Health Policy Newsletter

Volume 10, Number 1 **January, 1997** **Article 1**

From the Editor

Taking the Right PATH (Physicians at Teaching Hospitals)

David B. Nash, MD, MBA*

* Thomas Jefferson University

Suggested Citation:
Nash, DB. From the editor: taking the right PATH (physicians at teaching hospitals). Health Policy Newsletter 1997; 10(1): Article 1. Retrieved [date] from http://jdc.jefferson.edu/hpn/vol10/iss1/1.

From the Editor

Taking the Right PATH
(Physicians at Teaching Hospitals)

For more than 30 years, Medicare payments have been made to teaching hospitals and physicians to support their important mission of education, research and patient care. The Medicare program, of course, is administered by HCFA-the Health Care Financing Administration, an integral part of the United States Department of Health and Human Services (DHHS). Medicare Part A payment covers hospital and other institutional care for nearly 40 million Americans age 65 or older and for certain disabled persons. Medicare Part B covers most of the costs of medically necessary physician services. The HCFA, in turn, contracts with private insurance companies to process Medicare claims and to safeguard the payment function. Currently, HCFA contracts with 34 carriers that process these Part B claims including claims for physician services performed in the teaching hospital setting.

An obscure federal legislation issued in 1969 by HCFA, called Intermediary Letter-372 or IL-372, set forth specific conditions that physicians in teaching hospital settings had to meet to be considered "attending" physicians and thus qualified to charge these carriers for services involving interns, residents and fellows. This IL-372 has remained in effect since its issuance but, unfortunately, was not applied uniformly by all Medicare carriers across the country.

Indeed, my review of documents from HCFA, The Association of American Medical Colleges (AAMC), accounting firms, and law firms throughout the east coast, confirmed my suspicion that IL-372 has been the source of tension between HCFA and academic medical centers for nearly 25 years. Space precludes a detailed review of this tension, but documents from the AAMC, some dating back to the early 1970s, outline the sources of misunderstanding and misinterpretation. In a word, HCFA was willing to pay for faculty physician services even if the actual laying on of hands to the patient was accomplished by interns and residents under direct faculty supervision. This tension preserved the important teaching and education mission of academic medical centers by allowing trainees to assume increasing levels of autonomy and skill in patient care. One can picture busy surgeons overseeing the care of multiple patients through the work of residents and other trainees at all levels of expertise and experience. Indeed, in my own clinical experience at Jefferson, it would not be unusual to supervise four house staff teams caring for dozens of inpatients. (Please see my editorial in the Health Policy Newsletter Vol. 8, No. 3, September 1995 issue)

Now comes an interesting twist in this tension-packed story swirling around IL-372. No doubt faced with the specter of the escalating deficit in the Medicare Trust Fund and news reports of egregious fraud and abuse by administrators, physicians, and others in the health care industry, the Department of HHS saw an opportunity. After decades of quibbling about the interpretation of IL-372, HCFA proposed on December 8, 1995, a new rule that essentially said the attending physician must be "elbow-to-elbow" with the resident physician in order to receive Part B payment. Overnight, this new rule forever changed the relationship between academic medical centers and HCFA. No longer would trainees have, in a sense, a financial proxy from their

supervising teaching attendings.

The Department of Health and Human Services, Office of the Inspector General (OIG), then began a nationwide project involving a review of those Medicare Part B billings by physician group practices at teaching hospitals. This project is conducted jointly by the OIG and the United States Department of Justice (DOG). The first target of this nationwide review was the clinical practices of the University of Pennsylvania or CPUP. Four days alter the IL-372 nationwide revised ruling noted above, the CPUP was fined $30 million, payable to the United States Government, after a federal audit disclosed that false Medicare bills were submitted for faculty physician services. The audit claims to have found $10 million dollars in false claims filed between 1989 and 1994, based on a sample of only 100 patient charts from calendar year 1993.

The essence of the government's case is that institutions like CPUP have been violating the False Claims Act and "bankrupting" the Medicare program through the submission of fraudulent bills for services that were actually provided by residents or for which insufficient documentation existed that the service was ever performed. The False Claims Act specifically provided for triple damages, hence the $30 million tab for CPUP.

In researching this editorial, I learned that the OIG and DOG contacted other federal agencies such as the IRS and the Naturalization and Immigration Services. They tracked down passport visas linking physician international travel with simultaneous billing dates in Philadelphia. In short, the vast power of the federal government was brought to bear by the OIG. Many observers, whom I cannot name them for fear of retribution, claim that this entire federal exercise is akin to a Medicare tax of sorts to demonstrate to the public that academic medical centers will not get away with this reportedly fraudulent behavior. In the context of health reform, national elections and skyrocketing health care costs, this is obviously an intensely political issue. Insiders have noted that for every eight cents spent by the OIG, they get a one dollar return on their investigative investment.

Empowered by the successful investigation at the University of Pennsylvania, the OIG in its eight regions nationwide, begins investigations at 25 additional academic medical centers by informing them of a pending audit. Simultaneously, it created a unique program entitled, PATH-the Physicians at Teaching Hospitals. Under the aegis of PATH, teaching hospitals can volunteer or come forward and submit to an audit by the OIG refereed by some outside third party such as a national accounting firm. Jefferson stepped up to plate and became the first institution in the nation invited to participate in this voluntary disclosure program. Again, as it was widely reported in the lay press, TJU reached a $12 million settlement with the OIG to resolve issues surrounding physician compliance with Medicare billing regulations for the period 1990 through 1994. This agreement requires the Jefferson Faculty Foundation (consisting of 18 separate physician practices with 425 physician members) and the University to pay $6 million in overpayments and $6 million in fines to the federal government. Jefferson took this PATH to settlement to avoid long and costly litigation that would have diverted resources from other important activities.

The question remains then is, did we take the right PATH? One could certainly quibble about the size and implementation of the settlement itself. That is not my intent. Instead, let me pose some more important questions, in my view, including what good, if any, will come from this distasteful episode, how can we continue to

improve the high quality of care we deliver and document that care, and what unresolved future issues remain?

As a result of the OIG investigation, TJU has implemented a broad compliance program which is a comprehensive set of measures implemented to reduce the prospect of illegal conduct and to detect any offenses should a violation nonetheless occur. According to Brenton L. Saunders, JD, MBA, the corporate compliance officer for the University, compliance is everyone's business-from clinicians to senior management and the Board of Trustees. Details of the compliance are available from Mr. Saunders' office, but a key aspect is the implementation of a reporting mechanism which allows individuals to report violations without fear of reprisal-for example, the compliance hot line, which is 1-888-5-comply. To continue to improve our documentation and the quality of care rendered by Jefferson faculty physicians, all faculty must now participate in ongoing educational programs about good record keeping and appropriate supervision of trainees.

Finally, about those unresolved issues, one can only ponder what will happen as millions of Medicare patients are enrolled in managed care plans and the documentation requirements become significantly different. What about funding for graduate medical education and its effect on residency training across the country? What action will the new Congress take to limit the nearly $5 billion spent by HCFA on resident education in teaching hospitals? Frankly, from my perspective, those are the much more compelling issues deserving our attention in the future. I hope we can now focus our energies on taking the right path. As always, I am interested in your views.

(The author gratefully acknowledges the encouragement, support and materials lent to him by Joseph S. Gonnella, MD, Alan Kelly, Esquire, Brent Saunders, JD, MBA, and Ms. Cheryl Haze Luehrs. The opinions expressed herein are solely those of the author and not the official position of TJU).

- David B. Nash, MD, Editor