

FRAUD, COMPLIANCE, & EMERGENCY MEDICINE

DEVELOPED BY ACEP EXCLUSIVELY FOR ITS MEMBERS

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PREFACE

FRAUD, COMPLIANCE, AND EMERGENCY MEDICINE

This document has been prepared by members of the ACEP Reimbursement Committee as an educational tool for ACEP members in developing compliance programs. The content is based on the Office of the Inspector General (OIG) Compliance Program Guidances developed for both individual and small group physician practices as well as for third party billing companies with additional information pertinent to emergency medicine practice added from other sources.

This document is not a template for a compliance plan. Rather, this document provides information to emergency physicians to permit them to develop their own compliance plan. The OIG's Model Compliance Guidance for Physician Practices does not mandate any particular approach. The information presented in that document offers suggestions and general principles premised on the underlying themes present in all of the OIG Compliance Guidances. Physician practices will vary in terms of how to implement a compliance plan given the specifics of their situation. Factors which influence the content of a compliance plan include the size and legal structure of a practice as well as its business relationship with the hospital documentation methodology, nature of its coding and billing arrangements (in-house or outsourced), problem areas to address on a priority basis, resources available, personnel available, etc. There is no specific requirement regarding what should be taken into account, but the overall principles of compliance are now known. This document is intended to help emergency physician practices determine their own approach.

Every individual or group should develop an effective compliance plan that applies to their specific situation. A poorly written or generic compliance plan could be more harmful to your practice than no compliance plan at all.

For the purposes of this document, a hierarchy of language has been established. The word "must" is used in a statement to indicate that the action is required by law or regulation. Failure to perform these "must" actions will violate these published standards and invite charges of fraud and abuse. Statements containing the words "should" or "ought to" are suggested guidances from the OIG or other sources. These actions are strongly recommended but are not required by statute or regulation.

Some of the information contained in this document pertains specifically to the Medicare and select state Medicaid programs. The OIG Guidances emphasize "general federal health reimbursement principles." but clearly acknowledge the importance of compliance with non-governmental payers. Other private payers may have different regulations or payment policies that should be considered as well. The contractual or regional variations in payer policies make it difficult to address them in a document intended for a national audience. Physicians should understand that rules change and providers should refer to original source documents to verify that they are following the appropriate rules.

Additional information on compliance and other related issues described in this document is available on the ACEP Website at www.acep.org. Every effort was made to confirm that the content was correct at the time of publication. Readers should verify that all source documents are current and unchanged when using this material.

FRAUD, COMPLIANCE, AND EMERGENCY MEDICINE

INTRODUCTION

Concerned that provider fraud and abuse and improper payments threaten the Medicare program, Congress has mandated that the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Finance Administration (HCFA) as well as the Office of the Inspector General (OIG), increase and intensify their investigations of the health care sector. Already, a substantial number of hospitals, physicians, physician groups, and other providers have been investigated, and the number and amount of identified overpayments and penalties have increased dramatically. In this endeavor, the federal government has powerful tools such as the False Claims Act of 1986, the Health Insurance Portability and Accountability Act (HIPAA), the Sherman Antitrust Act, the Stark I and Stark II regulations, and the Balanced Budget Act of 1997. There are other legal bases for enforcement including use of mail fraud, wire fraud, and conspiracy statutes, and non-health-care related statutes, and other sources of authority the government can also apply in its search for illegal activity. These tools provide increased funding for the OIG's fraud and abuse activities and a variety of enforcement means. A health care fraud investigation can potentially lead to the imposition of criminal penalties including fines and imprisonment, and civil penalties, including monetary penalties and/or exclusion from the Medicare and Medicaid programs. Even the appearance of fraud and abuse can increase the risk of investigation or whistleblower claims.

Emergency physicians may be more vulnerable to allegations of fraud and abuse because at times there can be an indirect involvement with the administrative aspects of their practice. Coding and billing functions are often outsourced to the hospital or to a billing company without direct clinician involvement. However, the government has made it clear that the physician, if he/she provides the service, is always held accountable for billings in his or her name regardless of who submits or processes the claim. The law provides that the principal (the provider of the service) is responsible for the acts of the agent (e.g., an employer submitting bills on behalf of the individual physician or ancillary personnel including coding personnel employed by a physician practice, etc.)

WHAT IS A COMPLIANCE PROGRAM?

In simple terms, a compliance program is a quality assurance strategy. An effective program establishes, implements, and enforces internal controls and monitors its conduct in order to prevent and correct inappropriate activity. There are no statutes or laws that require an organization to have a compliance program. A compliance program is meant to ensure that an entity will not inadvertently, negligently, or intentionally engage in illegal activity. Should an entity subsequently be found guilty of fraud, the existence of an otherwise effective compliance program may decrease the penalties imposed. Essentially, an effective compliance program establishes a culture that articulates and demonstrates a commitment to legal and ethical conduct and functions to reduce potential penalties.

Some terminology should be made clear when referencing compliance plans and programs. A compliance plan is your documented strategy for ensuring compliance with payer rules and regulations. A compliance program is the action taken to implement that plan. Although clearly related, the terms are not interchangeable.

You should have a compliance plan, whether you are practicing with a small group, a large staffing company, as an academic physician, as an employee or independent contractor, or in any other coding/billing arrangement. Hospitals, as part of their compliance requirements, will expect or require hospital-based physicians to have their own plan and program.

Physician practices should be aware of the possibility of a qui tam or “whistle blower” suit originating from someone with inside knowledge of your entity’s practices. This can be an employee of your group, the hospital, the billing company, or consultant you use to audit your charts. There can be substantial rewards including a share of any penalties assessed for an individual who brings a successful false claims or fraud case to the government. (See section on Legal Assistance, p.23) Individuals have collected millions of dollars in false claims cases against providers; an effective compliance program can mitigate the possibility of such an event.

It is essential that whatever compliance plan or program is documented should be realistic and likely to be implemented completely. Adopting a compliance plan that the practice does not follow may be construed as reckless disregard or deliberate ignorance, both evidence of wrongdoing and possibly fraud.

OIG COMPLIANCE PROGRAM GUIDANCE

For the past six years, the OIG has been publishing recommendations to specific sectors of the health care industry regarding voluntarily developed and implemented compliance programs.

The OIG’s suggested guidances have been issued for: hospitals (2/23/98), home health agencies (8/7/98), clinical laboratories (8/24/98), Medicare + Choice organizations (11/16/99), the hospice industry (7/21/99) third-party medical billing Companies (12/1/98), nursing facilities (3/16/00), the pharmaceutical industry (04/28/03), and Ambulance Suppliers (3/24/03). Most recently, the OIG published proposed amendments to the Hospital guidance (Federal Register, June 8, 2004). On September 25, 2000, the OIG published the compliance program guidance for individual and small group physician practices. ACEP submitted comments on the draft of this guidance, many of which were adopted in the final OIG document that can be downloaded from ACEP’s web page. The elements and expectations described in the new guidance apply to physicians and medical practices as well. Any physician or group doing their own coding and/or billing must assume that the government expects them to adhere to these principles. Always remember that the principal is responsible for the acts of the agent when these functions are outsourced to another entity. Essentially the underlying basis for this is found on every claim form where the physician identified on the claim certifies: “that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or Champus regulations. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.”

ELEMENTS OF A COMPLIANCE PLAN

A compliance plan should address program design, implementation and enforcement. An effective compliance program needs to be “home grown” and unique to the entity. All compliance plans should have seven key elements. These are based on the seven steps outlined in the Federal Sentencing Guidelines and form the basis for all of the OIG’s “model” compliance programs.

1) Compliance Standards and Procedures

An entity should develop written standards of conduct, including a clearly delineated commitment to compliance, for all medical professionals, employees, and contractors.

Written policies for risk areas such as documentation, coding and billing should also be established. Risk areas to address pertinent to emergency medicine, many of which will be discussed in later sections of this document, include but are not limited to the following:

- Appropriate documentation of the service rendered and its medical necessity. Medical necessity is always an issue. There are a variety of methods for documenting medical necessity, e.g. ICD-9 codes, differential diagnoses, narrative descriptions, etc., or it may be implied^a by the presenting symptoms or chief complaint. (See section on Documentation of the Patient Encounter, p.14)
- Adherence to applicable documentation guidelines. (See section on Ongoing Education, p.16)
- Coding and billing for utilization of mid level providers. (See section on Non Physician Personnel Involved in an Encounter, p.11)
- EMTALA regulations (See section on Physicians Role in EMTALA, p.9) and Advanced Beneficiary Notices (ABNs) (See section on ABNs, p.10)
- Teaching physicians (i.e., attending physicians working with fellows, and/or residents) (See section on Non Physician Personnel Involved in an Encounter, p.12)
- Additional items including, X-ray/EKG interpretations, and critical care (See section on Documentation of the Patient Encounter, p.14)
- “Upcoding,” includes “assumption” (presumptive) coding, pattern billing, and computer software programs that encourage coding and billing personnel to enter data in fields indicating services were provided although they are not specifically documented. Assumption coding refers to the practice of assigning a code based on the “assumption” of a service, or a higher level of service, (presumed from a presenting complaint, diagnosis or disposition) was provided as opposed to coding based on the documentation that such a service was actually provided. An example would be the assumption that a laceration was sutured although the provider did not document this procedure. (See section on Documentation of the Patient Encounter, p.15)
- Coding errors, including failure to properly use modifiers (e.g., teaching physician modifiers, modifiers for surgical procedures where the emergency physician will not render postoperative care, –25 modifier indicating a separately identifiable E/M service, etc.) (See section on Teaching Physicians Medicare Policy, p.12)
- Fraudulent billing, including billing for items/services not performed or documented, unbundling (e.g., coding the individual components of a procedure separately when a single code should be used to describe the service), inappropriate balance billing, duplicate claims. (See section on Coding For Professional Services and Diagnosis, p.16)

^a Implied means construed by inference such that given the same facts (the same signs, symptoms, or patient complaint) most people with a reasonable knowledge of medical documentation and coding would infer or draw the same conclusion regarding the medical necessity.

- Inappropriate discounts and/or professional courtesy (including routine waiver of co-payments, co-insurance, deductibles, etc.) (See section on Professional Courtesy, p. 25)
- Billing company incentives that violate anti-kickback statutes or other similar Federal or State law or regulation. (See section on Professional Courtesy, p.25)
- More general risk areas mentioned by the OIG are appropriate management of credit balances (overpayments), maintaining the integrity of data systems (including back-up and patient confidentiality), and record retention (See section on Retention of Records, p.22). The OIG has made a point that physicians should have access to their coding, billing, and claims data and to be alerted to denials that may suggest coding or billing errors.

2) Oversight Responsibilities

Someone in an entity must be assigned the responsibility for overseeing compliance. For example, an organization could designate a chief compliance officer who reports directly to the CEO or Board of Directors. Depending on the size of the entity, such oversight may involve one individual, a compliance committee, or both. This person or committee will oversee and monitor the implementation of the compliance program, revise the program as needed, develop an educational and training program on the elements of the compliance program, and independently investigate and act on matters related to compliance including the flexibility to design and coordinate internal investigations.

However, if the resource constraints of a physician practice make it so that it is impossible to designate one person to be in charge of compliance, it is acceptable to designate more than one employee with compliance monitoring responsibility. One employee may be responsible for preparing written standards and procedures, while another could be responsible for conducting or arranging for periodic audits and ensuring that billing questions are answered. Therefore, the compliance-related responsibilities of the designated person or persons may be only a portion of his or her duties. In lieu of having a designated compliance officer, the physician practice could instead describe in its standards and procedures the compliance functions for which designated employees, would be responsible. It is also permissible for the physician practice to outsource all or part of the functions of a compliance officer to a third party, such as a consultant or third party billing company, but it is a mistake to outsource the entire compliance program. Similarly, physicians should not rely solely on their billing company for their own compliance program; this may represent a conflict of interest and may not satisfy all the objectives of an effective physician compliance program.

(See FAQ 12)

3) Education and Training

The entity should develop and provide education and training programs for all affected employees and contracted providers. The program should effectively communicate standards and procedures to all individuals involved. This may include mandatory meetings or internal publications outlining policies and procedures. It is important to document such meetings, maintain copies of agendas, attendance sheets, and minutes, when all is said and done, ‘if you didn’t document it then you can’t prove you did it’.

4) Developing Effective Lines of Communication

The entity should create and maintain a process that facilitates submission of concerns and complaints to the relevant authorities. (See FAQ 14) This should include procedures that preserve, as best as is possible,

the anonymity of complainants, if they so desire. In addition, complainants should be protected from possible retaliation.

5) Monitoring and Auditing

A compliance program should demonstrate that the entity has taken reasonable steps to achieve compliance through monitoring and auditing systems designed to detect inappropriate conduct by its employees or agents.

In addition to the standards and procedures themselves, it is advisable that bills and medical records be audited for compliance with applicable coding, billing, and documentation requirements. The practice's audits can be used to determine whether:

- a. Bills are accurately coded and accurately reflect the services provided (as documented in the medical records)
- b. Documentation is being completed correctly
- c. Services or items provided are reasonable and necessary, and
- d. Any incentives to render, document, or code unnecessary services

A baseline audit examines the claim development and submission process, from the patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improvement. This audit will establish a consistent methodology for selecting and examining records and this methodology along with the results will then serve as a basis for future audits to ensure consistency and reflect relative progress.

There are many ways to conduct a baseline audit. The OIG recommends that claims/services that were submitted and paid during the initial three months after implementation of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness.

Following the baseline audit, a general recommendation is that periodic audits be conducted at least once each year to ensure that the compliance program is being followed. Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately. Although there is no set formula to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payer (i.e., Medicare, Medicaid), or five to ten medical records per physician. The OIG encourages an auditing/monitoring process that consists of a review of claims from all Federal payers from which the practice receives reimbursement. Of course, the larger the sample size, the larger the comfort level the physician practice will have about the results. However, the OIG is aware that this may be burdensome for some physician practices, so, at a minimum, we would encourage the physician practice to conduct a review of claims that have been reimbursed by Federal health care programs.

If problems are identified, the physician practice will need to determine whether a focused review should be conducted and the frequency of follow-up focus reviews as needed. When audit results reveal weaknesses in a process or individual's behavior then the physician practice should determine and apply the appropriate remedy.

There are many ways to identify the claims/services from which to draw the random sample of claims to be audited. One methodology is to choose a random sample of claims/services from either all of the claims/services for which a physician has received reimbursement or all claims/services from a particular payer. Another method is to identify risk areas or potential billing vulnerabilities. The codes associated with these risk areas may become the universe of claims/services from which to select the sample.

The OIG recommends that the physician practice evaluate claims/services selected to determine if the codes billed and reimbursed were accurately ordered, performed, and reasonable and necessary for the treatment of the patient. Another selection process might reflect the Medicare process that matches individual provider E/M distribution against statewide or national E/M distributions. Code levels with a significant variance are subject to a focus study.

One of the most important components of a successful compliance audit protocol is an appropriate response when the physician practice identifies a problem. This action should be taken as soon as possible after the date the problem is verified. The specific action a physician practice takes should depend on the circumstances of the situation. In some cases, the response can be as straightforward as generating a repayment with appropriate explanation to Medicare or the appropriate payer from which the overpayment was received.

In others, the physician practice may want to consult with a coding/billing expert to determine the next best course of action. There is no boilerplate solution to handle problems that are identified.

It is a good business practice to create a system to address how physician practices will respond to and report potential problems. In addition, preserving information relating to identification and verification of the problem is as important as preserving information that tracks the physician practice's reaction to, and solution for, the issue.

6) Enforcement and Discipline

The entity should have a system to consistently investigate allegations of improper or illegal activities and should take appropriate disciplinary action against persons who have violated compliance policies, applicable rules, regulations, or laws.

7) Response and Prevention

After an offense has been detected, an entity must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses. The appropriate response to an offense will depend upon the underlying cause(s). Since the determination of such cause(s) can be open to interpretation, it would be prudent to seek the advice of someone knowledgeable regarding the requirements of repaying and reporting. In general, inadvertent (which itself might be open to interpretation) errors or mistakes can be addressed by appropriate repayment.

If an entity has discovered credible evidence of *its own* "misconduct" (e.g., possible violation of criminal, civil, or administrative law) in its own activities, it must report such conduct to the appropriate government agencies. In the face of a governmental audit, prior reporting of aberrant actions in the past will generally reduce the government's penalties, since the entity recognized the problem, responded to correct it, and reported it to the government entities.

There should be good communications between the billing company as an external party and the physician entity itself. The OIG Guidance for Third Party Medical Billing Companies requires that if an outside billing company discovers evidence of *provider* "misconduct", it should refrain from submitting any questionable claims and notify the provider in writing within 30 days. If a coding/billing company discovers credible evidence of a client's continued "misconduct", or discovers evidence of flagrant or abusive conduct, the coding/billing company should: 1) refrain from submitting any false or inappropriate claims; 2) terminate the client's contract; and/or 3) report such conduct to the appropriate Federal and State authorities within 60 days. While not a per se requirement, sound compliance principles would suggest that the opposite is also true. If the provider discovers evidence of billing company misconduct

the provider should notify the billing company as soon as possible and evidence of continued misconduct should be cause for termination.

EMERGENCY MEDICINE COMPLIANCE

The potential for fraud and abuse is a continuum that begins with a patient encounter and continues through the documentation of such encounter in the patient's medical record. The medical record is then the source document for subsequent coding and/or billing. For emergency medical services a compliance program requires a risk assessment and strategy to deal with each step in this continuum.

THE PHYSICIAN ROLE IN EMTALA

The OIG provides general guidance on the physician's role in EMTALA that is not specific to emergency medicine practice. That language from the Office of Inspector General Compliance Program Guidance for Individual and Small Group Physician Practices is reproduced in its entirety here. The updated EMTALA regulations released on September 9, 2003 and effective December 9, 2003 have been utilized to update information in this section.

The Emergency Medical Treatment and Active Labor Act (EMTALA) 42 U.S.C. 1395dd, is an area that has been receiving increasing scrutiny. The statute is intended to ensure that all patients who come to the emergency department of a hospital receive care, regardless of their insurance or ability to pay. Both hospitals and physicians need to work together to ensure compliance with the provisions of this law.

The statute imposes three fundamental requirements upon hospitals that participate in the Medicare program with regard to patients requesting emergency care. First, the hospital must conduct an appropriate medical screening examination to determine if an emergency medical condition exists. Second, if the hospital determines that an emergency medical condition exists, it must either provide the treatment necessary to stabilize the emergency medical condition or comply with the statute's requirements to affect a proper transfer of a patient whose condition has not been stabilized. A hospital is considered to have met this second requirement if an individual refuses the hospital's offer of additional examinations or treatment, or refuses to consent to a transfer, after having been informed of the risks and benefits.

If an individual's emergency medical condition has not been stabilized, the statute's third requirement is activated. A hospital may not transfer an individual with an unstable emergency medical condition unless:

1. The individual or his or her representative makes a written request for transfer to another medical facility after being informed of the risk of transfer and the transferring hospital's obligation under the statute to provide additional examination or treatment.
2. A physician has signed a certificate summarizing the medical risks and benefits of a transfer and certifying that, based up on the information available at the time of transfer, the medical benefits reasonably expected from the transfer outweigh the increased risks, or
3. If a physician is not physically present when the transfer decision is made, a qualified medical person signs the certification after the physician, in consultation with the qualified medical person, has made the determination that the benefits of transfer outweigh the increased risks. The physician must later countersign the certification.

Physician and/or hospital misconduct may result in violations of the statute. One area of particular concern is physician on-call responsibilities. Physician practices whose members serve

as on-call emergency room physicians with hospitals are advised to familiarize themselves with the hospital's policies regarding on-call physicians. This can be done by reviewing the medical staff bylaws or policies and procedures of the hospital that must define the responsibility of on-call physicians to respond to, examine, and treat patients with emergency medical conditions. In the instance where physicians frequently use physician assistants in their practices, any decision as to whether to respond in person or direct the physician assistant to respond should be made by the responsible on-call physician. This decision should be based upon the individual's medical needs and the capabilities of the hospital, and would, of course, be appropriate only if it is consistent with applicable State scope of practice laws and hospital bylaws, rules and regulations. The emergency physician and the on call specialist may need to discuss the best way to meet the individual's medical needs. CMS suggests that any disagreement between the two regarding the need for an on call physician to come to the hospital and examine the patient must be resolved by deferring to the medical judgment of the emergency physician or other practitioner who has personally examined the individual and is currently treating the individual.

The exception to this requirement is that a patient may be sent to see the on-call physician at a hospital-owned contiguous or on-campus facility to conduct or complete the medical screening examination as long as:

1. all persons with the same medical condition are moved to this location
2. there is a bona fide medical reason to move the patient; and
3. qualified medical personnel accompany the patient.

The preceding information is generic for all physicians. Emergency physicians have a greater interest in EMTALA because it applies to virtually every patient in the emergency department. Please refer to the references provided at the end of this document for additional resource material on EMTALA, or access information on the ACEP web site.

The group or practicing entity should have a policy(ies) in place to address these matters and have education strategies to educate providers as to its EMTALA obligations. An audit process is needed to establish compliance with such policy.

“Some managed care plans may seek to pay hospitals for services only if the hospitals obtain approval from the plan for the services before providing the services. Requirements for this approval are frequently referred to as “prior authorization” requirements. However, EMTALA (specifically, section 1867 (h) of the Act and DHHS' existing regulations at § 489.24 (c) (3)) explicitly prohibit hospitals from delaying screening or stabilization services in order to inquire about the individual's method of payment or insurance status” In addition, the General Accounting Office in June of 2001 made some assessments with regard to the implications of EMTALA (See references).

ADVANCED BENEFICIARY NOTICE (ABN)

The OIG provides general guidance on the use of ABNs that is not specific to emergency medicine practice. Excerpts of that language from the Office of Inspector General Compliance Program Guidance for Individual and Small Group Physician Practices are reproduced here.

An Advanced Beneficiary Notice is a form that allows Medicare to bill a beneficiary directly if a lab test or service is not covered. Physicians are required to provide ABNs before providing services they know are not covered by Medicare or may not be considered reasonable and necessary. A properly executed ABN acknowledges that coverage is not guaranteed and that the patient promises to pay the bill if

Medicare does not. Patients who are not notified before they receive these services are not responsible for payment. The ABN must specify why the physician believes the service may not be covered. This should give the patient enough information to make an informed choice on whether to receive the service and assume financial responsibility or to decline the service. The practice entity or hospital should establish an Emergency Department ABN policy and provide education for the providers as well as monitor for compliance.

The OIG is aware that ABNs pose difficulties for physician practices. ACEP has worked to clarify the paradox of ABN requirements with those of EMTALA.

The practice can help itself by educating the physicians and staff on the correct use of ABNs, reviewing carrier policy regarding interpretation of whether an ABN is needed where services are not covered, developing a standard form for all applicable diagnostic tests/services, and developing a process to handle patients who refuse to sign ABNs.

The section of EMTALA that has been interpreted as precluding ABNs until such time as a medical screening exam has been given and stabilizing treatment is under way is section 1876(h) of the Social Security Act. This provision states, "A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required under subsection (b) in order to inquire about the individual's method of payment or insurance status." It is thought that inquiring about an individual's ability to pay may deter that individual from seeking necessary emergency care, regardless of whether the individual is otherwise "under great duress." CMS and the OIG have expressed concern that asking a beneficiary to sign an ABN may deter the individual from seeking care and violate EMTALA.

In a 1998 letter to then ACEP President Nancy Auer the Inspector General stated, "We agree that utilization of ABNs in an emergency room setting may lead to a violation of the patient anti-dumping statute. It is therefore not advisable for a hospital to request that a patient sign an ABN before the patient has received a medical screening exam to determine the presence or absence of an emergency medical condition or until an existing medical condition has been stabilized. Such a practice could: (1) deter the patient from remaining at the hospital to receive care to which he or she is entitled and which the hospital is obligated to provide regardless of the ability to pay; and (2) could unnecessarily delay the medical screening exam. Once an emergency medical condition has been stabilized the patient anti-dumping statute no longer applies and it is at the hospital's discretion whether or not to utilize ABNs."

In the November 10, 1999 special advisory bulletin, CMS stated that a hospital would violate EMTALA if it delayed a medical screening exam or necessary stabilizing treatment in order to prepare an ABN and obtain a beneficiary signature.

Please refer to the ACEP web site for more in-depth information on ABNs. The CMS web site has a series of frequently asked questions on ABNs that may also be helpful. (See references)

NON-PHYSICIAN PERSONNEL INVOLVED IN A PATIENT ENCOUNTER

Numerous personnel, other than the attending emergency physician, may be involved in evaluating or managing a patient, including Residents/Fellows, Physician Assistants and Nurse Practitioners (PA's/NP's), Medical Students, Nurses, and EMS providers. Specific rules address each category in addition to the generic concerns about documentation, coverage and medical necessity. Please refer to the ACEP web site for more in depth information about each of the following scenarios.

- **Teaching Physicians (*Medicare Policy*)**

Teaching hospitals represent approximately one fourth of the hospitals participating in the Medicare program. It was therefore inevitable that CMS's attention should be drawn to this area. In 1995, CMS began to clarify the conditions under which a teaching physician can bill for patients jointly seen with residents. The new rules were implemented in July 1996. In October 2002, CMS released Transmittal 1780 to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues, and update regulatory references. Below are documentation examples that are **not** acceptable.

A brief note indicating "discussion" with or "supervision" of the resident is insufficient, because CMS considers that this level of the teaching physician's responsibilities is already reimbursed to the institution through Graduate Medical Education (GME) payments.

According to the transmittal, unacceptable documentation includes:

- "Agree with above", followed by legible countersignature or identity
- "Rounded, Reviewed, Agree", followed by legible countersignature or identity
- "Discussed with resident. Agree.", followed by legible countersignature or identity
- "Seen and agree.", followed by legible countersignature or identity
- "Patient seen and evaluated.", followed by legible countersignature or identity
- A legible countersignature or identity alone

The teaching physician must be personally involved in the part (or parts) of service that they determine are the critical or key portions, and must document in the medical record his or her participation in the service. Documentation of key elements in each of these components may be satisfied by a combination of medical record entries made by the resident and the teaching physician. For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- b. The participation of the teaching physician in the management of the patient.

For the purposes of this discussion, "physically present" means the teaching physician is at the patient's bedside with the resident as opposed to present somewhere in the emergency department.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

When billing for minor procedures, the teaching physician must be present during the entire procedure. For all other procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

When billing for critical care services, the medical record must demonstrate that the teaching physician documented that he/she was physically present for the time for which the claim is made. Time spent by the resident in the absence of the teaching physician cannot be included. No other methodology is as good as timed physician notations documenting the time the physician spent in constant attendance of the patient. This applies to any time based code.

In summary, if a teaching physician relies upon any part of a resident or fellow's documentation in order to substantiate a service billed to Medicare in his /her name, he/she must follow the Medicare documentation rules for teaching physicians. As of 1/1/97, CMS requires the use of the "GC modifier" when coding all claims where the service was performed in part by a resident under the supervision of a teaching physician. The complete text of the CMS final rule for teaching physicians and Transmittal 1780 are available on the ACEP Website.

- **Medical Students (*Medicare Policy*)**

The physician cannot use documentation by medical students as part of his/her documentation, except for the Review of Systems (ROS) and Past/Family/Social History (PFSH) for which CMS does not require personal documentation. When ancillary personnel record history elements, the physician must verify and redocument the history of present illness as well as perform and redocument the physical exam and medical decision making activities of the service. A physician's mere countersigning of the chart does not make the services reimbursable to the physician. (See FAQ 9)

According to Medicare, services performed independently by students are not billable, but teaching physicians can involve students in services they personally perform. To the extent that a medical student is involved in procedures under the personal supervision of the teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services. When a student is supervised by a resident while performing or providing a service, the teaching physician can bill for the service only when he/she is there throughout the critical or key portion of the procedure providing direction. If the teaching physician is not present when the resident is supervising the student then the teaching physician cannot bill for the service.

- **Nurse Practitioners/Physician Assistants (*Medicare Policy*)**

In November 2002 CMS released Transmittal 1776. The transmittal revises the section in the Medicare Carrier Manual to address payment for E/M services provided by physicians and non-physician practitioners (NPPs) and also shared evaluation and management services between a physician and an NPP in the same group practice. Some language from the Transmittal has been included in this section.

Specific areas of focus in a compliance plan should include:

- a. The employment status of the Nurse Practitioner/Physician Assistant,
- b. Proper documentation of Nurse Practitioner/Physician Assistant activities.
- c. Correct application of the "incident to" rules, which, under Medicare do not apply to the professional provider in the emergency department setting.

“When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN.” If the PA/NP is an employee of the physician’s practice, and if the PA/NP performed a service without physician/patient face-to-face involvement, the services are billed by the practice using the PA /NP’s provider number. CMS requires that there be, if not an employment relationship, at least a contractual relationship between the physician group and the NPP.

- **Nurses**

Physicians cannot bill for services provided by the hospital’s W-2 employees unless specifically authorized by the relevant payer. It would be prudent to obtain such authorization from the payer in writing. Such billing is illegal for Medicare patients. However, certain procedures performed by such personnel may be billed, depending upon payer policy, if the physician supervises the activity. Also, many payers acknowledge that a physician may perform and bill for procedures ordinarily performed by nurses, if the record supports the medical necessity of having the physician perform the service. For example, a physician may be required to start a difficult IV, insert a NG tube, Foley catheter, or draw blood from the femoral artery. These areas, if appropriate to your practice, should be addressed in the compliance plan.

- **EMS Providers**

Medicare does not consider attending physician radio-direction of EMS Care (CPT 99288) a billable service. Other payers may have different policies. If such services are billed, the practice should have a policy describing the specific provision of services and applicable payers that may be billed.

INTERPRETATION OF DIAGNOSTIC STUDIES

CPT is clear that the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. However, Medicare rules differentiate between a separately identifiable interpretative report and the “review” of a diagnostic study included in the medical decision making portion of the E/M service. Both CPT and CMS require the preparation of a separate, distinctly identifiable signed written report in order to bill the appropriate CPT code with a modifier -26 (professional interpretation) appended.

Some years ago, CMS ruled that it would only pay for one interpretation of a diagnostic test in the emergency department, and that should be the interpretation on which the diagnosis and treatment of the patient was based. This can cause conflicts between emergency physicians and other specialists such as radiologists and cardiologists. CMS has taken the position that it will not get involved in these conflicts and encourages the hospital to facilitate who will bill for these interpretations. However, if CMS does receive two claims for the same diagnostic interpretation, it will audit both to determine which one to pay. If the wrong claim has already been paid, CMS will undertake recovery action. In a situation where an ED physician has billed for a contemporaneous interpretation and a radiologist made an additional finding on the film unrelated to the ED visit, it would be appropriate for the carrier to pay for both interpretations. It

is useful to work these issues out at the hospital level since duplicate bills from different specialties will raise 'compliance' issues.

DOCUMENTATION OF THE PATIENT ENCOUNTER

CMS states that "Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examination, tests, treatments, and outcomes." Further, CMS states that the medical record should "facilitate accurate and timely claims review and payment." The importance of accurate documentation cannot be overstated. Your compliance plan should include provider education and policies addressing documentation standards required for all patient encounters. Reasonable areas to address are:

- **The Patient Record**

The OIG requires that documentation should be legible, should identify the individual(s) providing the service, and should be available for audit and review. Your hospital may have other requirements (i.e.: JCAHO) that may be appropriate to include in your Compliance Program as well.

- **Recording Methodologies**

Printed templates, check off lists, use of scribes, or voice recognition systems with macros are acceptable to CMS, as are hand-written or dictated charts as long as it is clear from the documentation who actually provided each part of the service and each chart reflects information specific to that patient encounter. "If it wasn't documented, it wasn't done" is a familiar axiom. However, the corollary, "If it was documented, then it *WAS* done" is equally important. Printed templates, check-off lists and "normal exams" generated by a keystroke or voice command may unintentionally facilitate documenting an element that was not actually performed.

Areas where explicit documentation should be considered are:

- Explicit documentation of the CPT 99285 acuity caveat should detail the urgency of the patient's clinical condition and/or mental status that precluded the physician from obtaining a full comprehensive history and/or physical exam.
- Explicit documentation of the date and context of any Review Of Systems or Past, Family or Social History elements from a prior patient encounter to which reference is made in the physician's documentation. The date and context of the previous note ought to be recorded. CMS allows the use of the statement "all other systems are negative" in the Review of Systems. However, some payers do not follow CMS's guidelines. Therefore, consider listing all the systems reviewed anyway to minimize audit failures.
- Explicit documentation of critical care times is essential. The physician should note in the patient's record the times during which he or she was providing critical care

services. This documentation should meet or exceed defined clinical criteria for the use of these codes and the time recorded should meet or exceed published time thresholds for critical care service. The physician must devote constant attention to the critically ill or injured patient and therefore cannot provide service to any other patient during the calculated period of critical care time. For example, for any billed unit of time, the care provided must be constant for that patient, but need not be continuous. You may stop the critical care clock if you have to step away from the patient for a few minutes and restart counting critical care time when you are back in constant attention with that patient. Critical care time can include time spent at patient's bedside or at the nursing station as long as the above criteria are met. The time expended on procedures considered included or bundled with critical care should be deducted from the total critical care time.

→ Formal procedure note indicating which provider actually performed the procedure, as well as which portions of a procedure were supervised by an attending or teaching physician.

- **Ongoing Education**

As part of a compliance plan, there should be a strategy to educate providers as to current documentation requirements, and changes as they occur. Verification or proof of such efforts is essential. Periodic audits of patient chart documentation should be used to ensure the success of, or need to repeat or refine such educational efforts. At this writing, CMS and the AMA are still considering whether to modify E/M Documentation Guidelines. Visit the ACEP or AMA web sites for the latest information on the progress of documentation guideline revision.

- **Effective Communication Between Providers and Coders**

The OIG Compliance Guidance frequently emphasizes the importance of an "open dialogue" between providers and coders to maximize accuracy. Policies should address how such communication is effected and recorded. Physicians ought to receive feedback on their chart documentation as an educational and reinforcing tool. Coders should have access to the treating physicians so that they may ask questions about ambiguous documentation and receive clarification on actual services rendered before submission of claims. However, amendments or addenda to medical records should only be made in accordance with Group and/or Hospital policy. It is appropriate to include such amendment or addenda policy in the Group's Compliance Program.

CODING FOR PROFESSIONAL SERVICES AND DIAGNOSES

Coding is essentially an abstract of the medical record to address two basic components of the record: (1) the services and procedures performed and (2) the diagnoses, signs, and/or symptoms identified. More and more, payers have the ability to link this information, and together they are part of what establishes the medical necessity for any claim. Whether the documentation of the patient encounter is adequate to support the CPT code submitted and whether the diagnostic codes support the appropriateness of the service are critical elements of a compliance system. In addition, medical necessity of the service is required for all services. An encounter may be perfectly documented and appropriate to the diagnosis, or a test may meet the same standards, yet not be medically necessary for the patient in that instance.

Medical necessity is an on-going theme of the OIG, and should be an integral part of any compliance program.

Tools such as random audits, pattern analysis, and review of denied claims might be useful in uncovering problems in this area. (See legal assistance on page) Where audits are conducted, they may turn up problems. There is a statutory provision that says that a practice that does not return money that it becomes aware it received inappropriately could have criminal exposure.

Coding associated with the provision of professional services encompasses two basic components:

- a) identification of the specific service(s) provided
- b) identification of the patient's presenting problems

Identification and reporting of professional services provided is usually accomplished by means of the AMA's Current Procedural Terminology (CPT) listing of medical nomenclature. In certain circumstances some payers may require that claim submissions by participating providers must utilize the payer's specified coding system (e.g., Medicare's HCPCS). However, the Health Insurance Portability and Accountability Act of 1996 mandated the use of specific standard transaction code sets only, such as CPT and HCPCS when electronically transmitting health information. Identification and reporting of patient diagnoses and/or symptoms in the United States is usually accomplished by means of the World Health Organization's International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM). For a single patient encounter the interrelationships among individual CPT codes (e.g., Correct Coding Initiative edits that identify coding combinations deemed inappropriate by Medicare) may preclude billing certain codes separately. Also, the linking of CPT and ICD-9-CM codes and the sequencing of ICD-9-CM codes are critical to correct coding when reporting medical encounters on health insurance claims.

WHO PERFORMS SUCH CODING?

Coding for professional services may be performed by a number of persons:

1. the health care professional who personally performed the entire clinical service (e.g., treating physician, treating nurse practitioner, treating physician assistant, etc.);
2. a health care professional who personally provided some part of the clinical service and/or appropriately supervised another health care professional's performance of part of, or the entire service (e.g., physician in a resident teaching situation, etc.);
3. employees of the entity that also employs the health care professional who personally performed or appropriately supervised the service (e.g., coding personnel employed by the provider's medical group, coding personnel employed by a hospital, etc.);
4. employees of an appropriate entity to which the health care professional who personally performed or appropriately supervised the service (or his/her medical group) has contracted (e.g., a hospital for which the professional or group is an independent contractor);
5. an agent (e.g., coding/billing company) engaged by any of the preceding entities having the legal right to initiate such engagement.

WHO IS ULTIMATELY ACCOUNTABLE FOR THE CODES SELECTED?

The Federal government maintains that irrespective of who performs the coding, the provider, in whose name the claim is submitted, is ultimately accountable for the correct processing of the claim associated with the patient encounter. The OIG strongly recommends that any coding entity coordinate with its provider clients to establish clearly delineated compliance responsibilities.

WHAT ARE THE RESPONSIBILITIES OF THE CODING ENTITY?

The basic responsibility of the entity that does the coding is to assure that its policies and procedures concerning proper coding reflect the current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payer health care program requirements.

THE OIG COMPLIANCE GUIDANCE FOCUSES ON THE FOLLOWING ITEMS:

- The pre-engagement screening of personnel or entities, who will perform coding, in order to determine if the individual or entity has any prior history of noncompliance with reimbursement law or appropriate private payer program requirements. The existence of such prior history might preclude the proposed engagement, and at least requires the employer to adopt policy measures necessary to prevent avoidable recurrence of the past non-compliance.
- Establishment of procedures to ensure that the coding personnel, as well as any aids used in coding (e.g., written lists, computer software, etc.), remain in compliance with both the principles of the necessary coding systems (including the concept of medical necessity) and current reimbursement principles set forth in applicable statutes and regulations.
- Ensuring that all relevant patient encounter documentation necessary for coding, both CPT and ICD-9, is available at the time of coding.
- Ensuring that the selection of codes, including pertinent modifiers, is based solely upon appropriate documentation, which is legible and available for audit and review.
- Ensuring that the individual who provided the service is identified in the documentation.
- Establishment of a procedure whereby reasons for denials or rejections of services or procedures reported on claims pertaining to diagnosis and procedure codes are reviewed by the coder or coding department.
- Establishment of a process for post-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with applicable coverage criteria for reimbursement.
- Establishment of procedures to maintain the confidentiality of the patient's information/record (See HIPAA guidelines on ACEP website).
- A recommendation that the coding entity conduct a comprehensive risk analysis, either self-administered or out-sourced, in order to identify and rank the various compliance and business risks that may be experienced.
- If the coding function is not performed by the identified health care professional:

- the compliance safeguards should be formalized, written, indexed in a user friendly manner, and actively disseminated among the coding personnel;

It is recommended that the coder's acknowledgement and agreement to address the coding compliance safeguards should be incorporated into the contract between the provider and the bill processing entity.

- compensation for the coding personnel should not provide any financial incentive to improperly code; as an extension of this principle, the OIG has stated that contracts whereby the coding entity is compensated as a percentage of collections will be closely scrutinized;
 - coding personnel should obtain clarification from the identified provider when documentation is confusing or inadequate;
 - there should be a process available to the provider for pre-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement (a periodic review of a random sample may be adequate); and
 - coding personnel should have access to and or receive guidance from qualified physicians and medical experts on clinical issues.
- If the coding function is performed by the identified provider:
 - the bill processing entity should notify the provider to implement and follow compliance safeguards with respect to documentation of services rendered; and
 - it is recommended that the provider's acknowledgement and agreement to address the coding compliance safeguards should be incorporated into the contract between the provider and the bill processing entity.
 - if the provider discovers evidence of billing company misconduct the provider should notify the billing company as soon as possible and evidence of continued misconduct should be cause for termination. (See pg 8)

POST-CODING BILL PROCESSING

After the coding function is completed there are still numerous billing processes to address, some examples include:

- identification of primary and subsequent guarantors
- Identify any third party payers,
- computer input of billing information,
- claims submission,
- invoice mailing,
- handling of inquiries,
- payment posting,
- collection of co-insurance or co-payment, etc.

WHO PERFORMS THESE FUNCTIONS?

Once again, these functions can be provided by any of the entities listed in the preceding coding section. In summary, three basic types of relationships can exist between a service provider and a biller:

1. the health care professional, who provided or appropriately supervised provision of the service, could personally process the bill, although this would be extremely uncommon;
2. the health care professional and the billers could be employees of the same entity; or
3. the health care professional could appropriately assign billing rights or hire an agent to perform billing.

WHO IS ULTIMATELY ACCOUNTABLE FOR THESE FUNCTIONS?

The Federal government maintains that irrespective of who performs the billing, the provider, in whose name the claim is submitted, is ultimately accountable for the correct processing of the claim associated with the patient encounter. The OIG strongly recommends that any billing entity coordinate with its provider clients to establish clearly delineated compliance responsibilities. The physician's signature on the claim attests that the patient's condition and the physician's services are correctly stated.

WHAT ARE THE OBLIGATIONS OF THE ENTITY THAT PERFORMS THESE FUNCTIONS?

The basic obligation of the billing entity is to ensure that its policies and procedures concerning proper billing reflect the current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payer health care program requirements.

All applicable statutes and legal regulations must be followed. Where payor program requirements are not statutory or based on legal regulation, they must be followed only if a provider has agreed in a separate contract to comply with such requirements, for example in a participation contract.

The OIG Compliance Guidance focuses on the following items:

- The pre-engagement screening of personnel or entities who will perform billing functions in order to determine if the individual or entity has any prior history of noncompliance with reimbursement law or appropriate private payer program requirements. The existence of such prior history might preclude the proposed engagement, and at least require the employer to adopt policy measures necessary to prevent avoidable recurrence of the past non-compliance.
- Establishment of procedures meant to ensure that billing occurs only for services actually provided.

- Establishment of procedures to ensure that personnel, as well as any aids used in billing (e.g., written lists, computer software, etc.) comply with current reimbursement principles set forth in applicable statutes, regulations and Federal, State or private payer health care program requirements. For example, ensure that only appropriate “balance billing” occurs (i.e., billing for the difference between the payer’s allowable charge/payment and the amount actually paid by the payer). Medicare does not allow balance billing.
- Establishment of procedures meant to ensure that the site of service and the individual who provided the service are appropriately identified.
- Establishment of procedures to maintain confidentiality of the patient’s information/record. (See HIPAA guidelines on ACEP website)
- Establishment of procedures to prevent duplicate billing to gain duplicate payment.
- Establishment of procedures meant to ensure that all overpayments are appropriately resolved. An overpayment may be an improper or excessive payment for a variety of reasons such as multiple payers inappropriately paid for the same service or because payment was made for a service not provided or not covered. Services that are not properly reported or documented also may represent an overpayment.
- Establishment of procedures meant to ensure that waiver of co-payments, co-insurances, and/or deductibles are only implemented in appropriate circumstances. The entity responsible for post-coding bill processing and/or collections must make good faith efforts to collect co-payments and deductibles for covered services.
- Establishment of procedures meant to ensure that discounts and professional courtesy are appropriately implemented. The OIG has stated that any discount, either in part or in whole (including professional courtesy), is inappropriate if an intent of such discount is to increase referrals.
- Establishment of a process for pre- or post-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with applicable coverage criteria for reimbursement.
- The OIG recommends that the billing entity conducts a comprehensive risk analysis, either self-administered or out-sourced, in order to identify and rank the various compliance and business risks that may be experienced.
- If, as is likely, the post-coding billing functions are not performed by the identified health care professional:
 - the compliance safeguards should be formalized, written, indexed in a user-friendly manner, and actively disseminated among the billing personnel;
 - the billing personnel or entity should not have incentives that violate the anti-kickback statute of other similar federal or state statute or regulation; as an extension of this principle, the OIG has stated that contracts whereby the billing entity is compensated as a percentage of collections will be closely scrutinized; and

- a process for pre-submission review of claims to ensure that they accurately represent services provided, are supported by sufficient documentation, and are in conformity with any applicable coverage criteria for reimbursement should be established.
- If the post-coding billing functions are performed by the identified provider:
 - the coding entity should notify the provider to implement and follow compliance safeguards with respect to documentation of services rendered; and it is recommended that the provider's acknowledgement and agreement to address the billing compliance safeguards should be incorporated into the contract between the provider and the coder.

REASSIGNMENT

The revision permits independent contractor physicians and non-physician practitioners to reassign the right to payment for Medicare-covered services to contracted third parties and meet such program integrity and other safeguards as HHS may require.

According to CMS Transmittal 111, released on February 27, 2004, "A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill. The contractual arrangement between the entity and the physician or other person should include the following program integrity safeguards:

1. Joint and several liability is shared between the entity submitting the claim and the person actually furnishing the service, for any Medicare overpayment relating to such claim.
2. The person furnishing the service has unrestricted access to claims submitted by the entity for the services provided by that person."

The complete Transmittal may be found on the ACEP website.

RETENTION OF RECORDS

Policies, procedures, and education regarding record retention are also an integral part of a compliance program. There is the issue of retention of patient medical records, as distinct from the practice's ordinary business records, with both of them distinct from the retention of the records of the compliance program. The sensitivity of many of these documents as they relate to potential legal matters as well as patient confidentiality means that the procedures involved here would benefit from input from legal counsel. In addition, policies should address those types of records that could be subject to subpoena or search warrant, and those which should be maintained in a manner which safeguards attorney/client privilege.

When implementing a program with regard to compliance materials themselves, the sensitivity of these records should be addressed. The legal liabilities to the practice and the individuals involved make the contents of the compliance plan itself, including how it is

updated and how records of compliance activities are maintained, important to consider. Similarly, how to safeguard the sensitivity of compliance information within the practice while maintaining appropriate records that compliance activities are truly taking place is a matter each emergency physician practice should address.

In light of the documentation requirements faced by physician practices, it would be to the practice's benefit if its standards and procedures contained a section on the retention of compliance, business, and medical records. These records primarily include documents relating to patient care and the practice's business activities. The designated compliance contact could keep an updated binder or record of these documents, including information relating to the compliance activities, internal investigations and internal audit results. Particular attention should be paid to documenting investigations of potential violations uncovered by the compliance program and the resulting remedial action. There is no requirement that the practice must retain its compliance records, but having all the relevant documentation relating to the practice's compliance efforts or handling of a particular problem can benefit the practice should it ever be questioned regarding those activities. If the practice decides to design a record system, privacy concerns, federal, and state regulatory requirements should be taken into consideration. In short, it is in the best interest of all physician practices, regardless of size, to have procedures to create and retain appropriate documentation. The following record retention guidelines are suggested:

- The length of time that a practice's records are to be retained can be specified in the physician practice's standards and procedures. (Federal and State statutes should be consulted for specific time frames, if applicable)
- Medical records (if in possession of the physician practice)^b need to be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption, or damage; and
- Standards and procedures can stipulate the disposition of medical records in the event the practice is sold or closed.
- It is recommended that groups consult with counsel about the way in which records should be handled to preserve attorney/client privilege. Although there is some dispute as to whether in house counsel also functioning as a corporate officer can claim attorney-client privilege. In addition, HIPAA privacy regulations have significance for record retention and that HIPAA will require its own compliance program, which is beyond the scope of this specific document. (See section on Legal Assistance, p.23)

ADDITIONAL CONSIDERATIONS

LEGAL ASSISTANCE

Provider, coding, and billing entities must comply with all applicable Federal law, State law, and local payer legal requirements. While Federal law is consistent throughout the country, State law and payer requirements are highly variable. Therefore, an attorney, knowledgeable of coding and billing requirements in the relevant jurisdiction(s), can be an invaluable asset in delineating expectations and compiling an effective compliance plan. Furthermore, there may be benefits in having an attorney participate in the development and implementation of monitoring initiatives.

^b The most common emergency physician arrangements make the hospital and not the practice the custodian of the official medical record. It is important that the practice ensures that its arrangement with the hospital provides for the appropriate retention of and access to the physicians' medical records.

Attorney/client privilege can offer some protection on compliance issues, although there is some dispute as to whether in-house counsel can claim attorney/client privilege. Discussion of these issues with your current legal counsel is advised. Some matters that would benefit from legal advice include retention of records, development of corrective action processes, implementing correction of problems going forward, and even advising regarding clauses in employment contracts that take into account compliance issues

CONCURRENT vs. RETROSPECTIVE MONITORING BY THE PHYSICIAN PRACTICE

Retrospective monitoring occurs after a claim has been submitted to a payer, and perhaps even after a payer has acted on the claim. Concurrent monitoring is performed prior to a claim being submitted to a payer. The Federal government states that provider knowledge of a claim inappropriately submitted to a relevant governmental payer creates an obligation to act on such knowledge either through refunding or reporting such knowledge.

Therefore, retrospective monitoring, which has the potential to demonstrate such inappropriately submitted claims, might create the quandary of what to report, how to report, and to whom to report it.

Presumably, effective concurrent monitoring should, at the least, significantly decrease the likelihood of such quandary occurring. An intervening educational program should be implemented to correct any discovered errors. Obviously, some retrospective monitoring will be required in order to demonstrate and/or refine the effectiveness of concurrent monitoring. If a problematic pattern is found, an obligation to correct prior claims (i.e. reimburse prior overpayments) might also arise.

REPORTING OBLIGATIONS OF THIRD PARTY CODERS/BILLERS

The OIG maintains that, if third party coding/billing entities find evidence that a provider client is engaging in misconduct, (e.g., inaccurate documentation and/or coding); the coding/billing entity should refrain from the submission of questionable claims and notify the client within 30 days of such determination.

If the coding/billing entity discovers credible evidence of the client's continued misconduct, or discovers evidence of flagrant or abusive conduct, the coding/billing entity should: 1) refrain from submitting any false or inappropriate claims; 2) terminate the client's contract; and/or 3) report such conduct to the appropriate Federal and State authorities. (See pg 8)

Additional compliance issues need to be taken into account when the group enters into a billing contract with a third party. Other matters that arise under the contract include, but are not limited to: responsibility for doing the coding, the billing company's responsibility to have a compliance plan, the emergency group's ability to review the compliance plan, and the obligation of the biller to bring any problem to the group or be foreclosed from making an additional report. Consider adding contract clauses which say that the billing company represents and warrants that it has not served as a whistleblower in the past and will not during the term of the agreement. While there is some dispute as to whether that is enforceable, there is a big difference between making sure that the billing company is doing the right thing and the billing company using its customer contracts as a hunting ground to make money on qui tam cases.

BILLING FOR NON-COVERED SERVICES AS IF COVERED

The OIG provides general guidance for billing for non-covered services as if they were covered. That language from the OIG is included here:

“In some instances, we are aware that physician practices submit claims for services in order to receive a denial from the carrier, thereby enabling the patient to submit the denied claim for payment to a secondary payer.

A common question relating to this risk area is: If the medical services provided are not covered under Medicare, but the secondary or supplemental insurer requires a Medicare rejection in order to cover the services, then would the original submission of the claim to Medicare be considered fraudulent? Under the applicable regulations, the OIG would not consider such submissions to be fraudulent. The denial may be necessary to establish patient liability protections. Medicare denials may also be required so that the patient can seek payment from a secondary insurer. In instances where a claim is being submitted to Medicare for this purpose, the physician should indicate on the claim submission that the claim is being submitted for the purpose of receiving a denial, in order to bill a secondary insurance carrier. This step should assist carriers and prevent inadvertent payments to which the physician is not entitled. (See the section on ABNs, p. 10)

In some instances, however, the carrier pays the claim even though the service is non-covered, and even though the physician did not intend for payment to be made. When this occurs, the physician has a responsibility to refund the amount paid and indicate the service is not covered.”

PROFESSIONAL COURTESY

On March 26, 2004, CMS released Phase II of the Stark regulations. Professional courtesy has been defined in this regulation and the conditions required to meet this arrangement are provided below. (See references at the end of document to access the full document).

“We are persuaded to promulgate an exception for certain services provided to a physician or his or her immediate family members. We are defining “professional courtesy” in § 411.351 as the provision of free or discounted health care items or services to a physician or his or her immediate family members or office staff. To qualify for the new exception, the arrangement must meet the following conditions:

1. The professional courtesy is offered to all physicians on the entity’s *bona fide* medical staff or in the entity’s local community without regard to the volume or value of referrals or other business generated between the parties;
2. The health care items and services provided are of a type routinely provided by the entity;
3. The entity’s professional courtesy policy is set out in writing and approved in advance by the governing body of the health care provider;
4. The professional courtesy is not offered to any physician (or immediate family member) who is a Federal health care program beneficiary, unless there has been a good faith showing of financial need;

5. If the professional courtesy involves any whole or partial waiver of any coinsurance obligation, the insurer is informed in writing of that reduction so that the insurer is aware of the arrangement.
6. The professional courtesy arrangement does not violate the antikickback statute or any billing or claims submission laws or regulations.

While professional courtesy discounts may be covered under the employee exception, nothing in this new exception precludes hospitals or other entities from extending their professional courtesy policies to employees, including non-physician employees, under the new exception. Nothing in these regulations should be construed as requiring or encouraging professional courtesy arrangements. Moreover, parties are cautioned that some professional courtesy arrangements may violate the antikickback statute or the civil monetary penalties law against giving inducements to Medicare and Medicaid beneficiaries (section 1128A (a) (5) of the Act). Concerns regarding those laws should be addressed to the OIG. Private insurers may also have concerns about professional courtesy in the form of coinsurance waivers. The requirement to notify private insurers of a professional courtesy arrangement may provide an additional check against abusive arrangements.”

GAINSHARING ARRANGEMENTS AND CIVIL MONETARY PENALTIES FOR HOSPITAL PAYMENTS TO PHYSICIANS TO REDUCE OR LIMIT SERVICES TO BENEFICIARIES

(Summary of a Special Fraud Alert issued by the OIG on this topic)

The term “gainsharing” typically refers to an arrangement in which a hospital gives a physician a percentage share of any reduction in the hospital’s costs for patient care attributable in part to the physician’s efforts. The civil monetary penalty (CMP) that applies to gainsharing arrangements is set forth in 42 U.S.C. 1320a-7a (b) (1). This section prohibits any hospital or critical access hospital from knowingly making a payment directly or indirectly to a physician as an inducement to reduce or limit services to Medicare or Medicaid beneficiaries under a physician’s care.

It is the OIG’s position that the Civil Monetary Penalties Law clearly prohibits any gainsharing arrangements that involve payments by, or on behalf of, a hospital to physicians with clinical care responsibilities to induce a reduction or limitation of services to Medicare or Medicaid beneficiaries. However, hospitals and physicians are not prohibited from working together to reduce unnecessary hospital costs through other arrangements. On a case by case basis, the OIG has approved certain types of gainsharing.

For example, hospitals and physicians may enter into personal services contracts where hospitals pay physicians based on a fixed fee at fair market value for services rendered to reduce costs rather than a fee based on a share of cost savings. Consult with competent legal counsel before entering into any gainsharing arrangements.

RENTAL OF SPACE IN PHYSICIAN OFFICES BY PERSONS OR ENTITIES TO WHICH PHYSICIANS REFER

(Summary of the Special Fraud Alert, February 2000)

Among various relationships between physicians and labs, hospitals, home health agencies, etc., the OIG has identified potentially illegal practices involving the rental of space in a physician’s office by suppliers that provide items or services to patients who are referred or sent to the supplier by the physician-landlord. A suspect arrangement is the rental of physician office space

by a durable medical equipment (DME) supplier in a position to benefit from referrals of the physician's patients. The OIG is concerned that in such arrangements the rental payments may be disguised kickbacks to the physician-landlord to induce referrals.

To avoid potentially violating the anti-kickback statute, the OIG recommends that rental agreements comply with all of the following criteria for the space rental safe harbor:

1. The agreement is set out in writing and signed by the parties.
 2. The agreement covers all of the space rented by the parties for the term of the agreement and specifies the space covered by the agreement.
 3. If the agreement is intended to provide the lessee with access to the space for periodic intervals of time rather than on a full-time basis for the term of the rental agreement, the rental agreement specifies exactly the schedule of such intervals, the precise length of each interval, and the exact rent for each interval.
 4. The term of the rental agreement is for not less than one year.
 5. The aggregate rental charge is set in advance, is consistent with fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program
- The aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purpose of the rental.

CONCLUSION:

It is clear that a laissez faire approach to medical documentation, coding and billing is problematic. Although Medicare often develops specific policies, other governmental payers (e.g., state Medicaid programs) as well as private payers may have no stated policy concerning a particular subject or their policies may substantively differ from Medicare and/or each other. Furthermore, providers must comply with payer policies only when there is a legal requirement to comply (e.g., a participation contract between a provider and payer). And finally, laws and Medicaid programs policies often vary among States. These payer dissimilarities, differing relationships between providers and payers, and variations in jurisdictional law all contribute to making the issues associated with correct coding and billing highly complex. Nevertheless, health care providers will need to be aware of and address these elements.

Issues such as accountability for coding, billing processes, education, monitoring, and discipline, must be incorporated in any formalized compliance program developed by the group, hospital, or individual emergency physicians. Contractual relationships between emergency physicians and their employers and/or practice locations need to clearly delineate compliance responsibilities. It is evident that development and implementation of an effective and usable compliance program is rapidly becoming an industry standard. Compliance programs are a powerful tool to promote a strong ethical approach to coding/billing and might provide at least a partial mitigation of any penalties resulting from a governmental audit or fraud investigation.

FREQUENTLY ASKED QUESTIONS (FAQs) ON COMPLIANCE ISSUES

- 1. Q.** Am I liable for any coding errors made by the hospital that does my billing?
A. The government maintains that ultimately the provider of service is responsible for the claims filed using his/her provider number. The principal is responsible for the acts of the agent.
- 2. Q.** I never see the charts after I finish with them. Someone else does the coding and billing. Am I in compliance?
A. PERHAPS. Compliance is an outcome measure. If your documentation and the subsequent coding and billing are in compliance, then you will be in compliance. If, however, the documentation, coding, and/or billing are not in compliance, then you might not be in compliance. The best way to assure that you are in compliance is to be familiar with the compliance plan of any facility or group with whom you do business. The use of audits can assure compliance. ACEP policy states that the emergency physician should retain the right to review what is billed and collected for his or her services on his or her behalf. In addition, the emergency physician should be knowledgeable about state regulations regarding fraud and abuse and reassignment issues.
- 3. Q.** Can I just use the OIG Model Compliance Plan for my group/facility compliance plan?
A. No, the OIG specifically states that its document is not a model compliance plan or program, but rather only provides suggested guidelines with regard to what should be taken into account for the content of your plan. You must tailor these guidelines to your specific situation for your plan and program to have any value.
- 4. Q.** Do we need to appoint a compliance officer from our group to be responsible for this? Is he/she then liable for anyone or everyone else's mistakes?
A. Yes, a compliance officer should be identified. If the resource constraints of physician practice make it necessary, the OIG guidance allows for a physician practice to designate more than one employee with compliance monitoring responsibility. In lieu of having a designated compliance officer, the physician practice could instead describe in its own standards and procedures the compliance functions for which designated employees would be responsible. One employee may be responsible for conducting or arranging for periodic audits and ensuring that billing questions are answered. Therefore, the compliance related responsibilities of the designated person or persons may be only a portion of his or her duties. While that position might carry some liability, the government maintains that ultimate liability still rests with the provider in whose name the claim is filed. You may wish to investigate the appropriateness of Director's and Officer's liability insurance as well as Errors and Omissions insurance.
- 5. Q.** Won't a compliance plan just be used against me in the case of an audit?
A. Absence of a compliance plan will not help you in cases of bad audit outcomes. Making the effort to produce an effective compliance plan demonstrates an attempt to understand and follow the rules and makes it harder to apply the "willful and knowingly committed fraud" or the "willful blindness" tests for fraud, unless you fail to follow your compliance plan. A compliance program is essentially a quality control device. It can't hurt you unless you don't pay attention to it. One might think of one's compliance program as a form of risk management and insurance to limit the likelihood of illegal or unethical behavior and mitigate the damages if errors occur.
- 6. Q.** What are my responsibilities to ensure billing is done correctly for teaching physician services involving residents provided to Medicare beneficiaries?

- A.** As part of the regular compliance guidelines, you must follow the CMS guidelines for services of a teaching physician involving the work of residents as spelled out in the December 8, 1995 Federal Register and Transmittal 1780. The personal involvement of the teaching physician must be demonstrated in the documentation. This information appears on the ACEP web site at www.acep.org.
- 7. Q.** What about compliance for services provided by PAs & NPs, to Medicare beneficiaries?
A. As part of the regular compliance guidelines, you must follow the CMS guidelines for provision of services. Updated information may be found in Transmittal 1776.
- 8. Q.** Is offering professional courtesy really fraud?
A. Offering professional courtesy is not a per se violation. However, problems might develop based upon why and how you offer such courtesy. If courtesy is offered with intent to increase referrals, such activity might raise legal concerns. This may be considered as a possible kickback by the OIG. Also, routine waiver of co-payments, co-insurances or deductibles may be construed as insurance fraud because you are in effect charging the carrier more than you are actually willing to accept. If you decide to provide professional courtesy, consider not billing. (See Professional Courtesy section)
- 9. Q.** Is my billing company required to report me if they suspect fraudulent activity?
A. If a billing company has credible evidence of fraudulent activity, it should not submit the questionable claims. The OIG Compliance Guidance suggests that a billing company should notify you within 30 days of first finding such activity. If the activity continues, the billing company should terminate your contract AND/OR report you to the government within 60 days of finding credible evidence of violation. The billing company does have liability itself if it is found to have submitted inappropriate claims. These liabilities exist under the federal health care laws as well as under the conspiracy statutes and possible state statutes.
- 10. Q.** What should I do if the OIG or other government investigators shows up at my door?
A. Designate one person to take charge of the situation, whether it be your compliance officer or an attorney. Verify the documents that authorize the audit before releasing any information. Be cooperative, but it is often prudent to not volunteer any additional information.
- 11. Q.** I am a teaching physician. When providing services to government beneficiaries, can I use the documentation of a medical student in the same way I use a resident's notes?
A. CMS' teaching physician requirements describe the conditions under which documentation by physicians in graduate training ("residents and fellows") can be used as part of the teaching physician's documentation. Medical students are not physicians, and their documentation cannot be used this way. However ancillary emergency department staff members, including medical students, can document a patient's review of systems and past/family/social history. CMS allows the attending physician to use this information if the time and date of the charting is referenced along with a note by the physician confirming, revising, and/or expanding the information recorded by ancillary staff. Any practice involved with medical student rotations should address this compliance issue.
- 12. Q.** Is it better to have an outside entity do our group's routine compliance audits and how many charts should be reviewed in this exercise?
A. The purpose of a periodic internal review is to self-monitor your compliance program. There may be a perceived benefit from having an outside entity perform this function. In either case, the sample of charts used for such monitoring should be of sufficient size to provide a good cross

section of your coding and billing practices. CMS provides no guidelines regarding the absolute number of charts to be audited and there is wide variability with regard to what constitutes an appropriate number. The OIG recommends that periodic audits be conducted at least once a year using a randomly selected number of medical records to ensure the coding was performed accurately. Although there is no set formula for how many records should be reviewed, a basic guide is five or more medical records per Federal payer or five to ten records per physician. At a minimum, the OIG encourages physician practices to conduct a review of claims that have been reimbursed by Federal health care programs. The real issue is to evaluate each physician in the group to determine whether there are patterns.

- 13. Q.** Is there any special compliance requirement for the 99285 acuity caveat?
- A.** The key components of emergency department E/M code 99285 are a comprehensive history, comprehensive physical examination, and medical decision making of high complexity. The level 5 acuity caveat that pertains to code 99285 is based on the language in the CPT book that reads "...requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status." CMS has apparently adopted the CPT coding principle that allows a physician to defer the usual requirements of performing these key components of 99285, if the patient's condition and/or mental status does not reasonably allow these elements of the E/M to be fully provided, and if the patient's presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. However, some regional Medicare carriers apply the caveat to only the history component, while others apply the caveat to both the history and examination components, but not medical decision making. Physicians should state why the caveat is being invoked in their documentation of the patient encounter.
- 14. Q.** What is the best way for our group to handle reports of compliance violations from our own employees? I'm concerned about qui tam activity.
- A.** The key to an effective compliance program is communication; both in terms of disseminating policies and reporting suspected problems. An open line of communication is an integral part of implementing a compliance plan. Many qui tam suits seem to arise from frustrated employees feeling like they do not have a way to report suspected violations internally. OIG guidance has encouraged the use of several forms of communication between compliance officers and other personnel. Some suggested communication methods are use of a designated email address, or a telephone "hotline" that employees may call to anonymously report compliance violations. One or more of these methods could be outsourced to allay employees' fears about confidentiality or reprisals for reporting suspected violations. These methods may not be feasible in a small group practice, but any method chosen should be user-friendly and display a spirit of "open door" communication with assurances of no retribution for reporting conduct that a reasonable person acting in good faith would have believed to be erroneous or fraudulent. In addition to whatever other method of communication is being utilized, the OIG recommends the physician practice post the HHS-OIG hotline telephone number (800-HHS-TIPS) in a prominent place.

References

1. OIG Special Fraud Alert in the Federal Register, 12/19/1994, 59 Fed Reg 65,373.
2. Queen, David D. *Designing a Health Care Corporate Compliance Program*. Second Edition. Atlantic Information Services, Inc. 110 17th Street NW, Suite 300 Washington, D.C. 20036. (202) 775-9008
3. Malone, Sue MA. *Essential Compliance Documents: Understanding Healthcare Fraud and Abuse*. Clinical Information Consulting. 148 West Mikado Drive, Colorado Springs, CO 80919. (719) 266-1431.
4. *Current Procedural Terminology for Hospital Outpatient Services*. CPT Intellectual Property Services American Medical Association, 515 North State Street, Chicago, IL 60610, (312) 464-5930
5. Today's Corporate Compliance for the Health Care Professional. Health Care Compliance Association (HCCA), 1211 Locust Street, Philadelphia, Physician Assistants 19107. (888) 580-8373.
6. Medicare Compliance Alert (newsletter). UCG, 11300 Rockville Pike. #1100, Rockville, MD 20852. (888) 287-2223.
7. Report on Medicare Compliance (newsletter). Atlantic Information Services, Inc., Washington, DC (800) 521-4323. www.aispub.com.
8. Bitterman, Robert A. MD, JD, FACEP. *Providing Emergency Care Under Federal Law: EMTALA*. American College of Emergency Physicians, P.O. Box 619911 Dallas, Texas 75261-9911. (800) 798-1822
9. American College of Emergency Physicians. Emergency Physician Contractual Relationships [policy statement] Revised 1999. Available at <http://www.acep.org/1,4243,0.html>

Web Sites

1. ACEP's Comment Letter to the OIG on Compliance Program Guidance for Physician Practices <http://www.acep.org/library/pdf/OIGreport.pdf>
2. Advanced Beneficiary Notice Links <http://cms.hhs.gov/medlearn/refabn.asp>
http://www.cms.hhs.gov/manuals/104_claims/clm104c30.pdf
3. The American Health Lawyers Association www.healthlawyers.org
4. CMS Program Transmittals and Program Memos http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
5. CMS Update to EMTALA http://www.access.gpo.gov/su_docs/fedreg/a030909c.html
6. Compliance Links <http://corporateethics.com/resources.html>

7. EMTALA Links
www.acep.org/1,441,0.html
8. The False Claims Act Legal Center
www.taf.org
9. GAO Report on EMTALA
<http://www.acep.org/2,2788,0.html>
10. HIPAA
<http://www.cms.hhs.gov/hipaa/>
<http://www.acep.org/1,32638,0.html>
11. National Health Care Anti-Fraud Association
www.nhcaa.org
12. OIG Compliance Program Guidance (includes model compliance plans)
<http://oig.hhs.gov/fraud.html>
13. OIG Compliance Program Guidance for Individual and Small Group Physician Practices
<http://oig.hhs.gov/authorities/docs/physician.pdf>
14. OIG Semiannual Reports:
<http://oig.hhs.gov/publications/semiannual.html#1>
15. Stark Phase II
http://www.access.gpo.gov/su_docs/fedreg/a040326c.html