactive Application of Guidelines for Correct Coding of Level of Physician Visits.** -- As of August 1, 1995 physicians are required to meet explicit documentation standards when submitting bills to Medicare for physician visits. Prior to August 1995 there were no uniform guidelines for physician visit documentation and HCFA informed carriers not to include physician visit services in their regular audits until guidelines could be finalized. Nonetheless, during the audits the OIG *retroactively* applies the new visit code documentation standards for services provided from 1990 through 1995.

No Netting of Undercoding

- As the OIG noted in a 1995 report, correct coding of physician office visits is difficult, even for Medicare carriers. While a visit may be inadvertently upcoded, it also is not unusual for a visit to be undercoded, with the result that a physician receives a lower payment than that to which he/she is entitled. While the OIG is seeking recoupment when a teaching physician overbills or "upcodes" because the documentation does not support the level of service billed, it refuses to net this overpayment against underbilling by the teaching physician.

Assessment of Penalties

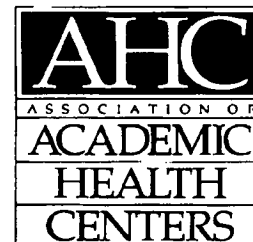
- In the two cases brought to conclusion so far, the Justice Department has assessed treble and double damages on the amounts of overpayments. Moreover, the government is threatening institutions with the possibility of: exclusion from the Medicare program, criminal prosecutions of individual academic physicians, and fines of \$10,000 for each "false claim" being submitted, unless the institution settles.

Proposed Solution

- Countersignature by the teaching physician, in and of itself, should be adequate documentation that the physician provided a "personal and identifiable" service, as required by statute and regulation, until July 1, 1996, when a more explicit documentation requirement went into effect.
- For physician visit services, HCFA's documentation guidelines for Evaluation and Management services should not be used as an audit tool except for services furnished on or after August 1, 1995, the effective date of the guidelines.
- During an audit, examples of overcoding of services should be offset against examples of undercoding.
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Briefing Paper
Office of the Inspector General's
Physicians at Teaching Hospitals Initiative

The Problem

The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) is conducting a national audit of teaching hospitals (most of which are affiliated with medical schools and medical school faculty practice plans) to determine compliance with standards for billing by teaching physicians for patient care. During the audits the OIG is examining medical records to determine: (1) whether teaching physicians were physically present for all services provided to Medicare patients; (2) how the teaching physician documented his/her involvement in those cases; and (3) whether documentation supports the level of service billed to Medicare for physician visits. In conducting these audits the OIG is applying standards and regulations retroactively that did not go into effect until August 1, 1995 and July 1, 1996 and is disallowing millions of dollars in fees billed from 1990 through 1995. Moreover, in the two cases brought to conclusion, the Department of Justice has assessed penalties calculated as double and treble the amounts disallowed. Unless fair audit standards are established, our nation's medical schools, teaching hospitals, and faculty practice plans will be required to forfeit millions of dollars to the Federal government which will undercut their ability to fulfill their education, service and research missions.

The OIG's audit standards conflict with certain policies of the Health Care Financing Administration (HCFA), the federal agency charged with implementing the Medicare law, and disregard the government's own admission that certain other policies are unclear. That admission appears in the preamble to the new rule on teaching physician billing that went into effect on July 1, 1996, which states that:

...the [Medicare teaching physician] policy as set forth in IL-372 and related issuances specifically stated that the attending physician had to be present when a major surgical procedure or complex or dangerous procedure was performed *but was vague, perhaps necessarily, on the matter of presence of the physician during other occasions of inpatient service.* 60 Fed. Reg. at 63138 (December 8, 1995) (Emphasis added) (Attachment 1).

Since 1967 the Medicare regulations have been clear that a teaching physician must be physically present during the critical portions of major surgeries and other complex or dangerous procedures. See 42 C.F.R. §405.521(b)(2) (Attachment 2). However, in contrast to major surgeries and similar procedures, the standard for other inpatient and outpatient services clearly stated in the Medicare law is simply "personal and identifiable *direction*" to the residents by the teaching

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physician. See 42 C.F.R. §405.521(b)(1) (Attachment 2); see also Social Security Act §1842(b)(7)(A)(i)(I) (Emphasis added) (Attachment 3).

The new teaching physician rule, that was issued in accordance with the Administrative Procedure Act, significantly clarifies decades of chaos with respect to the government's requirements for teaching physicians to bill Medicare for patient care services. This new rule requires teaching physicians to be physically present for all services (with very limited exceptions) and clarifies the standards for documentation of this presence. However, these are requirements that apply from July 1, 1996 *forward*. If these requirements had always been the standard, why was a new rule needed? Further, why did HCFA delay implementing this new rule from December 8, 1995 when it was promulgated until July 1, 1996 to allow Medicare carriers "adequate time to educate all affected parties"? (See Attachment 1 at p. 63142-43.) In fact even a year after this rule was promulgated, HCFA still is conducting educational programs for its carriers and academic medical centers on these requirements.

No one in the academic medical community questions the authority or appropriateness of the OIG to conduct audits. However, the standard to which the OIG holds teaching physicians must be fair and must be the standard articulated in the Medicare statute and regulations. As described below, neither is the case in the ongoing OIG investigations.

Background

Who is Being Audited? - In June 1996, the OIG launched a nationwide review of the billing practices of teaching physicians for services provided to Medicare patients. This effort is known as the Physicians at Teaching Hospitals ("PATH") initiative. Teaching physicians typically have a medical school faculty appointment and provide patient care during the course of educating medical students and residents and conducting state-of-the-art medical research.

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- 1994 data from approximately 280 non-federal teaching hospitals, which are members of the Association of American Medical Colleges ("AAMC"), show that while teaching hospitals account for only 6% of all short-term non-federal acute care institutions, they provide 24% of all Medicaid inpatient days, 27% of all bad debt expense, and 45% of all charity care (\$5.6 billion) written off by these institutions.
- In addition, according to a 1994 AAMC survey, it is estimated that teaching physicians dedicated 28% of their income from providing patient care to support undergraduate and graduate medical research and education.

What Is Being Audited? - For these PATH audits, the OIG primarily is reviewing medical records of teaching physicians for three issues -- (1) whether a teaching physician was physically present;

(2) how a teaching physician documented his/her involvement in the care of a Medicare patient; and (3) whether the documentation supports the level of Evaluation and Management service (physician visit) billed to Medicare. **The audits do not focus on, or question, the quality of care or whether a patient received proper care.**

Audit Problems

Retroactive Application of the Physical Presence Requirement for All Services

With respect to the first issue, physical presence of the teaching physician, the OIG has stated that it is using criteria contained in HCFA's Intermediary Letter 372 ("IL-372") as its standard. ***IL-372 is a HCFA document issued in 1969 that was never subjected to public notice and comment as required under the Administrative Procedure Act.*** The OIG is not relying on Medicare law or regulations in conducting the PATH audits. Instead, the OIG is retroactively applying a standard that did not become effective until July 1, 1996.

- The Medicare statute and regulations prior to July 1, 1996 clearly establish two different degrees of teaching physician involvement required to bill for patient care involving residents. The first is a general rule, and the second is a higher standard for major surgeries and other complex and dangerous procedures. The general rule in 42 C.F.R. §405.521(b)(1) reads:

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. (Emphasis added) (Attachment 2.)

Paragraph (b)(2) establishes the higher standard for a subset of services:

In the case of major surgical procedures and other complex and dangerous procedures or situation, the attending physician must ***personally supervise the residents and interns*** who the physician involves in the care of the patient. (Emphasis added) (Attachment 2.)

- With respect to IL-372 itself, HCFA on numerous occasions has admitted that everyone, carriers, physicians, and hospitals, found it confusing. In the preamble to the new teaching physician rule that went into effect on July 1, 1996, HCFA stated that the "Intermediary Letter 372 policy left it to individual carriers to determine coverage of the [teaching physician] services based on customary practices in the area" (Attachment 1 at p. 63139). HCFA described IL-372 which was adopted in 1969 as being "controversial ever since." (Id. at 63138.) HCFA also acknowledged that IL-372 "was not applied uniformly by all Medicare

carriers," (Id. at 63137), and "might be viewed as not entirely consistent with the payment mechanism enacted in OBRA '86." (Id. at 63138.)

- There is additional evidence that the Medicare law did not require the physical presence of the teaching physician for all services until July 1996. In February of 1989, just 10 months before the beginning time period covered by the PATH audits, HCFA issued a proposed rule in this area that clearly stated an "immediately available" rather than a "physically present" standard for all outpatient services. (See Attachment 4 at p. 5968, proposed §415.178.) HCFA's preamble to this proposed rule stated it was simply issuing regulations to implement a 1980 regulatory revision and not to overturn IL-372. HCFA never repudiated this proposed rule until it published the new rule effective in July 1996. Thus, it was wholly reasonable for teaching physicians to believe that the 1989 proposed rule represented the best guess as to HCFA's current thinking. In fact, many times regulatory agencies (including FDA) take the position that a proposed rule represents current agency policy and may be relied upon by regulated entities.
- Going back to 1986, a report by the General Accounting Office ("GAO") (Attachment 5) documented that IL-372 did not articulate a clear standard for Medicare billing by teaching physicians. The GAO concluded that under IL-372, there was substantial variation of interpretation by local Medicare carriers as to what would constitute a "personal and identifiable" service provided by the teaching physician. The GAO report stated that "HCFA's instructions [IL-372] did not explicitly define what constituted appropriate and adequate documentation to support teaching physicians' claims for reimbursement." (Attachment 5 at p. 10,272.) The report concluded that "HCFA needs to establish and enforce explicit documentation requirements so that teaching physicians and hospitals know what is expected to [sic] them and understand that they are to be held accountable for not complying with Medicare requirements." (Attachment 5 at p. 10,278.) HCFA did not heed these recommendations until publication of its July 1, 1996 rule.
- It is true that in December 1992, Charles Booth, then-Director of HCFA's Office of Payment Policy, sent a memorandum (the "Booth memorandum") to the HCFA regional offices concerning resident involvement in physician visit services. As an aside in this memorandum, Mr. Booth stated that the teaching physician must be present in all cases involving residents to bill Medicare. This memorandum caused a furor in the academic medical community, because no one had understood that to be the standard in the wake of the 1989 proposed rule. This memorandum triggered the commencement of a series of meetings over a number of years between HCFA officials and representatives of the AAMC, the Medical Group Management Association ("MGMA"), and the American Medical Association ("AMA") to resolve this issue. The plain language of documents prepared by HCFA staff for these meetings contradicts the Booth memorandum. A HCFA issue paper prepared in July 1994 illustrates that HCFA was continuing to have discussions with outside groups, even at that late date, over what the true standard under IL-372 should be. Moreover, in this same issue paper, HCFA admitted again that IL-372 instructions were *"ambiguous and have not been vigorously*

enforced" and that it was willing to make application of the Booth memorandum *"prospective."* (See HCFA issue paper at Attachment 6.)

- When a few carriers attempted to implement a physical presence requirement in the aftermath of the Booth memorandum, Thomas Ault, Director of HCFA's Bureau of Policy Development, instructed them *not* to institute a "physician presence" requirement until HCFA could issue a final rule on this issue. (See letter from Bob Saner, counsel to MGMA, to Thomas Ault at Attachment 7 and Ault response at Attachment 8.)

Teaching Physician Documentation of Involvement in Patient Care

- Without any statutory or regulatory authority, the OIG takes the position that a countersignature by the teaching physician of a resident's note in the medical record, in and of itself, would *not* be sufficient documentation of involvement by the teaching physician. The OIG requires the teaching physician to provide additional evidence of involvement either through explicit reference to this in the resident's note or some independent source. It is important to note that a requirement to explicitly include a statement in a medical record such as "I (or teaching physician X) was there" is contrary to the way physicians have typically been trained to document services since the beginning of the practice of medicine.
- The OIG's requirement of more than a countersignature is not supported even by the plain language of IL-372 and its progeny, IL-70-2.

Performance of the activities . . . 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. IL 372, Item A.3 (Emphasis added) (Attachment 9, p. 3).

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 personally examined the patient and determined the course of treatment to be followed. Frequent reviews of the patient's progress by the physician would be established by the appearance in the record at 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. IL 70-2, Answer to Question 22. (Emphasis added) (Attachment 10).

- Moreover, there had never been a statutory nor regulatory requirement for documentation by more than a countersignature prior to the July 1, 1996 rule. Many carriers conducted audits throughout the years reviewing teaching physicians' medical records and had required only a countersignature as sufficient documentation that a reimbursable service had been performed.
- Thus, the teaching physician was not put on notice before the July 1, 1996 rule that he/she literally must document "I was there." Absent clear regulatory requirements, the teaching

physician's countersignature in the medical record should be sufficient documentation of his/her involvement in the service provided.

Adequate Documentation of Evaluation and Management Services (Physician Visits)

- Physician visit services (clinic or hospital visits), so-called Evaluation and Management services, have various levels of billing with different descriptions and payment amounts. For example, clinic visits have five levels of service, with level 1 being a brief visit, encompassing a problem-focused patient history, a limited examination, and straightforward decision making, with a typical time of 10 minutes and the lowest reimbursement. A level 5 visit describes a complex visit, with a comprehensive history and exam, and decision making of high complexity, with a typical time of 60 minutes and the highest reimbursement.
- The OIG again is applying *retroactively* documentation guidelines that did not go into effect until August 1, 1995 for services provided from 1990-1995.
- From January 1, 1990 until August 1, 1995, HCFA had *no* uniform documentation guidelines for appropriate levels of visit services for its carriers to follow in reviewing these services or to educate physicians as to what documentation was required. Indeed, HCFA explicitly informed carriers that it should not conduct audits on level of visit services until the documentation guidelines are finished and put into effect. (See American Medical Association's CPT Assistant article at Attachment 11; see also at Attachment 8 page 61 of the article in Family Practice Management, dated January 1995, quoting Barton C. McCann, medical officer in HCFA's Bureau of Policy Development, as stating, "*Up to now there has been no yardstick for reviewing claims for E/M [Evaluation and Management] services.*")
- In May 1995 the OIG report, *Physician Use of New Visit Codes* (OEI-04-92-01060) (Attachment 12), confirmed that the carriers themselves had no idea what constituted proper coding and documentation for physician visit services. That report raised concerns about "... the ability of carriers to correctly advise physicians on coding matters . . ." (p. ii) This conclusion was reached after the OIG surveyed 8 Medicare carriers to determine how they implemented and monitored the new visit codes to be used for billing for physician services. The survey found: (1) a lack of uniform coding by carriers (p. 4) and (2) that 6 of the 8 carriers "... said the new visit codes are not clear" (p. 5). Physicians should not be held to documentation standards for services rendered from 1990 forward when HCFA's own carriers did not know how to code physician visits appropriately as late as 1995.
- HCFA was aware of the need to work with the physician community on developing visit documentation guidelines even prior to the publication of the OIG's report. The guidelines, a collaborative effort of HCFA, the AMA and other physician specialty groups, were released to carriers in November 1994. Upon instruction by HCFA, carriers were to conduct educational seminars on the guidelines from November 1994 - May 1995. Between May 1 and July 31, 1995, the carriers were to begin a "phase in" of the documentation process.

HCFA instructions to carriers were that no medical review audit should include the guidelines until after August 1, 1995. (See CPT Assistant and Family Practice Management articles at Attachment 11.)

- As noted in a September 1, 1993 memorandum of the American Society of Internal Medicine ("ASIM"), HCFA officials had orally stated that carriers "will not attempt to retroactively enforce [the documentation guidelines] during the period when guidelines were still being developed." (See ASIM memorandum at Attachment 11)

No Credit for Undercoding

- Thus far, in the OIG audits of teaching physician billing, the government has refused to use undercoding (i.e., the documentation in the medical record that would have supported the teaching physician billing for a higher level of service) as an offset against overcoding when determining overpayments and assessing penalties. Instead, although the OIG is well aware that in most instances the deadline for appeal has long since passed, the government's response is for the provider to appeal **each** instance of undercoding because, according to the government, extrapolation cannot be used to correct underpayments to physicians. Nonetheless, the government freely uses extrapolation as a technique to determine overpayments and assess penalties.

Assessment of Penalties

- Compounding the OIG's retroactive application of recently promulgated standards, the Department of Justice has imposed penalties under color of the False Claims Act amounting to double and treble the alleged and projected overpayments in the two cases settled to date. Moreover, the government is threatening institutions with the possibility of: exclusion from the Medicare program, criminal prosecution of individual academic physicians, and a fine of \$10,000 for each "false claim" being submitted, unless the institution settles.

Proposed Solution

Given the uncertainty of the billing rules concerning the documentation required to demonstrate both the adequate involvement by the teaching physician and the appropriate level of service billed from 1990-95, we recommend the following audit guidelines for the PATH initiative:

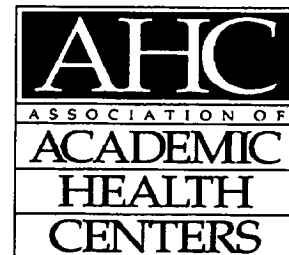
- Countersignature by the teaching physician, in and of itself, should be adequate documentation that the physician provided a "personal and identifiable" service, as required by statute and regulation, until July 1, 1996, when a more explicit documentation requirement went into effect.
- For physician visit services, HCFA's documentation guidelines for Evaluation and Management services should not be used as an audit tool except for services furnished on or after August 1, 1995, the effective date of the guidelines.
- During an audit, examples of overcoding of services should be offset against examples of undercoding.
- Double and treble damages, fines for each "false claim", threats of criminal prosecution of individual physicians and of exclusion from the Medicare program, cannot be justified as punishment for violation of retroactively imposed standards, and should play no role in any audit of pre- August 1, 1995 coding of Evaluation and Management services (physician visits) or pre- July 1, 1996 documentation of reimbursable services by teaching physicians.

Conclusion

In short, as currently implemented, the Physicians at Teaching Hospitals initiative amounts to an OIG program to coerce medical schools and teaching physicians into forfeiting millions of dollars of fees billed in good faith by threatening punitive damages if they do not settle audits based on the retroactive application of HCFA regulations. This process is fundamentally unfair. Billing practices should be audited based on clear policies in effect when patient services were provided. In no event should teaching physicians be subject to punitive financial or criminal penalties based on the OIG's retroactive application of HCFA regulations.



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**Summary of Issues
Office of the Inspector General's
Physicians at Teaching Hospitals Initiative**

- **Nationwide Audits Applying Standards Retroactively.** -- OIG currently is conducting a nationwide audit of Medicare billings by teaching physicians. In conducting this audit, the OIG is applying (for the period 1990-95) documentation guidelines for Evaluation and Management services (physician visits) that were not effective until August 1, 1995, and a uniform physical presence requirement that did not go into effect until July 1, 1996.
- **Regulations Required Teaching Physicians To Be Present for Major Surgeries and Complex Procedures; A Different Standard Applied To All Other Services.** -- Since 1967 the Medicare regulations have been clear. For major surgeries and complex procedures, a teaching physician's physical presence is required to bill Medicare for physicians' services. For all other services, the regulations required only that the teaching physician provide personal and identifiable *direction* to interns and residents who participate in the patient's care for the teaching physician to bill. See 42 C.F.R. §405.521(b)(1) & (2).
- **OIG Audit Standards Inconsistent With Standards In Effect.** -- The OIG primarily is reviewing Medicare billings by teaching physicians for three issues: (1) whether teaching physicians were physically present for all services provided to Medicare patients; (2) how the teaching physician documented his/her involvement in those cases; and (3) whether documentation supports the level of service billed to Medicare for physician visits. The academic medical community agrees that the OIG has the authority to conduct audits. However, the standard to which the OIG holds teaching physicians should be the standard articulated in the Medicare statute and regulations at the time the services were provided.

Audit Problems

Retroactive Application of the Physical Presence Requirement for All Services

- **OIG Relying on Internal HCFA Document and Not Medicare Law or Carrier Practice.** -- In conducting these audits, the OIG is relying on HCFA's Intermediary Letter 372 ("IL-372") as its audit standard. IL-372 is an internal HCFA document issued in 1969 that was never subjected to public notice and comment as required under the Administrative Procedure Act. The OIG contends that IL-372 requires the physical presence of the teaching physician for all services and deems a countersignature of a resident's notes, in and of itself, as insufficient documentation of physical presence.

January 16, 1997

- **OIG Retroactively Applying Medicare Rules and Guidelines.** --The OIG's interpretation of IL-372 is contrary to that of HCFA and local carriers. In effect, the OIG is retroactively applying a standard that did not become effective until July 1, 1996.

Teaching Physician Documentation of Involvement in Patient Care

- **OIG Failing to Recognize Sufficiency of Countersignatures.** -- The OIG takes the position that a countersignature by the teaching physician of a resident's note in the medical record, in and of itself, would *not* be sufficient documentation of involvement by the teaching physician. The OIG requires the teaching physician to provide additional evidence of involvement either through explicit reference to this in the resident's note or some independent source. Contrary to the OIG's belief, the plain language of IL-372 and its progeny IL 70-2 deems a countersignature to be sufficient documentation. Moreover, during past audits many carriers have accepted a countersignature as sufficient.

Adequate Documentation of Evaluation and Management Services (Physician Visits)

- **Retroactive Application of Guidelines for Correct Coding of Level of Physician Visits.** -- As of August 1, 1995 physicians are required to meet explicit documentation standards when submitting bills to Medicare for physician visits. Prior to August 1995 there were no uniform guidelines for physician visit documentation and HCFA informed carriers not to include physician visit services in their regular audits until guidelines could be finalized. Nonetheless, during the audits the OIG *retroactively* applies the new visit code documentation standards for services provided from 1990 through 1995.

No Netting of Undercoding

- As the OIG noted in a 1995 report, correct coding of physician office visits is difficult, even for Medicare carriers. While a visit may be inadvertently upcoded, it also is not unusual for a visit to be undercoded, with the result that a physician receives a lower payment than that to which he/she is entitled. While the OIG is seeking recoupment when a teaching physician overbills or "upcodes" because the documentation does not support the level of service billed, it refuses to net this overpayment against underbilling by the teaching physician.

Assessment of Penalties

- In the two cases brought to conclusion so far, the Justice Department has assessed treble and double damages on the amounts of overpayments. Moreover, the government is threatening institutions with the possibility of: exclusion from the Medicare program, criminal prosecutions of individual academic physicians, and fines of \$10,000 for each "false claim" being submitted, unless the institution settles.

Proposed Solution

- Countersignature by the teaching physician, in and of itself, should be adequate documentation that the physician provided a "personal and identifiable" service, as required by statute and regulation, until July 1, 1996, when a more explicit documentation requirement went into effect.
- For physician visit services, HCFA's documentation guidelines for Evaluation and Management services should not be used as an audit tool except for services furnished on or after August 1, 1995, the effective date of the guidelines.
- During an audit, examples of overcoding of services should be offset against examples of undercoding.
- Double and treble damages, fines for each "false claim", threats of criminal prosecution of individual physicians and of exclusion from the Medicare program, cannot be justified as punishment for violation of retroactively imposed standards, and should play no role in any audit of pre- August 1, 1995 coding of Evaluation and Management services (physician visits) or pre- July 1, 1996 documentation of reimbursable services by teaching physicians.