This is Mike Passanante and I’m glad we’re back with you here on the Hospital Finance Podcast. Today, I’m joined by Cyndy Kowalski who is a manager in our Compliance Services Team.

Cyndy, can you give us an overview of how the government approaches healthcare compliance related to physician coding and documentation?

Sure! Generally speaking, compliance programs have been evolving since 1991. That started with the Federal Sentencing Guidelines. There have been several revisions over the years and then a few years later, the voluntary OIG compliance guidelines came out. And then there was a revision put out in 2010. It was related to the infamous Affordable Care Act which then required organizations to have a compliance program.

In today’s regulatory climate, implementing a compliance program can be like proactively looking at preventive medicine. It’s something that you would want to put in place before you would actually have the need for such a thing. So that’s a little bit of the overview. It’s actually having a program in place before actually needing one.

Right. How active is the government in healthcare compliance and what types of actions do you see?

We’re seeing a very active role as far as the government goes. We’re seeing the government taking non-compliance with these regulations extremely seriously. This is not just one agency when you think about compliance. There’s actually a variety of agencies that are involved specifically with healthcare compliance.

You will see the Department of Health and Human Services participating, the Office of Civil Rights as it relates to patient information, the Office of the
Inspector General (that’s where we get the infamous OIG) as well as the Department of Justice.

And certainly when the Department of Justice starts to become involved, organizations start being concerned.

At any one given time, you can have all of these agencies on your doorstep and we are seeing that they do come. Whether you open the door to them, they are showing up.

The Centers for Medicare also release information which would basically provide organizations a heads up if you will. They will provide areas of high risk, identifying what organizations should be looking at.

An example would be looking at changes in your billing practice. Are you having spiked billing and increased number? Is there billing of inappropriate specialties as well as billing of inappropriate diagnoses? So, organizations can easily see what the trends are, what the OIG is actually looking at.

Back in November of 2014, the DOJ issued a press release reporting that just shy of $5.7 billion in settlements and judgments – and this is specifically for civil cases involving fraud and false claims.

In addition, in fiscal year 2013, the Department of Health and Human Services improperly spent a total of $65.3 billion which is a dollar out of every $10 spent on Medicare beneficiaries. And this was all sent out by mistake.

So there is a significant amount of dollars that is being expended on this for all the wrong reasons if you will.

And I think it’s important to understand a little bit about the False Claims Act because basically that’s where a majority of these issues arise. And the False Claims Act sets out seven bases of liability.
And the most common ones that are related specifically to physician coding and documentation that we’re discussing today has to do with presenting or causing to be presented a false or fraudulent claim for payment. I think what’s important here is to recognize it’s presenting the claim or causing it to be presented. It’s not just one or the other, it could be both.

Another common cause is making, using or causing to be used a false record or statement to get a false claim paid. And again, the key is making a false record, but in addition, it’s using the record or causing the record to be used falsely. That could generate a claim. So I think it’s important to recognize that.

When you think about the mistakes, there are some that are purely what we would describe as **administrative mistakes** such as not enough documentation. A documentation error is just not enough to validate the selection that was chosen for the coding.

The services that the physician documented or the physician ordered for this patient may not have been sufficient, but that doesn’t necessarily mean that the patient didn’t need the service. The patient could have required that service, but the way that the doctor documented the order or the justification for that order was not significant enough to have that claim supported or paid.

**Michael:** Okay.

**Cyndy:** Another area where we see some mistakes has to do with medically unnecessary services. The service based on what the patients was reporting as their concern is not supported medically by the documentation. And then there are some basic just diagnosis coding errors, the wrong code was selected.

One reason of many that brought us to where we are today is that hospitals and health systems are rapidly buying up physician practices. It’s a whole new area. And when you think about it, one of those reasons includes preparing for
population health management, bringing onboard additional providers. And when you start doing this, there is almost a culture clash. You go from small independent facilities to these large corporate structures. Corporate structures generally have a more formal process.

Stark laws are also becoming more relevant and they’re integrating into the new structures. And this is then resulting in change and we all know there’s often some resistance to that change.

We are also seeing some criminal actions, thus, as I mentioned earlier, the actual involvement of the Department of Justice. This could be against individuals or entities in addition to the civil actions. The criminal actions can result in exclusion sanctions. And basically what that means is that the provider or the entity can no longer participate in Medicare or Medicaid. When you think about the revenue that’s generated from Medicare and Medicaid beneficiaries, that’s a significant amount of money.

So when an exclusion is imposed, there is no payment. No one receives payment for that service. And then the provider may not submit claims automatically until they are then restored, that their services are then reinstated if you will.

**Michael:** Is there any way to avoid being excluded?

**Cyndy:** Yes. Good question. The OIG can impose compliance obligations. And really what that means is it’s a part of a settlement of the Federal Enforcement Actions. Basically it’s referred to as a corporate integrity agreement obligation, which would then be in return, for the OIG, not seeking program exclusion. So when you think of the two evils if you will, more organizations would move more toward corporate integrity agreement so that they continue their business and their ability to bill their claims versus being excluded and not being able to submit claims at all.
Michael: Can you tell us a bit more about corporate integrity agreements?

Cyndy: Certainly. A corporate integrity agreement is basically what the OIG uses to communicate and I think the keyword probably would be to establish some prudent approaches to the compliance program.

Certainly an organization that has an effective corporate compliance program would benefit in the eyes of the OIG. And the OIG would then work with the organization to establish parameters, initiatives around education, training, auditing, monitoring.

And really it is structured as an agreement, almost a contract where certain activities will be done. There will be frequency all established, who will be educated, when the audits will occur, who will be audited. So that’s a little bit about what a corporate integrity agreement is.

Michael: Why would an organization choose a CIA?

Cyndy: First, to avoid the exclusion. The exclusion alone could, as we mentioned, financially cripple an organization. And again, imagine what would happen if they could not bill for any Medicare services.

CIAs, the corporate integrity agreements may represent the OIG’s opinion on your own, the organization’s compliance program. If the OIG is satisfied with the type of program that you have in place already and you’ve developed it and implemented it effectively, theoretically they give you credit for that and they will work with you if you will.

The corporate integrity agreements will also adhere to the seven essential elements that are based back to the sentencing guidelines. That’s where that comes from. So organizations have an opportunity through their corporate integrity program to either improve the effectiveness or establish effectiveness of a compliant program.
Michael: How can you go about mitigating these risks?

Cyndy: The key concept would be again going back to the standard terminology, an effective compliance program. And the keyword there would be effective. Having a compliance program that is very nicely written and it’s bound up nicely and stored on a shelf collecting dust does not mean that it is in fact effective.

Simply speaking, it’s just good business practice to have a compliance program. It helps promote a culture of commitment to compliance and it would either prevent or hopefully detect bad behavior.

There’s a tremendous amount of resources out there that are available to develop an effective program, especially through CMS. They freely share these types of resources. You can access the Office of the Inspector General, the OIG work plan which comes out every year where they identify what the risks are that you can look at again whether it’s applicable to your organization. CMS also issues fraud alerts, which will come out, as well as advisory opinions and settlements.

There is a large amount of information out there to assist with the development of an effective program. To mitigate some of the risks, you’d also want to perform risk assessments, one component of an effective program and as basic as it sounds, creating comprehensive policies and procedures around compliance, being sure that it captures what you want your program to look like and behave like, what the culture is that you want to ensure that you are sharing with your organization.

You also want to develop training and education. This would be something that’s continuous. It’s not training and education on compliance where it’s a one and done. We do it once when we bring you on as part of an onboarding process or orientation. It’s something that is comprehensive and repeated. It’s an annual education, depending on the departments. It may be more frequently than annually, depending on the risk.
And I think as far as mitigating risks, I think it’s important to appoint a compliance officer. There has been a lot of information and resources out there regarding compliance officers, the role of a compliance officer in relation to the reporting structure, the development of a compliance committee, whether the organization chooses to develop a committee within the hospital or in this case, perhaps it’s related to a physician practice group.

Theoretically, when hospitals are looking toward acquiring physician practices, it is not unusual to see a compliance officer who is part of the physician group as well as a compliance committee. And as the physician group is acquired, there is then a synergy if you will between the hospital compliance officer as well as the hospital compliance committee. So those are just a few examples of how to mitigate those risks.

Michael: Can you expand and tell us about how to develop an effective compliance program related to physician coding?

Cyndy: Healthcare overall is compliant when it is documented accurately, concisely and it is charged and billed correctly. It should also be provided in an approved facility. It also should be medically necessary and it should be reimbursed collectively.

What’s important is that each of these areas that would contribute to an effective program could involve different departments. It may not just be one provider, one entity. This could include clinical documentation teams, coding and billing teams, reimbursement teams. So it’s a broad initiative if you will to develop an effective program related to physician coding.

Also to be effective, the adequate training and education that we spoke a little bit about, whether it is shared throughout the organization and then more specifically with other departments, it is also important to establish specific monitoring and auditing practices. And we’ll talk a little bit about that too down the road, specifically auditing and monitoring.
Reporting, there must be a mechanism in place for all members of the organization to feel comfortable reporting any area where they may have questions or if they’re concerned that the practice perhaps is not as sound as it should be. There should be reporting, perhaps a compliance hotline and things like that.

And you also want to be sure on the backend that there is adequate follow up. There should be investigations. There should be corrective actions. And once those things have been developed and implemented, it’s time then to circle back to be sure that the monitoring is occurring and the corrective actions that have been put in place are actually continuing as you intended.

I think it’s also important to keep up to date on billing, being aware of the code and the CCI edits, which stands for the National Correct Coding Initiative or CCI for short. These are what you would use for your CPT and your HCPCS codes for physicians in outpatient hospital settings.

Michael: And as we wrap up today, could you just leave us with one important takeaway related to physician coding and compliance?

Cyndy: One important takeaway for today would have to be remembering the importance upfront of performing due diligence when bringing on additional physicians, when acquiring practices. This will help establish your baseline information. It will then feed in and be a component of an effective compliance program. And all of these components will build on establishing the actual effectiveness of what you are doing.

I think it’s important as well to understand that it truly requires a team effort and commitment.

Michael: Cyndy, thanks for spending some time with us today. This was great.

Cyndy: Thanks, Mike.