Medical McCarthyism: Medicare, teaching hospitals, and charges of health care fraud

Real fraud cannot be tolerated, but spurious fraud charges are equally intolerable

FOR MANY YEARS the village of Linndale, Ohio, ran a lucrative speed trap on a stretch of Interstate 71 that passes through this small village of 159 citizens. The speed trap was notorious for several reasons.

First, the stretch of interstate that ran through Linndale is just 440 yards long. Second, since there is no entrance to or exit from I-71 in Linndale, the police who staff the speed trap must actually leave the village to get into position on the freeway. Third, the money generated from the speed trap accounted for from 70%[1] to 91%[2] of the total village budget. Finally, Linndale was planning to build a jail with proceeds from the speed trap. The village didn't need a jail to house its own prisoners; rather, the plan was to rent out cells to other communities with overcrowded jails as an additional fund-raising ploy.

In 1994 outrage over this activity resulted in the passage of a law by the Ohio General Assembly prohibiting operation of the speed trap. The legislation's sponsor was quoted as saying, "The Ohio General Assembly does not believe the criminal code should be used as a fund-raising tool..."[3] Unfortunately, the Court of Common Pleas did not agree, and in January 1997 the law was overturned allowing the speed trap to be reinstituted.[4]

HEALTH CARE FRAUD INVESTIGATION AS A FUND-RAISING TACTIC

But the issue of whether a primary purpose of the criminal justice system should be fund-raising is relevant in health care today. Recent regulations defining fraud and abuse related to Medicare payments are crafted in such a way as to render some common practices in hospitals, particularly teaching hospitals, newly and retroactively illegal. A case in point is that of the Physicians At Teaching Hospitals (PATH) audits, authorized by the Office of the Inspector General (OIG) of the Department of Health and Human Services, which specifically target academic medical centers.

In Philadelphia the first of these audits identified deficiencies in record-keeping that cost the University of Pennsylvania $30 million and Thomas Jefferson College of Medicine $12 million. (The latter got off easy because, seeing the OIG juggernaut coming, they essentially turned themselves in.) PATH auditors judged the medical records inadequate to justify the bills that were issued, and the universities were made to refund the charges, with a threefold penalty in the case of the University of Pennsylvania and double in the case of Thomas Jefferson. This money is in part used to fund further audits. At least 33 other PATH audits are currently underway, and more are planned.

Were the charting deficiencies and billing errors deserving of the pejorative term "fraud" in these cases? From the outside it is hard to tell, but we are skeptical, and we believe that the standard now being applied is one that few institutions can meet.

At issue is the documentation of patient care performed by residents and overseen by

attending physicians—and what level of documentation is needed to meet Medicare billing standards. Is a simple cosigning of the chart by the attending physician adequate documentation, or is something more extensive needed?

THE SWIRL OF CHANGING FEDERAL RULES

Many of the OIG's claims of fraud and inadequate documentation are being made based on regulations issued in 1996, which "clarify" instructions issued 27 years ago. The "clarified" 1996 regulations require that a specific statement be in the medical records attesting to the fact that the attending physician was physically present during the billed event. Before those regulations were published last year, there was widespread confusion about the extent of documentation required.

The federal government has created a speed trap, but the speeding was done before the limits were set

During the time period currently under investigation by the OIG (which can go back up to 6 years prior to the start of the audit, ie, to 1991 for audits beginning this year), some Medicare insurance intermediaries (private insurers who administered the Medicare program in different states and regions) tried to clarify the documentation requirements. In some cases, they issued guidelines that conflict with the 1996 regulations. However, some Medicare intermediaries in other states issued no "conflicting" guidelines. Others issued no guidelines at all.

Amid this swirl of shifting instructions, guidelines, clarifications, and regulations, the government is enforcing the 1996 regulations retroactively, as if the institutions should have anticipated the rules that ultimately materialized. When the OIG found that the University of Pennsylvania and Thomas Jefferson documentation did not meet the 1996 standards, they charged fraud and levied penalties accordingly. The federal government has created a speed trap of sorts, but in this case, the alleged speeding was done before the speed limits were set. Even Linndale didn't go that far.

Adding to the controversy surrounding the PATH audits, where conflicting guidance was issued by the intermediaries and the targeted institutions can produce proof of it, the audits were discontinued.[5] This has occurred at 16 institutions. However, the OIG has refused to reveal which institutions these are and where they are located.

The American Association of Medical Colleges has expressed doubts about the validity of the PATH audits. The House Committee on Appropriations recommended that they be suspended until the General Accounting Office completes its study;[5] nonetheless, the audits are proceeding.

TEACHING HOSPITALS NOT THE ONLY TARGET

Should clinicians worry if teaching hospitals are the subject of the OIG's wrath? There is a good chance this form of governmental fundraising will in the future target physicians and many other health care providers as well as teaching hospitals.

Investigations of billing for services not rendered or not reimbursable, kickbacks, and improper physician referrals to entities in which the referring physician has a financial interest (eg, an MRI facility in which the physician is a partner) will come under investigation as well. Home health services will also be scrutinized.[6] The OIG is opening six new offices this year and eight more next year to pursue these investigations.[7] The effort is named Operation Restore Trust. While the OIG's lavish estimates of the extent of fraud that exists in the system may seem shocking—about 24% for health care delivery in general and up to 40% in home health care—it is probably prudent to reserve judgment about the fairness of these audits until more investigations have been completed and it becomes clearer what standards of fraud are to be applied.

The money to be generated by these investigations is anticipated to be astronomical, and, because of that, the motivation to call a halt, or at least take a hard look in the interests of fairness may be lacking. Indeed, HCFA Administrator Bruce Vladek recently boasted that "...besides Operation Restore Trust's 23-to-1 return, the Medicare Integrity program is saving $14 for every $1 spent by making sure Medicare payments are appropriate..."[8] If such a statement of monetary

motives were found in a hospital's records by the OIG, it would be considered prima facie evidence of nefarious intent.

Nonetheless, it will not serve us well in the long run to unfairly debase the reputation of the whole health care system in a McCarthy-like atmosphere. Real fraud cannot be tolerated, but intimidating providers with spurious charges of fraud as part of a fund-raising scheme is equally intolerable. Someone, especially Congress, needs to be watching the watchers.

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1997 REVIEWERS

We thank those who reviewed manuscripts submitted to the *Cleveland Clinic Journal of Medicine* for the year ending September 30, 1997. Reviewing papers for scientific journals is an arduous task and involves considerable time and effort. We are grateful to these reviewers for contributing their expertise this past year.—*John D. Clough, MD, Editor-in-Chief.*

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