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Feds train 10,000 elderly as Medicare fraud spies

American Medical Association says program pollutes integrity of doctor-patient relationships

Last week, at locations across the country, more than 10,000 senior citizens got their marching orders from HCFA and the FBI: Scrutinize any Medicare billing information you receive, grill your physician if something seems fishy, and rat him or her out to the feds if the answers you get don't add up. The reward for this detective work? At least $1,000 per case.

The Chicago-based American Medical Association (AMA) has led the charge against the program, which received strong support from the American Association of Retired Persons (AARP) in Washington, DC. While stressing that the organization doesn't tolerate "genuine fraud," AMA president **Nancy W. Dickey**, MD, says that understanding the difference between fraud and a simple mistake is tough enough for the experts. Elderly amateur gumshoes with reward money on their minds could clog the system with invalid tips and ill-advised lawsuits.

"This is a big problem," says **Vicki Myckowiak**, JD, an attorney with Steinberg, O'Connor, & Burns in Detroit. "Because some Medicare beneficiaries have nothing better to do than sit there and misunderstand their bills."

At the two-hour training sessions, government investigators taught Medicare beneficiaries how to file qui tam suits against physicians on behalf of the government. In addition to the $1,000 bounty, beneficiaries could get up to 30% of any damages

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New database to include sanctioned physicians

It's official: Despite the protests of numerous physician groups, the Office of the Inspector General has gotten its way with the new Healthcare Integrity and Protection Data Bank (HIPDB): the database will register all so-called adverse actions taken against physicians and other providers — even if those actions are still under appeal.

The HIPDB, mandated by the Healthcare Insurance Portability and Accountability Act (HIPAA), is intended to be a register of any adverse

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Professional courtesy or kickback? OIG can't decide

A whisper of a rumor last November has turned into an uproar in March. It was November, American Medical Association (AMA) officials say, when federal officials began dropping hints that the OIG might soon begin regarding physicians' traditional practice of extending "professional courtesy" to other physicians and their families as fraud under the anti-kickback statute. While OIG refuses to officially clarify its position until it can draft a report on the matter, sources in the IG's office say unofficially that the AMA's concerns might be justified, and a crackdown could be on the way.

That troubles physicians like **Percy Wooten**, MD, a clinical cardiologist in Richmond, VA, and immediate past president of the Chicago-based AMA. Wooten, who in the past has frequently provided medical services to other physicians under a professional courtesy arrangement, says the practice of extending courtesy is as old as the

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awarded by a jury under the False Claims Act — which can penalize physicians with up to $10,000 per case as well as triple the damages sustained by Medicare. Medicare contractors will attempt to screen the expected flood of fraud allegations from seniors taking part in the program.

"Sending patients out to fight Medicare fraud with little more than a baseball cap, a magnifying glass, and an 800 number trivializes real fraud," Dickey says. "This broad-brush approach to weeding out a few bad apples threatens to taint the vast majority of honest physicians whose biggest challenge is getting through mountains of Medicare paperwork so they can spend more time with patients."

Indeed, physicians' biggest concern is that the anti-fraud campaign will corrupt the doctor-patient relationship by destroying trust between physicians and those they treat. Dickey says the campaign itself will probably create "an adversarial tension" that is "contrary to quality patient care."

Steve Hahn, who helped to spearhead the campaign at AARP, says such concerns aren't valid. "We've always said that the majority of physicians are honest," he says. "And honest providers have nothing to worry about." He adds that, although the AMA has vehemently opposed the campaign, other provider organizations have endorsed it.

And he denies that the program will have a chilling effect on physician-patient relationships. If anything, he says, it will encourage patients to become more interested and involved in their care and lead to a greater level of communication between patients and physicians.

The program, which AARP calls a "Medicare Neighborhood Fraud Watch," advises Medicare beneficiaries to check all Medicare statements they receive in light of three questions:

• Did you receive the service or product for which Medicare is being billed?

• Did your doctor order the service or product for you?

• To the best of your knowledge, is the service or product relevant to your diagnosis or treatment?

Myckowiak says she's particularly troubled by the third question, which essentially asks patients to make a determination of medically necessity that they're almost certainly not qualified to make. "How's a patient going to know that?" she asks. She adds that the only effective way physicians can deal with potential misunderstandings on the part of patients is to educate them beforehand, explaining exactly what's being done to them and why. **(See related story on how to deal with patients' questions, page 3.)**

According to program guidelines, if the patient answers "no" to any of the three questions, and you the physician can't explain away the concerns, the patient should report the questionable charges to the local Medicare carrier for "clarification." AARP also says patients "shouldn't hesitate" to report a questionable charge to OIG's Medicare Fraud Hotline (800-447-8477).

The AMA counters the program amounts to nothing more than a "public relations gimmick" on the part of AARP and the government, and that federal investigators would be better served by working with physicians and other provider groups to develop "targeted strategies for rooting out fraudulent conduct."

"The fact is," Dickey says, "the government simply does not know the split . . . between genuine fraud and unintentional billing errors caused by hideously complex, incomprehensible government forms. [This initiative] shows that it would rather threaten physicians with harsh rhetoric than educate them with clear answers." ■

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Head off problems with early patient education

The best way to reduce patients' misunderstandings about their Medicare statements is to educate them in advance about what service is being provided and how it will be billed, says **Vicki Myckowiak**, JD, an attorney with Steinberg, O'Connor, & Burns in Detroit.

"It's important to pre-empt questions, because often when patients get their statements they simply don't understand what's going on there," she says. "The wording on the codes doesn't always correspond exactly to what the physician provided."

When a Medicare patient enters the office, it's important that there be a patient liaison who understands coding issues to explain clearly what the bill says or is likely to say.

Unfortunately, what often happens is that patients ask questions to staff members who themselves haven't been educated to understand coding issues.

"Most of the time, misunderstandings arise from coding issues and nothing else," Myckowiak says.

Another way to reduce the potential for problems is to scrutinize coding practices to ensure accurate and well documented coding, she recommends.

"If the codes don't seem to correspond exactly to what the beneficiary thinks happened, that right away sets their antenna off," she says.

Myckowiak cites the example of a case where coders at a physician practice "unbundled" a particular procedure. Inadvertently, the patient was billed for an injection he never received. That simple error set off a full-blown audit against the group.

But the hard fact is that even if you've got your coding under control and have made an effort to educate your patients about the care being provided to them, there's no guarantee that some patient won't drop a dime on you.

"Most of the time, beneficiaries have no problem just picking up the phone," Myckowiak says. "After all, they get paid if they turn someone in. And to someone on a fixed income, there can be a real benefit to turning in their doctor." ■

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actions against providers, including civil or criminal judgments or convictions, licensing actions, and exclusions. It will include actions that involve unsound fiscal, business, or medical practices that cost Medicare money, don't meet accepted standards of care or affect patient care.

The problem, critics say, is that the "final adverse actions" the database is supposed to contain aren't really final at all. Cases under appeal can still be included in the database. "We remain opposed to the ruling in its final form on that point," say **Pat Smith**, director of governmental relations for the Englewood, CO-based Medical Group Management Association. "Every provider group's concern here is that the information [in the database] is accurate and that it doesn't go in until there is some kind of final adjudication."

In addition to physicians, the database will also include records on dentists, nurses, pharmacists, and all other health care practitioners who are licensed or authorized at the state level. It also includes health care suppliers who furnish or provide access to health care services or supplies. These include durable medical equipment companies, pharmaceutical companies, medical record services and billing companies.

If you're thinking it might be interesting to see what your colleagues or providers you work with have been up to, forget about it. The database is primarily for federal and state government agencies, but health plans can take a peek, too, to help them size up existing or potential physician partners. And anyone included in the database is allowed to review what it says about them.

OIG says it will routinely mail copies of any report filed in HIPDB to the subject, who is allowed to contest the accuracy of the information. If you don't receive a copy, you're allowed to submit a "Request for Information Disclosure" to: *Tony Marziani, director, Information Systems and Investigative Support Staff, Office of Investigations, OIG, Room 5046, Cohen Building, 330 Independence Avenue, SW, Washington, DC 20201; or call (202) 205-5200.*

OIG cautions, however, that submitting a request under false pretenses is a criminal offense, subject to a minimum fine of $5,000. ■

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Hippocratic oath. And until very recently, any decision to offer such courtesy was left exclusively to the discretion of the physician and his or her patients. "The covenant between a physician and any patient is a matter of trust and honor," he says. "There should not be any consideration of a kickback."

But with federal investigators now scrutinizing physicians' relationships with home health agencies and durable medical equipment suppliers, it seems likely that those same investigators will soon be scrutinizing physicians' relationships with each other.

Problems arise when, instead of simply waiving the entire charge for a service, the physician accepts whatever the insurance plan allows as full payment and any co-payment is waived. Under Medicare, however, physicians receive 80% of the allowable amount for a service (defined as the lower of the payment schedule amount or the actual charge).

So if Medicare allows a payment of $100, the program pays the physician $80, and the co-payment amount is $20. According to a brief prepared by the AMA's legal counsel, "A determination to only accept 'what insurance pays' as payment in full could be seen as the physician having an actual charge of $80, and the resulting insurance payment should be $64."

Viewed that way, the treating physician's professional courtesy toward a colleague ends up short-changing Medicare by 20%.

In practice, however, Medicare rarely is short-changed at all, Wooten says. He points out in his more than 30 years as a practicing physician, he's never known a physician who used Medicare without also having MediGap insurance, which covers the 20% copayment.

Still, waiving copayments — at least under certain circumstances — has already gotten some physicians in trouble. Wooten cites the example of unscrupulous clinics who as way of advertising their services offer to write off copayments for all patients. "That's fraudulent," he says, "because the law requires that physicians make every effort to collect the copayment."

But even if you skirt that issue by not accepting any payment from Medicare for the services you provide another physician, you could still be in hot water if the government decides the "free" service actually constitutes a kickback to another provider.

Be particularly wary, experts say, if you have any professional link to the other providers, especially one involving the referral of patients. Indeed, the Healthcare Insurance Portability and Accountability Act (HIPAA) includes an amendment to the anti-kickback statute that addresses this very issue.

According to HIPAA, a kickback now can include "waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value." There are exceptions in cases of financial need, but most physicians don't come close to meeting the financial need requirements.

The OIG reports that, so far, it has never prosecuted an anti-kickback case involving professional courtesy, but worries that the agency might be gearing up to do just that have already prompted some providers to begin drafting policies on the matter. For example, officials at Chilton Memorial Hospital in Pompton Plains, NJ, are in the process of drafting such a policy now, says spokeswoman **Carla DeWitt**.

Chilton's policy will essentially stress that any physicians who come to the hospital for treatment will have to pay as though they were any other patient. DeWitt says the policy is meant more to protect the hospital itself than the physicians involved. ■

Plaintiffs not giving up on PATH

The plaintiffs in the PATH lawsuit against the federal government have filed an appeal in a U.S. District Court in California seeking to overturn Judge Carlos Moreno's dismissal of the suit. Moreno ruled that the plaintiffs, which include the American Medical Association, the Medical Group Management Association, and the American Association of Medical Colleges, had not exhausted all possible administrative remedies before pursuing the lawsuit. Oral arguments in the case should be scheduled within six months. ■