DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAR 13 1996

From June Gibbs Brown
Inspector General

Subject Status Report--Office of Inspector General/Department of Justice Joint Project - Review of Medicare Part B Billings by Physician Group Practices at Teaching Hospitals (A-03 -94-OO016)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our report on the status of a nationwide project involving a review of Medicare Part B billings by physician group practices at teaching hospitals. This project is being conducted jointly, in two phases, by the Office of Inspector General (OIG) and the Department of Justice (DOJ).

Phase I involved a review of Medicare Part B billings submitted by the Clinical Practices of the University of Pennsylvania (CPUP), a component of the University of Pennsylvania Health System located in Philadelphia, Pennsylvania. The OIG/DOJ Project Team which conducted the review consisted of representatives of the OIG regional office in Philadelphia and the United States Attorney's Office for the Eastern District of Pennsylvania. The Project Team was assisted by medical personnel provided by XACT Medicare Services, the Medicare carrier serving the Commonwealth of Pennsylvania. Phase II involves an expansion of the project to physician group practices at other teaching hospitals nationally.

The primary objectives of both phases of this review are to:

- determine whether Medicare Part B reimbursements for professional services provided to beneficiaries by physician group practice providers at teaching hospitals were reasonable, allowable, and documented in accordance with Medicare regulations.

- recover improper Medicare payments for unallowable and inadequately documented services.

- require physician group practices to establish a corrective action plan aimed at correcting the billing problems identified.

Phase Z of our review at CPUP is completed Using the results of the OIG audit at CPUP, the OIG/DOJ Project Team entered into a series of negotiations with CPUP representatives. On December 12, 1995 these negotiations culminated in a signed settlement agreement under which CPUP agreed to pay over $30 million to the Federal Government as full and final settlement for claims submitted during the period January 1, 1989 through December 31, 1994. The settlement was based on audit findings that medical records for selected Medicare beneficiaries did not always document:

- a CPUP physician's presence at the time that a service was rendered by a resident.

- the level of care billed by CPUP.

The settlement agreement also required CPUP to develop and implement a corrective action plan to address the two major problems identified in our audit. We are recommending that the Health Care Financing Administration (HCFA): (1) monitor the recovery and distribution of the over $30 million and (2) review CPUP'S implementation of the corrective action plan. Any instances of noncompliance should be reported to the OIG/DOJ Project Team.

Phase II of our review is just beginning. Although the objectives of Phase II remain the same as Phase I, our approach is different in that we will give most of the selected hospitals the opportunity to use independent auditors to conduct the audits under OIG/DOJ's oversight. This approach should not only conserve audit and investigative resources, it should also reduce the need for Medicare carrier support. We will closely coordinate this phase of the review with HCFA. In fact, HCFA representatives in both Region III and in Headquarters have received initial briefings. Additional briefings will be scheduled to obtain HCFA'S input and, where necessary, the assistance of Medicare carriers. One such briefing of HCFA's senior management was held on February 27, 1996.

Should you have any questions, please contact me or have a member of your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Thomas J. Robertson, Regional Inspector General for Audit Services, at (215) 596-6744.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

STATUS REPORT
OFFICE OF INSPECTOR GENERAL/DEPARTMENT OF JUSTICE JOINT PROJECT
REVIEW OF MEDICARE PART B BILLINGS BY PHYSICIAN GROUP PRACTICES AT TEACHING HOSPITALS

JUNE GIBBS BROWN
Inspector General

MARCH 1996
A-03-94-OO016

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAR 13 1996

From June Gibbs Brown
Inspector General

Subject Status Report--Office of Inspector General/Department of Justice Joint Project - Review of Medicare Part B Billings by Physician Group Practices at Teaching Hospitals (A-03-94-00016)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This report is to inform you of the status of a nationwide project involving a review of Medicare Part B billings by physician group practices at teaching hospitals. This project is being conducted jointly, in two phases, by the Office of Inspector General (OIG) and the Department of Justice (DOJ).

Phase I involved a review of Medicare Part B billings submitted by the Clinical Practices of the University of Pennsylvania (CPUP), a component of the University of Pennsylvania Health System (UPHS) located in Philadelphia, Pennsylvania. The OIG/DOJ Project Team which conducted the review consisted of representatives of the OIG regional office in Philadelphia and the United States Attorney's Office for the Eastern District of Pennsylvania. The Project Team was assisted by medical personnel provided by XACT Medicare Services (XACT), the Medicare carrier serving the Commonwealth of Pennsylvania. Phase II involves an expa.mien of the project to physician group practices at other teaching hospitals nationally.

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BACKGROUND

The Medicare program is administered by HCFA. Medicare Part A covers hospital and other institutional care for about 37 million persons age 65 or older and for certain disabled persons. Medicare Part B covers most of the costs of medically necessary physician and other noninstitutional services. The HCFA contracts with private insurance companies to process Medicare claims and to perform payment safeguard functions. The HCFA has contracts with 34 carriers that process Part B claims, including claims for physician services performed in a hospital setting.

The OIG/DOJ project emanated from an OIG audit of Medicare Part B billings at CPUP. We initially focused on whether medical records documented that a physician either performed the service or was present when a resident performed it. While reviewing the services, we noted indications that the levels of care billed by CPUP were not supported by medical records. At that point, DOJ became involved and the OIG/DOJ joint project was born.

To complete the level of care review at CPUP, XACT provided its Utilization Review (UR) staff, who had the necessary medical expertise, to evaluate the various levels of care. At our request, XACT UR personnel reviewed selected services to determine whether the level of care billed to Medicare was supported in the beneficiary's medical records. The XACT UR staff also advised us, in some instances, on whether the medical records supported the presence of a physician when services were rendered by a resident.

RESULTS OF THE PHASE I REVIEW AT CPUP

The OIG'S review of CPUP'S Medicare Part B billings is complete. Using the results of the review as a basis, the OIG/DOJ Project Team entered into a series of negotiations with CPUP representatives, resulting in a negotiated settlement agreement of over $30 million. The settlement agreement was based primarily on two major audit findings.

No Evidence of Physician Presence

For a significant number of Medicare Part B bills that we reviewed, there was no documentation in the medical records showing that a CPUP physician was present when a resident performed the service. Without such documentation, these bills were ineligible for Medicare reimbursement.

Although residents may be medically qualified to perform a medical procedure on Medicare beneficiaries, they are not allowed to bill Medicare Part B for that service. The reason for this prohibition is that the salaries of residents are factored into the Medicare Part A payment made on behalf of the Medicare beneficiaries served. Therefore, if the group practice bills Medicare Part B for services provided by a resident as part of his teaching program, this would (in effect), represent a duplicate payment.

Services performed by a resident maybe billed to Medicare Part B by a beneficiary's physician only when that physician was present. This requirement was included in Intermediary Letter 372 which HCFA issued in April 1969. The letter clarifies and supplements the regulations that govern reimbursement for services provided to Medicare beneficiaries by supervising physicians in a teaching setting. Medical records must demonstrate the physician's presence during the performance of the service by the resident, and must be countersigned by the physician. Part B benefits cannot be paid for those services for which the physician was not personally involved and which are merely supervisory in nature.

In our review at CPUP, we accepted as adequate documentation a progress note or consultation report written by a physician. If the progress note or consultation report was prepared by a resident, we reviewed the note to determine whether there was indication that a physician was present when the services were performed. We were told that residents usually performed the consultations and may or may not have called the physician to discuss the case, depending on a patient's condition. For the services which we questioned, the physician did not write the progress note or consultation report, and there was no evidence in the note or report of the physician's presence when the service was provided by a resident.

Level of Care Billed Not Supported

A significant number of Medicare Part B bills also lacked documentation in the medical records to support the level of care which was billed. Of the bills for which the level of care could not be supported, 94 percent represented what XACT UR personnel determined to be upcoding (billing for a more complex level of care than that which was provided results in increased Medicare reimbursement).

Medical records must contain documentation to support all services rendered. The American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4) contains various codes used for the reporting and billing of medical services. The CPT-4 defines the service and the level of care within a service. Medicare reimbursement is based on the CPT-4 code billed. Generally, the higher the degree and complexity of the service or level of care provided, the higher the Medicare reimbursement.

To determine if the level of care billed by CPUP was supported by documentation contained in the medical records, we requested the assistance of XACT UR personnel. The XACT UR personnel reviewed the medical records and, based on the documentation therein, determined the level of care or service rendered to the patient. The XACT UR personnel also reviewed any subsequent documentation provided by CPUP for the services in question.

The XACT UR personnel determined that a significant number of services were billed at a higher level of care than the level supported by the medical records. While most of the upcoding involved just one level of care, many services were upcoded two levels, and some were upcoded three levels.

Negotiated Settlement Agreement

We provided CPUP officials details on each of the services we questioned, and gave them the opportunity to provide additional documentation to support the Medicare Part B bills. The OIG/DOJ Project Team and XACT UR officials reviewed additional documentation provided by CPUP and revised their preliminary findings. These final results were used as the basis for negotiations between the OIG/DOJ Project Team and CPUP representatives.

On December 12, 1995, CPUP entered into a settlement agreement under which it agreed to pay the Federal Government $30,013,490 as fill and final settlement for Medicare Part B claims submitted during the period January 1, 1989 through December 31, 1994. The CPUP also agreed to implement a corrective action plan entitled, ***Professional Fee Billing Compliance Program,*** to correct the billing problems disclosed by the audit.

The corrective action plan consists of four comprehensive, proactive elements. The four key elements are:

- Centralized Billing. The CPUP is centralizing all business and financial fictions under the direction of UPHS's Chief Financial Officer (CFO). The first phase is the implementation of centralized inpatient chart abstraction throughout the Medical Center. As this system is implemented, all coding of professional fees for inpatient services will be handled by a central abstraction office. This phase is expected to be completed on or before June 30, 1996.

- Oversight. The CPUP will establish separate internal monitoring and external auditing procedures that will be implemented throughout the next 5 years. Internal monitoring procedures include the establishment of an Office of Billing Compliance by June 30, 1996. The Office will regularly audit the effectiveness of compliance policies and procedures, and make recommendations to the CFO to improve compliance with billing requirements. The Office will also review each chart abstracter's work at least twice annually, and sample each physician's professional fee billings on an annual basis.

  External audit procedures include an independent audit of professional fee billings beginning with the 1995 professional fees. The audits will be conducted in accordance with generally accepted Government auditing standards. The audit reports for the 1995 and 1999 audits will be provided to the OIG. The results of the 1996 through 1998 audits will be provided to the Medicare carrier.

- Mandatory Education and Training. The CPUP will continue its program of mandatory education and training for all physicians and

billing personnel which it began in mid-1 994. The CPUP is committed to this training and agreed to continue it for at least the next 5 years.

- Information and Reporting. The CPUP agreed to establish two special telephone lines dedicated to billing information and reporting. The information line will provide a resource for physicians and staff to obtain answers to questions they have about billing for professional services from chart abstracters or other employees with expertise in Medicare billing requirements. The reporting line will permit faculty and employees to report billing practices they believe should be reviewed by the CFO or his designee on a confidential basis.

Phase I Recommendations to HCFA

Under the negotiated settlement agreement, CPUP agreed to refund $30,013,490 to the Federal Government, and make procedural improvements to prevent similar situations from occurring in the future. If CPUP complies with the provisions of the settlement agreement, no further actions are required.

We are recommending that HCFA:

1. Monitor the recovery and distribution of the $30,013,490,

2. Review CPUP implementation of the agreed corrective action plan. Any instances of noncompliance should be reported to the OIG.

STATUS OF PHASE II--NATIONAL EXPANSION TO OTHER TEACHING HOSPITALS

Because of the significance of the findings in Phase I, the OIG and DOJ are expanding the project nationally. The objectives of Phase 11 will remain essentially the same as those of Phase I. The selection of hospitals to be included in Phase II has not been finalized. We have, however, decided to modify the manner in which the reviews will be conducted.

Selection of Hospitals

Hospital selection isunderway. Sixhospitals in Pennsylvania have beencontacted and informed that they have been tentatively selected for review. These hospitals are: (1) Albert Einstein Medical Center; (2) Graduate Hospital; (3) Jefferson Medical College; (4) Medical College of Pennsylvania and Hahnemann University; (5) Temple University Hospital; and (6) University of Pittsburgh Medical Center.

In addition, representatives of the United States Attorney's Office for the Eastern District of Pennsylvania, who participated in Phase I, are in the process of querying their counterparts nationally to determine their level of interest. In the areas where Phase II will be conducted, OIG/DOJ Project Teams will be established to either conduct or provide oversight for the hospital reviews. Prior to making final decisions regarding the selection of hospitals, the Project Teams will seek HCFA'S input.

Method of Conducting Reviews

Rather than having OIG/DOJ Project Teams responsible for conducting all of the reviews in Phase II, most hospitals selected will be given the opportunity to arrange for an independent auditor to conduct the reviews with Project Team's oversight.

This oversight will include the development of a review protocol by the Project Team and the independent auditors which must be agreed to by all parties prior to the start of the review. Among the items to be included in the protocol are: the number of years to be reviewed, the type of claims to be reviewed, the statistical sampling methodology used to select the claims, the method of review, the type of audit evidence to be gathered, the use of medical professionals to conduct level of care reviews, and the basis for a settlement agreement upon completion of the review. The OIG/DOJ Project Team will reserve the right to monitor the independent auditors' work in progress, and review working papers as appropriate. Indications are that hospitals will be receptive to this approach. Two of the six Pennsylvania hospitals tentatively selected for inclusion in Phase II have expressed a strong interest in this option.

Phase II Recommendations to HCFA

At this time we have no recommendations to make to HCFA. The HCFA can, however, anticipate recommendations similar to those made in Phase I. Additional recommendations may be warranted if the conditions identified in Phase I are widespread.