Reporter

TMLT
Texas Medical Liability Trust

September/October, 1998

Avoiding Fraud & Abuse In Health Care

By Scott R. Berglund, TMLTVice President, Risk Management

What's The Problem?

The General Accounting Office estimates that as much as 10 percent of the $1 trillion spent annually by the U.S. health care system may be attributed to fraud and abuse. Because of the astronomical amount of money involved, the Department of Justice has named health care fraud and abuse as its number two law enforcement priority. Violent crime is number one.

"Fraud" is defined as gaining something of value through misrepresentation or concealment of material information. "Abuse" is any practice not consistent with standards, rules or regulations, which provides unfair advantage for those with responsibilities for the public trust. Any individual or entity providing health care services to patients in any government health care program and who submits a claim for payment is subject to compliance regulations.

Liability For Inappropriately Submitted Claims

In 1996, with the enactment of the Health Insurance Portability and Accountability Act, Public Law 104-191, the federal government clarified and increased its authority to investigate claims and enforce penalties. The law allocated funds to significantly increase the number of OIG auditors as well as to expand the investigative involvement of the FBI concerning health care fraud. The law also created the
Medicare
Integrity Program, allowing HHS to contract with private entities to review and audit Medicare programs. It also established a program to encourage Medicare beneficiaries to report questionable activities.

The government has the authority to impose both civil and criminal sanctions, with sanctions being as much as $10,000 per claim plus an assessment of up to three times the amount improperly claimed. Asanction for an anti-kickback violation could be as much as $50,000. Where a person "knowingly and willfully" defrauds Medicare, Medicaid or another federal health care program, criminal penalties may be imposed. Sanctions may include a fine of up to $250,000 per claim as well as an exclusion from participation in government health care programs. Fortunately, the burden of proving intent to commit health care fraud is with the investigators and the government. Unfortunately, many doctors and their administrators are not informed about the investigations, what causes a practice or entity to be investigated and how to set up a compliance plan to prevent mistakes, detect inadequacies and correct them.

Creating An Effective Compliance Plan

To avoid treating Medicare or Medicaid patients is rarely a viable solution. The best solution may be to create and carefully manage a compliance plan that demonstrates due diligence and honest intent. It should con tain the following elements:

A statement of intent to offerclearcom mitment to compliance—similar to mission statement. The document mus reflect the intent of the organization t adhere to a specific standard in order t ensure that everyone in the organization i obligated to comply. The plan shoul include a checklist of specific actions to b undertaken.

Appointment of a qualified and trust worthy compliance officer with a hig level of authority. Measures of trustwor thiness may include the organization' experience with that employee as well a a background check. In addition to com pliance responsibilities, this person ma have other duties that carry authority an require a high level of trustworthiness. Thi individual must be able to influence behav ior and organizational standards.

Education and training programs for a professional and support staff. Educationa activities should be conducted at least annu ally. The educational programs should con tain an overview of the laws related to frau and abuse investigation, the importance an operation of the compliance plan, and th role of each employee in the plan. Physiciar

continued on page 2

Seldom, if ever, in the history of medicine have more fear and anger been engendered among physicians than with the initiation of the federal fraud enforcement and compliance program. To date,enforcement actions against physicians have been isolated horror stories, but more physicians and their practices could easily become targets in the future. Many find it depressing and humiliating that this topic would ever be associated with the practice of medicine. Be that as it may, those who provide health care should consider the presence of the federal government in health care delivery as a matter to be dealt with in a well thought out and orderly process.

need to be informed about the necessity for proper and accurate documentation in the medical record, and also about their responsibility to have billing records conform to the medical record. Documentation of the training program should include both the content and the identification of those who participate.

A process to monitorand audit claims. This critical aspect of the compliance plan entails developing a system to regularly review the development and submission of claims, beginning with initial point of service to the patient and ending with the actual submission of the claim. While most audits seem to be made on an annual basis, some experts recommend a quarterly audit schedule.

An effective communication process among all personnel involved in the process and the compliance officer. Two-way communication with the compliance officer is one of the keys to a successful compliance program. The compliance officer has the responsibility to ensure that the communication process does not become clouded by fear or threat of retribution. He or she should be able to provide information about the organization and about audit results. Other personnel should communicate their questions or complaints. It would be wise to establish an anonymous hotline that is internal to the organization.

A process for internal investigation and enforcement through published guidelines and actions. When information is received about any potential violation or misconduct, the compliance officer has the responsibility to initiate an investigation that includes interviews with appropriate personnel, review of medical records, billing documents and other relevant documents. Qualified legal counsel should conduct the investigation in order to ensure that all information is obtained properly and without coercion. Attorney/client privilege may provide some protection in the event that the OIG or another agency requests information gathered in the course of an investigation. Organizations should maintain a written policy for internal enforcement and discipline, and all personnel should be aware of disciplinary guidelines. Organizations should maintain records concerning internal disciplinary actions.

A process to respond to identified inaccuracies and correct them. When a compliance problem is discovered, organizations have a responsibility to take specific corrective steps. Voluntary disclosure to the federal government of a compliance problem is a very difficult issue that should be discussed with legal counsel.

Feeling Abused?

By Oren Renick, JD, MPH, ThM, FACHE, Associate Professor of Health Administration, Southwest Texas State University

The sage Anonymous has written, "For every complex problem there is a simple solution that is wrong!" Such warnings aside, how can physicians reasonably and prudently respond to a government that "is serious about prosecuting Medicare and Medicaid fraud and abuse" and address a problem that it identifies as enormous (Schutte, 1998)? There is a simple solution that is right and that is also a positive, proactive approach based on doing three things.

1. **Document, Document, Document.** The Office of the Inspector General (OIG) audited Medicare expenditures in 1996 and concluded that $23.2 billion, or 14 percent of all Medicare expenditures, had been spent inappropriately. The Medicare Program continues to spend billions and billions of dollars, and we do not know where the money is going. "What accountability,?" we ask. However, before rushing to judgment, let us consider that every inappropriate expenditure (except noncovered services) has a direct relationship to documentation; $22 billion may be linked to documentation. At a minimum, $10.8 billion is essentially rooted in documentation. Do we have a fraud and abuse problem, or do we have a documentation problem? The answer to the former is maybe, but the answer to the latter is definitely. About $5 billion of those payments were for physician services, and thus, physicians are increasingly being held accountable for the documentation of services they order and provide for their patients (Schutte, 1998).

Documentation, or lack of documentation, is an old story. It is always a finding in the early stages of any quality improvement initiative. It is the "low hanging fruit." Documentation takes time. Physicians know how to document their practices. It is essential to their training and all aspects of clinical practice. But managed care places time constraints on physicians that make detailed documentation seem less than doable. Therefore, the first fix is to document in detail but to do so in a way that doesn't take a great deal more of your time. Not to document in detail raises suspicions about fraud and abuse, which although often exaggerated, may precipitate problems that are more time consuming than detailed documentation. It is time to document smarter, devising forms that reduce the time it takes to say on paper what ought to be said.

2. **Build a Team.** If you are "feeling abused" by Medicare regulations it is helpful to get

continued on the back cover

Billing Compliance: *A Step-by-Step Program*

Jamie Claypool, a practice management consultant endorsed by the Texas Medical Association, has compiled this 15-step program, which can be included in your practice's written compliance plan.

1. Each quarter, the compliance officer should review a random sample of 25 to 35 charts per physician, along with all the associated encounter documents, claim forms, and their respective explanations of benefits and payment stubs.
   - Are necessary elements documented to support the level of care billed?
   - If tests have been ordered, is the reason for the test evident through the chart note? If not, can the reason be clearly inferred?
   - Does the chart contain documentation to support ordered ancillary services?

2. Review the associated claim form or transmittal documents (computerized claims may have to be printed on paper for review). Did "unbundling" occur? To determine if the code has been unbundled, refer to the Correct Coding Initiative, which can be ordered from the National Technical Information Services at 703-487-4140.

3. Review internal billing for consultation. Are these requirements met?
   - The request and need for consultation must be documented.
   - The consulting physician's findings must be documented in the medical record and communicated to the referring physician.
   - Once the consulting physician assumes management of one or all of the patient's conditions, evaluation and management codes should be used, rather than the billing codes for consultations.

4. Check the medical record for complete information on the internal encounter form. Is a clear, written diagnosis for the current encounter on the internal encounter form?

5. Make sure the chart has a clinical and clerical audit trail. Every billed charge should be evident from the clinical record, and each clerical transaction should have all the necessary support documentation.

6. Train and educate all staff responsible for posting charges and payments. These personnel should have a solid coding background and should be aware of the codes and code pairings noted in the Correct Coding Initiative (see 2).

7. Strive for neatness and organization. If a review officer has to read an illegible, disorganized and sloppy record, the likely conclusion is that the service was never performed.

8. Examine the number of claims your billing personnel resubmit each month for review or appeal. Ahigh number of these could indicate a high level of internal billing errors.

9. Periodically review your daily and weekly charges to determine whether all the services claimed to have been rendered on a given day were actually completed within that time frame. Conduct a similar review of your hospital charges, especially with "time sensitive" services such as critical care services.

10. Keep the Medicare Part B Manual and newsletters handy for clarification. Route the newsletters (with the important items flagged) to all billing and coding personnel and to physicians. Medicare newsletters may be printed from the Internet at www.the-medicare.com.

11. Make certain all necessary waivers are on file in the patient's chart if you are providing services that are not considered "medically necessary" by the carrier or not covered. Waivers are also necessary if the practice provides screening lab tests.

12. Check your use of modifiers, the two characters that are added to procedure codes to "modify" the scope, definition, circumstances, or charges associated with services provided. Improper use of modifiers can lead to claim denials, payment reductions, and time-consuming claim appeals.

13. Check credit balances and refunds. If you owe money to Medicare or to a Medicare patient, refund it promptly. Credit balances can lead to problems.

14. Ensure that all requirements are met for nurse practitioners, physician assistants, and clinical nurse specialists who bill for services "incident to" those provided by a physician. Some of these services should be reported using the "YR" modifier to indicate that services were ordered by the physician, but performed by auxiliary personnel under the physician's immediate supervision. In these cases, the physician does not have to be physically present with the patient at the time of service, but he/she must be within the confines of the office.

15. Review internal charge documents such as encounter forms or superbills. Are the codes current? If the lower level codes are not included, providers are forced to use only the higher paying codes, which may not be appropriate.

Who Ya Gonna Call?

Many resources are available for education on Fraud and Abuse. Information is available from Medicare Provider Services at 972-766-6076. Texas Medical Foundation at 800-725-9216 and the Texas Medical Association's Health Care Financing Department at 800-880-1300 offer educational programs on Fraud and Abuse. Practice management consultants available for compliance assistance are Jamie Claypool at 512-265-3323 for the South Texas area and Diane Adams at 800-939-7651 for the North Texas area.

Texas Medical Liability Trust
P.O. Box 160140
Austin, TX • 78716-0140

Tel: 800-580-8658 *or* 512-425-5800
Fax: 512-328-5637
Email: scott-berglund@tmlt.org
URL: www.tmlt.org

Editor: Scott R.Berglund

Managing Editor: Judith H. Fine

Staff: Kerry Farias, Natalie Gilmore

Graphic Design: Stephen Cullar-Ledford

© 1998 TMLT
September/October, 1998
Printed on recycled paper

Bulk Rate
U.S. Postage
PAID
Permit No.90
Austin, Texas

All articles and any forms, checklists, guidelines and materials are for general information only, and should not be used or referred to as primary legal sources nor construed as establishing medical standards of care. They are intended as resources to be selectively used and always adapted—with the advice of the organization's attorney—to meet state, local, individual organizations and department needs or requirements. The Reporter *is distributed with the understanding that neither Texas Medical Liability Trust's Risk Management Department nor Texas Medical Liability Trust is engaged in rendering legal services.*

Feeling Abused *(continued)*

some support, be proactive and solve problems. Along with visionary leadership, a quality team is the foundation for any successful initiative. It is the means to reach the goals you set.

Who is on such a team? It is composed of key individuals who are presently part of your medical office practice. Ideally it is interdisciplinary and composed of four to eight persons, but that may not be realistic for your practice. The important thing is to start from wherever you are.

What is your proactive charge to the team? Its mission should include the development of a compliance plan, as outlined in the article on page 3. Know what the team is doing and keep involved. Stop, look and listen to what is going on in your business office. Not keeping informed about practices and policies in the business office can lead to unwelcome surprises for physicians who believe their domain is solely in their exam rooms (United States v Krizek).

3. **Expand Your Vision of Quality.** Physicians want quality in their practices and strive to constantly improve the art and science of medicine. As the shape of health care in the United States has changed in recent years, more and more attention is being paid to the business aspects. Physicians have demonstrated their success in peer review as it relates to patient outcomes and the improvement of the quality of care. It is time to consider applying the objective peer review process beyond the clinical aspects of practice, using peer review as a means to evaluate, improve, and control other aspects of health care such as documentation and financial management. It is this control or evaluation function that is the base on which continuous quality improvement rests (Renick, 1994). Objective peer review processes constitute physicians' primary and legitimate link to expanding their vision of quality patient care to one of continuous quality improvement in all areas by their organization.

References

Renick, O. "The Search for Value: A Quality Improvement Cycle Linking Process Outcomes and Patient Satisfaction." *The Journal of Health Administration Education* (Winter 1994), pp. 29 – 38.

Schutte, J. Fraud and Abuse Prevention. Austin, Texas: Texas Medical Association, 1998, pp. 9 and 11.

United States v Krizek, 859 F. Supp. 5 (D.D. C. 1994).

Obstetrical Records Reminder

Obstetrical medical records must be kept at least until the baby reaches 21 years of age.