An Open Letter to Health Professionals about Insurance

Paul R. Glanville, M.D.

Dr. Glanville is in the practice of family medicine in Chandler, Arizona

Dear Fellow Health Professional:

The medical profession is at one of the most crucial points in its entire history. We are under God's righteous judgment. All health professionals stand under judgment, individually and corporately. Those who have not personally performed or assisted in abortions, or referred to abortionists, have condoned the practice by silence, or participated indirectly by not proclaiming truth to patients, giving birth control pills to the unmarried and prescribing intrauterine devices. God's judgment is already falling on the medical profession in three areas; (1) loss of respect of the general public, (2) the malpractice insurance crisis, (3) the "imminent captivity into Babylon (the world system of money or business)"

The third area of judgment - the "captivity to Babylon" - is where I want to elaborate. In the Bible, Babylon is frequently used to connote the world system of finance. Whether we health professionals recognize it or not, we are being inexorably taken captive into the world's business system, most often in the form of HMO, PPO, Medicare and other insurance systems. These systems have "forced" us into a system of fraudulence which is as deceptive as it is pervasive.

In conversation with fellow physicians I am shocked to see how we have been deceived into a fraudulent system by Current Procedural Terminology codes (CPT4 for fourth edition). The contracts that we sign with various insurance companies and HMO/PPO organizations have clauses that, if we knew and understood them, would make us tremble for fear. Yet, our business advisors tell us we are doing the right thing and give us recommendations for performing fraudulent functions which we willingly allow ourselves to be deceived into following. After all, we must protect our "physician's lifestyle."

I want to discuss the CPT4 coding and another problem and ask that you consider these points prayerfully. The CPT4 code book is one of the "bibles" of the HMO/PPO insurance systems. When we sign any type of agreement with one of these companies, when we receive privileges at hospitals and when we sign our discharge summaries or discharge face sheets from the hospital, there are paragraphs in these contracts and in our licensure agreements which state that we have read the CPT4 codebook and understand it and have complied with every rule and regulation in the book. Also, insurance forms sent out by our office are legal documents from us to the insurance company, whether or not we have personally signed it.

By that document we are stating that we are in legal compliance with all the proper procedures necessary to use those codes. Our personal integrity is supposed to be backing that up. The problem is that most of us have not read the CPT book or the interpretations of it, and we have allowed our business advisors to interpret the book to us. Our business advisors can tell us anything at all and, if they lead us into any fraudulent system of coding and charging, they have no liability. The liability falls upon the physician and he has no excuse for any fraudulent practice. He alone bears the brunt of any erroneous information.

Of utmost importance is for a physician to read the description of the levels of effort required to code for the various primary visits which are numbered 90000 - 90080. These are the so-called "new" and "established patient" visits, with various descriptions such as "minimal", "brief", "limited", "intermediate", "extended", and "comprehensive". Now I'm not going to say that I agree with all their descriptions and with the amount of

time and commitment required by the various insurance companies. As persons of integrity, however, we should realize that our signature on a contract, licensure agreement or hospital privilege agreement requires us to keep our commitment. "He that swears to his own hurt and changes not..." says Psalm 15:4.

Basically, most of the HMO and PPO companies have agreed with Blue Cross/Blue Shield standards of CPT requirements. Blue Cross/Blue Shield has, in addition, a time requirement which is officially accepted by virtually all insurance companies. Blue Cross/Blue Shield means to hold doctors to this time requirement, one of the most insidious parts of the whole program. The time commitment required for the various levels of visits are as shown in the chart below.

Let me give you a short example of the results of these above requirements. Blue Cross/Blue Shield officially sent out a circular about May of 1989 stating the maximum reimbursement for a 90060 visit, which has a requirement of 25 to 30 minutes of personal contact time by the physician, is $35. Extrapolate this to a full 6-hour work day of continuously seeing patients, with phone calls, book work, etc., consuming another 1 or 2 hours. Add in three weeks of vacation, and three days of continuing medical education, six holidays and one-half day a week off. The maximum gross business income from just seeing patients in the office is $104,000. Whereas a physician at one time could make most of his income from simply seeing patients, the modem physician has to find all kinds of ways to increase his income through laboratory testing, adding X-ray or mammography equipment, etc.

I know many doctors in my part of the country, both Christian and non-Christian, who see 60 to 120 patients per day! Most of them are -charging at least a 90060 visit for each patient! Obviously, this works out to 30 to 60 hours of patient contact per day, patently impossible.

Enterprising doctors have found multitudes of ways to defraud the insurance companies with the excuse that they are defrauding us to such a great extent. I agree that, in some ways, the insurance companies are defrauding us, but I see this as God's judgment on us individually and as a profession to get us to repent. For us to kick and complain would be like the

Jews complaining against God for sending the foreign armies against them to take them into captivity. God sent these armies to chasten them and teach them to stop prostituting themselves. Here are just a few of the ways some Christian colleagues have shared with me about how they use the system in what they consider a legal way.

For allergy immunizations charge a 95115 allergy injection, a 99178 therapeutic injection (the argument is that the 95140 is to pay for supervision of the injection), a 99070 syringe and needle, a 99070 allergen (even though the patient had paid for the whole bottle once before), and a minimal or brief office visit. The total is about $55 when it goes directly to the insurance company. Three "born again" general practitioners urged me to do the following: Send letters to all your patients in a certain age group, warning them that they were in imminent danger of developing colon cancer, and that they need to see you right away. See them for an intermediate visit and schedule them for a flexible sigmoidoscopy. They said that they got about one to two centimeters past the sigmoid, so they billed for a distal colonoscopy. Sigmoidoscopy pays about $150, and distal colonoscopy pays about $350. They said that they were doing about 10 to 15 per week and getting paid for every one! First the extra billing of $200 is clearly direct fraud. But, even the number of procedures is tremendously fraudulent. There is just no way a general practitioner could justify 15 sigmoids a week. In my experience, hardly one would be justifiable. This represents between $3000 and $4900 fraud per week for each one of these men.

List of Office Visits for Medical (not complete) From 1988 COT Manual, page 5			Approx Charges for G.P. or Fam Prac in Phoenix	Time BC/BS Considers Appropriate
NEW PATIENT				
90000	New Pt.	Brief Service	$10-$15	10-15 minutes
90010	"	Limited Service	$30-$40	15-20 "
90015	"	Intermediate Service	$50-$60	25-30 "
90017	"	Extended Service	$70-$90	30-40 "
90020	"	Comprehensive Service	$90-$130	60+ "
ESTABLISHED PATIENT				
90030	Est. Pt.	Minimal Service	$10-$15	0-10 minutes
90040	"	Brief Service	$20-$25	10-15 "
90050	"	Limited Service	$27-$32	15-20 "
90060	"	Intermediate Service	$35-$55	25-30 "
90070	"	Extended Service	$55-$90	30-40 "
90080	"	Comprehensive Service	$90-$120	60+ "

Moving from Blue Cross/Blue Shield to Medicare we again find that doctors have found ways to "get even" with the system. There are actually seminars all over the country teaching ways to do it. For example, Medicare allows doctors to charge for an extended visit one time for each new diagnosis in each patient's lifetime. Then you can charge an intermediate visit twice each 6 months for the same diagnosis. After the second intermediate visit in 6 months for the same diagnosis, Medicare will decrease the charges to a limited visit. When 6 months are up, you can again charge 2 more intermediate visits for the next 6 months. Medicare doesn't, at least at this time, officially care how long you actually take for the visit, or what the diagnosis is. So, you could see a patient for some new problem that takes you 3 minutes, literally, and charge for an extended visit (30 - 40 minutes).

Conversely, you may see a very ill patient for the third time in 6 months and require 45 minutes, but you can only use the code for a limited visit (15-20 minutes). So you start the numbers game with the diagnosis. A patient comes in with congestive heart failure for the first time. You charge the extended visit for a diagnosis of edema (valid), choosing not to put down the full diagnosis. In a few days, during a recheck visit, you use the congestive heart failure diagnosis and another extended visit ("new" diagnosis). In a few more days, at a recheck visit, you use the congestive heart failure diagnosis and a limited visit. If the patient has a rash due to medication, you can use several different codes such as "drug eruption", and then "dermatitis", and then "eczema", and use up the extended visits for each one of these. Then use the two intermediate visits per 6 months for each one of those.

Always, you look for new things to use for "new" diagnoses to use the extended and intermediate visits. With care, you should never have to lower your charges to a limited visit. Sometime in the future, Medicare plans to correlate the ICD-9 diagnosis code with the CPT procedure code and start kicking out extended visits for diagnoses that do not justify the longer visits. (But, will they have any way to reimburse for patients with longer

visits or multiple problems? The only thing the government seems to know how to do is take away rights and make things harder, so I doubt it.) But the word "on the street" is to milk the system till they plug the holes, and then find new holes. The general attitude is that Medicare underpays so grossly for legitimate short visits that we had better take advantage of the charges for the first time diagnoses to make up the difference.

Another area of fraud is the use of psychiatry codes, including the use of non-psychiatrists for counseling. Let me say at the outset that I believe people with master's degrees or PhD.'s without state certification may frequently do as good or better counseling than M.D. or D.O. psychiatrists or state certified PhD.'s. I believe that they should have their own CPT codes, and that there should still be the supervised codes (explained below). The insurance companies could pay what they want and set up a fair reimbursement amount for the different levels of services. First, most of my patients tell me that psychiatrists almost always spend only about 10 minutes with them and that is only to discuss their medication. The patient is still charged for a full therapeutic hour (usually 45 to 50 minutes). Secondly, a large number of M.D.'s either have people with master's degrees on their staff or they are in some loose affiliation with a group of people with master's degrees, and "supervise" their work. At one time there were two sets of CPT codes in the manual. One set was for M.D.'s and state certified PhDs. The number series for these is 90841 (time unspecified), 90843 (20 - 30 minutes) and 90844 (45 - 50 minutes). Another set of numbers was for "supervised counseling" and those numbers were 90847 (15 minutes), 90846 (25 minutes), and 90845 (45 - 50 minutes). These numbers for supervised counseling have been removed completely or changed to represent a completely different medical or psychiatric procedure. ("Family medical psychotherapy ... by a physician ..." now has code 90847, which was formerly for supervised counseling of 15 minutes duration.) The correct use of the supervised counseling codes would tell the insurance company that the M.D. did not do the counseling but rather was supervising the counseling of a non-certified counselor. There have been two fraudulent uses of these codes of which I am aware. The first is that some M.D.'s I know (professing Christians) have always used the M.D. only codes even though someone else was doing the counseling. They have been using this fraud even before the supervised codes were removed. Some other men began by using the supervised codes (which was legal) but have continued using them after they were removed, or have begun leaving out any code at all, implying (but not directly stating) that they did the counseling when they did not, or they have switched over to using the M.D. only codes.

The supervised counseling codes have been totally removed in the last four to six years, and the CPT4 codes for M.D. counseling can only be used by state licensed M.D.'s or state certified PhDs. There are a great number of M.D. psychiatrists who submit the CPT4 codes for M.D. psychiatry when someone with a master's degree or

other level degree did the actual counseling. This has been fraud since the beginning and is still fraud. The number of M.D. psychiatrists who do this is absolutely astounding. I've been approached by at least ten to twenty people with master's degrees and PhDs and have been requested to submit their forms for them. When I discuss this with them, their reply is usually something like, "Well, that's the way everybody does it." I have confronted a couple of M.D. psychiatrists and they have told me that insurance companies have told them that's the way they want it done. I called three insurance companies, the Board of Medical Examiners and the Board of Psychology in Arizona and all stated unequivocally that the above practices are considered insurance fraud..

Now, a few words about business consultants, office managers and those seminars to which we are invited to send our office personnel. Physicians, not office managers, are culpable for fraudulent use of codes. Those who run seminars stand to gain most by convincing us and our personnel of "the best way to maximize our return by optimum utilization of CPT codes". This could be subtitled "How to creatively defraud the insurance companies and your patients."

Such advisors can cross as far as they want into the gray zone of legality and even safely into fraud with no

personal danger except that of causing our staff to question the seminar. The further they can convince us to use fraudulent practices, the more money we can make and the more they can charge us for their seminars. As to business consultants, is it likely that they want to tell us to tighten our belt and perhaps even cut back in our use of their services? Would they charge us less per hour during this time of crisis or is it more likely that they will develop more imaginative (make that fraudulent) ways for us to keep up our income, and thus their fees?

What business consultant would ever say to a doctor, "I think you may have left your sense of ministry before God and His people, and there are many poor people who need your care at a reduced rate. However, they are not getting past your front office procedure to see you. I think you need to decrease your overhead, dispense with some of the fancy things, decrease your prices, take less home, get a smaller house, fewer cars, etc. And, by the way, you won't be able to see me quite as much, but I am decreasing my overhead and lifestyle so I will be decreasing my charges. We'll get through this thing together." It sounds unlikely to me. Have we been stupid to buy the system we have these years? Or, is the word "greedy"?

Highly-placed executives in some of the HMO's and PPO's are aware of such practices. They send their people to the coding seminars just to find out what to investigate. Arizona Health Plan told me in August, 1989, that they have had investigations going on for six months or longer, and that they plan to "bust" large numbers of doctors in the next six to twelve months for many of these frauds. Even if they don't levy large fines or send doctors to jail, those of us who are participating in such frauds are guilty before God and will pay in some way at some time. God does give a choice to repent and turn from our ways (Hosea 9:1-4; Is.1:1-31, 58:1-14). Some of us need mild reproof and some harsh rebuke. I pray that we will all embrace God's discipline in whatever way He sees that we need it.

As businessmen we have gotten away with such fraud for years. With the advent of computers our fraud was initially aided but will be brought down fairly soon when insurance companies begins sharing computer data. Within a very few years, insurance companies will be able to communicate among themselves and discover how many patients a doctor did see on a specific day. When they reveal 30 or 40 hours of medical office visits billed for a single day, something unpleasant is going to happen. As Christians, we should not wait until we have been caught by the system to detach ourselves from deception. It is better to willingly "fall on the Rock and be broken" than to stiffen our necks and wait for the "Rock to fall on us and crush us to powder."

Our beginning must be a genuine internal repentance towards God, a desire to do His will, a regeneration of our lives and a revitalization of our walk with the Lord. We need to see that Jesus Christ must be the Lord and Master of our lives, not just a sweet, cotton-candy Savior. He must rule every area of our lives. We must end the artificial separation between what we consider "spiritual" and "physical", which is a false philosophical concept from Greek dualism. This false concept has colored almost all of our thought today, tainting even Christian truth.' Following individual repentance there is a need for corporate repentance for our profession as a whole. Perhaps individual and corporate repentance may avert some or even all of God's judgment on us.

Reference

1. In this regard I recommend a short book by Rousas J. Rushdoony entitled **Flight from Humanity,** out of print, but possibly available through Ross House Books, P.O. Box 67, Vallecito, CA 95251 or Thoburn Press, Fairfax Christian Bookstore, PO. Box 6941, Tyler, TX, 75711.

Editorial Note to Pastors and elders: The article on the previous pages presents complicated issues in billing, which amount to fraud. If doctors are unaware of the sin involved, they must be taught. Those aware but persistent in the practice of fraud, must be confronted. We encourage you to take this article to each health professional under your oversight and begin the process of averting God's condemnation.