OIG COMPLIANCE

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LEARNING OBJECTIVES:

• What is the Office of Inspector General?
• What are the major risk areas identified by the OIG for physician practices?
• What is a compliance program?
• What are the benefits of a compliance program?
• What are the 7 elements of an effective compliance program?
Healthcare Compliance Programs

- Were largely nonexistent until the early 1990s
- HIPAA established a national Health Care Fraud and Abuse Control Program to be implemented by:
  - the United States Attorney General
  - the Department of Health and Human Services (HHS)
  - the Office of Inspector General (OIG)

Purpose of HIPAA’S Health Care Fraud and Abuse Control Program

- to combat health care fraud and abuse
HIPAA Program Results

- False payments in excess of $5.69 billion have been recovered since 1997.
- During 2003, HHS excluded 3,275 individuals from Medicare and Medicaid programs due to convictions related to Medicare and Medicaid, patient abuse or neglect and licensure revocations.

Role of the OIG:

- Principal federal agency responsible for combating health care fraud and abuse
- Is an implementer of HIPAA’s Health Care Fraud and Abuse Program
- Excludes providers from Medicare, Medicaid, and other federal health care programs for violating program rules and regulations
Primary way to avoid penalties from the OIG:

- The adoption and operation of an effective compliance program
- The OIG has published compliance program guidance for physicians and small group practices

Update of Previous Healthcare Compliance Program Guidelines

- On January 31, 2005, the OIG published a supplemental guidance for hospital compliance programs
- this supplement can be used as a guide to measure and evaluate the effectiveness of current health care compliance program
The OIG identifies four major risk areas for physician practices

1. Coding and Billing
2. Reasonable and necessary services
3. Documentation
4. Improper inducements, kickbacks and self-referrals

CODING and BILLING

- Many risks for physicians surround coding and billing and fall under the Civil False Claims Act
- The single biggest RISK is in the submission of claims or other requests for payments
- Violations in this area are serious!
- Potential violations include *
Billing for items or services not provided or rendered or not provided as claimed

- The use of CPT codes to bill for new procedures that are not included in the CPT system can give rise to a false claim.
- Billing patients for “no shows” is billing Medicare for services not furnished and can be considered a false claim.

Billing for non-covered services as if covered

- Example: Billing Medicare using a covered office visit code when the actual service was a non-covered annual physical.
- With the exception of claims that are properly coded and submitted to Medicare solely for the purpose of obtaining a denial, physicians are to bill Medicare/Medicaid only for items and services that are covered.
*Submitting claims for services, equipment, or medical supplies that are not reasonable and necessary

• should not seek reimbursement for a service that is not warranted by a patient’s documented medical condition

• do not assume that the reason for the service ordered can be inferred from chart entries

*Double billing resulting in duplicate payment

• Duplicate bills are often submitted to third party payors under the mistaken belief that the original claim has been lost or misplaced

• physician practices must clarify responsibility for billing with third-party service providers used to provide certain services to their patients
**Knowing misuse of provider ID numbers, resulting in improper billing**

- Example: Practice bills for service performed by Dr. B, who has not been issued a Medicare provider number, using Dr. A’s number
- Physician practices must bill using the correct provider ID, even if that means delaying billing until the physician receives his/her provider ID number

**Unbundling**

- Billing for multiple components that must be included in a single fee
- Example: If dressings and instruments are included in a fee for a minor procedure, the provider may not also bill separately for the dressings and instruments
*Failure to properly use coding modifiers

- Medicare Provider Manual
- CMS developed the National Correct Coding Initiative ("NCCI") to promote correct coding and control improper coding
- Pain management providers need to have a system in place to screen for NCCI restrictions, coding patterns and groupings

*Clustering

- Clustering is the practice of coding/charging one or two middle levels of service codes exclusively, figuring that some will be higher than the patient's actual level of treatment and some will be lower, so that the charges will average out over an extended period
- This overcharges some patients and undercharges others
*Upcoding

• Billing for a more expensive service than was actually performed
• Example: Billing at a higher E&M code than what was actually rendered

Question: How many hours are in one day?
Answer: 24. Your E&M codes better not add up to more than 24 hours!!!

*Miscoding

• relying on untrained personnel to select procedure and diagnoses codes on admitting sheets and outdated “cheat sheets” leads to miscoding problems

• government investigation focuses on evaluation and management coding
**“Incident-to” Billing**

- When coding care as “incident to”, ensure that the care meets the strict supervision criteria
  - physician must be physically on-site and immediately available when the auxiliary practitioner is providing services

**OIG Recommendation**

- Institute a policy that a coder/physician must review all rejected claims pertaining to diagnosis and procedure codes
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REASONABLE AND NECESSARY

- Medicare’s definition: “for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member”
- Can bill to receive a denial only if denial is needed for reimbursement from secondary payor
- Medical records and physician orders should support appropriateness
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DOCUMENTATION

- Medical record guidelines
  - Medical record is complete and legible;
  - Documentation of each patient encounter includes:
    - reason for encounter
    - any relevant history
    - physical exam findings
    - prior diagnostic test results
    - assessment, clinical impression, diagnosis
    - plan of care
    - date and legible identity of observer
DOCUMENTATION, cont’d

• Medical record guidelines, cont’d
  - CPT and ICD-9-CM codes used for claims submission are supported by documentation/medical record;
  - Appropriate health risk factors are identified
  - The patient’s progress, his/her response to, and any changes in, treatment, and any revision in diagnosis is documented

DOCUMENTATION, cont’d

• CMS 1500 form
  - Link the diagnosis code with the reason for the visit or service;
  - Use modifiers appropriately
  - Provide Medicare with all information about a beneficiary’s other insurance coverage under the Medicare Secondary Payor policy, if the practice is aware of a beneficiary’s additional coverage
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Improper inducements, kickbacks and self-referrals

- Policies and procedures should encourage compliance with Anti-Kickback Statute and Stark and address the following:
  - Financial arrangements with outside entities to whom the practice may refer Federal health care program business
  - Joint ventures with entities supplying goods or services to the practice or its patients
  - Consulting contracts or medical directorships
  - Office and equipment leases with entities to which the physicians in the practice refer
Improper inducements, kickbacks and self-referrals, cont’d

• Policies and procedures should encourage compliance with Anti-Kickback Statute and Stark and address the following:
  - Soliciting, accepting or offering any gift or gratuity of more than nominal value to or from those who may benefit from a physician practice’s referral of Federal health care program business

Developing an effective Compliance Program
Benefits of a Compliance Program:

- helps protect against government or private payor enforcement activities
- enables a practice to operate more efficiently
- helps physician practices fulfill their legal duty to refrain from submitting false or inaccurate claims
- helps practices refrain from engaging in illegal or unethical practices
- demonstrates commitment to honest and responsible conduct
- enhances patient care
- minimizes billing mistakes and optimizes proper payment of claims
- deters unethical behavior
- avoids conflict with self-referral and anti-kickback statutes
- encourages employees to report problems
- minimizes financial loss
What is a Compliance Program?

• A series of internal controls that promote the prevention, detection, and resolution of conduct that may be inconsistent with applicable laws, regulations, rules, or program or practice policies

Seven Elements of an Effective Compliance Program
1. Regular Auditing and Monitoring

• Perform a comprehensive baseline audit of the practice’s operations to ascertain whether current practices conform with legal requirements
  – a. review key documents
  – b. review coding and billing practices
  – c. perform physician practice walk-through
  – d. interview staff
  – e. review medical charts

1. Regular Auditing and Monitoring, cont’d

• Perform yearly follow-up audits
  – check to see if standards and procedures are current and update them to reflect changes in regulations and in CPT and ICD-9-CM codes
  – review bills and medical records for compliance with coding, billing, and documentation requirements (at least 5 medical records per Federal payor or 5-10 medical records per physician)
  – If a problem is identified, YOU MUST ACT
2. Written practice standards including a Code or Standard of Conduct

- Using findings from the baseline audit, the practice should adopt Practice Standards or Standards of Conduct that identify risk areas for the practice and establishing controls to counter the risk
- Practice Standards will include broad categories of practice’s operations

3. Designation of compliance officer or compliance committee

- Identify an individual or group of individuals responsible for the operation and monitoring of the compliance program
- The compliance officer or compliance committee will report directly to the practice’s governing body
4. Education and training for all personnel in the practice

• After plan and practice standards have been established, implement training for personnel
• Conduct annual training sessions and refresher courses
• Live sessions are more productive than written materials
• Keep personnel updated on new rules and regulations

5. Existence of response mechanism and corrective action plan

• Develop a mechanism for responding to and correcting identified problems
• Establish procedures for compliance officers to respond to complaints or take corrective action concerning complaints
• Develop warning indicators
• Screen new personnel
6. Open lines of communication

- Establish a procedure for communicating questions or complaints to compliance personnel without raising concerns of retaliation.
- The compliance officer must be able to communicate with all practice personnel.
- Open discussion of ethical and legal issues without fear of retaliation is vital.

7. Enforced and well-publicized disciplinary process

- Establish a disciplinary protocol and advise personnel about the discipline that may be imposed for those who:
  - fail to follow the Practice Standards
  - violate applicable rules and regulations
  - do not conduct themselves in a way that is conducive to an effective compliance plan
Adoption of a Voluntary Compliance Plan will...

✓ reduce the risk of a criminal charge
✓ reduce the risk of civil fines or penalties

Don’t Take the Gamble…

Develop and Maintain an Effective Compliance Program for your Practice!
Sources for Slides

- Stark Law – 42 U.S.C. § 1395nn
- Controlled Substances Act – 21 U.S.C. § 801

Sources for Slides, cont’d

Sources for Slides, cont’d

• Medicare Carriers Manual, Part 3, Claims Process, § 2050
• The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2003 (Dec. 2004).

Sources for Slides, cont’d

• Medicare: Fraud and Abuse (http://www.nebraskamedicare.com/policy/fraud.htm)
Sources for Slides, cont’d

• HHS-OIG-Fraud Prevention and Detection (http://www.oig.hhs.gov/fraud.html).
• Physician Information Resource (http://www.cms.hhs.gov/physicians/)