

## Searching For New Criminals For The Millennium?

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Picture an average office suite in suburban New York City. Suddenly, the office door is slammed open and in burst more than twenty FBI agents! Wearing bulletproof vests and with guns drawn, the FBI agents round up everyone in the office and begin pat-down personal searches. Employees are separated, detained and refused access to telephones. Miranda warnings are issued to everyone on the premises. Thousands of pages of documents are confiscated. Computers are seized as office personnel are interrogated in separate offices.

The targets? Drug lords? Organized crime? Terrorists? Counterfeiters? No. It's a physician's office on a quiet street in an affluent, suburban community -- just like a thousand others throughout New York. It's a billing investigation by Medicare.

Shocking? Absolutely. Exaggerated? Not a word of it. Still, you might be thinking, was the billing for patients never seen or services never rendered? No. Each of the patients was seen and treated. The "crime?" An interpretation of CPT coding for the documentation of pre-treatment examinations.

Since 1990, there has been a 400% increase in the number of physicians excluded from Medicare. By 1997, the rate had grown to nine physicians per day. While not every Medicare action takes the form of this physician's nightmare, every physician must be aware that the potential for such action does exist. Every physician must remain ever vigilant of the latest Medicare demands, no matter how obscure the regulation, in order to avoid a similar plight.

### Documentation

The greatest weapon in the hands of Medicare fraud investigators is the issue of documentation. Investigators have little interest in whether appropriate medical care was rendered or not. Instead, the first "red-flag" for a Medicare reviewer is the adequacy of documentation provided by the provider. "Documentation," according to Medicare, requires every medical record to indicate the following in a clear, accurate, legible manner:

- The Presenting Problem: A clear and complete notation or description as to the patient's complaints, conditions or reasons for presenting at the physician's office.
  
- Evaluation: A clear and complete notation or description of the physician's assessment and plan.
  
- Action Taken: A clear and complete notation or description of the personal and identifiable

service(s) rendered. 1

According to Medicare, only when the services are described in a clear, accurate and legible manner, inclusive of all of the requirements set forth above, can a reviewer validate that services billed have been rendered; were appropriate for the patient's medical condition; met reasonable standards for medical care; and were billed and reimbursed under the most appropriate procedure code(s). 1

If Medicare finds insufficient documentation that can form the basis for more egregious accusations, such as the services were never rendered, were medically unnecessary, deviated from accepted standards and/or were billed inappropriately, this can then trigger a higher level of review as to whether the charges attendant to those services can be substantiated. If not, the charges will be considered "overpayments" which will lead to demands for repayment, and possibly removal from the Medicare program. Worse, it can also lead to criminal prosecution.

When conducting an investigation, Medicare possesses the legal capability to use even a single denied charge as a basis to formulate an "extrapolation" of the amount owed. Basically, if Medicare finds an error, it denies payment and then assumes that the same error carries back for a period of time. This creates what Medicare terms a "Claims Universe." The amount of the initially denied medical services is multiplied by the number of claims found in this universe, creating an amount for Medicare to demand as repayment from the physician.

The purpose of extrapolation is clear-to dramatically increase the amount of money to be sought from the physician. In fact, Medicare routinely extrapolates an overpayment per claim of less than fifty dollars into a demand for repayment of hundreds of thousands of dollars.

### Billing Resources

In years past, and even today, nearly all physicians placed their trust for billing proprieties with an office manager, bookkeeper or even the physician's own spouse. Physicians focused instead on meeting the rigors of practicing medicine, many possessing no knowledge as to the details of day-to-day office billing practices.

Today, however, ignorance (no matter how worthwhile or innocent the rationale) is truly no defense under the law. Physicians hold a personal, non-delegable responsibility for their billing practices, regardless of how complex the system may have become. Keeping the billing "in-house" requires constant supervision and monitoring of staff members and their efforts. Investments in training for staff members are an absolute necessity. Referring to an outside billing company requires diligence in investigating the experience, references and knowledge base of the firm to be utilized.<sup>2</sup> Physicians must be especially wary of vendors who promise to "maximize their reimbursement."

Given today's climate, physicians are well advised to employ "preventive medicine." An audit of Medicare billing practices and the office's overall legal structure should be a mandatory, routine effort for every medical practice. For obvious reasons, such an audit should not be performed by the same company the physician has retained to perform day-to-day billing. In fact, some physicians have even gone as far as having this audit performed through the offices of their health law counsel, so that the attorney-client privilege may be invoked to limit any disclosure of the audit results.

#### Medical Equipment Companies

A classic scenario which entangles physicians in a Medicare fraud investigation involves the utilization of, or contracting with, a medical equipment company. Physicians have routinely relied upon the "claims" or assurances of the company regarding the propriety and/or legality of the relationship and the billing methodology being recommended by the medical equipment company. When a Medicare fraud investigation brings down that company, however, the newly obtained list of physicians utilizing their services becomes a tailor-made target list for further investigations.

Physicians' claims that they relied upon assurances of company personnel who are now either indicted, convicted, missing or cooperating with that very same Medicare fraud investigation will fall upon deaf ears. No physician should ever rely upon assurances of anyone who stands to gain from the sale, lease or ongoing billing of medical equipment. Any such relationship should only be commenced upon the receipt of an appropriate opinion letter from experienced health law counsel, confirming its propriety from all aspects of regulatory/legal review.

In conclusion, it is reality that demands that physicians act. Medicare has been empowered to target physicians as the new criminals for the coming millennium. To escape that grasp, every physician must, today, scrutinize his/her billing methodology, re-evaluate the quality of their personnel, analyze and confirm the legitimacy of their business relationships and initiate a system of detailed documentation. Should you, as a physician, consider doing otherwise, think of your own quiet New York street, an FBI van pulls to the curb...

1. Medicare Report, May 1993.

2. The names of billing companies which have been investigated and endorsed are available from the Medical Society of the State of New York and most of the County Medical Societies throughout New York State.