HOW HCFA IS CHANGING PHYSICIAN PRACTICE

by Jonathan W. Emord[1]

Medicare is destroying quality medical care in America, reducing care to the lowest common denominator. It is also driving solo and small group practices out of existence in favor of large managed care groups and hospitals.

Although there are numerous perverse effects that result from Medicare regulation, I will focus on five particularly pernicious effects that are rapidly degrading the quality of health care in America:

1. **Inducing one-size-fits all, substandard care for all Medicare beneficiaries;**
2. **Causing patients to become federal agents at war with their physicians;**
3. **Forcing solo and small group medical practices to increase time spent on Medicare compliance and to reduce time spent on patient care;**
4. **Taxing medical practice with hidden costs not reimbursed by Medicare;**
5. **Violating patient privacy rights.**

Inducing one-size-fits all, substandard care for all Medicare beneficiaries.

When physicians bill Medicare they are mindful of the fact that the Medicare insurance carrier will scrutinize every billing entry, questioning its medical necessity and reasonableness. They are also mindful of the fact that the Medicare fee schedule places caps on billing amounts for services and is uniformly below market rates. In addition, they know that the costs of complying with Medicare recordkeeping requirements often equals or exceeds the fee amounts Medicare pays. Consequently, if Medicare subjects a

physician to any inquiry, investigation, or audit, those acts carry with them costs, taxes in effect, that can cause service to Medicare beneficiaries to result in a net loss for the practice. Many physicians now experience that net loss and must depend upon higher than market rates for services to patients not in Medicare to compensate for the losses.

The carriers employ sophisticated computer programs that flag billing outliers and trigger automatic inquiries upon repeat occurrence of atypical billing patterns. Those inquiries can lead to Medicare inquiries, audits of a physician's patient files, and investigations by federal and state authorities (including the United States Attorney's office, the HHS Office of Inspector General, the Federal Bureau of Investigation, and local law enforcement). Indeed, Medicare inquiries, audits, and investigations are frequently the prelude to either a reimbursement demand or legal action for Medicare fraud or abuse.

The cost of obtaining legal counsel to explain the physician's rights, Medicare procedures, and defenses can cost tens of thousands of dollars. Indeed, a single erroneous bill for less then $100 not infrequently ends up causing the physician to spend tens of thousands, if not hundreds of thousands, of dollars to pay legal fees and to satisfy ultimate reimbursement demands made by Medicare. Thus, all physicians, the vast majority of whom are honest and conscientious, greatly fear Medicare and hope to get by without Medicare's notice. They know that Medicare can rob them not only of their precious time but also of their money, their reputations, and—indeed—their ability to practice medicine.

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To avoid the risks associated with Medicare inquiries, investigations, and audits, physicians frequently select common billing and service level codes. They thus choose what they perceive to be the path of least resistance, the one likely to make them least visible to the Medicare carrier's billing review staff. Although Medicare considers it an abuse for physicians to use common billing and service level codes when the medically reasonable and necessary service provided would more accurately be reflected by an uncommon billing and a higher service code, physicians seek in the first instance to avoid any inquiry from Medicare. In short, they loathe legal trouble and seek to minimize their risks as much as possible, recognizing that the complex array of regulations imposed by Medicare make it likely that if an investigation or audit occurs invariably at least something they have done may be viewed as improper by the Medicare carrier. The modern practice of medicine is so complex that virtually every election made by a doctor in the course of treatment can be called into question if examined later in microscopic detail (either based on insufficient documentation of decisions, perceived overutilization, perceived underutilization, improper coding, billing for a service that is ancillary to a non-covered service or some other among a myriad of regulatory issue). That is particularly so when Medicare limits the scope of its examination to physician patient records and considers the absence of written detailed justifications for treatment evidence of inadequate treatment and the need for reimbursement of Medicare fees.

As a consequence of physician fear of Medicare and risk avoidance, physicians not only tend to bill Medicare for common services at common levels, but they also tend to provide Medicare beneficiaries common services—even when the best patient care would require different or more intensive service. They are forced to balance their desire

to help the patient with their fear that doing so in a manner not generally accepted by Medicare may result in substantial costs and penalties down the road. As a result, Medicare patients do not reliably receive the best medical care in America. Rather, they usually receive the lowest common denominator. That lowest common denominator is a result of the intense scrutiny and second-guessing Medicare uses to restrict and control the exercise of a physician's professional judgment.

Medicare patients do not receive the care their physicians think best for them. They receive the care that their physicians think Medicare wants for them. All too often the difference between those two is profound—and profoundly negative for the long term health care interests of Medicare beneficiaries.

Causing patients to become federal agents at war with their physicians.

In its zeal to recover from physicians an estimated $3.2 billion in improper claims payments, Medicare—under the Health Insurance Portability and Accountability Act—has established the Medicare Incentive Reward program for Fraud and Abuse. HCFA began the program in July 1998. It is designed to give a financial reward to patients who complain against their physicians when those complaints lead to a recovery of Medicare funds from the physicians. The program encourages patients to complain against their physicians whenever they suspect that the physician might have billed them improperly, treated them improperly, or otherwise violated Medicare regulations. Medicare has established a "Medicare fraud hotline" to permit complaints by phone. Upon receipt of a complaint, Medicare will investigate it. The investigation alone may cost the physician thousands of dollars in legal defense costs, even if the complaint proves false. There is

no penalty for false complaints and there is no limit to the number of complaints any Medicare beneficiary may make.

HCFA has not only encouraged patients to complain against their doctors, it has also contracted with over a dozen private associations charging them with the duty of being HCFA's "eyes and ears," to quote Secretary Shalala, to watch physicians and report all suspicious moves to the Government. The American Association of Retired Persons, for example, is under contract with HCFA to perform this investigatory service.

As a result of these extraordinary moves by the government, physicians now harbor fear and suspicion not only of Medicare but also of their patients. They must now look upon each Medicare patient as a potential government agent with a financial incentive to subject their every move to scrutiny and to complain in search of profit. They wonder whether a patient who is upset about a physical or mental condition, who is impatient with the progress of treatment, or who is inconvenienced in some other minor way will resort to the complaint process in retaliation. They wonder whether the financial award (up to $1,000 per complaint) is so great, particularly for indigent patients, that patients will be tempted to abuse the process and file false complaints in an effort to reap the economic benefits. They know that every complaint will be investigated and that the cost of defending against each investigation will tax their already overtaxed practices, perhaps to the breaking point. Most importantly, they lament that the very people who they have devoted their lives to serve, their patients, are now being enlisted by Medicare into a fraud and abuse army, charged under federal law with waging a war in which they are the targets.

Forcing solo and small group medical practices to increase time spent on Medicare compliance and to reduce time spent on patient care. When a physician submits a bill to Medicare, he frequently is paid an amount prescribed under the Medicare fee schedule, but that is the start, not the end, of Medicare's dealings with the physician. Years after a bill has been submitted and paid for, Medicare can conduct a post-payment review leading to inquiries, investigations, and audits. Years after the service has been provided and the physician has been paid, it can question the reasonableness and necessity of the service, the billing code used for the service, the sufficiency of medical records documenting the service, the extent to which the service is covered or non-covered, among many other bases for Medicare reimbursement demands.

If Medicare finds a billing irregularity, it can compel the physician to produce a random sample of Medicare patient files. The carrier will review those files and determine which contain errors. It then mathematically extrapolates from the sample to the entire universe of Medicare patients served by the physician. Relying on the error ratio in the sample, Medicare routinely presumes (without examining any other files) that the error rate occurs with equal regularity in the entire universe of patients served. Accordingly, if Medicare finds that $10,000 in Medicare payments should be reimbursed based on a sample of one hundred files, it may employ its mathematical formula to force the physician to reimburse it several hundred thousand dollars based on its mathematical formula. Physicians are effectively presumed guilty until proven innocent. They frequently must pay the demanded amount within a few weeks of receiving notice or be charged exorbitant interest rates compounded monthly on the unpaid portion of the demand.

To make matters worse, billing Medicare is frequently a guessing game. Medicare has no master list of covered and non-covered services. While Medicare publishes its conclusions that certain services are non-covered (or are covered with certain limitations), it does not publish an all inclusive list. Indeed, it encourages its over sixty Medicare insurance carriers to make their own additional coverage determinations on a case by case basis. Thus, at any one time, it is impossible to discern all services that are covered and non-covered, necessarily resulting in a guessing game for physicians. Physicians who guess wrongly are the subject of inquiries, investigations, and audits and may be charged with Medicare fraud or abuse.

Moreover, Medicare demands copious recordkeeping to justify all billings. Full justifications are required to be written in the patient file for every material decision affecting billing. The absence of adequate recordkeeping is the basis for a reimbursement demand or, in extreme cases, a fraud or abuse charge. Even if the actual service provided is wholly proper and compensable, the lack of contemporaneous documentation in the medical file is in the minds of the Medicare bureaucrats a basis for demanding repayment of fees. Physicians therefore view their medical records for Medicare patients more as correspondence to Medicare than as places to explain treatment modalities and the rationale for their exercise of independent professional judgment. Physicians are mindful that their every word can be scrutinized later to determine whether their treatment was medically reasonable and necessary. They thus stick to common billing justifications and avoid inclusion of written information that, while therapeutically helpful, may nevertheless be misconstrued by Medicare and used as a basis to demand reimbursement.

To reduce these and other risks requires counsel from lawyers, accountants, and risk managers who dedicate their professional careers to parsing and evaluating the over 100,000 pages of Medicare regulations, the thousands of Medicare carrier notices, the decisions of carriers and Social Security Administration ALJs, and the decisions of the Courts, governing physician practices. For solo and small group practitioners, the current burden is tremendous. Most solo and small group practices that I represent spend between 25% and 50% of their time on compliance issues. That time goes uncompensated. It is a high tax that they must bear to practice medicine in the United States. Were they in a large group practice or a hospital practice, they would spend less time, relying on a cadre of lawyers, accountants, and risk managers employed by the institution to serve all physicians. In the March 1998 edition of Physicians Management, the magazine reported that one group practice of 284 physicians pays between $130,000 and $195,000 per month for dictation and transcription costs associated with preparation of patient files to comply with Medicare recordkeeping requirements. Those figures do not take into account the costs associated with all other compliance activities performed by the group.

The effect of the regulatory burden is to force solo and small group practitioners to devote substantially less time to patient care as they work to comprehend and comply with the myriad regulations Medicare and Medicare carriers impose upon them. That tax is destroying solo and small group practices all across the United States. Physicians incapable of affording the lawyers, accountants, and risk managers now needed just to avoid high risks of adverse government action are electing to close shop and go to work for large managed care groups and hospitals. HCFA is reorganizing the health care

marketplace, forcing solo and small group practices out of existence in favor of large managed care groups and hospitals. For those patients who have come to appreciate the privacy, intimacy, and responsiveness of the local family practice, the new regulatory world increasingly deprives them of that option and forces them to choose the large urban group practice or hospital as their only recourse.

Taxing medical practice with hidden costs not reimbursed by Medicare. The public is largely unaware of the extraordinary costs the federal government has imposed on the practice of Medicine. No solo or small group practice in the United States can comprehend the full extent of their legal obligations under Medicare without consulting with lawyers and few can fulfill their legal obligations properly without consulting with accountants and risk managers. There are literally thousands of rules covering every aspect of a physician's practice from renting office space to giving and receiving referrals to determining whether each particular service is covered under Medicare or is covered only if "bundled," attendant to a Medicare covered service, or necessary for emergency care.

To minimize risks (elimination of risks is not possible because the law is forever changing) requires personnel on staff trained in billing, coding, risk management, and compliance; counsel from lawyers expert in the field; counsel from accountants; and counsel from risk managers. Those costs are borne by the physician and must be paid for, ultimately, by the patients. Because Medicare prohibits billing Medicare patients for covered services beyond a fee limited amount, the costs are invariably borne by patients not in Medicare.

Every time Medicare conducts an inquiry, investigation, or audit and every time it sends a reimbursement demand, a physician must pay for legal and accounting advice. The risks of being wrongly accused are so high that no physician can protect his or her own best interests without the aid of a plethora of professionals. The costs are taxing solo and small group practices to death. Their time, romantically portrayed in serials such as Gunsmoke and Marcus Welby M.D., is about to become a relic of a bygone era, not due to market forces but due to Medicare regulation.

Violating patient privacy rights. Every Medicare beneficiary must sign a waiver of his or her privacy rights as a condition precedent to accepting the benefit. The waiver of rights authorizes Medicare to inspect his or her medical records at any time without requesting permission from the patient. The waiver makes it impossible for the physician to refuse turning the files over to Medicare. Indeed, doing so can result in severe regulatory sanctions against the physician.

Under the Health Insurance Portability and Accountability Act, Congress has vastly expanded federal funding for Medicare investigations, audits, and prosecutions. It has involved the Department of Justice, the Department of Health and Human Services, the HHS Office of Inspector General, the Federal Bureau of Investigation, and state and local law enforcement in a massive combined federal and state campaign to ferret out all perceived waste, fraud, and abuse in the Medicare system. Over $1 billion is being spent between 1996 and 2004 on this effort. Funds recouped are deposited in a trust fund and are earmarked for use to fund more enforcement, creating a self-perpetuating prosecutorial machine. With this vast expansion will come greater inquiry into patient files.

On the slightest suspicion of wrongdoing or billing impropriety, Medicare can order a physician to turn over Medicare patient's files. Those files can be reviewed by the Medicare carriers and by federal and state authorities, exposing to a large number of people the most intimate details of a Medicare patient's life and health. Over the next several years, greater and greater numbers of patient files will be examined by the carriers and the authorities in their zealous attempt to uncover every possible basis for demanding reimbursement or charging providers with waste, fraud, and abuse.

Based on 1998 statistics, HHS believes physicians wrongfully hold $3.2 billion in Medicare payments. Of that sum, Medicare believes 12.3% was paid for services lacking medical necessity; 47.1% was paid for incorrect coding; 12.3% was paid despite inadequate documentation; 17.3% was paid despite the absence of documentation; and 11.1% was paid for non-covered services. HCFA has called for a substantial increase in "medical review and post payment data analysis" to recoup all $3.2 billion from the marketplace. Along the way many an innocent physician will be harmed and many an innocent patient will be the unwitting victim of a privacy rights violation, as medical records from across the country come under greater Medicare carrier and federal and state government scrutiny.

In sum, Medicare regulation is destroying the quality of medical care in America. Among the perverse effects caused by the Medicare system are: the provision of substandard care, the transformation of the patient into an agent for the federal government, the destruction of solo and small group medical practices, and the violation of patients' privacy rights.

So long as government maintains a system in which it serves as a third party payer of patient bills, there is little likelihood that regulation will lessen or that quality medical care will survive. The over $200 billion Medicare system grows in cost annually. Congress's favored political remedy to the mushrooming budget is to demand that HCFA recoup from those it has paid more and more of the funds Congress has allocated for the system. The result is our current, and worsening, draconian system of payments followed by law enforcement recoupment. That system labels physicians who lack any moral culpability for wrongdoing as cheats and frauds. It depends upon vilification of the physician. Increasingly, the option of a career in medicine is loosing its luster for the best and brightest.

Viable alternatives depend upon reestablishment of free markets in the provision of medical care. Those alternatives include tax free medical savings accounts; a patient by patient option to contract privately for specific medical services outside of the Medicare system; a flat standard payment to those 65 and older, graduated based on need or medical necessity, for use by the patient to pay for medical services in lieu of Medicare reimbursement; and provision for private medical insurance to compete directly with Medicare and serve as an alternative to Medicare at the individual patient's election. Ultimately, we will not arise from the morass Medicare has created until Medicare is replaced with market-based mechanisms that leave the patient in charge of choosing his or her own medical care and leave the physician with the freedom to exercise independent professional judgment in the provision of that care.