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Combating Medicare Fraud and Abuse

During the past few years, the federal government has stepped up its efforts to combat Medicare fraud and abuse. The Health Care Financing Administration (HCFA), the Office of Inspector General (OIG), the Federal Bureau of Investigation (FBI), the Department of Justice, and other law enforcement agencies have coordinated many activities to identify and prosecute fraudulent and abusive behavior in the provision of Medicare services and supplies. This column examines recent Medicare fraud and abuse initiatives that affect clinical laboratory services.

What Are Fraud and Abuse?

In a 1996 address on fraud and abuse, HCFA Administrator Bruce Vladeck, PhD, said,

"Fraud occurs when a provider knowingly and willfully lies to get paid. Examples of fraud include: a physician knowingly billing for a service not provided or knowingly 'upcoding' that is, changing the description of care to get paid more; or a supplier knowingly billing for equipment or supplies not furnished. Fraud is not the result of an honest billing mistake; it happens when someone knowingly and willfully lies about what was supplied or what care was provided. It often involves careful planning and efforts to entice others into the scheme through kickbacks, waiver of copayments, or some other inducement."

Further, Vladeck said,

"Abuse encompasses a broader range of problems. Abuse happens whenever Medicare pays for an item or service it should not, or any time Medicare is billed for services that were not medically necessary, or competently performed, or fairly priced. Examples of abusive practices are ordering lab tests or an extra office visit not really needed, or using substandard equipment or unqualified personnel."

Medical Necessity Documentation

Effective March 1, 1996 (October 1, 1996, for hospitals), HCFA instructed Medicare carriers to pay only for those clinical laboratory tests in an automated profile that are medically necessary. Previous policy allowed for payment of an entire profile if one of the tests was medically necessary. HCFA instructed Medicare carriers to assume a laboratory test is medically necessary if documentation indicates that each test was ordered individually by a physician.

Under the new policy, Medicare carriers are encouraged to recoup any payment if medical necessity documentation does not exist for each test ordered. HCFA's revised carrier policies continue to grant local carriers broad discretion in requiring medical necessity documentation if the carrier believes a pattern of excessive test ordering exists.

To indicate to Medicare carriers that medical necessity documentation is on file for each test ordered, clinical laboratories may use a -QP modifier, which indicates that "documentation is on file showing that the laboratory test(s) was ordered individually or ordered as a CPT-recognized panel other than automated profile codes 80002-80019, G0058, G0059, and G0060."

Reimbursement for Teaching Physicians

In December 1995, HCFA issued a final rule to tighten criteria for reimbursing teaching physicians for Medicare Part B services. According to HCFA, a concern exists that Medicare may be losing money as a result of payments made for services not directly performed or reviewed by the teaching physician. Under the new rule, which took effect July 1, 1996, HCFA gave Medicare carriers the following instructions:

Pay for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than the resident. If the teaching physician's signature is the only signature on the interpretation, you may assume that he or she is indicating that he or she personally performed the interpretation. If a resident
prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Do not pay for an interpretation if the documentation shows simply a countersignature of the resident's interpretation by the teaching physician.

Law enforcement agencies have made efforts to identify and prosecute fraud and abuse in the provision of Medicare services and supplies.

National Audit Program for Teaching Physicians (PATH)
Last year the OIG began the process of reviewing the records of every physician affiliated with each of the 125 academic teaching institutions in the country. According to the OIG, the purpose of the audit is to examine inpatient and outpatient claims from 1990 to 1995 and to determine whether Medicare payments to teaching physicians were reasonable. The audits focus on the documentation appropriate for the level of service billed. The OIG also says that records must indicate that the physician performed the service personally or was present when the service was performed. The audits seek to recover Medicare reimbursement and require doctors to make corrective action plans if abuse is found.

The OIG offers teaching institutions two methods of audit. Under PATH 1, the OIG sends auditors to the institution. Under PATH 2, the teaching institution chooses a third-party auditor (with the approval of the OIG), which provides findings to the OIG. The OIG encourages the third-party audit system and will consider such cooperation when deciding whether to exclude an entity from the Medicare program.

Health Insurance Portability and Accountability Act of 1996
The Health Insurance Portability and Accountability Act, signed into law on August 21, 1996, contained significant fraud and abuse provisions seeking to toughen existing laws and stiffen penalties.

Fraud and Abuse Control
This provision establishes a program under the attorney general and the Department of Health and Human Services (HHS) secretary to coordinate federal, state, and local law enforcement efforts against fraud in health care programs. The provision establishes a special account to pay for the program through the collection of fines, forfeitures, and damages from the coordinated antifraud effort.

Advisory Opinions and Safe Harbors
This provision requires the HHS secretary to issue legally binding “advisory opinions” on the legality of prospective business practices proposed by Medicare providers. The provision expands the list of “safe harbors” or exceptions that can be made to allow business practices that otherwise are prohibited.

Civil Penalties
This provision increases the penalty for health care fraud from $2,000 to $10,000 per violation. The new law adds two practices to the list of those subject to civil monetary penalties. One is upcoding. The other is submitting a claim for a service the provider knows is not medically necessary.

Intent To Commit Fraud
This provision redefines the level of intent associated with fraud violations punishable by civil penalties. The new law says individuals must know that they engaged in the prohibited activity and that they acted in “reckless disregard or deliberate ignorance” of the law. The previous standard required an individual to know that an activity occurred but the person did not necessarily have to act consciously to violate regulations.

Conclusion
President Clinton has indicated in his 1998 proposed budget plan that he would like to achieve significant Medicare savings by increasing current fraud and abuse measures. Combating fraud and abuse has become a top priority within HHS. In addition, Congress has identified increased fraud and abuse measures as a useful tool for achieving future Medicare savings.