

## I. Introduction

In recent years, the federal government has become more aggressive in identifying and prosecuting physicians and other health care providers suspected of what is commonly referred to as Fraud and Abuse. During this period, the government has increased funding and personnel devoted to fraud/abuse detection and prosecution. New legislation— most notably the Health Insurance Portability and Accountability Act of 1996 (best known as HIPAA), and various state efforts –has expanded fraud and abuse statutes, even to non-governmental health care programs. The government is also considering the need to perform more *random audits* rather than simply targeting so-called outliers.

While the vast majority of physicians are making an honest attempt to bill appropriately under overly complex rules, it certainly makes sense to assess your situation and adopt reasonable *compliance* efforts to keep risks low. **The goal of this document is to help you assess your situation and minimize exposure by adopting reasonable steps to prevent, detect and correct possible deficiencies** There are many relatively easy steps you can take to reduce and manage compliance risks.

It is easy for the public to get the impression that *most* physicians and other health care providers are billing inappropriately when the government conducts highly publicized fraud seminars for beneficiaries or officials make statements about tens of billions of dollars in fraudulent billings by those “who would rip off our health care system.”

We’re not quarreling with the need to identify and prosecute those who bill fraudulently, because it hurts everyone. It’s just that everyone must realize that the vast majority of physicians are making an honest attempt to comply with very complex laws and guidelines while they attend to patients’ medical needs. **Honest mistakes by physicians are no more indicative of fraudulent billing than a carrier’s failure to pay a health insurance claim form correctly indicates fraud on the government’s part.**

Even the most honest/cautious physician could find themselves under investigation in an environment where: media publicity makes it sound like most providers are billing fraudulently; some private attorneys openly solicit – and offer to pay “bounties” to – the elderly and employees for reporting possible fraudulent activities; and the government encourages the reporting of *suspected* fraud. Under this pressure, many physicians and other providers may become *overly* cautious and actually downcode their services (i.e., bill lessor services than actually performed). Under Medicare’s *tight* reimbursement system, overly cautious billing could produce insufficient income to maintain a quality medical practice.

**In this environment, an increasing number of medical practices are establishing formal Compliance Programs/Plans designed to prevent, detect and correct possible deficiencies.** In fact, the government has indicated that the presence of a compliance program that is really designed to prevent improper billing activities *might* mitigate ultimate fines and penalties in the event of a fraud/abuse action.<sup>1</sup> Mandatory Compliance Programs are often part of fraud and abuse settlements. Actually, many medical practices will find that formal compliance efforts help to improve billing effectiveness.

**The example below is a true story that illustrates how a medical practice can get into trouble even though physicians think they are doing everything right.** It’s also a good example of how important it is to make reasonable compliance efforts such as periodic internal audits comparing documentation to items billed and ultimately paid.

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<sup>1</sup>Readers must understand that while the presence of an *effective* compliance program might mitigate fines/penalties, one will still have to repay improper collections and hefty interest charges. There is also some question as to how much fines and penalties would be reduced because it could be difficult to demonstrate a compliance program is *effective* if the types of improprieties that produce penalties actually occur. **The real purpose of a compliance program should be to prevent improprieties from occurring in the first place.**

### Are you sure your billing activities are proper?

Recently, we evaluated a seemingly desirable medical practice for a potential purchaser. We assessed the practice's equipment, patient base, payer mix, gross billings and receipts, overhead, etc. Additionally, we audited a sample of records to assess the accuracy of billing because receipts seemed greater than average.

It didn't take long to find that a well meaning billing clerk routinely upcoded Evaluation and Management codes above what the physician marked on encounter forms because she "found that this would get the practice reimbursement closer to what they wanted." This physician was putting his practice in jeopardy with Medicare and managed care plans because his billing profiles indicated a much higher percentage of CPT™ code 99214 than his peers.

While Medicare and other payers had not audited the physician, the risk associated with the *fraudulent/abusive* – if unintentional – billing practice squelched the deal and left the physician quite concerned.

This is a perfect example of what a compliance plan would help prevent– unintentional, at least on the physician's part, but *fraudulent/abusive* billing activities. This illustration is more common than it should be. Similarly, it is not that uncommon to find billing staff placing ICD-9 diagnosis, modifiers or other codes on claim forms that may justify the medical necessity of the service, but which are not clearly documented in the medical record. Add to that, physicians who refuse to listen to concerns of their billing staff or seem to ignore new billing guidelines or simply fail to follow overly complex rules, and you start to see why compliance problems occur, even in "good" medical practices.

Even when *inappropriate* billing practices are not deemed to be fraudulent, Medicare carriers will seek recoupment of funds paid in excess of the "correct" amount. Thus, one may avoid the exorbitant penalties imposed upon fraudulent activities and any potential criminal sanctions, but still have to repay substantial funds (plus some hefty interest charges). Medicare carriers will commonly audit a small number of medical records and determine an *overpayment percentage*. Then, the carrier will extrapolate the "overpayment" percentage over several years worth of payments to determine the amount they will seek. While there are several levels of appeal that often allow physicians to reduce the overpayment request, it may become a costly, stressful and time consuming process.

The point should be clear– it's prudent to take reasonable efforts to ensure compliance. In the examples above, periodic auditing and monitoring would likely have identified these problems very early. If you implement a compliance program correctly, it should help identify deficiencies in your billing and collection operations that might actually increase revenue.

**At this point, the question becomes what are reasonable compliance efforts.**

⇒ Let's answer some questions that usually arise before beginning a detailed description of a compliance program including plan documents and an internal auditing protocol.

## Exactly What is a Compliance Plan?

A *formal* compliance plan is a set of documents and activities designed to prevent, detect and correct compliance deficiencies (i.e., inappropriate activity) and promote adherence to applicable federal and state law, and the program requirements of federal, state and private health plans.

In the context of this document, compliance plans are directed at preventing, detecting and correcting inappropriate activities **related to billing for physician services and violations of anti-kickback statutes and illegal self-referrals under Stark I and II (and similar state laws)**. Of course, there are other laws that medical practices and businesses must comply with that are not addressed in this book such as: Health Insurance Portability and Accountability Act (HIPAA) provisions related to privacy and security of patient information; Clinical Laboratory Improvement Act (CLIA); Occupational Health and Safety Administration (OSHA); antitrust; employment and benefit laws; the Americans With Disabilities Act; standards of clinical practice; sexual harassment; moral issues; tax issues; building codes; credit and collection policies; licensing requirements; and the like.

### Documents commonly found in formal compliance plans include:

1. Code of Conduct
2. Reporting Mechanism for Compliance Concerns/Complaints
3. Policies Related to – and Documentation of – Training Programs, Topics Covered, and Attendees
4. Duties and Responsibilities of Compliance Contact/Officer (Or Equivalent)
5. All Policies and Procedures Related to Billing, Coding and Reimbursement Activities
6. Log of Compliance Incident Reports, Results of Investigations, and Corrective Action
7. Minutes of Compliance Committee Meetings
8. Listing of Board of Director Actions Related to Compliance Issues
9. Contracts with Compliance Implications
10. Disciplinary Actions
11. Other Related Topics

## Are You Required By Law to Implement a Compliance Plan?

Technically, you do not have to implement a compliance plan because it is not mandated by law (except as part of Fraud and Abuse settlement agreements that may be imposed on physicians who have been convicted of fraud/abuse). However, some level of compliance effort seems prudent in today's environment to ensure your practice is operating properly. (See the next question for a list of benefits.)