Compliance Programs

Proof of Good Faith

Fully document policies and procedures for federal reimbursement, physician groups are advised.

BY MARY ELLEN SCHNEIDER

Senior Writer

LAS VEGAS — Proper documentation is key to an effective corporate compliance program and can serve as evidence of a good-faith program to investors, one compliance expert said at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Documentation should include the group’s compliance policies and procedures, training, and any compliance issues, the panel speaker said. Edward R. Gaines III, senior vice president for compliance and general counsel for Healthcare Business Resources Inc. of Durham, N.C., said that documentation can be a double-edged sword if it’s inaccurate when it’s created or if it has been manipulated to pass an audit, Mr. Gaines said.

The Health and Human Services Department Office of Inspector General outlines seven elements of an effective corporate compliance program:

- Compliance standards and policies
- Oversight
- Education and training
- Effective lines of communication
- Monitoring and auditing
- Enforcement and discipline
- Response and prevention

Another important element of a compliance program is the ability to prevent and detect fraud and abuse, Mr. Gaines said.

Implementing a corporate compliance program will mitigate the risk of potential liability, Mr. Gaines said.

Penalties under the Federal False Claims Act are possible as well. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) expanded the federal False Claims Act to all payers including commercial claims. And the government does not need proof of intent to take action. Physicians are liable for knowingly allowing or encouraging false claim submission, being deliberately ignorant, or having a reckless disregard for the truth, according to the HIPAA law.

In addition, if the physician is not responsible for performing the billing and coding, he or she is liable if the claim is submitted in the physician’s name.

The stakes in compliance are high, Mr. Gaines said. For example, in a two-hospital system with 100,000 annual visits and a 30% Medicare/Medicaid mix, if 0.1% of the claims from those 30,000 Medicare/Medicaid visits have compliance issues, that translates into a minimum of $16.5 million in penalties. If there was a finding of intentional bad conduct, that penalty is closer to $33 million.

Don’t forget to account for attorney’s fees, bad press, a loss of contracts, poor employee morale, and private payer audits, he said. And commercial payers do pay attention to what happens on the government side, he said.

Mr. Gaines advised physicians to start at the top by getting a commitment to the compliance program from senior level executives in the organization.

“One of the [places] where compliance programs frequently fail is that they don’t have clear leadership from the top,” he said.

Create an environment where physicians and staff members are free to ask questions without fear of retribution or retaliation. And groups should be willing to bring issues to resolution even if it takes years, Mr. Gaines said.

Some of the risk areas to address when creating a comprehensive compliance program include the role of nonphysician providers; teaching physicians and residents; coding for critical care, x-rays, and EKGs; and computer programs that provide instantaneous feedback for coding or billing purposes.

On the back end, discounts or copay waivers and secondary payer issues also must be taken into account, Mr. Gaines said.

Medicare contractors and other auditors will use data analysis to detect aberrant billing practices.

The auditors tend to rely on comparable billing reports that examine providers of the same specialty in a given area. The auditor might also look at comparative billing reports that examine providers in the same specialty in a different area. The auditor might also look at comparative billing reports that examine providers in the same specialty in a different area.

But physician groups can be proactive. Mr. Gaines said, by considering the role of nonphysician providers; teaching physicians and residents; coding for critical care, x-rays, and EKGs; and computer programs that provide instantaneous feedback for coding or billing purposes.

On the back end, discounts or copay waivers and secondary payer issues also must be taken into account, Mr. Gaines said.

Medicare contractors and other auditors will use data analysis to detect aberrant billing practices.

The auditors tend to rely on comparable billing reports that examine providers of the same specialty in a given area. The auditor might also look at increases in critical care utilization versus historical trends for the group, for example.

But physician groups can be prepared, Mr. Gaines said, by considering whether their E/M coding and billing data might be different from CMS national or Medicare carrier data. For example, higher coding could result from features such as the presence of urgent care facilities or clinics in close proximity to the emergency department, admission to the hospital, or emergency medical service preference, or the presence of a nursing home nearby or on the hospital campus, he said.