

Medicare Attacks; a Practice Survives

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Senior Service Founded to Fill a Need

Senior Service was created in March of 1998 to provide in-facility geriatric service to the Northern Sacramento Valley. It delivered continuous medical care to seniors in acute-care hospitals, skilled nursing facilities, and less intense medical environments.

Medicare reforms of the late 1990s had changed both the mission of the skilled nursing facility and its relationship to the acute-care hospital. Previously, the nursing home had cared for stable, chronic patients. After 1998, the nursing homes integrated with the system as acute-care hospitals were encouraged to discharge their patients more quickly.

From 1998 to 2001, acute hospital bed capacity in our area declined by a third, part of a national trend. Medicare changed payment policy to stimulate more efficient use of hospital diagnostics and therapeutics, so most hospital beds were no longer paying for themselves past three to four days. Hospitals cut both beds and nursing services.

Physicians were reluctant to follow patients to the intermediate-care facilities that expanded to accommodate the increasing numbers of sicker patients being transferred. The physicians were not prepared to visit nursing-home patients more often than once a month. They did not like the geographic dispersal or the Medicare fee schedule or the regulatory requirements. Moreover, changes in managed care concentrated their efforts in their offices or in the acute-care hospital.

Senior Service was designed to respond to the need for continuous care between separate institutions, and became the only entity providing such service. Patients did not need to spend an extra day in the hospital because the same physicians were committed to caring for them in a different setting as soon as they were transferred. Senior Service also provided care to a 12-bed respiratory subacute unit, one of only three in Northern California providing prolonged respiratory support for ventilator-dependent patients. These patients were unstable, prone to pneumonia and other types of infections, and required continuous physician monitoring.

In three years Senior Service grew to provide medical care to more than 1,000 institutional patients. It doubled its volume in 1999, 2000, and 2001. The number of physicians and nurse practitioners expanded to meet the need. More than 80 percent of the Medicare subacute unit patients in our area belonged to Senior Service physicians.

In effect, Senior Service regulated an acuity cascade, starting at the intensive care unit (ICU), to the medical-surgical floor bed, to the Medicare subacute unit bed, to the skilled nursing bed, to the

board-and-care bed, and eventually home. The ability to move the patients between these environments requires a dedicated physician who understands the patient and can provide expert medical assessment and care. Medicare provided the incentive behind this acuity cascade, where the prompt transfer of the patient meant financial benefit to the accepting institution as well as the transferring institution. If transfer was delayed, both institutions suffered financially as did Medicare.

Hospitals and the nursing homes were enthusiastic participants in the Senior Service program. In spring 2001, hospitalized patients from Redding, Calif., 75 miles north, and Yuba City, Calif., 50 miles south, were being transferred to our facilities because local shortages meant there were no beds available in Redding or Marysville. In the last 10 years, no new nursing homes have been built in our area and no nursing-home beds been added, despite the loss of hospital beds.

This process of clearing beds allows the hospitals to function. Because hospitals need open beds on the day of surgery, they're forced to close their surgical suites and divert their patients if those beds are unavailable. Similarly, ambulances must be diverted from the emergency room if the hospital has no beds for admitting patients.

The system has become susceptible to disruption because of the lack of capacity engendered by increased efficiency. By facilitating efficient movement of patients, Senior Service prevented the hospitals' main function from being compromised and became an integral part of the Northern Sacramento Valley medical system.

Medicare Attacks

On Dec. 27, 2000, Senior Service received a letter from the Medicare carrier, National Heritage Insurance Corporation (NHIC), requesting more than 300 medical records from the period March 1998 to September 1998 for auditing. The records, predominantly of treatment at Willows Sunbridge and North Valley Care West (NVCW) facilities, were the responsibility of the facilities. At the time, Senior Service did not make duplicates.

Nevertheless, Medicare demanded all the records in 28 days. Senior Service scrambled to gather them and obtained 80 percent. The rest were removed when NVCW was closed, and stored somewhere in the San Francisco Bay Area, 200 miles away. Senior Service could not find them. Neither could the U.S. Department of Health and Human Services (HHS) or the Federal Bureau of Investigation (FBI). Because 20 percent of the records could not be found, NHIC assumed fraud (ghost billing) and notified the FBI. The FBI under the jurisdiction of the Justice Department began an investigation of Senior Service.

Catch 22

In February 2001 an FBI agent accosted a Senior Service female nurse practitioner in a nursing-home parking lot on a stormy night. He informed her that he was investigating her and Senior Service for Medicare fraud. He asked her to cooperate, offered immunity, and attempted to intimidate her by reciting personal information—telling her where she had been the previous day and that she was leaving for Tennessee.

Over the next two months, the FBI agent visited one of the facilities served by Senior Services every week, always on Friday. His inquiries were related to our attendance and our job performance. We were never contacted by this agent, Medicare, the U.S. Attorney's Office, or NHIC. It was only through our lawyers that we were able to determine that Medicare and the U.S. Department of Justice were investigating Senior Service for fraud.

How could we have come to this?

In February 2001 Medicare informed Senior Service that electronic billing would stop, and that the business would be placed on a continuous audit of paper claims. Payments to Senior Service would stop for more than two months and no more would be made until we submitted multiple records to the Medicare carrier, including the doctor's orders and dictated notes about the visit. Continuous audit lasted more than 14 months. Cash flow to Senior Service for its nursing-home services stopped from February to April 2001. The financial burden would have been overwhelming if Senior Service had been solely dependent on these monies, but it was not, and thus it was able to remain in business and to continue its 24-hour, 365-day care of these patients.

On March 14, 2001, Medicare requested a second audit of more than 900 records from 1999 and 2000. This audit was completed in early summer of 2001 and submitted to Medicare. Because Senior Service had recorded and stored its own records from January of 1999, there was less difficulty in obtaining patients' charts than in 1998. It should be emphasized that hospital records are not the responsibility of any physician or physician group, but of the hospital. However, because Senior Service went through the effort to maintain its own copies, it was able to fulfill Medicare's demands.

The financial burden placed on Senior Service by switching from electronic to paper claim reimbursement was a common method employed by Medicare and its carriers, and can destroy a practice. Once financially incapacitated, the practice is unlikely to mount a defense; thus the carrier, the FBI, and the U.S. Attorney usually have a defenseless defendant and easy victory.

Defense costs for an individual or small group practice are enormous. In our case, five employees worked for two years to obtain records, review the material, organize it, and respond to Medicare. Our attorneys required a substantial retainer and charged five times our hourly income. By imposing prepayment review, one of our providers had to collate and review more than 2,000 bills per month in the form of dictated reports. Review required a hospital order sheet to accompany the dictated notes, and therefore significant cooperation between the various institutions. All this reduced our efficiencies and significantly increased our costs.

In April 2001 Medicare said it had found significant irregularities in Senior Service billing, and imposed an overpayment amount of more than \$50,000 in excess billing, mostly in what it called unnecessary visits and the 20 percent of visits for which no records could be obtained. The auditor assumed fraud in all cases for which records were not available.

The Medicare reviewer in this instance was a licensed vocational nurse (LVN) who relied solely on the material submitted by Senior Service, had no access to the medical histories, and therefore had no information about the patients' illnesses except through chart notes.

Multiple visits were often deemed medically unnecessary. The majority of these cases were in the respiratory subacute unit at Willow View Hospital. One ventilator-dependent patient who had multiple visits denied was a 47-year-old man with a history of myotonic dystrophy. He was prone to respiratory infections, cardiac arrhythmias, chest pain, and chronic severe dermatitis. The patient had multiple episodes of pneumonia, sepsis, urinary tract infections, gastrointestinal disturbances, respiratory failure, and infections with organisms that were resistant to most antibiotics. Most of the visits to treat these life-threatening problems were deemed unnecessary.

The State of California had mandated visits twice weekly by Senior Service physicians to the subacute unit. Because of the nature of the illnesses, sometimes physicians visited four times per week. The Medicare reviewer did not take into account the fact that patients maintained in the subacute unit would have needed transfer to the ICU at the acute-care hospital in the absence of careful physician monitoring.

The audit was on paper only. Senior Service staff could not speak with Medicare reviewers. Interaction between Medicare and Senior Service occurred only through Senior Service attorneys.

If a patient's acuity of illness did not correspond to the review standards, the reviewer determined that we had engaged in a medically unnecessary visit, and payment was denied. This was a post-fact analysis of the patient's condition. The physician, however, had been asked to see the patient, either by the patient himself or a nurse. Refusal to respond would have constituted malpractice had there actually been a significant medical problem.

We were in a medical Catch-22.

Medicare laws were changed in 1994 to force physicians to meet a complicated set of requirements in their notes in order to justify Medicare payment. Subsequent changes were imposed in 1995 and 1997. Senior Service attempted to comply with these requirements. We produced one to three pages of single-spaced typed notes per hospital visit detailing the history, physical, laboratory, and interval history on each patient. This paperwork, imposed only in the last year of the last administration, was a new phenomenon. Failure to comply, or failure to justify the Medicare point system, was considered a felony or at least a potential one. If the proper form was not met, the charge was considered inappropriate.

The process of accommodating to these changes impeded our productivity, and our time with each patient was cut in half. The amount of time spent on paperwork was at least half the time spent with the patient.

Medicare review was based solely on the physician's notes. There was no review of the nurse's notes, the laboratory data, the patient's previous medical history, the interval history between examinations, or orders given by telephone or facsimile. Time to gather all the information was not considered, nor was severity or complexity of a disease.

The physician's abbreviated coverage of all this information in the traditional pattern of progress notes was used to downgrade coding and to threaten criminal charges for upcoding. We petitioned for reconsideration. They told us only a Medicare-sponsored administrator could review the determination. In effect, we were in an inquisitorial court under administrative law, designed and controlled by the department.

The Defense

Far from committing criminal fraud, Senior Service had generated millions in savings for Medicare Part A. It proceeded with a two-pronged defense strategy. First was a comprehensive defense of the previously billed charges. Second was an exposition of Senior Service's value to the community.

Senior Service hired a nationally known group of attorneys in February 2001. They strongly suggested that Senior Service obtain the lost records. A private investigator was hired. After a five-month search, the records were found in a small warehouse 200 miles from Chico, where they were about to be destroyed. We got them all, reviewed them, and submitted them to the carrier in July 2001. Only 3 percent of the cases could not be documented. The threat of criminal prosecution was over, and the case was reassessed.

It became clear that our attorneys, who were former prosecutors, were not interested in pursuing a defense. Their function seemed to be to remove us from criminal prosecution and obtain a plea bargain with Medicare concerning the fine. This was unacceptable to Senior Service. We felt that no crime had been committed and no penalty was reasonable.

After July 2001 we changed attorneys and began looking for allies. We found the California Medical Association and the American Medical Association to be uninterested in our case. No local attorneys were familiar with Medicare. Regional attorneys in Sacramento and San Francisco did not seem to share our philosophies. Only the Association of American Physicians and Surgeons (AAPS) supported us.

After the initial FBI contact, Senior Service immediately informed the nursing homes and hospitals about the FBI investigation and our response. We also informed the patients and their families of the constraints that were being placed on us by the Medicare review. We encouraged them to contact their congressional representatives.

We contacted our local congressman, Rep. Wally Herger (R-2nd/CA) and received a warm reception from him and his staff. They spent many hours with us as we explained Senior Service to them, including its value to the community and what could be the results of service disruption. They toured Senior Service, the nursing homes, and the local hospital. We showed them how the

acuity cascade worked and how the Medicare Act of 1998 functioned in practice.

Senior Service held town hall meetings in the nursing homes, informing patients and their families about the problem and the restricted visits. The local administrators of the nursing homes were generally supportive. The patients and their families were encouraged to write letters to the congressman and to the carrier, and they did so.

The congressman's staff began contacting the carrier, asking that contact be established between the carrier and Senior Service to resolve the issue, but for more than 10 months the carrier refused to substantively discuss the issues with Senior Service. We began collecting cases that demonstrated our cost savings to Medicare and the consequences of NHIC's actions. We obtained the hospital bills from these cases and compared the differences between the cost of subacute care and acute hospital costs. This information was given to our congressman.

Because we could no longer provide appropriate care we withdrew from the Willow View Respiratory Care Unit and limited our visits to other subacute facilities.

The financial loss to the Medicare program and to hospitals was incalculable. One case is illustrative. A 45-year-old quadriplegic admitted by Senior Service to the acute-care hospital for aspiration pneumonia could not be weaned from the ventilator when the acute episode resolved. Because Senior Service had withdrawn from managing the subacute respiratory care unit at the convalescent facility, and no other physicians in the area were willing to provide pulmonary management there, the patient had to remain in the acute hospital. During his lengthy stay, the hospital was on diversion many times, affecting the trauma program and helicopter transportation service. After half a year and half a million dollars, the patient was finally weaned and transferred to a facility that could now provide care.

Accountability

Senior Service attempted to communicate with NHIC. We asked why our prepayment review had continued past six months. We asked for the results of their review and for clarification of the claims denied. The carrier did not respond. NHIC was supposed to educate and inform us about the billing being denied. Officials were supposed to indicate what actions on our part would justify billing. When asked, they could not give instances, nor could they answer questions on how to fix specific claims for proper payment.

No specific state, federal, or Medicare regulations could be cited to define the criteria for denials. The usual response was to use the denial code PR B6, which states: "The service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider and this type of facility or by provider of this specialty." No reasons other than that statement were ever given.

Finally, in October 2001, a letter from the LVN reviewer at NHIC to Senior Service was obtained. It stated that the two reasons for denial were the frequency of our visits and lack of documentation of services. The LVN also claimed that she had been

providing us with appropriate publications for the correct use of management codes.

Senior Service requested a definition of medical necessity. We asked how we could refuse to make visits that were specifically requested by a nurse or a patient at a facility. Correspondence with the carrier's LVN concerning these issues continued without resolution. Reasons for denial were never defined, in general or in specific claims. This correspondence was sent to the congressional office.

On Jan. 24, 2002, Ms. Anne Dalton, the account delivery executive for NHIC in Washington D.C., communicated with Senior Service. Her letter reads:

In regard to your Medicare claims, NHIC is fully complying with its obligations to CMS. NHIC has received confirmation from CMS that its actions in regards to your claims and services were correct and in accordance with acceptable federal rules and regulations. Enclosed you will find appropriate regulations under which appeals can be filed in regards to any NHIC actions that you feel were made in error.

Please be advised that your statements contained in your letter are false, baseless and inaccurate. The continuation on the part of you and/or your company to further release knowingly inaccurate statements will result in NHIC pursuing available legal remedies in conjunction with CMS and other appropriate Federal law enforcement agencies.

Dalton claimed that NHIC welcomed the opportunity to meet with us and discuss the situation. At that point NHIC had never met with us and did not do so for another 90 days. NHIC nevertheless told the congressman that it had met with us and was working cooperatively to resolve the problem. We informed the congressman that this was false.

Our congressional office informed us that when the process had matured, they would facilitate a meeting with HHS to discuss the case. In early 2002, our congressional representative informed us that no contacts with HHS could be made. Medicare had established a rule that during an investigation HHS could not discuss the case with the defendant.

The help of AAPS at this point was extremely useful, since the only means for redress would be through congressional offices and the media. AAPS also allowed us to present our material at its national meetings.

The Outcome

In February 2002, the first audit determination was presented to us along with a bill for \$50,000. We requested a hearing officer for the first audit. This was granted five months later at the end of July 2002.

In March 2002, a mid-level executive from NHIC contacted Senior Service and requested a visit. This was the first physical contact in a year and a quarter. There had been no communication for two months, since the Dalton letter. The NHIC executive spent

three hours at Senior Service and was given a tour and an explanation of the service and its part in the community.

A week after his visit, the prepayment review was suspended and Senior Service was informed that it could proceed with its business.

At the end of February 2002, the preliminary review of the second audit was presented to us and the overpayment was cited at \$365,000. We were given 30 days to respond and another 30 days if we filed an extension. We reviewed the cases and reasons for denial, including the previous dates of service as well as the patient's history, medical condition, condition on admission, recent labs, and any change in his medical condition that prompted the visit. We submitted our response in April 2002.

In November 2002 we had three meetings with the hearing officer to resolve the first audit. In three days of presentation we showed the interaction between Senior Service and the medical facilities. We demonstrated that Senior Service provided a necessary and cost-effective service to Medicare, particularly to Part A. We informed the reviewer of the state and federal laws requiring the hospital to retain its own records, and stated that these have never been a physician's responsibility. We showed that the missing dates of service were the result of lost hospital records, not poor compliance or malfeasance on the part of Senior Service or its physicians. We argued that the stratum used by Medicare magnifies the fine, and that it was inappropriate in our cases because of the acuity of our patients' illnesses.

The hearing officer responded in a week and reduced the fine by half. But the reviewer was not willing to accept the medical necessity and reasonableness of the visits because she believed this was above her authority. She suggested that an administrative law judge review the case. We immediately filed an appeal with the Office of Administrative Law Judges in California.

In January 2003 the final audit for the second fine was received. This fine was reduced from \$365,000 to \$9,000. No stratum was employed. The \$9,000 was justified by the carrier, who claimed excessive charges, lack of documentation, and upcoding of the visits.

As of December 2003, three years after the first Medicare assault, the first audit has not been appealed after discussions with the Administrative Law Judge. The court indicated it would not consider medical necessity in its judgment. The reviewer of the second audit refunded \$3,500.00 on December 3, 2003. The reviewer claimed upcoding, lack of documentation, and unnecessary visits as the reasons for withholding the remaining funds.

The Medicare program that created the need for Senior Service has made it impossible for that need to be supplied. Senior Services discontinued its comprehensive nursing home and hospital services. Two physicians including the author have withdrawn from Medicare. With considerable effort the practice was able to defend itself. The NHIC LVN reviewer has been reassigned, and the physician who served as Medical Director for California was fired.

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