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Democracy Dies in Darkness

Beat cancer? Your Medicare Advantage plan might still be billing for it.

Firms mined patient records for outdated, irrelevant conditions to increase profits, Justice Department contends

By Christopher Rowland
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Kathy Ormsby's work auditing medical case files uncovered an alleged scheme to defraud the federal government: The California health system that employed her was scouring health histories of thousands of elderly Medicare patients, then pressuring doctors to add false diagnoses it found to their current medical records.

The point of larding the medical records with outdated and irrelevant diagnoses such as cancer and stroke — often without the knowledge of the patients themselves — was not providing better care, according to a lawsuit from the Justice Department, which investigated a whistleblower complaint Ormsby filed. It was to make patients appear sicker than they were.

The maneuver translated into millions of dollars in inflated bills to the federal Medicare Advantage insurance program, the government alleged in its false-claims lawsuit filed in U.S. District Court in California.

The case was part of a broader government crackdown on abusive billing practices in Medicare Advantage, the privatized insurance option that by next year is expected to cover more than half of all Medicare beneficiaries. The Justice Department is pursuing civil lawsuits against multiple companies that participate in the privatized system, from huge insurers to prestigious nonprofit hospital systems, alleging they have cheated the system for unfair profit.

Ormsby's former employer, the Palo Alto Medical Foundation, which has 1,600 doctors, and its parent affiliate, Sutter Health, which runs 24 hospitals in Northern California, settled the case with the government in August 2021 for $90 million. It admitted no wrongdoing or liability.

The government said its investigation confirmed that Palo Alto Medical and Sutter systematically added false diagnoses to patient records. In a sample of hundreds of cases Ormsby audited, the government's lawsuit said, she discovered 90 percent of diagnoses for cancer were invalid, as were 96 percent for stroke and 66 percent for fractures.

"As we continued to audit, I started to see more things," Ormsby said in an interview with The Washington Post, the only time she has spoken publicly since reporting the alleged misconduct in 2015. "I couldn't believe how bad it was."

In response to questions from The Post, Sutter indicated it was ready to move on. “The agreement brought closure to a long-running dispute and enabled Sutter to avoid the uncertainty and expense of protracted litigation,” it said in an email statement.

Medicare Advantage, which is run by outside companies under contract with the government, was added to traditional Medicare in 2003 with the support of Republicans in an effort to improve care and lower costs through privatization. But it is costing taxpayers increasingly more money to run than traditional fee-for-service Medicare, according to MedPAC, a government watchdog panel. The higher cost, what MedPAC labels “excess payments,” reached $12 billion in 2020 out of total program costs of $350 billion and are projected to top $16 billion next year, MedPAC said in March.

The aggressive billing tactics stem from incentives built into Medicare Advantage. Under the program, companies are paid a flat fee per month to provide whatever care is required for a patient based on age, gender, geography and health risk factors. To compensate plans and providers for potential costs of care for individual patients with conditions such as diabetes, heart disease or cancer, Medicare boosts the monthly payment to Medicare Advantage plans under a “risk adjustment” for each additional condition. The system differs from the traditional “fee for service” payment, in which Medicare pays hospitals and doctors directly each time they provide a service.

If companies add more risk adjustment codes to a Medicare Advantage beneficiary’s medical record to receive higher payment — but don’t spend money on the additional care — they make more money.

Industry officials broadly rebut the charge that companies game diagnostic risk codes for financial gain. They say Medicare Advantage firms adhere to Medicare’s rules and follow the system’s guidance on regulations that are not always clear. Moreover, the industry says that listing all health issues on medical records is a crucial part of Medicare Advantage’s promise to anticipate health problems, proactively manage disease and reduce hospitalizations.

But the government considers it improper — potentially even fraudulent — for providers to add codes for medical conditions that have been resolved or have no bearing on a patient’s current health.

For-profit insurance companies have typically been the primary target of these probes. More recently, unsealed whistleblower cases such as Ormsby’s against Sutter Health, and a pending case against Kaiser Permanente, reveal how such investigations have spread to prestigious, nonprofit physician and hospital groups.

Doctors, or sometimes even non-physician medical coders, updated patients’ current records without providing treatment and often unbeknown to the patients themselves, the government’s investigations have found.

Heart attack, stroke, cancer, vascular disease, depression, obesity and malnutrition were among diagnoses most often cited by the government in its false-claims lawsuits. In an example cited in the Sutter case, thyroid cancer was added as a current condition in a patient record even after the thyroid gland had been removed five years earlier and the patient had been free of cancer for years. None of the allegations has been fully tested in court, because they were settled by the companies without an admission of liability or, in the case against Kaiser Permanente, remain pending.

Some critics contend that a byproduct of these practices is that patients’ medical records, padded with false diagnoses, are inaccurate. That could unnecessarily stigmatize patients who were improperly deemed obese, or malnourished, or mentally ill. It introduces potential phantom influences on treatment decisions, critics say.

In addition to her shock over thousands of alleged false billings, Ormsby “was not comfortable with what she perceived as the complete divorce from the reality of what was in patient records” at Sutter Health, said Sarah “Poppy” Alexander, a whistleblower lawyer at Constantine Cannon, which represented Ormsby.

“The accuracy of patient records is critical for anyone’s health-care treatment,” she said. “Think about all the decisions that are made based on what’s in your health-care record. If that health-care record is not accurate, it’s extremely dangerous.”

Several doctors interviewed by The Washington Post said it was common practice for insurance companies and medical systems to search or data-mine the histories of patients covered by Medicare Advantage. Health systems were known to advise doctors on the most lucrative billing strategies, cajole them to document the maximum number of illnesses, and grade and rank them among their peers based on how they coded patients, they said.

“The emphasis is on how to code for more. It’s not ethical coding, it’s how to code for more money. That pressure is there,” said David Terry, a recently retired psychiatrist who worked within large health organizations in Kansas that are not part of any of the lawsuits.

The Justice Department said in February that Medicare Advantage investigations are an “important priority.” In federal whistleblower cases, the government investigates allegations brought by people with knowledge of alleged fraud against the government and then decides whether it will join the lawsuit, based on its findings. Whistleblowers are rewarded for stepping forward with a portion of any settlement or court awards. Justice Department whistleblower allegations and similar lawsuits also are playing out in federal courts against UnitedHealth Group, Cigna and Anthem. The government’s Office of Inspector General has audited Humana and found it overbilled the government. United Healthcare, which is under the umbrella of UnitedHealth Group, and Kaiser Permanente denied any improper conduct. Cigna, Anthem and Humana did not respond to requests for comment.

The health insurance industry’s trade group, AHIP, did not comment on allegations of false billings. MedPAC’s estimates of excess payments, when compared with traditional Medicare, are exaggerated, AHIP executives said, because its calculations do not factor in all differences between the two payment systems.

“The Medicare Advantage system is designed to promote accurate coding and support integrated care,” said Mark Hamelburg, AHIP senior vice president for federal programs. “Plans have to consider the entire patient, and know all their conditions, and how their conditions interact.”

10-YEAR GROWTH IN MEDICARE ADVANTAGE ENROLLMENT	**2011**	**2021**
Beneficiaries (millions)	11.9	26.9
Share of all Medicare	26%	46%
Source: MedPAC		

Medicare Advantage plans cut costs using the tools of the private insurance industry. They control the use of MRIs and other costly tests, for instance, cutting down on waste. They restrict care to certain hospital and physician networks. Then they use a share of those savings to keep monthly premiums lower than traditional Medicare, while offering extra benefits traditional Medicare does not offer, such as dental and hearing and gym memberships.

“It is a vast, complicated system. It involves all these various components,” Hamelburg said. “Our view is that you shouldn’t just look at individual components, you need to look at the totality.”

An industry-backed study found that Medicare Advantage members pay $1,965 less in out-of-pocket costs, including premiums, than traditional Medicare beneficiaries. Beneficiary satisfaction is high. Membership in the plans grew by 10 percent last year; they are expected to cover more than 50 percent of all patients next year.

‘Something unseemly’

Ormsby, one of the Medicare Advantage whistleblowers whose case was investigated by the government, quit her job at Palo Alto Medical Foundation in 2015 after two years in her job as a risk adjustment project manager. An outside consultant had found 8,000 false codes for the years 2012 and 2013, the government alleged in the whistleblower lawsuit she initiated.

The government’s investigation of her complaint revealed how physicians received computerized “daily alerts” for their patients flagging “suspected” diagnoses unearthed via data-mining. When their risk-adjustment diagnosis numbers fell short, doctors were urged by higher-ranking colleagues to improve, the government lawsuit alleged. In some cases, the government said, coders would add diagnoses to patient records without participation of doctors.

Some doctors pushed back on the pressure to add diagnostic codes.

“With my patient on hospice, there is something that seems unseemly about pursuing a new diagnosis of PVD [pulmonary vascular disease] when she has weeks to live,” one physician, Joann Falkenburg, wrote to colleagues helping lead the pressure tactics. The email was obtained by Justice Department investigators. “I try to be pretty legitimate about how I diagnose, document and chart and want to avoid any possibility that it looks like I am working someone up just for the financial upside.”

The government’s lawsuit does not indicate how Palo Alto Medical responded to her email, and Falkenburg did not respond to a phone message requesting comment.

A Palo Alto Medical auditor reported in internal correspondence that another physician, Thomas Deetz, complained that “pre-populating diagnoses into his visit encounter is possibly fraud. … Does CMS know about what you all are doing?” Deetz also did not respond to a request for comment.

Ormsby maintains that her multiple warnings about the practices were ignored or rebuffed. She said she received a poor performance review in early 2015, but by then she had already sought out private lawyers, a step that led to her whistleblower suit.

“I was finding too many errors, and they didn’t want to send the money back,” Ormsby said in the interview. Under rules for federal whistleblower lawsuits, Ormsby, 56, will receive 15 to 30 percent of the $90 million Sutter Health settlement.

‘Coding parties’

The practices at Sutter were not isolated, according to the government. Kaiser Permanente, a nonprofit health-care organization that treats patients in California, Colorado and elsewhere, including Virginia and Maryland, is accused in a separate Justice Department lawsuit of similar tactics that allegedly brought in about $1 billion in improper billings from 2009 to 2018. The case, which is pending, was consolidated from six whistleblower complaints against the company.

“As each year drew to a close, some employees referred to Kaiser’s rush to capture as many diagnoses as possible as the ‘dash for cash,’ ” the government said in its lawsuit. It alleges that at Kaiser Permanente, doctors were invited to “coding parties,” where physicians would be gathered in a room after hours and be expected to add diagnosis codes found in data-mining operations to current patient records.

Kaiser Permanente said in response to the government’s allegations that it was following the rules.

“We are confident that Kaiser Permanente is compliant with Medicare Advantage program requirements and we intend to strongly defend against the lawsuits alleging otherwise,” the company said in a statement sent to The Washington Post. “Our medical record documentation and risk adjustment diagnosis data submitted to the Centers for Medicare and Medicaid Services comply with applicable laws and Medicare Advantage program requirements. Our policies and practices represent well-reasoned and good-faith interpretations of sometimes vague and incomplete guidance from CMS.”

Internally, some doctors questioned the company’s practices, the lawsuit contends. Among the diagnoses Kaiser Permanente physicians were frequently asked to add to patient medical records was aortic atherosclerosis, according to the government’s lawsuit.

The condition, a hardening of the aorta wall, could often be observed incidentally in a chest X-ray or scan for some other ailment. Radiologists were instructed to record the presence of the condition if they detected any calcium in the aorta, “regardless of significance,” according to the government’s complaint.

Physicians would then be pressured via computerized queries to amend the patient records retroactively to include aortic atherosclerosis, which Kaiser had identified as having a “high rate of reimbursement” in the Medicare Advantage risk adjustment formula, the government alleged.

Some Kaiser Permanente doctors objected, saying the disorder was typically not serious in their elderly patients.

According to the government’s lawsuit, one physician, Matthew James Sena, observed in internal correspondence that “Aortic atherosclerosis is nearly ubiquitous in patients this age. It is not a clinically relevant diagnosis and doesn’t require treatment. Isolated [chest X-ray] interpretations are not grounds for clinical diagnosis in this case. … [It’s] clinically inconsequential in almost all cases.”

A coding administrator for Kaiser Permanente is quoted in the complaint as saying “[n]o one believes it is a real diagnosis,” and since “it is non-compliant to tell people to code for money, we need to really sort out a way to package this.”

Medicare Advantage programs are touted by industry as a way of ensuring that chronic conditions are carefully monitored through disease-management programs. But Kaiser Permanente’s increased diagnoses of aortic atherosclerosis threatened to create so many new patients with the condition that its disease management program for cardiovascular disease threatened to buckle.

Kaiser Permanente managers in 2011 came upon a solution, the government said: stop automatically enrolling aortic atherosclerosis patients in the cardiovascular disease management program.

After the change, the lawsuit alleges, medical leaders continued to pressure doctors aggressively to code for the disorder, identifying it as worth an additional $40 million in annual billing opportunity at one physician practice.

“How do we rally the herd?” a physician executive director wrote to colleagues at Kaiser’s Northern California Medical Group, in an email quoted in the lawsuit. “Everybody join in the discussion. $40m is no chump change.”

‘Where’s follow-up care?’

Minnesota-based United Healthcare, the largest health-insurance company in the country, quotes a founding father on the homepage of HouseCalls, its program that dispatches clinicians to Medicare Advantage beneficiaries’ homes: “Benjamin Franklin said it best, ‘An ounce of prevention is worth a pound of cure.’ We agree.”

Under such initiatives, companies routinely send clinicians, often nurse practitioners, into patients’ homes to conduct “health risk assessments.” Companies say the assessments are intended to identify any risks to beneficiary health that their physicians may have overlooked or that have developed since their last doctor visit.

But government reports have questioned whether the practice is intended to improve or capture more lucrative diagnosis codes. The visits often result in new codes added to patient bills without any evidence of doctors’ having considered or treated the newfound diagnoses, the Office of Inspector General of the Department of Health and Human Services found in a report last year.

A Connecticut primary-care physician, Kenneth Dardick (whose spouse is the executive director of the Center for Medicare Advocacy, a nonprofit that advocates for patients), said he routinely receives copies of United Healthcare’s in-home risk assessments and never learns anything about his patients that he did not already know.

He does notice that new patient codes are added to the reports, documenting conditions he already knew about or were irrelevant, he said.

He shared a copy of one assessment, with identifying information of the patient removed, that was sent to him by HouseCalls in April. He was already treating the patient, a man in his 70s, for diabetes. But the health risk assessment, in a section called “new diagnosis,” had added a different code, diabetes with complications. The new diagnosis section also listed a personal history of a type of skin cancer. Dardick said a precancerous growth was removed from the patient’s skin nine years ago and is no longer being treated.

“My sense is they are doing that just to game the system,” Dardick said, citing the “new” diagnosis codes as “irrelevant.”

United Healthcare stood out among Medicare Advantage companies for its aggressive use of risk assessments without evidence new risk codes were related to ongoing medical care, according to the Office of Inspector General report last year. (OIG did not identify the company in its report, but it did confirm its identity after a records request from the Minneapolis Star-Tribune.)

United Healthcare has the largest share of Medicare Advantage patients in the country, with 7.2 million beneficiaries, or 27 percent of the total.

United Healthcare did not respond directly to the OIG report’s findings. In response to questions from The Post, spokesman Matt Wiggin emailed a brief statement. “Simply stated, compared to fee-for-service Medicare, Medicare Advantage costs less (for beneficiaries), is more equitable, has better quality, access, and outcomes with greater coverage and benefits and nearly 100% consumer satisfaction,” he said.

Jacqualine Reid, a government research analyst who led the review, said the findings about United Healthcare raised red flags. Of the $9.2 billion in risk adjustment payments in 2016 based on health risk assessments with no other records to support the diagnosis, United received $1.38 billion, Reid and her team found in their review.

The three top diagnoses generating those payments were peripheral vascular disease, major recurrent depressive disorder and Type 2 diabetes with peripheral angiopathy.

“These are serious medical conditions. If they are getting payments for in-home visits, but we do not see any other evidence of services being provided to them, it raises concern,” Reid said. “If they are appropriate, where’s the follow-up care that in most cases you would expect to see?”

CORRECTION

A previous version of this article said a Kaiser Permanente affiliate projected $40 billion in potential revenue from a change in policy on aortic atherosclerosis, according to a government lawsuit. It should have said $40 million. This version has been corrected.