Seven steps to physician practice compliance
Expert analysis of the OIG’s guidance
Dear PPCR reader,

This special report, a free supplement to your subscription of Physician Practice Compliance Report, provides you with an in-depth review of the recently released Office of Inspector General’s (OIG) Compliance Program Guidance for Individual and Small Group Physician Practices.

Ten highly regarded compliance experts offer their advice and analysis of the guidance in these pages.

The model guidance plan is presented in a step-by-step format, which gives practices a "road map" to navigate the OIG’s seven-step process to developing a compliance program. The OIG also lets physician practices know exactly where it believes they are most at risk.

While this guidance is intended for small and solo physician practices, the OIG suggests that larger practices can use it in conjunction with past guidances issued for other health care sectors.

Our appreciation goes out to all of the experts who contributed to this special report and to its author, Mary Krouth, assistant editor at Opus Communications, the publisher of PPCR.

We at PPCR hope you find this tool helpful in reaching your own compliance goals for your practice.

Sincerely,

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Step 1: Auditing and monitoring

The purpose of auditing and monitoring is to evaluate the standards and procedures you have in place to see whether they are current and accurate, as well as to examine whether claims are being submitted correctly and staff are fulfilling their responsibilities. In this compliance step you determine where your practice has problems and risk areas.

When monitoring and auditing claims, “you’re looking at the full reimbursement process,” says Curtis J. Udell, president and chief executive officer of EMPHYSYS, Inc., a physician reimbursement and compliance consulting firm based in Atlanta, GA.

In examining the full reimbursement process, you should look at operations, medical record documentation, transaction entries, the claims submission process, and the account management process. Furthermore, while looking at the process in general, you also want to “look at the risk areas relative to your operations and claims submission process,” Udell says.

The Office of Inspector General (OIG) says that you should do your monitoring and auditing in two steps. The first is a standards and procedures review, in which you check to see whether your operations are current and accurate; the second is a claims submission audit, in which you examine whether you are submitting claims correctly.

However, before you begin your auditing and monitoring, Udell advises that you outline some basic policies and procedures to give you guidance as you set out to audit and monitor.

Most importantly, you should outline some general audit procedures, giving you a step-by-step procedure to follow as you conduct your audit. When developing these guidelines, you should ask yourself some questions: How does your practice capture a charge, how do you translate to codes, and how do you send out claims?

Udell also recommends that as you go about auditing and monitoring, you prioritize federal programs and stay abreast of the latest changes in claims submission, compliance guidance, and OIG updates. Staying up-to-date is basically the first part of the auditing and monitoring step.

The next part is more in-depth, as auditing involves a bit more work. The OIG considers this step a baseline audit. It suggests that you compare your results with benchmark data to see how well you’re doing in relation to others. “For some physicians it’s a big eye-opener that they are a lightening rod for audits,” Udell says.

And when it comes to the auditing stage, the OIG states, “It is advisable that bills and medical records be reviewed for compliance with applicable coding, billing, and documentation requirements.” Also, the OIG says that the individuals involved in the audits should ideally include a medically trained person (a physician or registered nurse) and the person in charge of billing.

The Office of Inspector General (OIG) recommends that practices conduct periodic audits at least once a year. And the OIG says that, generally, practices should look at five or more medical records per federal payer and five to 10 medical records per physician to ensure that staff are following the compliance program.

Another important decision to make when starting to audit is whether to do a concurrent or retrospective audit. A concurrent audit means that you review your claims prior to submission, and a retrospective audit means that you review the claims after they have been submitted.
Step 2: Establish standards and procedures

After auditing and monitoring to determine where your practice needs to make corrections, it’s time to develop standards and procedures for dealing with those risk areas.

The Office of Inspector General (OIG) says practices that don’t have standards and procedures already in place should put together a standards and procedures manual and update their clinical forms to make sure they are clearly and completely documenting patient care.

These physician practices should look at every aspect of their daily operations, such as patient flow, data capture, and the patient billing process.

After determining what is required for compliance in each instance, the practice can then start developing policies and procedures that incorporate those compliance requirements.

However, if you do have policies and procedures in place, you should first examine those, says Howard Tepper, director of administration in the department of medicine at the University of Medicine and Dentistry at the New Jersey Medical School in Newark, NJ.

You can use the policies you already have as building blocks for those you will develop as you create your compliance plan, Tepper says. You already may have regular office policies for things such as checking out a patient and billing a patient, which could be considered compliance policies.

The OIG says that you may also consider using a third party’s compliance standards as the basis for your own. But if you do so, Tepper says, “you have to be careful that you build off them and not just take them straight out of the box.” One of the worst things you can do is use a third party’s operations manual with policies and procedures that aren’t applicable to your practice.

To do so would show that you realized the policies and procedures were important to have, but you still didn’t spend the time to put them in place correctly. And because no two practices operate the same way, you need to customize the standards and procedures to fit your practice.

When starting to write your policies and procedures, Tepper advises that you look at the OIG’s identified risk areas and at your office from a process point of view.

This should include every aspect from the minute the patient walks through the door to when the practice gets paid. Take your findings and build off of them to develop your standards.

Overall, your compliance focus should be on the OIG’s identified risk areas. These are the areas where noncompliance most commonly occurs, so the identified risk areas should be looked at closely.

The OIG’s four main risk areas are coding and billing; reasonable and necessary services; documentation; and improper inducements, kickbacks, and self-referrals. Other risk areas are included in the guidance’s appendix.

After you’ve developed the compliance operations manual (binder), make sure that every employee has access to a copy, Tepper says.
Step 3: Designation of a compliance officer/contact(s)

Now that you have compliance policies and procedures in place, you need to designate a compliance officer (if you haven’t already) to oversee all compliance activities and to develop a corrective action plan.

The Office of Inspector General (OIG) recognizes that it’s often difficult for one person to be responsible for all of the compliance activities, so it suggests that you have a variety of people involved in enforcing compliance. The OIG refers to these other compliance individuals as “compliance contacts.”

“For example, one employee could 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,” the OIG says in its guidance. “Therefore, the compliance-related responsibilities of the designated person or persons may be only a portion of his or her duties.”

But before you set out to designate the compliance officer and compliance contacts, you should first develop a list of criteria that the potential officer must possess to help you in your selection, says Joseph J. Russo, Esq., a health care attorney with Russo & Russo, LLP, in Bethlehem, PA. At the same time, you need to consider your resources. How much can you afford? What is the gross revenue of your practice? This guidance is meant for small group practices and solo practitioners, so “right off the bat, you have very serious economic and financial considerations,” Russo says.

The guidance does acknowledge, however, that small practices don’t need the same detailed compliance plan or full-time compliance officer as large practices.

Designate a compliance officer who is independent, Russo says, to protect against any conflict of interest that may arise from being in charge of compliance as well as another aspect of the practice.

In addition, Russo advises that the compliance officer should have three attributes: attention to detail, experience in billing and coding, and effective communication skills. Moreover, most compliance officers have a great deal of legal and regulatory experience. Because one of the high-risk areas is the coding and billing function, it’s a good idea to have a compliance officer with coding and billing experience.

If your practice’s compliance officer will oversee other areas such as coding and billing, Russo advises contracting an external audit. This way, you can ensure an objective audit.

Russo likes the use of compliance contacts with a caveat. “I think that that’s actually a good, cost-effective methodology,” but in the end, “the buck has to stop with someone on the compliance side.”

Further, one person should ultimately be responsible for overseeing the compliance plan. This person can then be a liaison with outside counsel to go over kickback, professional courtesy, and Stark issues.

Another option is to outsource a compliance officer, which can have advantages for a smaller practice. For instance, you wouldn’t have a salaried employee and the person may be more objective because he or she wouldn’t be involved in the day-to-day business of the practice. Also, because the person is outsourced, he or she may bring more experience to the job for less cost than hiring a full-time internal person, Russo says.

The OIG allows outsourcing of all of the compliance officer’s responsibilities or part of
Step 4: Conducting appropriate training and education

Once you’ve designated a person to oversee compliance activities at your practice, this person can begin working on an educational training program to teach your staff about compliance matters.

The Office of Inspector General (OIG) says that a training program should ideally be tailored to “the practice’s needs, specialty, and size and will include both compliance and specific training.”

According to the OIG, physician practices need to strive for two goals when conducting compliance training: to train all employees how to perform their jobs in compliance with the standards of the practice and any applicable regulations, and to make sure every employee understands that compliance is a condition of continued employment.

The guidance’s training and education section tries to recognize the resource constraints of smaller practices, says Bruce A. Johnson, principal at Medical Group Management Association Health Care Consulting Group in Denver, CO. Moreover, the OIG’s guidance isn’t prescriptive.

The OIG accepts that training can be conducted through various means, such as formal training sessions, bulletin boards, or newsletters. Training also can be conducted either in-house or by an outside source. In the end, it comes down to what your practice can afford and what would be most effective.

While the OIG guidance says that practices should have both compliance training and coding and billing training, it isn’t necessary to have separate training sessions for the two.

The combination of subjects isn’t important. “I always come back to the reality that effective compliance is also effective risk management and effective practice operations,” Johnson says.

Who needs training? “It depends on the type of training and the substance of the training itself,” Johnson says. He recommends that all staff should attend training with a compliance emphasis to make sure that everybody has at least a solid baseline of information.

But once you’ve gone through the general training, you can focus on more job-specific training. For example, if your practice has coding issues, then the physicians, coders, and billers should receive periodic education about this specific area to hone their technical competencies, he says.

What type of training do you need? The key, according to Johnson, is to figure out how to best promote effectiveness within the resource constraints of your practice. Perhaps you could just buy a compliance video and have staff watch it. Perhaps you need a more formal training session. Or maybe you could just read a memo in a three-minute morning staff meeting.

“If you’re really taking it seriously, you’ve got to have training programs that give you some level of comfort that people are actually taking it seriously,” Johnson says. In this way, it’s as if the format piece is as important as the content because both greatly influence the effectiveness of the training.

But when and how often should you conduct training? At the very least, the OIG recommends annual sessions for individuals involved in coding and billing.

The OIG guidance says new employees should receive a certain amount of baseline training when they start, and it is here that compliance may first be addressed. Also, the OIG says new employees need substantive training...
Step 5: Responding to detected offenses and developing corrective action initiatives

In your compliance plan, you also need to have policies for responding to violations and correcting noncompliance issues. It is in this step that you develop such guidelines and corrective action initiatives.

"Violations of a physician practice’s compliance program, significant failures to comply with applicable federal or state law, and other types of misconduct threaten a practice’s status as a reliable, honest, and trustworthy provider of health care," says the Office of Inspector General (OIG).

When responding to detected offenses, "all issues brought to your attention, no matter what way they come to your attention, should be responded to thoroughly and quickly," says Roy Snell, a principal at the Minneapolis, MN, office of PricewaterhouseCoopers.

Yet, while it’s important to act quickly, "you must be careful to limit the number of people that you make aware of the potential problem," he says.

You don’t want to overreact before you have researched the issue to be sure that there is an actual compliance problem. If you find that a problem has significant potential for being a legitimate issue, you should follow your investigative protocol, Snell says.

The investigative protocol outlines the steps you will take to resolve a suspected problem. Guidance about who should be involved, who should be informed, and how the issue should be researched should be in the protocol.

Some authoritative body in your organization, such as a compliance committee or the governing board, should review and approve the investigative protocol, Snell advises. In addition, he says that you seek advice from internal or external legal counsel.

After establishing this protocol, you should either publish it in a medium available to all staff or distribute a copy to all employees so as to "help them understand that there is a fair and thorough process, and to help them cope with or be prepared for an investigation in their area should one occur in the future," Snell says.

He adds that your corrective action plan should be developed with the assistance of legal counsel. The corrective action plan should include such things as how to go about determining the need for discipline as well as the potential need of a refund to payers, Snell says.

In addition, the corrective action plan should include how to go about determining the potential need to disclose the problem to enforcement authorities, such as the attorney general, Department of Justice, or the OIG.

And when selecting legal counsel to review a major problem, Snell advises that you find an attorney who has experience with your specific problem, rather than just health care. "An experienced legal counsel can make a remarkable difference in your ability to properly resolve the issue," he says.

To help you figure out whether your practice is staying in compliance, you should not only rely on staff to inform you of detected offenses, but you should also be aware of
Step 6: Developing open lines of communication

To further combat noncompliance, an important element of your compliance program must be open lines of communication. Why is this necessary? To prevent problems from occurring and to discuss why the problem happened in the first place, says the Office of Inspector General (OIG).

And what is the most basic way to develop open lines of communication?

“All [that practices] really need is an open-door policy, as stated in the guidance,” says Debbie Troklus, assistant vice president for compliance at the University of Louisville (KY) School of Medicine.

With an open-door policy, staff members feel welcome to discuss any noncompliance issues with the compliance officer, Troklus says. The compliance officer’s door is always open and staff are free to visit with any concerns.

The only drawback to this policy is that it doesn’t afford anonymity. It requires a face-to-face meeting, and some people aren’t willing to divulge information unless their identities remain unknown.

“To compensate, you need to find an alternative method for those people who don’t feel comfortable bringing issues directly to the compliance officer or their office,” Troklus says.

One such method is the use of an “issue box.” While the open door policy is an important element of communication, using an issue box gives employees the chance to remain anonymous. This box is available for people who wish to simply write down their issues and remain unidentified.

The issue box, combined with the open-door policy, increases the ways your employees can bring issues forward. The different lines of communication cater to different needs. “That might be the thing that will generate issues from your staff,” Troklus says.

Troklus suggests putting the issue box in a discreet place. If it’s in a place where there is heavy foot traffic or it is always being watched, anonymity is negated. It must be in an inconspicuous area to allow people to bring issues forward while keeping their identities unknown.

To further encourage communication, Troklus suggests that you discuss the open-door policy each time you have mandatory training.

In addition, she believes that the compliance officer should meet the staff to get familiar with everyone and let them know that he or she welcomes any issues anyone would like to discuss.

“Another way to market your program is that when you get issues, you react quickly,” Troklus says. If people see that their issues are taken seriously, it may increase the number of issues brought forward, helping to open the lines of communication.

Troklus further advises including a nonretalia-
Step 7: Enforcing disciplinary standards through well-publicized guidelines

The last step of the Office of Inspector General’s (OIG) compliance program guidance concerns enforcing disciplinary standards through well-publicized guidelines. “Enforcement and disciplinary provisions are necessary to add credibility and integrity to a compliance program,” says the OIG.

This step is meant to ensure that employees understand the consequences if they are not compliant. “An effective physician practice compliance program includes procedures for enforcing and disciplining individuals who violate the practice’s compliance or other practice standards,” the OIG states in the guidance.

An employee handbook may help small practices achieve this goal, says Lyn Chew, senior director at Compliance Concepts, Inc., a health care consulting firm in Wexford, PA.

An employee handbook may be the most economic and effective way to get the word out and make the staff aware of the consequences of noncompliance. It also satisfies the “well-publicized” requirement, Chew says.

The handbook should list the definition of compliance and the penalties for noncompliance. The penalties, according to the guidance, should be up to and including termination.

Disciplinary actions should also include warnings, reprimands, probation, demotions, and temporary suspensions. Each organization should decide which level of penalty is warranted for which sort of action, such that the disciplinary action is based on the level of noncompliance, Chew says.

It is also important to remember that, because each practice creates its own enforcement policies, they should be tailored to the specific organization.

A small practice may also consider instituting checklists and instruction forms “so that if an employee has a question on how to handle a certain issue, there are clear instructions for them to follow and guidelines put out by the practice,” Chew says. These checklists and forms are easy, are inexpensive tools, and they can further publicize the guidelines. The disciplinary standards should be included in in-house training as well.

Chew prefers annual in-house training for all employees and similar training for new employees. Part of the training is making employees aware of compliance standards and the consequences of not following them.

She also thinks that you should go over the standards in your practice’s regular morning or weekly meeting to enforce and publicize the guidelines.

But no matter how you educate your staff and publicize the guidelines, you must be sure that every employee clearly understands compliance, as well as the penalties for noncompliance, Chew says.

Remember that employees who are aware of an infraction but fail to report it are subject to penalties, as are the individuals responsible for the infraction.

The OIG says that people who fail to report noncompliance will be subject to disciplinary action. It is important to explain this to staff, and it should be part of the publicized standards, Chew says.

As you work on enforcing and publicizing disciplinary standards, it is essential to track and...
Where the risk is

Whether large or small, the government holds all practices equally accountable for fraud and abuse. Fortunately, the Office of Inspector General (OIG) lets physician practices know common risk areas that may run afoul of healthcare laws and regulations.

The OIG’s guidance identifies four main risk areas that physician practices should be aware of as they develop their compliance programs: coding and billing; reasonable and necessary services; documentation; and improper inducements, kickbacks, and self-referrals. (The OIG covers additional risk areas in an appendix.)

“This list of risk areas is not exhaustive or all-encompassing. Rather, it should be viewed as a starting point for an internal review of potential vulnerabilities within the physician practice,” the OIG states.

These areas have been well-defined by the government as points of concern, and the objective is to now incorporate these risk areas into the written standards and procedures of physician practices’ compliance programs, says Bill Sarraille, Esq., partner at the law firm of Arent Fox in Washington, DC.

Coding and billing
The area that poses the highest risk for physician practices is coding and billing, says Bob Saner, Esq., a principal at Powers, Pyle, Sutter and Verville, a law firm in Washington, DC. This area has great potential for mistakes, he says.

According to the OIG, your compliance plan’s written standards and procedures should ensure that coding and billing are based on the medical record documentation. It also recommends that you pay close attention to appropriate diagnosis codes and individual Medicare Part B claims.

In addition, physician practices can institute a policy mandating that the coder and/or physician review all rejected claims relating to diagnosis and procedure codes, the OIG says. This will help correct problems, such as double billing that results in duplicate payment, and billing for items or services that were not rendered or provided as claimed.

This compliance guidance is more flexible than those for other types of providers the OIG has issued in the past, Sarraille says. Although the OIG still emphasizes the value of an independent third-party review, it does not specifically recommend that physician practices conduct external coding and billing audits.

Still, physician practices should consider incorporating an annual external audit into their compliance programs because “the danger of relying only on internal monitoring is that you never effectively challenge your own assumptions about what is appropriate and what isn’t,” Sarraille says.

As you do your auditing, you should keep track of your findings and benchmark yourself against your own results to measure your progress over time, says Jolynn Hanson, manager in PricewaterhouseCoopers’ Healthcare Consulting Practice in Dallas, TX. She recommends that you do a baseline audit of your current state and measure yourself against that baseline each subsequent quarter.

“The fact that you’re making an effort to build a compliance program—and that you have it documented within your practice that this is something that you’re focusing on, that you have a work plan, that it’s important to you and your organization to be compliant with the rules and regulations—is the key,” she says.
If you ever have to undergo an OIG audit, investigators are likely to be more lenient because you can show that you take compliance seriously.

Reasonable and necessary
The next area of concern is reasonable and necessary services. "Billing for services, supplies, and equipment that are not reasonable and necessary involves seeking reimbursement for a service that is not warranted by a patient's documented medical condition," the OIG says. Your compliance program's written standards and procedures should include guidance about medical necessity issues, and all of the physicians in your practice should discuss their views on this area, Sarraille says.

Physicians often don't go over this, which can create a dangerous situation because "if you have widely divergent practice patterns within your practice, then your colleagues become witnesses against you or you can effectively become a witness against them just by your very different behaviors," Sarraille says.

To facilitate discussion and gain some consensus within a range of opinions, physician practices should develop protocols relating to medical necessity, Sarraille advises. Practices can look at the protocols that different groups have issued and use these protocols as building blocks for building their own protocol.

In the end, Medicare will only pay for services that meet the Medicare definition of reasonable and necessary. However, "a physician practice can bill in order to receive a denial for services, but only if the denial is needed for reimbursement from the secondary payer," the OIG says. But in such cases where your physician feels strongly about the medical necessity of a test, Hanson suggests calling your Medicare carrier to let it know your rationale.

"Document who you called and when you called. And remember that you can put up a fight," says Hanson. You can also try documenting your clinical pathway and sending it to your Medicare carrier. "While they probably aren't going to change their minds because it's not covered, at the same time, they may not construe any type of fraud because you are making an effort to say 'this is my viewpoint as a physician,' " Hanson says.

Perhaps the carrier will educate you regarding what your physician needs to do in the future to get paid for the service. (See "Get the risk out" in the December issue of Physician Practice Compliance Report (PPCR), for more information on this topic.) If you don't receive PPCR and would like to learn more, please call customer service at 800/650-6787.

Documentation
Poor physician documentation is a problem that won't seem to go away, despite its implications. "Physician documentation is necessary to determine the appropriate medical treatment for the patient and is the basis for coding and billing determinations," states the OIG.

Physicians may think that documentation is too much of a burden, "but if you haven't written it down, it didn't happen—at least that's the OIG's position," Sarraille says. Physicians need to be smart and efficient in how they go about the process. They need to examine exactly what they need to record, how best to record it, and what their specific needs are. They can then include these findings into their practice's standards and procedures.

For instance, if a physician has illegible handwriting, perhaps someone should sit in on the patient encounter and write down what the doctor says throughout the visit. Or, perhaps that physician should dictate his or her notes. Whatever the solution may be, adequate documentation is essential because it filters into all other risk areas. Improving one's documentation is an excellent protective measure, Sarraille says.

Another way to improve documentation
is to use a template, Hanson says. "The templates outline, step by step, all of the information [physicians] have to obtain and document during the visit in order to bill their evaluation and management code." She recommends using templates because they can help physicians remember all of the steps of the appropriate evaluation they have to make and then document. In turn, the use of templates could be incorporated into the policies and procedures of one's compliance program.

**Inducements, kickbacks, and self-referrals**

The OIG suggests that physician practices develop standards and procedures that encourage compliance with the anti-kickback statute and the physician self-referral law, commonly known as the Stark Law.

In looking specifically at inducements, the guidance says that your compliance plan’s standards and procedures should implement measures to avoid offering inappropriate inducements to patients. "Examples of such inducements include routinely waiving coinsurance or deductible amounts without a good-faith determination that the patient is in financial need or failing to make reasonable efforts to collect the cost-sharing amount," says the OIG.

Inducements are going to be a key area with pharmaceutical companies, Hanson says. To avoid any problems in this area, your practice should develop a gift policy that prohibits receiving gifts of greater than $25—for the practice as a whole, not per person—from outside vendors, she advises. This policy can then be addressed in the compliance program.

Self-referrals are also something to avoid. "Remuneration for referrals is illegal because it can distort medical decision-making, cause overutilization of services or supplies, increase costs to federal health care programs, and result in unfair competition by shutting out competitors [that] are unwilling to pay for referrals," says the OIG.

In addition, remuneration for referrals may affect quality of care because physicians may be encouraged to order supplies or services based on profit instead of the best medical interests of the patient, the OIG says.

Self-referrals are the second highest risk area, Saner says. He recommends that every physician practice make sure to address self-referrals in its compliance program.

Kickbacks are another big concern for physicians. "In general, the anti-kickback statute prohibits knowingly and willfully giving or receiving anything of value to induce referrals of federal health care program business," says the OIG.

The OIG advises that all business arrangements in which physician practices refer business to or order items or services from an outside entity should be on a fair market value basis and should be reviewed by legal counsel.

There is a greater focus on financial relation-