AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
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Fraud and Abuse

Fraud and abuse concerns continue to grow through out the medical community and emergency medicine is no exception. This course is intended to provide an update on the current audit environment and discuss means of staying in compliance with HCFA and OIG regulations.

- Describe the current audit activity as it relates to emergency medicine.
- Discuss the need for a comprehensive compliance plan to identify and prevent any fraudulent activities.
- Identify key elements that should be included in any compliance plan.

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FACULTY

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FRAUD AND ABUSE

Presented by: Mason Smith, MD, FACEP
and David McKenzie

Definition **of Fraud**
"An intentional deception or misrepresentation which individuals knows to be false or does not believe to be true, and makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person." (Medicare Carrier's Manual § 14006.2)

Definition of Abuse
"Incidents or practices of providers, physicians, or suppliers of services which, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices, directly or indirectly resulting in unnecessary costs to the program, improper reimbursement, or program reimbursement for services which fail to meet professionally recognized standards of care or which are medically necessary" (Medicare Carrier's Manual § 14006.1)

Statutory provisions and penalties for violations

A. Criminal statutes and penalties

1. Social Security Act § 1128B, 42 USC 1320a-7b

2. **$25,000** fine, 5 years' imprisonment, or both

B. Civil statutes and penalties

1. The Secretary of Health and Human Services has the authority to exclude physicians and other providers from **Medicare** and state health programs for program-related abuses.

2. The civil Money Penalties Law (Social Security Act § 1128A, 42 USC 1320a-7a) provides the Secretary of Health and Human Services with the authority to levy civil fines for fraudulently submitted Medicare and Medicaid reimbursement claims without initiating proceedings in the courts

   a. Violators may be fined up to $2,000 for each item or service fraudulently claimed, and
   b. Assess a penalty of up to twice the amount claimed for each item or service, and
   c. Provider may be suspended from participation in the Medicare and Medicaid programs

Environmental Analysis of Fraud and Abuse for Emergency Physicians

Medicare Carrier Audits

1. The Social Security Act requires carriers to apply "safeguards against unnecessary utilization of services furnished by providers."

2. The Medicare Carriers Manual (MCM) instructs carriers to conduct prepayment and postpayment "medical reviews" to identify inappropriate, medically unnecessary or excessive services and to take action when a questionable practice pattern is found.

   a. Prepayment Review-Medicare carriers use prepayment utilization screens to ensure that Medicare pays only for medically necessary services. Prepayment screens may include either manual or automated edits designed to suspend the processing of Part B claims involving services that meet specific criteria developed by HCFA or the Medicare carrier to identify questionable services raising coverage or medical necessity issues.

   b. Postpayment Review-used by Medicare carriers to identify potential fraudulent or abusive practices that warrant additional review.

      (1) Identifies physicians by locality and by specialty whose utilization patterns differ from medically recognized standards, criteria and norms.
      (2) Statistically compares individual physicians with other physicians in their specialty.
      (3) At least 7.5 physicians or suppliers per 1000 active providers in the carrier's files will be selected for comprehensive medical reviews. A comprehensive medical review involves a thorough analysis of a sampling of processed claims of the targeted physician or supplier.

Qui Tam Activity

Recent investigations

Specific risk areas for all billing companies

The OIG has identified 17 risk areas as "particularly problematic" in its model compliance guidance for third party billing companies:

1. Billing for items or services not actually documented.
2. Unbundling.

3. Upcommg, such as “DRG creep”--“DRG creep” is billing with a DRG that provides a higher reimbursement rate than that which should be used.
4. Inappropriate balance billing-Billing Medicare beneficiaries for the difference between the total provider charges and the Medicare Part B allowable payment.
5. Inadequate resolution of overpayments.
6. Lack of integrity in computer systems-All billing companies should have a back-up system.
7. Computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented.
8. Failure to maintain the confidentiality of information or records.
9. Knowing misuse of provider identification numbers.
10. Outpatient services rendered in connection with inpatient stays.
11. Duplicate billing.
12. Billing for discharge in lieu oftransfer.
13. Failure to properly use modifiers.
14. Billing company incentives that violate the Anti-Kickback Statute or other similar federal or state laws or regulations.
15. Joint ventures—OIG is concerned that these may violate the Anti-Kickback Statue by providing incentives to induce improper referrals.
16. Routine waivers of copayments and billing third party insurance only.
17. Discounts and professional courtesy.

Specific risk areas for billing companies that provide coding services

The OIG also identifies 7 additional risk areas for billing companies that do coding:

1. Internal coding practices-These, including software edits, should be reviewed periodically to make sure they meet all government requirements.
2. “Assumption” coding-Coding without supporting clinical documentation.
3. Alteration of the documentation.
4. Coding without proper documentation.
5. Billing for services provided by unqualified or unlicensed personnel.
6. Availability of all necessary documentation at the time of coding.
7. Employment of sanctioned individuals

FRAUD, COMPLIANCE, & EMERGENCY MEDICINE

DEVELOPED BY ACEP EXCLUSIVELY FOR ITS MEMBERS

PREFACE

FRAUD, COMPLIANCE, AND EMERGENCY MEDICINE

This document has been prepared by members of the ACEP Reimbursement Committee as an educational tool for ACEP members in developing compliance programs. The content is based on the Office of the Inspector General (OIG) Compliance Program Guidance for third party billing companies with additional information pertinent to emergency medicine practice added from other sources. Currently the OIG has not released compliance guidances for physician practices, Until such time as they do, the third party billing material is the most applicable guide.

This document should not to be used as a generic model compliance plan. Rather, the objective is to educate. emergency physicians as to key elements that should be a part of any compliance program. Every individual or group should develop a compliance plan that applies to their specific situation. A poorly written or generic compliance plan could be more harmful to your practice than no compliance plan at all.

For the purposes of this document, a hierarchy of language has been established. The word "must" is used in a statement to indicate that the action is required by law, regulation, or statute. Failure to perform these actions will violate these published standards and invite charges of fraud and abuse. Statements containing the words "should" or "ought to" are suggested guidances from the OIG or other sources. These actions are strongly recommended but are not required by statute or regulation.

Some of the information contained in this document pertains specifically to the Medicare and select State Medicaid programs. The OIG document itself concentrates on "general federal health reimbursement principles." Other private payers may have different regulations or payment policies that should be considered as well. The contractual or regional variations in payor policies make it difficult to address them in a document intended for a national audience. Physicians should understand that rules change and providers should refer to original source documents to verify that they are following the appropriate rules.

Additional information on compliance and other related issues described in this document is available on the ACEP Website at www.acep.org. Every effort was made confirm that the content was correct at the time of publication. Readers should verify that all source documents are current and unchanged when using this material.

INTRODUCTION

Concerned that provider fraud and abuse and improper payments threaten the Medicare program, Congress has mandated that the Health Care Finance Administration (HCFA) as well as the Office of the Inspector General (OIG) increase and intensify their investigations of the health care sector. Already, a substantial number of hospitals, physicians, and physician groups, and other providers have been investigated, and the number and amount of identified overpayments and penalties have increased dramatically. In this endeavor, the federal government has powerful tools such as the False Claims Act of 1986, the Health Insurance Portability and Accountability Act (HIPPA), and the Balanced Budget Act of 1997. There are other legal bases for enforcement including use of mail fraud, wire fraud, and conspiracy statutes, and non-health-care related statutes, and other sources of authority the government can also apply in its search for illegal activity. These tools provide increased funding for the OIG's fraud and abuse activities and a variety of enforcement means. A health care fraud investigation can potentially lead to the imposition of criminal penalties including fines and imprisonment, and civil penalties, including monetary penalties and/or exclusion from the Medicare and Medicaid programs.

Emergency physicians may be more vulnerable to allegations of fraud and abuse because at times there can be relative lack of involvement with the administrative aspects of their practice. Coding and billing functions are often outsourced by the hospital or to a billing company without direct clinician involvement. However, the government has made it clear that the physician, if he/she provides the service, is always held accountable for billings in his or her name regardless of who submits or processes the claim. The law provides that the principal (the provider of the service) is responsible for the acts of the agent (e.g., an employer submitting bills on behalf of the individual physician ancillary personnel including coding personnel employed by a physician practice, etc.)

WHAT IS A COMPLIANCE PROGRAM?

In simple terms, a compliance program is a quality assurance strategy. It sets up rules for an entity to establish internal controls and monitor its conduct in order to prevent and correct inappropriate activity. There are no statutes or laws that require an organization to have a compliance program. A compliance program is meant to ensure that an entity will not inadvertently, negligently, or intentionally engage in illegal activity. Should an entity subsequently be found guilty of fraud, the existence of an otherwise effective compliance plan may decrease the penalties imposed. Essentially, a compliance program functions as a potential shield, while establishing a culture that articulates and demonstrates commitment to legal and ethical conduct.

OIG COMPLIANCE PROGRAM GUIDANCE

For the past two years, the OIG has been publishing recommendations to specific sectors of the health care industry regarding voluntarily developed and implemented compliance programs. The OIG's suggested guidances have been issued for hospitals (2/23/98), home health agencies (8/7/98), clinical laboratories (8/24/98), and drafts for Medicare + Choice organizations (6/24/98) and the hospice industry (7/21/99). On 12/1/98, the Office of the Inspector General (OIG) issued guidance for developing a third-party medical billing compliance plan. This document can be

downloaded from ACEP's web page. Until the OIG develops specific guidance for providers, the elements and expectations described in the new guidance apply to physicians and medical practices as well. Any physician or group doing their own coding and/or billing must assume that the government expects them to adhere to these principles,

Some terminology should be made clear when referencing compliance plans and programs. A compliance plan is your documented strategy for ensuring compliance with payer rules and regulations. A compliance program is the action taken to implement that plan. Although clearly related, the terms are not interchangeable.

You should have a compliance plan, whether you are practicing with a small group, a large staffing company, as an academic physician, as an employee or independent contractor, or in any other coding/billing arrangement. Hospitals, as part of their compliance requirements, will expect or require hospital based physicians to have their own plan. Such expectations will most likely increase when HCFA's Ambulatory Patient Classifications program is implemented.

Physician practices must be aware of the possibility of a qui tam or "whistle blower" suit originating from someone with inside knowledge of your entity's practices. This can be an employee of your group, the hospital, the billing company, or consultant you use to audit your charts. There are substantial rewards including a share of any penalties assessed for an individual who "turns you in" to the government. (See section on Legal Assistance, p. 15)

It is essential that whatever compliance plan or program is documented should be realistic and is likely to be implemented completely. The worst thing a practice can do is to adopt a compliance plan that it does not follow.

ELEMENTS OF A COMPLIANCE PLAN

A compliance plan should address program design, implementation and enforcement, An effective compliance program needs to be "home grown" and unique to the entity. All compliance plans should have seven key elements. These are based on the seven steps outlined in the Federal Sentencing Guidelines and form the basis for all of the OIG's "model" compliance programs.

1) Compliance Standards and Procedures

An entity should develop written standards of conduct, including a clearly delineated commitment to compliance, for all medical professionals, employees, and contractors.

Written policies for risk areas such as documentation, coding and billing should also be established. Risk areas to address pertinent to emergency medicine, many of which will be discussed in later sections of this document, may include:

- Proper documentation of the service rendered and its medical necessity. Medical necessity is always an issue. There are a variety of methods for documenting medical necessity (e.g. ICD-9 codes, differential diagnoses, narrative descriptions, etc.) or it may be implied by the presenting symptoms or chief complaint. (See section on Documentation of the Patient Encounter, p. 8)

- Coding and billing for utilization of mid level providers. (See section on Non Physician Personnel Involved in an Encounter, p.6)

- Teaching physicians (i.e., attending physicians working with fellows, and/or residents) (See section on Non Physician Personnel Involved in an Encounter, p.6)

Fraudulent "upcoding," including "assumption" (presumptive) coding, pattern billing, and computer software programs that encourage coding and billing personnel to enter data in fields indicating services were provided although they are not specifically documented. Assumption coding refers to the practice of assigning a code based on the "assumption" of a higher level of service (presumed from a presenting complaint, diagnosis or disposition) as opposed to coding based on the documentation that such a service was actually provided. An example would be the assumption that a laceration was sutured although the provider did not document this procedure. (See section on Documentation of the Patient Encounter, p. 8)

- Coding errors, including failure to properly use modifiers (e.g., teaching physician modifiers, modifiers for minor surgical procedures where the emergency physician will not render postoperative care, etc) (See section on Teaching Physicians Medicare Policy, p.6)

- Fraudulent billing, including billing for items/services not performed or documented, unbundling (e.g., coding the individual components of a procedure separately when a single code is used to describe the service), inappropriate balance billing, duplicate claims. (See section on Coding For Professional Services and Diagnosis, p. 9)

- Inappropriate discounts and/or professional courtesy (including routine waiver of co-payments, co-insurance, deductibles, etc.) (See Post Coding Bill Processing, p.13)

- Billing company incentives that violate anti-kickback statutes or other similar Federal or State law or regulation. (See section on Post Coding Bill Processing, p.13)

More general risk areas mentioned by the OIG are appropriate management of credit balances (overpayments), maintaining the integrity of data systems (including back-up and patient confidentiality), and record retention.

2) Oversight Responsibilities

Someone in an entity must be assigned the responsibility for overseeing compliance. For example, an organization could designate a chief compliance officer who reports directly to the CEO or Board of Directors. Depending on the size of the entity, such oversight may involve one individual, a compliance committee, or both. This person or committee will oversee and monitor the implementation of the compliance program, periodically revise the program as needed, develop an educational and training program on the elements of the compliance program, and independently investigate and act on matters related to compliance

3) Education and Training

The entity ought to develop and implement education and training programs for all affected employees and contracted providers. The program should effectively communicate standards and procedures to all individuals involved. This may include mandatory meetings or internal publications outlining policies and procedures.

4) Developing Effective Lines of Communication

The entity should create and maintain a process that facilitates submission of concerns and complaints to the relevant authorities, such as a hotline. This should include procedures that preserve, as best as is possible, the anonymity of complainants, if they so desire. In addition, complainants ought to be protected from possible retaliation.

5) Monitoring and Auditing

A compliance program should demonstrate that the entity has taken reasonable steps to achieve compliance through monitoring and auditing systems designed to detect inappropriate conduct by its employees or agents.

6) Enforcement and Discipline

The entity should have a system to consistently investigate allegations of improper or illegal activities and should take appropriate disciplinary action against persons who have violated internal compliance policies.

7) Response and Prevention

After an offense has been detected, an entity must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. The appropriate response to an offense will depend upon the underlying cause(s). Since the determination of such cause(s) can be open to interpretation, it would be prudent to seek the advice of someone knowledgeable regarding the requirements of repaying and reporting. In general, inadvertent (which itself might be open to interpretation) errors or mistakes can be addressed by appropriate repayment

If an entity has discovered credible evidence of ***its own*** "misconduct" (e.g., possible violation of criminal, civil, or administrative law) in its own activities, it must report such conduct to the appropriate government agencies. In the face of a governmental audit, prior reporting of aberrant actions in the past will generally reduce the government's penalties, since the entity recognized the problem, responded to correct it, and reported it to the government entities.

There should be good communications between the billing company as an external party and the physician entity itself. If an outside billing company discovers evidence of *provider* "misconduct", it should refrain from submitting any questionable claims and notify the provider in writing within 30 days. If a coding/billing company discovers credible evidence of a client's continued "misconduct", or discovers evidence of flagrant or abusive conduct, the coding/billing company should: 1) refrain from submitting any false or inappropriate claims; 2) terminate the client's contract; and/or 3) report such conduct to the appropriate Federal and State authorities within 60 days.

EMERGENCY MEDICINE COMPLIANCE

The potential for fraud and abuse is a continuum that begins with an initial patient encounter and continues through the documentation of such encounter in the patient's medical record. The medical record is then the source document for subsequent coding and/or billing. For emergency medical services a compliance program requires a risk assessment and strategy to deal with each step in this continuum.

NON-PHYSICIAN PERSONNEL INVOLVED IN A PATIENT ENCOUNTER

Numerous personnel, other than the attending emergency physician, may be involved in evaluating or managing a patient, including Residents/Fellows, Physician Assistants and Nurse Practitioners (PA's/NP's), Medical Students, Nurses, and EMS providers. Specific rules address each category in addition to the generic concerns about documentation, coverage and medical necessity. Please refer to the ACEP web site for more in depth information about each of the following scenarios.

- **Teaching Physicians *(Medicare Policy)***

Teaching hospitals represent approximately one fourth of the hospitals participating in the Medicare program. It was therefore inevitable that HCFA's attention should be drawn to this area. In 1995, HCFA began to clarify the conditions under which a teaching physician can bill for patients jointly seen with residents. The new rules were implemented in July 1996. A brief note indicating "discussion" with or "supervision" of the resident is insufficient, because HCFA considers that this level of the teaching physician's responsibilities is already reimbursed to the institution through Graduate Medical Education (GME) payments.

The teaching physician must be personally involved in the key components of patient care, and must document in the medical record his or her participation in the service. The key components include: 1) relevant history of present illness and prior diagnostic tests, 2) major findings on physical examination 3) assessment, clinical impression or diagnosis, and 4) plan of care. Documentation of key elements in each of these components may be satisfied by combination of medical record entries made by the resident and the teaching physician.

When billing for minor procedures (i.e., those taking five minutes or less to complete), the teaching physician must be present during the entire procedure. For all other procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

When billing for critical care services, the medical record must demonstrate that the teaching physician documented that he/she was physically present for the time for which the claim is made. This documentation of time spent caring for the patient could be substantiated in nursing notes if absent from physician documentation Time spent by the resident in the absence of the teaching physician cannot be included. No other methodology is as good as timed physician notations documenting the time the physician spent in constant attendance of the patient. This applies to any time based code.

In summary, if a teaching physician relies upon any part of a resident or fellow's documentation in order to substantiate a service billed to Medicare in his /her name, he/she must follow the Medicare documentation rules for teaching physicians. As of 1/1/97, HCFA requires the use of the "GC modifier" when coding all claims where the service was performed in part by a resident under the supervision of a teaching physician. The complete text of the HCFA final rule for teaching physicians is available on the ACEP Website.

- **Medical Students *(Medicare Policy)***

The physician cannot use documentation by medical students as part of his/her documentation, except for the Review of Systems (ROS) and Past/Family/Social History (PFSH) for which HCFA does not require personal documentation. When ancillary personnel record history elements, the physician must document the source and date of the material, as well as confirmation, expansion, or revision of such elements. A physician's mere countersigning of the chart does not make the services reimbursable to the physician.

- **Nurse Practitioners/Physician Assistants *(Medicare Policy)***

  Specific areas of focus in a compliance plan should include:

  a. The employment status of the Nurse Practitioner/Physician Assistant,
  b. Proper documentation of Nurse Practitioner/Physician Assistant activities.
  c. Correct application of the "incident to" rules, which do not apply to the professional provider in the emergency department setting.

  Pursuant to the above, the attending physician's mere countersigning of a chart written by a nurse practioner (NP) or physician assistant (PA) does not justify billing the service in the physician's name. An emergency physician cannot bill, under his/her provider number, for a service or procedure performed by a physician assistant or a nurse practitioner. The physician must perform and document all services for which he/she submits a bill, with the exception of the E&M ROS or PFSH, where the physician may refer to the PA/NP's documentation. If the PA/NP is an employee of the physician's practice, and if the PA/NP performed a service, the services can be billed by the practice using the PA /NP's provider number.

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  Physicians cannot bill for services provided by the hospital's W-2 employees unless specifically authorized by the relevant payer. It would be prudent to obtain such authorization from the payer in writing. Such billing is illegal for Medicare patients. However, certain procedures performed by such personnel may be billed, depending upon participating payer policy, if the physician actively supervises the activity. Also, many payers acknowledge that a physician may perform and bill for procedures ordinarily performed by nurses, if the record supports the medical necessity of having the physician perform the service. For example, a physician may be required to start a difficult IV, insert a NG tube, Foley catheter, or draw blood from the femoral artery. These areas, if appropriate to your practice, should be addressed in the compliance plan.

- **EMS Providers**

  Medicare does not consider attending physician radio-direction of EMS Care (CPT 99288) a billable service. Other payers may have different policies. If such services are billed, the practice should have a policy describing the specific provision of services required to generate a bill

DOCUMENTATION OF THE PATIENT ENCOUNTER

HCFA states that "Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examination, tests, treatments, and outcomes." Further, HCFA states that the medical record should "facilitate accurate and timely claims review and payment." the importance of accurate documentation cannot be overstated. Your compliance plan should include provider education and policies addressing documentation standards required for all billable patient encounters. Reasonable areas to address are:

- The Patient Record

  The OIG requires that documentation should be legible, should identify the individual(s) providing the service, and should be available for audit and review

- Recording Methodologies

  Printed templates, check off lists, use of scribes, or voice recognition systems with macros are acceptable to HCFA, as are hand-written or dictated charts as long as it is clear from the documentation who actually provided each part of the service and each chart reflects information specific to that patient encounter. "If it wasn't documented, it wasn't done" is a familiar axiom. However, the corollary, "If it was documented, then it WAS done" is equally important. Printed templates, check-off lists and "normal exams" generated by a keystroke or voice command may unintentionally facilitate documenting an element that was not actually performed.

Areas where explicit rather than implied documentation should be considered are:

→ Explicit documentation of the CPT 99285 acuity caveat should detail the urgency of the patient's clinical condition or mental status that precluded the physician from obtaining a full comprehensive history and/or physical exam.

→ Explicit documentation of the date and context of any Review Of Systems or Past, Family or Social History elements from a prior patient encounter to which reference is made in the physician's documentation. The date and context of the previous note ought to be recorded. HCFA allows the use of the statement "all other systems are negative" in the Review of Systems. However, some payors do not follow HCFA's guidelines. Therefore, consider listing all the systems reviewed anyway to minimize audit failures.

→ Explicit documentation of critical care times is essential. The physician should note in the patient's record the times during which he or she was providing critical care services. This documentation should reflect defined criteria for the use of these codes and the time-recorded notes should meet or exceed published time thresholds for critical care service. The physician must devote constant attention to the patient and therefore can not provide service. to any other patient during the same period of time. Critical care time can include time spent at patient's bedside or at the nursing station as long as the above criteria are met.

→ Formal procedure note indicating which provider actually performed the procedure, as well as which portions of a procedure were supervised by an attending or teaching physician.

- **Continuing Education**

  As part of a compliance plan, there should be a strategy to educate providers as to current documentation requirements, and changes as they occur. Verification or proof of such efforts is essential. Periodic audits of patient chart documentation should be used to ensure the success of, or need to repeat or refine such educational efforts. HCFA and the AMA are once again in the process of modifying E/M Documentation Guidelines. (See June 1999 CPT suggested revisions on the AMA web site) The new version is expected to be in pilot testing by the end of 1999.

- **Effective Communication Between Providers and Coders**

  The OIG Compliance Guidance frequently emphasizes the importance of an "open dialogue" between providers and coders to maximize accuracy. Policies should address how such communication is effected and recorded. Physicians ought to receive feedback on their chart documentation as an educational and reinforcing tool. Coders should have access to the treating physicians so that they may ask questions about ambiguous documentation and receive clarification on actual services rendered before submission of claims.

CODING FOR PROFESSIONAL SERVICES AND DIAGNOSES

A crucial aspect of services provided during a patient encounter is the requirement for medical necessity. The concept of medical necessity is referenced frequently in all of the OIG's Compliance Guidances. The issue is whether or not the presenting complaint justifies the selected level of documented Evaluation and Management services, procedure(s) performed, and/or ancillaries such as lab and x-ray. Medical necessity should be addressed in the compliance plan. Tools such as random audits, pattern analysis, and review of denied claims might be useful in uncovering problems in this area. (See legal assistance on page 13) Note that undertaking these analyses will create an obligation to repay on the part of a group that discovers that there are problems.

Coding associated with the provision of professional services encompasses two basic components:

a) identification of the specific service(s) provided
b) identification of the patient's malady(ies)

Identification of professional services provided is usually accomplished by means of the AMA's Current Procedural Terminology (CPT) format. However, some payers may require that claim submissions by participating providers must utilize the payer's proprietary coding system (e.g., Medicare's HCPCS). Identification of patient diagnoses in the United States is usually accomplished by means of the World Health Organization's International Classification of Diseases 9" Edition, Current Modification (ICD-9-CM).

For a single patient encounter the interrelationships among CPT codes (e.g., Correct Coding Initiatives) and between CPT and ICD-9-CM codes are becoming increasingly critical in the delineation of "correct coding" for specified payers.

WHO PERFORMS SUCH CODING?

Coding for professional services may be performed by a number of persons:

1. the health care professional who personally performed the entire clinical service (e.g., treating physician, treating nurse practitioner, treating physician assistant, etc.)

2. a health care professional who personally provided some part of the clinical service and/or appropriately supervised another health care professional's performance of part of, or the entire service (e.g., physician in a resident teaching situation, etc.)

3. employees of the entity that also employs the health care professional who personally performed or appropriately supervised the service (e.g., coding personnel employed by the provider's medical group, coding personnel employed by a hospital, coding personnel employed by a HMO, etc.)

4. employees of an entity to which the health care professional who personally performed or appropriately supervised the service (or his/her medical group) has appropriately assigned billing rights (e.g., a hospital for which the professional or group is an independent contractor)

5. an agent engaged by any of the preceding entities having the legal right to initiate such engagement (e.g., coding/billing company engaged by the health care professional who personally performed or appropriately supervised the service, or by a medical group, or by a hospital, or by a HMO, etc.)

WHO IS ULTIMATELY ACCOUNTABLE FOR THE CODES SELECTED?

The Federal government maintains that irrespective of who performs the coding, the provider, in whose name the claim is submitted, is ultimately accountable for the correct processing of the claim associated with the patient encounter. The OIG strongly recommends that any coding entity coordinate with its provider clients to establish clearly delineated compliance responsibilities.

WHAT ARE THE OBLIGATIONS OF THE CODING ENTITY?

The basic obligation of whatever entity does the coding is to assure that its policies and procedures concerning proper coding reflect the current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payer health care program requirements.

Although all applicable statutes and legal regulations must be followed, payer program requirements that are not statutory or based on legal regulation must be followed only if a provider has agreed in any separate contract to comply with such requirements, for example in a participation contract.

The OIG Compliance Guidance focuses on the following items:

- The pre-engagement screening of personnel or entities, who will perform coding, in order to determine if the individual or entity has any prior history of noncompliance with reimbursement law or appropriate private payer program requirements. The existence of such prior history might preclude the proposed engagement, and at least requires the employer to adopt policy measures necessary to prevent avoidable recurrence of the past non-compliance.

- Establishment of procedures to ensure that the coding personnel, as well as any aids used in coding (e.g., written lists, computer software, etc.), remain in compliance with both the principles of the necessary coding systems (including the concept of medical necessity) and current reimbursement principles set forth in applicable statutes and regulations.

- Ensuring that all relevant patient encounter documentation necessary for coding, both CPT and ICD-9, is available at the time of coding.

- Ensuring that the selection of codes, including pertinent modifiers, is based solely upon appropriate documentation, which is legible and available for audit and review.

- Ensuring that the individual who provided the service is identified in the documentation.

- Establishment of a procedure whereby all rejected claims pertaining to diagnosis and procedure codes are reviewed by the coder or coding department.

- Establishment of a process for post-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement.

- Establishment of procedures to maintain the confidentiality of the patient's information/record.

- A recommendation that the coding entity conduct a comprehensive risk analysis, either self-administered or out-sourced, in order to identify and rank the various compliance and business risks that may be experienced.

- If the coding function is not performed by the identified health care professional:

  → the compliance safeguards should be formalized, written, indexed in a user friendly manner, and actively disseminated among the coding personnel;

  → compensation for the coding personnel should not provide any financial incentive to improperly code; as an extension of this principle, the OIG has stated that contracts whereby the coding entity is compensated as a percentage of collections will be closely scrutinized;

  → coding personnel should obtain clarification from the identified provider when documentation is confusing or inadequate;

→ there should be a process for pre-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement; and

→ coding personnel might benefit from general guidance provided by qualified physicians and medical experts on clinical issues.

- If the coding function is performed by the identified provider:

→ the bill processing entity should notify the provider to implement and follow compliance safeguards with respect to documentation of services rendered; and

→ it is recommended that the provider's acknowledgement and agreement to address the coding compliance safeguards should be incorporated into the contract between the provider and the bill processing entity.

POST-CODING BILL PROCESSING

After the coding function is completed there are still numerous billing processes that should be addressed:

- identification of primary and subsequent guarantors,
- computer input of billing information,
- claims submission,
- invoice mailing,
- handling of inquiries,
- payment posting,
- collection of co-insurance or co-payment, etc.

WHO PERFORMS THESE FUNCTIONS?

Once again, these functions can be provided by any of the entities listed in the preceding section (coding). In summary, three basic types of relationships can exist between a service provider and a biller:

1. the health care professional, who provided or appropriately supervised provision of the service, could personally process the bill, although this would be extremely uncommon;

2. the health care professional and the billers could be employees of the same entity; or

3. the health care professional could appropriately assign billing rights or hire an agent to perform billing.

WHO IS ULTIMATELY ACCOUNTABLE FOR THESE FUNCTIONS?

The Federal government maintains that irrespective of who performs the billing, the provider, in whose name the claim is submitted, is ultimately accountable for the correct processing of the claim associated with the patient encounter. The OIG strongly recommends that any billing entity coordinate with its provider clients to establish clearly delineated compliance responsibilities. The physician's signature on the claim attests that the patient's condition, and the physician's services, are correctly stated

WHAT ARE THE OBLIGATIONS OF THE ENTITY THAT PERFORMS THESE FUNCTIONS?

The basic obligation of the billing entity is to ensure that its policies and procedures concerning proper billing reflect the current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payor health care program requirements.

All applicable statutes and legal regulations must be followed. Where payor program requirements are not statutory or based on legal regulation, they must be followed only if a provider has agreed in a separate contract to comply with such requirements, for example in a participation contract.
The OIG Compliance Guidance focuses on the following items:

- The pre-engagement screening of personnel or entities who will perform billing functions in order to determine if the individual or entity has any prior history of noncompliance with reimbursement law or appropriate private payor program requirements. The existence of such prior history might preclude the proposed engagement, and at least require the employer to adopt policy measures necessary to prevent avoidable recurrence of the past non-compliance.

- Establishment of procedures meant to ensure that billing occurs only for services actually provided.

- Establishment of procedures to ensure that personnel, as well as any-aids used in billing (e.g., written lists, computer software, etc.) comply with current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payor health care program requirements. For example, ensure that only appropriate "balance billing" occurs (i.e., billing for the difference between the payer's allowable charge/payment and the amount actually paid by the payer). Medicare does not allow balance billing.

- Establishment of procedures meant to ensure that the site of service and the individual who provided the service are appropriately identified.

- Establishment of procedures to maintain confidentiality of the patient's information/record.

. Establishment of procedures to ensure that duplicate billing, in order to gain duplicate payment, does not occur.

- Establishment of procedures meant to ensure that any overpayments are appropriately resolved. An overpayment may be an improper or excessive payment for a service either because multiple payers inappropriately paid for the same service or because payment was made for a service not provided or not covered. Services that are not properly documented also may represent an overpayment.

- Establishment of procedures meant to ensure that waiver of co-payments, co-insurances, and deductibles are appropriately implemented. The entity responsible for post-coding bill processing and/or collections must make good faith efforts to collect co-payments and deductibles for covered services.

- Establishment of procedures meant to ensure that discounts and professional courtesy are appropriately implemented. The OIG has stated that any discount, either in part or in whole (including professional courtesy), is inappropriate if an intent of such discount is to increase referrals.

- Establishment of a process for post-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement.

- The OIG recommends that the billing entity conducts a comprehensive risk analysis, either self-administered or out-sourced, in order to identify and rank the various compliance and business risks that may be experienced.

- If, as is likely, the post-coding billing functions are not performed by the identified health care professional:

  → the compliance safeguards should be formalized, written, indexed in a user-friendly manner, and actively disseminated among the billing personnel;

  → the. billing personnel or entity should not have incentives that violate the anti-kickback statute of other similar Federal or State statute or regulation; as an extension of this principle, the OIG has stated that contracts whereby the billing entity is compensated as a percentage of collections will be closely scrutinized, and

  → a process for pre-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement should be established.

- If the post-coding billing functions are performed by the identified provider:

  → the coding entity should notify the provider to implement and follow compliance safeguards with respect to documentation of services rendered; and

  → it is recommended that the provider's acknowledgement and agreement to address the billing compliance safeguards should be incorporated into the contract between the provider and the coder.

AUDITIONAL CONSIDERATIONS

LEGAL ASSISTANCE

Provider, coding, and billing entities must comply with all applicable Federal law, State law, and local payor legal requirements. While Federal law is consistent throughout the country, State law and payor requirements are highly variable. Therefore, an attorney, knowledgeable of concerning coding and billing requirements in the relevant jurisdiction(s), can be an invaluable asset in delineating expectations and compiling an effective compliance plan. Furthermore, there may be benefits in having an attorney participate in the development and implementation of monitoring initiatives. Attorney/client privilege can offer some protection on compliance issues, although there is some dispute as to whether in-house counsel can claim attorney/client privilege. Discussion of these issues with your current legal counsel is advised.

CONCURRENT VS. RETROSPECTIVE MONITORING

Retrospective monitoring occurs after a claim has been submitted to a payer, and perhaps even after a payer has acted on the claim. Concurrent monitoring is performed prior to a claim being submitted to a payer. The Federal government states that provider knowledge of a claim inappropriately submitted to a relevant governmental payer creates an obligation to act on such knowledge either through refunding or reporting such knowledge. Therefore, retrospective monitoring, which has the potential to demonstrate such inappropriately submitted claims, might create the quandary of what to report, how to report, and to whom to report it? Presumably, effective concurrent monitoring should, at the least, significantly decrease the likelihood of such quandary occurring. Obviously, some retrospective monitoring will be required in order to demonstrate and/or refine the effectiveness of concurrent monitoring. If a problematic pattern is found, an obligation to correct prior claims (i.e. reimburse prior overpayments) might also arise.

REPORTING OBLIGATIONS OF THIRD PARTY CODERS/BILLERS

The OIG maintains that, if third party coding/billing entities find evidence that a provider client is engaging in misconduct (e.g., inaccurate documentation and/or coding), the coding/billing entity should refrain from the submission of questionable claims and notify the client within 30 days of such determination.

If the coding/billing entity discovers credible evidence of the client's continued misconduct, or discovers evidence of flagrant or abusive conduct, the coding/billing entity should: 1) refrain from submitting any false or inappropriate claims; 2) terminate the client's contract; and/or 3) report such conduct to the appropriate Federal and State authorities.

CONCLUSION:

It is clear that a laissez faire approach to medical documentation, coding and billing is problematic. Although Medicare often develops specific policies, other governmental payers (e.g., state Medicaid programs) as well as private payers may have no stated policy concerning a particular subject or their policies may substantively differ from Medicare and/or each other. Furthermore, providers must comply with payer policies only when there is a legal requirement to comply (e.g., a participation contract between a provider and payor). And finally, laws and Medicaid programs policies often vary among States. These payer dissimilarities, differing relationships between providers and payors, and variations in jurisdictional law all contribute to making the issues associated with correct coding and billing highly complex. Nevertheless, health care providers will need to be aware of and address these elements.

Issues such as accountability for coding, billing processes, education, monitoring, and discipline, must be incorporated in any formalized compliance program developed by the group, hospital, or individual emergency physicians. Contractual relationships between emergency physicians and their employers and/or practice locations need to clearly delineate compliance responsibilities. It is evident that development and implementation of an effective and usable compliance program is rapidly becoming an industry standard. Compliance programs are a powerful tool to promote a strong ethical approach to coding/billing and might provide at least a partial mitigation of any penalties resulting from a governmental audit or fraud investigation.

FREQUENTLY ASKED QUESTIONS (FAQs) ON COMPLIANCE ISSUES

1. Q. Am I liable for any coding errors made by the hospital that does my billing?
A. The government maintains that ultimately the provider of services is responsible for claims filed using ***his/her*** provider number. The principal is responsible for the acts of the agent.

2. Q. I never see the charts after I finish with them. Someone else does the coding and billing. Am I in compliance?
A. PERHAPS. Compliance is an outcome measure. If your documentation and the subsequent coding and billing are in compliance, then you will be in compliance. If, however, the documentation, coding, and/or billing are not in compliance, then you might not be in compliance. The best way to assure that you are in compliance is to be familiar with the compliance plan of any facility or group with whom you do business. The use of audits can assure compliance.

3. Q. Can I just use the OIG Model Compliance Plan for my group/facility compliance plan?
A. No, the OIG specifically states that its document is not a model compliance plan or program, but rather only provides suggested guidelines with regard to what should be taken into account for the content of your plan. You must tailor these guidelines to your specific situation for your plan and program to have any value.

4. Q. Do we need to appoint a compliance officer from our group to be responsible for this? Is he/she then liable for anyone or everyone else's mistakes?
A. Yes, a compliance officer should be identified. While that position might carry some liability, the government maintains that ultimate liability still rests with the provider in whose name the claim is filed. You may wish to investigate the appropriateness of Director's and Officer's liability insurance.

5. Q. Won't a compliance plan just be used against me in the case of an audit?
A. Absence of a compliance plan will not help you in cases of bad audit outcomes. Making the effort to produce an effective compliance plan demonstrates an attempt to understand and follow the rules and makes it harder to apply the "willful and knowingly committed fraud" or the "willful blindness" tests for fraud, unless you fail to follow your compliance plan. A compliance program is essentially a quality control device. It can't hurt you unless you don't pay attention to it.

6. Q. What are my responsibilities to ensure billing is done correctly for teaching physician services involving residents provided to Medicare beneficiaries?
A. As part of the regular compliance guidelines, you must follow the HCFA guidelines for services of a teaching physician involving the work of residents as spelled out in the December 8, 1995 Federal Register. The personal involvement of the teaching physician must be demonstrated in the documentation. This information appears on the ACEP web site at www.acep.org.

Q. What about compliance for services provided by PAs & NPs, to Medicare beneficiaries?
A. As part of the regular compliance guidelines, you must follow the HCFA guidelines for provision of services.

8. Q. Is offering professional courtesy really fraud?
A. Offering professional courtesy is not a per se violation. However, problems might develop based upon why and how you offer such courtesy. If courtesy is offered with an intent to increase referrals, such activity might raise legal concerns. Also, routine waiver of co-payments, co-insurances or deductibles may be construed as insurance fraud because you are in effect charging the carrier more than you are actually willing to accept. If you decide to provide professional courtesy, consider not billing.

9. Q. Is my billing company required to report me if they suspect fraudulent activity?
A. If a billing company has credible evidence of fraudulent activity, it should not submit the questionable claims. The OIG Compliance Guidance suggests that a billing company should notify you within 30 days of first finding such activity. If the activity continues, the billing company should terminate your contract AND/OR report you to the government within 60 days of finding credible evidence of violation. The billing company does have liability itself if it is found to have submitted inappropriate claims. These liabilities exist under the federal health care laws as well as under the conspiracy statutes.

10. Q. What should I do if the OIG shows up at my door?
A. Designate one person to take charge of the situation, whether it be your compliance officer or an attorney. Verify the documents that authorize the audit before releasing any information. Be cooperative, but it is often prudent to not volunteer any information.

11. Q. I am a teaching physician. When providing services to government beneficiaries, can I use the documentation of a medical student in the same way I use a resident's notes?
A. HCFA's teaching physician requirements describe the conditions under which documentation by physicians in graduate training ("residents and fellows") can be used as part of the teaching physician's documentation. Medical students are not physicians, and their documentation cannot be used in this way. However ancillary emergency department staff members, including medical students, can document a patient's review of systems and past/family/social history. HCFA allows the attending physician to use this information if the time and date of the charting is referenced along with a note by the physician confirming, revising, and/or expanding the information recorded by any ancillary staff. Any practice involved with medical student rotations should address this in its compliance plan.

Q. Is it better to have an outside entity do our group's routine compliance audits and how many charts should be reviewed in this exercise?
A. The purpose of a periodic internal review is to self-monitor your compliance program. There may be a perceived benefit from having an outside entity perform this function. In either case, the sample of charts used for such monitoring should be of sufficient size to provide a good cross section of your coding and billing practices. HCFA provides no guidelines regarding the absolute number of charts to be audited and there is wide variability with regard to what constitutes an appropriate number. The real issue is to evaluate each of the physicians in the group to determine whether there are patterns.

13. Q. Is there any special compliance requirement for the 99285 acuity caveat?
A. The key components of emergency department E/M code 99285 are a comprehensive history, comprehensive physical examination, and medical decision making of high complexity. The level 5 acuity caveat that pertains to code 99285 is based on the language in the CPT book that reads "… requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status." HCFA has apparently adopted the CPT coding principle that allows a physician to defer the usual requirements of performing these key components of 99285, if the patient's condition and mental status does not reasonably allow these elements of the E/M service to be fully provided, and if the patient's presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. However, some regional Medicare. carriers apply the caveat to only the history component, while others apply the caveat to both the history and examination components, but not medical decision making. Physicians should state why the caveat is being invoked in their documentation of the patient encounter.

References

1. OIG Special Fraud Alert in the Federal Register, 12/19/1994, 59 Fed Reg 65,373,
2. David D. Queen, Designing a Health Care Corporate Compliance Program. Second Edition Atlantic Information Services, Inc. I IO 17th Street NW, Suite 300 Washington, D.C. 20036. (202) 775-9008.
3. Sue Malone, MA. Essential Compliance Documents: Understanding Healthcare Fraud and Abuse. Clinical Information Consulting. 148 West Mikado Drive, Colorado Springs, CO 80919. (719) 266-1431.
4. Current Procedural Terminology for Hospital Outpatient Services. CPT Intellectual Property Services American Medical Association, 515 North State Street, Chicago, IL 60610, (3 12) 464-5930.
5. Today's Corporate Compliance for the Health Care Professional. Health Care Compliance Association (HCCA), 1211 Locust Street, Philadelphia, Physician Assistants 19107. (888) 580-8373.
6. Medicare Compliance Alert (newsletter). UCG, 11300 Rockville Pike. #1100, Rockville, MD 20852. (888) 287-2223. Customer@ucg.com.
7. Report on Medicare Compliance (newsletter). Atlantic Information Services, Inc., Washington, DC (800) 521-4323. www.aispub.com

Web Sites

1. OIG Compliance Program Guidance (includes model compliance plans)
   www.hhs.gov/progorg/oig/modcomp/index.htm

2. OIG Semiannual Reports:
   www.dhhs.gov/progorg/oig

3. Health Care Financing Administration Program Memorandums and Transmittals
   www.hcfa.gov/pubforms/transmit/transmit

4. National Health Care Anti-Fraud Association
   www.nhcaa.org

5. The False Claims Act Legal Center
   www.taf.org

6. Compliance Links
   www.medicarecompliance.com/Resources/compliancelinks.html

