



IOWA MEDICAL SOCIETY

Working for Iowa physicians and their patients

April 23, 2004

John D. Forsyth
Chairman & Chief Executive Officer
Wellmark, Inc.
636 Grand Ave., Station 77
Des Moines, IA 50309-2565

RE: Wellmark Fraud Report

Dear John:

The Iowa Medical Society read with interest recent reports in the *Des Moines Register* and the *Business Record* regarding Wellmark's efforts in controlling provider fraud and abuse. Those articles stem from an April 6, 2004 Wellmark news release announcing that "Wellmark Blue Cross and Blue Shield saved or recovered nearly \$2.8 million in 2003 through aggressive health insurance fraud investigations spearheaded by the company's Special Investigations Unit (SIU)." The *Register's* April 9 Business Section "Biz Buzz" article attributes the reported \$2.8 million in "fraud" *entirely* to doctors and patients in Iowa and South Dakota. That article goes on to cite Wellmark's claim that "the most common fraud by physicians was billing for services not provided."

The Iowa Medical Society does **not** support fraud in physician practice. "Fraud," however, often is a loosely – frankly, sometimes carelessly – used term. To claim that a person or class of persons committed fraud is a serious allegation with potentially damaging repercussions for the individual and the profession as a whole.

Any effort by private entities such as Wellmark to investigate fraud, whether singularly or in cooperation with federal and state enforcement agencies, necessitates a clearly delineated, evidence-based process that provides for notice and opportunity to defend against allegations of fraud. Known, defined and accepted standards need to be in place to measure whether fraud occurred and to correct billing and business practices considered to be fraudulent. Intent is key. It is well-established that a mistake or disagreement in coding, an inadvertent failure to fully document, a lack of understanding regarding proper billing practices, or an insurer's unilaterally defined and imposed coding edit, among other things, does **not** constitute fraud.

Congressional adoption of the federal 1996 HIPAA fraud and abuse amendments, accompanied by stepped-up federal funding for health care fraud and abuse enforcement, sparked a new relationship between IMS and local U.S. government enforcement

agencies. We established and embarked upon aggressive education of our physician members regarding appropriate coding, documentation and billing practices and procedures while at the same time educating congressional representatives and local enforcement authorities regarding essential distinctions between actual “fraud” and billing disagreements or mistakes. We included representatives from the offices of the U.S. Attorney, both the northern and southern districts of Iowa, in our outreach programming.

We take fraud seriously. Our commitment to education of our physicians and their staff on coding, documentation and billing matters, coupled with an established tradition among Iowa physicians to do things right, is key to the fact that actual physician fraud in this state is rare. Yet Wellmark’s release and subsequent reports in the news media based upon it leave the distinct impression that physician fraud is common.

Wellmark’s report of \$2.8 million in fraud in one year, particularly in light of the *Register’s* attribution of that fraud solely to physicians and patients, causes us great concern. To assure that we mean the same thing when Wellmark uses the term “fraud” and, further, to assist IMS in its ongoing educational efforts with physicians on coding, billing, and documentation practices, the Iowa Medical Society formally requests the following information from Wellmark relating to its April 6 announcement of “health insurance fraud schemes” in Iowa and South Dakota.

- 1) Specific, non-identifiable data supporting Wellmark’s claim that it “saved” or “recovered” nearly \$2.8 million in fraud, including:
 - a. Dollar amounts or percentage allocations of the \$2.8 million attributable to savings or recoveries from Iowa providers and patients and from South Dakota providers and patients;
 - b. Dollar amounts or percentage allocations of Iowa’s share of the \$2.8 million for each of the following Iowa provider or patient groups: hospitals, nursing homes, home health agencies, all other institutional providers; physicians, chiropractors, pharmacists, all other non-institutional-based provider groups; and patients;
 - c. Actual numbers of entities or persons in each Iowa provider category and patient group listed in (b) above against whom a finding of fraud was made by the Wellmark SIU in 2003;

- d. Dollar amounts or percentage allocations of the Iowa share of the \$2.8 million attributable each to “savings” and to “recovery”;
 - e. An explanation of how these dollars were “saved” and how these dollars were “recovered”; and
 - f. Verification that the reported dollars for Iowa physician fraud do *not* include any dollar amounts subsequently appealed within the Wellmark system and reversed.
- 2) Specific, non-identifiable information or data supporting the SIU’s finding of “fraud,” including:
- a. Wellmark’s definition of “fraud”;
 - b. The bases for each finding of Iowa physician fraud accompanied by actual dollar amounts or percentage allocation of total dollars attributable to Iowa for each of the identified bases of fraud, further broken down by amounts or allocations reflecting “savings” and amounts or allocations reflecting “recovery”; and
 - c. Specific explanation of what it means when Wellmark says a physician was billing for “services not provided.” In particular, please indicate whether “billing for services not provided” means that *no* services were provided or that services were provided but documentation failed to adequately support the code that was billed.
- 3) Explanation of the workings of the SIU; how a matter is referred to the SIU; criteria used to assess the appropriateness of referral to the SIU; staffing expertise within the SIU; investigative processes and procedures; notice, opportunity to be heard and other provider rights; criteria and processes for referral of a matter by the SIU to an outside enforcement agency (including whether the provider is given notice of such referral); annual cost of operations for the SIU; and sources of funding to support SIU initiatives.

Without a doubt, our questions are of even greater interest and importance given the recent announcement of the Blue Cross Blue Shield Association that its new anti-fraud strike force will collaborate with the FBI and other national, state and local law enforcement agencies to fight major insurance fraud schemes. That announcement claims: “The most common types of health care fraud are billing for services not rendered

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and misrepresentation of provided services.” Again, definitional and situational issues come into play. A dispute about a code or a failure to appropriately document can be mischaracterized as “not providing services billed” or “misrepresenting provided services.” These issues of concern are exacerbated by predictions of a soon-to-be-implemented ICD-10 system with an incredible expansion in the number of codes and fine, micro distinctions among them.

Thank you for your attention to this letter. The Iowa Medical Society looks forward to your response and receipt of the clarifications requested above.

Yours truly,

Jeanine Freeman, JD
Senior Vice President of Legal Affairs

cc: Joe DuBray, JD, Wellmark General Counsel
Michael Abrams, IMS Executive Vice President



June 29, 2004

F. Joseph Du Bray
Senior Vice President
General Counsel and Corporate Governance Officer
Wellmark, Inc.
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Des Moines, IA 50309-2565

RE: Fraud and Abuse – IMS Education Initiatives

Dear Joe:

Thank you for your letter of response dated May 20, 2004, and your willingness to meet with me to further address IMS inquiries regarding Wellmark fraud and abuse enforcement initiatives.

Again, as stated in our letter of April 23, IMS does not tolerate fraudulent activities in violation of state or federal law. It is imperative, however, that governmental and private enforcement entities understand and honor the distinction between fraud and billing/coding disputes or mistakes. Health care providers must have confidence that enforcers know and appreciate this distinction.

The United States attorneys for the Southern and Northern Districts of Iowa assured IMS that their enforcement efforts are focused on documented instances of fraud. Senator Charles Grassley, an ardent congressional spokesperson against health care fraud, also has assured the provider community that fraud, not billing or coding mistakes, is the focus of federal enforcement activity. Now that the Blue Cross Blue Shield Association and Wellmark have publicly announced their significant investment of resources to identify and eliminate health care fraud, it is imperative that physicians understand the processes and procedures in place for doing so.

You asked in your letter if I could provide information regarding IMS efforts to educate its member physicians re: fraud and abuse. Below is background in response to your inquiry.

HIPAA legislation passed by Congress in 1996 substantially enhanced federal fraud and abuse enforcement through changes in law and dedication of prosecutorial resources to support this initiative. IMS and the AMA responded with focused educational and advocacy initiatives. For instance, in 1997 IMS sponsored "The ABCs of Compliance

Programs” in twelve different locations throughout Iowa and published “Thou Shall Create a Compliance Program,” in *Iowa Medicine* (May-June 1997). In 1998 IMS sponsored an all-day seminar in Des Moines, “Cultivating Compliance – Advanced Topics for Compliance Professionals,” featuring lawyer experts on fraud and abuse and an enforcement panel. We sponsored an update seminar in November of 1999, including a presentation from the US Attorney’s office for the Southern District. IMS regularly met with the Medicare carrier and periodically with representatives of both US Attorney offices in Iowa. We monitored reports from the Office of Inspector General (OIG) to assure fair reflection of the extent of provider fraud (i.e., “Another OIG Fraud Report,” *Iowa Medicine* (March/April 1999)).

IMS worked in concert with CMS (then HCFA) to perform “shadow audits” to test the findings of CMS on coding/documentation errors (i.e., while in 1998, IMS and CMS disagreed on the appropriate code in 44 of 102 patient records, a 1999, joint focused audit revealed need for physician documentation adjustments); participated in a national initiative through the AMA on E&M coding documentation and guidelines; and met regularly with our local carriers on the many issues surrounding coding and documentation that otherwise might be viewed as fraud. IMS published articles on an as-needed basis to address particular relating to fraud (i.e., “Professional Courtesy Discounts,” *Iowa Medicine* (November-December 1997) in *Iowa Medicine* and IMS practice management newsletters. Our practice management staff provided education and coding/documentation consultations on-site and through chart audits for individual practices as well as in educational “rap group” sessions.

Since 1999, the primary focus of our practice management educational programming has been and continues to be on billing, coding and documentation (i.e., modifiers, non-physician practitioners, specialty coding). Of course such educational efforts cannot always encompass health plan editing systems generally unknown to physicians. We work in tandem with the AMA toward full acceptance by the payer community of uniform coding guidelines and conventions to preclude the array of commercial health plan policies relating to modifiers, edits and bundling of payments.

On the advocacy front, IMS closely coordinates with the AMA and works with our congressional delegation to assure that fraud and abuse enforcement is evidence-based, consistent with legal standards, and respectful of fundamental due process. Further, we seek to assure that investigative practices are appropriate and not unduly disruptive of a physician’s medical practice. Finally, we have long-advocated against public campaigns and newspaper articles that foster patient distrust of all physicians in order to advance general support for fraud and abuse enforcement (i.e., “Operation Restore Trust Won’t,” *Iowa Medicine* (July/August 1998)). We continue to insist upon public reports that fairly portray the extent of fraud and avoid drawing broad-based conclusions from statistically

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weak samples. And we seek balance: if it is fair to insist upon a return of dollars reflecting overpayments, it also is fair to insist upon additional dollars reflecting underpayments (*see* "HCFA Issues Audit Instructions," *Iowa Medicine* (September/October 2000)).

I hope this background is helpful to you, Joe. IMS is not looking to revisit old ghosts but we are seeking to assure the same fairness in process, accuracy in definition, and balance in reporting in private enforcement that we have repeatedly called for in government enforcement. I look forward to our meeting on July 15.

Yours truly,

Jeanine Freeman, JD
Senior Vice President of Legal Affairs

cc: Michael Abrams