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Small practice compliance plan offers guidance and some flexibility

Guideline emphasizes adherence to seven basic compliance principles

Individual physicians and small group practices lacking the resources to institute a full-blown compliance program are free to contract out the duties of an in-house compliance officer, according to guidelines for smaller physician practices released June 7 by the U.S. Department of Health and Human Services' Office of the Inspector General (OIG).

While refusing to define the difference between a small and big practice, OIG chief counsel **D. McCarty Thornton** says larger physician groups also should use this guidance — plus guidelines already issued for third-party billing companies and clinical labs — as the baseline for creating their own compliance programs.

The plan has been in development since last November, and the OIG hopes to finalize it this fall.

"It seems the OIG is showing more sensitivity to our argument that you can't have a one-size-fits-all guidance when it comes to physicians by offering some less-costly compliance alternatives," says **Robert Doughtery**, vice president for government relations of the American College of Physicians-American Society for Internal Medicine in Philadelphia.

The draft guideline is not an official rule or regulation, but it spells out what the OIG feels is a properly designed and managed compliance program for physician practices. "Adherence to these guidelines is strictly voluntary," Thornton stressed at the press conference unveiling the guidelines.

The bottom line is that if federal inspectors question a provider's actions, compliance with the guidance tends to create an unofficial assumption that the problem is probably a simple mistake rather than intentional attempt to defraud. However, if investigators don't see what they feel is an adequate effort to implement those compliance points, that could raise a red flag prompting a closer look at the group's books.

"The idea that this is a voluntary program — but not really — sends a

mixed message which we are not comfortable with," says **Arron Krupp**, a lobbyist for the Medical Group Management Association (MGMA) of Englewood, CO.

MGMA's reaction to the proposal also is mixed. "We're happy to see an attempt to make the guidance more flexible. But, frankly, we feel it's still too expensive for many smaller practices to implement," notes Krupp. "Basically, we just don't think the guidelines are necessary."

Mistakes vs. fraud

Physician groups have complained that in the past, doctors were treated like criminals for matters that were basically innocent billing mistakes or legitimate differences of opinion. In what amounts to a peace offering, the OIG will not subject physicians to civil or criminal penalties for innocent mistakes, says OIG lawyer **Larry Goldberg**. "We are not seeking to punish people for honest billing errors," he says.

Should an unintentional billing error be uncovered, Goldberg says the agency is only interested in having any overpayment returned; it won't even tack on any additional fines or penalties.

However, if the feds think a provider knew a false claim was being filed or that it exhibited reckless disregard or deliberate ignorance of inappropriate behavior, government lawyers will be ready to pounce.

Some actions that fall under this category include simply refusing to set up a system to stay current with government coding and reimbursement rules, or knowingly submitting an inflated bill "just to see if the carrier will pay it," says Thornton.

As with its previous compliance guidelines, the solo and small group practice guidance is based on seven principles the OIG says are fundamental to creating a legitimate compliance program:

1. **Written policies and codes of conduct**. It's not a compliance program if your policies and procedures are not written down. Specific high-risk compliance areas the OIG wants practices to pay particular attention are:

❑ **Coding and billing.** Hot-button topics to watch for include billing for items or services not rendered or provided as claimed; submitting claims for equipment, medical supplies, and services that are not reasonable and necessary;

Investigators increase focus on kickbacks

Cases heading to new forum

To drive home how serious they take the new compliance guidelines being developed by the Office of the Inspector (OIG), government compliance cops are launching a campaign to pinch providers who appear to be on the wrong side of federal referral and anti-kickback rules.

"We definitely plan to increased enforcement of the anti-kickback statute," reports **Kevin McAnaney**, who runs the OIG's industry guidance programs. "My advice is noncompliance with the new physician guidelines would be considered reckless," warns **Lewis Morris**, the OIG's deputy associate general counsel.

Referring to a study in the April 12 *Journal of the American Medical Association* that concluded 39% of physicians have lied to secure insurance coverage for a patient, **Leslie Caldwell**, an assistant U.S. attorney in the Justice Department's northern California district, predicted, "We may go after somebody to send a message."

Another sensitive area for physicians could be charges of kickbacks relating to office rental agreements covered under the OIG's recent safe harbor guidelines.

As part of this action, the OIG will bring the kickback cases it comes across to administrative law judges rather than run them through the regular court system. The reasoning behind this tactic is that the government's burden of proof is lighter when trying a case before an administrative law judge, making it easier to win the case.

When it comes to levying judgments, administrative law judges can bar providers from participating in federal heath programs plus hit them with civil fines of up to $50,000 per violation.

Other areas where federal investigators plan to focus attention are nursing homes, long-term-care facilities, and pharmaceutical benefit management agreements. There also will be more audits of managed care companies, with investigators looking for Medicare HMOs that cherry-pick healthy patients for membership and avoid signing up sicker seniors. ■

double-billing; billing for noncovered services as if covered; knowingly misusing provider ID numbers resulting in improper billing; billing for unbundled services; failure to properly use coding modifiers; and upcoding.

❑ **Reasonable and necessary services.** Compliance polices should stress that claims will be submitted only for medical services meeting Medicare's accepted definition of reasonable and necessary.

❑ **Documentation.** Medical documentation needs to be timely, accurate, and complete. That means being able to read the record, patient encounter information that includes reason for the encounter, relevant history, physical exam findings, prior diagnostic test results, assessment, clinical impression or diagnosis, and the date and identity of the observer.

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred. Past and present diagnoses also should be accessible to the treating and/or consulting physician. Appropriate health risk factors should be identified. The patient's progress and response to — or changes in — treatment and diagnosis need to be documented.

The OIG is very interested in seeing providers follow proper CPT and ICD-9-CM documentation and chart procedures and correctly complete the HCFA 1500 Form.

❑ **Kickbacks, inducements, and self-referrals.** Compliance programs should ensure providers adhere to federal anti-kickback and self-referral laws. The OIG wants physicians to pay special attention to any arrangements they have with hospitals, hospices, nursing facilities, home health agencies, durable medical equipment suppliers, and related vendors. **(See story on space rental agreements, p. 96.)**

❑ **Record retention.** A physician practice's compliance procedures should contain a section on the retention of compliance, business, and medical records," along with institution of a records retention system, advises the OIG.

2. **Designating a compliance officer or contact.** Practices need to designate one person from their staffs to oversee the compliance program. A critical criterion for selecting the compliance officer is that his or her job be independent enough to avoid possible conflicts of interests between staff duties and compliance responsibilities. More than one person can be appointed to monitor compliance. Such staffers will be called compliance contacts.

Practices also can choose to outsource part or all of the compliance officer's responsibilities to a third party such as a consultant, physician practice management company, management services organization, independent practice association, billing company, or professional association. Or, they can choose to be covered under the compliance program of another institution, such as a

OIG tightens up provider 'wiggle room'

Maximum penalties are boosted

The Department of Health and Human Services' Office of the Inspector General has issued a final rule eliminating much of the "wiggle room" providers had when defending themselves against unknowingly submitting inappropriate claims. For starters, the rule increases the maximum civil monetary penalties (CMPs) against providers from $2,000 to $10,000 per false claim.

Under the rule, providers and individuals can be held liable under CMP even if there is no proof they intended to defraud the government. In other words, ignorance is no defense. In fact, the rule says providers and other individuals can be held liable if they act in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth.

The final rule also:

— extends current CMP provisions to include all federal health programs;

— allows CMPs to be assessed for incorrect coding, medically unnecessary services, and offering remuneration to beneficiaries to influence their choice of a particular provider or supplier;

— establishes a new CMP for physicians' false certification of eligibility for Medicare-covered home health services;

— authorizes a fine up to $10,000 a day when an individual who is excluded from participating in a federal health program is retained in a prohibited relationship with a participating health care entity.

The full text of the rule is available at http://www.hhs.gov/oig/new.html. ■

hospital. However, those can't be just paper appointments. The OIG wants any outsourced or shared compliance person to have enough interaction with the practice to do the job effectively.

3. **Training and education**. Practices must ensure all employees are at least familiar with the key risk areas identified in this guidance and the annual OIG work plan, which highlights the agency's enforcement priorities for the coming year. The OIG wants to see new hires begin compliance training within 60 days of coming aboard. It's also asking practices to perform annual training emphasizing that compliance is a condition of continued employment with the group.

However, just giving employees compliance materials to read on their own will not meet the OIG's standards. The draft calls for such things as in-house training sessions, outside seminars, newsletters, videos, or often-used office bulletin boards to be part of your training effort.

4. **Communication**. It's not necessary to install a telephone hotline or e-mail system for employees to ask for information, pose questions or report possible problems. But the OIG does want to see evidence of a clear open-door policy when it comes to registering concerns. The other side of that is a strong emphasis on the fact employees can report any questions without fear of retribution.

5. **Internal audits and monitoring**. The OIG suggests the person in charge of a billing compliance program work with a designated physician to perform a regular self-audit of claims based around the practice's top 10 claim denials — or top 10 services provided.

Things the OIG wants the audit to look for include:

- ❑ bills accurately coded to reflect the services provided;
- ❑ services or items medically necessary and documented by specific codes;
- ❑ possible data errors;
- ❑ confirmation that orders were written and signed by a physician;
- ❑ confirmation that any tests ordered were performed and properly billed;
- ❑ correct assignment codes and modifiers.

6. **Disciplinary actions**. The OIG suggests consistent and appropriate sanctions ranging from oral warnings to termination for any physician or employee violating the practice's compliance program. That should include anyone failing to report possible violations or violators. If any questionable conduct comes to light, the compliance officer or contact needs to make a written entry noting date of the incident, name of the reporting party, name of person responsible for taking action, and any follow-up action taken.

7. **Responding to detected offenses**. Practices should quickly investigate and correct any possible compliance questions and take "decisive steps" to correct the problem. This could include such things as returning an overpayment, reporting the problem to government officials, or referring the situation to law enforcement.

Providers have a 90-day grace period from day of discovery until a possible problem is reported

OIG offers safe harbor for rental agreements

How to avoid prosecution

Providers who rent space to other physicians and suppliers who generate business for them can immunize themselves from prosecution under anti-kickback laws by adhering to all of the following safe harbor criteria, says the Department of Health and Human Services' Office of the Inspector General. Specifically, the agency says:

— Agreements must be in writing and signed by all parties.

— Contracts must specific and cover all the premises being rented for the term of the agreement.

— Agreements that give the lessee access to the premises for only certain time intervals instead of on a full-time basis must specify the times, their precise length, and the exact rent for this use.

— Rents must be set in advance and be consistent with fair market value in an arms-length transactions.

— Rents cannot be determined in a manner that considers 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.

— Total space rented can not exceed that reasonably necessary to accomplish the commercially reasonable business purpose of the rental. ■

to the appropriate government authorities before any future delay in notification is considered a bad faith action. Failure to report could "seriously endanger the reputation and legal status of your practice," notes the draft.

When it comes to notifying and returning an overpayment, a "knowing and willful failure to disclose overpayments within a reasonable period of time could be interpreted as an attempt to conceal the overpayment . . . establishing an independent basis for a criminal action," stresses the OIG. ■

Review your space rental agreements

Supplier rentals are considered suspect

Prompted by reports that some suppliers and providers are using overpriced office rental arrangements to disguise kickbacks to practitioners, earlier this year the Office of the Inspector General (OIG) issued a fraud alert warning physicians that any rental arrangements they have with health care suppliers and/or other providers must reflect fair-market value. **(See *Physician's Payment Update,* April 2000, pp. 51-53.)**

Given the OIG's current policy of ferreting out potential kickback schemes, any practice renting space to outside providers or suppliers would be wise to have its lawyer review those arrangements. Areas to which the OIG is paying particular attention include rental arrangements between physician-landlords and:

• comprehensive outpatient rehabilitation facilities that provide physical and occupational therapy and speech language pathology services in physicians' and other practitioners' offices;

• mobile diagnostic equipment suppliers that perform diagnostic-related tests in physicians' offices;

• suppliers of durable medical equipment, prosthetics, orthotics, and supplies that set up "consignment closets" for their supplies in physicians' offices.

Under the OIG's new policy, any payments for rental of consignment space or closets in physicians' offices automatically are suspect of being disguised kickbacks.

Here's a list of specific situations the OIG says are questionable:

• **Rental amounts**. Rents that do not reflect fair market value, are not fixed in advance, or are based directly or indirectly on the volume or value of referrals or other business generated between the parties will prompt an audit.

Examples would include:

— physicians who charge a supplier a higher rent than someone they could not refer patients to;

— rent for a sublease that exceeds the per square foot price of the primary lease;

— rents subject to modification more than once a year;

— rents that vary with the number of patients or referrals;

— rental contracts that set a fixed rental fee per hour but do not fix the number of hours or the schedule of usage in advance (i.e., "as needed" arrangements);

— rents that are only paid if there are a certain number of federal health care program beneficiaries referred each month;

— rental amounts that are conditioned upon the supplier's receipt of payments from a federal health care program.

• **Time and space considerations.** Suppliers should only rent premises of a size and for a time period that is reasonable and necessary for their business purposes, says the OIG. Renting more space than needed "creates a presumption that the payments may be a pretext for giving money to physicians for their referrals," notes the alert.

Examples of suspect arrangements include:

— paying rent for space that is unnecessary or not used by the provider/supplier. For instance, a comprehensive outpatient rehabilitation facility only requires one examination room and rents physician office space one afternoon a week when the physician is not in the office. However, it pays rent based on the square footage for the entire office even though it only uses one examination room;

— paying rent for time when the space is being use by the supplier/provider. For instance, an ultrasound supplier only has enough business to justify using one examination room four hours each week but rents the space for eight hours per week;

— non-exclusive occupancy. Rather than renting space in a physician's office, for instance, a physical therapist moves from examination

room to examination room, treating patients after they have been seen by the doctor. Because no particular space is rented, the OIG says it would "closely scrutinize any proration of time and space used to calculate" rent paid by the therapist.

• **Rent calculations.** To avoid investigation, rent should be based on the amount of space and duration of time the premises are used. Depending on the circumstances, the supplier's rent can consist of three components: exclusive office space, interior office common space, and building common space. Here are requirements for each:

1. **Apportionment of exclusive office space.** The supplier / provider's rent must be calculated based on the ratio of the time it uses the space divided by the total amount of time the physician's office is in use. Also, the rent should be based on the ratio of the amount of space that is used exclusively by the supplier / provider to the total amount of space in the physician's office.

2. **Apportionment of interior office common space.** Where permitted by regulations, rental payments also may cover the interior office common space in physicians' offices that is shared by the physicians and any subtenants, such as waiting rooms.

If other suppliers / providers use this common area for their patients, "it may be appropriate for the suppliers to pay a prorated portion of the charge for such space," says the OIG.

However, any "charge for the common space must be apportioned among all physicians and subtenants that use the interior office common space based on the amount of non-common space they occupy and the duration of such occupation."

Payment for the supplier / provider's use of office common space should be based the ratio of the exclusive space they use compared to total amount of available space (less common areas).

3. **Apportionment of building common space.** If a physician pays a separate charge for areas of a building that are shared by all tenants, such as building lobbies, it may be appropriate for the supplier / provider to pay a prorated portion of such charge, the OIG notes. But the cost of the building's common space must be apportioned among all physicians and subtenants based on the amount of noncommon space they occupy and the duration of such occupation. ■

Is capitation losing some of its allure?

Some insurers move back to fee-for-service

It's still more of a trickle than a full-fledged trend, but more insurers seem to be falling out of love with capitation — the payment method many consider the backbone of managed care — and are taking a second look at traditional fee-for-service payments.

"We've notice some shift away from capitation towards fee-for-service," notes **Joel Shoolin**, MD, medical director of the Chicago-area Advocate Lutheran General Physician Hospital Organization.

According to InterStudy, a St. Paul, MN-based HMO research company, studies indicate the percentage of HMOs using capitation to reimburse primary care physicians dropped from 78.7% in July 1998 to 65.7% in July 1999. Meanwhile, the percentage of HMOs using capitation to pay specialty physicians fell from 56.4% in July 1998 to 43.5% in July 1999.

This doesn't mean capitation is going to disappear anytime soon. In fact, the total number of people enrolled in plans that use at least some capitation is still on the increased, InterStudy notes.

The reason for this shift is that competition combined with much more efficient medical practices mean it is often cheaper for insurers to pay claims on a case-by-case basis than a prearranged capitated rate. "The insurers that are dropping primary care capitation realized they were paying more for capitation than for fee-for-service," observes **Clifford R. Frank**, a Jacksonville, FL-based capitation consultant.

Some HMOs that have dropped the cap plan, according to the research by the American Medical Association, include:

— United Healthcare of Colorado discontinued a capitation agreement last March with a third-party administrator that paid cardiologists on an episode-of-care basis. United now pays all 4,000 doctors in its Colorado network using discounted fee-for-service.

Nationally, United Healthcare, which already uses fee-for-service reimbursement for 90% of its physician contracts, plans to cut its reliance on

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Physician's Coding Strategist™

Involve doctors *and* coders in improving outcomes

Program helped slash complication rates

A creative and comprehensive project to bring physicians and coders together to better measure clinical outcomes has helped one Texas hospital slash its complication rate by dramatically improving the quality of physician documentation. But the changes leading to the turnaround weren't easy, and the fix wasn't quick. At the heart of the solution was the need to create an atmosphere of trust and understanding between physicians and coders.

Five years ago, Covenant Medical Center in Lubbock, TX, began a project to benchmark clinical outcomes data with peer facilities in Texas and the South. Results from that project indicated that the medical center could improve length of stay, mortality rate, and cost and complication rates for at least some of the 25 top DRGs and procedures identified as being part of the hospital's strategic priorities.

The problem was that when the data were presented to the medical staff, physicians questioned their accuracy — particularly the accuracy of the complication rates, which were based on coded data entered into the hospital's data repository.

"Basically, our physicians had a tendency to blame the coders for data quality," says **Janice R. Noller**, RRA, CCS, CPHQ, quality improvement specialist in the quality management department at Covenant.

Back then, Noller says, the coders had been sending occasional notes to the physicians requesting clarification on certain coding issues based on the physicians' documentation in the medical record. "They met with resistance from the physicians. It may just have been a communications problem," she says. "Coders and physicians have a problem communicating anyway, no matter where you go. They speak different languages, and they have to reach a common language somewhere."

Reaching common ground was a difficult proposition, however, because the physicians blamed the hospital's coders for inflating complication rates by "just picking everything up as complications," Noller says.

"Evidently, there was not a whole lot of communication explaining to physicians when and why things are coded as complications. As a result, they felt that there were too many issues with the coding, the documentation, and the whole communication process. We felt there was definitely an opportunity there to investigate and see what was going on," she adds.

Ensuring data accuracy

It wasn't yet clear whether the hospital's high complication rates were driven by coding or by physician documentation. Quality managers wanted to ensure that data used in clinical outcomes monitoring were accurate and consistent.

To investigate the complication rates, they first sought to define the term and the codes to be monitored on an ongoing basis. They reached a consensus with the director of medical records and the coding supervisor to use the ICD-9-M code range 996.00-999.9 in calculating the facility's complication rate. In June 1996, a certified coding specialist was added to the quality management department to help with the project.

Noller used the hospital's decision support system to list every DRG for a six-month period and the number of complications in the 996.00-999.9 code range for each. **(See table for sample**

Source: Covenant Medical Center, Lubbock, TX.

data, above, top.) Then she looked at the total number of cases for each complication regardless of the DRG. **(See table for sample data, above, bottom.)**

After comparatively analyzing the two lists, she determined that her first priorities should be DRG 358 (uterine and adnexa procedures for nonmalignancy with CC, including hysterectomies), DRG 148 (major small and large bowel procedures with CC), and code 997.4 (digestive system complications).

Quality management performed an extensive medical record review on all the cases in DRGs 358 and 148 with the secondary diagnosis code of 997.4. As a result of that review, Noller identified two trends:

- Accurate code assignment had been made due to physician documentation of the term "postoperative ileus."
- A physician documentation pattern in discharge summaries was noted: "Patient's postoperative course was complicated by ileus."

Staff sought to determine whether the clinical treatment of patients coded with this complication differed from those not coded with the complication. In most cases, those patients did not require more sources, additional length of stay, or additional monitoring. Given those facts, Noller questioned why the physicians documented the ileus complication in their discharge summaries. The physicians replied that the coding technicians weren't familiar with the clinical aspects of ileus, as well as other conditions that commonly occur postoperatively but aren't necessarily complications, such as atelectasis, hemorrhage, hematoma, and fever.

"The physicians were very adamant that some of the things that the coders were coding as complications were actually clinically things that normally occur after an open abdominal procedure," Noller says. Meanwhile, "[the coders] wanted me to be able to go to the physicians on a regular

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Source: Covenant Medical Center, Lubbock, TX.

basis and say, 'These are the data, this is why they appear this way, and this is what we'd like you to do to help the coders. Meanwhile, the coders will try to help you in understanding why they're asking what they're asking for.' This was not an overnight process. It was probably anywhere from a year to a year and a half before I even got a few physicians to finally give me some positive responses."

One of the biggest obstacles to improving the communication process was the physicians' idea that the coding of a complication meant they had done something wrong. Noller reports that it took almost a year to convince them otherwise.

To facilitate greater cooperation among the physicians and coders, Noller initiated a three-pronged action plan:

1. She started a coding newsletter in January 1997 to improve communication and educate the medical staff, their office staffs, and hospital staff on coding and documentation issues. Noller writes the newsletter, titled *Quality Notes*, which is edited by a physician champion. Currently, the newsletter has expanded its focus to include other health care issues, such as case management, fraud and abuse, and state and federal health care legislation. About 1,000 copies are distributed every other month.

2. Noller formed an ad hoc group of physicians to work with her and the coding supervisor to determine a set of basic clinical guidelines to assist the coding technicians in making decisions when it came to coding a condition as a complication. The group concentrated on the "complications" regarded as problematic by the physicians: ileus, hemorrhage, hematoma, atelectasis, and fever. The group was formed about the same time the newsletter was launched, six months after Noller came on board at Covenant.

"I thought that a six-month period was pretty good, to get these docs willing to work with us instead of being antagonistic," she says.

3. A few months later, Noller helped develop a coding subcommittee of the hospital's resource steering committee. The resource steering committee handles information management for the entire facility, including medical records, coding, and data quality.

"It was felt that because of all the coding and billing issues out there, a coding subcommittee would be useful in discussing these issues and working through them," Noller says.

Also, a process was formalized for referring coding discrepancies found on medical record reviews performed by the quality management department. **(See flowchart illustrating the chart review process, p. 101.)** Two databases — one to assist in communicating coding and documentation trends from quality management to medical records, the other to help quality management keep track of all individual record reviews and results — also were constructed.

Dramatic results

The results so far have been dramatic. For example:

- Within six months, the incidence of code 997.4 in DRG 358 decreased from 12.6% to 3.03%. A further review discovered that physician practice patterns in documenting ileus as a complication had changed.
- As a result of the education efforts directed toward physicians, doctors are now actually requesting presentations on coding guidelines.
- Noller reports that the quality management department now believes the data used in clinical outcomes monitoring and reporting are much more accurate and consistent.

"I think the physicians are starting to understand where the coders are coming from," Noller says. She credits the hospital's medical staff leadership for helping to facilitate the change. "Our medical director of quality improvement has always been able to work with our other medical staff leaders to get the medical staff involved in quality improvement housewide."

Also helpful was a medical staff leadership group called the clinical outcomes improvement team, made up of physician section chiefs. "They were the first to hear some of this information," Noller says.

"At the time, they were concerned from a monetary standpoint, because our hospital was undergoing talks of a merger with one of our main competitors. Administration was saying, 'Listen, guys, if documentation will help improve our financial picture, then that's what we need to do.' Like every other quality initiative, it has to start from the leadership on down. So, through that leadership role and our physician champions, and showing the physicians that it's not just the hospital that's affected but their office and business health as well, it finally sank in a little bit," she explains. ■

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capitation even more, say industry analysts.

— Cigna Healthcare of Colorado and Blue Cross Blue Shield of Florida have dropped capitation and switched back to discounted fee-for-service for primary care over the past year.

— PacifiCare Health Systems, which uses capitation for 90% of its contracts, says it is considering a "more flexible approach" to its methods of payment. Among the available options is discounted fee-for-service reimbursement for medical groups. ■

New PPS system carries requalification clause

Changes required by new PPS system

Medicare's new prospective payment system for hospital outpatients may require some physicians to be recertified by the Health Care Financing Administration (HCFA).

Physicians considered to be off-campus and some on-site physician practices that are owned by a hospital must be recertified by HCFA to ensure they meet the agency's new qualifications before being reimbursed by Medicare. This new requalification rule goes into effect Oct. 7. The new prospective payment system is expected to go into effect in July.

Some facilities and organizations that currently comply may find it hard — or impossible — to qualify for Medicare payments under the new arrangement. HCFA argues that it needs to implement these new standards to avoid several problems, including the following:

— inappropriate reimbursement;

— unwarranted Medicare coinsurance payments for facility services;

— inadequate physician supervision of hospital outpatient department services rendered incident to physician services;

— inadvertently certifying off-campus outpatient facilities not meeting health and safety requirements.

According to an analysis by the Medical Group Management Association of Englewood, CO, to qualify for provider-based status under the new rule, health systems need to show there is a relationship between a main provider and one of the following four categories of subordinate facilities:

1. **Provider-based entities:** an entity, including a rural health clinic or a federally qualified health center, that is created or acquired by a main provider to furnish health services different from the services furnished by the main provider under the name, ownership, and control of the main provider and may be licensed or certified to provide health services in its own right.
2. **Department of a provider:** a facility, organization, or physician office that is created or acquired by the main provider to furnish the same type of services provided by the main provider under the name, ownership, and control of the main provider. A department of a provider may not be separately licensed or Medicare-certified, but only operated as part of the main provider.
3. **Remote location of a hospital:** a facility or organization that is created or acquired by a main hospital to furnish inpatient hospital services under the name, ownership, and control of the main hospital and is not separately licensed or certified as a hospital.
4. **Satellite facilities:** a part of a hospital (or of a hospital unit) that provides services in a building used by another hospital or on the same campus as a building used by another hospital.

Under the final rule, a "campus" is the physical area located within 250 yards of the main provider's main buildings and any other area determined by the HCFA regional office on an individual basis to be part of the main provider's campus.

To qualify for provider-based status, you must prove to HCFA the subordinate facility is an integral and subordinate part of the main provider, operated under the name, ownership, and administrative, clinical, and financial control of the main provider. To do this, the providers need to pass the following seven tests:

❑ **Licensure.**

The department of the provider, remote location of the hospital, or satellite facility and the main provider are operated under the same license, except in areas where the state requires a separate license or in states where state law does not permit licensure under a single license. If a state health facilities' cost review commission (or other rate-setting agency) finds that a particular

facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

❑ **Ownership and control by the main provider.**

The facility or organization seeking provider-based status must be operated under the ownership and control of the main provider. The following requirements must be met:

— The business enterprise that constitutes the facility or organization must be 100% owned by the main provider.

— The main provider and the facility or organization seeking status as a department of the provider, remote location, or satellite facility must have the same governing body.

— The facility or organization must be operated under the same organizational documents as the main provider.

— The main provider must have the final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits / code of conduct), and final approval for medical staff appointments in the facility or organization.

❑ **Administrative integration and supervision.**

The reporting relationship between the main provider and subordinate facility must have the same frequency, intensity, and level of accountability that exists between the main provider and one of its departments.

The individual responsible for the day-to-day operations of the subordinate facility must maintain the same reporting relationship with, and accountability to, the management and governing board of the main provider as maintained by any department head of the main provider. The administrative functions of the main provider and subordinate facility, such as billing, records, payroll, human resources, and purchasing, must be integrated.

The final rule allows the outsourcing of a subordinate facility's administrative functions as long as the main provider manages the contract if the subordinate facility is operated under a management contract.

❑ **Clinical integration and supervision.**

The clinical functions of the subordinate facility must be integrated with those of the main provider, as evidenced by common credentialing, common clinical oversight, a standard relationship of reporting, supervision, and accountability between the medical director of the subordinate facility and the main provider's chief medical officer, common medical or professional staff responsibility for quality assurance and utilization review functions, a unified medical record retrieval (or cross-reference) system, and patient access to the main provider.

❑ **Financial integration**.

The financial operations of the facility or organization must be fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the main provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

❑ **Public awareness**.

The facility or organization seeking status as a department of a provider, remote location, or satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

❑ **Same patient population.**

The subordinate facility must either be located on the campus of the main provider or satisfy one of three tests intended to demonstrate that the facility serves the same patient population as the main provider.

The first two tests require the main provider to submit records showing that for the 12-month period immediately preceding the calendar month in which the provider-based application is filed, and for each subsequent 12-month period, at least 75% of the patients served by the subordinate facility resided in the same zip code areas as at least 75% of the patients served by the main provider; or at least 75% of the patients served by the subordinate facility who require the type of care furnished by the main provider — inpatient hospital services — obtained that care from the main provider.

If neither of those tests applies to the subordinate facility because it was not in operation during all of the applicable 12-month period, the facility can submit records showing that it is located in a zip code area included among those that, during the applicable 12-month period, accounted for at least 75% of the patients served by the main provider. ■

Doctor wins battle over exclusive contracts

State reverses lockout practice

A Los Angeles pediatrician has won a two-year battle allowing neonatologists in his practice to treat hospital patients despite a hospital policy that limited its neonatal intensive care staff to physicians in a competing practice that had an exclusive contract with the facility.

This situation reflects an increasingly common situation facing physicians where local hospitals let contracts guaranteeing certain practices the exclusive right to treat patients in a unit in exchange for them agreeing to manage that department.

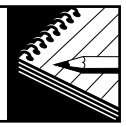
In this case, however, a California court and regulators have clarified previous state policy to conclude exclusive contracts outside the hospital-based practices of pathology, radiology, and anesthesiology are illegal in local hospitals that accept state funds. Meanwhile, Burbank's Providence Saint Joseph Medical Center, the hospital that originally refused to let neonatologists from the practice of Pejman Salimpour, MD, see patients, has reversed its position and opened the staffs of both its neonatal intensive care and cardiac surgery units to outside physicians.

Salimpour's argument to the both California's Medicaid agency and the U.S. Department of Health and Human Services' regional office was simple: All patients have a legal right to choose their physicians. He backed this up by pointing to a California regulation requiring all California hospitals' Medicaid contracts — except for pathology, radiology, and anesthesiology services — to maintain an open-staffing policy.

After organizing the physician and nursing community to lobby the legislature and the California Medical Assistance Commission (CMAC), the commission issued a statement clarifying that the open-staffing clause in the Medicaid contract applied to all patients, not just those in the state's Medi-Cal assistance program.

Bottom line: Open-staffing provisions required by California's Welfare and Institutions Code in state Medicaid contracts "provide plainly and simply that a contracting hospital cannot deny clinical privileges to one physician based upon the existence of a contract with others," CMAC said. ■

GUEST COLUMN



Billing industry challenges critical GAO study

Claims cited company isn't a biller

By **Bob Burleigh**, CHBME
Brandywine Healthcare, Malvern, PA

[Burleigh is a spokesman for the Healthcare Billing and Management Association (HBMA), a group that has raised objections to a recent General Accounting Office study that led to a congressional hearing highly critical of the billing industry. Following is his reply to the accusations.]

Behavioral Medical Systems Inc. (BMS), which was identified as a billing company in the General Accounting Office's (GAO) report, was not a billing company. BMS misrepresented itself as a provider to the Medicare program and to the real billing company that it used to submit claims. The GAO report did not identify the real billing company, indicating that it played no relevant role in BMS's fraud. (The billing company is not an HBMA member.) Government agencies should set a better example of fair, honest, and accurate reporting, particularly when attributing dishonesty to others.

HBMA deplores dishonest providers and billing companies, as our code of ethics reflects. We are aware that there have been instances of billing company misconduct. But, it appeared that the GAO's testimony on April 6 tried to avoid reporting "old news" and slanted the report about BMS in order to describe provider fraud as billing company fraud. The only other conclusion one might draw is that they do not know the difference between a provider and a billing company.

Almost a year ago, HBMA discussed the prospect of billing company identification with the GAO and Penny Thompson, director of the Office of Program Integrity, and her staff, at their request. The recommendations presented by the Office of the Inspector General included the same proposal. We support the concept — and have

never opposed the proposal — because identification could (and should) be a relatively benign requirement.

In her April 6 testimony before Congress, however, Thompson noted that if billing company registration already had existed, it would have done nothing to prevent or detect BMS's misconduct.

The economics of the BMS case is illustrative of several points. Although the "headline" indicated that the fraud was for $1.3 million, Medicare's payments were just $362,000. Had these claims been valid, the program paid only 28 cents per dollar billed. The fraud was, nevertheless, fraud, and is no less egregious because of the "lesser" amount. Based on the service fees — 5% of collections — charged by the billing company BMS hired, BMS paid $18,100 for billing services during the 20-month period cited. (We assume BMS actually paid for billing, although BMS's dishonesty could have included theft of services.) The billing company earned a gross income of $3.68 per claim; we estimate their per-claim profit would have been 55 cents, based on an industry norm of 15% of gross income.

Actual billing was required for payments to be produced and, therefore, actual billing costs were incurred for all claims. The billing company in this case realized $118 per month in "improper" profits, based on the GAO's figures. It seems clear that the potential for gain does not justify the risk to a billing company. This also illustrates the weakness of the "improper incentives" concern stated in another of the OIG recommendations.

The OIG's April testimony to Congress recommended prohibiting incentive (usually interpreted to mean percentage-based) fee arrangements between providers and billing companies. This is a well-known OIG concern and one that HBMA has addressed in a position paper posted on HBMA's Web site (www.hbma.com).

The OIG's March 2000 report "Medical Billing Software and Processes Used to Prepare Claims," served as a foundation document for an April commerce committee hearing. We reviewed this report in detail and while we respect the amount of effort and taxpayer expense invested in the report, we found it to be significantly flawed and factually inaccurate in virtually every section. At best, it reflects a superficial and incomplete knowledge of a very complex industry.

We are concerned that Congress and other readers might use this report as "gospel" from which to reach conclusions or on which to base decisions that could have a profound impact on a large and vital industry segment. We agree with the OIG that there could be a greater risk posed by so-called proprietary software, but the opposite is also true — there could be greater security and protections built into proprietary systems developed to fill the considerable void left by some commercial systems. HBMA has offered to meet with the authors of the report to share its concerns.

"We are concerned that Congress and other readers might use this report as 'gospel' from which to reach conclusions or base decisions that could have a profound impact."

HBMA is a voluntary trade association dedicated to compliance and training. We welcome additional training options, but any government-sponsored training program(s) should be developed for providers (our customers), as well as billing companies. However, we are skeptical of government representatives preparing training materials for private industry in view of our concerns related to the OIG's report.

Last year, we reported to HCFA concerns about inaccuracies and incomplete content in its Medicare computer-based training (CBT) materials. CBT has been represented as accessible training materials about Medicare claims submission, but we have found them to be significantly incomplete and, in some cases, they are inaccurate. Almost a year later, the content has not been expanded and the errors have not been corrected. ■

COMING IN FUTURE MONTHS

- How to handle episodes of care payments
- Tips for managing care audits
- The right way to report overpayments
- How you can make the most of the Internet
- There are ways to cut your collection cycle

Tips on structuring a billing arrangement

Look for internal compliance program

One of the ongoing areas of debate between regulators, providers, and the third-party billing industry is the propriety and legality of billing contracts in which fees are based on a percentage of funds collected.

"The OIG's concerns related to percentage billing agreements center on the potential for inducing upcoding, false claims, and duplicate billing," notes the Healthcare Billing and Management Association, (HBMA) a trade group representing the billing industry.

Billers, however, argue that percentage-based contracts are ultimately more efficient and less costly than "per claim" fee arrangements, which can create incentives to submit multiple claims and to "split bill" — divide legitimate, documented, multiple services performed on the same date into individual "one-code-per-claim" submissions — in order to increase billing fees.

Percentage-based contracts

If you have or are considering a percentage-based billing arraignment, here are some tips from the HBMA on the best ways to construct a contract that will help you avoid possible regulatory problems.

1. Ensure your third-party biller has implemented an internal compliance program.
2. To comply with the Medicare carrier's manual, all client funds should be deposited into an account under the exclusive control of the provider. Billing companies should not be a signatory on any accounts into which funds are initially deposited. A clear and complete set of records of all transactions should be maintained.
3. Any incentive fees assessed should be related to the collection of actual amounts due, based on the contractual amounts allowed, as defined by federal guidelines or payment contracts. No incentives should be related to average charge, gross charges, coding patterns, or coding profiles.
4. Companies that provide coding services should not offer coding employees incentives based on average charge, gross charges, coding patterns, or coding profiles, or for production output (charts per hour) above a level that could jeopardize accuracy. Companies that offer coding services are encouraged to offer incentives related to accuracy and compliance. Companies and / or their clients also are encouraged to contract for periodic, independent reviews of their coding by qualified review firms.
5. Companies providing follow-up services on unpaid claims should comply with the published requirements of Medicare carriers and Intermediaries, including use of approved forms and inquiry protocols. Claims requiring resubmission should be clearly marked as a resubmission to prevent duplicate payments.
6. Companies are encouraged to report carrier and other payer misconduct related to claim processing to the appropriate federal and / or state authorities.

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7. Companies charging a percentage of collected funds should not assess a fee on overpayments. Any fee related to overpayments, if charged, should be based on the cost of processing a refund or for following federal protocols on the processing of overpayments. ■

Court allows HMO suits in malpractice claims

Illinois ruling first of its kind

A landmark ruling by the Illinois Supreme Court has found health maintenance organizations can be held liable for negligence involving a patient's medical care. The decision, a major blow to the managed care industry, is expected to influence the current battle in Congress and state legislatures over whether HMOs can be liable for medical malpractice.

'Institutional negligence'

Illinois is the first state supreme court to address the issue of "institutional negligence," or HMO responsibility for care provided by doctors in their networks.

"This ruling means patients can now proceed directly against the HMO for the HMO's carelessness or negligence for causing an injury," notes **A. Denison Weaver**, the Chicago attorney who brought the action against Chicago HMO, a Medicaid managed care plan operated by United HealthCare of Illinois Inc. "HMOs can't hide behind the skirts of the doctor," Weaver says.

In overturning an appellate court ruling, the state Supreme Court found the particular issue of whether the HMO was negligent in assigning so many members to a doctor in its network that it resulted in harm "falls within the purview of institutional negligence" and, therefore, should go to trial.

"We hold that Chicago HMO had a duty to its enrollees to refrain from assigning an excessive number of patients, " the court said. "HMOs contract with primary care physicians in order to provide and arrange for medical care for their enrollees. It is thus reasonably foreseeable that assigning an excessive number of patients to a primary care physician could result in injury, as that care may not be provided." ■

NEWS BRIEF

State supreme court rules doctor termination illegal

The California Supreme Court has upheld an appeals court's decision that an insurer can not drop a physician from its provider network without a fair review process, despite a "without cause" termination clause in the provider's contract.

According to the court, this so-called "fair procedure doctrine" is activated when an "insurer possesses a power so substantial that the removal significantly impairs the ability of an ordinary, competent physician to practice medicine in a medical subspecialty in a particular geographic area, thereby affecting an important, substantial economic interest."

(See *Potvin v. Metropolitan Life Ins. Co.*, No. S061945, Cal., May 8, 2000.) ■