How doctors and hospitals have collected billions in questionable Medicare fees [1]

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

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

Medical groups argue that the fee hikes are justified because treating seniors has grown more complex and time-consuming, both due to new technology and declining health status. The rise in fees may also be a reaction, they say, to years of under-charging, and reflect more accurate billing. The fees are based on a system of billing codes that is structured to make higher payments for treatments that take more time and effort.

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

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

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

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

"This is an urgent problem," said Dr. Mark McClellan [4], who directs the Engelberg Center for Health Care Reform at the Brookings Institution in Washington. McClellan, a former director of the Centers for Medicare and Medicaid Services, or CMS, said the agency must send a message that it "won't stand by and do nothing … that they are paying attention to this."

Among the investigation's key findings:

- Doctors steadily billed Medicare for longer and more complex office visits between 2001 and the end of the decade even though there's little hard evidence they spent more time with patients or that their patients were sicker and required more complicated — and time-consuming — care. The higher codes for routine office visits alone cost taxpayers an estimated $6.6 billion over the decade.
- More than 7,500 physicians billed the two top paying codes for three out of four office visits in 2008, a sharp rise from the numbers of doctors who did so at the start of the decade. Officials said such changes in billing can signal overcharges occurring on a broad scale. Medical groups deny that.
- The most lucrative codes are billed two to three times more often in some cities than in others, costly variations government officials said they could not explain or justify. In some instances, higher billing rates appear to be associated with the burgeoning use of electronic medical records and billing software.
- Medicare administrators have struggled for more than a decade to crack down on medical coding errors and abuses, often in the face of opposition from medical groups including the American Medical Association, which helped design, and now controls the codes. Whether they make honest mistakes or engage in willful misconduct, there's little chance doctors who pad their charges will face any serious penalties.

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

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

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

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

Thomas Scully [5], an architect of the Medicare pay scales during his White House days under the first President Bush, is now critical of the system. He said it was put in place in order to curb rising doctors' fees, but Medicare's pay hikes have been too small to match rising medical office expenses. Many doctors have responded by picking the highest codes possible, he said.

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

However, the U.S. Department of Health and Human Services inspector general in a May report [6] stated that payments made under the doctor-visit codes rose 48 per cent between 2001 and 2010, from $22.7 billion to $33.5 billion. The report also noted that the coding system has been "vulnerable to fraud and abuse."

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

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

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

Secret Code

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Billing Norms

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

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

The investigation identified thousands of doctors, from a broad range of specialties and locales, who adjusted their billing patterns sharply upward and netted higher fees as a result. A 1979 federal court injunction [7] in Florida bars HHS from publicly releasing doctors’ names and Medicare reimbursements.

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

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

“Those are codes we see abused quite frequently,” said Trussell, of the HHS inspector general’s office.

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

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

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

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

Medicare has been paying for longer and more complex office visits despite annual surveys by the federal Centers for Disease Control and Prevention showing that the average time doctors spent with patients didn’t change much over the years.

Jerry Cromwell [8], a researcher with RTI International in North Carolina, in a 2006 study [9] found the average Medicare doctor visit lasted about 18 minutes, or less. Yet Medicare billing records show a sharp rise in services over the decade that were supposed to take 25 minutes or longer in face-to-face contact with a patient.

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

The Medicare billing data do not show that patients are getting more infirm; their reasons for visiting the doctor’s office were essentially unchanged over the decade. And the May report [6] by the HHS inspector general said its review of 2010 Medicare claims found that many high-end billers tended to treat patients who were slightly younger than average.

Researchers also said there’s not much evidence that elderly people on Medicare have been getting sicker over time — certainly not enough to justify the sharp rise in more costly billings.

Eric Seiber [10], an Ohio State University researcher who has studied physician billing trends, said Medicare officials have yet to conduct studies to determine to what extent the pay scales are being manipulated.

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

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

In addition, federal officials projected that Medicare overpaid nearly $658 million in 2010 as a result of wrongly coded bills for office visits at the second most expensive payment level. Officials found

underpayments to be a tiny fraction of that amount, or about $6.1 million, according to government records.

Malcolm Sparrow [11], a health care fraud expert and professor at the John F. Kennedy School of Government at Harvard University, said: “If there are changes [in billing] over time costing the public billions of dollars, there should be an explanation.”

Coding Errors

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

“When you submit a claim for services performed for a Medicare [patient], you are filing a bill with the federal government and certifying that you have earned the payment requested and complied with the billing requirements,” the manual [12] reads.

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

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

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

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

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

Scully said it was a “big mistake” for the government to give the AMA such a prominent role in creating the doctor payment yardstick. “As a result the AMA has amassed enormous power,” he said.

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

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

Princeton University Professor Uwe E. Reinhardt [13], a prominent health care economist, said government officials could have paid the AMA a lump sum to develop the codes, simplified them and retained their ownership for taxpayers. Doing so would have opened up the process to public scrutiny and given patients a better understanding of health care finances. Other critics note that millions of seniors might help the government check on the veracity of medical bills if they knew the lingo and how to crack the codes.

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

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

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

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

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

Medical organizations also teach their members ways to code at higher levels legitimately. In one 2009 article [14], the academy of family physicians noted that using the second-highest level for most office visits could put an additional $30,000 to $75,000 in a doctor’s pocket.

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

Error Prone

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

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

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

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

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

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

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

“Upcoding”

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

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

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

Minnesota family doctor David Lang [15] offers an example. He sued his employer, the Apple Valley Medical Clinic in suburban Minneapolis, as a whistleblower after concluding that some of the 14 doctors working there were upcoding Medicare claims.

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

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

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

The Apple Valley clinic’s managers denied wrongdoing, though they settled [16] the suit by paying the government more than $180,000 in December 2010. The clinic did not respond to requests for comment. But Lang, a partner in the clinic, says it now bills properly.

“We’ve cleaned it up,” he said.

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

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

But that seldom happens.

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

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

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

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

according to her lawsuit.

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

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

In June 2010, Kumar agreed to pay the government $586,000 in a settlement [17] deal in which he did not admit any wrongdoing. He still practices in Stoneham, Mass., and is in good standing with Medicare. He had no comment.

Growing Tensions

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

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

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

The agency, Tavenner wrote in a letter published in the May IG report [6], "must take into account the respective return on investment of medical review activities."

It is clear that CMS is meeting resistance to fraud-control audits from doctors' groups — and threats that some physicians might dump Medicare patients if the government doesn't back off.

In December of 2011, California Medical Association president Dr. James T. Hay fired off a letter [18] to federal officials in Washington noting that audits of doctor billings have "created great consternation" among the state's doctors and saddled them with what he deemed an "enormous administrative burden" on their office staffs.

"Clearly, physicians want their purposefully overbilling and illegally behaving peers to be found and stopped. We also want to be paid fairly," Hay later wrote [19] in a CMA publication.

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

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

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

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

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

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

“If it is a dishonest payment system, doctors will be dishonest,” Reinhardt said.

Links
[1] https://www.publicintegrity.org/2012/09/15/10810/how-doctors-and-hospitals-have-collected-billions-questionable-medicare-fees
[2] https://www.publicintegrity.org/authors/fred-schulte
[3] https://www.publicintegrity.org/authors/david-donald
[4] http://www.brookings.edu/experts/mcclellanm
[5] http://www.alston.com/professionals/thomas-scully/
[6] http://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf
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