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Helpful Hints from Uncle Sam The government doesn't want to prosecute physicians who make innocent mistakes, so the Office of Inspector General has drafted guidelines to help you comply with the laws surrounding fraud and abuse.

BY JOHN ALLEVATO



"I'm from the government and I'm here to help."

Those nine words strike fear in the hearts of most people, and rightly so in a lot of cases. Those nine words immediately came to mind when I learned that the Office of Inspector General of the Department of Health and Human Services (OIG), had recently issued "draft guidance" intended to help physicians in solo or small practices conduct voluntary compliance measures to prevent fraud and abuse of those government programs. The office is charged with the responsibility of enforcing the anti-kickback and fraud and

abuse provisions of the Medicare and Medicaid laws, as well as violations of the False Claims Act.

Of course, if those laws were comprehensible, such compliance measures would not be necessary, but that's another story for another time.

The press release accompanying the draft guidance included these comments: "The Office of Inspector General believes the great majority of physicians are honest and committed to providing high quality medical care to Medicare beneficiaries. Under

the law, physicians are not subject to civil or criminal penalties for innocent errors, or even negligence."

"The government's primary enforcement tool, the civil False Claims Act... simply does not cover mistakes, errors or negligence."

"The Office of Inspector General is very mindful of the difference between innocent errors... and reckless or intentional conduct..."

This is all comforting—really. While most practitioners thought the government would overlook unintentional billing

mistakes, it still is comforting to hear them say so. And it's always good to hear that your government believes the vast majority of you are honest.

Enough sarcasm. Let's get down to understanding what the "draft guidelines" say and what that means to physicians. First, it's important to note that the guidelines are merely aspirational—not mandatory. The OIG's goal is to suggest how "a practice can foster a culture that embraces compliance consistent with the size and resources available to the physician practice." Thus, the guidelines "suggest" ways that small group or solo practices can implement compliance policies for billing practices. The guidance does not define "small group," because the OIG believes that all groups can bene-

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fit from studying the guidance.

Let me be real clear from the start—a compliance policy for the office is a good idea for any practice. The penalties for violation of the False Claims Act or the Civil Money Penalties Act, which are the primary enforcement tools of the government for billing and coding errors, are both civil and criminal. This is serious stuff.

What the OIG did in the draft guidelines is focus on seven elements it deems key for any compliance model. Let's review each one and suggest ways each element can be integrated into your practice.

1. Implementation of Written Policies and Standards of Conduct. Starting out with a set of goals and, especially, standards and procedures is a good start to an effective compliance system. While it is impossible to tell if any one element is more important than the next, this one should be a high priority and included in every compliance plan.

It would be advisable to include a Code of Conduct to insure that your office employees know what is expected of them. Then somewhat detailed procedures should be set out, such as ones dealing with billing, coding, creation of forms, and billing and coding competency, to name a few. The procedures should be current, and updated as necessary.

The draft guidelines also highlighted what it called "specific risk areas," those that the OIG felt were particularly susceptible to error, abuse, or other forms of behavior that would be problematic with the federal reimbursement system.

First, coding and billing was noted as a high risk area—one ripe for error and noncompliance. Among the potential problem areas noted by the OIG were billing for services or items not rendered or provided as claimed; submitting claims

for equipment, medical supplies, and services that weren't reasonable or necessary; double billing; billing for non-covered services as if covered; knowing misuse of provider identification numbers, resulting in improper billing; billing for unbundled services; failing to properly use coding modifiers and upcoding the level of service provided.

The OIG also noted that claims should be submitted only for services that the practice finds to be reasonable and necessary, because Medicare will only pay for those services that it determines to fit that definition. Physician records should support the appropriateness of any service that the physician has provided and for which she is seeking reimbursement under the Medicare provisions.

Adequate documentation, which includes accurate, complete, and current medical records, physician orders, and medical files, is another area of high risk that demands physician time and attention. Required forms completed and submitted to HCFA for reimbursement should also be accurate, complete, and timely.

Finally, a medical record retention policy should be included in any compliance model to provide guidelines for the office staff. It is also wise to retain records pertaining to the compliance requirements and audit results for the office.

2. Designation of a Compliance Officer. Smaller or solo practices may have a problem complying with this aspiration, though choosing someone or a couple of people to be responsible for compliance with the policies and standards you have created is recommended in offices where such a designation is possible. This person would be responsible for overseeing and monitoring compliance with office procedures, as well as insuring that staff understand the importance of compliance with appropriate billing and coding procedures.

The compliance officer could also conduct training and education sessions for staff.

3. Conducting Effective Training and Education. As noted, this could be the responsibility of the compliance officer, but it should be done by someone. The staff must know how to perform their tasks, and the physician must insure that the appropriate level of training is conducted, and that refresher training and contact with a knowledgeable individual are available to the staff. It may be necessary to hire someone from outside the practice to conduct this training, and ongoing training may be necessary as the compliance requirements change. At the least, this training must be geared to make sure all employees are familiar with at least the key risk areas noted above, and that any outside billing company participate to insure that they receive the information necessary to submit accurate claims on behalf of the practice.

4. Developing Effective Lines of Communication. Open lines of communication are a necessary part of any compliance program. Employees should understand how to report conduct that may be fraudulent or erroneous; that failure to report such conduct may be a violation of a compliance program; that maintaining the confidentiality of reporting such behavior is critical; and that no retribution will follow from a good faith reporting of such alleged behavior. Self-policing seems to be the goal here. Still, the smaller the office, the more difficult this element may be to implement. In that regard, an open door to the physician's office may be the best method to insure open communication.

5. Auditing and Monitoring. An ongoing evaluation process is a necessary part of any effective compliance program. This can be accomplished in-house if the appropriately trained personnel are on staff, or by use of

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third-party “auditors.” This “self-audit” process, whether done in-house or by an outside vendor, usually starts with an initial audit, sometimes called a baseline audit, and then expands to an ongoing monitoring of the claims submission process and evaluates compliance with not only the law, but with the policies and procedures implemented in the office. If problems are highlighted, then immediate corrective action should take place.

Ongoing monitoring for compliance has become a necessary cost of doing business.

6. Enforcing Standards and Disciplinary Guidelines.

The compliance program should include procedures for enforcing and disciplining individuals who violate the program. Sanctions should be consistent and appropriate for the violation, and should be set out as part of the compliance model. Instances of noncompliance should be noted, monitored, and the penalty levied should be recorded.

7. Responding to Offenses and Developing Corrective Action Initiatives.

All alleged offenses of the compliance program must be investigated and documented, and procedures should be in place to insure such investigations occur and any problems resolved. Once an offense has been determined, then corrective action should be taken and well-documented.

These seven elements are not intended to be all-inclusive nor are they the only components of a well-organized compliance program. The extent to which any of them is incorporated into a compliance system is a function of the particular specialty and practice. To highlight their importance, it should be pointed out that they are derived from the Federal Sentencing Guidelines, which are used by those in the federal criminal justice system to determine appropriate sentencing for violations of federal

law—in this case those used in determining the culpability of organizations. In other words, what level of due diligence did the organization undertake to prevent and detect criminal conduct?

Finally, it is heartening to note that the draft guidelines do address the difference between fraudulent conduct, and that which is merely erroneous. The OIG points out that innocent billing errors will not be targeted by the laws enforcing compliance with the federal reimbursement system, but only those that include offenses committed with actual knowledge of the falsity of the claim, reckless disregard or deliberate ignorance of the falsity of the claim.

In the draft guidelines, the OIG is trying to give practices an idea of the types of office procedures and policies which will mitigate the use of the powerful forces of the government in its attempt to eradicate perceived abuses of the Medicare and Medicaid system. Physicians, take heed! ■

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