Some Evidentiary Considerations for Physician Billing

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In a criminal prosecution for medical billing fraud alleging up-coding and overbilling, the government's evidence may encompass the practice's entire billings and draw inferences from them. In addition, fraud may be demonstrated through statistical analysis comparing a physician's billings relative to other providers of the same specialty. The Federal Rules of Evidence govern the admissibility of evidence during a trial, to provide fairness for both the prosecution and the defense. Physicians and practice managers should be well versed in the billing requirements and particularly careful when CPT codes are expressed in terms of "required times" as opposed to "typical times."

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In a criminal prosecution for medical billing fraud, the government generally does not have difficulty demonstrating fraud when a physician bills for services that were never rendered. Demonstrating fraud through overbilling and up-coding is more difficult and challenging to prove. The Federal Rules of Evidence govern the admissibility of evidence during a trial, to provide fairness for both the prosecution and the defense. Admissibility of evidence hinges on whether it is relevant. According to the Federal Rule of Evidence 401, relevant evidence is "evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." But even if evidence is relevant, the Rules allow for the exclusion of certain evidence if such evidence would present the danger of unfair prejudice or confuse/mislead the jury. The CPT codes used in physician billing may present confusion depending on how they are presented in a fraud prosecution.

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UNDERSTANDING TIMED AND UNTIMED PHYSICIAN CODES

Physician E/M codes are untimed, stated in terms of "typical times." As will soon be explained, the "typical time" delineation may present some confusion to the jury in a fraud prosecution. In contrast, the CPT coding for "physical medicine and rehabilitation" (PM&R) codes is not nebulous. Medicare has clearly indicated the amount of time that is required to substantiate the billing of certain PM&R CPT procedures requiring "direct one-on-one patient contact." Those PM&R codes are governed by "required" times, rather than typical times spent with patients. This is an important distinction because some physicians provide rehab services for their patients in their office. These services are often provided for patients who have sustained injuries from motor vehicle accidents so the services are not governed by Medicare rules, but nonetheless the same CPT codes are used. (PM&R services provided to Medicare patients, under the "Incident to" exceptions, have their own sets of rules.)

Similar to certain PM&R codes, physician "prolonged services" are stated in required times and necessitate direct, face-to-face contact with the patient. These

codes, 99354 through 99357, are reported in addition to the designated E/M codes of any level. Prolonged time less than 30 minutes is not reportable. Likewise, physician "care plan oversight services" are measured in quantified times.

"TOO QUICK" OFFICE VISITS

To illustrate the distinctions between "typical time" and "required time," consider the following case that was tried in the Middle District of Pennsylvania. The government accused a physician of churning out patient examinations at a rate faster than is permissible, based on the physician's billings to the Medicare program. The CPT manual defines the requirements necessary for physician E/M codes. The CPT code for a level IV office visit, code 99214, states that "physicians typically spend 25 minutes face-to-face with the patient and/or family." The theory of the government's case was that the physician's billings to Medicare represented an "Impossible Day."

The government's evidence used the physician's Medicare billings and then multiplied those billings by the typical times ascribed to those visits by the CPT manual. Using this, the government's theory was that the physician billed for more visits than was possible on a given day. For example, where the physician indicated that he saw 60 patients in a day, the government's evidence suggested that it was not possible for the physician to have performed all of those visits as his billings indicated. Twenty-five minutes multiplied by 60 visits equals an impossible 25 hours in that day.

The case against the physician was brought under 18 U.S.C. § 1347, which is a Federal statute for healthcare fraud. Under that code section, it is a felony to knowingly defraud any health benefit program or to fraudulently receive payment from any health benefit program. In addition, the physician was also charged under Federal statute 18 U.S.C. § 1035, which makes it a felony to willfully make fraudulent statements or representations in connection with the receipt of payments for healthcare benefits.

THE EXCLUSIONARY EVIDENCE RULE

The physician's attorneys presented a motion to the court to exclude the government's Impossible Day evidence, arguing under Federal Rule of Evidence 403. This rule uses a cost/benefit analysis to determine whether the evidence should be admitted, by balancing the probative value of the evidence against the dangers of unfair prejudice, misleading the jury, or confusion of the issues. The court agreed with the defense. In the court's rationale, the defendant-physician billed for services that would typically take a doctor a great number of hours to perform. While recognizing that the physician more likely performed cursory examinations or exaggerated what he did, the court believed that the Impossible Day evidence of the aggregated time presented an inference that the physician did not perform the services.

At the heart of the matter was the court's issue with the government's use of the "typical time" contained in the CPT code. The CPT manual does not equate "typical time" with a "required time" or even a "suggested time." The evidence could confuse the issues placed in front of the jury because the government's presentation of evidence improperly converted "typical time" into "required time." The inclusion of the Impossible Day evidence could lead to the jury's assumption that the physician acted fraudulently because he did not spend the time he was supposed to spend with patients. Thus the Impossible Day evidence was excluded from the physician's prosecution.

THE EVIDENTIARY VALUE OF ELECTRONIC SCHEDULERS AND BILLING SYSTEMS

The physician's case was far from over. The court's ruling simply rejected the government's Impossible Day theory in that the government could not equate typical time into required time.

Billing and scheduling systems provide a wealth of information in building a fraud case. Many billing systems provide mechanisms to monitor compliance with Medicare requirements. But billing systems, especially when equipped with a scheduling function, can be a double-edged sword. Just as they can be useful in demonstrating compliance, they can also be used to prove fraudulent billing. Before the advent of electronic scheduling systems, pen and paper scheduling was used. Paper is not as easy to store as electronic media, and many practices did not retain their paper-based scheduling books. Computerized scheduling, on the other hand, does not take up any additional physical space. Because billing systems can use the scheduling data to provide in-depth reports and analysis, there is no need to erase or destroy the electronic scheduling data. Under 18 U.S.C.§ 1518, destroying or erasing scheduling data for the purposes of concealing fraud is illegal.

The data contained on a CMS 1500 claim form is in a vacuum. It provides no data regarding the treatment of patient "A" relative to patient "B." Inspection of the CMS 1500 claim forms for two Medicare patients treated on the same day yields no information as to whether the patients were treated at the same times or at different times that day. The claims data possessed by Medicare yield no information on whether any Blue Cross, Aetna, or United Healthcare patients were treated that day. Billing and scheduling systems, on the other hand, provide information relative to *every* patient seen at the practice that day. A stronger case is developed when the government can present evidence that Medicare and other patients were

seen that day exceeding the physician's capacity. From that perspective, it may be easier to assemble a fraud case.

THE IMPORTANCE OF CORRECT CODING

The challenge for physicians lies in the correct billing of these "required time" procedures when several Medicare patients receive services simultaneously. For codes specifying direct, face-to-face contact, Medicare's rules require a literal interpretation of this "one-on-one" contact. That is, two Medicare patients cannot simultaneously receive procedures requiring direct one-on-one contact. If two Medicare patients are treated during the course of an hour and billed for direct, face-to-face contact procedures defined in 15-minute increments, four units would be the most that could be billed between them. Each patient could be billed for two units, but the total number of units billed between the patients could not exceed four. This is particularly relevant for PM&R codes performed by the physician.

The physician's documentation needs to substantiate the physician's choice of the E/M code billed.

While not an issue in the case referenced, the physician's documentation needs to substantiate the physician's choice of the E/M code billed. Less emphasis is placed on time. Instead, the physician's billing should focus on the other criteria required to substantiate the appropriate level of billing. These criteria include the substantiation of two of the three key components—focused interval history, focused examination, and the complexity of the medical decision.

OTHER EVIDENTIARY CONSIDERATIONS

In establishing fraud cases, some government prosecutions have been based on a statistical analysis of the levels of office visits billed by the physician. A dramatic disparity between high-level and low-level office visits yielding low reimbursement in a physician's billing pattern can be suggestive of fraud using up-coding. Statistical analysis has also been used to compare a physician's billings relative to other providers of the same specialty. In one case, a physician billed for level V visits in 99% of the billings sampled, whereas other providers in the specialty billed for level V only 1.6% of the time for the same sample period. The documentation itself plays an important role in determining whether the CPT code used is substantiated by the service provided.

Evidence, however, is not necessarily black and white. The previously referenced "exclusionary rule," because it involves the court's balancing of factors, is a discretionary rule applied by the judge. Therefore, what may be admissible in one court may be met with a different result in another court. Judicial temperament also plays a role. As one judge presiding over a physician prosecution put it, "[t]he unrealistic billing concept of requiring doctors to bill only for face-to-face time is not consistent with effective use of a doctor's time or with the provision of good medical services. Doctors must be able to study, research, and discuss a patient's case and be reimbursed for such time" [*United States v. Krizek*, 859 F. Supp. 5, 14 (D. D.C. 1994)].

THE IMPORTANCE OF COMPLIANCE PROGRAMS

Compliance programs function to identify and manage areas of risk; to increase the likelihood of the physician's discovery of practices that could be interpreted as fraudulent or in violation of Medicare's rules and regulations; and to improve the practice's operations. Any disgruntled employee who has reasonable suspicion to suspect fraud may seek to benefit from the practice's failure to comply by initiating a whistle-blower suit. (Note that under the Federal False Claims Act, 31 U.S.C. §3729, a whistle-blower may share in up to 25% of any civil recovery against the physician.) Accordingly, such a program is important to uncover lapses in compliance. But it is not enough just to have a compliance plan. The provider must make a good faith effort to implement the plan. When diligently adhered to, a compliance program may be helpful in negating the intent, willfulness, or reckless disregard elements of the fraud statutes. The Office of Inspector General Web site provides guidelines for the development and implementation of such programs.

CONCLUSION

As the physician's prosecution suggests, the possible exposure to criminal penalties should serve as a warning to be especially diligent with Medicare compliance. While the rules of evidence function to ensure fairness to both the prosecution and defense, application of the rule is based on the court's discretion. Medical practices should be cognizant of the requirements necessary to support selected billing codes, and aware of what can be used against them should a fraud case be brought against them. Physicians and practice managers should be well versed in billing requirements and particularly careful when CPT codes are expressed in terms of "required times," as opposed to "typical times." ■

This article is not legal advice and is intended to provide only general, nonspecific legal information. This article is not intended to cover all the issues related to the topic discussed.