

**PHYSICIANS AT TEACHING HOSPITALS
[PATH] AUDITS**

HEARING
BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
ONE HUNDRED FIFTH CONGRESS
FIRST SESSION

SPECIAL HEARING

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TUESDAY, OCTOBER 21, 1997

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:35 p.m., in room SD-138, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senators Specter, Gorton, and Harkin.
Also present: Senator Bennett.

NONDEPARTMENTAL WITNESSES

STATEMENTS OF:

**MICHAEL MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL,
DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**JORDAN J. COHEN, M.D., PRESIDENT, ASSOCIATION OF AMERICAN
MEDICAL COLLEGES**
**C. McCOLLISTER EVARTS, M.D., PRESIDENT AND CHIEF ACADEMIC
OFFICER, PENNSYLVANIA STATE GEISINGER HEALTH SYSTEM**
**BARBARA WYNN, DIRECTOR, PLAN AND PROVIDER PURCHASING
POLICY GROUP, HEALTH CARE FINANCING ADMINISTRATION**

OPENING REMARKS OF SENATOR ARLEN SPECTER

Senator SPECTER. Good afternoon, ladies and gentlemen. We are going to proceed with the hearing of Labor, Health and Human Services, and Education. We will begin with a hearing on the issue of audits of teaching hospitals. The purpose for this hearing, called on very short notice, is because the House of Representatives has report language which suggests that the inspector general audits ought to be delayed until a GAO report is concluded and until there are more precise standards. It is a complicated subject and we have scheduled a hearing in the afternoon because there was no other time due to conflicts with other hearings.

I would like for Dr. Evarts, Dr. Cohen, Ms. Wynn, and Mr. Mangano to step forward. I'm going to ask that opening statements be limited to 4 minutes. The full statements will be made a part of the record. The essential question which is of concern to the subcommittee is what are the facts?

There is no question that audits are necessary to make sure that the Federal Government is getting its money's worth and that there is honesty in what is being done.

For many years as a prosecuting attorney, I have always been very much concerned about plea bargains in the context of concessions which were made with a large penalty overhanging which might be more of a blackjack than justice. When I have seen some of these cases settled long before this issue came to me with the House language, I made the comment that I would like to see the cases tried, and see what happens. If there is fraud, it is not only a matter of fines and penalties, it is a matter of jail.

Fraud is a criminal offense. Yet if there is no wrongdoing, then I would like to see people exonerated. There is nothing like trying cases to get a line on what really is going on.

SUMMARY STATEMENT OF MICHAEL MANGANO

Let me begin with you, Mr. Mangano, principal deputy for the Office of Inspector General, Department of Health and Human Services.

Mr. MANGANO. Thank you very much, Mr. Chairman. In very, very simple terms, what this review is designed to do is make sure Medicare pays only once for a service and pays a fair price. As a result of that, what we'll do is take a look at two issues: First, did the teaching physician perform the services which they billed for; and did they bill at the appropriate level? Let me take the first issue.

Medicare on a part A basis pays for in-patient stays at teaching hospitals exactly the way it does at any other hospital in the country, namely on the basis of the DRG system. Medicare also provides for training money to provide training for residents and interns, a future class of physicians in this country.

Last year, Medicare paid \$8 billion for the training of the residents and interns, and this—this covered costs like the salaries and expenses of the interns and residents. It also covered the other expenses in their training, including the time of the teaching physicians to train them.

To give you a practical example, the University of Pennsylvania, which is the first review that we did, received last year an average of \$126,000 for every resident that they trained. Medicare also allows teaching physicians at these hospitals to bill under the part B program. Medicare established its policy for this in the 1967 regulation which said that teaching physicians would have to provide personal and identifiable direction to the interns and residents.

Some 2 years later, through an intermediary letter, that is a letter that goes out to all the professionals in the community, the policy explained a little bit further and indicated teaching physicians would have to do two things: No. 1, provide personal and identifiable services; and No. 2 meet the criteria of the attending physician for that individual patient.

So really we get down to the question, what does it take to provide personal and identifiable services or direction? The vast majority of the policy statements that I've seen from HCFA indicate what that standard should be is the physical presence of the physician if they are not rendering the service themselves or performing the service themselves.

The Medicare Program operates on a contractor system. That is, local insurance companies all over the country administer that pro-

gram for them. Contractors have responsibilities to communicate policy, establish the standards and requirements that would meet that policy, review claims and conduct audits.

Our review found that 75 percent of the teaching hospitals in this country are serviced by a contractor that provided clear and consistent guidance which said, in order to meet the standard—the personal and identifiable services of direction—you must perform the service yourself or be present at the elbow of the resident when he, the resident, performs the service.

Hundreds of audits have been conducted over the last three decades on this issue using that standard. My testimony gives you the example of what happened in Pennsylvania where the contractor communicated that standard to the providers in his community and, in just a 1- to 5-year period, conducted 67 audits of teaching hospitals on that very same standard.

The Congress, in 1980, 1982, confirmed that in the amendments to the Social Security Act which called for teaching physicians to provide personal and identifiable services. The committee report from the Senate Finance Committee translated that into saying that physical presence would be the indicator of this standard.

Our findings show that hospitals have had varying degrees of compliance, from those that met the requirements quite well to others that did not. I provide examples in my testimony that showed some teaching physicians were billing for services, billing for patient visits when they weren't in the hospital that day, weren't even in the same State.

The second issue we look at is an issue of coding. That is, did they bill at the proper level? I want to assure you that we're not looking for inadvertent mistakes here but, rather, what we're looking for is evidence or patterns of abuse.

Patterns of abuse would be indications we'd find that the overwhelming majority of mistakes are in favor of the hospital and those mistakes were multilevel mistakes with—which would mean they were billing for far more expensive procedures than they actually provided.

Senator SPECTER. You are looking for physical presence, billing at the proper level and what else?

Mr. MANGANO. Those are the only two issues, that's correct.

Senator SPECTER. Those are the two issues.

Mr. MANGANO. Yes; I want to just conclude by saying that one of the charges against these audits is that they're unfair. I want to mention a couple of things that we believe prove that they are fair.

PREPARED STATEMENT

No. 1, we provide an opportunity to teaching hospitals, if they so desire, to conduct a self audit under our supervision. No. 2, we only review those teaching hospitals which had carrier guidance that was clear, over a long period of time that physical presence was required. No. 3, we offset upcodes with undercodes and, finally, it's the Department of Justice and not ourselves who evaluate that information and determine whether any penalties are warranted.

Thank you very much.

Senator SPECTER. Thank you very much, Mr. Mangano.

[The statement follows:]

PREPARED STATEMENT OF MICHAEL F. MANGANO

THE PHYSICIANS AT TEACHING HOSPITALS (PATH) AUDITS

Good afternoon, Mr. Chairman. I am Michael Mangano, Principal Deputy Inspector General of the Office of Inspector General (OIG), Department of Health and Human Services (HHS). Thank you for the opportunity to testify on the Office of Inspector General's ongoing review of the billing practices of physicians at teaching hospitals, commonly referred to as "PATH". Reduced to simple terms, these reviews are designed to ensure that Medicare pays only once for the same medically necessary service, and that payment fairly reflects the level of service actually provided. Our audits of the billing practices of physicians at teaching hospitals has revealed that some physicians have billed Medicare for services actually performed by an intern or resident without the presence of the teaching physician. In addition, Medicare has paid for complex levels of treatment when the patient's medical record demonstrates that a lower level service was provided.

The OIG's objective in conducting the PATH audits is to return to the Medicare Trust Funds these improperly claimed funds and, through the use of compliance programs, work with the physicians and their teaching hospitals to prevent a recurrence of these abuses. Under the PATH program, providers are given the opportunity to conduct self-audits with Government oversight. Those providers opting for self-audits are commonly referred to as "PATH II" participants. Those audits which are conducted solely by the Government are referred to as "PATH I" reviews.

BACKGROUND

Medicare Part A and Part B

To understand the basis of the PATH initiative, it is helpful to have some background on the structure of the Medicare program and its underlying reimbursement principles. Medicare is a combination of two programs, each with its own enrollment, coverage, and financing—Hospital Insurance (or Medicare Part A) and Supplementary Medical Insurance (or Medicare Part B). Claims for Medicare Part A cover services provided by participating hospitals, skilled nursing facilities, home health agencies, etc. Medicare Part B covers physician and outpatient care, laboratory tests, durable medical equipment, and other items and services. Medicare payments for services rendered in a teaching hospital combine these two programs and result in payments from both the Part A and Part B Trust Funds.

Under Part A, Medicare pays for inpatient stays in teaching hospitals exactly the same way it does other hospitals (i.e., reimbursement is based on the diagnostic-related group (DRG) code for the services rendered to the patient). Medicare also supports the costs of training residents and interns through the graduate medical education (GME) program. In addition, Medicare pays for other indirect medical education (IME) costs associated with training residents and interns by increasing the normal reimbursement rate for each DRG. Teaching hospitals can easily receive over \$100,000 per year per resident from the government through the direct and indirect medical education programs. Medicare paid over \$8 billion to teaching hospitals in 1996 for the costs of training residents. This amount includes payments to teaching physicians for their role in supervising residents and interns and the salaries of those residents and interns, as well as payments for IME. At the University of Pennsylvania, the first teaching hospital to settle its civil liability with the Department of Justice based upon a PATH audit, Medicare paid over \$126,000 per resident in GME and IME payments for physician training.

In light of these direct and indirect payments for training, the teaching physicians may not submit claims for payment to Medicare Part B for the same general supervision of residents and interns already paid for under Part A. Teaching physicians seeking reimbursement under Part B must do more. Physicians claiming Part B reimbursement for services performed by the intern or resident alone are making a duplicate claim—the general supervisory services of the teaching physician and the salaries of the interns or residents were already paid for by the Medicare program under Part A. As is the case for all medical services, the patient's medical record is relied upon to document the involvement of the teaching physician.

Role of the Medicare Contractor

When the Medicare program was established, Congress directed that it be administered locally through insurance companies, called contractors. These contractors are referred to as Part A intermediaries and Part B carriers. A significant part of

these contractors responsibilities is the communication of Medicare policy in their local area and the payment of claims for reimbursement consistent with these policies. In addition to enforcing Medicare policies through the claims payment process, the contractors conduct post-payment audits of providers to verify compliance with program's rules. Where an audit identifies a item or service for which the Medicare program should not have paid, the provider is informed of the error and the overpayment is recouped.

REVIEW OF PHYSICAL PRESENCE

Medicare established its policy for reimbursing teaching physicians under Part B through regulation and policy issuances. Through regulation in 1967, 42 CFR § 405.521 (1992 version), Medicare allowed teaching physicians to bill the program when they personally provide services and "when the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient."

In 1969, Medicare attempted to further clarify its policy to its contractors in Intermediary Letter 372 (I.L. 372). To be eligible for Part B reimbursement, this document required teaching physicians to "render personal and identifiable medical services" after first establishing themselves as the patient's attending physician. I.L. 372 went on to describe the criteria necessary to qualify as the attending physician including: reviewing the patient's history, personally examining the patient, confirming or revising the diagnosis and determining the course of treatment, performing the physician's services or supervising the treatment, and being present for all complex or dangerous procedures.

Over the years, Medicare issued numerous other policy documents to its program managers, contractors and participating health care providers discussing Medicare requirements for teaching physicians. Medicare often used the terms "personal and identifiable services" and "personal and identifiable direction" interchangeably. The vast majority of these documents conditioned Medicare Part B reimbursement to teaching physicians to when they furnished medical services themselves or when they were present and directly supervising residents or interns. There were some other documents that were not as distinctly stated. What was clear, however, was that teaching physicians had to have a personal role in delivering the medical service, and it had to be far more direct than the general supervision already compensated under GME. As the HHS General Counsel Harriet Rabb observed in her July 11, 1997 letter to the Association of American Medical Colleges:

It would be absurd to assert that physicians could receive the significant remuneration that characterized Part B reimbursement for supplying the same level of services that qualifies and was paid for as Part A services. The physical presence of a physician with the treating intern or resident at the time of treatment is one clear indication of a more patient-specific level of responsibility for the physician entitling her or him to Part B, rather than Part A, reimbursement. That view is consistent with both common sense and the history of this subject.

The Medicare contractors, consistent with their authority, provided health care professionals ample clarification of the standards they would use to determine whether teaching physicians provided "personal and identifiable services or direction." Our review of carrier policies and directives to teaching hospitals and physicians found that over 75 percent of the providers with teaching programs received guidance from contractors that conditioned Part B reimbursement on either personally furnishing a service or being present when it was furnished by an intern or resident. For the remaining contractors, we were unable to determine whether they had offered longstanding, clear guidance prior to 1993.

We recognize that some Medicare carriers did not uniformly apply and interpret the standard as the vast majority did. As a result and in the interest of fairness, the OIG will conduct PATH audits only when carriers, before December 30, 1992, issued clear explanations of the standards requiring teaching physicians to either personally furnish services or be physically present when the services were furnished by interns or residents.

In addition to the guidance issued by contractors, we found they conducted numerous audits of teaching hospitals over the last three decades that checked for compliance with the physical presence standard, and when they found institutions out of compliance, the contractor collected overpayments.

Legislative History

Based upon our review of the provisions of the Social Security Act (SSA) and its legislative history, we believe that the Congress clearly intended to condition Part B payment on a physician personally performing a service for a patient or, having

qualified as the patient's attending physician, providing "personal and identifiable services" when a service was rendered by an intern or resident. For example, in 1980 the Congress enacted Section 1842(b)(7)(A) of the SSA, which provides, in part, that "[i]n the case of physicians' services furnished to a patient in a hospital with a teaching program * * *, the carrier shall not provide * * * for the payment for such services * * * unless * * * (I) the physician renders sufficient personal and identifiable physicians' services to the patient * * *." The legislative history of this provision makes clear that personal identifiable services must be provided by a teaching physician to qualify for a fee-for-service payment. As the House of Representatives' Committee on the Budget stated:

The Committee strongly believes teaching physicians should personally perform or personally supervise patient services in order to qualify for fee-for-service payment. The Committee notes that failure of a physician, teaching hospital, or related entity to comply with these requirements would, among other things, constitute a false statement or representation of material fact in an application of payment under Medicaid or Medicare. The Committee expects the Department and State Medicaid Fraud and abuse control units to vigorously pursue any noncompliance. 1980 U.S.C.C.A.N. Vol. 5, 5582-5583.

Similarly, in 1982, section 1887(a)(1) of the SSA was enacted to direct the Secretary to determine criteria for distinguishing those hospital services personally rendered for an individual patient by a physician and thus reimbursable under Medicare Part B, and those Part A reimbursed services that are rendered for the general benefit of patients. As the Senate Finance Committee Report stated in its explanation of the 1982 amendments "services furnished by a physician to hospital inpatients are reimbursed * * * under Part B only if such services are identifiable professional services to patients that require performance by the physician in person and which contribute to the diagnosis or treatment of individual patients." S.Rep. No. 97-494, at 21-22 (1982) (emphasis added).

Medicare Contractor for Pennsylvania

Mr. Chairman, perhaps the simplest way to see how Medicare policy was translated into specific standards or documentation requirements for teaching physicians is to look at an example. The example I use here relates to the Commonwealth of Pennsylvania, the first State where a teaching institution underwent an OIG audit. The Medicare carrier for the Commonwealth, as well as for Delaware, New Jersey and the District of Columbia, has been Pennsylvania Blue Shield (PBS). The Medicare component of PBS changed its name to Xact Medicare Services (Xact) in 1995 and I will use that name when referring to the Medicare carrier. I will use the acronym "PBS" to refer to the company's private lines of business.

As early as the 1970s, Xact began informing teaching hospitals of the rules governing billing Medicare Part B for services in a hospital teaching setting through the distribution of I.L. 372. As an aside, the PBS Board of Directors subsequently adopted these Medicare documentation requirements for its private lines of business. Consequently, the guidelines to be followed for documenting Medicare and PBS-insured services provided in a Pennsylvania teaching setting are essentially the same. In addition to distributing national standards, Xact provides its teaching institutions with instructional manuals, issues a quarterly newsletter called the "Medicare Report", and maintains a provider relations department which responds to provider-specific questions and problems.

On October 27, 1977, the Medicare Regional Office responsible for Pennsylvania issued Regional Intermediary Letter No. 20-77 to all its contractors, stating that "* * * it will suffice for either the intern, resident or nurse to note in the record that the physician was personally involved in the particular service billed for. A physician countersignature of notes entered by a resident, intern, or nurse is not in itself evidence that a covered service was rendered unless the notes indicate that the physician was present."

Xact used Medicare guidance like this to help it formulate the specific requirements it communicated to teaching physicians in its service area. Listed next are some examples of directives Xact Medicare disseminated to its providers:

In 1980, the carrier issued a manual entitled "Attending Physician Documentation Teaching Setting." This manual was issued to enable physicians to understand the Medicare concept of "teaching setting" and assist them in adhering to the Medicare requirements for proper documentation of hospital services. It is also intended as a reference for hospital administration and medical records personnel in administering government regulations requiring documentation. The manual provides an (1) overview of Medicare guidelines regarding documentation of services in a teaching setting, (2) the carrier's role in the administration of Medicare guidelines, and (3) questions and answers to teaching setting situations. In defining the documentation

requirements for in-hospital medical visits, the manual directs that “the attending physician must have daily documentation either by a personally written note or by an indication in the daily progress notes of the intern, resident or nursing staff of his presence during the rendition of the services * * *. Countersignatures next to entries which fail to indicate that the attending physician was present are not in themselves evidence that a covered service was rendered.” The documentation section of the manual is attached as Attachment A.

In 1982, a second manual, “Attending Physician Documentation of Services Provided in a Teaching Setting” expanded on the guidance of the earlier manual. In discussing the documentation necessary to support a Part B claim, the carrier instructed that “Medicare B reimbursement on a charge basis is also intended where the attending physician criteria have been met and the physician is present at the time a resident or intern provides the service. Resident or intern entries must state the physician’s involvement i.e., presence and be appropriately countersigned by the attending physician.” (Emphasis added.) The manual provision is attached as Attachment B.

In September 1988, Xact distributed a newsletter “Medicare Report” to all Medicare providers in which it directed that “[t]he supervising physician when functioning as the attending physician in a teaching setting, should personally provide all services reported for Medicare Part B payment or be present when the resident renders the service.” (Emphasis added.) The newsletter is attached as Attachment C.

In addition to manuals and other program directives, teaching hospitals were informed of the applicable documentation standards through the post-payment audit process. Xact Medicare conducted over sixty-seven I.L. 372 reviews of services rendered by physicians in Pennsylvania hospitals. In each case where the carrier audit team found a lack of documentation in the medical record to support a claim by a teaching physician, an overpayment was assessed.

Protocol

The OIG has found that the regulatory language “personal and identifiable direction” as well as Medicare’s term “personal and identifiable service” have been clearly and consistently interpreted by the Medicare carrier in Pennsylvania to be the equivalent of “physical presence.” In recognition of some variation in how other Medicare contractors interpreted and applied the attending physician criteria, one of the first steps undertaken in all audits performed under the PATH initiative is to determine what guidance was provided by the Medicare contractor to each particular institution. This guidance may take the form of informational bulletins disseminated to all providers, correspondence between the contractor and the particular institution, or prior audits of the provider’s compliance with the rules governing reimbursement of teaching physicians. The OIG will not approach a hospital to discuss initiating a PATH review until the OIG has established what instructions the carrier has issued to the providers within its jurisdiction. Furthermore, a hospital selected for a PATH audit will have an opportunity to show that it received guidance from the contractor which, in the hospital’s view, contradicts the physical presence standard articulated above.

Findings

I now would like to report on some of the findings of the OIG’s audit of compliance with the teaching physician’s obligation to be physically present with the patient in order to bill for a Part B service. Because of our concerns over patient confidentiality and to protect the ongoing audits, I will not identify the particular institution or teaching physician involved at this time.

In the PATH audits that have been completed, as well as those which are ongoing at this time, the OIG found wide variance in compliance with the physical presence requirement. In some institutions, adherence to the rule has been quite good. We have discontinued PATH reviews at two institutions because of the low number of errors identified during the review. Unfortunately, in other cases the audits have uncovered significant noncompliance. The following examples are offered by way of illustration.

A physician billed Medicare for subsequent hospital care provided during a 3-day period in which his travel schedule placed him out of town.

A physician who was attending a medical conference out of state billed Medicare for one hour of critical care provided on each of two consecutive days.

A physician billed for radiological guidance of a procedure provided during a 10-day period when he was in travel status.

A physician who was on leave for a week, billed Medicare for a subsequent hospital visit on each of those days.

REVIEW OF "LEVEL OF SERVICE" CODING

As I explained at the beginning of my testimony, the PATH audit initiative also includes a review of Part B claims information and medical records to determine if the teaching physician claimed reimbursement commensurate with the level of service provided. Physicians claim Medicare reimbursement by using codes, developed by the American Medical Association, which indicate the level of service provided. As an illustration, codes for patient visits—called evaluation and management or "E&M" codes—have levels ranging from the least complex and time-consuming to the most complex. The coding decision is based on the complexity of the medical decision making and severity of the problem presented. For example, the AMA suggests that the lowest level for an inpatient consultation (CPT code 99251) could require an average of 20 minutes of physician time, while the highest code level (CPT code 99255) typically could require 110 minutes of time. Medicare payment rates increase with each higher level. In this example, in 1994 the lower code was reimbursed at \$47, while the highest code was reimbursed at \$146.

The audits are designed to detect abusive patterns or practices of improperly selecting codes which overstate the actual level of service provided. This practice of upcoding results in unwarranted losses to the Medicare Trust Fund and is a violation of program requirements. The OIG is concerned about patterns of abuse, not isolated, inadvertent mistakes. The coding or "level of service" reviews under the PATH initiative are performed by the local Medicare carrier medical review staff, as well as the independent medical experts retained by the institutions participating in the PATH II reviews. These experts utilize the same criteria relied upon by the HCFA contractor when conducting a routine review of a hospital's medical charts.

The OIG's work in this area demonstrates that upcoding the level of service provided is often a pattern or practice of multi-level upcoding potentially resulting in significant financial gain to the provider. During some PATH audits, significant upcoding errors have been identified by both the carrier medical review personnel and the institutions' independent medical experts. The most troublesome of these errors are related to multi-level upcoding. You would normally expect to find coding errors which are mixed, that is, some in favor of the hospital and some in favor of Medicare. When an audit demonstrates that the overwhelming majority of coding errors favor the provider, it is an indicator of billing abuse.

For example, at one teaching hospital, our audit revealed that very few of the consultations and subsequent hospital visits were billed at the lowest two levels of complexity and were disproportionately billed at the higher reimbursed levels of care. Upon further investigation, we found that the preprinted forms used by teaching physicians to record the level of service provided, omitted the two lower reimbursed codes for these services as choices. As a result, physicians rarely billed for a less expensive patient visit, even though the medical record clearly showed that, as the level of service actually provided.

Some have argued that this review of the level of service billed to Medicare unfairly involves the retroactive application of the 1995 documentation guidelines. In effect this view urges that there were no coding guidelines in effect between 1992 and August 1995 but rather this was an "educational period" during which the medical community could familiarize itself with codes that were implemented in 1992. We disagree with this position.

When HCFA adopted new evaluation and management codes in 1992, the agency began a collaborative process with the AMA, institutions, and physicians to train persons who would be using the codes and to review the experience under the new regime. In so doing, HCFA made a decision not to include evaluation and management codes in their focused medical review process. HCFA continued this policy until August 1995. At the same time, health care providers have never been absolved of the basic Medicare requirement to document the services actually provided, nor have they been permitted to indiscriminately bill the Medicare program for a level of service higher than that actually performed. In fact, HCFA instructed its Regional Administrators that, during the period of training, action could be taken at any time to deal with egregious cases of abuse or fraud. Thus, where OIG finds actionable cases of upcoding abuse or fraud as it audits pre-August 1995 records, such matters are appropriate for attention and resolution.

A brief summary of the educational efforts undertaken by Xact Medicare to inform providers of the evaluation and management (E&M) codes makes clear that the institutions received comprehensive guidance on the proper method for coding Medicare services. The following is just a partial list of the bulletins, seminars and guides provided.

November 1991. Memo to Medical Societies about seminars on E&M coding, which were held in December 1991.

December 1991. "Medicare—Special Bulletin—New Evaluation and Management CPT Codes." Bulletin was sent out by Xact and is patterned after the instruction manual developed by American Medical Association in November 1991.

1992. "Medicare Evaluation and Management Codes—A pocket Reference for Physicians." The carrier developed a pocket-size reference manual to facilitate the understanding of the new E&M codes.

February 1992. "Medicare—Special Bulletin—Monitoring of the new Evaluation and management Codes." Bulletin issued by Xact explaining Early Claims Review Program for use of E&M codes.

September 1992. "Medicare—Special Bulletin—Policy Clarifications and Changes relating to Evaluation and Management Codes." Bulletin explaining policy clarifications with the use of the E&M codes. This bulletin is considered to be reflective of current carrier policy.

November 1993. "Medicare Report-Your Turn-Billing E&M and Chemotherapy." Bulletin provides Q&As about proper billing of E&M services.

ADMINISTRATION OF PATH INITIATIVE

The OIG is committed to limit the scope of the PATH audits to those hospitals served by carriers that issued clear, long-standing guidance requiring the physical presence of the physician. However, this decision does not affect the Department of Justice which, under its own authority, is engaged in cases concerning Medicare Part B billing by physicians in teaching hospitals. As you are aware, DOJ has sole authority to compromise or close cases involving fraud or fraud allegations. The determination as to whether the submission of improper claims is false or fraudulent, and thereby subject to prosecution under the False Claims Act, lies exclusively within the prosecutorial discretion of the Justice Department. If, as a result of a PATH audit, and/or other available information, the DOJ concludes that a health care provider knowingly submitted false claims to Medicare, the Justice Department may seek damages and penalties pursuant to the terms of the False Claims Act.

In administering all investigations, audits and program evaluations conducted by the OIG, the Inspector General June Gibbs Brown insists we take every measure to be fair. The PATH initiative is consistent with this fundamental philosophy. For example, the initiative is limited to jurisdictions where the Medicare contractor has issued longstanding and clear guidance to hospitals and physicians of the physical presence requirements. As stated above, the vast majority of institutions did receive clear guidance. We provide the hospitals with the option to contract for the audit with an outside audit firm, under the general supervision of the OIG. When evaluating the sample of claims and calculating any losses to the Medicare program, the auditors offset instances of upcoded physician services with undercoded services. Finally, a third party, the Department of Justice, makes the decision whether to seek imposition of any fines or penalties in cases where the audit uncovers potential false claims.

Having listed some of the steps we have taken to be fair to the teaching hospitals and their physicians, it is important that we do not lose sight of the impact of this review from the beneficiaries' perspective. When a physician bills for a hospital visit or a surgical procedure, the patient has the right to be treated by that doctor. Most Medicare Part B services have a copayment of 20 percent, for which the beneficiary is responsible. Consequently, each time a noncovered service is billed to Medicare, such as when a physician inappropriately bills for services rendered by a resident, the beneficiary receives a bill for the 20 percent coinsurance. This is an improper health care expense for our elderly population.

CONCLUSION

In concluding my remarks, I would like to provide a brief status report of the PATH initiative to date. Two institutions have entered into settlement with the Federal Government to resolve their False Claims Act liability for overpayment related to improper claims submitted in the teaching setting and for upcoding, resulting in the Government's recovery of more than \$42 million in overpayments and penalties. These hospitals have also implemented corporate integrity programs to prevent and detect any future false claims. Audits completed at two other institutions disclosed no major problems in these areas, demonstrating that providers can and do bill the Medicare program appropriately. At least two additional reviews have been completed and settlement negotiations are underway. There are an additional 48 PATH audits underway in various phases of completion.

This concludes my testimony, Mr. Chairman. I would be pleased to answer any questions.

ATTACHMENT A

ATTENDING PHYSICIAN DOCUMENTATION IN A TEACHING SETTING, JULY 1980

REQUIRED DOCUMENTATION

To be in compliance with Medicare regulations, the following documentation requirements are necessary to substantiate an attending physician-patient relationship:

1. The supervising physician should personally note in the patient's medical records that he or she saw the patient on admission; or within a reasonable period after admission;
2. The supervising physician should personally note in the patient's medical record that he or she rendered services to the patient during the critical period of illness;
3. The supervising physician should personally note in the patient's medical record that he discharged the patient.

During the remaining period of the patient's stay in the hospital, it will suffice for either the intern, resident or nurse to note in the patient's medical record that the physician was personally involved for the particular service billed. A physician's countersignature of a note entered by a resident, intern or nurse is not evidence that a covered service was rendered unless the notes indicate that the physician was present.

The Institutional Relations Department of PBS will conduct annual reviews of attending physician claims in a teaching setting. These post-payment audits must verify that the physician established an attending physician relationship with the patient. Listed below are the specific requirements for documentation of various claim situations found in a teaching setting:

1. *Admission History and Physical.*—An admission note written by the attending physician. This may be brief and may consist of a note on the history and physical sheet indicating his/her findings on examination of the patient.

2. *In-Hospital Medical Visits.*—The attending physician must have daily documentation either by a personally written note or by an indication in the daily progress notes of the intern, resident or nursing staff of his presence during the rendition of the services. Physician countersignatures of notes entered by a nurse are considered valid documentation of Part B covered services only when the notes themselves indicate that the coverage requirements have been met. Countersignatures next to entries which fail to indicate that the attending physician was present are not in themselves evidence that a covered service was rendered.

Discharge summaries are not required by some hospital Medical Records Departments if admission and discharge occurs within forty-eight hours. However, there must be documentation of a visit by the attending physician on the day of discharge if a fee for a hospital visit is to be requested on that day.

3. *Consultation Claim.*—Must have the consultation report signed by the staff physician performing the service. Follow-up care should be documented in the same manner as in-hospital medical visits.

4. *Anesthesia Claim.*—The operative report or anesthesia report should indicate the name of the staff physician who performed the anesthesia service.

5. *Surgery Claim.*—Operative notes with the attending physician's (surgeon's) name listed first under surgeon performing operation and signed by him. The anesthesia record should indicate the attending physician (surgeon) was present. It is also required that there be either personal notations by the attending physician or indications by the house staff or nurses of the attendings' presence both pre-operatively and post-operatively. Minor surgical procedures should be indicated in the progress notes since an operative report is not always written.

6. *Radiology. EKG, EEG, etc.*—Any type of report, e.g., report of findings or progress notes indicating the test was performed, is accepted. Reports should be signed by the staff physician rendering the service.

7. *Outpatient Claim.*—Hospital records should clearly indicate either that; the supervising physician personally performed the service; or he/she functioned as the patient's attending physician and was present at the furnishing of the service for which payment is claimed. His/her presence must be documented by the intern, resident or staff nurse in the outpatient/clinic chart.

8. *Emergency Room Claim.*—The hospital records should clearly indicate either that; the supervising physician personally performed the service; or he/she functioned as the patient's attending physician and was present at the furnishing of the service for which payment is claimed. His/her presence must be documented by the intern, resident or staff nurse in the emergency room progress record.

ATTACHMENT B

DOCUMENTATION

Services by a teaching physician which meet general coverage requirements may be reimbursed by Part B if the physician qualifies as the "attending" physician in the sense of Section A.1. (a)-(1) of IL 372.

To qualify as the patient's attending physician for an entire period of hospital care, the teaching physician must as a minimum:

1. Review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress.

This requirement may be presumed met if the physician has personally entered the initial history and physical report, the reports for subsequent examinations and tests which were made and the progress notes, or countersigned an entry.

Example: A physician has billed for a five day confinement, and the record establishes that for two of the five days the physician's only documented activity is a counter signed resident entry. The resident entries do not indicate the physician's presence or involvement with the patient.

Those two days would be acceptable in establishing the activities necessary to satisfy Medicare B attending criteria i.e. review of patient progress, but are not notes reflecting direct personal services provided to the patient and, therefore, are not a billable service. In this case no payment could be made for the 2 days.

Special attention should be given the above example in that there is a distinction made between satisfying the attending physician criteria set by the regulation and the concept of what is billable to the Medicare B program. Countersigning of resident and intern entries is evidence that will satisfy the attending physician criteria but will not document a billable charge. Personal entries as described below will document both attending status and a billable charge.

Medicare B reimbursement on a charge basis is intended where the physician has provided the personal and identifiable service as reflected by his personal entry in the medial record or where a resident or intern entry specifically identifies the service provided by the physician and is countersigned by the attending physician.

Medicare B reimbursement on a charge basis is also intended where the attending physician criteria have been met and the physician is present at the time a resident or intern provides the service. Resident or intern entries must state the physician's involvement i.e., presence and be appropriately countersigned by the attending physician.

This reimbursement is a special consideration for a teaching setting which is based on the satisfying of the Medicare B, attending physician criteria and the physician's presence at the time the service was provided by the house staff. Further reading of this manual will develop some contingent aspects of these regulations that apply this case that can affect the reimbursement issue.

2. "Personally examine the patient."

This examination must be personally performed and documented by the physician and signed by him/her or prepared by a resident, intern, or other medical staff member for the physician. If the note is not written personally by the physician, the note must state the name of the physician performing the examination and be signed or countersigned by that physician.

ATTACHMENT C

PENNSYLVANIA BLUE SHIELD WINS NEW JERSEY MEDICARE CONTRACT

Effective January 1, 1989, Pennsylvania Blue Shield will administer the Medicare Part B contract for the State of New Jersey.

The Health Care Financing Administration awarded Blue Shield the New Jersey contract, which includes the processing of 13.8 million claims annually for 1 million beneficiaries. Pennsylvania Blue Shield will be responsible for making annual payments of approximately \$1 billion for the services of 23,000 physicians and other suppliers.

"We are delighted to have been awarded a contract to serve Medicare beneficiaries in New Jersey," said Everett F. Bryant, Blue Shield's Vice President, Government Business.

"Our winning this major Medicare contract is a testament to the outstanding work and efficiency of our staff here in Camp Hill. We would not have been able to secure this added business without the successful track record our employees have earned."

The Company will immediately begin recruiting for 570 management, technical, clerical, and support staff to handle the new business. At present, Blue Shield plans to base the additional employees in Harrisburg, Pennsylvania. The Company will also maintain a service center in New Jersey.

"Our present role as the nation's largest processor of Medicare Part B claims is an advantage in accepting the New Jersey contract," said Bryant.

"Our data and claims processing systems are designed so that the addition of the New Jersey volume represents no capacity problem whatsoever."

According to HCFA, Pennsylvania Blue Shield has consistently been rated significantly above the national average among Medicare contractors in terms of efficiency and cost savings.

"In Pennsylvania Blue Shield, we have selected a high quality firm with proven Medicare experience to assume the New Jersey business," said William Roper, MD, Administrator of the Health Care Financing Administration.

Prudential Insurance Company, based in New Jersey, previously held the contract but will withdraw from the program by the end of 1988 to concentrate on other lines of business. Prudential has been the Medicare contractor in New Jersey since 1966.

Pennsylvania Blue Shield currently administers Medicare Part B for Pennsylvania, Delaware, and the Washington D.C. metropolitan area.

PHYSICIAN ASSISTANT MODIFIERS CHANGE

The 1988 HCPCS update includes a change in modifiers to be used when reporting services performed by a physician's assistant. The new modifiers are AN and AS. AN should be used with services other than assistant at surgery (replacing QA) and AS should be used for assistant at surgery services (replacing QS). The change to AS and AN modifiers is effective for claims submitted on or after September 1, 1988.

PROVIDER INFORMATION DEPARTMENT

The Provider Information Department (which now includes the former Provider File Section) maintains records of over 300,000 providers who report claims under all programs administered by Pennsylvania Blue Shield.

To serve you better, Blue Shield has assigned a dedicated post office box number to Provider Information:

Pennsylvania Blue Shield, Provider Information, P.O. Box 8842, Camp Hill, PA, 17011-8842

Please use this address to report any changes in your provider status, such as: Practice name; Special designation; Practice address; Tax identification number; Retirement from practice; Changes in assignment account membership.

NEW PROCEDURE FOR ASSIGNMENT ACCOUNTS

As of June 1, 1988, Blue Shield approves and updates assignment accounts for Medicare programs separately from accounts for Blue Shield Private Business programs.

Although we will continue to use the same provider identification number for these accounts, separate paperwork is required for new accounts and for changes to existing assignment account compositions. Thus, effective dates of new accounts or changes to existing accounts may differ between programs.

You may begin the process of establishing or changing an assignment account by contacting either your local Blue Shield or Medicare field representative.

SPECIFIC DOCUMENTATION REQUIREMENTS FOR THE SUPERVISING PHYSICIAN FUNCTIONING AS THE ATTENDING

Impatient medical services

The supervising physician, when functioning as the attending physician in a teaching setting, should personally provide all services reported for Medicare Part B payment or be present when the resident renders the services.

If you are the supervising physician, you must make the following documentation in the hospital records:

Personally note in the patient's medical records that you examined the patient on admission or within a reasonable period after admission.

If you receive payment for a comprehensive history and physical examination, but did not perform the history and physical examination or were not present during its rendition, Medicare considers the Part B payment to be an overpayment.

A resident may perform the comprehensive history and physical examination, but this is not a Part B covered service for the supervising physician, unless the resident's notes indicate that the supervising physician was present. Medicare does not accept an "admission note" that does not clearly indicate that the supervising physician actually performed the services reported for payment.

Personally note in the patient's medical record that you provided services to the patient during the critical period(s) of illness.

Personally note that you saw and examined the patient on the day of discharge.

If you fail to meet any one of these three criteria Medicare cannot consider you to be the "supervising physician." Medicare then pays you only for those services you personally rendered.

When the attending physician criterion has been met, notations by a resident or nurse which indicate your presence on the other days would be acceptable.

Surgical services

When acting as the attending surgeon, you should sign the operative report.

You also are required to provide a personal notation which indicates your presence both pre-operatively and post-operatively. A notation by the resident or nurse could also indicate your presence.

There may be a reduction in future Medicare payments when the attending surgeon fails to document the pre-operative and post-operative care.

Consultation services

If you are the supervising physician, you should sign the consultation report.

If you are a consultant acting as a supervisor, and you submit a claim for payment, you should personally provide notations on the report that indicate your personal involvement in consultation.

It is acceptable if the resident indicates you were present and participated in the consultation service.

Radiology, Pathology and other Diagnostic Services

If you are the supervising physician, you should sign the reports for radiology, pathology and other diagnostic services.

For additional information, contact Medicare Facility Relations at (717) 763-3695.

SERVICES FURNISHED BY INTERNS AND RESIDENTS WITHIN THE SCOPE OF AN APPROVED TRAINING PROGRAM

Effective July 1, 1987, Medicare Part B payments are prohibited for medical and surgical services rendered by interns and residents, within the scope of their training program when performed in a "non-provider" setting. In these situations, Medicare Part A will pay the parent hospital if that hospital incurs all or substantially all of the costs of the training program. If the hospital does not incur the costs in the non-provider setting, these services can be paid by the carrier on a reasonable charge basis.

Prior to July 1, 1987, the covered services of interns and residents were reimbursed by the carrier on a reasonable charge basis as physician services, if performed by a licensed physician off the provider premises, regardless of who incurred the training costs.

A written statement indicating that other forms of treatment (e.g., medical care and physical therapy directed at secretions, bronchospasm and infection) have been tried and have not been sufficiently successful and that oxygen therapy is still required.

If a portable oxygen system is prescribed, the Certificate of Medical Necessity must include a description of the activities or exercises that the patient will undertake on a regular basis.

DRUG CHARGE REIMBURSEMENT

When you submit claims reporting charges for drugs administered via injection, always provide the patient's diagnosis, the complete name of the drug (do not use abbreviations), and the exact dosage administered. Medicare's reimbursement is based on these criteria.

UNSOLICITED REFUNDS

The Medicare Secondary Payer Department had experienced problems processing unsolicited refunds due to insufficient information.

In order that we may credit your account in a more timely manner, please provide us with the following information on refund checks:

Beneficiary name and HIC number; Provider number; ICN of the claim in question; Date of service; Reason for returning money: be specific (e.g., Aetna Insurance Primary due to TEFRA). Explanation of Benefits from the primary insurance when applicable.

CONCURRENT CARE SERVICES

Medicare covers services involving medically necessary concurrent care when:

(1) Two or more separate conditions require the services of two or more physicians or specialists.

(2) The severity of a single condition requires the services of two or more physicians or specialists for proper management of the patient.

The patient's diagnosis and condition must substantiate the medical need for concurrent care. Medicare cannot make payment to more than one physician to treat the same patient for the same condition at the same time under routine circumstances. When reporting concurrent care, please use a procedure code modifier 75.

PHYSICIAN'S ASSISTANT SERVICES

As of January 1, 1987, Medicare covers certain services performed by a physician's assistant (P.A.) when employed by and acting under the supervision of a doctor.

If you are a physician's assistant, you must accept assignment by checking "yes" in Block 26 of the 1,500. (1-84) claim form when submitting claims to Medicare. You must accept Medicare assignment, regardless of how the performing physician reported the services on his claim.

Report your name, address and provider number in Block 31 of the claim form. Do not report your services on the same claim or under the name of your employing physician. Medicare will not make payments directly to you, even though we use your provider number to process the claim.

We still send reimbursement for all eligible services you provide to your employing physician. Consequently, you should advise our office immediately of any changes you make in employment.

SUMMARY STATEMENT OF DR. JORDAN COHEN

Senator SPECTER. I would like to turn now to Dr. Cohen, president of the Association of American Medical Colleges.

Dr. COHEN. Thank you, Mr. Chairman. I am speaking for myself and on behalf of the over 100,000 teaching physicians in this country who in the course of caring for their own patients permit residents in training to take part in that care so that they can acquire the skills necessary to practice the challenging medicine of the future.

First, let me emphasize that we welcome the inspector general's help in identifying how many there are among us who may have abused the public's trust and may have billed for services not personally delivered. I find it appalling that any physician would even consider getting paid for something he or she did not do.

Physicians individually, and the medical profession as a whole, must be accountable to the public if we are to sustain the public trust on which all of us depend. If the inspector general's PATH audits will assist us in culling out those bad apples, no one would be happier than I.

But, Mr. Chairman, it is imperative that this PATH audit process, like any audit process, apply the rules that were in place when the activity being audited took place. Indeed, as you know, audits have been conducted regularly since the inception of the Medicare Program and with very few exceptions, the billing practices of teaching physicians have been found repeatedly to conform to contemporary standards.

If an auditor were to come along, however, and attempt to apply today's billing standards retroactively, I'm sure you would agree that that would be a serious breach of faith with any acceptable concept of justice and fairness.

And that is the fundamental quarrel we have with the PATH audit process to date. It is attempting to apply billing standards that simply did not exist during the period being audited: Standards governing the complex interactions among teaching physicians, residents, and patients, standards governing the coding of billable services and standards governing the documentation in the medical record.

Let me quickly add that at no time has the inspector general or anyone else alleged that the services in question were not in fact received by Medicare beneficiaries or that those services were not of the highest quality. We're talking about the high quality medical care that Medicare patients did in fact receive in our Nation's premier teaching hospitals.

The only issue on the table is whether the teaching physician was entitled to get paid for the services they rendered. And to make that judgment, in the process of auditing medical records, requires that the auditor understand what billing directions HCFA provides to the teaching physicians that were in effect at that time.

In my written statement to the committee, I have summarized the lengthy history surrounding this complicated issue and have indicated the few adjustments in the PATH process that would bring them into compliance with the applicable billing standards.

In brief, the billing standards in place during 1990-95, the period under audit, recognized two tiers of billable services as laid out in intermediary letter [IL] 372, as Mr. Mangano said.

In the cases of major surgery and other complex procedures, in order to bill for the services, the teaching physician must have been physically present, elbow-to-elbow with the resident and prepared to perform the procedure if necessary. That standard was clear, everyone understood it and everyone should be held accountable to it.

The majority of cases, however, do not involve major surgery or other complex procedures. In these instances, in order to bill for services that IL-372 stipulated that the teaching physician must establish an attending physician relationship with the patient and must provide medical direction to the residents whom he involves in the care of his patient.

The teaching physician's presence is obviously required to provide medical direction, and HCFA stipulated that countersignature, countersigning the note in the medical record written by the involved resident provided presumptive evidence of that presence for billing purposes.

The inspector general has interpreted HCFA's medical direction standard to require the teaching physician to be elbow-to-elbow with the resident in these nonsurgical instances, as well and moreover, the inspector general is insisting that contrary to the standard practice in this country for 30 years or more since Medicare was enacted that countersignature does not constitute adequate documentation of the teaching physician's presence when IL-372 clearly stipulated that that was an adequate documentation.

We've attempted on a number of occasions to persuade the inspector general that the relevant language in the governing Medicare laws and regulations do not support the present PATH audit parameters, but thus far, the inspector general has insisted on an interpretation of those governing standards that simply does not conform to the reality of the time.

As you no doubt know, the general counsel, the Department of Health and Human Services did an exhaustive review of the legal basis of the PATH audits and concluded, as we had, that HCFA had never articulated the standards that the inspector general was attempting to apply nationally.

As a result of the general counsel's findings, which were made public in July of this year, 16 of the 49 audits already in process at that time were terminated.

Why were all the audits not terminated? Because the inspector general now, having conceded that HCFA itself did not provide clear support for its view, contends that local contractors to the so-called carriers should be the source of guidance for the teaching physicians.

We now have the bizarre situation, Mr. Chairman, in which teaching physicians in one region of the country face potentially ruinous penalties under the Federal False Claims Act because of their past billing practices while those in other possibly adjacent regions whose billing practices were identical are held totally harmless.

We don't believe Congress intended for private contractors to set billing standards that go beyond what Medicare law and HCFA regulations require. Medicare is a national program with a clearly defined rulemaking process designed to assure that all beneficiaries and providers are dealt with consistently and fairly.

PREPARED STATEMENT

That is why we were pleased when Chairman Thomas requested the GAO conduct an independent review of the legal basis of the PATH initiatives and when the House Appropriations Committee included report language requesting that the inspector general suspend the audits until the GAO completes its study.

Our hope, Mr. Chairman, is that the conference committee also will request the inspector general to suspend, not terminate, just suspend the audits.

[The statement follows:]

PREPARED STATEMENT OF JORDAN J. COHEN, M.D.

Mr. Chairman and distinguished members of the Subcommittee, I am Jordan J. Cohen, President and Chief Executive Officer of the Association of American Medical Colleges (AAMC). The AAMC welcomes the opportunity to participate in this special hearing to review the basis for the Physicians at Teaching Hospitals (PATH) initiative of the HHS Office of Inspector General. The Association represents all of the nation's 125 medical schools, approximately 350 major teaching hospitals which participate in the Medicare Program, the 88,000 full time faculty of these institutions represented by 86 academic and professional societies, and the more than 160,000 men and women in medical education as students and residents.

On June 21, 1996, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced what it described as "a series of nationwide reviews of compliance with rules governing physicians at teaching hospitals (PATH) and other Medicare payment rules." The letter announcing the PATH initiative

went on to state that, "This initiative grows out of the extensive work performed by the OIG at a major east coast university. The focus of the review was compliance with Intermediary Letter 372 (IL-372), the Medicare rule affecting payment for physician services provided by residents. We found that the institution was not complying with this rule. We also found that teaching physicians were improperly 'upcoding' the level of service provided in order to maximize Medicare reimbursement * * *. The OIG has initiated the PATH project in order to determine whether, and to what extent, similar problems are present at other teaching institutions throughout the country." Teaching physician services for years 1990 through 1995 were selected for review. Thus, on the basis of an audit conducted at one institution, the PATH initiative was born.

From June 1996 until July 1997 the OIG initiated PATH audits at forty-nine teaching institutions. During this same time period the Department of Health and Human Services, the HHS Office of Inspector General and the Health Care Financing Administration (HCFA) were asked by medical schools, faculty practice plans, teaching hospitals, members of Congress and organizations representing medical schools and teaching hospitals to clarify the parameters that would be utilized to conduct the PATH audits. These requests for clarification and the ensuing discussions and disagreements over the standards being utilized by the OIG were an indication of the confusion which had existed for almost 30 years regarding the standards which teaching physicians must fulfill and document to support Medicare billing for their services when medical residents were involved in the care of their patients.

This confusion is reflected in a February 24, 1997 letter to Representative John Porter (R-IL) from former HHS Secretaries Otis Bowen, M.D. and Louis Sullivan, M.D. In their letter Drs. Bowen and Sullivan stated that, "Really since the inception of the Medicare program the Department of Health and Human Services has had a difficult time in setting forth a bright line standard that could be used to separate the services provided by an attending physician that are strictly teaching in nature and those that involve care to a specific patient". Drs. Bowen and Sullivan further stated that, "Given the contorted history of this issue [IL-372] through the years, it would appear to be an unlikely candidate for an OIG investigation."

It became clear through written and oral responses to various requests for information and clarification that the OIG had adopted a standard for teaching physician billing which reflected the rules which went into effect on July 1, 1996, rather than the rules and requirements that were in effect from 1967 through June 30, 1996. With respect to the audit activity which focused on possible 'upcoding' (charging for a higher level of service than was actually provided) it also became clear that the OIG was auditing against guidelines which became effective in August 1995—subsequent to the date of the records generally being audited.

It is also clear from early briefing materials used by the OIG in public forums that their expectation was that institutions would be found to have violated the Federal False Claims Act (FCA) and would, presumably, owe the government money. One OIG document states that PATH has among its objectives to:

"Recover Medicare reimbursements for unallowable and inadequately documented services in amounts imposed by the Federal False Claims Act, or determined by settlement between the OIG/DOJ project teams and the physician group practices." (emphasis added)

The FCA prohibits anyone from submitting a claim to the federal government if the person: (1) knows the information is false, (2) acts in deliberate ignorance of the truth or falsity of the information, or (3) acts in reckless disregard of the truth or falsity of the information. A violation of the FCA may result in an assessment of double or treble damages, plus an additional \$5-10,000 per claim. Fraud must never be tolerated, but for the OIG to begin an audit initiative under the premise that monies will be recovered under the FCA suggests that there is an underlying assumption that any errors found will be fraudulent.

On July 11, 1997 Harriet Rabb, the General Counsel for the Department of Health and Human Services, completed an exhaustive review of the PATH audits, including an examination of the history of Medicare rules governing payment to teaching physicians. Her conclusion was that "the standards for paying teaching physicians under Part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades." (emphasis added). She then stated: "When HCFA policy is not unambiguously clear, carrier clarification is warranted and appropriate. Thus, where a carrier informed a teaching institution that physicians must either personally furnish a service or be present when it is furnished by an intern or resident in order to be reimbursed under Part B, that guidance would be controlling." Ms. Rabb, whose analysis was articulated in a letter to the AAMC and AMA, then set forth new guidelines under which the PATH audits were to be con-

ducted. It is questionable whether carriers have the authority to promulgate requirements which have the effect of rules. Yet, on the basis of the conclusions and guidelines in Ms. Rabb's letter, the OIG ended sixteen of the forty-nine PATH audits then underway because it was determined that local carriers had not provided clear guidance.

In the succeeding months approximately twenty more institutions were notified that they had been selected for PATH audits. Additionally, in September 1997 the U.S. Attorney for the District of Massachusetts sent civil investigative demands (CIDs)—akin to subpoenas—to at least a dozen teaching hospitals and faculty practice groups in Boston, each of which had been told by the OIG, in the wake of the Rabb letter, that it was no longer being audited under the PATH initiative. The CIDs requested extensive documents covering the same issues that were the subject of the PATH audits—IL-372 and coding of physician services.

Congress is concerned about the direction of the PATH audits. In addition to numerous letters from members of Congress to the HHS Secretary and Inspector General, on July 14, 1997 Congressman Bill Thomas (R-CA), chair of the Health Subcommittee of the House Ways and Means Committee, requested that the General Accounting Office (GAO) examine this issue and report to Congress. The GAO review is ongoing. In 1986 the GAO issued a report on 'Documentation of Teaching Physician Services' that concluded that the federal rules were unclear and that HCFA needed to issue new regulations and provide physicians with unambiguous billing standards.

What Is Wrong With the PATH Audits?

There is no argument that Congress has provided the OIG with ample authority to conduct audits of Medicare payments. However, in conducting those audits the OIG by law must look to the rules promulgated by the federal agency—in this case the Health Care Financing Administration (HCFA)—charged with implementing the relevant law to determine the audit standards. The OIG is without legal authority to create rules that differ from those promulgated by HCFA. The OIG also may not apply a new rule to services that were rendered prior to the rule's effective date. Those services must be audited under the HCFA rules in place at the time of the service.

As described by the OIG in the June 1996 letter announcing the PATH initiative, the audits would focus on two issues: (1) "compliance with Intermediary Letter 372 (IL-372), the Medicare rule affecting payment for physician services provided by residents"; and (2) whether the level of the physician service was coded properly. Therefore, to determine the standards under which the audits must be conducted it is necessary to understand the requirements of IL-372 and of coding for physician services.

IL-372

When the Medicare program began in 1965, there were no separate rules under which teaching physicians were paid for services to patients. By 1967, rules were issued which, until December 1995, underwent only minor revisions. For all services, a teaching physician could bill Medicare once an "attending physician relationship" was established between the teaching physician and the patient. The attending physician had to also "assume and fulfill the same responsibilities for this patient as for other paying patients" and be recognized by the patient as his or her personal physician.

The 1967 general rule clearly established two standards of teaching physician involvement required to bill for services that involved residents, depending upon the type of service performed. Section 405.521 (b) of the rule establishes a general standard and states:

"Payment on the basis of the physician fee schedule applies to the professional services furnished to a beneficiary by the attending physician when the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient."

Paragraph (b) (2) establishes a higher standard for other services and reads:

"In the case of major surgical procedures and other complex and dangerous procedures or situations, the attending physician must personally supervise the residents and interns who are participating in the care of the patient."

The 1967 rule, in its general provisions, encompasses both activities of personal service and medical direction of residents by teaching physicians providing service for payment purposes under the Medicare program. The general provision, however, makes no mention of a strict physical presence requirement in order to bill Medicare for visit and consultation services or minor procedures. The rule establishes a higher standard of physical presence of the teaching physician when performing or provid-

ing direction to a resident participating in a major surgical or complex procedure and teaching physicians generally understood that they must be present for the key component of these activities.

The rule also acknowledged that teaching physicians differ from their non-teaching counterparts in that they not only provide patient care, but they also educate and provide medical direction to recently graduated medical students, known as resident physicians. Sometimes the education occurs through traditional teaching methods—apart from patient care activities—such as lectures; many times it occurs at the patient's bedside or in the physician's office as the resident observes the teaching physician, works in collaboration with the teaching physician, or provides care under the medical direction of the teaching physician. Medical direction of a resident by a teaching physician is, in general, distinguishable from education since it is patient and service-specific and is an integral component of the overall management of the patient's care.

While recognizing the joint nature of a teaching physician's activities, Medicare payment policy attempts to distinguish between the activities of education and medical direction by paying for educational activities under Medicare Part A and the activities of medical direction of residents, under Part B. To support and guide the payment of teaching physicians under Part B, the Medicare program established specific criteria to qualify when medical direction activities are occurring and when a teaching physician's personal care to the beneficiary constituted a billable unit of service. The attending physician criteria in the 1967 rule included:

Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission; confirming or revising diagnosis; determining the course of treatment to be followed; ensuring that any supervision needed by the interns and residents is furnished; and making frequent reviews of the patient's progress throughout the period of care.

Even after the 1967 regulations were issued, there continued to be confusion among Medicare carriers concerning the standards for teaching physicians. Thus, in 1969, HCFA issued Intermediary Letter 372 (IL-372) to "clarify and supplement the criteria that govern reimbursement" for services rendered to patients by teaching physicians. An intermediary letter is not, as the OIG has stated on a number of occasions, a rule. It is an elucidation of a rule but it cannot change the substance of the rule. Unlike a rule, it is not subject to public comment.

IL-372 clearly states that for a teaching physician to be eligible for Medicare payment the physician must be the patient's 'attending physician.' IL-372 then lists the criteria found in the regulation discussed above, as the minimum requirements that must be fulfilled to establish the attending physician relationship. It reiterates two very distinct standards of involvement for teaching physicians—one for the medical direction activities and personal services performed relative to visit and consultation services, and another for the medical direction activities and personal services performed relative to major surgical and complex procedures.

According to IL-372, "performance of the activities referred to above [the attending physician criteria] must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician." (emphasis added) When the carrier audits physician claims, IL-372 says: "provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart."

The confusing standards set out in 1967 and "clarified" by IL-372 continued to be a problem, so in 1970 HCFA issued a second intermediary letter (IL-70-2) that "summarizes the major questions [raised about IL-372] and provides the basic policies applicable to making reimbursement." IL 70-2 continued to look toward the attending physician relationship as the keystone to teaching physician billing, and made the distinction between major surgical or other complex or dangerous procedures and all other physician services. It also states that "if the physician countersigned the entries in the record pertaining to the patient's history and the record of examinations and tests, it would be presumed the physician reviewed these activities." (emphasis added). IL 70-2 goes on to say that "frequent reviews of the patient's progress by the physician would be established by the appearance in the records of the physician's signed notes and/or countersignature to notes with sufficient regularity that it could be reasonably concluded that he was personally responsible for the patient's care."

Various rules and documents were issued by HCFA in subsequent years, but none changed the criteria established by the 1967 rule and elaborated on by IL-372. It was not until HCFA issued new teaching physician regulations in December 1995, effective July 1996, that the agency required that a teaching physician must be present to perform or observe the resident perform the 'key portion' of every unit

of service billed to Medicare. In issuing the regulations HCFA described as “inappropriate” the fact that carriers (private companies, usually insurers, that contract with HCFA to process and pay Medicare bills) were inconsistently applying standards that could result in a payment of several thousand dollars for a surgical procedure in one area of the country, and a zero payment for the same procedure in another locale. Moreover, HCFA delayed its implementation of this new rule for six months to allow carriers “adequate time to educate all affected parties.”

Despite what is written in IL-372, and admissions by HCFA that the rules have been inconsistently applied, the Inspector General has chosen to audit physician billings under the PATH initiative by using the following standard:

“The medical record must clearly indicate that the teaching physician personally performed the service or was present when the service was performed.”

This may be considered a reasonable audit standard for those teaching physician services performed after July 1, 1996 when the new Medicare teaching physician rules went into effect, but it does not reflect the standard in effect from 1990 through 1995, the dates covered by the PATH initiative. During that time, IL-372 and its related regulation were in effect. The OIG originally acknowledged that the PATH audits were being conducted under IL-372. This means that prior to July 1996, the standard for auditing teaching physician billings should be the 1967 regulation, IL-372, and IL-70-2. Based on these regulations, and clarifying documents, the countersignature of the record by the teaching physician should be the documentation standard applied to determine compliance with IL-372 requirements. The presence of a countersignature on the record should be viewed as compliance with the minimum audit documentation requirements unless other information indicates the teaching physician did not meet the required standards.

As noted above, it is not appropriate to rely on standards promulgated by the Medicare carriers. To rely on such standards would be a delegation of rule making authority to these agents of the Medicare program with no opportunity for application of the Administrative Procedures Act or other rule making requirements. Furthermore, the utilization of variable standards by the carrier will inevitably mean that teaching institutions will have differential standards applied relative to their compliance with a national program. To have such a system is patently unfair and inequitable.

Coding of physician services

The PATH audits also focus on whether teaching physicians documented in accordance with AMA/HCFA guidelines for Evaluation and Management (E/M) services. E/M services are physician visit and consultation services furnished during an outpatient or inpatient visit during which the physician evaluates and prescribes a course of treatment to manage a patient's illness or injury.

In 1992, the manual used by physicians to code their E/M (visit and consultation) services, Physicians' Current Procedural Terminology (CPT), was revised substantially by the American Medical Association CPT Editorial Panel, with participation of HCFA personnel. This revision was a result of the implementation of the resource-based Medicare Fee Schedule payment system. The new coding architecture requires that physicians select from multiple levels of care for a particular E/M service category. Categories of E/M codes differ depending upon: (1) the type of service, i.e., visit or consultation performed; (2) if the patient is a new or an established patient with the physician; (3) whether the service is performed in the hospital, office or other delivery setting. Consultation and office visit codes, for example, have up to five levels from which to select.

The revisions added an elaborate and complex set of criteria that a physician must determine in order to select a level of E/M code that best describes his/her visit service. For a new patient the key components of the visit service that must always be performed are: history, review of systems, physical exam, and medical decision-making. The more complex the patient, the more work and intensity of care the physician is expected to perform in order to bill at the highest level of service within an E/M category.

In 1994, HCFA and the AMA agreed upon a national standard in the form of guidelines for documentation of E/M services. The new guidelines were circulated to all physicians in November 1994 to be effective August 1995 for purposes of Medicare audits of physician services.

In 1995, the OIG reviewed the use of the new visit codes to determine whether or not physicians were using them accurately. Given the complexity of the coding system it is not surprising that the OIG found that both physicians and carriers had difficulty selecting the appropriate new codes. The OIG determined it was not going to take further action in this area aside from monitoring to see whether the newly issued HCFA/AMA guidelines would make a difference.

When Harriet Rabb conducted her review of the PATH audits, she concluded that "HCFA instructed its Regional Administrators that, during the period of training [on E/M codes] prior to August 1995, action could be taken at any time to deal with egregious cases of fraud and abuse. Thus, where OIG finds egregious cases of upcoding abuse or fraud as it audits pre-August 1995 records, such matters are appropriate for attention and resolution." The question becomes what are 'egregious cases of upcoding'.

In the absence of any definition, the OIG has indicated their intent to conduct full reviews of coding activity and to determine, at the conclusion of an expensive and lengthy audit process, if there were egregious cases of fraud and abuse.

CONCLUSION

The academic medical community has recognized for almost three decades that the rules governing when a teaching physician can appropriately bill Medicare when a resident is involved in the care of his or her patient have been ambiguous and has actively encouraged and supported efforts to develop revised regulations. The lack of clarity relative to these rules has been acknowledged on numerous occasions by government officials, through a GAO report, in the development of proposed regulations in 1989 and the development and issuance of regulations in 1995 which became effective on June 30, 1996. This history of confusion has recently been confirmed during a thorough review by the General Counsel for the Department of Health and Human Services.

When the PATH audits were initiated they were characterized as a review of compliance with the requirements of IL-372. The PATH audits should and must be limited to auditing teaching physicians on the national, not carrier specific, standards in effect at the time. Likewise, it is inappropriate to conduct audits of coding activity prior to August 1995 unless there is a clear definition of egregious behavior and indications prior to undertaking an audit that there was egregious behavior. As currently constituted the PATH audits are applying differential standards by carrier region and retrospectively determining what—if any—egregious coding behavior was occurring. It is also inappropriate to assume that the Federal False Claims Act penalties will be applied to these audits absent a finding of fraudulent activity. To do otherwise is inequitable, costly, and disruptive to teaching physicians and the academic medical community.

The PATH audits must be conducted under fair and just standards. To apply standards retroactively, as the OIG has done under the PATH initiative, is to engage in conduct that is outside the broad authority that Congress has granted the OIG. Fraud must be eliminated from the Medicare program. Yet, there also must be a recognition that if a physician's behavior complied with the standards in effect at the time, then fraud was not committed. The OIG is not free to change past standards nor may it determine current standards. That job has been delegated by Congress to HCFA. HCFA has now issued explicit rules about what is expected of a teaching physician if he/she is to bill Medicare. Not even the OIG can reasonably hold a physician to those rules prior to the date on which they became effective.

As the subcommittee members are aware Congressman Thomas (R-CA); Chairman, Health Subcommittee of the House Ways and Means Committee; has requested that the GAO conduct an independent review of the PATH initiative and that the House Appropriations Committee included report language requesting the OIG to suspend the audits until the GAO completes its study. Our hope, Mr. Chairman, is that the Conference Committee will also ask the OIG to suspend the audits until the GAO study is completed. We have never asked that the audits be stopped but we believe it is imperative that teaching physicians across the country be treated equitably and fairly.

DIFFERENT STANDARDS

Senator SPECTER. We understand what the House did. Let me turn to Mr. Mangano just to come to grips with what Dr. Cohen has had to say. Is he correct in his statement that the inspector general is requiring standards which were different than those in effect at the time the procedures were carried out?

Mr. MANGANO. Absolutely not. We applied the standards that the local carrier applied to their providers and their community. Hundreds of audits have been carried out—

Senator SPECTER. Is he correct when he says you are looking for local contractors in some areas, as opposed to other areas where there are not local contractors?

Mr. MANGANO. No; there are local contractors everywhere in the country, Mr. Chairman.

Dr. COHEN. That wasn't my point, Mr. Chairman.

Senator SPECTER. Go ahead.

Dr. COHEN. It was that some local carriers interpreted HCFA regulations in one way and other local carriers in another way.

Senator SPECTER. Is that true, Mr. Mangano?

Mr. MANGANO. The overwhelming majority of contractors have applied the physical presence standard, over 75 percent of the ones that had teaching hospitals in their communities.

Senator SPECTER. Mr. Mangano, on the language of the House report that the PATH audits were highly ambiguous, and they come to the conclusion of retroactive enforcement of possibly ambiguous standards, do you disagree with that conclusory language in the House report?

Mr. MANGANO. I sure do because we believe the standards were very clear in those communities that had that standard from the contractors.

SUMMARY STATEMENT OF DR. C. MC COLLISTER EVARTS

Senator SPECTER. Let us turn now to—we will come back to some of these points later.

Dr. Evarts.

Dr. EVARTS. Yes; I'm Mac Evarts. I'm the president, chief academic officer of Penn State Geisinger Health System and senior vice president for health care and dean of the Pennsylvania State University.

I'm not going to repeat all that Dr. Cohen has said and I share with his disagreement with the first person testifying. And I also am here on behalf of the board of trustees of both the Penn State Geisinger Health System and the Pennsylvania State University, who are very familiar with the possible PATH audit.

Now, our system represents a recent merger of Penn State and the Milton S. Hershey Medical Center and the Geisinger Health System. It creates a physician-led, not-for-profit system which spans over 40 counties in central Pennsylvania and includes over a thousand physicians.

We were quite taken back and surprised when we received notification of the intent of the OIG to conduct a PATH audit in August of this year. Coincidentally, such notification came after the House passed report language urging the OIG to suspend PATH audits until the General Accounting Office had completed an independent review of the issue.

We strongly support the House Appropriations Committee report language requesting that the OIG suspend PATH audits until the report is completed. In particular, it may allow us and the other academic health centers now involved in this process to minimize and perhaps avoid the substantial expenditure of funds that such audits entail. Because the PATH audit has only recently been initiated, it is difficult to judge at this time the costs which we will

incur, but they will be substantial as based on the evidence from other institutions.

Not only must we secure attorneys and experts to assist us, an extraordinary expense in itself, but really what gets at the issue is that this is detracting from what we are supposed to be doing, and that is taking care of patients and providing health care services for our population of people that are served by our system.

This has been very disruptive internally to our organization, and it does cost us not only in terms of real dollars but also in terms of the diversion from our principal message and mission. This, in my view, is directly contrary to our mutual objective of controlling the cost of health care in central Pennsylvania.

Now, upon completion of the GAO report, all parties to this process, including the Congress, Department of Health and Human Services and academic medical centers, will have the opportunity to reassess the basis for and the standards to be used in the audits of teaching physician billing. It seems a particular waste of our resources to pursue the PATH audit process before the reassessment is completed.

PREPARED STATEMENT

Now, you're completely aware of the report language requested. We strongly urge you, Mr. Chairman, and the other subcommittee members to include the language in the conference committee report. It appears quite clearly that given the continuing questions and uncertainties surrounding this issue that it would be reasonable to allow the General Accounting Office to independently review the issue. My hope is that the GAO report will provide an objective view of the PATH audit process prior to institutions like ourselves incurring the expense of this process.

Thank you for the opportunity to be here.

Senator SPECTER. Thank you very much.

[The statement follows:]

PREPARED STATEMENT OF C. MCCOLLISTER EVARTS, M.D.

Good afternoon Mr. Chairman and members of the Subcommittee. I am C. McCollister Evarts, M.D., President and Chief Academic Officer of the Penn State Geisinger Health System and Senior Vice President for Health Affairs and Dean, The Pennsylvania State University, College of Medicine. I am pleased to have the opportunity to testify at this special hearing to review the basis for the PATH audit initiative and appreciate your invitation to outline our concerns with the ongoing initiative as it specifically relates to our Health system.

The Penn State Geisinger Health System, which represents the recent merger of Penn State's Milton S. Hershey Medical Center and the Geisinger Health System based in Danville, Pennsylvania, is a physician-lead, not-for-profit system which spans 40 counties in central Pennsylvania and includes over 1,000 physicians. Our Health System received notification of the intent of the OIG to conduct a PATH audit in August of this year. Coincidentally, such notification came after the House passed report language urging the OIG to suspend PATH audits until the GAO had completed an independent review of the issue.

We support the House Appropriations Committee report language requesting that the OIG suspend PATH audits until the GAO report is completed. In particular, it may allow us and the other academic health centers now involved in this process to minimize and perhaps avoid the substantial expenditure of funds that such audits entail. Because the PATH audit of the Penn State Geisinger Health System has only recently been initiated, it is difficult to judge at this time the costs which we will incur. However, if experience of other institutions is any indication, that cost will be substantial. Not only must we secure attorneys and experts to assist us—

an extraordinary expense in itself—but large numbers of our internal staff must be engaged in order to respond to the audit. This is a very real cost in terms of dollars and diversion from our principal mission of providing health care to central Pennsylvania and beyond. I am told by my colleagues that the level of workforce disruption and distraction is substantial, and in my view this is directly contrary to our mutual objective of controlling the cost of health care in the United States.

Upon completion of the GAO report, all parties to this process—including the Congress, the Department of HHS and academic medical centers—will have an opportunity to reassess the basis for and standards to be used in audits of teaching physician billing. It seems a particularly egregious waste of our resources to pursue the PATH audit process before the reassessment is completed.

As you are aware, the House Appropriations Committee included report language requesting the OIG suspend PATH audits until the GAO completes its study of the issue. I would urge you, Mr. Chairman, to include this language in the Conference Committee Report. It appears that given the continuing questions and uncertainties surrounding this issue that it would be reasonable to allow the GAO to independently review this issue. My hope is that the GAO report will provide an objective view as to the PATH audit process prior to institutions like ourselves incurring the expense of this process.

Thank you again for the opportunity to share our views with you.

SUMMARY STATEMENT OF BARBARA WYNN

Senator SPECTER. I turn now to Ms. Barbara Wynn, director of the planned provider purchasing policy unit of the Health Care Financing Administration.

Ms. Wynn, the floor is yours.

Ms. WYNN. Mr. Specter, I do not have a formal statement, however, I am pleased to answer any questions that you might have.

Senator SPECTER. Well, let us come to grips with the central issue as to whether or not these standards are retroactive. Dr. Cohen, what is the best evidence you can provide?

Dr. COHEN. Let me quote, Mr. Chairman from a letter from the general counsel, in response to our request for an analysis of the legal basis, in which he says: “The standards for paying teaching physicians under part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades.”

Senator HARKIN. Who did you just quote?

Dr. COHEN. That is Harriett Rabb, the general counsel of Health and Human Services.

Senator SPECTER. Mr. Mangano, what do you have to say about that?

Mr. MANGANO. As I indicated in my statement, we found that the overwhelming majority of statements that HCFA has put out were consistent with the physical presence requirement, but we recognize there were some that were not. That’s why we, to be fair, only used the standards that the carriers told the providers.

Senator SPECTER. You are saying some are not consistent but you do not enforce the ones that have not been consistently interpreted?

Mr. MANGANO. That’s correct.

Senator SPECTER. Dr. Cohen, have you seen standards which are inconsistent?

Dr. COHEN. We have requested repeatedly, Mr. Chairman, we be given a chance to see the evidence on which the inspector general is basing its judgment about clear standards and they have not made those forthcoming.

If I could quote one more thing for you, though, and this is from the—

Senator SPECTER. Let me ask Mr. Mangano about that. That seems like a fair request to me. If you have some standards which are inconsistent, they ought not to be applied. You can have an audit on consistent standards if there are other standards as long as you leave out the ones which are inconsistent. Is there any problem in supplying the information which Dr. Cohen has requested?

Mr. MANGANO. We have, at the beginning of every audit, we're supplying this information to every hospital at which we are doing these audits. We're keeping the information at the local level as opposed to giving this information to national associations. And Dr. Cohen mentioned that we had—

Senator SPECTER. Is there any problem in complying with Dr. Cohen's request so they can make their own analysis?

Mr. MANGANO. We can provide Dr. Cohen with all the carrier guidance for each of the carriers in the United States. I believe they made that request to the Health Care Financing Administration.

Senator SPECTER. How about the issue of retroactive enforcement? Dr. Cohen, do you have some specific instances where audits were applied retroactively?

Dr. COHEN. Well, the parameters of the PATH audit themselves apply the standards that were put in place in December 1995 and promulgated in December 1995 and put in place in July 1996.

Senator SPECTER. For procedures carried out before December 1995?

Dr. COHEN. No; for procedures carried out prospectively. Those standards that we've been asking for clarification of the part B billing standards for literally decades because they have been unclear.

Senator SPECTER. What has been applied retroactively, then?

Dr. COHEN. The countersignature requirement that was in place at that time is no longer regarded as being—

Senator SPECTER. You felt that had been sufficient? Is it true that the countersignature had been considered sufficient and is no longer considered sufficient?

Mr. MANGANO. No, sir; we consider countersignatures, when the countersignatures are affixed to documentation from the resident or intern, if they perform the service, that indicated that the physician was present.

Senator SPECTER. So that is sufficient proof?

Mr. MANGANO. That is the carrier guidance in most of the places. They allow countersignatures as long as the medical record indicates the physician was present.

Senator SPECTER. So that is sufficient proof?

Mr. MANGANO. That's correct.

Dr. COHEN. Mr. Chairman, there is a fundamental issue here that we have not touched on, at least sufficiently in my view, and that is that the fact that HCFA, the agency that is delegated by law to set the regulations for billing for part B, had not made those standards clear. And what the inspector general is depending upon is the interpretation by private contractors of HCFA's regulations in some cases—

Senator SPECTER. Let me yield to Senator Harkin on that.

REMARKS OF SENATOR HARKIN

Senator HARKIN. I have a statement I want to make. I know you have to leave here for a second, Mr. Chairman. I want to make my opening statement, make it clear where I am coming from on this.

First, I want to thank the chairman for having this hearing. We have excellent witnesses. This subcommittee has taken an aggressive leadership roll in ferreting out, stopping waste, fraud, and abuse in the Medicare Program, both under the leadership of Senator Specter and my leadership when I had the chairmanship before.

We have had countless hearings and I am pleased to say that our work has resulted in billions of dollars of savings to the taxpayers.

The work of the Health and Human Services Inspector General has been critical to many of our successes. While we do not agree on every issue, I believe the OIG is doing a great service and I support their aggressive—I underline aggressive pursuit of waste, fraud, and abuse on behalf of the American taxpayer, no matter where it leads.

I reviewed a great deal of material relative to the so-called PATH audits. While it may be that there were some instances in which Medicare could have been clearer about policy in this area, as I have gone through this from beginning to the end, it is clear to me that what it really boils down to is good old common sense.

Medicare pays the salaries and fringe benefits of residents and interns in teaching hospitals to the tune of about \$100,000 per resident per year. The residents and interns get only about \$30 to \$40,000 of this. In addition, hospitals were paid an additional \$8.1 billion last year for the indirect costs of training and supervising these residents and interns. So the taxpayer's paying for training and supervision in two ways.

It just defies common sense that Medicare would pay a physician for a service they did not provide and in fact were not even present when it was performed, particularly when the Government had already paid the services and the salaries of the residents and interns who actually provided the service.

Several years ago, under my chairmanship of this subcommittee, with the help of the inspector general and the GAO, we found that Medicare was paying hospitals for parties, alcoholic beverages, trips to Italy, fine works of art that were not related to patient care.

At the time, before this subcommittee, the hospitals argued that Medicare policy was not clear on this. And I had to admit it was not, but common sense would dictate that Medicare should not pay for a trip to Italy to inspect art. It should not pay for parties and alcoholic beverages. That is just good old common sense.

Well, it is my belief that the PATH audits are a legitimate and necessary law enforcement effort. There is clearly evidence of violation of Medicare law and rules. While any investigation must be done fairly, I am concerned that some are trying to stop a legitimate review. In my view, that would be a serious mistake.

I have, Dr. Cohen, for many years in Congress here been a very, very strong supporter of our medical colleges. My record is clear in that regard. I take a back seat to no one. But from my looking at

these PATH audits, as I understand it, is that there are regions in this country, Dr. Cohen, where hospitals had clear, unequivocal guidelines.

Do you disagree with that?

Dr. COHEN. I believe that every physician, every teaching physician in this country, Senator Harkin, understood the vagueness of these rules. There was—and physicians in this country, teaching physicians move from one region to another repeatedly.

Let me be absolutely clear and I'm sure you didn't hear my opening statement. I absolutely agree with you, Senator, that HCFA and Medicare should never pay for something that a physician didn't do. A physician that bills for something they didn't do should clearly be sanctioned severely for that. We would like to weed out anybody who tries to defraud the Government in that way, and that's clearly not our purpose here, is to try to argue that physicians ought to be paid for things they didn't do, No. 1.

No. 2, there's no question about the fact that the physician has to be present in order to provide the service. The question only is what is the standard of that presence in circumstances of medical direction? In the surgical circumstances and in the complex procedures for which HCFA made it very clear that the presence of the physician, elbow-to-elbow with the resident, was a requirement and anybody who tries to bill for a major surgical procedure who didn't conform to that standard ought to be sanctioned.

The issue is what does presence mean in the course of the major, not the largest number of services that teaching physicians provide, namely medical direction to the resident? I'm a teaching physician. I did it for 30 years on my wards. I was always present for every major decision that was made on my patients.

I was never—I wasn't present on every occasion that a resident went in the patient's room to do things for, on behalf of that patient under my direction, but I was present on every occasion of service, every occasion where there was a decision made, everything that was done, it was my responsibility and I took that seriously.

I indicated my presence in the care of that patient by signing the resident's note. I countersigned the resident's note if that resident's note was accurate, if it wasn't, I corrected it. That was the standard under which all teaching physicians were operating in this country. I didn't have knowledge of what the local carrier was saying. I knew what the circumstance was nationally. I knew that there was vagueness in this issue. I knew that there was debate continually about what it was that the teaching physician needed to do in order to document for its standard, and we were waiting for better clarification from HCFA which hasn't come—which didn't come until July 1996.

From that time forward, we now know exactly what HCFA is requiring out of every teaching physician in this country.

Senator HARKIN. And what is that requirement?

Dr. COHEN. It's requiring that the physician be present for the key portion. That's the term of art—

Senator HARKIN. What do you mean by present, you mean physically present?

Dr. COHEN. Physically present for the key portion—

Senator HARKIN. For that which he is seeking to be reimbursed.

Dr. COHEN. For that which he is seeking to be reimbursed, precisely. And that's the first time that language was used by HCFA. HCFA acknowledged when it promulgated that rule that its previous rules were vague and unclear. On repeated occasions, HCFA itself has acknowledged that.

Senator HARKIN. Dr. Cohen, I am going to read—I am going to ask to put this in the record at this point, a letter that was put out by your predecessor, Robert G. Petersdorf, president of the Association of American Colleges, May 13, 1993. Basically it discusses a letter from Charles Booth, Director of Office of Payment Policy, Health Care Finance Administration, which I will also submit for the record.

[The information follows:]

MEMORANDUM

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
Washington, DC, May 13, 1993.

To: Council of Deans; Council of Teaching Hospitals; and Council of Academic Societies.

From: Robert G. Petersdorf, M.D., President.

Subject: HCFA Response to AAMC Comment Letter on Teaching Physician Requirements (IL-372 guidelines).

Enclosed is a letter dated May 7 from Charles Booth, Director, Office of Payment Policy at the Health Care Financing Administration (HCFA) for your information. This letter is in response to the Association's comment letter of April 2 to Mr. Booth on HCFA's change in policy with respect to the teaching physician requirements as originally stated in IL-372 Guidelines. This change in policy was announced as a "clarification of existing payment policy" in a December 30 memorandum from Mr. Booth to all HCFA regional administrators. (These documents are also enclosed for your information.) In this memo, Mr. Booth states that: "physicians' fees, are payable in teaching hospitals if (1) the physician personally performs an identifiable service; or (2) the chart indicates that the physician has performed those activities necessary to qualify as an 'attending physician', and the physician is physically present when the resident performs the identifiable service for which payment is sought." Many of our faculty practice plans and teaching physicians have already received updated instructions from their local Medicare part B carriers based on the December 30 memo. The Association recognizes that compliance with this change in the interpretation of IL-372 Guidelines may represent a significant problem to many of our faculty practice plans and clinical faculty.

The AAMC Ad-hoc Committee on Physician Payment Reform, chaired by Michael E. Johns, MD, dean of the Johns Hopkins University School of Medicine, will meet June 22 to deliberate the appropriateness of the "physical presence" requirement and to assist the Association in updating its position on HCFA's interpretation of IL-372 Guidelines. For this reason, we encourage you to give us your comments on the Booth letters, the "physical presence" requirement, and what you believe constitutes appropriate medical direction by the attending physician when services are performed by residents. Please mail your comments to Robert D'Antuono, Senior Staff Associate, in the AAMC's Division of Clinical Services.

Thank you for your input.

Attachments.

MEMORANDUM

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, DC, December 30, 1992.

To: All Associate Regional Administrators for Medicare.
From: Director, Office of Payment Policy, Bureau of Policy Development.
Subject: Assigning the Level of Evaluation and Management (E&M) Codes in the Teaching Setting.

We have been asked to clarify how the CPT E&M codes that became effective in 1992 are to be applied in teaching hospitals and other teaching settings in which physicians involve residents in the care of their patients. We have heard allegations that some carriers automatically reduce the level of the billed code for payment purposes simply because a resident is involved in furnishing the services. In addition, we have been asked to clarify whether the services provided by a resident outside of the attending physician's presence are included in the content of the visit in establishing the level of the visit for payment purposes.

The policy, as set forth in Intermediary Letter No. 372, Part B Intermediary Letter 70-2, and MCM section 15016, is that physicians' fees are payable in teaching hospitals if:

- (1) the physician personally performs an identifiable service; or
- (2) the chart indicates that the physician has performed those activities necessary to qualify as an "attending physician," and the physician is physically present when the resident performs the identifiable service for which payment is sought.

Generally speaking, it has been our position that when situation (2) exists, Medicare payment is the same whether the physician personally performs the service, or the resident performs the service in the presence of the attending physician. There should be no reduction in payment simply because a resident, instead of the attending physician, performs the hands-on service. A service furnished by a resident without the presence of the attending physician is not covered as a physician's service to an individual patient.

Medicare liability for paying for such a service is met through direct graduate medical education payments (hospital-specific per resident amounts) by the intermediary to the hospital. We would point out that one of the I.L. 372 conditions for an attending physician relationship indicates that the presence of the attending physician should not be superfluous as in the case where a resident is fully qualified from a medical standpoint to perform the service. As a practical matter, however, we do not know how a carrier could be expected to assess a resident's professional progress which would suggest that this aspect of the requirements is not enforceable by carriers.

It has been alleged that some carriers have imposed the requirement that, for a higher level hospital care code to be used, the physician must personally take the comprehensive history and perform the physical examination, and that when the attending physician countersigns a history and physical examination performed by a resident, a minimal level E&M code must be used. It is our position that I.L. 372 requires only that the teaching physician review the history taken by the resident, and that he or she personally examine the patient. We believe that the appropriate code should be the one describing the content of the service provided (level of history, physical examination, and decision making) by the attending physician personally or by the resident in the attending physician's presence. If the situation is one in which the potential attending physician simply countersigns the report of resident's physical examination without personally examining the patient, the criteria for establishing an attending physician relationship have not been met at that point, and no E&M service is payable.

With respect to subsequent hospital care after the attending relationship has been established, the service that is payable is also based on the content of the service provided (level of history and physical, decision making, etc.), whether performed directly by the attending physician or by a resident in the presence of the physician. The level of the service should not be automatically reduced because a resident was involved in the care. However, if a resident obtained relevant information prior to the rounds visit of the attending physician and this resulted in a lesser service being provided in the attending physician's presence, the level of the code which should be paid is the code reflecting the content of the service provided by the physician personally or by the resident in the attending physician's presence. In addition, we would emphasize that no E&M service is payable on a day when the E&M service was performed by the resident without the attending physician being present

and all the attending physician does is to review the resident Is notes and counter-sign the record.

Please convey this information to carriers in your region.

CHARLES R. BOOTH.

CHANGE IN POLICY

Senator HARKIN. For your information, this letter is in response to the association's comment letter of April 2, from Mr. Booth on HCFA's change in policy with respect to the teaching physicians requirements as originally stated in IL-372 guidelines. To quote Dr. Petersdorf:

In this memo, Mr. Booth states that, quote, "physicians' fees are payable in teaching hospitals if: (1), the physician personally performs an identifiable service; or (2), the chart indicates the physician has performed those activities necessary to qualify as an," quote, "attending physician," end quote, and the physician is—

And this is underlined in Dr. Petersdorf's letter, "physically present when the resident performs the identifiable service for which payment is sought."

You just told me at this witness table that the first time HCFA ever promulgated anything like that was in 1995. Physically present for the reimbursed item which was sought to be reimbursed. Yet, here is a letter from your predecessor as an advisory to all medical colleges stating exactly that in 1993.

Dr. COHEN. Senator Harkin, the Booth memo to which that letter was a response was a, I believe, an aberration in the department. And the reason I say that—let me—

Senator HARKIN. People can pick and choose what they want. I am just reading you the plain language here.

Dr. COHEN. Let me read you the language of Mr. Booth's supervisor at that time in a letter saying, I'm responding to your letter regarding—

Senator HARKIN. What's his name or her name.

Dr. COHEN. Thomas A. Ault, Director of Bureau of Policy Development. This letter is dated—

Senator HARKIN. What's the date?

Dr. COHEN. April 1995. April 2, 1995, here it is.

Senator HARKIN. April 2, 1995.

Dr. COHEN. I'm responding to your letter—

Senator HARKIN. I talked to you about a letter from Mr. Booth.

Dr. COHEN. Booth's memo is December 30, 1992. And this is Thomas Ault responding to Booth's memo in a query that was made.

In responding to your letter regarding implementation of physician presence requirements for attending physician's services by the carrier for South Carolina, it is our position that carriers which did not apply a physical—a physician presence requirement prior to the issuance of the Charles B. Booth memorandum on December 30, 1992, should not institute such a policy until a revised rule on payments for teaching physician services is finalized.

In that regard, we received a letter, stating: "the carrier would not be changing its policy pending revision of national—revision of national guidelines."

Thomas Ault, Mr. Booth's supervisor, is saying in this letter that physical presence was in fact not the clear standards of HCFA, despite what Booth said.

Senator HARKIN. First, I have got some more I want to read on this, but we can go all the way back to 1965 if you want on this one.

Mr. Mangano.

Mr. MANGANO. Let me just mention, I do not think that is what Mr. Ault said at all. I think what he said was this was a response to a lawyer who was representing one teaching hospital, I believe it was South Carolina. He said that if the carrier had not implemented a policy that required physical presence before 1990, December 30, 1992, they should not change their policy at that point. Therefore, if the policy already existed before that time, it should be carried out.

Senator HARKIN. Is that a correct interpretation, Dr. Cohen?

Dr. COHEN. It's not my view that that's the interpretation.

Senator HARKIN. What does the letter say? Can I get a copy of that letter?

Dr. COHEN. Of course you can.

[The information follows:]

LETTER FROM THOMAS A. AULT
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Baltimore, MD, April 2, 1995.

Mr. ROBERT J. SANER,
Washington Counsel, MGMA, Powers, Pyles, Sutter & Verville, P.C., attorneys at law, Washington, DC.

DEAR MR. SANER. I am responding to your letter regarding implementation of a "physician presence" requirement for attending physicians' services by the Part B carrier for South Carolina.

It is our position that carriers which did not apply a "physician presence" requirement prior to the issuance of the Charles R. Booth memorandum of December 30, 1992, should not institute such a policy until a revised rule on payments for teaching physicians' services is finalized. In that regard, you have received a letter from the carrier medical director for South Carolina explaining the basis for the misunderstanding and clarifying that the carrier would not be changing its policy pending revised national guidelines.

I hope that this matter is now resolved.

Sincerely,

THOMAS A. AULT,
Director, Bureau of Policy Development.

INSTRUCTING TEACHING PHYSICIANS

Dr. COHEN. Let me quote you from Mr. Ault again. This is in a meeting that he had trying to instruct teaching physicians about the need for the requirement: "Although there are existing instructions going back many years that support our interpretation, the instructions are admittedly ambiguous and have not been vigorously enforced."

At this point, we are not aware of instances in which there have been claims denied on the basis of the memorandum, referring to the Booth memorandum. We are writing to make its application prospective if it has not yet been applied.

We would not argue the policy—the point that some or many carriers may have not applied this policy or that carrier ability to ver-

ify the physician's presence during individual service is problematic.

So what we interpret that, the discussion to be—and this went back and forth for almost 30 years since the 1967 IL-372 letter. It was not that you cannot find language some places that calls for physical presence, but you can also find language in other places that says it is not necessary.

So what I am trying to make clear is that the standards were never clear. Those of us working in the field were begging for clarity. We were never given clear instructions. And the problem we have now is for the inspector general to come in and insist that those standards were clear, and clear enough—

Senator HARKIN. But they were clear in some regions. Here is one from the University of Kentucky, Dr. Cohen.

Dr. COHEN. I don't doubt that some carrier regions promulgated language that was clear. What I'm saying is that every—

Senator HARKIN. Well, if the language was clear in a region, why should they not continue their audit in those areas? Or are you arguing that it was never clear in any region?

Dr. COHEN. I'm arguing that the regions, that the regional carriers, the private contractors, were never authorized to overinterpret HCFA's regulations. HCFA is the agency that makes the rules. We understood what HCFA's rules were.

Where is it written that a private contractor has the authority to establish rules that go beyond what HCFA's regulations stipulate? I don't believe that that's what Congress intended. I think in order to apply that—

Senator HARKIN. You are setting yourself up, it seems to me, as the judge and jury of what a region has interpreted. For example, the region in Kentucky where the carrier said here is the way we have always interpreted it.

The Kentucky letter is dated April 15, 1993. It is from the University of Kentucky Medical Center to their carrier, Blue Cross/Blue Shield of Kentucky, talking about the Booth amendment, December 30. It states:

Quite frankly, when our institution read the memo, we were neither surprised nor dismayed; his summation and his literal definition were exactly as we understood the regulatory statute governing IL-372. Billings should not be allowed when the teaching physician has not performed a personal identifiable service or performed direct, not indirect, supervision of interns and residents."

And then the letter goes on to say:

That if a change is to be submitted, documentation must include: personal handwritten or dictated notes by the teaching physician, mention made in the intern or resident note that the teaching physician was present, and a cosignature by the supervising physician; or if the resident or intern failed to mention the supervising physician's presence, the supervising physician must add a personal note.

In other words, they are saying what they have had is what they have understood the requirements always to be. Here's another quote from the letter: "We instill within our faculty that no bill is to be rendered without their direct personal involvement."

So I am saying here is one region where the guidelines were very clear. Now you tell me why the inspector general should not audit that?

Dr. COHEN. Because we have—Medicare is a national program, Senator Harkin, as you well know. There should be national standards by which physicians are held accountable for their billing practices under a national program. It is bizarre to have one region of the country allowing certain billing practices without any question and other regions of the country subjecting teaching physicians to potentially ruinous penalties under a Federal False Claims Act.

Senator HARKIN. If that is what physicians in that region were told—

Dr. COHEN. That's not what the physicians were told.

Senator HARKIN. They were in the Kentucky region.

Dr. COHEN. I'm a teaching physician. I don't go around reading the carrier regulations on a daily basis. I know what the standard of practice is among the culture that I'm operating in, and I'm moving from one region to another. I've operated in six different regions in my career and I bet each of them had different standards for their Medicare—

Senator HARKIN. Wouldn't you check with your hospital, and ask what you can bill for?

Dr. COHEN. Of course not.

Senator HARKIN. If that hospital said "no," you cannot bill unless you are directly there, you would bill for it anyway?

Dr. COHEN. If my hospital had made that clear to me, then I would obviously try to conform to what the hospital said. But the hospital never tells us that. I mean, Dr. Evarts—

Dr. EVARTS. Let me just try and put this in a slightly different context. I've practiced in three different States. I'm a practicing physician. I have been all my career. I've also been responsible for the education of other physicians all these three separate places, major responsibilities, and in my entire career, I operated and so did those who were surrounding me to the best of my knowledge in doing the things that we interpreted the regulations to—to require.

Now, it was not clear, it was different in Ohio than it was in New York State and it certainly was different in Pennsylvania. None of these times were anybody trying to, deliberately trying to misrepresent or fraud or abuse or any of those things. We were trying our best to take care of our patients, and as Dr. Cohen has said, I didn't read the regulations.

The hospital directors were not directly involved in the day-to-day patient care. These were things that we did as physicians trying our very best to give the appropriate care for each and every patient.

And in that, in the teaching setting, it is very clear that there is a very close relationship between the student and the teacher, if you will. And that was always there, it was never violated, and if it was violated then we tried to step in and do something about that.

But if you were to poll the hundreds of thousands of teaching physicians in this country, you would get about that many different interpretations of what these rules were supposed to be. And it wasn't until 1995 and now 1996 that once and for all, we all very clearly understand where we were coming from. And I tell you that

in direct sincerity that is exactly what—and if we want to do a national poll, that's where it would come down.

Senator HARKIN. Doctor, I do not understand because here is this letter—you did not really respond to me on this, Dr. Cohen. This is Dr. Petersdorf's letter, dated May 13, 1993. If you have a copy—

Dr. COHEN. I've seen that letter, I know it well, thank you.

Senator HARKIN. It says quite clearly: "And the physician is physically present when the resident performs the identifiable service for which payment is sought."

This went to every medical college. Now, I don't understand how now you can say that they weren't fully advised. This is from your own association.

Dr. COHEN. He's commenting on Charles Booth's memo.

Senator HARKIN. I do not care what he is commenting on. Read the plain language.

Dr. COHEN. He's commenting on the Booth memo, which was subsequently disavowed by HCFA, and everybody knew that. Everybody knew Thomas Ault, Booth's superior, had disavowed himself of that standard that Booth went out on a limb to articulate.

Senator HARKIN. I do not believe that. I am sorry, where does Mr. Ault disavow this?

Dr. COHEN. Could—can I read you the piece of the letter that—and he also—

Senator HARKIN. I do not think that is on point. Mr. Mangano, can you comment? Do you know about this Ault letter, dated April 2, 1995?

Mr. MANGANO. Yes; I do.

Senator HARKIN. What do you know about it?

Mr. MANGANO. As I understood what Mr. Ault said was that if a contractor had not required physical presence prior to the Booth memo on December 30, 1992, a contractor should not now apply it because we're getting ready to issue new regulations. Therefore, my interpretation is, if you had a policy of physical presence in place prior to that time, you leave it in place.

Senator HARKIN. Let me read it to you, Dr. Cohen. It says here:

It is our position that carriers which did not apply physician presence requirement prior to the issuance of the Charles R. Booth memorandum of December 30, 1992, should not institute such a policy until a revised rule on payments for teaching physicians' services is finalized.

Dr. COHEN. What that says to me, Senator, is that HCFA did not believe that that was its standard, so that it was not standing behind Booth's memorandum and allowing that to be the standard going forward, recognizing that it had standards that needed to be clarified. And they were instructing the carriers that did not have that standard not to apply it because it wasn't the national standard.

Senator HARKIN. What you are saying Mr. Ault is that if a carrier had a physician presence requirement before 1992, it did not mean anything.

Dr. COHEN. No; I am saying that it was not HCFA's national standard. The fact that a carrier—I concede that the carriers had interpreted HCFA's language, some carriers, in that fashion. My position is and our position is that the carrier is not authorized to

read law, make law. The carrier must carry out the national standard.

HCFA, the people that make the national standard, disavowed that standard. The fact that certain carriers were interpreting them that way is immaterial and, more importantly, they were auditing patient records all through this period of time and never sanctioned the teaching physician for billing on the basis of a countersignature.

Senator HARKIN. Mr. Mangano.

Mr. MANGANO. Let me just say that there have been hundreds of audits over these three decades that looked at this issue of physical presence. In my testimony, I recited the examples from Pennsylvania where they conducted 67 audits at teaching hospitals in a 5-year period.

When they found violations of physical presence, they assessed overpayments. For example, two of those audits were done on two of the hospitals that are in the Geisinger system, Hershey Medical Center. I've got reports from 1986 and 1988 that said they were out of compliance.

Senator HARKIN. They are out of compliance.

Mr. MANGANO. Out of compliance. And the chief, the principal issue they looked at there was physical presence. They were told by the auditors, once again, you must be present in order to bill Medicare for part B service.

I think the concept here is real simple. If you want to bill for a patient visit, you ought to visit the patient.

Senator HARKIN. Ms. Wynn, let me ask this. Do you agree with the position taken that it has always been Medicare policy to require physical presence of a supervising physician in order for that physician to be eligible for reimbursement of the service performed by a resident? You are from HCFA.

Ms. WYNN. Yes; I am. HCFA has not articulated within IL-372 or some of its other policy issuances a clear and unambiguous policy that the physician needed to be present. There are some explicit statements that the physician should be present in supervising the interning resident; in other cases, it's vague.

Senator HARKIN. Where is that?

Ms. WYNN. IL-372 very clearly states certain criteria that need to be met for an attending physician relationship to be established.

Senator HARKIN. It says personally perform or personally supervise, IL-372 does.

Ms. WYNN. I believe what it says is that the physician must perform personal and identifiable services.

Senator HARKIN. No; it says the teaching physician should personally perform or personally supervise patient services in order to qualify for fee-for-service payment. I just read it to you. So what are you saying?

Ms. WYNN. For major medical services, surgical services or complex medical services, the physician is expected to be personally present. There's not an explicit statement, I don't believe, within IL-372 to that effect. However, there are some other areas where we have—

Senator HARKIN. I just read it. I mean, am I losing my common sense? I keep coming back to common sense around this place. You

can argue about how many angels can dance on the head of a pin, but—

Ms. WYNN. Mr. Harkin, I think that may in the legislative history rather than—

Senator HARKIN. That is the legislative history. That is exactly what I am reading to you. And the legislative history, you certainly pay attention to that, don't you?

Ms. WYNN. Yes, sir.

Senator HARKIN. I hope so.

Ms. WYNN. However, there are areas and questions where we have explicitly required physician presence, over the course of time in various policy issuances. I don't see Mr. Ault's letter as contradicting Mr. Booth's memorandum, for instance. It was recognizing, however, that there have been some differences in carrier enforcement of the policy and that since we were about to revise the policy, they were not to change their enforcement activities.

Senator HARKIN. Are you saying you agree with Mr. Mangano's interpretation of the Ault letter?

Ms. WYNN. Yes; I do.

Senator HARKIN. And that position is that if carriers had not articulated a physician presence requirement, they did not have to institute one, but if they did, they were held to that standard.

Ms. WYNN. That's correct.

Senator HARKIN. That is what you are saying?

[Ms. Wynn nods.]

Senator HARKIN. Dr. Cohen, that seems to me to be exactly what I read in Mr. Petersdorf's letter, representing your own association: A physician must be physically present when the resident performs the identifiable service for which payment is sought.

Now, I know that this has been a controversial issue going back to 1970, at least. That—

Dr. COHEN. At least.

Senator HARKIN. It has been controversial. But I do not know that it has been all that ambiguous.

Dr. COHEN. Well, could I—Senator, if I could quote you from two distinguished physicians, Otis Bowen and Lewis Sullivan, both former Secretaries of Health and Human Services themselves:

Both as former Secretaries of Health and Human Services and as physicians who have trained residents, we are personally disturbed by the direction and tone of the current OIG investigations on this issue. There appears to be a complete lack of understanding and appreciation for how complicated this matter has been pretty much since the beginning of the Medicare Program. Given the contorted history of this issue through the years, it would appear to be an unlikely candidate for an OIG investigation.

And that's certainly what our view is, that this is not a fertile soil for allegations of fraud and abuse. We—

Senator SPECTER. Dr. Cohen, what do you think the standard should be?

Dr. COHEN. I think the standard going forward is very clear. I think audits against the new Medicare standards from July 1996 are absolutely clear and we ought to be held accountable to those standards. I believe that what we ought to do in the PATH audits is to adjust the parameters as follows: We ought to accept countersignatures as prima facie evidence for presence unless there's evidence to the contrary. I mean, if there are reasons to be-

lieve that the physician wasn't there, wasn't in the hospital, was out of town, was in another country—

Senator SPECTER. Mr. Mangano, what is wrong with that?

Mr. MANGANO. We accept countersignatures, and according to the policy that—

Dr. COHEN. That's not true.

Senator SPECTER. Let him finish. Go ahead.

Mr. MANGANO. The policies that the carriers put out, by and large, state that countersignatures will be accepted as long as the note written by the resident or nurse, whomever's providing the service, indicates that the physician was present when the service was delivered.

Senator SPECTER. When you say by and large, are you excluding matters there—

Mr. MANGANO. Almost all the carriers had that requirement.

Dr. EVARTS. No nurse or other person would write that in their note. That wasn't common practice. You wouldn't write that so and so was there. That was—you were writing about the patient.

Senator SPECTER. Wait 1 minute, Dr. Evarts. Are you saying, Mr. Mangano, somebody else has to have a notation in the file that the physician was present?

Mr. MANGANO. The medical record is the key document that we use. Physicians fill that out. And the carriers required the physician fill out the medical record and indicate what they did. If they were not there, if they—if the resident provided the service, if the physician did not fill that out, the resident must indicate that the physician was present when the service was delivered, and that's in almost all the carrier guidelines.

Senator SPECTER. The question now is whether a signature by the physician would be sufficient to establish his presence. Are you saying that in addition to the physician's signature, there has to be something else in the record to affirmatively state the doctor was present?

Mr. MANGANO. There must be something in the record, as all carriers required, that indicate the physician was present in order to bill for it.

Senator SPECTER. Now that is in addition to the physician signature.

Mr. MANGANO. If the physician signature is there as though the physician has delivered the service, that's sufficient.

Senator SPECTER. Wait just 1 minute. As though a physician delivered the service. Suppose you have the physician's signature and nothing else. Is that sufficient proof that the physician was there?

Mr. MANGANO. We would look at the medical record, and the medical record would say I visited patient X. This is what the diagnosis was, this is what I did. That's sufficient.

Dr. COHEN. That's not what happens.

Senator SPECTER. Just 1 second, Dr. Cohen, Dr. Evarts. As soon as you are the chairman, you can ask the questions. Suppose it does not say I visited. We are on a narrow question as to whether the signature alone, standing by itself, is sufficient proof that the physician was present.

Mr. MANGANO. All the carriers—I won't say all, but the overwhelming majority of the carriers say that a countersignature by

the physician is sufficient as long as the medical record indicates that the physician was there to either deliver the service themselves or at the elbow of the intern or resident.

Senator SPECTER. Well, you repeated that answer now three times. On the face of what you have said, the signature is not sufficient, unless the records show the physician was there.

Mr. MANGANO. That's correct.

Senator SPECTER. So the physician signature alone is not sufficient.

Mr. MANGANO. That's correct.

Senator SPECTER. Dr. Cohen, Dr. Evarts you are contending that is a retroactive application of a different rule.

Dr. COHEN. Absolutely. Let me—

Senator SPECTER. At what point in time, Dr. Cohen, was the signature of the physician sufficient to establish his presence, her presence?

Dr. COHEN. I think from 1967 through 1996, that was the standard. Let me quote you from IL-70-2.

If the physician's countersigned the entries in the record pertaining to the patient's history and the record of examination and tests, it would be presumed the physician reviewed these activities.

That is the presumption, and that is what we all acted on.

Senator SPECTER. Wait a minute, presumed that he reviewed the activities. But does that deal with his presence?

Dr. COHEN. Of course, reviewed the activities. He was there providing medical direction. This is the standard HCFA provided to nonmajor surgeries and noncomplex procedures.

Senator SPECTER. I do not know what that language does; read it again.

Dr. COHEN [reading]: "If the physician countersigned the entries in the record pertaining to the patient's history and the record of examinations and tests, it would be presumed the physician reviewed these activities." And that is exactly what, speaking for myself—

Senator SPECTER. Just a minute, would reviewing the activities necessarily mean that he or she was present?

Dr. COHEN. How could you sign the note if you weren't present?

Senator SPECTER. You are present when you signed the note and you can review the procedures. But that might be something different from being physically present at the time the procedures are done. I am just asking, I do not know.

Dr. COHEN. Well, we're talking about the medical direction of nonsurgical, noncomplex procedures. There's no quarrel about the surgeries and the complex procedures, as I hope I made clear. The physician does need to be physically present at the time that that surgery and complex procedure is performed, no question about it. And there ought to be clear indications in the record that the surgeon or the other physician or whoever provided those services was present with the resident, plain and simple.

Senator SPECTER. You are agreeing with what Mr. Mangano is saying.

Dr. COHEN. We never disagreed with surgeries and these complex procedures, Mr. Chairman. It's all these other procedures, with which the vast majority are nonsurgical, noncomplex proce-

dures where the physician was required, teaching physician was required to provide the medical direction to the resident.

And the way in which that direction is provided very often is by the teaching physician.

Of course being present, the patient knowing the physician, knowing the—that physician is the attending physician, but that the teaching physician indicates his presence in that capacity as directing the medical care by countersigning the notes in the record. That was common practice. That's what I did throughout all those years. I'm sure that's what Dr. Evarts has done. This is what the standard was. And now we're being held to a standard that simply didn't exist at that time.

Senator SPECTER. Do I understand you to be making a distinction between a major procedure where the physician has to be present and some lesser procedure where the physician would not necessarily be present?

Dr. COHEN. Well, let me be sure we're using the word "presence" in the same way. I'm not suggesting that a physician should ever charge for something where they weren't present, if they weren't involved, if they weren't there providing the service that HCFA indicated they were prepared to pay for.

Senator SPECTER. You mean there at the time it is being performed?

Dr. COHEN. Well, when is a patient with cardiac failure getting a service from a teaching physician? It certainly isn't 24 hours a day around the clock. It's when that patient is getting—

Senator SPECTER. There is a representation, in a sense, that the signature states that the physician was at the spot some time during that day.

Dr. COHEN. Absolutely. Absolutely.

Senator SPECTER. Are you looking for something more, Mr. Mangano?

Mr. MANGANO. The kinds of bills that we're looking at under Medicare part B are for patient visits, they're also for consultations. So if the consultation took place at 2 p.m., we'd be looking for the physical presence of the doctor at that time to deliver the service themselves or be at the elbow of the resident directly supervising it.

What we don't believe is correct is for a physician to tell a resident to go look at a patient, then at the end of the day, after reviewing the medical record that the resident wrote, initials off on that and be able to bill Medicare for a patient visit.

When Medicare develops the cost of a patient visit, they determine it is going to take so much time, so much skill—

Senator SPECTER. Do you disagree with that?

Dr. COHEN. No; Let me indicate—

Senator SPECTER. Wait a second, Dr. Cohen. Do you disagree with that?

Dr. COHEN. With what?

Senator SPECTER. With what he just said.

Dr. COHEN. I don't disagree that the consultation that's provided by the teaching physician needs to be done by the teaching physician. But the way—let me—that's what I did for a living for all these years. I was a consultant in kidney disease.

Senator SPECTER. In trying to cut through, Mr. Mangano is suggesting that the physician comes by at the end of the day and simply signs off without having been present.

Dr. COHEN. That's simply not true.

Senator SPECTER. Wait a minute. Do you agree with what Mr. Mangano says, that the physician has to be present at the time the consultation was performed, as opposed to coming by at the end of the day and signing off?

Dr. COHEN. Yes; but it's more complicated than that, if I may, Mr. Chairman, just to give you a typical example.

We would get a consult request from a physician on a patient. The resident, fellow, would go see the patient, evaluate the patient, come back, describe not only to me but to the other residents who are involved in the team, what the situation was, assuming this wasn't an urgent situation, in which case we would all go there immediately.

But in the typical situation, he would come back, report the findings of the consultation. We'd all go as a team, see the patient, confirm the findings, discuss the issues, decide what we're going to do. I would be responsible for making those judgments ultimately about what was going to be done. More often than not, the resident would have made the right decisions and I would simply be confirming what the resident had done, but I would be very much involved in that consultation.

I might not sign that record that day. I might have had 12 consultations to see that day. I might have come back the next day and countersigned the resident's note, describing precisely what happened in that consultation and all the decisions that were made. I was present there. I would not have signed that note if I wasn't present. I would not put my signature on a record indicating that I provided a service if I wasn't present to provide that service. My signature in that record documented my presence and my involvement in that case.

Senator HARKIN. Dr. Cohen, I listened very intently to what you just said about the consultations. These would be residents and interns that would come to you, right?

Dr. COHEN. Well, the typical situation would be that a patient's doctor would request a consultation. The consultation request would come through my office. I would assign a resident in training—

Senator HARKIN. Right.

Dr. COHEN. If it was not an emergency situation—

Senator HARKIN. Right.

Dr. COHEN. To evaluate that patient and they'd come back and tell me what they found.

Senator HARKIN. And you would consult with that resident.

Dr. COHEN. And the patient. I would go and see the patient, confirm everything that the resident had said, discuss the issues. If there were things the resident wanted to do that I didn't think was right, I would correct it. More often than not, the resident was on target.

Senator HARKIN. What if you never went to see the patient?

Dr. COHEN. I would never bill for a patient I didn't see. I wouldn't sign that chart.

Senator HARKIN. For the consultations that you're talking about, I believe that's what costs \$8.1 billion every year out of Medicare part A. These funds pay for training and supervising residents and interns.

Dr. COHEN. I beg to differ with you, Senator.

Senator HARKIN. That \$8.1 billion is not for that?

Dr. COHEN. No.

Senator HARKIN. What is it for?

Dr. COHEN. First of all, the \$8.1 billion includes indirect medical education, expenses, which cover a whole gamut of expenses in teaching hospitals that has nothing directly to do with the teaching of residents. But that's neither here nor there at the moment.

What those payments in part A are for, are for supervising and administering the teaching program, interviewing the residents' applications, reviewing their progress through the program, making arrangements with other institutions how they rotate to get their experiences, evaluating their performance, counseling them, giving lectures, giving seminars, all the things that are involved in the general education of residents.

What we're talking about in part B are the personal services each teaching physician provides to their individual Medicare patients. They involve residents in delivering those services. HCFA has acknowledged that that service is valuable and paid for under part B.

Senator HARKIN. So none of that \$8.1 billion is for supervision in hospital settings or anything like that.

Dr. COHEN. Not for the individual patients for which I am taking care.

Senator HARKIN. It is only for teaching in a classroom.

Dr. COHEN. Well, not teaching in a classroom. Administering the program, the seminars, all of the things that are involved in putting together a complex teaching program.

Senator HARKIN. It is not involved in discussing with interns and residents your care of patients?

Dr. COHEN. No.

Senator HARKIN. The \$8.1 billion is not for that? There is a line someplace that says you can only use it for teaching out of a textbook in a classroom?

Dr. COHEN. All I'm saying, Senator, is that HCFA has acknowledged that teaching physicians, by definition physicians who involve residents in the care of their patients, that those teaching physicians are entitled to bill for their services.

Senator HARKIN. Medicare contributes \$100,000 per resident per year to teaching hospitals for salaries and fringe benefits of residents and interns; \$100,000 a year. I am told that the residents themselves get about \$30 to \$40,000 of this amount.

Now, here is an example of abuses found in PATH audits. In the PATH audits that have been completed, according to the Office of Inspector General statement presented today, a physician billed Medicare for subsequent hospital care provided during a 3-day period in which his travel schedule placed him out of town.

What say you to that Dr. Cohen? Should that doctor have billed Medicare for hospital care provided when he was out of town?

Dr. COHEN. Of course not.

Senator HARKIN. But that is an example of what these audits uncover. Here's another: A physician who was attending a medical conference out of State billed Medicare for 1 hour of critical care provided on each of 2 consecutive days. Should that physician have billed for that?

Dr. COHEN. That physician should not have billed for that, Senator, but I cannot comment on these people—

Senator HARKIN. I can go on. You are saying that these PATH audits should be stopped from finding these kinds of abuses.

Dr. COHEN. No; I'm not, Senator.

Senator HARKIN. Why not? Mr. Mangano, can we find these abuses other than through PATH audits?

Mr. MANGANO. No; we can not.

Senator SPECTER. Senator Harkin, Dr. Evarts has been looking for an opening here for some time.

Senator HARKIN. I am asking whether or not you can find these abuses without going through the PATH audits.

Mr. MANGANO. No; we cannot.

Senator HARKIN. Well then, if you stop the PATH audits, you will not find them.

Mr. MANGANO. That's correct.

Senator HARKIN. Thank you very much.

Dr. EVARTS. Simply to reiterate that no one would support anybody billing for services when someone wasn't there.

Senator HARKIN. How are we going to find them if you don't audit it?

Dr. COHEN. Look at the vacation schedule, at the travel schedule.

Senator HARKIN. But that is what the audits are doing.

Dr. COHEN. The audits are not looking at that. They're looking at whether or not there's a countersignature in the patient's record.

Dr. EVARTS. They're using the wrong criteria.

Senator HARKIN. Excuse me, Mr. Mangano, what are you looking for in the audits?

Mr. MANGANO. We are looking, in some cases, to find out what the travel schedule of the physicians were, and that's where we were able to find some of those examples. Where there was no indication that a physician delivered the service, we then went a step further in those reviews to find out where was the physician that day and found them out of town.

Senator HARKIN. Mr. Chairman, before you came, I was saying in the past this subcommittee's had hearings on hospitals that were billing Medicare for trips to Italy and fine silverware and alcohol and all kinds of art work and the hospitals argued, well, the guidance was not clear. I think we both said at the time, whether guidance was clear or not, people should use common sense. We shouldn't try to dance all around and say well, there was this letter and this person and that interpretation.

It seems to me that since the very beginning, this matter has been controversial, just like a lot of issues in Medicare are controversial because Medicare has been a cash cow. There has been a lot of abuse of Medicare over the years, which is what we are trying to cut down on. As far as this matter goes, it seems to me the letter from Dr. Petersdorf in 1993 was very clear, stipulating the physical presence requirement.

I see nothing wrong with continuing the PATH audits as long as they are done on the basis of the law and the interpretation of the law in those regions where it was made unequivocally clear that physical presence had to be required.

Senator SPECTER. Senator Harkin, we have another panel here and we are running very long, so I would like to move to the issue about billing at the proper level.

Dr. COHEN, do you—

Senator HARKIN. I just have one follow-up question.

Senator SPECTER. Just one follow-up question, just one? OK.

Senator HARKIN. Dr. Cohen, are you opposed to legitimate audits for upcode, which is clearly a violation of Medicare law and regulations?

Dr. COHEN. Of course not.

Senator HARKIN. You are asking that these reviews be put on hold, I understand.

Dr. COHEN. I'm asking that the reviews be suspended, not stopped. Again, before you came in, I made an opening statement saying we very much appreciate the inspector general's efforts to try to eradicate fraud and abuse from our program, no question about that. But we believe that the audits ought to be suspended until the GAO has a chance to do an objective study of this very complicated background that you conceded has been very confused and very controversial.

Senator HARKIN. I did not concede. Do not put words in my mouth. I did not say it was confused, I said it has been controversial.

Dr. COHEN. Correct.

Senator HARKIN. Only because I think there are a lot of people out there who want to rip this system off, I am sorry.

Dr. COHEN. I am sure you are guided by that.

Senator SPECTER. Let us move on for just a moment or two to this issue of billing at the proper level. Is there any problem, Dr. Evarts, as to that aspect of what the inspector general is doing?

Dr. EVARTS. Well, I think again, we're looking at whether it is a deliberate act to say I'm going to bill up from where I think that we—

Senator SPECTER. That is what it requires, a deliberate act, a knowing intentional act.

Dr. EVARTS. I would say it has not been a deliberate act in a great majority of cases. People simply bill legitimately for where they think their services come in.

Senator SPECTER. Dr. Cohen, do you see a problem with audits on the issue of billing at the proper level?

Dr. COHEN. Yes; I see a problem again with regard to retroactivity, that the documentation standards for the proper coding of these level of services.

Senator SPECTER. And what do you see that is retroactive here?

Dr. COHEN. It is insisting on a documentation standard that wasn't articulated until August 1995.

Senator SPECTER. How about that, Mr. Mangano?

Mr. MANGANO. We would disagree with that—in this way. Physicians have always been required to document the medical records. What our reviews are designed to do is determine did the physician

deliver the service which the medical record says was delivered, or did they—did they deliver a service that was far less than what they billed for? What we're looking for is not inadvertent mistakes where somebody misses by one level, in favor of the hospital one time, in favor of Medicare another time.

Senator SPECTER. What are you looking for?

Mr. MANGANO. We're looking for patterns of abuse. And what signals that to us is when the overwhelming majority of those—those mistakes are in favor of the hospital and those mistakes are multi-level mistakes. In my testimony, I gave you an example of where you could bill—

Senator SPECTER. Let's not have an example. Let's see if we can come to specifics with Dr. Cohen as to what he says is a retroactive application, come to grips with that issue. It is a question of principal about a lot of examples. What do you say they are now doing which is retroactive?

Dr. COHEN. They're insisting on documentation standards that the teaching physician—

Senator SPECTER. Such as what?

Dr. COHEN. Such as indicating the—all of the specificity of what the levels of coding of the service implied. It's now very clear as of August 1995, there's a very clear standard about what you need to document in order to assure the auditors and anybody else that you delivered the service at a certain level. Prior to that—

Senator SPECTER. What was the prior—

Dr. COHEN. Prior to that time—

Senator SPECTER. Excuse me, listen to the question. What was the prior unclear standard?

Dr. COHEN. The prior standard was whatever the physician—that the assumption was the physician billed for the service that they delivered. There were no documentation standards, no documentation standards.

Senator SPECTER. How about that, Mr. Mangano?

Mr. MANGANO. What Dr. Cohen is talking about is in 1992, HCFA put in new codes that would indicate the service that was delivered.

Those codes were developed by the American Medical Association. And over the next several years, there was a lot of training for people on how to use those codes. But never did the HCFA ever intend that people would bill for more services, for a higher level of service than what was delivered. In fact, what HCFA told their regional administrators was that they should be on the lookout for egregious cases of fraud in those cases, and that's what we're looking for.

Senator SPECTER. Mr. Mangano, let me try to bring this hearing to a close and ask you a question as to what Dr. Evarts testified to about the tremendous cost involved. What weight do you give to that factor considering that there is a GAO report pending which will be finished in the spring?

Mr. MANGANO. OK, there are a number of ways to look at it. One, this is one of the first reviews in which we offer people the opportunity to do a self audit if they want to do one. If they choose not to do that, we will do the audit and there won't be any cost to the university. For universities that have decided to do the self

audit, I've gotten all different kinds of quotes as to what the cost would be, ranging anywhere from \$200,000 on up to \$375,000.

One of the things that we do in that area to cut the cost down is, at certain points of the review, to take a look at what we found. For example, in one of the universities, Dartmouth, which came clean, we stopped halfway through and didn't continue the audit. Another review that we just finished, we didn't even get that far. So we look for ways to cut the costs. Audits are always inconvenient, we know that, but they need to be done.

Senator SPECTER. What attention will the inspector general pay to the GAO audit, if you can generalize?

Mr. MANGANO. We would certainly want to review what they find and the recommendations they make.

Senator SPECTER. But you are not bound by what they say.

Mr. MANGANO. That's correct.

Senator SPECTER. Anything further, Dr. Cohen?

Dr. COHEN. I just again would ask that you ask the inspector general to suspend the audits, not stop them but suspend them until we can get a GAO report. This issue is very complicated, very controversial, as Senator Harkin has said. In order for an audit process, I think, to be cooperated with enthusiastically, which we very much want to happen, we want our constituents to be fully cooperative and fully enthusiastic about cooperating with these audits. But unless they can be seen as being fair and applying rules that existed at the time, there's going to be continued resistance to these audits, as there should be, until we clearly understand that they are lawful and fair and comply with the rules at the time. All we're asking is—

Senator SPECTER. We are going to make a part of the record the letter from Assistant Attorney General Andrew Fois the essence of which is this quote: "We believe that the suspension of these audits could affect law enforcement activity pursuant to the False Claims Act."

Would it be useful if you men and women sat down and tried to resolve these issues? We are dealing here in a legislative context with a report from the House, which troubles me a lot where it talks about retroactive enforcement of possibly ambiguous standards. I do not know what a possibly ambiguous standard is. I do not see how you can deal with something which is a possible ambiguous standard.

We are not really equipped to deal with it here, to come to grips with the conclusive point. I would like to get into details and find out why these multimillion dollar settlements have been made, what the facts were, why they were not litigated and fought out. We do not want to impede law enforcement. Similarly, we do not want to have the possibility of a high fine or jail as a blackjack which coerces plea bargains. I have had a lot of experience with plea bargains. Invariably they are unfair to one side or the other.

You might take a try at it, Dr. Cohen, Dr. Evarts, or Mr. Mangano, instead of leaving it to the conference. Nobody knows what happens when the jurors go out in conference.

Anybody else have anything they want to say?

Dr. EVARTS. Just simply to say, getting back to Senator Harkin's comments, over the years, that if this wasn't ambiguous, then why

are we having new regulations introduced in 1995–96, which very clearly try to state what we should be doing in the future or prospectively? And I will tell you, they have been ambiguous and that the majority of the practicing teaching physicians have not tried to gain this system and are really trying to do their job as teachers in the centers that are really providing the education and the research for biomedical care in this country. And this is a—this is not to say that we support anything to do with fraud and abuse. You should know that from coming from the University of Iowa setting, because they're just like all the rest of us in their intent to do the right thing.

But we cannot have—we cannot be held to standards that we do not clearly understand. You read something from Petersdorf, that isn't promulgated around the whole country. The practicing physician doesn't look at that.

Senator SPECTER. Thank you very much, Dr. Evarts, Dr. Cohen.
[CLERK'S NOTE.—The following letter and statement was received by the subcommittee subsequent to the conclusion of the hearing. They will be inserted into the record at this point.]

LETTER FROM ANDREW FOIS, ASSISTANT ATTORNEY GENERAL

U.S. DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
Washington, DC, October 21, 1997.

Hon. ARLEN SPECTER,
*Chairman, Subcommittee on Labor, Health and Human Services, and Education,
and Related Agencies, Committee on Appropriations, U.S. Senate, Washington,
DC.*

DEAR MR. CHAIRMAN: Thank you for providing the Department of Justice with an opportunity to participate in the hearing you have scheduled for October 21, 1997, about the Department of Health & Human Services (HHS) Inspector General's ongoing audits of payments to Physicians at Teaching Hospitals (PATH). We believe that the suspension of these audits could affect law enforcement activity pursuant to the False Claims Act.

Medicare part A funds teaching hospitals that pay faculty physicians to supervise residents who treat Medicare patients. Medicare also reimburses hospitals for a portion of residents' salaries allocable to treatment of Medicare patients. Medicare regulations provide that the teaching physician also can bill Medicare Part B for providing a service to the patient if the teaching physician provides personal and identifiable direction to the resident when the resident is providing a service to the patient.

The PATH audit program being conducted by the HHS Inspector General reviews hospital patient records to determine whether teaching physicians who have billed Medicare Part B for providing personal and identifiable direction to residents have, in fact, provided personal and identifiable direction beyond the routine supervision paid for through Part A payments to hospitals. In practice, the PATH audit protocol reviews the patient's file to determine whether the teaching physician was with the resident when the resident performed a service for the Medicare patient.

The PATH program was announced by the HHS Office of Inspector General in the spring of 1996, following a \$30 million settlement with the University of Pennsylvania Hospital and its clinical practice group over allegations of several improper Medicare billing practices. These included billings by faculty physicians who had not provided personal and identifiable direction to residents and inflated diagnostic codes for evaluation and management services. The HHS Inspector General invited teaching hospitals to volunteer to perform PATH audits themselves—under the Inspector General's supervision—and stated that it also would select hospitals to audit.

Following the announcement of the PATH initiative, PATH audits/investigations could arise in any of three ways: First, a number of hospitals responded to the HHS Inspector General's proposal and either offered to perform a PATH audit or at least began discussions regarding the possibility of performing a PATH audit. Second, the HHS Inspector General selected a few hospitals and began its own audits. Third,

False Claims Act qui tam complaints could be brought to remedy alleged PATH violations.

The Department of Justice relies heavily on audit information developed by the HHS Inspector General in prosecuting fraud in the Medicare program under the False Claims Act, 31 U.S.C. 3729. Moreover, when a hospital approaches the HHS Inspector General, or the HHS Inspector General selects a hospital to audit, the local United States Attorney's Office routinely is notified and has an opportunity to participate in discussions on whether and how the PATH audit should be performed. If a qui tam complaint is filed, the Justice Department is involved in the audit/investigation from its inception. The level of involvement in the audit by the Department of Justice depends upon the facts regarding the specific hospital. However, in most instances, a Department of Justice attorney actively monitors or participates in the audit/investigation because of the potential for identifying significant Medicare mischarging in violation of the False Claims Act.

At present, more than a score of PATH audits are in progress. Although a few audits have been completed, or are near completion, most audits are at beginning or intermediate stages. In most of these audits, the Department of Justice is an active participant. Since the settlement with the University of Pennsylvania, PATH audits have resulted in one False Claims Act settlement—with Thomas Jefferson University—for about \$12 million. The misbilling allegations at Jefferson were similar to those at Penn. Settlement discussions with other institutions are occurring or are likely.

The Department of Justice makes assessments on whether to pursue False Claims Act cases based in significant part on the information developed in the PATH audits. If audits are suspended indefinitely, it could affect the Department's enforcement efforts in several respects. First, in the case of qui tam cases, the False Claims Act gives the United States only 60 days to decide whether to intervene in the lawsuit and take over responsibility for litigating the case. 31 U.S.C. 3730(b). Courts can, and often do, grant the Government extensions of time to make an intervention decision, but only upon the Government showing good cause for the extension. If audits are suspended indefinitely, showing good cause could be made more difficult. In such instances, the qui tam plaintiff would be free to litigate the case without the participation of the Department of Justice, and any judicial decisions on liability and damages would likely be binding upon the Government. The lack of Department of Justice participation in these cases increases the likelihood of inconsistent and inequitable results for both the United States and the medical facilities.

Second, if all PATH audits are suspended, it is highly unlikely that any hospital would show interest in engaging in a self-audit of its past billing practices or voluntarily discuss with the Government potential past Medicare mischarges. It would be difficult to proceed with the investigative efforts that normally precede a PATH audit if the audits themselves are in suspension. Third, a national suspension of PATH audits could stall or halt the ongoing, salutary efforts of some teaching hospitals to address their potential overpayment obligations.

Thank you for the opportunity to comment on this issue. Please contact us if we can provide any further information.

Sincerely,

ANDREW FOIS,
Assistant Attorney General.

PREPARED STATEMENT OF SENATOR CARL LEVIN

PATH AUDITS

First, I would like to commend Chairman Specter and the Ranking member, Senator Harkin, for convening this special hearing on the Department of Health and Human Services Inspector General's audits of Teaching Hospitals, commonly known as the PATH audits. Mr. Chairman, I support the Department in its efforts to combat waste, fraud, and abuse. Every Medicare provider has a responsibility to be fully accountable for the expenditure of Medicare dollars and it is appropriate for the Office of the Inspector General to audit teaching hospitals. It is equally important that the audits be conducted in a manner that is both fair and objective.

Harriet Rabb, General Counsel of HHS has acknowledged in her July 11, 1997 letter that "the standards for paying teaching physicians under Part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades." Given that there were no clear national standards, the OIG is attempting to audit based on local carrier guidance. However, in a 1986 GAO report, the GAO found there was substantial variation by local carriers on this issue. The GAO did

not believe that variation among local carriers was appropriate and instead the report concluded that:

“HCFA needs to establish and enforce explicit documentation requirements so that teaching physicians and hospitals know what is expected of them and understand that they are to be held accountable for not complying with Medicare requirements. We believe HCFA’s current requirements for documenting physicians’ fee-for-service billings are not explicit enough and the requirements being enforced vary substantially among carriers.”

Mr. Chairman, I do not believe it is appropriate, in the absence of specific congressional authorization, to rely on the carrier to substitute for national standards. Doing so allows carriers, in essence, to make rules. It also results in inconsistency and confusion, which is demonstrated in this situation.

HCFA finally did issue rules establishing requirements for teaching physician billing that became effective July 1, 1996. I do not know why it took HCFA ten years after the GAO report to establish guidelines.

As you know, Mr. Chairman, Representative Bill Thomas, Chairman of the Health Subcommittee of the Ways and Means Committee has requested the GAO to conduct an independent review of the PATH initiative and the House Appropriations Committee included report language requesting the OIG to suspend the audits until the GAO completes its study. Given the ongoing controversies in this area over the last 30 years, this would seem to be an area that needs further review by an objective third party such as the GAO. As previously stated, I’m all for supporting the OIG in its efforts to combat fraud and abuse in the health care system. However, the system must be fair and just. Suspending the audits pending the GAO findings simply ensures this result. Thank you, Mr. Chairman.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 4:50 p.m., Tuesday, October 21, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]