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COMPLIANCE PROGRAMS

In October of 2000, the Office of Inspector General (OIG)of the Department of Health and Human Services, published its Compliance Program Guidance for Individual and Small Group Physician Practices, and this guidance is still in effect. The OIG is the office within the Centers for Medicare and Medicaid Services (CMS) that conducts audits of Medicare and Medicaid programs.

While the OIG's guidance acknowledges that compliance programs are not compulsory and takes into account the fact that many smaller practices will not have sufficient financial or staffing resources to implement a full-scale program it describes, it is wise for all physicians to at least make an effort to integrate some of the elements it sets forth into the administration of their practices. Any practice in which Medicare billings are moderate or greater will benefit from acting on at least some of the OIG's suggested measures to better assure compliance with the rules and regulations of the Medicare program.

Having a compliance program in effect should make it far less likely that you will run into trouble if you are audited by your Medicare Carrier or Medicare Administrative Contractor. If an audit should find something improper, the fact that you have a compliance program in place, which shows that you are genuinely trying to do the right thing, can serve as a mitigating factor in how you will be dealt with.

Physicians are likely to have to deal with "compliance" in some form or another within their practices for the next several years -- if only because Medicare audits have proved to be so successful in reducing improper payments. Inevitably, there will also be a spillover into the private sector in areas such as credentialing and private insurance billing. The first step we recommend is for you to become familiar with the elements of the OIG's compliance program, as given here, and to then assess whether or not it is feasible for you to implement one or more of the components of a compliance program in your practice.

AN OVERVIEW OF THE OIG'S GUIDANCE

The program guidance provides the OIG's views on the fundamental components of physician practice compliance programs, as well as the principles to consider when developing and implementing such a program. Though the guidance presents basic procedural and structural information, it also states that "there is no 'one size fits all' compliance program." Emphasis is placed on the notion that a compliance program must be "living and breathing" and an active part of day-to-day operations, and that it must be woven into the practice's culture to achieve maximum benefit.

According to the OIG, the benefits of a voluntary compliance program may include: enhancement of patient care due to improved accuracy of documentation; improvement of claim processing and payment; reduction of billing mistakes; reduction of the likelihood of a CMS or OIG audit; and avoidance of conflicts with self-referral and anti-kickback statutes. Having a compliance program sends a message to employees that they have an affirmative duty to come forward and report any erroneous or fraudulent conduct so that it may be corrected. The underlying, fundamental principle driving the OIG's compliance guidance is that all healthcare providers have a duty to reasonably ensure "that claims submitted to Medicare and other federal health care programs are true and accurate." Although your compliance program's focus should be on claims submitted to federal healthcare programs, it will also assist you with private payer claims.

The OIG guidelines describe seven basic components of a voluntary compliance program, but acknowledge that full implementation of all components may not be feasible for all practices. As a starting point, a practice may adopt only the components deemed necessary based on its specific history with billing problems or other compliance issues. The adoption of other components will depend on the size and resources of a practice. To minimize costs, the OIG encourages practices to participate in other provider compliance programs such as those available through hospitals, physician practice management companies, etc. A small practice could also collaborate with other practices, enabling them to conduct training and education programs based on the policies and procedures mandated by Medicare that would not be possible for a practice working alone.

THE SEVEN BASIC COMPONENTS OF A COMPLIANCE PROGRAM

1. CONDUCTING INTERNAL MONITORING AND AUDITING

There are two types of audits. One involves a review of the "practice's standards and procedures to determine if they are current and complete." The second is a claims submission audit in which bills and medical records are reviewed for compliance with coding, billing, and documentation requirements. The practice can determine whether to review retrospectively or concurrently and who should conduct the audit. After the initial audit, periodic audits should be conducted no less than once per year. There is no set formula on how many records should be reviewed. The suggestion is to do five or more per federal payer or five to ten per physician. Responding appropriately to any problem discovered during one of these audits is key. Circumstances may merit the refund of an overpayment, conferring with a coding billing expert, etc. It is extremely important to document identification of a problem and its ultimate resolution.

2. IMPLEMENTING COMPLIANCE AND PRACTICE STANDARDS THROUGH WRITTEN STANDARDS AND PROCEDURES

After the internal audit identifies risk areas, the next step is to develop a method for dealing with those risk areas through the development of written standards and procedures. Many practices have something similar called “practice standards,” and other practices have adopted the standards and procedures of third parties where appropriate. If your practice has no standards and procedures in place, you can develop your own written standards and procedures manual and update clinical forms periodically. Another possibility is to create a resource manual from publicly available information such as relevant CMS (or HCFA, for documents published prior to June 14, 2001) directives, carrier bulletins, etc.

Specific risk areas for coding and billing that psychiatrists need to be aware of are: billing for services not provided as claimed; submitting claims for services that are not reasonable and necessary; double billing resulting in duplicate payment; billing for noncovered services as if covered; knowing misuse of provider identification numbers; unbundling; failure to properly use coding modifiers; clustering; and, upcoding. Your practice should be able to provide documentation to support appropriateness (reasonable and necessary) of services provided. As for documentation risk areas, one of the most important compliance issues is the appropriate documentation of diagnosis and treatment. In that regard, the medical record: may be used to validate site of service, appropriateness of services, accuracy of billing, and identity of a care giver; must be complete and legible; and must document each patient encountered, reason for the encounter, relevant history, physical exam findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan of care, and date and identity of observer. CPT and ICD-9-CM codes must be supported by documentation, and the medical record and health risk factors must be referenced; the patient’s progress, his or her response to and changes in treatment, and any revision in diagnosis must also be documented. As on the HCFA 1500 Form, the diagnosis code must be linked with the reason for the visit or service; modifiers must be appropriate; and Medicare must be provided with all information regarding other insurance coverage.

The practice’s standards and procedures should also address any improper inducements, kickbacks, and self-referrals. The standards and procedures should provide, for example, that all business relationships where the practice refers or receives services are based on fair market value. If the practice intends to enter into a business relationship that involves making referrals, such arrangements should be reviewed by legal counsel. The practice should be careful not to offer inducements to patients such as waiver of co-pays, deductibles, etc.

Standards and procedures concerning the retention of records are also important. There should be a section on retention of compliance, business, and medical records.
Record retention policies should specify the length of time various records are to be retained; how medical records should be secured against loss, unauthorized access, etc.; and the direct disposition of medical records in the event that practice is sold or closed.

3. DESIGNATING A COMPLIANCE OFFICER AND/OR OTHER CONTACTS TO MONITOR COMPLIANCE EFFORTS AND ENFORCE PRACTICE STANDARDS.

Once audits are complete, an individual needs to be designated to develop a corrective action plan, if necessary, and oversee adherence to the plan. If this role is outsourced, the compliance officer must have sufficient interaction with the practice to be able to understand its inner workings. Suggested duties of compliance officers include: overseeing and monitoring the compliance program; establishing methods to improve practice efficiencies and reduce vulnerability to fraud and abuse; periodically revising the program in light of changes in the law; ensuring that compliance materials and training are up to date and appropriate; ensuring that all employees, contractors, and partners are checked against the OIG's List of Excluded Individuals and Entities; and investigating any report or allegation concerning unethical or improper conduct.

4. CONDUCTING APPROPRIATE TRAINING AND EDUCATION

The OIG guidance lists three steps for establishing educational objectives: 1.) determine who needs training; 2.) determine the type of training needed; and 3.) determine when and how often the training is needed. Items that should be part of a training program include: the importance of the compliance program and how it works; the consequences of violating its standards; and the role of the employee in the compliance program. The goal is that all employees will receive training and that each employee will understand that compliance is a condition of employment. As for coding and billing training, this will be necessary for certain members of the staff, depending on their responsibilities. Some examples of items that could be covered in coding and billing training include: coding requirements; claim development and the submission process; proper documentation of services rendered; proper billing standards and procedures; and legal sanctions for submitting false or reckless billings. The training program may be conducted by an inside or outside source. It may be through a community college and/or professional association, carrier, third party billing company, or other entity. It is advisable for the practice to maintain updated ICD-9, HCPCS and CPT manuals

There is no set formula for training, but at least annual training is recommended.

5. RESPONDING APPROPRIATELY TO DETECTED VIOLATIONS THROUGH INVESTIGATION OF ALLEGATIONS AND DISCLOSURE OF INCIDENTS TO APPROPRIATE GOVERNMENT ENTITIES.

Any allegations of wrongdoing must be investigated to determine whether a violation of the law has occurred. If a violation has occurred, the practice must take decisive steps to correct the problem. This may involve a corrective action plan; the return of any overpayments; a report to the government; or, if necessary, referral to law enforcement authorities.

6. DEVELOPING AN OPEN LINE OF COMMUNICATION WITHIN STAFF

The OIG suggests that in a small practice the communication element of the compliance program can be met with a clear, "open door" policy between physicians, compliance personnel, and other employees. The office compliance program should require that employees report any conduct that a reasonable person would believe to be erroneous or fraudulent; should create a user-friendly anonymous means for reporting, such as a drop box or hot line; should specify in the written standards and procedures that failure to report errors or fraud is a violation of the program; should develop simple and readily accessible procedures for followup; should establish a procedure for communicating to the billing company, if one is used, regarding areas of concern; should maintain the anonymity of persons involved in reporting; and should ensure that there is no retribution for good faith reporting.

7. ENFORCING DISCIPLINARY STANDARDS THROUGH WELL PUBLICIZED GUIDELINES

Last, but not least, a practice's compliance program should include procedures for disciplining individuals who violate compliance or other practice standards. Such disciplinary actions can include warnings, reprimands, probation, demotion, temporary suspension, termination, restitution of damages, and, of course, referral for criminal prosecution.

CONCLUSION

Take a hard look at the OIG's seven recommendations and then decide whether or not to implement one or more of them into your practice. You may already have some of the components in place, albeit under other names. You may be able to weave other components into your practice without much burden. What is important is that any effort to implement compliance measures must be genuine, and sufficient time and attention must be invested to make them work. Compliance endeavors do confer a net benefit on a practice -- and individual physicians are well advised to consider the efforts they can reasonably undertake to make compliance a more viable, active component of their practice.