Medicare Says It Paid $24 Billion Improperly in 2009

BY ALICIA AULT

The Centers for Medicare and Medicaid Services made approximately $24 billion in improper payments to physicians and other vendors in fiscal year 2009, an error rate that was almost double the rate of the previous year.

In fiscal year 2009, 7.8% of Medicare fee-for-service claims were paid in error, compared with 3.5% in fiscal year 2008, said the agency in a statement. The CMS said that the increase in the error rate resulted largely from a change in how it identified improper payments.

"This year, we made the call to stop calculating our error rate in fee-for-service Medicare the way that the previous administration did and to start using a more rigorous method in calculating this rate in keeping with our mandate to root out errors and fraud," Health and Human Services Secretary Kathleen Sebelius said in a statement.

This year CMS used a more rigorous method for calculating the payment error rate in keeping with the mandate to root out errors and fraud, according to Secretary Sebelius.

The CMS assesses the accuracy of its Medicare payments each year and includes an accounting in the HHS Agency Financial Report.

The agency calculates Medicaid error rates in a different way, and does not yet have statistics for fiscal year 2009. It uses a 17-state sample to calculate the national error rate; each state is reviewed once every 3 years. According to the most recent assessment, the Medicaid error rate decreased from 10.5% in fiscal year 2007 to 8.7% in fiscal year 2008. The reporting of an error rate for the Children's Health Insurance Program (CHIP) has been suspended while the CMS develops a new way to assess the payments, as directed by the reauthorization of CHIP earlier this year.

The agency is also still developing measures for the Medicare Advantage program and for Medicare Part D. But the baseline for Medicare Advantage was 15.4% in 2007, accounting for $12 billion paid out in error.

The CMS said that the higher improper payment rate is not necessarily an indicator of greater fraud. Rather, it was "a more complete accounting of errors," according to Ms. Sebelius.

To ensure that physicians and other health care providers are not inappropriately accused of fraud, the CMS is working to ensure that they submit all required clinical and medical documents to support a claim, and that signatures on documents are legible. Durable medical equipment claims will have to include medical information from a health care provider in addition to suppliers' records.

"As we move forward in our review of the Medicare and Medicaid error rate data, we expect to be able to determine if there are specific trends that can better help us identify weaknesses in our programs or systems," said acting CMS Administrator Charlene Frizzera in a statement. ■

Last Minute Law Delays SGR Pay Cut

BY ALICIA AULT

The Senate on Dec. 19 passed a Defense Department spending bill that included a 2-month delay in the scheduled 21% cut in the rate Medicare pays physicians. President Obama signed the bill into law the same day.

Physician groups hope to secure a permanent overhaul to the Sustainable Growth Rate (SGR) formula, which governs the Medicare payment rate.

In a statement, Dr. J. James Rohack, president of the American Medical Association, said that the group agreed with Senate Majority Leader Harry Reid (D-Nev.) who removed a 1-year fix from his health reform package with an aim of separately winning a permanent overhaul.

"As we call for a permanent solution, the AMA acknowledges the House and Senate votes to stop the cuts for 2 months so that access to care for Medicare and TRICARE patients is not disrupted while the Senate works on solving the problem once and for all," he said.

The House of Representatives voted for a permanent fix in a stand alone bill, but the Senate later rejected it. Neither the House nor the Senate has included a permanent fix in their respective health reform bills.

The fee reduction was due to go into effect Jan. 1. Lawmakers had ways left to avert that cut, and thus attached the delay to the Defense spending bill, knowing that, with American military in Iraq and Afghanistan, it was a must-pass proposal.

The $636 billion Defense appropriations bill had passed the House. The package includes almost $14 billion in non-Defense spending, including an extension of unemployment benefits and subsidies to help pay for COBRA benefits. The Senate passed the bill on an 88-10 vote. ■

EXPERT OPINION

A Farewell to Consultation Codes

BY JOSEPH S. EASTERN, M.D.

A brand new year has begun, and that, as usual, means brand new surprises from our friends at the Centers for Medicare and Medicaid Services.

This year's big surprise: The CMS has decided it will no longer pay for consultations in either outpatient (99241-99245) or inpatient (99251- 99255) settings.

This decree has caused a great deal of protest, particularly from rheumatologists, neurologists, and other specialists who depend on consultations for a majority of their income. After all, specialists should be appropriately compensated for the special expertise they provide.

It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care. At the least, consulting physicians may feel less inclined to provide reports to referring physicians, which will substantially hurt coordination of care at a time when policymakers claim to be looking for ways to improve it.

Further objections abound; nevertheless, the decision has been made, and adjustments must be taken to accommodate it.

For office visits, the CMS expects consultation codes to be replaced with new or established visit codes (99201-99205 or 99212-99215). They have increased relative value units for those visit codes by 6% to soften the blow, but the difference will be substantially noticeable if a lot of consultations were billed last year.

On the inpatient side, admission codes (99221-99223) are to be used in lieu of consultation codes. The "true" admitting physician will use a new modifier (not yet published at press time) along with the admit code, while all consulting physicians will use the admit code unmodified. Physicians performing a lot of inpatient consultations should anticipate denials, appeals, and confusion as admitting physicians and consultants adjust to this change.

'It is hard to envision how eliminating consultation payments could be anything but detrimental to patient care.'

As usual, some commercial insurers will follow the CMS lead, while others will continue recognizing the consultation codes (which remain in the 2010 CPT book). This means a decision will need to be made about whether to continue billing consultations for non-Medicare patients whose insurers continue to pay for them. If this route is chosen, Medicare will provide secondary coverage, and will, of course, not pay its portion. So this situation needs to be recognized in advance. It is probably worth reviewing some past explanation of benefits to determine how often Medicare is a secondary payer, and whether any extra revenue will be worth the extra vigilance and work involved.

Others are understandably concerned about a potentially significant loss of income. Do not be tempted, however, to bill for more services as compensation for lost revenue. The CMS is well aware of that tendency (they even have a name for it: "code creep"), and they will be watching.

If billing patterns change significantly, an audit can be expected; increased billings must be proved to be of medical necessity, not compensatory revenue generation. If increased billings cannot be proved to be medically necessary, abuse or fraud charges will come. In an audit, remember, everyone is guilty until proven innocent.

Billing patients directly for consults has been proposed as a way to recover lost revenue. If consults are no longer covered by the CMS, physicians have reasoned that they should be able to use a "noncovered service" code (such as 99199-GA) and have Medicare patients sign an Advance Beneficiary Notice (ABN). It is not clear, however, if this is permissible by the CMS.

Another proposed counterstrategy is to bill Medicare for a new patient visit and add a "surcharge" for consultative care, billed directly to the patient (again using a National Supplier Clearinghouse [NCS] code and an ABN). This would be considered a "priority service," analogous to "concierge services" offered by some internists. No one knows if the CMS (or patients) would go along with this option.

Even proponents of such strategies admit they are speculative and untested; I would not advise attempting them without a careful legal review with an experienced health care attorney.

No matter how individuals choose to deal with the loss of consultation codes, I believe physicians should continue sending reports to referring physicians even though they will not specifically be paid for them. Doing what is best for patients should always be the top priority. ■

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