

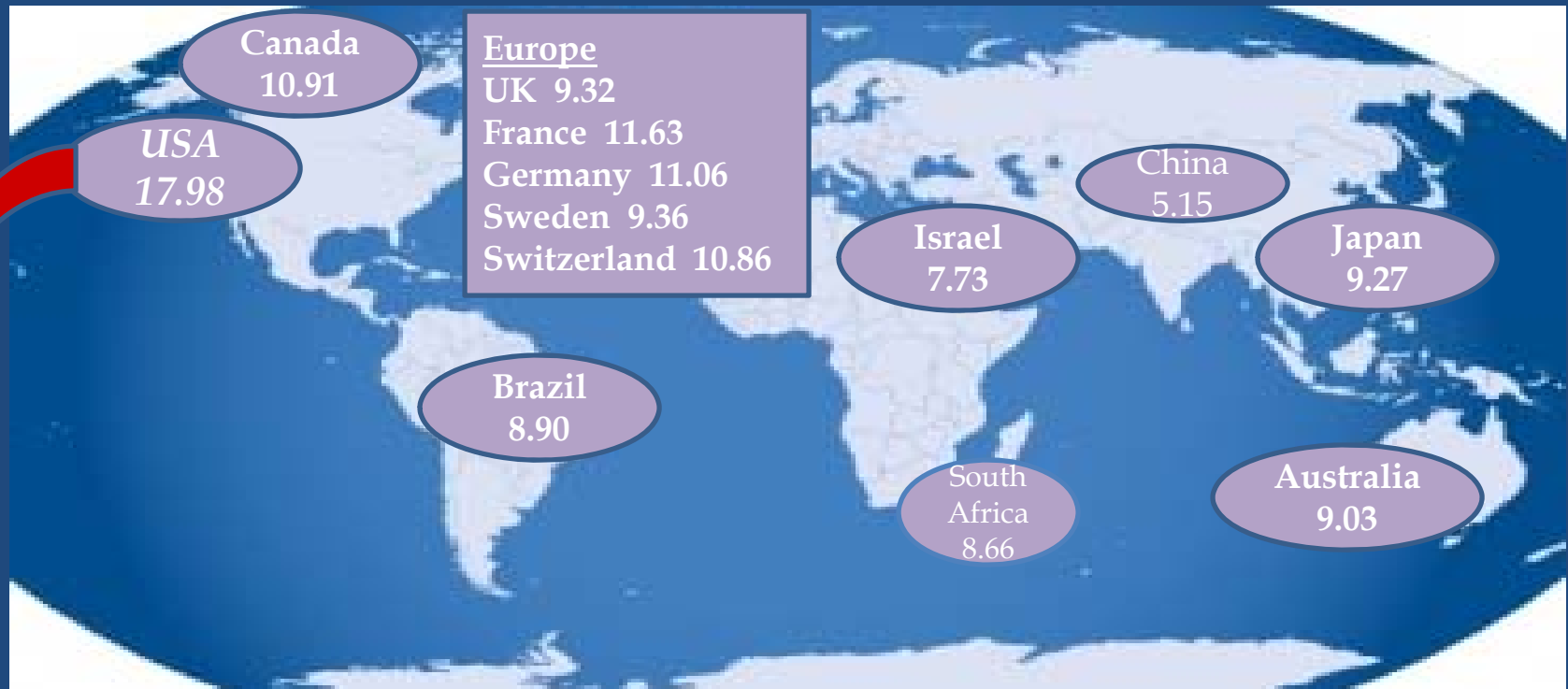
HEALTH CARE FRAUD & ABUSE

PREVENTIVE STRATEGIES IN PROGRAM INTEGRITY

Department of Health Care Services

Audits & Investigations
Medical Review Branch

Healthcare Expenditures Industrialized Nations : % 2011 GDP



World Health Organization
Total expenditure on health as a % of Gross Domestic Product, 2011

Fraud, Waste & Abuse
19%
Thomson Reuters, 2009

US GDP 2011 : \$14 .9 trillion
Health care spending: \$2.8 trillion

Issues and Examples

Mistakes

Inefficiencies

**Bending the
Rules**

**Intentional
Deception**

Error

Incorrect
Coding



Waste

Medically
Unnecessary
Service



Abuse

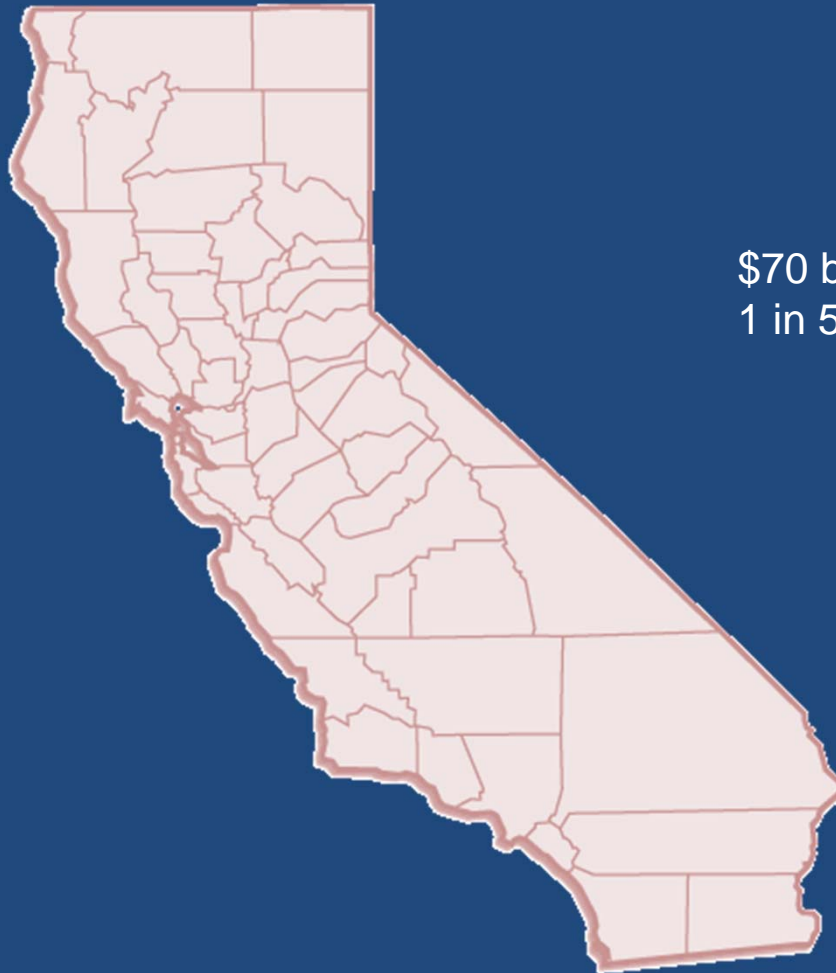
Improper
billing
practice



Fraud

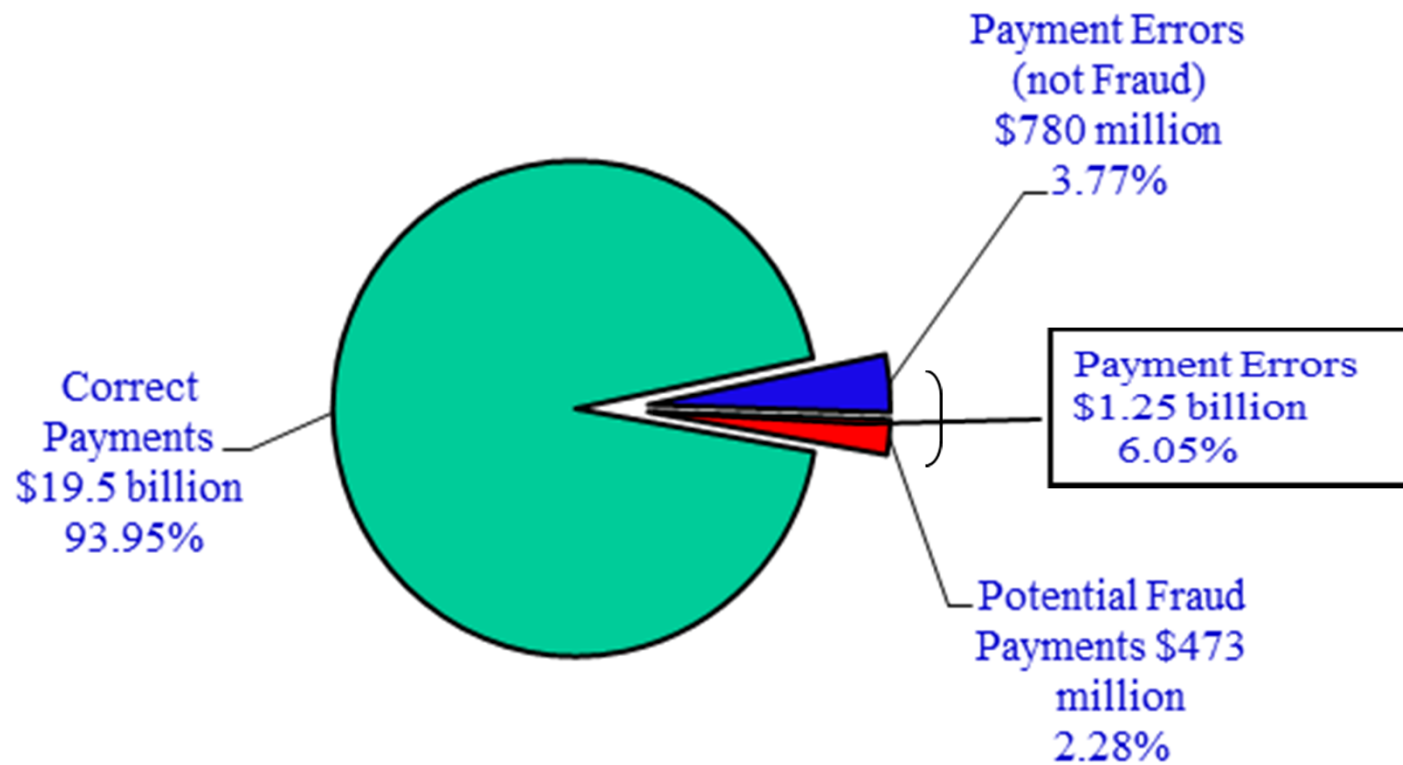
Billing for
unnecessary
Services or
Supplies not
Provided

California Department of Health Care Services



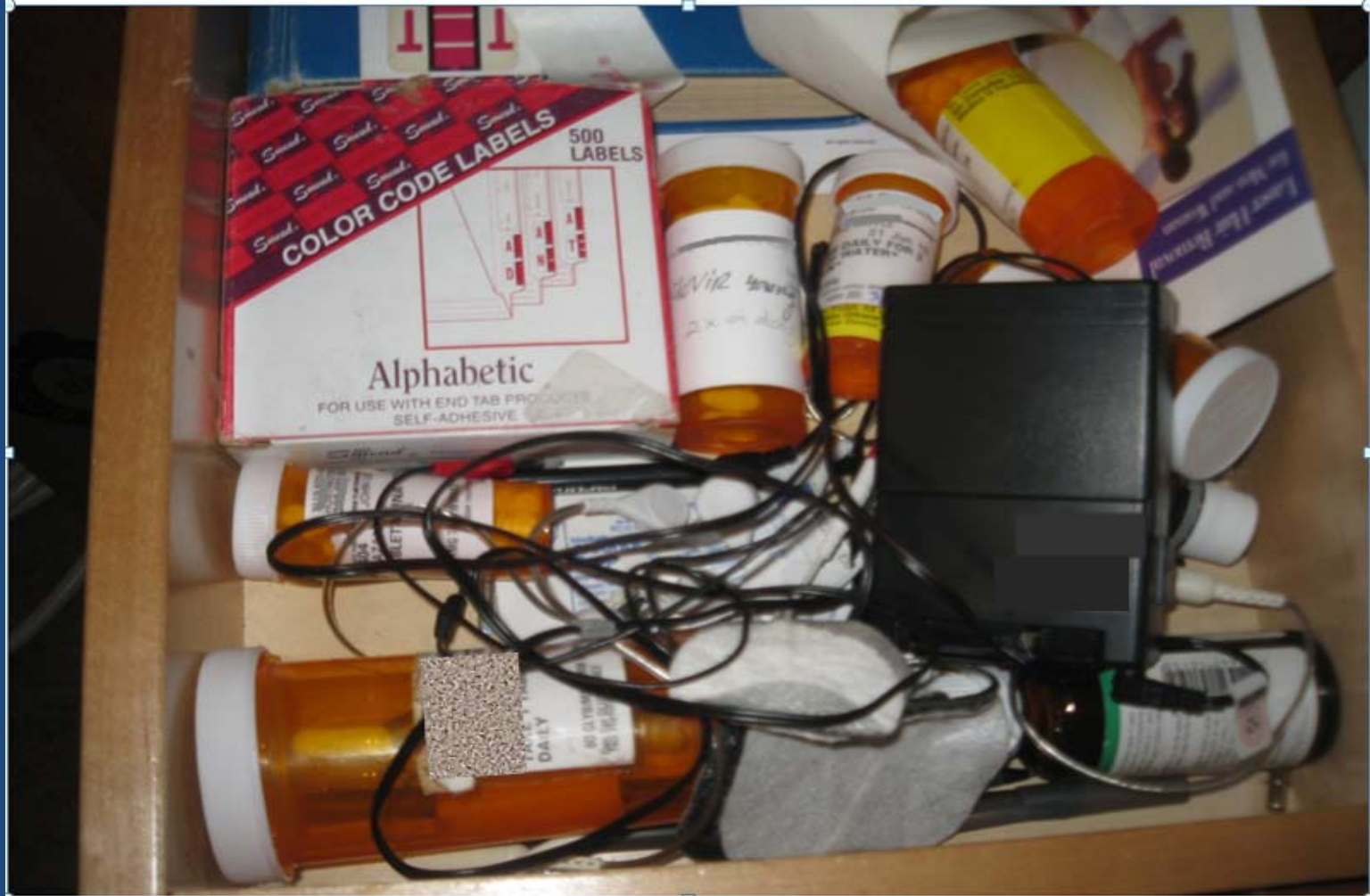
\$70 billion (2014)
1 in 5 people covered

Medi-Cal Fee-for Service Payment Proportions Paid Correctly Error, Including Fraud - 2011



Fraud = Bad Practice







Con Artists

- ▣ A con artist is a professional
- ▣ A con artist needs a conduit
- ▣ A con artist needs a victim to take the fall
- ▣ A con artist doesn't care about the harm

Physicians

- ▣ Focus on medicine
- ▣ Not taught about business
 - (e.g. Don't sign a blank contract!!!)
- ▣ The National Provider Identifier is like a credit card without a limit

Program Integrity

- ▣ Deficit Reduction Act of 2005
- ▣ Program integrity is the practical concept that programs should be organizationally and structurally sound
- ▣ Health care – programs efficient, effective, ethical
 - Corollary: prevent fraud, waste & abuse

Medical Review Branch

- ▣ Medical and Audit staff
 - Pre-Enrollment Reviews
 - Utilization Controls
 - Sanctions
 - Referrals
 - Studies
 - Compliance Audits
 - Outreach

Referrals

- ▣ Medical Board
- ▣ Pharmacy Board
- ▣ Centers for Medicare and Medicaid
- ▣ Department of Justice

Eliminate “Pay & Chase”

- ▣ Prevention
 - Disclosure
 - Knowledge is Power
 - Stop unlicensed practice
- ▣ Affordable, quality care
- ▣ Best use of dollars

Screen Applicants



Physician Office



Current FDA Approved Drugs



Issues in Provider Community

- ▣ Identity Theft versus Identity Lease
- ▣ Avoid Patient Harm
- ▣ Close the Knowledge Gap

Outreach Efforts

- ▣ Professional Societies
- ▣ California Medical Association Webinars
- ▣ Partner with Centers for Medicare & Medicaid
- ▣ Residency Programs
- ▣ Journal articles
- ▣ Education materials
 - Patients
 - Providers

Next Steps

Need to Reach a Wider Audience

Online Training

- ▣ 3 one hour Interactive Webinars
- ▣ Developed with Xerox (fiscal intermediary)
- ▣ Free
- ▣ Goal – Free Continuing Medical Education
- ▣ Subject Matter Experts

Subject Matter

- ▣ Module I
 - Impact of fraud, waste & abuse

- ▣ Module II
 - Prescribing & Referring

- ▣ Module III
 - Documentation & Internal Controls

Module II

- ▣ Timeliness
- ▣ Impact of prescribing
- ▣ Videos/input from other experts
- ▣ Welcome Medical Board support

Change the Dynamic

- ▣ Attitudes
- ▣ Education
- ▣ Benefit for the greater good

An Ounce of Prevention



Protect Your practice

- Do not sign something unless you have read it, understand it, and have retained a copy.
- Document your services thoroughly and legibly, including the medical reasons behind the services provided.
- Know your employees, especially the qualifications of those providing billing services.
- Beware of individuals offering to pay you to be clinic "medical directors" with little or no patient contact.
- Do not allow patients or their families to pressure you into ordering medically unnecessary services or products.

Suspicious Behaviors

Patients reporting receiving unrequested goods or services. (Delivery of unsolicited goods or services to patients is a problem. We want the patient to report to a physician if unsolicited goods or services are received.)

Offers of money or goods in exchange for allowing unnecessary services or testing.

Patient frequently requesting script for replacing "lost" prescriptions, particularly narcotic or high cost medications.

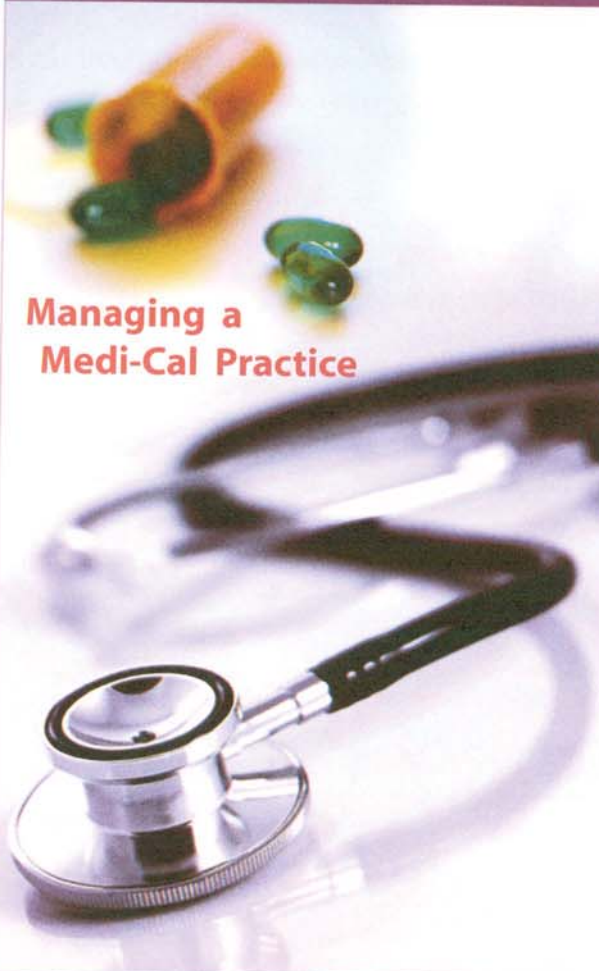
Report Fraud and Abuse

- DHCS Medi-Cal Fraud Hotline:
 - Toll Free 1-800-822-6222
 - Caller may remain anonymous
 - Languages available are English, Spanish, Russian, Vietnamese and Cambodian
- DHCS Fraud Prevention email: stopmedicalfraud@dhcs.ca.gov
- Written complaint to:
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
- Attorney General Medi-Cal Fraud and Elder Abuse Hotline:
 - Toll-free 1-800-722-0432

California Department of Health Care Services
Audits and Investigations Division



California Department of Health Care Services (DHCS)



Managing a Medi-Cal Practice

**PROTECT MEDI-CAL AGAINST
FRAUD, WASTE AND ABUSE**

Knowledge is the best defense.

The Department of Health Care Services (DHCS) seeks to promptly pay providers and eliminate fraud, waste and abuse. Most claims are paid with the assumption that the claims are accurate and most services are approved under the belief that the services were medically necessary and delivered as represented.

This system best serves beneficiaries and providers. However, it does provide an opportunity for erroneous payments.



What Is Fraud?

Fraud is the intentional deception or misrepresentation perpetrated to acquire an excessive Medi-Cal reimbursement or other unauthorized benefit.

Although 95 percent of Medi-Cal billing is accurate, the small minority of fraudulent providers account for \$1 billion in annual loss to California taxpayers.

Why Be Concerned?

Fraud, waste and abuse drain health care dollars and resources from everyone. Fraud, waste and abuse can result in incorrect information in your patient's health record.

We share a responsibility to prevent fraud. A vigilant provider is a strong defense against fraud, waste and abuse.

Conversely, inattention to detail could jeopardize your practice or otherwise limit your ability to participate in Medi-Cal and Medicare programs.

Fraud May Present As:

- *charges for goods or services that were not provided or were not necessary*
- *kickback arrangements for referrals for services, drugs or supplies*
- *use of the wrong medical identity*

Waste and abuse also represent a significant portion of payment errors. These can occur when:

- *providers order excessive services or drugs and supplies*
- *patients request and are granted services that are not utilized or have questionable medical value*
- *higher cost services or products are ordered when there are equivalent lower cost options*
- *providers are unfamiliar with the rules governing care under the Medi-Cal Program*

Reporting

What to Report

Report if your medical identification number has been lost, stolen or otherwise compromised.

Report suspicious activities, such as waiving of copayments or rewarding with gifts or bonuses.

Report suspicious individuals or companies, such as those conducting door-to-door or telephone marketing.

Where to Report

Three Options for Reporting Medi-Cal Fraud

1. DHCS Toll-Free Medi-Cal Fraud Hotline:

1-800-822-6222

- Caller may remain anonymous
- Languages available are English, Spanish, Russian, Vietnamese, and Cambodian

2. DHCS email: stopmedicalfraud@dhcs.ca.gov

3. Attorney General Medi-Cal Fraud and Elder Abuse Toll-Free Hotline: 1-800-722-0432

- \$1,000 reward offered for information leading to the arrest and conviction of providers of Medi-Cal goods or services who commit fraud

How to Report

Collect the following facts about the situation:

- Service, product or action you are questioning
- Reasons for concern
- Provider's name and identifying number
- Date of occurrence
- Dollar amount
- Your name and medical identification number

WORKING TOGETHER

When patients, health care providers, and Medi-Cal work together against health care fraud, the benefit is felt throughout the entire system. Thank you for your help.



California Department of Health
Care Services (DHCS)

**BE A PARTNER
IN HEALTH CARE**

**PROTECT MEDI-CAL AGAINST
FRAUD, WASTE AND ABUSE**

How You Can Help

- *Protect your medical benefits identification number*
- *Be alert for possible schemes and scams*
- *Report concerns*



What Is Health Care Fraud?

Health care fraud is an intentional attempt by someone to receive unearned money or undeserved benefits from an insurance program.

It can take the form of...

- *charges for goods or services that were not provided or were unnecessary*
- *kickback arrangements for referrals*
- *use of the wrong medical identity to acquire goods or services for someone else*

Why Be Concerned?

Fraud, waste and abuse drain health care dollars and resources from everyone.

- *This hurts you, your fellow patients and your health care providers.*

Fraud can result in incorrect information in your health record.

- *This can mislead your doctor and result in improper treatment.*

Fraud can complicate your life.

- *It can bring legal authorities to your door.*

Identifying Possible Schemes and Scams

Be suspicious of the following:

- *Offers of free services or gifts in exchange for your medical identification number.*
- *Visits by solicitors, calls by telemarketers or requests for payment over the telephone or Internet.*
- *Pressure tactics for you to request or accept medical services or supplies that you do not need.*
- *Charges for services or supplies you did not receive.*
- *Copayments automatically being waived (kickbacks).*

Protecting Your Medical Benefits Identity

Keep your personal information (i.e., Social Security Number, medical identification number, and credit card numbers) safe and secure.

Do not allow your medical identity to be borrowed and used by another person.

Do not give your personal information to solicitors or marketers. Only give your personal information directly to your doctor or other official health care providers.

Expanding Physician Education in Health Care Fraud and Program Integrity

Shantanu Agrawal, MD, MPhil, Bruce Tarzy, MD, Lauren Hunt, MPH,
Julie Taitsman, MD, JD, and Peter Budetti, MD, JD

Abstract

Program integrity (PI) spans the entire spectrum of improper payments from fraud to abuse, errors, and waste in the health care system. Few physicians will perpetrate fraud or abuse during their careers, but nearly all will contribute to the remaining spectrum of improper payments, making preventive education in this area vital. Despite the enormous impact that PI issues have on government-sponsored and private insurance programs, physicians receive little formal education in this area. Physicians' lack of awareness of PI issues not only makes them more

likely to submit inappropriate claims, generate orders that other providers and suppliers will use to submit inappropriate claims, and document improperly in the medical record but also more likely to become victims of fraud schemes themselves.

In this article, the authors provide an overview of the current state of PI issues in general, and fraud in particular, as well as a description of the state of formal education for practicing physicians, residents, and fellows. Building on the lessons from pilot programs conducted

by the Centers for Medicare and Medicaid Services and partner organizations, the authors then propose a model PI education curriculum to be implemented nationwide for physicians at all levels. They recommend that various stakeholder organizations take part in the development and implementation process to ensure that all perspectives are included. Educating physicians is an essential step in establishing a broader culture of compliance and improved integrity in the health care system, extending beyond Medicare and Medicaid.

Editor's Note: A commentary by M.A. Lyles appears on page 1061.

Health care fraud is a pervasive element of the current delivery system for both public and private payers in the United States, and schemes like those described below are perpetrated every day.

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Scope of Program Integrity Issues

Beginning in 2002 and continuing until they were arrested in 2010, owners of a mental health services company executed a Medicare fraud scheme. They submitted fraudulent claims in seven different locations throughout south Florida and Orlando and paid kickbacks to owners and operators of assisted living facilities and halfway houses in exchange for delivering patients to sham treatment programs. In total, Medicare paid over \$200 million in unnecessary or illegitimate services, and, to date, 11 individuals have pleaded guilty or been convicted at trial.¹

In southern California, 17 individuals, including a pharmacist and a physician, were charged with stealing millions of dollars from Medicare and Medi-Cal, the state Medicaid agency, in an elaborate prescription drug scheme that allegedly resulted in the government repeatedly paying for the same pills. Using stolen Medicare beneficiary cards, members of the ring were alleged to have obtained prescriptions for expensive drugs from the complicit physician, filled the prescriptions at pharmacies using the stolen Medicare cards, and funneled the drugs back to other pharmacies involved in the scheme.²

Fraud, such as these schemes, not only drives up health care costs but also

reduces the funds available for legitimate health care services and endangers the long-term solvency of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Currently, nearly 100 million Americans depend on these public, tax-funded programs for health care.³ Fraud can take many shapes, but common schemes involve billing for services or supplies that were never rendered or were clearly medically unnecessary. Violations also can include *up-coding*, or billing for a more expensive service or procedure than the one performed, or double billing for the same service or product. In one example of a physician-initiated scheme, an Illinois psychiatrist was found to have billed Medicaid for so many clinical hours of activity in one year that those hours nearly exceeded 24 hours each day.⁴ Other providers have been found to bill services for patients who were dead at the time the alleged services were performed.

Despite these examples, the vast majority of physicians, suppliers, and other providers are honest and do not seek to defraud or abuse public or private programs. Hundreds of thousands of clinicians help to serve Medicare and Medicaid beneficiaries daily by providing necessary, high-quality care. Physicians, however, may generate other forms of improper payments, which

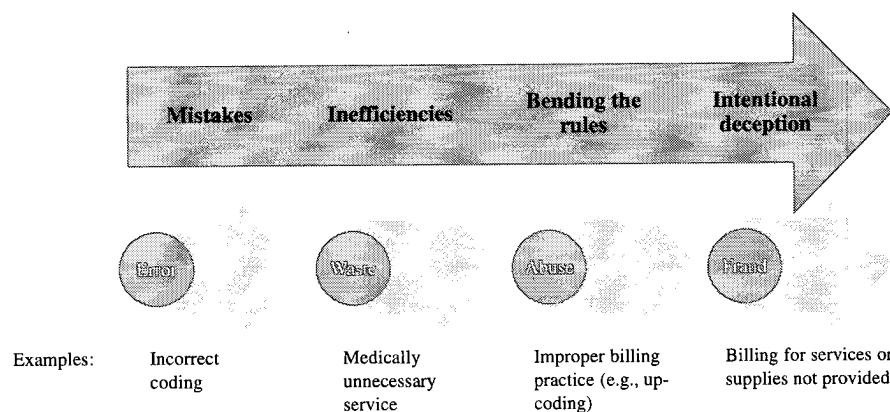


Figure 1 Spectrum of program integrity issues and examples of each.

can create challenges for the integrity of public and private programs.⁵ *Program integrity* (PI) spans the entire spectrum of improper payments, from fraud to abuse, errors, and waste in the health care system (see Figure 1). Relatively few physicians will perpetrate fraud or abuse, but nearly all physicians will contribute to the remaining spectrum of improper payments.⁶ In addition, unsuspecting physicians may become involved in fraudulent activities through their associations with intentional fraud perpetrators.

Like other complex systems with numerous financial transactions, Medicare, Medicaid, and CHIP are susceptible to payment errors called improper payments. These can result from a variety of circumstances, including billing for services with insufficient or lack of documentation, incorrectly coding claims, or providing services that were not “reasonable and necessary.” Many identified improper payments by physicians and suppliers relate to claims for which the information in the patient’s medical record did not support the services billed.⁷ Previous articles have characterized other forms of physician-driven waste, including failures of care delivery, lack of coordination, and spending on services that do not improve or preserve health. In 2012, the Institute of Medicine estimated that the U.S. health care system loses about \$765 billion a year to waste. Of that \$765 billion, about \$210 billion is attributable to unnecessary services, \$190 billion to excess administrative costs, \$130 billion to inefficiently delivered services, \$105 billion to excessive prices, \$75 billion to fraud, and \$55 billion to missed prevention opportunities.⁸

Physicians generate improper payments not only from the services they perform and bill directly but also from the services and supplies that they either order or for which they make referrals, such as durable medical equipment, diagnostics, laboratory analyses, and prescription drugs. The expenditures for such physician-authorized services and supplies far outstrip physician professional fees. One prominent example is improper payments for diabetic supplies, which are too often provided in excessive quantities or to beneficiaries who do not need them. These improper payments are caused in part by the lack of appropriate physician documentation accompanying orders. Payment errors for glucose measuring supplies, for example, amounted to more than \$1 billion in waste in 2010 for Medicare alone.⁹

Improper payments of any type cause significant financial impact. For consumers, improper payments can mean higher premiums and out-of-pocket expenses, as well as potentially reduced benefits. For employers, improper payments increase both the cost of providing insurance benefits and the overall cost of doing business. Beneficiaries also can potentially be harmed through the compromising of their medical records, such as by receiving services that are not appropriate for their actual health issues.¹⁰

Organized medicine has long recognized the need to codify medical services so that physicians are appropriately paid relative to their peers. The American Medical Association’s Current Procedural Terminology (CPT) guidelines represent national provider–payer alignment on the importance of “uniform language that

accurately describes the medical, surgical, and diagnostic services ... and provide[s] an effective means for reliable nationwide communication among physicians, patients, and third parties.”¹¹

The importance of consistent, service-appropriate documentation is relevant not only to the payer community. The relationship between documentation and coding is woven into the fabric of the health care system. The 2012 CPT report states that it is useful for “the development of guidelines for medical care review” and is “applicable to medical education and outcomes ... and quality research by providing local, regional, and national utilization standards.”¹¹ Thus, although the nexus between care and documentation may seem at times strained on an individual physician basis, its overall significance is broadly appreciated by the various health care stakeholders.

Physicians can be critical safeguards against such improper payments. The Centers for Medicare and Medicaid Services (CMS) employs a broad strategy to address fraud, abuse, and other improper payments, but the success of these approaches depends on increased awareness in the physician community. Health care fraud prevention education, then, is vital to mitigating the financial and health consequences of improper payments of all kinds.

Although the scope of PI has often been couched in terms of wasteful or abusive services, the overall goal is to ensure that the highest level of appropriate and medically necessary health services possible for the available dollars is provided. PI issues must play a role during discussions about best practices and standard protocols. Although certain care practices will recommend unnecessary care to some individuals, overall such methods should provide improved outcomes and/or lower costs to the greater population. Debates over the appropriateness and timing of health screening tests or protocol-driven care, for example, often reflect the tension between cost/benefit and patient concerns.

We, however, also must acknowledge that we are treating patients, both individually and as population groups. Issues of public safety, quality of care, and human

dignity must be a part of PI discussions and, at times, take priority. Although PI may be a relevant consideration in care discussions, it may not always be the most appropriate lens through which to view a problem like patient safety or poor quality care. In these discussions, the overriding concern should be something more than cost. All of these factors must be part of ongoing discussions regarding health care policy and approaches to adequate PI, and these discussions should rightfully involve physicians, payers, governmental oversight agencies, and public stakeholders.

Current Physician Education in PI

Despite the significant impact that fraud and other PI issues have on public and private insurance programs, efforts to control these issues historically have focused on the enforcement of policies and the recovery of funds. More recently, however, especially with the passage of new PI authorities in the Affordable Care Act in 2010, such initiatives have begun to focus on prevention. Still, medical education does not include sufficient emphasis on fraud awareness or best practices for ensuring proper payments. Some corporate integrity agreements (CIAs) from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) may include PI training, but it is not a general requirement in all CIAs or for all providers.

Current education programs and challenges to addressing PI issues

A survey by the HHS OIG revealed a lack of consistent efforts at medical schools and residency programs to teach trainees about fraud and abuse. Only one-third of the schools contacted provided “some” training on these topics.¹² In small-group discussions with residents, the California Department of Health Care Services (DHCS) found little practical awareness of PI issues such as identity theft, fraud schemes, and documentation requirements.¹³ In addition, a study done at the University of California, Irvine, revealed that foreign medical graduates represented a significant percentage of the physicians sanctioned for Medicaid billing violations.⁴ Educational efforts, then, to be broadly effective, need to target all physicians and areas of known vulnerability.

Few services in government-sponsored health care programs require preauthorization, and payments to physicians are made under the assumption that claims are accurate. Yet studies have shown that the information gap between claims and documentation is significant. For example, a recent OIG report revealed that 64% of claims for surgical debridement cases did not meet Medicare program requirements, resulting in \$64 million in overpayments.¹⁴ In addition, in 2009, DHCS released its Medi-Cal Payment Error Study which showed that claims errors cost the state over \$1 billion per year.¹⁵ The CMS Comprehensive Error Rate Testing (CERT) process identified an overall error rate of 8.6% of payments within the Medicare fee-for-service program in 2011, amounting to nearly \$30 billion.¹⁶ The CERT process also identified insufficient documentation, lack of medical necessity, and coding errors as the main contributors to the overall improper payment rate. The 2010 Implementation of Recovery Auditing at the Centers for Medicare and Medicaid Services report also identified a variety of reasons for overpayments for Medicare services, including payment for services and items that did not meet coverage and medical necessity criteria, were not correctly coded, or for which the accompanying documentation submitted did not support the ordered service.¹⁷

Physician education often does not address the rules governing the relationship between documentation and claims—specifically, the requirements of public programs. This lack of guidance certainly contributes to the measured error and overpayment rates. In addition, the increasing numbers of midlevel professionals (e.g., nurse practitioners and physician assistants) providing health care services add complexity to preventing PI issues. Supervising physicians are responsible for ensuring that these individuals have the required oversight, practice within the scope of services for which they are trained, are appropriately licensed and credentialed, and are identified as the rendering practitioner. Even with strict protocols, the opportunities for billing errors are magnified. Physicians, then, need additional education not only in preventing PI issues themselves but also in supervising midlevel professionals who may be unaware of such issues.

Health care innovation presents another set of challenges to preventing PI issues. For example, while offering numerous benefits for improved quality and coordination of care as well as assisting with long-standing documentation challenges such as legibility, electronic medical records (EMRs) also create vulnerabilities. The use of repetitive language stemming from electronic templates and cloning could create documentation that misrepresents the true nature of the patient–physician encounter. The ability to “populate” data fields in the elements of a history and physical with one click can compromise the role of a physician in affirming each individual answer. This practice can lead to inaccuracies embedded in the patient record and responses that are inappropriate. In addition, some EMR programs contain prompts that encourage physicians to document additional and potentially unnecessary elements of a history or physical to “code” for a higher level of service. Thus, to be successful, PI education programs also need to address health care innovations.

Physician-identified concerns and liability issues

Physicians and trainees themselves have identified a need for significantly more PI education. A 2010 survey, for example, found that 82% of emergency medicine residents and 100% of attendings wanted additional PI education, specifically in adequate documentation and billing.¹⁸ The findings from this study corroborated those from a 2009 survey of pediatricians, which found that 81% of respondents favored additional PI training that “highlights the acute and pervasive perception regarding the inadequacy of training in this specific area.”¹⁹ This perceived gap in training occurred despite the fact that the American Academy of Pediatrics passed a resolution in 2006 to enhance PI training for residents. The authors of the 2009 report were careful to note that “pediatrics is not the only specialty where training in billing and coding is considered inadequate.” Perhaps the most alarming findings, clearly emphasizing how early PI education must be implemented, are from a 2010 survey which found that 14% of interns from three different residency programs reported engaging in “falsification of patient records,” including back-dating

notes and documenting physical findings that they personally did not obtain.²⁰

Physicians' lack of awareness of PI issues makes them more likely not only to submit inappropriate claims and document inadequately in the medical record but also to become victims of fraud schemes. Such schemes include sophisticated operations by organized crime. Such groups, for example, can gain access to physicians' medical identities through compromised records or by physicians themselves unknowingly disclosing personal information. One such ploy is to offer a physician a position as the "medical director" of a non-physician-staffed clinic. The physician is given some remuneration to sign charts completed by others, ostensibly for oversight. What the physician may fail to realize, though, is that his or her medical identity then is used to bill Medicare, Medicaid, or other insurance programs for unnecessary or undelivered services at the clinic and possibly other locations. In another such ploy, a specialist, such as a radiologist, may be asked to "overread" diagnostic studies for a clinic which bills for the specialist's services. What the specialist may fail to realize is that the services are for patients recruited from vulnerable populations, such as the homeless, and are medically unnecessary. The result of such schemes is that the physician whose identity was misused may lose the ability to participate in public and private insurance programs, thus becoming potentially unemployable.

Even in these examples, the physician is responsible for performing due diligence to ensure that his or her employment positions and billing practices are legitimate and that he or she abides by good medical practice. Physicians who agree to sign charts without evaluating the volume and quality of services delivered or to "overread" films can be culpable. Compensation disproportionate to the work being done should raise a red flag for any medical professional, and he or she should further investigate and report such situations.

PI issues are not confined to the fee-for-service arena. Medicare auditors, for example, are familiar with issues such as diagnostic-related group up-coding or inaccurate increases in the risk adjustment factors which determine payments to Medicare managed care

plans.²¹ In addition to the direct financial impact, these inaccuracies, whether deliberate or not, corrupt patient medical records. Successful diagnostic coding is dependent on physicians having sufficient training in recognizing the sometimes subtle but important differences embedded in the codes.

Educational requirements and approaches

The complexity of these PI issues poses challenges for education. Multiple authors have suggested that deceptive physician billing practices against third-party payers in general, and public programs in particular, are based in part on the conflict between physicians' need to care for their patients and the rules of the insurers' governing benefits.^{22,23} Although this rationale is self-serving, a number of parties believe that physician education should include training in the ethics governing patient care and the consequences of PI shortcomings to the individual, the profession, and the health care system.^{4,12,23} Such a program should be designed to increase physicians' awareness of how they could unintentionally become involved in fraudulent activities, the nexus between documentation and coding, patient demand issues, and the consequences of inappropriate behavior.

An advantage of teaching hospitals educating residents and fellows about PI issues is that faculty and other physicians also will learn the information. Long-standing members of the academic medicine community may remember Physicians at Teaching Hospitals (PATH) audits that OIG initiated in the late 1990s. The government collected millions of dollars from numerous teaching hospitals for common billing problems, including up-coding and inadequate supervision or personal participation in procedures billed by attending physicians but performed by trainees.²⁴ For example, the University of Pennsylvania agreed to repay \$10 million for disputed billings and \$20 million in damages, and Thomas Jefferson University agreed to repay \$6 million for disputed billings and \$6 million in damages. Currently, OIG is undertaking a series of hospital compliance audits. Teaching hospitals that better educate their physicians, both trainees and faculty, can better avoid billing improprieties that would

ultimately make the hospital vulnerable in government audits and enforcement actions.

Errors, abuse, waste, and fraud have a significant impact on our nation's ability to address the health care needs of its citizens, particularly with regard to government-sponsored programs. The cost of such issues can be measured not only in dollars but also in impact on the overall quality of patient care. Many have acknowledged widely the importance of physician education in this domain. For example, Michael Lubao²⁵ stated that "payers can make a valuable contribution to the health care community by educating physicians in such a way that they can avoid claims submission mistakes and elevate their billing practices." Julie Taitzman,¹² OIG chief medical officer, wrote, "Better education can provide honest physicians with a road map to keep them from losing their way." The 2010 CMS recovery auditing report included the creation of a robust physician education program as an essential element in the effort to reduce improper Medicare payments.¹⁷ Given the magnitude of PI issues, private and public payers, medical educators, health care organizations, regulators, and specialty societies should consider making PI education mandatory for participation, licensure, or board certification.

Despite the diverse evidence that additional PI education is needed, we also should consider whether such educational programs will impact and improve behavior. A small but growing body of work exists in this area, though additional research is required. Educational interventions have, for example, been shown to improve elements of documentation.²⁶ They also have been shown to improve billing and coding, particularly for evaluation and management (E&M) services, a primary area of concern for physicians.^{27,28} Beyond such research, public payers have used educational interventions as a means of addressing aberrant or outlier billing and practice behavior. The Individual Provider Claims Analysis Report²⁹ is a tool that DHCS used to raise awareness among physicians and other providers about billing and prescribing behavior through peer comparisons. The program has yielded significant changes in E&M billing as well as pediatric drug prescription

practices, the tool's initial focus areas. CMS also has been successful in lowering the improper payment rate in several areas, in part because of proactive education efforts. Internal data from CMS, for example, revealed increased provider documentation compliance after webinar-based educational programs. Together, these results lead us to believe that PI education, like education in a multitude of other areas in health care, such as clinical quality and patient safety, can improve practice.

Together, these education efforts and the published literature identify features common to successful PI education programs. First, they emphasize the need for focused and dedicated time for education through a variety of mechanisms. Second, they highlight that education should start early in graduate medical education, potentially even in medical school. Third, they underscore that education must be repeated periodically to enforce positive behaviors and dispel negative behaviors which may progress from improper practices to those that are abusive and beyond. Anecdotal experience suggests that a team-based approach to learning is best, with providers, compliance staff, and others working together to improve PI practices. Finally, they stress that peer comparisons can aid physicians in understanding their behavior and can create an impetus for change.

Proposal for a Model PI Education Curriculum

Building on the lessons from pilot programs conducted by CMS and numerous partner organizations, we propose a model PI education curriculum. We recommend optimizing the timing of such a curriculum to reach physicians as early as possible in their careers, to ensure that these skills are a core part of their knowledge set, and to make certain that physicians periodically renew such training. We believe our program is ideal for residents and fellows as part of the standard graduate medical education curriculum. To reach individuals who have completed their formal training, though, we recommend that practicing physicians complete such a program as part of their continuing education requirements and maintenance of state licensure. Efforts to establish such programs therefore

could be led by academic medical centers, state medical boards, or medical specialty societies, which in particular could design curricula most applicable to their specialties. Our hope is that numerous organizations will step forward to collaborate in establishing programs suitable for physicians at various points in their careers.

Various stakeholders should contribute to the development of such programs, including physicians with training and experience in medical review; representatives from private and public payers (both federal and state); representatives from organized medicine; hospital compliance staff; billing and coding experts; state medical boards; and law enforcement representatives. To provide a comprehensive curriculum, all stakeholders who are committed to fighting health care fraud and protecting PI must be involved in the curriculum development process.

We divided our model PI education curriculum into three modules. In the following paragraphs, we describe each module and identify the corresponding competencies and learning objectives. For additional details about our curriculum, see Appendix 1.

Module 1: Overview of health care fraud and broader PI issues

This module introduces physicians to the spectrum of PI issues, including waste, abuse, and fraud, with vivid case examples and a discussion of known fraud schemes. The module also includes a discussion of the legal and regulatory considerations for PI issues, including the civil and criminal penalties for fraud. Finally, the module describes the response of health care and law enforcement organizations to these issues to contextualize the daily activities of physicians within the broader PI framework.

Competencies and learning objectives:

- Learn the spectrum of PI issues, including the scope and variety of fraud and common fraud schemes and systemic issues such as conflicts of interest and perverse incentives.
- Learn the legal framework for PI issues.
- Learn how public regulatory agencies, law enforcement, and organized medicine are responding to PI issues.

Module 2: Preventive strategies to improve PI

This module provides physicians with a host of preventive approaches and tools to protect their medical identities, to institute practice safeguards and compliance activities, and to improve their communication with patients about PI issues. This module includes a discussion of a range of practice settings, including the use of midlevel providers, the corporate practice of medicine, practices in academic centers, and the use of alternative payment models.

Competencies and learning objectives:

- Learn the risk factors for and strategies to avoid medical identity theft.
- Learn the key elements of compliance programs to avoid fraudulent or abusive billing.
- Learn how to help patients avoid and identify fraud schemes.
- Learn how to access resources for further education or reporting of PI issues.

Module 3: Documentation and billing best practices

This module specifically addresses documentation and billing issues, with an emphasis on developing best practices and error prevention strategies, as well as understanding the consequences of shortcomings in these areas. The module also addresses the various types of payment and financial audits of physician practices, discussing the differences between them and how they differ from fraud investigations. As in Module 2, special attention is paid to the range of practice settings and major innovations and trends in health care.

Competencies and learning objectives:

- Learn the importance of accurate documentation and billing, including typical issues, relevant fraud schemes, and error prevention strategies.
- Learn about the various payer audits of physician practices and fraud investigations, including potential consequences.
- Learn documentation and billing best practices.

In Conclusion

About 18% of the gross domestic product in the United States is consumed by health care—more than in any other industrialized country—and that number is expected to rise to 20% by 2020.⁵ About \$765 billion of that spending is lost to waste, including fraud.⁸ Resources lost to such PI issues, regardless of the payer, are potentially being diverted from supporting needed health care services. Physicians are the principal gatekeepers who decide when, how, and what health care services are delivered. With so much of our nation's spending at risk, the education of our medical professionals on issues of fraud and PI must be thoughtfully planned and universally delivered.

With this article, we hope to encourage a greater national recognition and sense of urgency regarding the need for physician education in health care fraud and PI. Ideally, this recognition should act as the impetus for leaders to create programs that will support universal physician continuing education. Only through such efforts—as one aspect of a broader detection and prevention strategy—can we reasonably expect to make significant and permanent changes to reduce the impact that fraud, waste, and other PI issues have on the overall cost of health care and, perhaps more importantly, on the experience and safety of patients and providers alike. Educating physicians is an essential step in establishing a broader culture of compliance and improved integrity, extending far beyond Medicare and Medicaid.

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Appendix 1

A Model Health Care Fraud and Program Integrity (PI) Education Curriculum for Physicians

Topics	Elements
Module 1: Overview of health care fraud and broader PI issues	
Spectrum of PI	<ul style="list-style-type: none"> Define spectrum of PI issues: errors, waste, abuse, and fraud Differentiate mistakes and inefficiencies from intentional deception Discuss scope of fraud and the extent to which it occurs in Medicare, Medicaid, and private health insurance systems Discuss potential conflicts of interest and perverse incentives in medicine and impact on physician behavior May include a general review of public and private payers if necessary
Fraud schemes	<ul style="list-style-type: none"> Discuss variety and types of fraud schemes, especially as relevant to practicing clinicians, including medical identity theft; billing for unnecessary services, substandard products, or undelivered products or services; employment of unenrolled or excluded providers; persistent and pervasive up-coding; enabling beneficiary fraud; kickbacks; and fraud in capitated payment models (e.g., withholding of necessary services) Provide a personal account of medical identity theft or other inadvertent physician involvement, as feasible
Legal context of PI	<ul style="list-style-type: none"> Review fraud and abuse laws enforcing PI efforts: False Claims Act, Anti-Kickback Statute, Physician Self-Referral Statute, Exclusion Statute, Civil Monetary Penalties Law Identify recent cases related to these statutes Discuss requirements to report and the range of consequences for fraudulent providers
Stakeholder response	<ul style="list-style-type: none"> Review efforts by major stakeholders in fraud and PI: payers, law enforcement, clinicians, patients Describe initiatives particularly relevant to clinician audience
Module 2: Preventive strategies to improve PI	
Protect yourself and your medical identity	<ul style="list-style-type: none"> Review scope and examples of physician medical identity theft and how stolen identities are used in fraud schemes Detail risk factors for medical identity theft Discuss strategies for avoiding medical identity theft, including security of practice documents and information technology (IT) security Review additional factors impacting identity security, such as billing reassignment, the corporate practice of medicine, use of midlevel providers, and special issues for academic medical practices
Protect your practice	<ul style="list-style-type: none"> Review common fraud schemes involving physician practices Describe key elements and best practices of compliance programs and internal controls to prevent fraudulent or abusive billing Discuss special considerations, such as teaching institution practices, use of midlevel providers, health care innovations including novel payment models, the corporate practice of medicine, and fraud and PI issues in managed care Detail typical practice vulnerabilities that allow patients and physicians to be victimized
Protect your patients	<ul style="list-style-type: none"> Review the scope of patient-mediated fraud including patient medical identity theft Discuss examples of patient medical identity theft and resulting impact, including to medical records Discuss resources to educate patients about fraud, and acquire tools to help them prevent and detect fraud Provide a personal patient account of medical identity theft or other inadvertent involvement, as feasible
Report PI issues	<ul style="list-style-type: none"> Discuss resources and contacts for clinicians and patients to promote PI and report fraud or identity theft Review resources for practice compliance programs and voluntary self-reporting of PI issues
Module 3: Documentation and billing best practices	
Billing and documentation fraud	<ul style="list-style-type: none"> Detail scope of billing and documentation fraud with relevant examples Review importance of accurate documentation and billing with respect to patient care, PI, and legal and payer requirements Identify typical problems with and shortcomings of physician billing and documentation, including preventive strategies Discuss documentation and billing requirements that may be specific to certain public or private payers, including relevant state variation
Public and private payer audits	<ul style="list-style-type: none"> Review various types of public and private payer audits of physician practices: Medicare administrative contractor audits, Medicare and Medicaid recovery audits, error rate audits (e.g., Comprehensive Error Rate Testing [CERT], Medicare; Payment Error Rate Measurement [PERM], Medicaid), state Medicaid agency audits, and risk adjustment data validation (RADV) audits in managed care Differentiate these audits from fraud investigations, and discuss the main investigative units, such as Medicare zone PI contractors, Medicaid integrity contractors, Department of Health and Human Services Office of Inspector General, and Medicaid fraud control units Describe key differences between audit types and the potential consequences of audits, including the appeals process Discuss resources for assistance and guidance in audit response and management
Compliance, oversight, and best practices	<ul style="list-style-type: none"> Discuss important elements of good documentation, including sources of information in this area for public and private payers and relevant differences between payers Describe key elements and best practices of compliance programs and internal controls for billing and documentation, including internal audits and what providers should do if they identify a problem (e.g., return overpayments, self-disclosure protocol) Review special considerations in documentation, such as use of midlevel providers and clinical practices in teaching institutions Discuss relevant payment innovations and such major changes as the transition to ICD-10 and the increasing adoption of electronic medical records