S. HRG. 107–358

PRESCRIPTION FOR FRAUD: CONSULTANTS SELLING DOCTORS BAD BILLING ADVICE

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

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WEDNESDAY, JUNE 27, 2001

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:03 a.m., Hon. Max Baucus (chairman of the committee) presiding.

Also present: Senator Grassley.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. The hearing will come to order. Today, the American people will hear some startling news. They will hear that they may be getting cheated, cheated by consultants who teach health care providers to take unfair advantage of the Medicare system. As a result, taxpayers are losing billions and elderly patients are getting inadequate treatment. As I said, startling news.

Let us put it in perspective. The vast majority of health care consultants provide a valuable and constructive service. They help our health care system run better. This hearing is not intended to undermine their contributions or reputations. As is too often the case, there may be some bad apples. That is what this hearing is about, focusing on those bad apples and hopefully finding some constructive lessons and conclusions therefrom.

The Office of Special Investigations of the U.S. General Accounting Office will take us behind the closed doors of two private health care consulting seminars. We will hear what is being said by these consultants and how they are instructing providers to "game the system." This is the first time, in my recollection, that this has been done.

I want to commend my good friend and colleague, Senator Grassley, for initiating this important investigation. Senator Grassley is a tireless crusader against waste, fraud, and abuse. His investigations into the Defense Department uncovered $400 hammers and $7,000 coffee makers. Senator Grassley requested the GAO investigation last year when he was Chairman of the Committee on Aging. He brought this project with him when he became Chairman of the Finance Committee. In a moment, Senator Grassley will provide additional details on the results of this investigation.

I want to thank him for drawing the committee's attention to this serious problem. The committee has a responsibility to conduct oversight of the programs within its jurisdiction, and we will con-

tinue to work together to do just that. There is no partisanship when it comes to eliminating waste, fraud, and abuse in government programs.

I want to conclude my remarks by making a couple of comments on today's hearing. First, the success of the Medicare program is dependent in large part upon the ability of health care providers to offer quality, efficient services to beneficiaries.

The Senate Finance Committee is committed to making commonsense adjustments to the program in order to improve communication among elements of the Medicare delivery system and reduce the regulatory burden facing providers. The end goal is to free providers to practice medicine and enhance and maintain the health of Medicare beneficiaries.

In this regard, I am concerned about the pending legislation that might inadvertently make it more difficult for the Federal Government to maintain the integrity of Medicare trust funds. I am working with Senator Grassley to improve the legislation by finding the right balance between, on the one hand, protecting health care providers who are just trying to do their jobs and, on the other, protecting the fiscal integrity of the Medicare trust funds.

Finally, this hearing is not just about consultants. It is also about the dignity of patients. It is about subjecting patients to tests that are not medically necessary. It is about treating patients differently, depending upon the level of reimbursement by their insurance provider. Just as every patient deserves a bill of rights, every patient deserves the right to be billed fairly and not bilked by unscrupulous consultants that advise doctors to put profit ahead of their patients' health care needs.

Again, I want to thank Senator Grassley for his leadership in highlighting this issue and I look forward to hearing from today's witnesses.

Because the GAO report was done at Senator Grassley's request, I am also going to ask him to manage today's hearing, to introduce our witnesses, and to lead off with the questioning.

I will turn to my colleague and friend, Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Well, thank you very much. The Chairman has, first of all, given us this opportunity to have this hearing, and I thank him very much for doing that. Second, he himself has made a very strong statement about the issues that face us, about what we can do legislatively about it, and also he has talked about the cooperation that he and I have had over a long period of time. So obviously, I want to thank him for the continuation of that cooperation by having this hearing.

Obviously, we thank our witnesses who are taking time out of their busy schedules to testify. Their testimony today will assist the committee greatly in determining how best to address the matters that are raised.

The Centers for Medicare and Medicaid Services, which we call CMS, provide health insurance coverage for millions of Americans. Countless older, as well as low-income Americans depend on the benefits of Medicare and Medicaid for their good, sound health.

With this in mind, then any fraud, waste, and abuse directed at these programs cannot be tolerated. Therefore, Mr. Chairman, you can understand how concerned I was when allegations were brought to my attention several months back, regarding health care consultants teaching providers how to defraud vital government programs.

Upon receiving these allegations, I, of course, like I so often do, turned to the General Accounting Office for help and their investigation and particularly to the Office of Special Investigations, simply known as OSI. I asked OSI to look at the nature of the training being offered by consulting firms to physicians who bill Medicare and Medicaid.

Today, the General Accounting Office is releasing a report of these findings. In brief, as part of an undercover operation, agents at OSI attended seminars and workshops given by health care consultants. What they found is astonishing.

Consultants were teaching providers how to upcode, circumvent compliance regulations, in certain instances even discriminate against patients with lower-paying insurance. Providers were being shown how to bill for services never rendered, how to keep overpayments that should be returned to the Medicare trust fund, and how to create separate plans of treatment based on insurance reimbursement levels for patients with the same diagnosis.

The Department of Health and Human Services, Office of the Inspector General has also been doing work in the area of health care consulting. They have seen large providers being taught how to unbundle payments and how to regularly upcode a large volume of common illnesses, such as pneumonia.

The promotion of fraud, abuse, and discrimination in any form is unacceptable and must come to an end. Let me add at this point that there are many consultants who provide sound and proper advice. I am sure a majority of health care consultants are always operating within the law and with extreme integrity.

The problem is, there is no way to know how many consultants are providing advice. There is no mandatory accreditation or certification of health care consultants. Anyone can put out a shingle and call themselves a health care consultant. It is the less-than-scrupulous consultants who are the subject of this hearing.

I am pleased to be able to introduce the witnesses and to say that I hope with today's hearing, we can send a very loud message and a clear message to health care consultants who advocate fraud that this behavior is unethical, it can be illegal, and it is certainly intolerable. If you are a bad actor, see the light and clean up your act and know that you are at risk of getting caught and prosecuted if you do otherwise.

Our witnesses for today's hearing will be on one panel. They are already at the table.

Thank you for coming.

We have Mr. Robert Hast, Director of Investigations, Office of Special Investigations. And obviously, I give him a special thank you and the General Accounting Office a special thank you. We have Mr. William D. Hamel, Assistant Director of Investigations, Office of Special Investigations. Then, we have Dr. Kathryn

Locatell, a private practitioner from Sacramento, California, who worked with the OSI in this investigation.

We thank you for coming a long distance.

We have Dr. Marjorie Kanof, Deputy Director for Payment Policy, Centers for Medicare and Medicaid Services. And finally, we have Lewis Morris, Assistant Inspector General for Legal Affairs, Department of Health and Human Services.

The National Association of Health Care Consultants was also invited to testify. Although they were unable to attend, the association did provide the committee with a statement that will be included in the record.

[The prepared statement of Rebecca Anwar appears in the appendix.]

Senator GRASSLEY. I want to advise the witnesses, as they have been told hopefully, that you have 5 minutes for oral testimony. We have agreed that Mr. Hamel, because of his presentation which is oral and video, would have 15 minutes.

Again, I thank you all for being here.

We will begin with you, Mr. Hast.

STATEMENT OF ROBERT HAST, DIRECTOR OF INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. HAST. Thank you, Chairman Baucus and Senator Grassley. I am pleased to be here today to discuss the results of our investigation concerning health care billing consultants who conduct seminars and workshops that offer advice to health care providers on how to enhance revenue and avoid audits or investigations. My testimony is based on our recent report of that investigation which we are releasing today.

Accompanying me are Dr. Kathryn Locatell, a physician we contracted with to assist us on this investigation, and William Hamel, a criminal investigator in my office.

In summary, consultants, at two workshops we attended, provided in-depth discussions of regulations that pertain to billing for evaluation and management health care services and compliance with health care laws and regulations. Certain advice provided during those discussions is inconsistent with Federal law and guidance provided by the Department of Health and Human Services, Office of the Inspector General. Such advice could result in violations of both civil and criminal statutes.

Specifically, certain consultants advocated not reporting or refunding overpayments received from insurance carriers after they were discovered. The consultants also encouraged the performance of tests and procedures that are not medically necessary to generate documentation in support of bills for evaluation and management services at a higher level of complexity than actually confronted during patient office visits.

Furthermore, one consultant suggested that providers discourage patients with low-paying insurance plans, such as Medicaid, from using their services by limiting services provided to them and scheduling appointments for such patients at inconvenient times of the day.

In addition, we are similarly concerned with statements about billing practices made by a private consultant we also contacted. This consultant claims to have a large client base. We did not incorporate the private consultant's remarks into our report due to time constraints. However, Dr. Locatell will discuss the consultant's statements in her testimony today.

If followed, the advice provided in the two workshops that we attended would exacerbate program integrity problems in the Medicare and Medicaid programs and result in unlawful conduct.

Moreover, the advice raises concerns that some payments previously classified by the Department of Health and Human Services' OIG as improperly paid health care insurance claims may actually stem from conscious decisions to inflate claims by providing unnecessary services or manipulating documentation in an attempt to increase revenue. We have discussed with the OIG the need to monitor workshops and seminars similar to the ones we attended.

Mr. Chairman, at this time, Mr. Hamel will play excerpts from the tapes we recorded at the workshops and during our discussions with the private consultant. He will also explain the context under which these recordings were made. We will then be available to answer any questions that you or other members of the committee may have.

Thank you.

[The prepared statement of Mr. Hast appears in the appendix.]

STATEMENT OF WILLIAM D. HAMEL, ASSISTANT DIRECTOR OF INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. HAMEL. Good morning, Mr. Chairman and Senator Grassley. The first two cuts of tape that I am going to play concern a consultant that advocated not returning overpayments to insurance carriers if discovered during a self-audit. This workshop focused on how to create a compliance program to audit proof your practice.

Immediately prior to making this recording, the consultant had been instructing the group on how to conduct the self audit as a required step in setting up the compliance program. There was a lengthy discussion on the OIG's requirements for performing such an audit which included a discussion on how to select a sample of claims to review.

The workshop took a break, and I approached the consultant privately to ask him this question:

Q. When we do the baseline audits and we say we pick our sample, whatever we think appropriate——
A. Right.
Q. And we determine there's some kind of systemic issue——
A. Okay, yes.
Q. And obviously we take the steps we need to correct that, but we have identified that this may be like a long-term, ongoing problem which may expose us to some risk or liability——
A. Yes.
Q. Is there some issue that we need to contact, you know, insurance——
A. Sure.
Q. ——carriers or Medicare and let them know that this may be an issue? Or, I mean, how do you deal with that?
A. Well——
Q. Obviously, we've done the right thing by correcting the fault.

A. As you—as you always say when you don't have an answer, that's a very good question. In practice, what's back here in the Federal Register. When you're officially on that side of the table, I say, okay, you are to "fess up, turn yourself in, and give refunds. Now, on this side of the table, what people are doing is they are changing their behavior and keeping their mouths shut."

Mr. HAMEL. After the break, the consultant continued the discussion on setting up a compliance program and addressed the entire group on this issue. He began reading from his instructor's manual which included his paraphrasing from the Federal Register. I will play that cut two now.

A. The OIG indicates that reporting violations of criminal, civil, or administrative law will indicate your willingness to cooperate and thus mitigating sanctions. Yes. Right. What does that mean? We don't get a better definition beyond that. And what they're saying is you should 'fess up, turn yourself in, and they will look more kindly on you. So I don't know. Maybe, you go to a better jail. I don't know. But in fact—and that's what you should do, the official voice. We were talking a little during the break. What most practices are doing is, if they're seeing a problem, they're changing their behavior and just getting on with life. The concern I have had is if you follow what is supposedly required of turning in, refunding the money, you're—there's not a more redder flag than that. So most practices are just changing behavior and getting on with life. And when asked if they're going to compare your coding patterns from last year to this year, supposedly they do not.

Mr. HAMEL. It should be noted that this consulting firm advertises on its web site that "This workshop instructs participants to avoid the red flags that can lead to an audit, resulting in the discovery of fraud." That is a quote.

The next two cuts numbers 3 and 4 were questions asked by our contractor, Dr. Locatell, after a lengthy discussion at the same workshop concerning how to meet HCFA's, now CMS' documentation requirements for evaluation and management of service codes as it relates to compliance.

The consultant had the group engage in an exercise in which the doctors were asked to code a couple of hypothetical patient encounters. The group was given handouts with scenarios of patients presenting certain complaints and physical conditions and asked to determine the level of coding and reimbursement to claim. The thrust of the discussion was about how to document services to avoid an audit.

I will now play cut number 3:

Q. That to me is kind of at the heart of this because, I mean, you can document everything you want so you get through the audit.
A. Sure, oh, yes.
Q. Get through the audit. But if you didn't actually perform the services, but you have it documented, then——
A. Sure. Well, it's documentation is the important thing.

Mr. HAMEL. In the next cut, Dr. Locatell asked the consultant rhetorically at the very end at the workshop what it is we really learned with respect to billing for evaluation and management service codes.

I will now play cut number 4:

Q. What I've taken away from this—and I've been through another one of these, but it was a more abbreviated one. But what I've taken away from it is, you know, basically game the system by documentation.
A. That's right. That's the thing. Build a better mousetrap.
Q. That's amazing.
A. Yes.

Mr. HAMEL. The next cut is another consultant's advice on a methodology for upcoding by having non-physicians perform the bulk of services rendered to patients, but billing these services out as if the physician had actually performed them. This occurred during another workshop that focused on how to increase revenue.

This is a slightly more lengthy cut number 5:

A. Data collection, let the patient provide the data and let a non-physician gather as much data as possible, our prime example in well-run cardiology practices. I am using them for a very particular reason. A patient sees the doctor at the emergency room. The doctor treats the patient. And in many cases, there's not a problem. All right. The patient is discharged. I mean, the patient is in an outpatient setting. The doctor does the tests and says, well, you have this, but you ought to come in for a complete work-up, our smarter cardiologists. The patient comes in for a complete work-up, but there's no doctor involved. The RN does all the input. Blood is drawn. Tests are done. And a week later after the test results are in, and the same would be true of your specialty, the doctor then spends quality time with the patient and talks about lifestyle, all these other goodies, and, you know, tosses a stethoscope on and all these other things that makes a patient feel better. But the doctor already has all the data, if you will, or 50 percent of the data needed. That to me makes sense from an efficiency point of view and, by the way, a very high level of patient satisfaction because it's very thorough. Two visits, it's slightly inconvenient for the patient, but the patient knows that the doctor has all the data there and is not, you know——

Q. And could—that would then be a level 1 visit with the nurse only and the subsequent week would be a level 2?

A. If you wanted to. No, I wouldn't even bother to bill the nurse visit. I would just bill it out as a level 3, 4, or 5 as the doctor. But the fact it took place in two different days doesn't really matter, okay, because the doctor himself could have done that, made two visits out of it, but he's not going to be able to get two level 4's out of it. All right.

Mr. HAMEL. The next three cuts deal with the issue of increasing revenue by substituting low-paying insured patients, primarily those with Medicaid, with higher-paying patients and the possible implications of civil rights violations that may result.

I will now play cut number 6:

A. What it may mean is that the lower—a higher ratio of lower payers came in. And I'm going to show you later on how you analyze this. You do a payer-by-payer analysis. And I'm going to give you a little case study in the next hour to show you that this can happen. And where it happens more frequently than any other place is when the scheduler is too busy to think, where that person simply has time to say, okay, I'll work you in here or there, and does not think about the fact that maybe we ought to be rationing certain of the lower-paid patients to come right on in. Now, I'm going to give you a strategy. And by the way, I'm not talking about real discrimination. I'm talking about somewhat discrimination, all right, in the same manner that many practices discriminate and don't allow every Medicaid patient to come in. We may have a rationing.

Mr. HAMEL. In the next cut, the consultant instructs the group on how to accomplish the substitution of patients. He introduces the idea with a case study that his firm had done work for. The consultant had analyzed all the patients' insurance carriers that were billed and identified Medicaid as the lowest and slowest payer.

I will now play cut number 7:

A. Medicaid, they're a low payer and a slow payer. Two to 4 months hurts your practice immensely. Why was that happening? Because they had a person on the phone doing the scheduling who was so busy checking patients in and checking patients out, she didn't have time to think. And, of course, we all know that Medicaid people are higher utilizers of services, not because it's free, but because they're sicker, right? So what we said about it to do there,

you have to ration your Medicaid. And if anybody calls from Blue Cross/Blue Shield, you say, when do you want to come in? We'll come and get you. [Laughter.] I mean, good payer or bad payer. Listen, what we did there is we said, no more Medicare, no more Medicaid. Keep the ones you've got. But now, we now reduce their numbers because they're either going to go, leave town, or perhaps get a better insurance plan. You always lose some patients, but no more. And so that means we now can accept higher-paying patients because, remember, these were the two lowest. Anything other than them will pay us more. The same would be true here. We might ration. And that's what they did at this practice. They said, no more Medicaids. Where we are, we still have a lot of Medicares and Medicaids, but here's what we do. We don't want them taking the best appointment slots. So they get scheduled only 10:00 to 11:30 in the morning and 2:00 and 3:30 in the afternoon. That's it. Now, there are always exceptions, but we didn't want them getting the best appointment slots. We want the best appointment slots to go to the best payers. So you now start to realize if you start thinking not only of rationing, but when do we want them to come in.

Mr. HAMEL. The red light has come on. Do you wish me to play the last two?

Senator GRASSLEY. Oh, please.

Mr. HAMEL. All right. The next concerns the same topic which demonstrates that quality of care issues are also raised by this type of discriminatory conduct.

This is now cut number 8:

A. A person has come in with a cold. If the person says to you at the end of the visit, I want you to be my doctor, the doctor sees that this person's got a good insurance plan. This person is pretty alert. The doctor says, I would like you to come in sometime in the next couple of months to do a complete work-up so we can develop a good data base, but he may not say that to a Medicaid patient. But I've seen discrimination like that. Is that discrimination? Absolutely.

Mr. HAMEL. The last cut that I will play, Mr. Hast had stated in his remarks that we had made contact with a fourth consultant whose tape we did not have time to incorporate into our blue book report, but I was able to fashion a cut to bring to the hearing today which raises upcoding issues.

This is a situation where the consultant was suggesting the use of the prolonged service code to increase revenue. This is a code that is used for patient visits that are based on the length of time for a visit instead of a traditional criterion used for evaluation of management codes.

This consultant receives as his fee, a large percent of any additional revenue he brings to a practice, thus creating an inherent incentive to increase revenue and increasing the risk of fraudulent and abusive billing.

I will play the last cut which is number 9:

A. You're billing for the time that—given the opportunities where you use the prolonged service codes as well.
Q. Okay. Now, prolonged service codes, I have not used before.
A. Okay.
Q. And I'm somewhat familiar with them, but what kinds of, you know, medical conditions are—how do you justify a prolonged service for an outpatient visit?
A. Say, you have a patient who comes into your office for a minor problem, say, a sore throat or diabetes. That's not a minor problem. They come in for just, you know, like a routine check-up, a hypertension follow-up, anything like that. But during the visit, you want to ask them other questions that they can't answer due to Alzheimer's, senile dementia, organic brain syndrome. So then therefore, you end up spending a lot longer with the patient or you end up picking up the phone and calling the family member to ask him questions.
Q. I see.

Mr. HAMEL. That concludes my presentation. And I will be happy to answer questions at the conclusion of the panel.

[The information submitted by Mr. Hamel appears in the appendix.]

Senator GRASSLEY. After hearing that, you can come to the conclusion very easily that it is the consultant that is sick and not the patients we are talking about.

Dr. Locatell.

STATEMENT OF KATHRYN LOCATELL, PRIVATE PRACTITIONER, SACRAMENTO, CA

Dr. LOCATELL. Senators, thank you for inviting me to speak about my participating in this investigation. I am a physician specializing in geriatric medicine and was first exposed to issues of coding and compliance while employed as a faculty member of an academic medical center.

The faculty was required to attend a billing and coding seminar in anticipation of a potential government audit. Since most of our patient care centered around teaching, trainees would see the patients first, perform an exhaustive history and physical exam that was usually more detailed than was necessary.

The seminar was intended to educate the faculty about how to bill for the visit, using the information collected by the trainee at the highest allowable level. What I and the other faculty members I discussed this seminar with afterward took away was that we were to game the system, that is, bill at a higher level because the trainees had gathered and documented sufficient information to justify the higher billing codes regardless of medical necessity in order to bring in more revenue for the medical center.

This same theme that documentation is the key to higher billing codes and thus higher revenues permeated the seminars and workshops that I attended with the GAO. Similarly, regarding compliance plans, audit proofing your practice was simple if you adhered to a formulated documentation system designed to ensure that the needed elements for billing at a higher level were recorded in the patient's chart. What was generally missing, however, was guidance about medical necessity.

In 1 workshop, the attendants reviewed sample cases involving simple patient problems, such as a 14-year-old with a sore throat. By adding documentation about extraneous information obtained from the patient that in my opinion would not have been necessary in the course of a normal visit, the provider could justify coding the visit at a higher level of complexity and thus obtain a larger payment.

The use of templates for recording patient visits was encouraged as an easy way to simply check off bits of information that would justify billing at higher levels.

Another consultant we contacted advocated increasing the revenues for our practice by performing certain diagnostic tests in the office. All diabetic patients could receive a peripheral nerve testing study and cardiac patients could receive a heart monitoring test. Medical necessity, no problem, provided we had the right diagnosis codes.

There were other types of ancillary testing that could be set up and performed in the office, but some of them were to be avoided as they seem to invite increased scrutiny from overseers.

Gaining increased reimbursement for patients with Alzheimer's disease was no problem. Just use modifier codes since obviously it would take longer to gather information from someone with memory problems.

This consultant advertises on his Internet web site that he can increase the revenues for a physician's practice by at least $10,000 per month with 40 percent of the proceeds going to the consultant. In an e-mail communication, he exhorted that I would soon be able to afford that Lexus or that Kincaid painting I had my eyes on as a beneficiary of his practice enhancement program.

In spite of cost containment and compliance pressures, physicians and medical groups continue to operate in a climate and culture where gaming the system is necessary and desirable according to the consultants we investigated.

In my opinion, increasing the focus on issues of medical necessity would help to stem some of the fraud and abuse that is wasting a large portion of our spending on health care.

Again, thank you.

[The prepared statement of Dr. Locatell appears in the appendix.]

Senator GRASSLEY. Thank you very much and thank you also for participating with the General Accounting Office in this effort as well.

Senator GRASSLEY. Dr. Kanof.

STATEMENT OF MARJORIE KANOF, DEPUTY DIRECTOR FOR PAYMENT POLICY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Dr. KANOF. Good morning, Chairman Baucus and Senator Grassley. Thank you for inviting the Centers for Medicare and Medicaid Services to discuss Medicare's provider education efforts with you. Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries receive quality health care.

We know, and as you have stated, that the vast majority of physicians and providers are honest and conscientious. We also know that at times, many of them feel overwhelmed by Medicare's requirements.

Coding consultants have found a niche in which they offer physicians and other providers training on how to code and bill for Medicare services. These training sessions are not affiliated with the Medicare program, and we do not endorse, accredit, or certify these programs.

We believe that our educational efforts and outreach are essential to the success of the program and will ultimately reduce Medicare physician and provider dependence on outside consultants. We are enhancing our efforts to ensure that our educational programs help physicians and providers understand how to bill Medicare appropriately and receive payment for the care they provide.

Administrator Tom Scully has made it a prior to bring a culture of responsiveness to CMS. I am here to assure you that these are not empty words. They stand for ensuring high quality medical

care for beneficiaries, and that includes improving our communication and our educational efforts for physicians, providers, and beneficiaries.

The vast majority of our physician and provider training is provided through our contractors. Working with them, we have taken a number of steps to ensure the information we share with physicians and providers is consistent, clear, and unambiguous.

We are making materials and information available through the Internet, by toll-free telephone lines, and by satellite broadcasts. We are reaching out to physicians and providers with mailings and classroom educational seminars.

We have a Medicare Learning Network on our website. "MedLearn" provides timely, accurate, and relevant information about Medicare coverage, coding, and payment policies. Our site averages about 100,000 hits per month, with reference guides, frequently asked questions, and computer-based training programs having the greatest activity. In fact, many of the examples presented this morning are in fact discussed on these sites.

We need to do a better job in increasing physician and provider awareness of these services. Our role in educating physicians and providers about the billing process is largely on the front end.

We provide extensive education and training materials to newly enrolled physicians and providers, and offer resources to them when regulations are changed or added. In addition, we are committed to simplifying the regulatory process and providing better training and, in doing so, reduce the need for physicians and providers to turn to consultants.

These efforts in part have contributed to reduction in the Medicare error payment rate from 14 percent in fiscal year 1996 to 6.8 percent in fiscal year 2000. Nevertheless, we have to take more steps toward improving our information sharing and education to make it easier for physicians and health care providers to follow Medicare regulations without having to turn to consultants.

We recognize that we have more work to do, and we are seeking the health care community's input as we work with our contractors to further enhance our working relationships with physicians, providers, and their staffs while fulfilling our responsibility to safeguard the Medicare trust fund.

I appreciate the opportunity to discuss coding consultants and our provider education efforts with you today, and I also am happy to answer your questions.

Senator GRASSLEY. I forgot to mention that all of you have summarized, and your entire statement will be put in the record.

[The prepared statement of Dr. Kanof appears in the appendix.]

Senator GRASSLEY. Mr. Morris.

STATEMENT OF LEWIS MORRIS, ASSISTANT INSPECTOR GENERAL FOR LEGAL AFFAIRS, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MORRIS. Good morning, Mr. Chairman and Senator Grassley. Health care providers who take care of Medicare and Medicaid beneficiaries should be fully compensated for their services. Therefore, it is entirely reasonable and beneficial for them to use expert consultants to help them navigate the sometimes complex rules of

health care programs. However, expert knowledge and sophisticated billing techniques should never be used to abuse Medicare or Medicaid.

Needless to say, when laws are broken by consultants, the Office of Inspector General takes action to investigate the allegations and to seek appropriate civil and criminal penalties. Our preference, however, is to work with the health care industry to promote ethical conduct, ensure quality care for beneficiaries, and thus avoid the need for enforcement actions.

Responsible consultants play an integral role in identifying practices that enhance a client's business objectives, as well as improve the efficiency of the health care system. By contrast, a small minority of consultants encourage abuse of Medicare and Medicaid programs. Depending on the circumstances, these practices can expose both the consultant and his or her clients to potential legal liability.

Consider the recent case of a hospital that contracted with a coding consultant to maximize revenues by upcoding claims associated with pneumonia patients. A subsequent investigation determined the medical records did not support the complexity of the illness as represented on the Medicare claim.

The hospital agreed to pay the government several million dollars to settle allegations that it had improperly upcoded these claims. An additional 26 hospitals have already paid a total of $28.6 million under the false claims for improperly upcoding of pneumonia-related care. The consultant and many more hospitals are currently under investigation for their participation in this fraud scheme.

Of particular concern in this case, other consultants learned of the pneumonia upcoding scheme and ultimately encouraged their hospital clients to falsify claims for the treatment of pneumonia. As word spread among consultants, the scheme expanded throughout the hospital industry. Be assured, we are continuing to pursue these cases.

Other abuses that have resulted from consultants' bad advice range from improper billing for laboratory tests to inflated claims for physician services.

Unethical consultants sometimes attempt to enhance their credibility by claiming their services are endorsed by the government. For example, a consultant, currently under investigation, falsely represented that providers were required to attend its seminars in order to maintain a Medicare provider number.

In addition to misrepresenting an affiliation with Federal health care programs, some consultants make claims that are simply too good to be true. For example, a billing consultant may represent its advice will result in a specific dollar and percentage increase in Medicare reimbursement regardless of the prospective client's particular circumstances.

Although not necessarily illegal, health care providers should be leery of doing business with anyone who relies on half truths. We have found that unethical health care consultants often crafted their advice to bring their clients up to the line without expressly advocating illegal behavior.

While it is very difficult to prosecute this conduct under applicable statute, this aggressive and unethical marketing puts the client, as well as the Federal health care programs at substantial risk. Ultimately, providers need to recognize that hiring a consultant does not relieve them of the responsibility to ensure the integrity of all their dealings with Medicare and Medicaid.

The examples that I have discussed show that providers must exercise judgment when selecting and relying on a consultant. The axiom still applies: if it is too good to be true, it probably is.

To assist providers and consultants in avoiding these pitfalls, today, the Office of Inspector General is issuing a special advisory bulletin on the practices of business consultants. This bulletin alerts providers to certain abusive consultant practices that have come to our attention, such practices that may raise concerns for providers and may put the Medicare and Medicaid programs at increased risk. The bulletin, like the OIG's compliance guidances and advisory opinions, is another tool for each provider's compliance tool box.

Mr. Chairman and Senator Grassley, I hope my testimony and our advisory bulletin will prevent inappropriate practices by business consultants. I would be pleased to answer any questions you may have.

[The prepared statement of Mr. Morris appears in the appendix.]

Senator GRASSLEY. Senator Baucus went to vote. I am going to ask questions. If he does not get back before I have to go and vote, then we will just have a short lull until he returns. Then, I will come right back after I vote.

I kind of wanted to start where you left off, although this was not the place I was going to start. You gave some advice: if it is too good to be true, raise questions, or something like.

Dr. Locatell, because you were at these seminars, when something was said that appeared too good to be true, and you probably recognized it, but in the small number of people that were at your meeting, was there kind of a sense of the advice that was being given? In that environment of all those people, was there kind of a feeling that maybe this guy is just not telling it the way it ought to be because it does not meet the test of common sense?

Dr. LOCATELL. Well, I think the general feeling was that if people were there looking for ways to increase their revenues, they were given information about how to do that. My sense was that at least some of the attendees in the seminars were there for information.

I think because of some of the concerns about compliance, when they were told, just check off some boxes that you can build at a higher level, I did detect some dismay among at least a couple of the attendees.

Senator GRASSLEY. All right. Mr. Hamel, is there any way to quantify the number of health care consultants that exists? In other words, what kind of a universe might we be talking about if you know?

Mr. HAMEL. Well, I suppose somebody could go out and tally up all the health care consultants that are advertising, but we did not do that. We basically did an Internet search. And we found hundreds and hundreds of individuals who have put out a shingle and advertised either from broad-based kind of services to the narrow

niche kinds of health care consulting services. So there are a lot of them out there.

Senator GRASSLEY. We might not be able to quantify the extent to which bad advice is given by consultants, but do you believe that the three seminars and the one telephone conference that you taped are representative of serious problems for the Medicare trust fund?

Mr. HAST. Yes, Senator Grassley. I would think that we did not have any tips that took us to this particular seminars. We found them just by browsing the Internet for these seminars. I think that if we were able to find that, using that type of methodology, I do not know how widespread it is, but it is certainly a problem that needs to be investigated.

Senator GRASSLEY. Dr. Locatell, is there a need for health care consultants? Do physicians and their staffs that feel that they are inadequately trained or prepared and therefore need these type of consultants?

Dr. LOCATELL. Well, I think it depends on the type of practice and how large it is and whether they have knowledgeable, trained individuals as part of their management team for their practice.

I also think though that it is clear from the research that we did on the Internet and browsing the materials that there are practices out there, looking to be told how to make more money. So to the extent that they want to know these things that were shared with us in the seminars, they are going out there not to really learn, but to make more money from the system.

There are so many different insurance plans. Certainly, I think Medicare has a fantastic provider education program. I do not know that physicians take advantage of it though.

Senator GRASSLEY. Mr. Hast, do the medical societies and the associations that sponsor these training sessions know that questionable advice might be given out?

Mr. HAST. We do not know that, Senator, but I believe if they are sponsoring it and taking a fee for having people attend it, they certainly have a responsibility to know what it is that they are sponsoring and what type of information is going to be given.

Senator GRASSLEY. All right. And Mr. Morris, I need to thank you for that advisory that you have sent out. In addition to that, my question is, are there ways to hold consultants legally responsible for the advice that they give that violate laws and regulations?

Mr. MORRIS. As my testimony indicated, we have pursued consultants that have been a direct participant in fraud schemes with their clients. One of the challenges we face is that advice given to 50 or 100 potential clients in a large room does not necessarily translate in and of itself to criminal conduct.

Our most successful cases have dealt with consultants who developed the next level of relationship with a particular client and we can establish that the consultant with its client have engaged in a conspiracy to defraud. So we do have the tools available to us to pursue these clients, as well as the consultants.

The client, for example, that takes advice, that after having identified an overpayment, they should do nothing, they should just keep the money, well, that right now is a violation of Federal law.

If a consultant is an active participant in that scheme, the consultant and the provider can be subject to prosecution.

Senator GRASSLEY. I am going to have to call a temporary recess. There is 3 minutes left. So we will right back. When Senator Baucus comes back, he will start with his questions.

[Whereupon, at 10:51 a.m., the hearing was recessed, and at 11:05 a.m., the hearing was resumed.]

Senator GRASSLEY. I thank everybody for your patience. I do not think we will bothered with a vote before we get done now, unless a lot of members come.

Mr. Morris, do providers need to return overpayments?

Mr. MORRIS. Yes, they do, Senator. The OIG has made it quite clear that if a provider identifies an overpayment, it has a duty both to report that overpayment to the contractor, as well as refund it. The law we believe is quite clear in this area. If a provider identifies money that it is not entitled to and take efforts to conceal that fact or convert those funds to its own use, it has committed a felony.

Senator GRASSLEY. Dr. Kanof, are there ways that CMS can better protect itself from fraudulent advice given by consultants?

Dr. KANOF. I think, as we talked about this morning, probably our best way to protect ourselves and the trust funds against fraudulent advice is actually to make sure that all physicians and providers know about our educational efforts, know about the Medicare toll-free line that physicians and providers can use, and know about the web sites so that they know that there is a reliable source that they can use to get the answers to the questions that they need.

Senator GRASSLEY. In a sense, what you just said, are you saying that that ought to preclude any sort of advice of consultants or it is just a certain way of getting an answer without going through that trouble?

Dr. KANOF. Well, no. I think that if we look at where we should put our primary efforts, it really should be indirectly educating the physicians and providers. I think that we, working with the OIG, need to emphasize and will also be publishing the OIG's bulletin about concerns about consultants, but that we believe that our primary effort should be directed to the physicians and the providers.

Senator GRASSLEY. Something I just thought of, in your time dealing with this area, is there ever any implication in the writing of the regulations and the process of communicating with health care providers that a consultant might be not only a source of information, but it is all kind of implied from CMS that maybe health care providers ought to get this sort of advice?

Dr. KANOF. I am not sure if I understand.

Senator GRASSLEY. Let me state that again. Has there ever been any thought on the part of CMS, formerly HCFA, that with the complications of coding and all the other things that are involved that maybe it is quite appropriate and even insinuated that seeking the advice of consultants would be the way that you would expect health care professionals to go?

Dr. KANOF. I do not think so. In fact, short of the CPT codes which are really under the auspices of the AMA, that is really the only source that we would be referring physicians. In fact, we have

worked with recent regulatory implementation, such as outpatient prospective payment services and home health payment services to actually come up with specific provider education and physician education efforts in order not to have physicians and providers feel the need to use consultants.

Again, I think we will be following up with the OIG bulletin and actually publicizing that to give people the heads-up. We really do believe that it is our responsibility to do the education.

Senator GRASSLEY. Thank you.

Mr. MORRIS. If I could add something, Senator?

Senator GRASSLEY. Yes.

Mr. MORRIS. We very much concur that the first line of responsibility is to the provider and the direct relationship with CMS. In the physician voluntary compliance guidance that we issued last year and found on web site so that they can build compliance infrastructures into their medical practice, one of the things that we observed is that sometimes there is an effective role for consultants.

Physician practices may have engaged in a long-term practice of billing in a particular way or assuming that certain codes are correct. A consultant with a fresh eye can come in, evaluate that practice, and correct misassumptions and misapplications of regulation.

To that end, we think internal audits and other self-review processes where consultants bring best practices to the physician, actually adding benefit. That, of course, is a world of difference than a consultant who comes in and tries to teach a provider how to cut corners or inappropriately upcode.

Senator GRASSLEY. Now, to Mr. Chairman.

The CHAIRMAN. Thank you very much. The questions I have are just a few specifics and a few facts. How many providers are there who fall in the scope of maybe needing a little bit of advice and help in figuring out how to code and how to fill out the forms, etcetera?

Dr. KANOF. I cannot answer that question specifically. I can tell you that we have about 1 million physicians and providers participating in the Medicare program. I can tell you that our 1–800 numbers got about 23 million telephone calls in the past year.

The CHAIRMAN. Let us say roughly 1 million?

Dr. KANOF. One million.

The CHAIRMAN. How many of that 1 million does CMS reach either proactively or reactively on any consistent basis?

Dr. KANOF. That is hard. We can take the telephone calls that I just gave you. We can tell you our web site gets 100,000 hits per month with people using that to get answers to questions and references. We have our contractors having seminars that have a range of about 200 to 400 attendees.

The CHAIRMAN. How many seminars would there be?

Dr. KANOF. Let us say that we have about 50 contractors throughout the country. So let us average about 20 seminars every other month.

The CHAIRMAN. These are contractors that contract with CMS?

Dr. KANOF. Right. These are Medicare fee-for-service contractors.

The CHAIRMAN. Those contractors only provide information. You are talking about contractors like Cross, those contractors?

Dr. KANOF. Correct. These contractors specifically have education programs in terms of understanding the Medicare rules and regulations.

The CHAIRMAN. All right. My next question, those contractors, how much of their time is "educating" as opposed to billing?

Dr. KANOF. All of them send out quarterly bulletins. So on a quarterly basis, they are all sending out bulletins with Medicare information both direct mail and through the Internet to all of the physicians.

The CHAIRMAN. In addition to sending out mailings, how much honest to goodness, good faith, and quality seminar time is there?

Dr. KANOF. For the record, I cannot tell you that off the top of my head. I can tell you that we provide them with a budget of approximately $40 million to provider education and outreach and that they all have staffs that are specifically devoted to provider education.

The CHAIRMAN. Right. Is there any way of knowing the quality of that outreach? Do you check up on the quality? Maybe, they just take that money and send out a bunch of bulletins.

Dr. KANOF. No, I understand that. We in fact have begun to actually assess the quality of the bulletins, the answering of the telephone calls, and the seminars. So we do have staff that do attend all of these activities just to ensure that the information is being accurate and delivered in a proper fashion.

The CHAIRMAN. So how many consultants are there that we are talking about today?

Dr. KANOF. That was previously asked.

The CHAIRMAN. I am sorry.

Does anybody know?

Dr. KANOF. We did not know the answer to the question.

The CHAIRMAN. Do you know how many consultants there are?

Dr. LOCATELL. There are hundreds if you do an Internet search. You can find hundreds.

The CHAIRMAN. Anyone who wants to be a consultant certainly can. I mean, it is a free country.

Senator GRASSLEY. That would be, I think you were just answering that, in regard to just health care consultants, right?

Dr. LOCATELL. Right.

Senator GRASSLEY. As opposed to consultants in every area?

Dr. LOCATELL. Specifically, I looked for reimbursement consultants and coding consultants.

The CHAIRMAN. Roughly, how many reimbursement consultants and coding consultants, do you think?

Dr. LOCATELL. Oh, hundreds.

The CHAIRMAN. Now, how many of those have web sites?

Dr. LOCATELL. Quite a few, most.

The CHAIRMAN. Most do. Does CMS contact those web sites and say, here we are, we are CMS, we see you are out there, we are all trying to provide the same kind of service and make sure all of this is done efficiently and correctly and properly and so forth, and send them a little red flag?

Dr. KANOF. No, we do it the other way. We contact the physicians and the providers and the medical associations to let them know about access to our web site.

The CHAIRMAN. How often does CMS attend these seminars themselves?

Dr. KANOF. These seminars that are discussed today?

The CHAIRMAN. Yes, pop in, show up, be helpful.

Dr. KANOF. We have been asked to attend some seminars sponsored by State medical societies and the AMA. We do attend those society-sponsored seminars.

The CHAIRMAN. What about these we are talking about here?

Dr. KANOF. I cannot answer whether we have been asked or not asked. And I cannot answer whether we have attended them.

The CHAIRMAN. I am not asking whether you have been asked. I am asking whether you have asked. Does the government ask? I am sure the government is not asked. They are not the askee. I am asking whether the government is the askor to attend.

Dr. KANOF. Well, I am not sure whether that would be CMS or in fact the OIG.

The CHAIRMAN. Or whoever, somebody. I do not know who the right agency would be. You have an enforcement question here and a compliance question here. You have to be creative about it.

Senator GRASSLEY. I will put his question in the context of maybe, for instance, we have heard from IRS in testimony about their sending somebody out from IRS to check tax shelter consultants, as an example, and those sort of seminars. I think that could be along the lines of what he is asking about this.

The CHAIRMAN. Right.

Dr. KANOF. Right. I think that Mr. Morris and I have in fact discussed the possibility of just what you have discussed, that we would work collaboratively to be looking at some of these seminars.

Mr. MORRIS. Perhaps, I can expand on that. The OIG provides education and involvement with the consultants in two ways. We actively participate in an overt fashion in training. We are invited to speak before medical societies, trade associations.

In addition, we prepare compliance guidances, special fraud alerts, advisory opinions, all to put providers on notice of what is expected of them and through bulletins like the special advisory bulletin and the special fraud alerts alert providers to risk areas so they can self correct.

In addition, in light of what we have learned recently through the GAO, we are actively considering a more covert relationship with the consultants and going in to observe what is said when they do not know we are in the room.

The CHAIRMAN. It just seems to me if I am physician where I am getting bombarded by CMS, HCFA, HHS that I know after awhile, I know some of this is helpful, but I have a practice to conduct here. The tone might be if not ominous, somewhat firm, to say the least. As a practitioner, I am not the one who is guilty here. It is the consultants that we are talking about.

It just seems to me that there should be much aggressive action taken against the consultants and just keep making sure that they are in line, much more than the physicians and the hospitals are in line.

My guess is that here are a lot of physicians, practitioners who are a little bit confused with all this, that is the coding and so on and so forth, and need a little help and advice. Part of that prob-

ably is because of the laws being passed. Part of it is the regulations and all the red tape and so forth. We are trying to make Medicare generally more simple. I know it is a tall order.

Working with Secretary Thompson in a hearing not too long ago, we have some time line actions we are taking, we because we are in this together, to eliminate a lot of the duplication and overlap and help straighten out CMS.

It seems to me that the OIG's office could be more aggressive and early on in attending some of these consultant seminars and so forth because that may really be where the problem is. It is those few bad applies that tend in some cases, most cases I suppose, to lead good, well meaning people astray.

Can you not do more upfront, do you think?

Mr. MORRIS. Well, we are certainly looking into expanding both awareness on the part of providers what their obligations are and, as I mentioned ago, exploring other options. I would observe that ultimately it is the provider, the physician or the hospital that makes the decision how it is going to conduct itself with our program.

A consultant that gives advice, such as you can keep money that is not yours, that is bad advice. It may even be illegal advice. It is the provider who takes the advice and keeps the money that is not theirs that first and foremost has violated the law.

We do a lot more to ensure that providers understand their obligation. The Inspector General's office has a self-disclosure protocol which expressly tell providers how to come in when they have identified overpayments or misconduct. We have a streamlined process to get the problem identified, quantified, and resolved.

We do believe that first and foremost, it is the provider that needs to do the right thing by our programs.

The CHAIRMAN. Well, I think it is the obligation and responsibility on the part of HHS generally, or whatever office is specifically involved to not also frankly spend a lot of time on enforcement action, investigations on these consultants.

You are a good guy, a good doctor. You are going to do what is right. You attend one of these seminars. It is all confusing. They tell you all kinds of things. It is borderline. You are atempted. You probably, as a doctor, know that it is not right, but the consultant has some ideas on how to do this, how the doctor can cut some corners and so forth.

I just urge you to be much more aggressive with respect to the consultants. That is really the real key here. I would not just wash my hands and say, well, it is the responsibility of the doctor. It is certainly, but you have to make it easier by going after these consultants.

Mr. MORRIS. In my written testimony, we reference one case where not only did we go after the consultants and impose fines against them, but we excluded them from our programs. So none of the services that they provide can be charged indirectly to our program. We require them to inform all prospective clients about the fact.

The CHAIRMAN. How many consultants are actually helpful—wear white hats, some black hats? What is your guess because this is probably an industry here that is trying to make a buck, trying

to do what is right, see an inch and see an opportunity,not trying to do anything illegal or unethical, although on the tapes they are simply unethical and probably illegal? I mean, what percent, 10 percent good guys, 50 percent?

Dr. Locatell, what do you think? You can guess.

Mr. Hamel?

Anybody?

Dr. LOCATELL. My gut guess is that there is an awful lot of information that is being given out at these seminars that physicians can use the way they want to use it.

So, yes, you can upcode by doing these template forms for your patient visits and you can just by billing at a level 5. No one is going to come and say to the patient, were you ever examined? Did he ask you 10 questions in your review of systems? I mean, that is the level of detail that has to be documented in order to justify the higher billing codes.

So I think the information and the tenure of these seminars was clearly, hey, you can do these things. You just need to have it all documented appropriately.

The CHAIRMAN. Yes, but again, you are not sure how many are basically on the right side of the line and how many are on the wrong side?

Dr. LOCATELL. Well, I think they are marketing mainly to the desired increased reimbursement. I suspect that probably half of them are giving information that could result in difficulties for the physicians and probably for hospitals too if they follow that advice.

The CHAIRMAN. Dr. Kanof, I apologize. I was absent when you spoke. Specifically, what is the administration doing about this?

Dr. KANOF. The administration is in fact increasing its commitment and its activity related to specifically reaching out directly to physicians and providers to get them the information they need and the mechanism that they can use to best reach it. So for those providers that wish to have one-on-ones in terms of seminars, we are sponsoring seminars.

We are working with the providers in each of the local communities to determine what they need and how they want to obtain specific training and guidance. So we sponsoring seminars specifically to get to those needs.

We have improved our web site access and in fact have specific information on Medicare coding rules and regulations. We have a specific book for residents.

So we are looking to improve the education and giving the providers and physicians access. I think our most recent commitment is the 1–800 number so that physicians and providers have a direct access to get the information they need.

In summary, we are working with the community at large to be able to channel them the right information in a fashion that is usable for them.

The CHAIRMAN. Yes, I very much commend your efforts here. How many dollars is at stake here, as the subject of this hearing, do you think that is overpaid and over billing, upcoding, discrimination, discriminating against Medicaid, lower-paying patients and so forth? What is the dollar amount involved here do you think?

Dr. KANOF. Well, I think for us, our best reference point is probably the Medicare error rate which in fiscal year 2000 was 6.8 percent, down from 14 percent in 1997.

The CHAIRMAN. How many dollars in fraud do you think?

Senator GRASSLEY. It is 11.9.

Dr. KANOF. 11.9. I am not sure. It is not just fraud. It is medical error and abuse.

The CHAIRMAN. This gets back to error. I am not talking about good faith errors. I am talking about bad faith errors.

Dr. KANOF. Well, these were errors that are related to what we heard about today. These are errors related to the E&M code, the visit codes.

The CHAIRMAN. So let us say $12 billion.

Dr. KANOF. Correct.

The CHAIRMAN. All right. Now, what is your goal here? What percent of that $12 billion in terms of results with all these outreach efforts you are undertaking that you are trying to get down to? Say, today, it is $12 billion. What do you want to get down to?

Dr. KANOF. Well, we started at 14 percent and we have gotten down to 6 percent. In our GPRA goals, we acknowledged that we would like to get it down to 5 percent. And we will continually work to get that goal down: zero would be the ultimate.

The CHAIRMAN. I am sorry to take so much time here, Senator Grassley.

With the physicians and providers who use these illegal and unethical practices, how do you know when you determine your error rate, how much of that error rate is because a lot of this behavior is unaudited, it is unreported, etcetera? So how do you know?

Dr. KANOF. Are you asking me how do I know how much of the error rate that we know we have is due to physicians and providers getting incorrect information?

The CHAIRMAN. Right.

Dr. KANOF. That, we do not know. In working with the medical societies and the associations, to date, no one has addressed that as a contributing factor. What they have addressed to us is going back to what you acknowledged, some of the complexities of our rules and regulations. So we are working on the E&M codes to make those more clear and to simplify them.

The CHAIRMAN. Do you think it would be a good idea to make that determination, how much is due to these consultant practices, as opposed to just legitimate, good faith mistakes?

Dr. KANOF. I think that is a question that we would ask the IG to help us with, as they have helped us to determine the error rate.

The CHAIRMAN. Let me ask you, when are you going to have the answer to that question, by what date?

Dr. KANOF. The question to how much of our error rate is due to consultants giving——

The CHAIRMAN. Giving and physicians and following up on illegal, unethical advice.

Dr. KANOF. I will turn to my colleague here.

Mr. MORRIS. Let me try to answer the question this way——

The CHAIRMAN. If we are going to make any progress, we got to know what we are starting with.

Dr. KANOF. No, I understand that. I am just concerned about how to go about actually answering that question.

The CHAIRMAN. I know you are also concerned about results.

Dr. KANOF. Correct. So when I think about how we determine the error rate, part of that is to go back to the medical records and actually get the documentation.

The CHAIRMAN. When will we know how much of the error rate is due to these kinds of unethical, illegal practices?

Mr. MORRIS. To be very direct, I do not know that we ever will.

The CHAIRMAN. When will you have a gut guess?

Mr. MORRIS. I think we have a gut guess now.

The CHAIRMAN. How much?

Mr. MORRIS. I would say that at this point, a 7-percent error rate. There may be somewhere in the area of another 3 or 4 percent on top of that, that we simply cannot document as abusive for this reason. You recall from the transcripts that what these consultants are saying is documentation is the name of the game.

The CHAIRMAN. Right.

Mr. MORRIS. And if the paper work is there, you have won the game. The better mousetrap I think was referenced.

The CHAIRMAN. That is right.

Mr. MORRIS. When we conduct a review of the fee-for-service program and determine what percentage of those claims should not have been paid, what the OIG and its auditors do is go to the medical records or other documentation and see whether the paper work supports the claim.

If someone is intent on defrauding us, they will have "built the better mousetrap." They will have the paper work in place so it will appear that this is a legitimate service appropriately billed.

The CHAIRMAN. I understand all of that. We know there is a problem here. We are trying to solve it. So I, first, am trying to quantify the problem so we know and then look at the actions we are taking down the road, maybe 6 months or a year from now, look to see on a quantifiable basis whether we are making any progress or not.

All these good sounding words are wonderful and these great things we intend to do, but you know about the phrase of good intentions, where that leads. It is all results. And to get results, we have to quantify the beginning point and benchmark at that point.

Mr. MORRIS. I think one of the challenges to getting you an affirmative number and a specific quantified base line from which to work is that the amount of resources that would be required to actually tell you what percentage of claims which on their face based on documentation appear legitimate, but in fact are not. This would require a tremendous amount of resources and disruption of practices because we would have to go beneficiaries and see whether they recalled whether the service as billed was consistent with their experience.

The CHAIRMAN. In fact, you are telling me that we are always going to have this problem or it is just not going to get any better because you are not going to do anything of significance about it. That is in effect what you just told me.

Mr. MORRIS. No. I hope what I am saying is that by dealing with the vast majority of providers who are honest and making the pro-

gram more efficient and easier to comply with and heightening their awareness of potential pitfalls, that we would in effect have a positive sentinel effect. We may never be able to measure those providers who have the opportunity to abuse us and chose not to.

The CHAIRMAN. I am sorry. I would like for you to give the committee your best guess in a reasonable period of time. I am going to leave that up to you as to when you think that reasonable period of time is, but for me, it has to be less than a couple of weeks, your best guess.

Then, we will take it from there. We will have a subsequent hearing at a subsequent time to try to determine how much progress we have made. I will be very reasonable. We are here to serve the public.

Dr. KANOF. Neither one of us is disagreeing with you. I think what we need is ample opportunity to determine what the current base line is.

The CHAIRMAN. Right.

Dr. KANOF. We have heard from the GAO today.

The CHAIRMAN. Right.

Dr. KANOF. And if we can understand how we obtain the base line since no one today could give you the number for the base line, we could then figure out how to measure.

The CHAIRMAN. Right. And I do not want to be disruptive either clearly, but we still need to get some results here.

Dr. KANOF. I do not think that we are disagreeing. We just want the opportunity to determine the base line.

The CHAIRMAN. Right. To determine, to do it, and to do it in a good, fair sound way.

Dr. KANOF. Right.

The CHAIRMAN. Good. All right. Thank you.

Senator GRASSLEY. Thank you. Once again, I want to thank the Chairman for his cooperation and the gentlemanly way in which we have worked together on this. I appreciate that very much.

I just have two questions. The first is to you, Dr. Kanof. This is a question that could be a personal view of yours, Dr. Kanof, or speaking for your department. Does CMS somehow need to certify and/or monitor health care consultants or is it better left to the industry itself? And if you do not have a view for the department, that is all right, but I just wanted to ask you.

Dr. KANOF. I am going to give you my personal view.

Senator GRASSLEY. All right.

Dr. KANOF. And we can get back to you on the department view.

Broadly, CMS is here to ensure that beneficiaries get the high-quality medical services they need and they have access to care and that physicians and providers are paid appropriately for those services. And I believe that is our primary goal.

So therefore, if that is our primary goal, extending out to consultants or lawyers or auditors, the whole realm of other consultants that physicians and providers might use in the regular course of their business, I would not put that under the purview of CMS.

Senator GRASSLEY. Mr. Hamel, this will be my last question for anybody on the panel. We have not talked about this until now because we have talked about saving money and bad advice being given and efforts to cheat legally or illegally, all those things.

You brought up I think about the civil rights laws perhaps being violated. Could you tell us a little bit more about how the Civil Rights Act is implicated by the advice that you have told us about?

Mr. HAMEL. I will let Mr. Hast answer that question.

Senator GRASSLEY. That is all right.

Mr. HAST. Although the consultant used the term "discrimination", without a live set of circumstances, the Civil Rights Act is so complicated, the GAO is not taking the position on the question of whether or not the conduct promoted by the consultant violates the civil rights laws.

The important point we make though, I want to stress, is that the contact promoted might result in depriving the Medicaid patients of medically necessary services or in better paying insurance plans, paying for services that are not medically necessary, but are performed just for the purpose of affiliating those better paying patients to the medical practice.

Senator GRASSLEY. All right. So in my reading of it, you are not saying that the civil rights law has been violated?

Mr. HAST. We have no indication that that has happened.

Senator GRASSLEY. All right. But in a very general way, subtle discrimination not necessarily in violation of the civil rights laws?

Mr. HAST. Yes.

Senator GRASSLEY. Well, I think, as you have heard from our very good Chairman here, we are going to continue an interest in this, but I think this hearing in and of itself has been very useful and hopefully if no more than the publication of this information and the good work of the report of the General Accounting Office will have a chilling effect upon this bad information of people giving out advice about how it is somehow legal to not return money to the department that ought to be returned to Medicare or that it is all right to charge more and that it is okay to cheat legally by proper documentation and all that.

As I think you have indicated, it is difficult to find all this information and particularly documentation as a basis for it. Hopefully, this will have a chilling effect on that practice.

Also, I think that it emphasizes what is the basis for Medicare payments as maybe the same basis as our voluntary compliance with our tax laws. That is the good faith of people to do what is right. In our system of government and our society, we rely to a great extent on that.

That is why it is quite disturbing to me to find a sick consultant being more sick than the patients we are trying to treat sometimes with this advice, a sickly attitude that somehow it is all right to game the system. That is what we have to deal with and it is very difficult to deal with.

On the other hand, I thank all of you who have provided this information and for those of you who have to constantly be on the enforcement end of it. So I thank you for testifying. I think your testimony will be very helpful in focusing on the issue of health care consultants and the advice they give.

As we have heard today, there are those who would advise health care providers to improperly bill the government and circumvent compliance regulations. We know that this is just not

right. OSI has even determined the action of some health care consultants to be criminal.

Is that fair to say?

Mr. HAST. If followed, it would cause criminality, yes.

Senator GRASSLEY. All right. Thank you.

An appropriate referral I think will be made to your office of Inspector General. As part of OSI's criminal referral to OIG, Senator Baucus and I are asking the Inspector General to keep us apprised of any findings or conclusions. I am hoping that we can stop these consultants from doing this sort of behavior.

I think I want to repeat something I said in my opening remark, that I hope to send a message loud and clear to health care consultants who advocate fraud that this behavior is unethical, it can be illegal, and it is certainly intolerable. If you are a bad actor, see the light, clean up your act, and know that you are at risk of getting caught and prosecuted.

Once again, Chairman Baucus and I thank you for being here, and I thank Chairman Baucus for holding this hearing. I look forward to working with you all as we strive to protect valuable government programs and most importantly deliver good health care and at the same time get the taxpayers the most for their dollars. Thank you very much.

[Whereupon, at 11:40 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF ROBERT H. HAST

Mr. Chairman, Ranking Minority Member, and Members of the Committee:

I am pleased to be here today to discuss the results of our investigation concerning health care billing consultants who conduct seminars or workshops that offer advice to health care providers on how to enhance revenue and avoid audits or investigations. My testimony today is based on our recent report of that investigation, which you are releasing today.[1] Accompanying me today are Dr. Kathryn Locatell, a physician we contracted with to assist us on this investigation, and William Hamel, a criminal investigator with my office.

In summary, consultants at two workshops we attended provided in-depth discussions of regulations that pertain to billing for evaluation and management health care services and compliance with health care laws and regulations. Certain advice provided during those discussions is inconsistent with federal law and guidance provided by the Department of Health and Human Services' Office of Inspector General (OIG). Such advice could result in violations of both civil and criminal statutes. Specifically, certain consultants advocated not reporting or refunding overpayments received from insurance carriers after they were discovered. The consultants also encouraged the performance of tests and procedures that are not medically necessary to generate documentation in support of bills for evaluation and management services at a higher level of complexity than actually confronted during patients' office visits. Furthermore, one consultant suggested that providers discourage patients with low-paying insurance plans, such as Medicaid, from using their services by limiting services provided to them and scheduling appointments for such patients at inconvenient times of the day.

In addition, we are similarly concerned with statements about billing practices made by a private consultant we also contacted. This consultant claims to have a large client base. We did not incorporate the private consultant's remarks into our report due to time constraints; however, Dr. Locatell will discuss the consultant's statements in her testimony today.

If followed, the advice provided at the two workshops we attended would exacerbate program integrity problems in the Medicare and Medicaid programs and result in unlawful conduct. Moreover, the advice raises concerns that some payments previously classified by the Department of Health and Human Services' OIG as improperly paid health care insurance claims may actually stem from conscious decisions to inflat claims by providing unnecessary services or manipulating documentation claims in an attempt to increase revenue. We have discussed with the OIG the need to monitor workshops and seminars similar to the ones we attended.

Mr. Chairman, at this time, Mr. Hamel will play excerpts from the tapes we recorded at the workshops and during our discussion with the private consultant. He will also explain the context under which these recordings were made. We will then answer any questions that you or other members of the Committee have.

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[1] See *Health Care: Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims* (GAO–01–818, June 27, 2001).

GAO
Accountability * Integrity * Reliability
United States General Accounting Office
Washington, DC 20548

June 27, 2001

The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

Dear Senator Grassley:

This report responds to your request that we investigate health care consultants who conduct seminars or workshops that offer advice to health care providers on ways to enhance revenue and avoid audits or investigations. Specifically, you asked that we (1) attend seminars or workshops that these consultants offer and (2) determine whether the consultants are providing advice that could result in improper or excessive claims to Medicare, Medicaid, other federally funded health plans, and private health insurance carriers.

To assist us in identifying consultants who provide advice on billing practices and compliance programs, and to analyze the information provided by these consultants, we contracted with a licensed physician. This physician and a criminal investigator, who posed as a member of the physician's staff, attended two workshops and one seminar. The focus of our work was seminars and workshops that advertised how to enhance revenue and avoid audit, rather than on those that provide advice on coding for reimbursement. We raise issues in this report about advice given at two workshops—"How to Run a More Profitable Practice," which was sponsored by the Medical Society of the District of Columbia and "Creating a 7-Step Compliance Plan Audit/Audit-Proof Your Practice," which qualified for continuing education credits by the American Association of Medical Assistants. The same consulting company presented both workshops.[1] We raise no issues regarding the advice provided at the seminar we attended, which was sponsored by the American Academy of Physician Assistants. We conducted our investigation from July 2000 to June 2001 in accordance with investigative

[1] This company advertises that (1) it has designed, developed, and presented hundreds of workshops on behalf of many medical societies and hospitals and (2) its workshops have been attended by over 50,000 physicians and 100,000 office managers and medical assistants.

standards established by the President's Council on Integrity and Efficiency.

Results in Brief

In summary, the two workshops about which we raise issues in this report offered in-depth discussions of regulations that pertain to billing for evaluation and management health care services[2] and compliance with health care laws and regulations. During the course of discussions at those workshops, certain advice was provided that is inconsistent with guidance provided by the Department of Health and Human Services' Office of Inspector General (OIG). Such advice could result in violations of both civil and criminal statutes. Specifically, certain consultants advocated not reporting or refunding overpayments received from insurance carriers after they were discovered. The consultants also encouraged the performance of tests and procedures that are not medically necessary to generate documentation in support of bills for evaluation and management services at a higher level of complexity than actually confronted during patients' office visits. Furthermore, one consultant suggested that providers discourage patients with low-paying insurance plans, such as Medicaid, from using their services by limiting services provided to them and scheduling appointments for such patients at inconvenient times of the day.

Background

Medicare and Medicaid have consistently been targets for fraudulent conduct because of their size and complexity. Private health care insurance carriers are also vulnerable to fraud due to the immense volume of claims they receive and process. Those who commit fraud against public health insurers are also likely to engage in similar conduct against private insurers. The Coalition Against Insurance Fraud estimates that in 1997 fraud in the health care industry totaled about $54 billion nationwide,[3] with $20 billion attributable to private insurers and $34 billion to Medicare and Medicaid.

[2] Evaluation and management health care services encompass the basic services provided by physicians in diagnosing and treating patients.

[3] The Coalition used private insurance information provided by the Health Insurance Association of America and public insurance information supplied by the Health Care Financing Administration. The most current year for which statistics were available is 1997.

In addition to losses due to fraud, the Department of Health and Human Services' OIG has reported that billing errors, or mistakes, made by health care providers were significant contributors to improperly paid health care insurance claims. The OIG defined billing errors as (1) providing insufficient or no documentation, (2) reporting incorrect codes for medical services and procedures performed, and (3) billing for services that are not medically necessary or that are not covered. For fiscal year 2000, the OIG reported that an estimated $11.9 billion in improper payments were made for Medicare claims.[4]

OIG Guidance

In a March 1997 letter to health care providers, the Department of Health and Human Services' IG suggested that providers work cooperatively with the OIG to show that compliance can become a part of the provider culture. The letter emphasized that such cooperation would ensure the success of initiatives to identify and penalize dishonest providers. One cooperative effort between the IG and health care groups resulted in the publication of model compliance programs for health care providers.

The OIG encourages providers to adopt compliance principles in their practice and has published specific guidance for individual and small group physician practices[5] as well as other types of providers to help them design voluntary compliance programs. A voluntary compliance program can help providers recognize when their practice has submitted erroneous claims and ensure that the claims they submit are true and accurate. In addition, the OIG has incorporated its voluntary self-disclosure protocol[6] into the compliance program, under which sanctions may be mitigated if provider-detected violations are reported voluntarily.

Evaluation and Management Services

Evaluation and management services refer to work that does not involve a medical procedure—the thinking part of medicine. The key elements involved in evaluation and management services are (1) obtaining the patient's medical history, (2) performing a physical examination, and (3) making medical decisions. Medical decisions include determining which

[4] Department of Health and Human Services' OIG report, *Improper Fiscal Year 2000 Medicare Fee-for-Service Payments*, A-17-00-02000, (Feb. 5, 2001).

[5] 65 F. Reg. 59434 (Oct. 5, 2000).

[6] 63F. Reg. 42410 (Aug. 7, 1998).

diagnostic tests are needed, interpreting the results of the diagnostic tests, making the diagnosis, and choosing a course of treatment after discussing the risks and benefits of various treatment options with the patient. These decisions might involve work of low, medium, or high complexity.

Each of the key elements of evaluation and management services contains components that indicate the amount of work done. For example, a comprehensive medical history would involve (1) determining a patient's chief complaint, (2) tracing the complete history of the patient's present illness, (3) questioning other observable characteristics of the patient's present condition and overall state of health (review of systems), (4) obtaining a complete medical history for the patient, (5) developing complete information on the patient's social history, and (6) recording a complete family history. A more focused medical history would involve obtaining only specific information relating directly to the patient's symptoms at the time of the visit.

Providers and their staffs use identifying codes defined in an American Medical Association publication, titled *Current Procedural Terminology* (CPT), to bill for outpatient evaluation and management services performed during office visits. The CPT is a list of descriptive terms and identifying codes for reporting all standard medical services and procedures performed by physicians. Updated annually, it is the most widely accepted nomenclature for reporting physician procedures and services under both government and private health insurance programs. The CPT codes reported to insurers are used in claims processing, and they form the basis for compensating providers commensurate with the level of work involved in treating a patient. Accordingly, the higher codes, which correspond to higher payments, are used when a patient's problems are numerous or complex or pose greater risk to the patient, or when there are more diagnostic decisions to be made or more treatment options to be evaluated.

The CPT has two series of evaluation and management codes for outpatient office visits, one series for new patient visits and another for established patient visits. Each series of CPT codes has five levels that correspond to the difficulty and complexity of the work required to address a patient's needs. The code selected by the provider to describe the services performed in turn determines the amount the provider will be paid for the visit. For example, under the current Medicare fee schedule

for the District of Columbia and surrounding suburbs,[7] a provider would be paid $39.30 for a new patient who is determined to have received services commensurate with a level 1 visit and $182.52 for a level 5 visit. Similarly, payments for level 1 and level 5 visits by an established patient are $22.34 and $128.03, respectively.

Some Advice Provided by Consultants Could Result in Violations of Law

The two workshops we attended provided certain advice that is inconsistent with the OIG guidance and that, if followed, could result in violations of criminal and civil statutes. Specifically, at one workshop the consultant suggested that when providers identify an overpayment from an insurance carrier, they should not report or refund the overpayment. Furthermore, consultants at both workshops suggested that providers attempt to receive a higher-than-earned level of compensation by making it appear, through documentation, that a patient presented more complex problems than he or she actually did. Additionally, one consultant suggested that providers limit the services offered to patients with low-paying insurance plans, such as Medicaid, and that they discourage such patients from using the provider's services by offering appointments to them only in time slots that are inconvenient to other patients.

Nondisclosure of Overpayments

One workshop focused on the merits of implementing voluntary compliance programs. The consultant who presented this particular discussion explained that a baseline self-audit to determine the level of compliance with applicable laws, rules, and regulations is a required step in creating a voluntary compliance program. Focusing on "how to audit-proof your practice" and avoid sending out "red flags," the consultant advised providers not to report or refund overpayments they identify as a result of the self-audit. The consultant claimed that reporting or refunding the overpayment would raise a red flag that could result in an audit or investigation. When asked the proper course of action to take when an overpayment is identified, the consultant responded that providers are required to report and refund overpayments. He said, however, that instead of refunding overpayments, physician practices generally fix problems in their billing systems that cause overpayments while "keeping

[7] Medicare has separate fee schedules for various geographic regions throughout the United States.

their mouths shut" and "getting on with life." Such conduct, however, could result in violations of criminal statutes.[8]

Creating Documentation to Support Higher-Than-Warranted Code Levels

According to the most recent OIG Medicare audit report, the practice of billing for services that are not medically necessary or that lack sufficient diagnostic justification is a serious problem in the health insurance system. The OIG estimated that during fiscal year 2000, $5.1 billion was billed to insurance plans for unnecessary services. Intentionally billing for services that are not medically necessary may result in violations of law.[9]

Moreover, based on advice given at workshops that we attended during this investigation, we are concerned that insurers may be paying for tests and procedures that are not medically necessary because physicians may be intentionally using such services to justify billing for evaluation and management services at higher code levels than actual circumstances warrant. Specifically, two consultants advised that documentation of evaluation and management services performed can be used to create, for purposes of an audit, the appearance that medical issues confronted at the time of a patient's office visit were of a higher level of difficulty than they actually were.

For example, a consultant at one workshop urged practitioners to enhance revenues by finding creative ways to justify bills for patient evaluation and management services at high code levels. He advised that one means of justifying bills at high code levels is to have nonphysician health professionals perform numerous procedures and tests. To illustrate his point, the consultant discussed the hypothetical case of a cardiologist who examines a patient in an emergency room where tests are performed and the patient is discharged after the cardiologist determines that the patient has a minor problem or no problem at all. To generate additional revenue, the consultant suggested that the cardiologist tell the patient to come to

[8] See, for example, 18 U.S.C. § 641 (intentional conversion of federal property to personal use), and 42 U.S.C. § 1320a-7b (duty to report changed circumstances that affect a provider's entitlement to payment).

[9] Among the criminal statutes applicable to health care fraud are 18 U.S.C. § 1347 (knowing, willful scheme to defraud federal health care programs), 42 U.S.C. § 1320a-7b (knowingly providing false statements to obtain federal benefits). The False Claims Act 31 U.S.C. § 3729 applies civil penalties plus damages for knowingly presenting to federal authorities a false claim for payment, and 42 U.S.C. § 1320a-7b also applies civil penalties to improper claims made on the federal health programs.

his office for a complete work-up, even when the cardiologist knows that the patient does not have a problem. He advised that the work-up be performed during two separate office visits and that the cardiologist not be involved in the first visit. Instead, a nurse is to perform tests, draw blood, and take a medical history. During the second visit, the cardiologist is to consult with the patient to discuss the results of the tests and issues such as life style. The consultant indicated that the cardiologist could bill for a level 4 visit, indicating that a relatively complex medical problem was encountered at the time of the visit. The consultant made clear that the cardiologist did not actually confront a complex problem during the visit because the cardiologist already knew, based on the emergency room tests and examination, that the patient did not have such a problem.

Another consultant focused on how to develop the highest code level for health care services and create documentation to avoid having an insurer change the code to a lower one. The consultant engaged in "exercises" with participants designed to suggest that coding results are "arbitrary" determinations. His emphasis was not that the code selection be correct or even that the services be performed, but rather that it is important to create a documentary basis for the codes billed in the event of an audit. He explained that in the event of an audit, the documentation created is the support for billing for services at higher code levels than warranted.

During the exercises, program participants—all were physicians except for our criminal investigator—were provided a case study of an encounter with a generally healthy 14-year-old patient with a sore throat. Participants were asked to develop the evaluation and management service code for the visit that diagnosed and treated the patient's laryngitis. The consultant suggested billing the visit as a level 4 encounter, supporting the code selection by documenting every aspect of the medical history and physical examination, and mechanically counting up the work documented to make the services performed appear more complicated than they actually were. All of the participants indicated that they would have coded the visit at a lower level than that suggested by the consultant, who stated that "documentation has its rewards." The consultant explained that in the event of an audit, the documentation created would be the basis for making it appear that a bill at a high code level was appropriate.[10]

[10] The OIG's most recent audit of Medicare claims at level 4 showed that over the last 5 years, providers on average incorrectly coded at level 4 in over 41 percent of the cases the OIG reviewed.

Limiting Services to Medicaid Patients

One workshop consultant encouraged practices to differentiate between patients based on the level of benefits paid by their insurance plans.[11] He identified the Medicaid program in particular as being the lowest and slowest payer, and urged the audience to stop accepting new Medicaid patients altogether. The consultant also suggested that the audience members limit the services they provide to established Medicaid patients and offer appointments to them only in hard-to-fill time slots.

Workshop participants were advised to offer better-insured patients follow-up services that are intended to affiliate a patient permanently with the practice. However, the consultant suggested that physicians may decide not to offer such services to Medicaid patients. He sent a clear message to his audience that a patient's level of care should be commensurate with the level of insurance benefits available to the patient. This advice raises two questions: First, are medically necessary services not being made available to Medicaid patients? Second, are better-paying insurance plans being billed for services that are not medically necessary but performed for the purpose of affiliating patients from such plans to a medical practice?

Program participants were further urged to see at least one new patient with a better-paying insurance plan each day. The consultant pointed out that, by seeing one new patient per day, a provider can increase revenue by $6,000 per year because the fee for a new patient visit is about $30 more than the fee for an established patient visit. He said that over time such measures would result in reducing the percentage of Medicaid patients seen regularly in the practice and increase the number of established patients with better-paying insurance.

The consultant also recommended that providers limit the number of scheduled appointment slots available to Medicaid patients on any given day and that Medicaid patients be offered appointments only in hard-to-fill time slots rather than in the "best," or convenient, time slots. He suggested that insurance information and new patient status be used to allocate the best time slots to the best payers. He identified this approach as "rationing," which he described as "not real discrimination," but "somewhat discrimination."

[11] The presenter recommended rating the various insurers based on the amount they allow for services, the percentage of claims collected, and the timeliness of their claims processing.

While neither the Social Security Act[12] nor Medicaid regulations require physicians to accept Medicaid patients, title VI of the Civil Rights Act of 1964[13] prohibits discrimination based upon race, color, or national origin in programs that receive federal financial assistance. The Department of Health and Human Services, which administers the Medicare and Medicaid programs, takes the position that the nondiscrimination requirement of title VI applies to doctors in private offices who treat and bill for Medicaid patients. While the conduct promoted by the consultant is not overt discrimination on the basis of race, color, or national origin, under certain circumstances, such conduct might disproportionately harm members of protected groups and raise questions about title VI compliance. Moreover, even if the conduct promoted is not unlawful, it raises serious concerns about whether it would result in depriving Medicaid patients of medically necessary services, and whether better-paying insurance plans are billed for services that are not medically necessary but performed for the purpose of affiliating patients to a particular medical practice.

Conclusion

Advice offered to providers at workshops and seminars has the potential for easing program integrity problems in the Medicare and Medicaid programs by providing guidance on billing codes for evaluation and management services. However, if followed, the advice provided at two workshops we attended would exacerbate integrity problems and result in unlawful conduct. Moreover, the advice raises concerns that some payments classified by the OIG as improperly paid health care insurance claims may stem from conscious decisions to submit inflated claims in an attempt to increase revenue. We have discussed with the Department of Health and Human Services' OIG the need to monitor workshops and seminars similar to the ones we attended.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will make copies of the report available to interested congressional committees and the Secretary of the Department of Health and Human Services.

This report will also be available at *www.gao.gov*. If you have any questions about this investigation, please call me at (202) 512-7455 or

[12] 42 U.S.C. § 1396, *et seq.* (1994).

[13] 42 U.S.C. § 2000d.

Assistant Director William Hamel at (202) 512-6722. Senior Analyst Shelia James, Assistant General Counsel Robert Cramer, and Senior Attorney Margaret Armen made key contributions to this report.

Sincerely yours,

Robert H. Hast
Managing Director
Office of Special Investigations

PREPARED STATEMENT OF MARJORIE KANOF, MD, MPH

Chairman Baucus, Senator Grassley, distinguished Committee members, thank you for inviting me to discuss Medicare's provider education efforts with you. Physicians and other health care providers play a critical role in ensuring that Medicare beneficiaries receive quality health care. We know that the vast majority of physicians and other providers are honest and conscientious. We also know that at times, many of them feel overwhelmed by Medicare's requirements. Due to Medicare's complexity, coding consultants have found a niche in which they offer physicians and other providers training on how to code and bill for Medicare services. These training sessions are not affiliated with the Medicare program, and the Centers for Medicare and Medicaid Services (CMS) do not endorse, accredit or certify these programs. Some of these programs may offer physicians and other providers an alternative, or more frequent, forum for learning billing procedures. We recognize we have many areas in which we need to improve, and we are redoubling our efforts at CMS to ensure that our own educational programs help physicians and other providers understand how to bill Medicare appropriately and receive payment for the care they provide. Enhancement of our education efforts and outreach are essential to the success of the program, and we believe will ultimately reduce Medicare physicians' and other providers' dependence on outside consultants.

CMS promulgates the regulations and billing instructions to which physicians and other providers must adhere. As such, it is critical that we offer extensive, on-going provider education programs—in both urban and rural areas—to ensure that physicians and other providers clearly understand the billing process and what resources are available to assist them in properly coding and billing for the services they provide. Further, we must provide reliable, easily accessible resources for physicians and other providers when they confront billing problems or have questions.

Before discussing the many initiatives underway in CMS to educate physicians, providers and suppliers of services, I would like to recognize that there are many authoritative sources of coding information available from the professional and scientific community on which physicians, providers and suppliers of services can rely. In fact, Medicare's Common Procedural Coding System (generally know as HCPCS) is based largely on the Current Procedural Terminology (CPT) created, maintained and owned by the American Medical Association (AMA). The AMA publishes not only the CPT codes that form the basis of Medicare coding of physician services, but also provides a wealth of information and services to enable physicians, providers and others to code and bill Medicare properly. Moreover, other professional organizations provide education and resources to members and others with respect to the scope of their professional services. We have worked closely with these professional organizations in the past and continue to do so in recognition of the valuable services they furnish to the physicians, providers and others who care for our beneficiaries.

With respect to CMS's role in educating and assisting physicians, providers and others to correctly bill Medicare for the services they furnish (of which an important part is selecting the correct code for the service furnished), CMS's role is largely on the front-end: we provide extensive education and training materials to newly enrolled physicians and other providers, offer resources to providers when regulations are changed or added, and field provider questions regarding Medicare billing and payment systems. For the small number of physicians and other providers with continuing problems, the contractor program integrity staff provides individualized counseling and tutoring. By simplifying the regulatory process and providing better training, we will clarify the billing system and reduce the need for providers to turn to consultants. However, despite our best education efforts, there likely will always be physicians and other providers who use outside consultants to get, for example, a "second opinion" on how to bill the Medicare program.

CMS Administrator Tom Scully has announced that he is making it a priority to bring a culture of responsiveness to the agency. These are not empty words: they stand for ensuring high-quality medical care for beneficiaries, improved communication with providers and beneficiaries, and redoubled education efforts. Two weeks ago, Secretary Thompson announced that CMS will designate a senior-level staff member as the principal point-of-contact for each specific provider group, such as hospitals, physicians, nursing homes, and health plans. These designees will work with the industry groups to facilitate information sharing and enhance communication between the Agency and its business partners. The vast majority of CMS's provider training is provided through Medicare's contractors, the fiscal intermediaries and carriers who process Medicare claims. Working with the Medicare contractors, we have taken a number of steps to ensure the educational information we share with physicians and providers is consistent, clear, and unambiguous. We are making materials and other information available through the Internet, by toll-free telephone service, and via satellite broadcasts. We also are reaching out to physicians and providers with mailings and classroom educational seminars.

While we have made substantial progress, we still have important work to do. We are seeking out physician and provider input so that we can work to reduce burden and better focus our education efforts. We have been working closely with the physician community to develop new guidelines for billing physician office visits under Medicare, and we are rewriting our manuals, which will simplify and clarify our billing instructions and enhance provider education. We have formed a special team to pinpoint problem areas for physicians and develop suggestions for simplifying Medicare requirements.

We share a common mission with physicians and providers—ensuring high quality medical care for Medicare beneficiaries. We continue to work hard to make sure physicians and providers understand and can comply with Medicare laws and regulations, and we want to work with providers and Congress to simplify these requirements, while at the same time ensuring that we pay appropriately for Medicare services rendered. We look forward to our continued partnership with Congress and the physician and provider community to further improve our education efforts.

BACKGROUND

This year, Medicare will pay approximately $240 billion for the health care of nearly 40 million beneficiaries, involving nearly one billion claims from more than one million physicians, hospitals, and other health care providers. The Centers for Medicare and Medicaid Services strive to ensure that Medicare pays only for the services allowed by law while making it as easy as possible for qualified health care providers to treat Medicare beneficiaries. We have to carefully balance the impact of Medicare's laws and regulations on providers with our accountability for the billions of dollars of Medicare payments. We are committed to providing good service to our physicians and provider partners while protecting the Medicare Trust Fund from errors and abuse.

Although Medicare pays over 93 percent of claims correctly based on the information submitted, improper payments occur for reasons such as insufficient documentation, lack of medical necessity, and improper coding by physicians and health care providers. During the past five years, we have worked with physicians and providers to improve their understanding of the process. As a result, Medicare has reduced its payment error rate by half, from 14 percent in fiscal year 1996 to 6.8 percent in fiscal year 2000, meeting our 2000 Government Performance and Results Act goal. We realize that the volume of laws and regulations covering Medicare's responsibilities is substantial, and we know we must continue to improve our communications so physicians and other providers understand Medicare's requirements.

This responsibility has never been plainer. Over the last five years new laws have dramatically altered the Medicare program and the health care arena, including the *Health Insurance Portability and Accountability Act of 1996 (HIPAA), Balanced Budget Act of 1997 (BBA), Balanced Budget Refinement Act of 1999 (BBRA), and Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act*. Combined, these laws contained hundreds of provisions that we have been responsible for implementing, including new prospective payment systems for numerous segments of the health care industry, new preventive benefits, and new health plan choices for Medicare beneficiaries. The number and complexity of these changes were greater than any we had ever before experienced.

We pursued an open process as we implemented these new programs and policy changes, seeking insight and recommendations from physicians and providers, their associations, and other members of the public. This is far different from the way many private insurers conduct their business, and greatly benefits us and physicians and providers as we incorporate their recommendations into our new policies and regulations. As a result of these legislative changes we have undertaken the most extensive education program in Medicare's history, including outreach to beneficiaries, physicians, and providers to make sure they understand the changes and the requirements these changes create.

IMPROVING OUTREACH TO PHYSICIANS AND PROVIDERS THROUGH MEDICARE CONTRACTORS

We primarily rely on the private sector contractors, who by law process and pay Medicare claims, to communicate policy changes and other helpful information to educate the physicians and providers they serve. We recognize that the decentralized nature of this system has led to inconsistency in the contractors' communications with physicians and other providers, and we have taken a number of steps to improve the educational process. We have centralized our educational efforts in our Division of Provider Education and Training, whose sole purpose is educating and training the contractors and the provider community regarding Medicare policies. These efforts include:

- **Installing toll-free provider inquiry lines at the Medicare contractors**. In 2000, we established Medicare contractor call centers to provide up-to-date information to physicians and providers regarding billing questions and other topics. The toll-free numbers for the call centers are listed at *www.hcfa.gov/medlearn/tollfree.htm*. Each contractor also maintains a website and electronic bulletin boards to provide information to physicians, providers, and their staff. We are now working to ensure the highest quality service to physicians and providers at the call centers.
- **Providing consistency through standardized training for contractors**. We are providing contractors with in-person instruction and a standardized training manual for them to use in educating their constituency. These programs provide consistency and ensure that our contractors speak with one voice on national issues. For example, in coordination with the Blue Cross/Blue Shield Association, we developed train-the-trainer sessions for implementing both the Hospital Outpatient and Home Health Prospective Payment System (HHPPS) regulations. We then developed a satellite broadcast, which was rebroadcast several times prior to the effective date of the regulation. Following up on the train-the-trainer sessions, we coordinated a town hall meeting, participated in weekly conference calls with regional offices and fiscal intermediaries to monitor progress in implementing these changes and answering questions. We continue to refine our training on an on-going basis by monitoring the training sessions conducted by our contractors. For example, this fall, we will premier a CMS digital satellite network to send interactive training to all Medicare carriers and intermediaries. Our goal is to provide at least one hour of video training and each month, supplemented by materials on our "Best Practices" website.
- **Working to improve contractor outreach**. We also are strengthening and standardizing the way in which our contractors carry out education and customer service activities. We require all contractors to provide information via printed bulletins and newsletters, as well as via the Internet. This includes requiring each contractor to have the ability to link to our website from their own website, giving physicians and providers immediate access to our Medicare learning network (*www.hcfa.gov/MedLearn*). And we are exploring the possibility of having e-mail listservs for specific provider types available at the contractor level to facilitate the sharing of information.

WORKING CLOSELY WITH THE HEALTH CARE COMMUNITY

Just as we are working with our contractors, we also are working directly with physicians to improve our communications and ensure that we are responsive to their needs. In 1998, we created the Physicians Regulatory Issues Team (PRIT) to improve the agency's responsiveness to the daily concerns of practicing physicians as we review and create Medicare requirements. The PRIT, which operates under physician direction and includes physicians working throughout CMS, seeks to make Medicare simpler and more supportive of the doctor-patient relationship. As part of the PRIT's efforts, we asked physicians about their information needs, and they recommended that we take advantage of new technologies, leverage our resources by working with other involved parties, and strive to produce and distribute pertinent, clear, and consistent educational materials.

As a result, we are pursuing a broad range of activities designed to support physicians as they care for Medicare beneficiaries. For example, we are developing a system to capture and compile the many individually answered questions that come into the Agency. We plan to refine them into Frequently Asked Questions (FAQ) lists, and make them widely available via our website, publications, speeches, and other channels. This way we can provide consistent explanations not only to the inquiring physician, but any physician or provider that chooses to read or listen to our communications.

In addition, we are consulting physicians about proposed program changes, developing an easy-to-use handbook to guide physicians through relevant Medicare laws and regulations, and investigating physician concerns to find ways to simplify or eliminate unnecessary Medicare requirements. The work of Team members has led to changes to allow physicians to fax their orders for patients to receive wheelchairs and other needed equipment, and to allow physicians to receive separate payments for their work determining patients' eligibility for the Medicare home health benefit.

To complement these efforts, we provide free information, educational courses, and other services to the health care community using today's advanced technologies. For example, we have a variety of resources available on the Internet at *www.hcfa.gov/MedLearn*, the homepage for the Medicare Learning Network. This Network provides timely, accurate, and relevant information about Medicare coverage and payment policies, and serves as an efficient, convenient provider education tool. For the six-month period of October 2000 through March 2001, the MedLearn website averaged over 100,000 hits per month, with the Reference Guides, Frequently Asked Questions and Computer-Based Training pages having the greatest activity. Moreover, we are:

- **Creating a more useful website**. The existing array of Medicare information on our agency website (*www.hcfa.gov*) for practicing physicians and their office staff is extensive, but is poorly presented for their office and billing needs. We are creating a new website architecture that takes this existing information and organizes navigation to be both easy and intuitive to the physician user. The same design is being used in creating a manual of "Medicare Basics" for physicians. We just completed field-testing the first mock-ups for the project at the recent American Medical Association House of Delegates meeting. Once this is successfully implemented, we will move to organize similar web navigation tools for other Medicare providers.
- **Providing free computer and web-based training courses**. Doctors, other providers, practice staff, and other interested individuals can access a growing number of informational courses designed to improve their understanding of Medicare. Some courses focus on important administrative and coding issues, such as how to check-in new Medicare patients or correctly complete Medicare claims forms, while others explain Medicare's coverage for home health care, women's health services, and other benefits. From October 2000 to March 2001, the computer-based training courses have averaged over 14,000 hits per month.
- **Sponsoring satellite broadcasts**. We sponsor national satellite broadcasts for physicians and other health care providers about Medicare topics such as women's health, preventive benefits, and preventing errors and abuse. The broadcasts can be viewed in hospitals, medical schools, and other Medicare Learning Centers in volunteer locations across the country through satellite television. Our broadcasts have also been picked-up by FOX Health and GE's JIP TV Network.
- **Issuing e-mail updates**. To share information as quickly as possible, we are e-mailing updates about the OPPS and HHPPS to interested hospitals, home health agencies, and others. As of February 2001, almost 10,000 subscribers received timely updates about these topics such as the two new prospective payment systems implemented in 2000 for outpatient hospital services and for

home health services. We are exploring ways to provide e-mail updates to physicians and other providers.

- **Conducting monthly conference calls with physicians**. Each month, we are holding conference calls with physician organizations across the country to provide information and obtain feedback on topics of concern. The calls are open to representatives of more than 100 national, state, and specialty associations. Participating associations often share information from these calls with their physician members. Our staff, including physicians, also attend national, state, and local medical society meetings to meet with physicians, to hear their concerns, and to explain Medicare policies in greater detail.
- **Simplifying evaluation and management guidelines**. In June 2000, we held a town hall meeting with physicians to discuss a new proposal to simplify the documentation guidelines for physician office visits under Medicare. After the town hall meeting, we sought and obtained broad input from practicing physicians, including the Practicing Physician Advisory Council, and we continue to refine the guidelines and are preparing to pilot test them later this year. We also sent a letter to more than 800,000 physicians on how to address the most common documentation problems. We also recently implemented a process to do testing of major claims systems changes with providers before those changes are fully implemented to ease their transition to new systems. We want to develop guidelines that make sense to physicians while ensuring accurate payment for their services, and then we make a strong effort to educate physicians about any changes to the payment system.
- **Preventing errors through compliance guidance**. Last summer, we worked with the HHS Inspector General to develop guidance for physicians and providers on how to comply with Medicare policies, and invited public comments on this guidance. Additionally, we are sharing feedback with physicians and providers, both on an individual and community level, about how to correct and prevent the types of errors identified in medical review of claims. This will help to reduce the number of improper claims among the vast majority of physicians and providers who make only honest errors.
- **Creating a Resident Training Program**. We are reaching out to new physicians, making Medicare information available to residents at teaching hospitals and medical schools to introduce them to Medicare and ensure they have an understanding of the program's policies early on in their careers. This program includes an in-person training session, a video, computer-based training course, and a comprehensive training manual.

CONCLUSION

Physicians and other providers play a crucial role in caring for Medicare beneficiaries. We have taken many steps toward improving our physician and provider education efforts and sharing important information so it is easier for physicians and providers to follow Medicare's laws and regulations without having to turn to consultants. We recognize we have a number of issues to address, and we are seeking the health care community's input as we work with our contractors to further enhance our working relationship with physicians, providers, and their staffs, while fulfilling our responsibility to safeguard the Medicare trust fund. I appreciate the opportunity to discuss coding consultants and our provider education efforts with you today, and I am happy to answer your questions.

PREPARED STATEMENT OF DR. KATHRYN LOCATELL

Dear Senators Baucus and Grassley,

Thank you for inviting me to speak before the Committee concerning my participation in the General Accounting Office's investigation of health care consultants that advise physicians and medical groups how to enhance revenues for their practices and avoid audits.

Pressures to contain and reduce the costs of providing health care have had a major impact on the practice of medicine, and will increasingly shape the way care is provided as our population ages. The costs of fraud and abuse are of additional concern as a substantial portion of our global health care spending is wasted. I am a physician specializing in internal medicine and geriatric medicine, and have practiced in both managed care and fee-for-service environments. When asked by GAO to assist in the investigation of consulting companies that market themselves to physicians and medical groups regarding revenue-enhancement and compliance with anti-fraud measures, I was intrigued because of a prior experience with such an organization.

While employed as a faculty member of the faculty of the University of California, Davis School of Medicine in early 1998, I attended a "mandatory" seminar about coding and billing for faculty outpatient medical care presented by consultants to the medical center. The seminar was arranged in anticipation of a government audit of billing practices in academic institutions. The medical center at the University of Pennsylvania had recently been audited and been made to pay fines of approximately $40 million; the UC system was preparing for the potential of a similar action by the government within UC.

Most of the faculty's outpatient clinical activities were conducted for the purposes of teaching as well as providing patient care. A medical student or physician-trainee (intern, resident or fellow) would see the patient initially, perform a history and physical examination (usually quite exhaustive, as the trainee was still learning what was important), and then present the findings to an attending faculty member. Discussion and teaching would ensue, followed by a joint visit with the trainee and faculty member. The attending faculty was responsible for determining the billing code for the visit.

The purpose of the coding seminar was to educate the faculty about how to accurately bill for clinic visits. Of particular importance was the need to document that the faculty member had validated all of the information that had been gathered by the trainee. To that end, new encounter forms for clinic visits were being rolled out to aid the faculty and the trainees in documenting what information had been collected during the course of the visit in order to justify the (higher) billing code. It was made clear to us that the primary purpose of the new forms was to enable billing at a higher reimbursement level.

What I and the other faculty members with whom I discussed the seminar afterward took away from this was that we were to "game the system"—that is, bill at a higher level because the trainee had gathered and documented information sufficient to justify the higher billing codes, regardless of medical necessity, in order to bring in more revenue for the medical center.

This same theme, that documentation is the key to higher billing codes (and thus higher revenues), permeated the seminars and workshops that I attended with the GAO during the course of this investigation. Similarly, regarding compliance plans, "audit-proofing" your practice was simple if you adhered to a formulaic documentation system designed to ensure that the needed elements for billing at a higher level were recorded in the patient's chart.

On the face of it, it seems reasonable that higher reimbursement is given for more complicated physician work—this is the basis for the Evaluation and Management [1] system of payments to physicians. However, what is missing from the schema is a defined way to determine that a given quantity of work was medically necessary. The information presented to us at the seminars did not include any method of documenting or ensuring that the services billed for were medically necessary. Rather, it was implicit, as in the sample case of billing at a high level for a visit by a 14-year-old with a sore throat by adding documentation, that the medical necessity would not be questioned, or that if it was, the documentation would support that the service provided and billed for was reasonable and prudent.

One of the consultants we contacted advocated incorporating "ancillary" services, such as offering Holter monitors for cardiac patients and peripheral nerve testing for diabetics, into "our practice" in order to enhance revenues. The use of extended service codes (based on time, resulting in higher reimbursement) for Alzheimer's patients was also recommended, since obviously it would take longer to gather information from a patient with dementia. I, as the primary beneficiary of such enhancements, would then be able to go out and buy that new Lexus or that Kincaid painting I had my eyes on! Justifying the performance of the testing was easy if we simply documented the "right" diagnosis codes, independent of the actual medical necessity for the procedure. This consultant advertises on his Internet web site that he can increase physician practice revenues by "$10,000 per month" through the generation and performance of such tests in the physician's office. One of the services offered includes an on-site visit to the practice and assistance with setting up the ancillary services, with a percentage of the revenues generated to be paid to the consultant in the process.

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[1] "Evaluation and management" services refer to the work that physicians do that does not involve a procedure. Traditionally and to this day, doctors are paid more for procedures than for "mental work". The current system to determine payment for evaluation and management services was developed in order to compensate physicians more when they do more mental work, i.e. the patient's problems are more numerous, more complex, there are more treatment options or diagnostic decisions to be made, and there is more risk to the patient involved in terms of serious outcomes from the problem(s) at hand.

In conclusion, the information we gathered in the course of our investigation suggests that the consultants marketing to and attracting physicians and physician groups advocate enhancing revenues in an "audit-proof" fashion through systematic documentation efforts, regardless of medical necessity. The timbre of these seminars was consistent with my prior experience in an academic medical center. In spite of cost reduction and containment pressures, providers of health care to Medicare beneficiaries continue to practice in a climate and culture where maximizing reimbursement and avoiding audits are emphasized. In my opinion, improving efforts to reduce fraud and abuse should include increasing the focus on issues of medical necessity.

Thank you, and I respectfully request that you make my statement part of the official hearing record.

PREPARED STATEMENT OF LEWIS MORRIS

Good morning Mr. Chairman. I am Lewis Morris, Assistant Inspector General for Legal Affairs at the U.S. Department of Health and Human Services, and I am here to discuss vulnerabilities that may arise from the use of billing consultants by providers.

Health care providers who take care of Medicare and Medicaid beneficiaries should be fully compensated for their services. Therefore, it is entirely reasonable and beneficial for them to use expert consultants to help navigate the sometimes complex rules of health care programs. However, expert knowledge and sophisticated billing techniques should never be used to abuse Medicare or Medicaid. Today I will share some examples of providers and consultants that stepped out of bounds and violated our trust.

Needless to say, when laws are broken by consultants, the Office of Inspector General (OIG) takes action to investigate the allegations and seek appropriate civil and criminal penalties. Our preference, however, is to work with the health care industry to promote ethical conduct, ensure quality care for beneficiaries, and thus avoid the need for enforcement actions. To this end, in my testimony today I will describe the vital role that consultants play in the health care system, identify questionable practices engaged in by a small minority of consultants, and emphasize the need for providers to exercise good business sense when selecting a consultant.

Consultants' Role in Health Care

We believe that most consultants, like most providers, are honest and that the majority of relationships between providers and consultants serve legitimate business purposes. Providers use the services of consultants, such as accountants, attorneys, business advisors, and reimbursement specialists, for many *bona fide* reasons. These include improving the efficiency and effectiveness of the provider's operations (including its coding and billing systems), conserving resources through outsourcing, and ensuring compliance with applicable laws, regulations, and rules. Responsible consultants play an integral role in developing and maintaining practices that enhance a client's business objectives, as well as in improving the overall efficiency of the health care system.

Consultants and Providers Subjected to Penalties

Notwithstanding the benefits that can be derived from the use of consultants, a small minority of consultants engage in improper practices and encourage abuse of the Medicare and Medicaid programs. Depending on the circumstances, these practices can expose both the consultant and his or her clients to potential legal liability. The following are some examples of how unscrupulous consultants can undermine the integrity of the Federal health care system.

In one case, two consultants advised more than 100 hospitals improperly to unbundle clinical laboratory tests into their component parts and bill higher rates for the individual components. The consultants first sent letters to hospitals claiming they had methods of increasing Medicare revenues for laboratory services. If a hospital engaged their services, the consultants conducted an on-site visit, assessed the hospital's coding and billing ¶procedures, and then advised on "reimbursement maximization" techniques. Although some of the advice was legitimate, some resulted in hospitals submitting false claims for unnecessary tests and for services that were not provided as claimed.

Facing civil charges, the two consultants each agreed to pay $30,000 and to be excluded from the Medicare and Medicaid programs for 3 years. Of equal importance, they agreed to cooperate in the Government's effort to investigate the hospitals that benefitted improperly from the billing scheme. To date, the investigations

have resulted in civil actions against 36 hospitals and the payment of fines and penalties in excess of $11 million. In addition to the monetary recovery, the OIG required the hospitals to adopt and implement certain integrity measures to prevent a recurrence of the fraud.

Another example of abuse is found in the recent case of a billing consultant that contracted with physicians to code, bill, and collect for emergency department services. Our investigation found that the consultant's employees were routinely billing Medicare and Medicaid for higher levels of treatment than were provided or supported by medical record documentation. The consultant was found liable under the False Claims Act and agreed to pay $15.5 million to resolve his civil and administrative monetary liabilities. The Government is continuing its investigation of the physicians who benefitted from the fraudulent billing practices. To date, the consultant's clients have paid $5.8 million to resolve the civil liabilities stemming from this fraud scheme.

In yet another example, a hospital contracted with a coding consultant who claimed he could help maximize Medicare revenues by "optimizing" the coding of claims associated with pneumonia patients. That hospital agreed to pay the Government to settle allegations that the hospital improperly upcoded Medicare claims. An additional 26 hospitals also have settled their civil and administrative liabilities for a total of $26.8 million. The consultant and many more hospitals are currently under investigation for their participation in this fraud scheme. Of particular concern in this case, other consultants learned of the pneumonia upcoding scheme and also encouraged their hospital clients to falsify Medicare claims for the treatment of pneumonia. As the word spread among consultants, the scheme expanded throughout the hospital industry.

In these examples, both the consultants and their clients were implicated in the fraud scheme. We suspect that in other instances, unethical health care consultants carefully craft their advice to bring their clients up to the line, without expressly advocating illegal behavior. This aggressive and unethical approach puts the client, as well as the Federal health care programs, at substantial risk. Ultimately, providers need to recognize that hiring a consultant does not relieve them of the responsibility to ensure the integrity of all of their dealings with Medicare and Medicaid.

Misuse of Federal Agency Names

Unethical consultants sometimes attempt to enhance their credibility by claiming that their services are endorsed by the Government. For example, a consultant currently under investigation made false representations that its seminars were sanctioned by Medicare and that attending the seminars was mandatory to maintain a Medicare provider number. In truth, the Medicare program does not condition participation in the program on a provider attending seminars. Pursuant to section 1140 of the Social Security Act, the OIG may impose civil monetary penalties of up to $5,000 per misrepresentation against anyone who uses various specified words, acronyms, and symbols, such as "Social Security," "Health and Human Services," and "HCFA" to convey the false impression that they are approved or endorsed by our agencies. We are working to end these abusive marketing practices.

Recently, we have become aware of a company that uses its website to claim falsely that its health care business venture has OIG approval. Although this is a significant misrepresentation, the OIG's ability to address the problem is limited because the terms "Office of Inspector General" or "OIG" are not expressly protected by the statute. With the recent name change of the Health Care Financing Administration to the Centers for Medicare and Medicaid Services, many sections of the Social Security Act will need revising. This would be a good time to add the terms "Office of Inspector General" and "OIG" to the appropriate sections to preclude further misrepresentation of OIG approval or endorsement.

Other Questionable Activities

In addition to misrepresenting an affiliation with the Federal health care programs, some consultants make claims that are simply too good to be true. Although not necessarily illegal, health care providers should be leery of doing business with anyone who relies on puffery or half-truths. In our experience, providers that succumb to the temptation to cut corners or game the reimbursement system can face civil and criminal liability.

Promises or guarantees that may be problematic could include, for example:

- A valuation consultant promising that its appraisal of a physician's practice will yield a "fair market value" that satisfies a client's demand for a particular valuation, regardless of the actual value.

- A billing consultant representing that its advice will result in a specific dollar or percentage increase in Medicare reimbursements, regardless of the prospective client's particular circumstances. The consultant's fee is often based on a percentage of the increased reimbursement.
- A consultant promising to increase Medicare revenues for laboratory services by showing its clients how to disguise double billings and claims for medically unnecessary services.
- A reimbursement specialist suggesting that a client use inappropriate billing codes in order to elevate reimbursement and describing methods to avoid detection.
- A consultant advising a client to modify or customize a routine medical supply in an insignificant manner solely to justify billing the item at a higher rate.
- A reimbursement specialist suggesting that a client bill for an expensive item with a high reimbursement rate when a less expensive item with a lower reimbursement rate was actually provided to the patient.

Using Good Business Sense when Selecting a Consultant

Not all consultants attempt to mislead providers or Medicare. To the contrary, most consultants provide valuable services to providers and, indirectly, to the Medicare and Medicaid programs. Consultants gain insights from their experiences with different clients, and providers can benefit from this expertise and "best practices" knowledge. We believe that only a small minority of consultants engage in questionable marketing practices or promote abuse of the Medicare and Medicaid programs. The examples I have discussed show that providers must be vigilant and exercise judgement when selecting and relying on consultants. The axiom still applies: "If it looks too good to be true, it probably is."

Both providers and consultants need to avoid business relationships that can place them in jeopardy of violating health care laws and regulations. To assist providers and consultants in avoiding these pitfalls, today we are issuing a Special Advisory Bulletin on Practices of Business Consultants. This Bulletin alerts providers to certain abusive consultant practices that have come to our attention. Such practices may raise concerns for providers and may put the Medicare and Medicaid programs at increased risk. The Bulletin, like the OIG's compliance guidances and advisory opinions, is another tool for each provider's compliance tool box.

Conclusion

Mr. Chairman, I hope my testimony and our Advisory Bulletin will help prevent inappropriate practices of business consultants. I would be pleased to answer any questions you may have. Thank you.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES,
OFFICE OF INSPECTOR GENERAL.

[SPECIAL ADVISORY BULLETIN]

PRACTICES OF BUSINESS CONSULTANTS

June 2001

INTRODUCTION

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, abuse, and waste in the Department's programs, including the Medicare and Medicaid programs, and to promote efficiency, economy, and effectiveness in departmental operations. Historically, the OIG has primarily carried out this mission through a nationwide program of audits, investigations, and inspections. More recently, the OIG has augmented its efforts to detect fraud, abuse, and waste with increased efforts to promote prevention through the issuance of guidance to the health care industry.

Providers, suppliers, and others [1] involved in the health care industry not only serve the health care needs of Federal program beneficiaries, but they also play an essential role in safeguarding the integrity of the Federal programs. As part of our commitment to working with industry, we want to alert providers to certain mar-

[1] For purposes of simplicity, the term "providers" as used in this bulletin refers to providers, suppliers, and practitioners that provide items or services payable in whole or in part by a Federal health care program.

keting and other practices used by some independent consultants that should concern providers and that may put the Medicare and Medicaid programs at increased risk of abuse. While some of the practices described in this bulletin may not themselves rise to the level of fraud and may not be illegal in all cases, all of the practices increase the risk of abuse of the Medicare and Medicaid programs. We encourage providers to recognize and protect themselves and the Federal programs against these questionable practices.

Providers use the legitimate services of consultants, such as accountants, attorneys, business advisors, and reimbursement specialists, for many *bona fide* reasons, including, for example, improving the efficiency and effectiveness of the provider's operations (including its coding and billing systems), enhancing the accuracy of the provider's claims, conserving resources through outsourcing, and ensuring compliance with applicable laws, regulations, and rules. Responsible consultants play an integral role in developing and maintaining practices that enhance a client's business objectives, as well as in improving the overall integrity of the health care system.

We believe that most consultants, like most providers, are honest and that the vast majority of relationships between providers and consultants are legitimate business activities. Unfortunately, a small minority of unscrupulous consultants engage in improper practices or encourage abuse of the Medicare and Medicaid programs. Depending on the circumstances, these practices may expose both the consultants and their clients to potential legal liability.[2] Hiring a consultant does not relieve a provider of responsibility for ensuring the integrity of its dealings with the Federal health care programs.

QUESTIONABLE PRACTICES

To safeguard themselves, providers engaging the services of consultants should be alert to the following questionable practices:

Illegal or Misleading Representations. Consultants may make illegal or misleading statements or representations about their relationship with the Medicare program, the Centers for Medicare and Medicaid Services (CMS),[3] or the OIG. For example, consultants may misrepresent that they have "inside" or "special" access to the OIG or to OIG materials. In other cases, consultants may misrepresent that their services or products are approved, certified, or recommended by Medicare, CMS, the Department of Health or Human Services, or the OIG. Such claims are misleading and potentially harmful to well-meaning providers. Illegal or misleading statements or representations include, for example:

- An educational consultant misrepresenting that its Medicare reimbursement seminars are mandatory for obtaining or maintaining a Medicare provider number. Although such training may be valuable, the Medicare program does not require a provider to attend training courses in order to participate in the Medicare program.
- A consultant misrepresenting that a provider that fails to attend its "Medicare-sanctioned" seminars will be subject to government penalties. In truth, the government does not penalize providers for such conduct.
- A consultant improperly using Federal program logos or symbols on its marketing materials.[4]

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[2] The practices described in this bulletin are illustrative, and this bulletin does not purport to identify every potentially improper practice arising from the relationship between a provider and a consultant, nor does it purport to identify every potential violation of the criminal or civil statutes. In particular, this bulletin is not intended to identify every potential violation of the False Claims Act or the Anti-Kickback Statute, although some of the practices described may contribute to, or increase the risk of, violations of these provisions. This bulletin does not address the many fraud and abuse concerns that arise from sham consulting arrangements.

[3] The Health Care Financing Administration (HCFA) is being renamed the Centers for Medicare and Medicaid Services; misuse of the eitehr the new or former name would be equally deceptive.

[4] Section 1140 of the Social Security Act prohibits the improper use of the words "Medicare", "Medicaid", "Health Care Financing Administration", "HCFA", "Department of Health and Human Services", "DHHS", "Health and Human Services", "HHS", "Social Security", "Social Security Account", "Social Security System", "Social Security Administration", "Supplemental Security Income Program", "SSI", and "SSA", and any variation on these words, as well as the symbols or emblems for the SSA, HCFA and HHS. Violations are punishable by civil money penalties of $5,000 per violation (in the case of mail solicitation or advertisement, each piece of mail constitutes a separate violation) or $25,000 in the case of a broadcast or telecast. The OIG enforces this authority.

- A consultant claiming that it is recommended by the OIG. The OIG does not recommend or endorse particular consultants or particular consultants' services.
- A compliance consultant falsely asserting or implying that it offers recognized accreditation or certification for compliance programs or compliance officers.

Promises and Guarantees. Consultants may explicitly or implicitly promise or guarantee specific results that are unreasonable or improbable. In some cases, consultants may resort to improper means to effectuate these promises or guarantees, such as submitting false claims or preparing false cost reports on behalf of a client. This misconduct potentially subjects both the consultant and the provider to liability under the False Claims Act.[5] Problematic promises would include, for example:

- A valuation consultant promising or assuring a client that its appraisal of a physician's practice will yield a "fair market value" that satisfies the client's need for a particular valuation, regardless of the actual value of the practice.
- A billing consultant promising a prospective client that its advice or services will produce a specific dollar or percentage increase in the client's Medicare reimbursements. The consultant's fee is often based on a percentage of this increased reimbursement.

Encouraging Abusive Practices. Some consultants may knowingly encourage abuse of the Medicare or Medicaid programs. In some cases, reimbursement specialists or other consultants advocate that their clients engage in aggressive billing schemes or unreasonable practices that are fraudulent or abusive of the Medicare or Medicaid programs. This conduct potentially subjects both the consultant and the client to liability under the False Claims Act. For example:

- A reimbursement specialist may suggest that a client use inappropriate billing codes in order to elevate reimbursement and may describe methods to avoid detection.
- A consultant may encourage a client to modify or customize a routine medical supply in an insignificant manner to justify billing the supply as a device that generates higher reimbursement.
- A reimbursement specialist may advise a client to bill for an expensive item or service with a high reimbursement rate when a less expensive item or service with a lower reimbursement rate was actually provided to the patient.
- A consultant may advise a client to adopt a patently unreasonable interpretation of a reimbursement law, regulation, or rule to justify substantially greater reimbursement.
- A consultant may promise to increase Medicare revenues for laboratory services by showing its clients how to disguise double billings and claims for medically unnecessary services.
- A consultant may suggest the creation of deceptive documentation in order to mislead potential reviewers.

Discouraging Compliance Efforts. Some consultants may make absolute or blanket statements that a client should not undertake certain compliance efforts (such as retrospective billing reviews) or cooperate with payor audits, regardless of the client's circumstances. As reflected in the OIG's compliance guidances,[6] the OIG believes that voluntary compliance efforts, such as internal auditing and self-review, are important tools for doing business with the Federal health care programs. Left undetected and, therefore, unchecked and uncorrected, improper billing or other conduct may exacerbate fraud and abuse problems for a provider in the future.

CONCLUSION

Consultants who abuse their position of trust pose a risk to their provider clients, to the Federal health care programs, and to themselves. While most consultants are honest and provide valuable services to their clients, a small minority engage in questionable practices or promote abuse of the Federal health care programs. In general, if a consultant's advice seems too good to be true, it probably is. We urge providers to be vigilant and to exercise judgment when selecting and relying on consultants.

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[5] The False Claims Act ascribes liability only where the party knows or acts with reckless disregard or deliberate ignorance of the falsity of the claim.

[6] The OIG's compliance guidances are available on our webpage at http://www.hhs.gov/oig.

COMMUNICATIONS

STATEMENT OF THE NATIONAL ASSOCIATION OF HEALTHCARE CONSULTANTS

[SUBMITTED BY REBECCA ANWAR, PH.D., PRESIDENT]

Let me take this opportunity to express my sincere appreciation to the Senate Finance Committee for asking us to present a statement as it relates to consultants who advise physicians. I am pleased that you have given us the opportunity to discuss our organization's experience via its broad national membership representation.

The National Association of Healthcare Consultants was formed to bring together a number of consulting groups. Its history involves members from organizations that were in existence since 1932. It evolved as an organization designed to facilitate highly regarded professionals, focused on service to the healthcare market on a wide array of business issues, with the opportunity to share experiences and learn from one another. The Association promotes education and a number of members are certified healthcare consultants and/ or carry other certifications through other professional organizations.

Attached to this document is a copy of the Association's bylaws and code of ethics. Members are required to demonstrate that they both meet and are willing to continue to abide by the association's bylaws and ethics standards.

We appreciate that the Senate Finance Committee has concerns regarding consultant coding advice to physicians and other provider groups. The issue of physician and provider billing is a complex one. Practicing physicians receive information on coding and billing from a number of sources. Information is provided by medical societies, Medicare, Medicaid, and other payers. In addition, there is the Internet and listserv resources, as well as publications such as magazines, newsletters, and books. There are also companies that offer seminars on coding and reimbursement.

A number of members offer coding advice to physicians, either directly or through other individuals in their firms. We state unequivocally that, to the best of our knowledge, there has never been a complaint received by the Board of Directors or Association headquarters by a member consultant or by a provider (physician, non-physician provider, or otherwise) regarding coding advice.

Billing for medical services is, probably, the most complicated and highly regulated form of invoicing that exists in the United States. Many of our members assist physicians with meeting these arduous billing guidelines as well as other compliance standards. In fact, the physicians are requesting these services. The objective of a consultant should be to have the physicians consistently implement work procedures that are compliant with reimbursement related rules and regulations.

Existing legislation such as HIPAA, Fraud and Abuse regulations, and the tools provided to the Office of the Inspector General, incorporate significant penalties and recourse. They are of great concern to physicians and their staff. Advisors in the billing arena including consultants and billing service companies are equally preoccupied and focused on the issues.

Many of our members have expressed concern that clients are considering leaving the Medicare or Medicaid program, or "opting out" of other payer arrangements due to the high degree of regulatory risk, even when "innocent mistakes" are made. We do not think it is the intent of the Federal government to reduce access to care.

Change is expensive. The National Correct Coding Initiative provides billing information and changes quarterly. Medicare carriers may change guidelines on an even more frequent basis. Additionally; Medicare carriers vary from State to State on their interpretation of the rules. They also have latitude, in some cases, to make their own roles.

Private insurance carriers make their own rules, sometimes in conflict with the coding standards established by the American Medical Association.

Studies by Medicare and other payers indicate that if physician's coding is evaluated according to the services actually rendered and medically indicated, the physicians are under coding. When physicians implement comprehensive documentation for service rendered, the payers should expect to see an increase in payments. Consultants are being asked by physicians to assist with documentation education and methods to make the task easier.

As a body of consultants, we support the importance of correct coding. However, we do not believe that the current complexities of coding result in significant overpayments to physicians.

The Association offers the following recommendations:

1. Standardize coding guidelines by requiring payers to:
   a) Implement coding policies that are consistent with the standards established by the American Medical Association.
   b) Communicate coverage and payment policies to physicians and patients.
   c) Inform providers of limitations in covered services including specific conditions and/or frequency of services.
   d) Provide reference and training materials relevant to coverage and payment policies.
2. Use HIPAA regulations to achieve compliance with the standardized guidelines.
3. Use the existing enforcement rules within the Office of the Inspector General to ensure compliance with coding and billing related rules and regulations.

We thank you for the opportunity to supply information as it relates to our membership and some of their experiences in the billing and coding arena. We apologize that the short notice we received did not allow for sufficient time for a consultant representative to rearrange their schedule to appear before you. We would certainly welcome future contact with the Committee as it relates to this or other issues.

Attachment.

NATIONAL ASSOCIATION OF HEALTHCARE CONSULTANTS

BYLAWS

As Amended:
June 17, 1995
June 21, 1996
June 26, 1998
June 22, 2000
Oct. 27, 2000

ARTICLE I

NAME

The name of this organization shall be the "National Association of Healthcare Consultants."

ARTICLE I

PURPOSE AND MISSION

The purpose for which the Association is formed shall be:

1. To provide group association for those interested in and qualified to render business management and consulting services to the Healthcare professions in an ethical and professional manner;
2. To develop among Association members the broadest possible interpretation of the need for our services by the professions, and to promote such services through publications and associations;
3. To develop a better understanding on the part of the healthcare professions of the aims and objectives of Association members;
4. To promote greater proficiency in professional business management and consultant services through the voluntary exchange of scientific and educational ideas, information and operating experiences and by special programs;
5. To gain the benefits and inspiration of an association among members based on mutual respect, full cooperation, and ethical consideration of our business and personal relations with each other;
6. To actively encourage its members to become Certified Healthcare Business Consultants and to promote the designation among the professions we serve. To this

end, the Association will provide education and training to assist members in fulfilling the requirements of certification and provide support and funding for the Certification Committee.

ARTICLE III

MEMBERSHIP

Section A. Classes of Membership

The Association shall be composed of Fellow, Active, Affiliate, and Life Members.

1. **Fellow Members**: Individuals who have met and continue to meet the requirements for and have been voted to Active Membership. In addition, they will be required to have been Certified by the Institute of Certified Healthcare Business Consultants as well as complete fifty (50) hours of Active Continuing Professional Education every two years. Fellow Members shall have the right to participate and vote in all Annual and special meetings of the Association.

2. **Active Members**: Active Members shall complete fifty (50) hours of Active Continuing Professional education every two (2) years; attend one Association sponsored meeting every three (3) years; have spent at least 75 percent of gainful employment time engaged in professional business management or consulting services for healthcare professionals for at least the preceding two (2) years at the time of initiation to Active Membership; have demonstrated competency in this field; and have been in compliance with the Code of Ethics and Rules of Professional Conduct of this Association. Active Members shall have the right to participate and vote in all Annual and special meetings of the Association. Active Members who fail to meet the meeting attendance requirement at any time shall automatically become Affiliate Members until that requirement is again met.

3. **Affiliate Members**: Individuals who are engaged in the business of providing professional business management or consulting services for healthcare professionals, and who otherwise do not choose to be considered as a candidate for Active Membership and/or who do not meet all or some of the eligibility requirements for Active Membership shall be eligible for Affiliate Membership. Affiliate Members shall not have the right to vote in any Annual or special meetings of the Association, nor serve on the Association's Board of Directors, but are otherwise entitled to the rights and privileges of Active Membership, except that they shall not be permitted to display the association logo on letterhead, correspondence and similar materials.

4. **Life Members**: Individuals who are no longer engaged in the business of providing professional business management or consulting services for healthcare professionals, and who otherwise meet the eligibility requirements for Fellow and Active Membership, and have served the Association and have held membership for over eight years shall be eligible for Life Membership. Life Members shall be entitled to attend annual meetings and special meetings, but they shall not be entitled to vote. Service years in SPBC, PM Group, SMD, and ICHBC shall be credited to members of these organizations who joined the Association prior to July 1, 1997.

Section B. Admission to Membership

1. **Eligibility for Membership**: All Members shall accept and abide by these Bylaws in their entirety, and shall accept the Code of Ethics currently in effect and as they may be amended from time to time. The status of membership shall be conclusive evidence thereof and shall be contingent thereon.

2. **Proposal of Candidates**: Prospective Members shall make application in the form and manner prescribed by the Board of Directors.

3. **Election to Membership**:

a. Fellow, Acts and Life Members shall be elected by a majority vote of the Voting Membership attending an annual meeting, pursuant to Article VIII, Section E, of these Bylaws. b. Affiliate Members shall be granted membership upon review and approval of application by the Secretary or his/her designee.

Section C. Retention of Membership

Continued membership status is contingent upon payment of annual dues and meeting such other requirements as are specified in Article III, Section A of these bylaws.

Section D. Changes in Membership

1. **Resignations**: Any Member who is not in arrears in any financial obligation and is in full compliance with all membership requirements may resign in good standing. Resignations shall be made in writing to the Secretary.

2. **Termination for Cause**: A membership may be terminated by three-fourths vote of the Board of Directors upon finding of cause. No member shall be terminated

for cause without having first been notified in writing of the reasons therefore and afforded an opportunity for a hearing before the Board of Directors.

3. **Reinstatement**: A Member who has resigned while in good standing may be reinstated within three years by a majority vote of the Board of Directors.

ARTICLE IV

DUES

Section A. Annual Dues

1. **Amount**: The Board of Directors may establish annual dues and assessments for each class of Members in such amounts as may be deemed appropriate to defray expenses and to establish and maintain reserves of the Association.

2. **Payment**: Annual dues are payable as determined by the Board of Directors. The Board of Directors shall have the authority to establish appropriate delinquency fees. Members whose dues are three months delinquent shall have their membership terminated automatically. In cases of hardship and upon written application from a Member to the Board of Directors, the Board may make other arrangements.

3. **Resignations**: A resigning member shall remain liable for all unpaid dues and assessments for the full fiscal year in which the resignation took place, unless the effective date of resignation occurs within 30 days after the commencement of the fiscal year.

Section B. Initiation Fees

The Board of Directors may establish initiation fees for all classes of membership. These fees will be in addition to the dues regularly assessed to members.

Section C. Reinstatement Fee

The Board of Directors may establish reinstatement fees for all Classes of Membership.

ARTICLE V

BOARD OF DIRECTORS

Section A. Eligibility

Voting Members shall be eligible to become members of the Board of Directors.

Section B. Nomination

The Nominating Committee shall present a slate of candidates to fill vacancies on the Board of Directors. The slate shall be provided to the entire membership of the Association at least 30 days before the Annual Meeting. Nominations may be made from the floor at the Annual Meeting.

Section C. Election

Provided the number of nominees does not exceed the number of vacancies, the Board of Directors may be elected by a majority vote of Voting Members by the adoption of a slate presented by the Nominating Committee. In the event that the number of nominees (whether on the slate or from the floor) exceeds the number of directors to be elected, the election shall be by secret ballot. Each voting Member present in person or by proxy shall be entitled to the same number of votes as the number of directors to be elected, but cumulative voting shall not be allowed. Those nominees receiving the most votes and a majority vote shall be elected. In the event that fewer nominees receive a majority vote than there are seats to be filled, an additional ballot or ballots shall be held until each seat is filled by majority vote. In the event of a tie between two or more nominees for the last available seat, a runoff balloting among only such nominees shall be held until such tie is resolved. Board Members shall assume their duties at the close of the Annual Meeting at which they are elected.

Section D. Term and Composition

1. The term of office shall be three years or until such time as a successor has been duly elected and installed, except that the Officers and the Chairman of the Certification Committee, shall serve one year terms. The terms of the directors other than the Officers and Chairman of the Certification Committee shall be staggered.

2. The Board of Directors shall be comprised of the Officers, nine elected voting Members, and the Chairman of the Certification Committee.

Section E. Duties

The Board of Directors shall have full authority to direct the operation of this Association. Consistent with these Bylaws, the Board shall determine all policies of this Association and prescribe its various functions. The Board may appoint, delegate authority to, and reasonably compensate an executive director and/or executive secretary or any other agent.

Section F. Vacancies

Vacancies on the Board may be filled by majority vote of the remaining members of the Board of Directors. Persons so elected shall serve for an unexpired term or until their successors are elected and installed.

Section G. Removals

A Director may be removed by a two-thirds vote of the voting membership at an annual or special meeting of the membership.

Section H. Meetings

The Board of Directors shall meet at the Annual Meeting of the Association, and at such other times as may be deemed appropriate or necessary by the President with the approval of a majority of the Board.

Section I. Executive Committee

There shall be an Executive Committee as defined in Article VI, Section A, which shall have the power of the Board of Directors between meetings of the Board except in matters of removal of a member, officer, or director. The Executive Committee shall hold a meeting whenever deemed necessary by the President. The minutes of the meetings of the Executive Committee shall be mailed to members of the Board of Directors within two weeks and shall be submitted to the Board of Directors for acceptance at its next meeting.

Section J. Quorum

A majority of the Board of Directors shall constitute a quorum. A majority of the members of the Executive Committee shall constitute a quorum.

Section K. Referendum

Notwithstanding any authority granted to the Board of Directors by these Bylaws, and subject to any limitation or restriction imposed by law, a referendum may be initiated by any five voting Members of this Association. Upon proper evidence of notification to all Voting Members of the Association, and upon proper evidence that a majority of the total Voting membership affirms the proposed resolution, by whatever method of voting and at whatsoever time, then such resolution shall be considered an action of the Board of Directors and shall be executed by the Board of Directors.

Section L. Interested Director

Directors shall conduct themselves in accordance with the best interest of the Association. However, no transaction between the Association and any individual Director, or any firm in which he or she may have an interest by way of ownership, employment or otherwise, shall be voidable solely because of such interest, provided that the Director's interest is fully disclosed to or otherwise known by the Board of Directors. Any interested Director shall abstain from voting on any matter in which the Director has an interest.

ARTICLE VI

OFFICERS

Section A. Composition

The officers shall consist of a President, a President-Elect, a Secretary-Treasurer, and an Immediate Past President. They shall constitute the Executive Committee and shall be ex officio voting members of the Board of Directors.

Section B. Election

1. The officers shall be elected by the Voting membership for a term of one year or until their successors are elected and installed. A vacancy among the officers shall be filled by the Board of Directors for the unexpired term or until their successors are elected and installed. The officers shall assume their duties at the close of the annual meeting at which they are elected. In order to be elected an officer, an individual must be a current member of the Board of Directors.

2. The Chairman of Certification Committee cannot concurrently hold the office of President or President-Elect.

Section C. Duties

1. **President**: The President shall be the executive officer of the Association, shall preside at meetings of the Association, Board of Directors and Executive Committee, is an ex-officio member of all committees, and shall perform such other and further duties as may be determined from time to time by the Board of Directors. The President shall, with the approval of the Board of Directors, appoint committees not otherwise provided for.

2. **President-Elect**: The President-Elect shall assist the President and assume the duties of the Presidency in the absence of the President. The President-Elect is an ex-officio member of all committees, and shall perform such other duties as may be determined from time to time by the Board of Directors.

3. **Secretary-Treasurer**: The Secretary-Treasurer shall see that the minutes of meetings for the Association, the Board of Directors, and the Executive Committee are maintained, that a file of essential records of the Association is maintained, that all dues and assessments are received, and that all payments are made in accordance with the budget or the direction of the Board of Directors. The Secretary-Treasurer shall see that full and accurate accounts are maintained and that financial statements are presented at the Annual Meetings of the Association and of the Board of Directors, shall annually review the books of account and report to the Board of Directors, and shall perform such other duties as may be determined from time to time by the Board of Directors.

4. **Immediate Past President**: Duties include attending all Board of Directors and Executive Committee meetings acting in an ex officio and advisory capacity.

Section D. Removal

An officer may be removed from office by a three-fourths vote of the entire Board of Directors, or two-thirds vote of the entire membership by referendum or a two-thirds vote of those attending an annual or special meeting of the membership.

ARTICLE VII

COMMITTEES

Section A. Committees and Responsibilities

The standing Committees and Sub-Committees shall be:

1. Certification Committee:

The Certification Committee shall be responsible for encouraging the certification of Members by the Institute of Certified Healthcare Business Consultants. The Chairman of the Certification Committee shall be appointed by the Executive Committee of the Association from among the members of the Institute of Certified Healthcare Business Consultants, Inc., who are also members of the Association.

2. Membership Services Committee: This committee shall identify and recommend such services that might be appropriate to advance the purpose and mission of the Association.

3. Membership Committee:

The Membership Committee shall be responsible for identifying and recommending candidates for Active Membership.

a. Ethics Sub-Committee:

The Committee shall review any ethics complaint filed by a member and make a recommendation to the Board.

4. Bylaws Committee:

The Committee on Bylaws shall advise the Board of Directors on the interpretation of the Associations Bylaws (but the Board of Directors shall have final authority to interpret the Bylaws with the advice of legal counsel) and shall appoint a parliamentarian for each Annual Business Meeting whose decisions as to procedure shall be final.

5. Nominating Committee:

The Nominating Committee shall:

a. Present a slate of nominees to fill anticipated vacancies on the Board of Directors in accordance with Article V, Section B.

b. Present a slate of officers to the Board of Directors in accordance with Article VI, Section B.

c. Nominate at large 2 members at the Annual Meeting each year to serve on the Nominating Committee the following year. Additional nominations can be made from the floor.

d. Select and contact nominees.

e. Make certain that all nominees are eligible and willing to serve, and also are willing to serve as President or other officer, if elected.

f. To develop guidelines, policy, and procedure to be approved by the Board as needed.

The Nominating Committee will be composed of 5 members: the Immediate Past President, the President, the President-Elect, and two other Members elected by the membership at the Annual Meeting. The Immediate Past President will serve as chairperson.

6. Planning Committee:

The Committee on Planning shall consist of the President-Elect, who shall be its Chairperson, the Chairpersons of all Committees, Sub-Committees, Ad Hoc Committees, and the Association's Executive Director. The Committee on Planning Shall:

a. Develop, maintain and monitor a long range plan for the Association's activities.

b. Provide advice and recommendations to each other Committee and Subcommittee of the Association with respect to actions, which may conflict with such long range plans.

c. Develop and monitor the Association's annual budget in concert with the Secretary-Treasurer.

7. Education Committee:

The Committee on Education shall 1)establish educational goals andpriorities for the Association and its Membership; 2) ascertain and monitor past educational program acceptance; 3) obtain objective criteria of Members' current educational interest; and 4) monitor, approve and report to the Executive Committee on the activities of the Sub-Committee on Educational Meetings. The Chairman of the Certification Committee shall be an ex officio Member of the Education Committee.

8. Finance Committee:

The Finance Committee shall be responsible for recommending and monitoring the annual budget of the Association. The Finance Committee shall consist of, but not be limited to, the SecretaryTreasurer as chair and the President-Elect.

9. Marketing Committee:

The Marketing Committee shall develop and recommend programs to inform and promote the Association to potential clientele. The Marketing Committee will also inform non-members about the Association and promote the Association to other peer professionals.

The Committee will be responsible for liaison activities between the Association and other organizations or groups.

10. Vendor Committee:

The Vendor Committee shall be responsible for the following:

a. Developing and maintaining mutually beneficial relationships with those companies that sell good and reputable products and services to the clients of the Association's members.

b. Invite those vendors identified above to display their goods at meetings of the Association.

c. Coordinate the necessary activity between the vendors exhibiting at the meetings and the meeting planners.

d. Determine the appropriate means and fees for vendors exhibiting at the Association's meetings.

e. Always be diligent that all of the relationships are appropriate in fact and in appearance to all who may view them.

11. Statistics Committee:

The Statistics Committee shall be responsible for the following:

a. Facilitating the gathering of data from the members.

b. Determining the design, scope and format of the statistics reports.

c. Set policy regarding the statistics cost, and determine what is appropriate and nonappropriate use of the statistics by members and non-members.

d. Select and work with the individuals, staff and or vendor(s) that will produce the statistics.

Section B. Appointment & Election of Committee Members

With the exception of the Executive, Finance, Nominating, and Certification Committees, committee members and Chairs shall be appointed by the President with the approval of the Board of Directors.

Section C. Special Committees

The President may appoint special committees with the approval of the Board of Directors.

Section D. Governance

Committees shall be subject to policies and procedures approved by the Board of Directors.

ARTICLE VIII

MEMBERSHIP MEETINGS

Section A. Annual Meetings

The Annual Meeting shall be held at such time and place as the Board of Directors may d direct direct.

Section B. Special Meetings

Special meetings of the Association may be held at the call of the President if approved by a majority of the Board of Directors, or by referendum of the Voting Membership in accordance with Article V, Section K of these Bylaws.

Section C . Other Meetings

The Association may sponsor programs, seminars, and other educational meetings.

Section D. Quorum

Thirty-five percent (35%) of the Voting Members of the Association present in person or by proxy shall constitute a quorum for the transaction of business.

Section E. Proxies and Voting

Voting Members of the Association shall be the Fellow and Active Members present in person or by proxy. They shall be entitled to one vote. A majority vote of the Voting Members present and voting shall decide all questions and proposals presented to any meeting, unless otherwise provided in the Bylaws, except that reversal of any Board of Directors action shall require a twothirds vote of those present and voting. Affiliate and Life members shall have no vote.

Section F. Notice

Written notice of the meetings shall be given not less than 5 days and not more than 60 days prior to the meeting.

ARTICLE IX

FISCAL YEAR

The fiscal year of the Association shall be the twelve months ending March 31 of each year.

ARTICLE X

INDEMNIFICATION

Each person who has been, now is, or hereafter shall be a member of the Board of Directors or an officer of this Association, shall be indemnified by the Association to the extent of its treasury funds and available insurance coverage, unless otherwise prohibited by law, against all expenses reasonably incurred in connection with any action, suit, proceeding, or the settlement or compromise thereof, or payment of any judgment or fine resulting therefrom, in which the member may become involved by reason of any action taken or omitted to be taken by the member in either such capacity, provided that such action was taken or omitted in good faith. It shall be a mandatory requirement that the Association purchase Directors and Officers Liability Insurance.

ARTICLE XI

DISSOLUTION

Any decision to dissolve the Association shall be made in accordance with the Law of the State of Incorporation and shall require a two-thirds vote of the voting members at a meeting called for that purpose.

Upon the dissolution of the Association, the Board of Directors shall, after paying or making provision for the payment of all the liabilities of the Association, dispose of all of the assets of the Association exclusively for the purpose of the Association in such manner, or to such organization or organizations as shall at that time qualify as an exempt organization or organizations under Section 501 (c) of the Internal Revenue Code of 1986, as amended (or any future United Sates Internal Revenue Law), as the Board of Directors shall determine.

ARTICLE XII

AMENDMENTS AND RULES OF ORDER

Section A. Amendments

These Bylaws may be amended by a two-thirds vote of Voting Members present in person or by proxy at any Annual or special meeting of the Association, providing the proposed amendment shall have been submitted in writing to all Voting Members of the Association not less than 15 days prior to the meeting at which they are to be introduced.

Section B. Rules of Order

"Robert's Rules of Order Newly Revised" shall be the parliamentary authority governing the proceedings by this Association in all cases not provided for in these Bylaws.

CODE OF ETHICS

1. INTRODUCTION

Ethical conduct is the hallmark of any profession. The National Association of Healthcare Consultants recognizes the responsibility of each member to the public and emphasizes their further responsibility to clients and colleagues, since behavior in those relationships has a direct effect upon the reputation of the profession as a whole. The Association Code of Ethics establishes minimum levels of acceptable professional conduct.

II. CODE OF ETHICS

- **INTEGRITY**

  A member shall offer and perform services in the field of healthcare business management in an honest and forthright manner. A member shall disclose to clients all information material to their professional relationships. A member shall disclose actual or potential conflicts of interest to clients before services rendered. A member shall not solicit through false or misleading statements or advertising.

- **OBJECTIVITY**

  A member shall exercise reasonable and prudent professional judgment in the best interests of the client. Members shall not subordinate their judgment to others nor seek to exploit a client relationship for personal advantage.

- **COMPETENCE**

  A member shall perform in an efficient and reasonable manner as recognized by the field of health care business management. Members shall keep abreast of current developments in the field and seek to improve their competence in all areas of service in which engaged. Members shall offer advice only in those areas in which they have expertise.

- **FAIRNESS**

  All transactions between the member and the client shall be fair and reasonable to both parties. Members shall perform their services in the best interests of their clients and consistent with responsibilities to the public. Members shall treat the property of their clients with full fiduciary care and responsibility.

- **CONFIDENTIALITY**

  A member shall not disclose, unless required by law, any confidence obtained in the course of a professional client relationship without the consent of the client.

- **PROFESSIONALISM**

  A member shall act in a manner which will reflect credit upon the professional and promote harmony among its members.

THE NATION'S NEWSPAPER
USA TODAY
NO. 1 IN THE USA

Wednesday, June 27, 2001

Caught on tape: Docs learn to pad bills

Panel will investigate rule-skirting seminars

By Kevin McCoy
USA TODAY

Intensifying a crackdown on health care fraud, congressional investigators are targeting a cottage industry suspected of coaching doctors to boost income by overcharging federal and private health insurers.

Secret audiotapes to be played at a Senate Finance Committee hearing today depict consultants at three seminars advising doctors on techniques to circumvent health insurance regulations. Investigators suspect the sessions, held in the Washington area since July, are symptomatic of a growing problem.

Transcripts provided to USA TODAY show instructors advising doctors how to:

- Bill insurers for care that was either not provided or was administered at lower cost by assistants.
- Cut caseloads of patients with lower-paying federal insurance for the poor and elderly by limiting their appointment times.
- Ignore federal rules that require them to report Medicaid or Medicare overpayments.

"I think it's outrageous that we would have people going around and showing health care providers how to bill for services that were never rendered," said Sen. Chuck Grassley, R-Iowa, who requested the undercover operation by the General Accounting Office, the investigative arm of Congress.

One taped example raising concern involves a consultant who outlined the theoretical case of "a little 2½-year-old terrorist" with hyperactivity and other relatively common ailments.

The child's multiple symptoms represent a higher billing opportunity, the instructor was recorded as advising.

"It buys the beer. You know, it's worth doing."

The evidence is alarming enough that federal health officials today are to issue a special advisory that warns doctors about insurance claims. Those who act on improper billing advice risk prosecution and fines.

Grassley, the ranking minority member of the Finance Committee, and Sen. Max Baucus, D-Mont., the panel chairman, also will ask the Department of Health and Human Services (HHS) to investigate the companies that ran the seminars and check insurance records of doctors who attended for billing violations.

The investigation provides a rare inside look at suspected tactics that investigators say might contribute to billions in improper claims.

Health care industry fraud totaled $54 billion nationwide in 1997, including $34 billion from Medicaid and Medicare, according to the most recent estimates by the Coalition Against Insurance Fraud. While characterizing most medical insurance consultants as honest, Michael Mangano, acting HHS inspector general, says some "are pushing the envelope."

Contributing: Julie Appleby

▸ How the seminars work, 3B

USA TODAY · WEDNESDAY, JUNE 27, 2001 · 3B

Seminars teach doctors to play insurance game for profit

By Kevin McCoy
USA TODAY

▸ Secret tapes to be played today, 1A

Gathered in the boardroom of the Medical Society of the District of Columbia, a group of about 20 doctors listened as a consultant lectured on one of the hot topics in American medicine: "How to Run a More Profitable Practice."

In return for their $265 attendance fees, the physicians heard about ideas not found in the Hippocratic oath:

▸ Boosting insurance income by filing claims for services that were never provided or that were performed by lower-paid assistants.

▸ Limiting caseloads of lower-paying Medicare and Medicaid patients by "rationing" appointments.

▸ Ignoring federal rules that require reporting of Medicare and Medicaid overpayments.

It was the type of alleged insurance billing gamesmanship that federal health officials say they have long suspected but rarely proved. Only this time, a doctor working with an undercover staffer from the General Accounting Office (GAO), Congress' investigative arm, secretly got it all on tape.

Transcripts were provided to USA TODAY in advance of a Senate Finance Committee hearing today that is to demonstrate how a cottage consulting industry may contribute to billions in improper insurance payments.

Senate staffers and federal investigators say the virtual absence of regulations governing medical business consultants has enabled the firms to coach doctors on potentially questionable insurance billing techniques.

The experts are concerned that such instruction may be on the rise even as tougher monitoring has reduced improper payments from some insurance plans, including Medicare.

"There's a whole industry out there of hundreds of companies advising doctors, and odds are that within that industry there are some companies that cross the line," says William Mahon, executive director of the National Health Care Anti-Fraud Association.

Senate staffers say Dr. Kathryn Locatell, a California geriatrician concerned about health insurance overcharges, brought the GAO investigator to three seminars in the Washington, D.C., area since July.

"We're not paid for seeing patients; we're not really paid for taking care of patients," the hidden recorder taped one instructor as saying. "We get paid by knowing what codes we submit to describe the services, and that's where the money is at."

During one seminar, an instructor readily agreed when Locatell said the session's theme was circumventing insurance rules with creative documentation. "That's right. That's the thing. Build a better mousetrap," the transcript shows the instructor replied.

Discussing ways to cut Medicare and Medicaid caseloads, an instructor outlined a strategy labeled as "somewhat discrimination."

"We don't want them taking the best appointment slots. So they get scheduled only 10 to 11:30 in the morning, and 2 to 3:30 in the afternoon," the instructor said.

One instructor also advised doctors to consider following the example of medical colleagues who ignore federal regulations that offer leniency to those who voluntarily report insurance overpayments.

Many doctors "are changing their behavior and keeping their mouths shut" about excess reimbursements, the transcripts show the consultant said.

Citing potential legal liability, Senate staffers declined to identify the consulting companies and instructors. However, USA TODAY independently learned that Conomikes Associates, a California firm that charges doctors about $250 each for its workshops, held one of the seminars at the Medical Society of the District of Columbia.

CEO George Conomikes says his company has never coached doctors to use improper insurance billing techniques.

"Our role in workshops is not to tell you what to do but tell you what we see happening (at doctors' practices) around the country, and then it's up to you," Conomikes says.

Conomikes says insurers, including Blue Cross-Blue Shield, raised no concerns after executives attended several of the seminars.

A spokesman for the Medical Society of the District of Columbia said it would study evidence from the hearing before commenting.

Contributing: Julie Appleby

Improper payments cut

Federal health officials say more vigilant monitoring of Medicare reimbursements has cut improper payments nearly in half since the mid-1990s:

Fiscal year	Estimated improper payments (in billions)
1996	$23.2
1997	$20.3
1998	$12.6
1999	$13.5
2000	$11.9

Source: Department of Health and Human Services Office of Inspector General

By Frank Pompa, USA TODAY