**Ensure Stark, anti-kickback compliance for physician contracts**

The physician self-referral law (Stark) and the anti-kickback statute place strict regulations on how hospitals can pay physicians for performing services, so make sure all of your organization’s physician contracts are in compliance.

The Office of Inspector General (OIG) is increasing its focus on physician contracts, says James Kopf, president of Health Care Oversight, a New York City–based consulting firm. In spring 2003, the OIG issued an advisory bulletin on joint ventures and other arrangements. “This indicates that the OIG will again focus on contracts that may violate the anti-kickback statute. The Centers for Medicare & Medicaid Services [CMS], which enforces Stark, is expected to follow suit.”

“It is extremely important to ensure that contracts with physicians are not disguised payments for patient referrals,” says Brian Kozik, director of compliance and audit services at the North Shore Medical Center in Salem, MA.

Hospitals often have legitimate reasons for paying physicians...

**Cardiac rehab: Ensure compliance in top OIG focus area**

Make sure your hospital is complying with Medicare’s requirements for outpatient cardiac rehabilitation services—before the Office of Inspector General (OIG) comes knocking. This has been one of its top concerns in recent months: In October and November 2003, the OIG released 15 audit reports in this area alone. It found improper payments in nearly ever facility.

**How to prepare**

Update your policies and procedures for outpatient cardiac rehabilitation services so they comply with the following Medicare coverage requirements:

- Direct physician supervision
- Incident-to services
- Medicare coverage decisions

The OIG is especially concerned with physician supervision of these services, says Hank Vanderbeek, president of HAV Compliance Services in Haverhill, MA. Many hospitals don’t have a designated physician supervising their outpatient cardiac rehabilitation services.

*TIP:* “Physicians must be available for emergencies and they...
Physician contracts

for services, such as performing chart reviews and training staff on compliance, says Robert Breighner, audit director for Select Medical Corporation in Mechanicsburg, PA.

However, because there are many potential illegitimate reasons for paying, “hospitals must define payments to physicians for appropriate services in a proper contract with fair rates for services,” Breighner says. “The key is defining the scope of work and the hourly rate at a reasonable fair-market value.”

Compliant contracts

Under Stark, physicians cannot refer patients for designated health services to entities with which they or immediate family members have financial relationships. Stark law violations can cost a facility in civil monetary penalties, exclusion from government health care programs, and payment denials or recoupment from Medicare.

The anti-kickback statute targets payments intended to induce referrals and penalizes providers only when they demonstrate intent to influence or induce referrals.

Make sure all contracts comply with both Stark and the anti-kickback statute, says John McGinty, senior consultant with The Greeley Company, a division of HCPro, Inc. “People have gone to jail because of noncompliant physician contracts that violate Stark and the anti-kickback statute.”

When you review contracts, use common sense, says Kopf. “Ensure that compensation is not based on the amount of revenue generated for the hospital by the physician. Compensation based solely on volume is a kickback,” says Kopf.

TIP: Pay attention to loans and grants to physicians that appear too generous compared to other loans, last for an extended period of time, have terms not in line with current standards, or are forgiven after a period of time, says Kopf.

When to review contracts

Place each contract on a cycle for review. During the review, verify all specific duties or find the individual who does this verification for your hospital, says Kozik.

Consider reviewing contracts 12–20 months after legal counsel approves them, adds McGinty. New government regulations could make a contract that was compliant two years ago, noncompliant today.

Physician contract problem areas

While you audit physician contracts, pay attention to these potential problem areas:

✔ Unsigned contracts and those that do not leave anyone accountable for monitoring the contract’s terms and conditions.
✔ Contracts for services that a hospital employee or another physician is already performing.
✔ Numerical thresholds tied to compensation. For example, hospitals should not pay a physician for the number of rehabilitation referrals he or she made.
✔ Contracts that roll over indefinitely without requiring physicians to record that they performed the duty.
✔ Hourly rates above market value.
✔ Time sheets copied from one month to the next with the same work and hours performed each month.
✔ Unsigned time sheets.
✔ Hours worked exceeding the contract.
✔ Inappropriate duties performed.

To ensure that your hospital’s contracts with physicians and hospitals comply with Stark and the anti-kickback statute, follow these 10 steps:

1. **Obtain the contract**
   Verify first whether the physician and a proper hospital authority signed the contract, says Brian Kozik, director of compliance and audit services at the North Shore Medical Center in Salem, MA.

2. **Verify that counsel has reviewed all contracts**
   Confirm that your hospital’s legal counsel has approved all contracts to ensure that administrators negotiate all contracts within the hospital’s protocols, says Kozik.

3. **Identify the payment rate**
   Make sure your legal counsel verifies that the hourly rate for duties performed are reasonable, says Robert Breighner, audit director for Select Medical Corporation in Mechanicsburg, PA.

4. **Identify the physician’s duties**
   Check whether the contract clearly states the duties for a medical director or other contract-ed physician—this is required by Stark. Include, as required, the physician’s hourly rate in the contract, says John McGinty, senior consultant with The Greeley Company, a division of HCPro, Inc.

5. **Identify an evaluation process**
   Ensure that your organization has clear standards of performance or a review process that verifies that the physician is doing his or her job, says McGinty.

6. **Identify documentation requirements**
   Ensure that the physician is required to document his or her hours spent performing duties.

7. **Review documentation**
   Review whether appropriate documentation supports payments. Keep documentation in the form of a time sheet that includes the date a physician performed the work, the type of work performed, and the hours worked. For example, if a medical director contract requires the physician to devote 10 hours per week to administrative functions, make sure the physician records those hours, says Kozik.

8. **Compare documentation to the physician’s schedule**
   Review the physician’s schedule for a week and compare the hours spent on patient care to the hours spent on administrative functions. “Make sure physicians don’t claim that they worked more hours than is possible in one week,” says Kozik.

9. **Review payments**
   Ensure that the organization pays physicians appropriately. Run a check-disbursement report from the accounts payable department for all payments to physicians and physician groups. Review a sample of physician payments and verify that these payments comply with the contract, says Breighner.

10. **Assess gifts**
    Ensure that your organization has a code of conduct that lists the types of gifts physicians and employees may accept from patients and others. Ensure that each physician completes a conflict of interest statement annually.

    Track all gifts in your compliance department, says Breighner. Auditors should review an accounts-payable disbursement report to identify payments coded to expense accounts for gifts and marketing. Follow up on questionable items to determine the nature of the transaction. 

Sample physician contract audit program

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Cardiac rehab

must see the patient often enough to assess the
course of treatment and the patient’s progress,” says
Vanderbeek. “Policies and procedures should reflect
these tenets.”

The requirements
Medicare considers cardiac rehabilitation services
reasonable and necessary for patients who exhibit
clear medical need, are referred by their physician,
and who have had one of the following conditions:

- Acute myocardial infarction within the previous
  12 months (must have documented diagnosis)
- Coronary artery bypass graft surgery
- Stable angina pectoris

TIP: Medicare usually only considers services rea-
sonable and necessary for up to 36 sessions.

Medicare also requires physicians to directly
supervise outpatient cardiac rehabilitation serv-
ices. To bill under Medicare’s incident-to benefit
in an outpatient hospital department, nonphysi-
cians must furnish these services as an integral,
though incidental, part of the physician’s profes-
sional service.

Ensure appropriate billing
To ensure that all payments for these services
are for Medicare-covered diagnoses, do the
following:

1. Work with your fiscal intermediary to ensure
   that the outpatient cardiac rehabilitation pro-
   gram meets the Medicare coverage requirements
   for direct physician supervision and for services
   provided incident to a physician’s professional
   service.

2. Monitor hospital bills—namely, evaluation and
   orientation visits that physician personnel per-
   form—to make sure they comply with the local
   medical review policy.

3. Implement controls to ensure that the hospital
   maintains medical record documentation to sup-
   port these Medicare services.

4. Start your audit by using a probe sample of 30
   outpatient cardiac rehabilitation claims. To
   select these claims, use a random number gen-
   erator, says Vanderbeek. Expand the sample to
   additional claims if your review warrants it.

TIP: You must have adequate documentation and
make sure that reimbursement is allowed for your
services, adds Vanderbeek.

See the box on p. 5 for a sample audit plan.

Red flags for cardiac rehab

During your audit of outpatient cardiac rehabili-
tation reimbursement, watch for the following
problem areas that the Office of Inspector Gen-
eral found in its audits:

 ✓ Direct physician supervision: A physician
   must be in the exercise area and immediately
   available and accessible for an emergency at
   all times the exercise program is conducted.

 ✓ Incident to physician services: During any
   course of treatment rendered by auxiliary per-
   sonnel, the physician must personally see the
   patient, periodically and with sufficient fre-
   quency, to change the treatment program.

 ✓ Medicare covered diagnoses: Outpatient
   cardiac rehabilitation services must be reason-
   able and necessary. See above for more on
   Medicare’s requirements.

 ✓ Inappropriate billing: A physician must per-
   form initial evaluation and orientation ses-
   sions; nonphysician personnel cannot. Also,
   the hospital must maintain adequate docu-
   mentation to support outpatient cardiac reha-
   bilitation services.
Sample outpatient cardiac rehab audit plan

Make sure that all outpatient cardiac rehabilitation (OCR) services that your hospital provides meet Medicare’s standards.

Follow the steps that the Office of Inspector General (OIG) uses when it audits outpatient cardiac rehabilitation:

1. Compare the hospital’s policies and procedures for OCR to national Medicare coverage requirements and fiscal intermediary (FI) local medical review policies. Identify any differences.

2. Document how the hospital staff provides direct physician supervision for OCR services.

TIP: Nonphysician personnel must provide cardiac rehabilitation under the direct supervision of a physician. This means the physician must be in the exercise area and immediately available and accessible for an emergency while the nonphysician conducts the exercise program.

3. Verify that the hospital’s cardiac rehabilitation program personnel are qualified in accordance with Medicare requirements. Ensure that nonphysician personnel have received training in both basic and advanced life support techniques and exercise therapy for coronary disease.

4. Verify the availability of advanced cardiac life support equipment in the cardiac rehabilitation exercise area.

5. Obtain the medical record for each patient in your sample. These records should include the following:
   - Cardiac rehabilitation services documentation
   - Inpatient medical records
   - Physician referrals
   - Supporting medical records

6. For each Medicare beneficiary in your sample, obtain the most recent calendar year’s Medicare OCR paid claims and compare this data to the hospital’s OCR service documentation.

7. Review the medical records to determine whether personnel provided services incident to a physician’s professional service.

TIP: In order to be covered under the “incident to” benefit in an outpatient hospital department, personnel must furnish services as an integral, though incidental part of the physician’s professional service in the course of diagnosis or treatment of an illness or injury.

8. Verify the accuracy of the diagnoses identified on the Medicare claims against each beneficiary’s inpatient medical record, prescribing physician’s referral form, and the hospital’s OCR medical record.

9. Obtain and review the referring physician’s medical records for a beneficiary with a Medicare-covered diagnosis of stable angina. The goal here is to verify the accuracy of the diagnosis.

10. Verify whether Medicare reimbursed the hospital beyond the maximum number of services allowed. Cardiac rehabilitation services may be considered reasonable and necessary for up to 36 sessions—usually three sessions per week—in a single 12-week period, according to the OIG.
GME: Ensure accurate education reimbursement

There’s a risk of fraud for incorrectly billing graduate medical education (GME) payments, says Lisa Colletti, associate dean for graduate medical education at the University of Michigan in Ann Arbor. However, if you carefully audit these services, you’ll practically eliminate your fraud risk and maximize your organization’s allowable reimbursement.

The Office of Inspector General (OIG) has performed numerous GME audits. Follow its lead and review how your organization bills for GME and indirect medical education (IME) costs.

To assess your organization’s compliance with GME billing requirements, increase documentation of where residents are working. Then ensure that your hospital bills for resident efforts in specific locations within hospital and nonhospital settings, says Colletti.

Billing requirements
Medicare reimburses medical education costs separately for GME and IME. The Medicare reimbursement calculations for medical education costs are also different for GME and IME full-time equivalent (FTE) residents, according to the OIG. The following details how they differ.

Graduate medical education
GME reimbursement covers direct costs for salaries and fringe benefits for medical residents in an approved medical resident training program, expenses paid to teaching physicians for direct teaching activities, and overhead expenses related to the program. The following must be met to count GME FTEs:

• Residents must be in an approved program.
• All residents in their initial residency period (IRP) count as 1.0 FTE. After the IRP, count residents as 0.5 FTE. The IRP is the minimum time it takes the resident to be eligible for board certification.
• All residents who graduated from a foreign medical school must pass a foreign medical graduate examination for the hospital to include the resident in the GME reimbursement count.
• Residents’ time in inpatient and outpatient settings is allowable. If a resident works in an outpatient

Top GME risk areas

The Office of Inspector General has identified the following problem areas in its audits of graduate medical education (GME) and indirect medical education (IME) reimbursement:

• Nonreimbursable residency programs—make sure an appropriate accrediting body approves all programs. This is required. See audit plan on p. 7 for more information.
• Rotations outside the hospital without written agreements—state in agreements that the hospital will pay the resident’s salary and fringe benefits while the resident is training at the nonhospital site. Also, make sure it lists the hospital’s payment to the nonhospital setting for teaching activities and the hospital’s requirement to incur all costs for the training program.
• Unallowable research activities—don’t include residents engaged exclusively in research in the IME count and don’t count residents involved in research that is not part of an approved program for direct GME or IME reimbursement.
• Improper weighting factor for resident’s outside the initial residency period—count residents as 0.5 in the full-time equivalent (FTE) count when they exceed the initial residency period.
• Unallowable activities—do not include residents in a hospital’s FTE count if they exceed the leave limitations during their residency. You may include a resident after he or she makes up the time. Also, make sure programs assign residents to the prospective payment system or the outpatient area of the hospital.
setting that is not part of the hospital, the hospital may claim the time as though the resident worked in a part of the hospital—as long as a written agreement exists between the hospital and the nonhospital provider.

- Residents must perform research as part of an approved residency program.

**Indirect medical education**

IME reimbursement covers increased patient care costs, such as the costs associated with the additional tests residents may order that a more experienced physician would not. The IME is an add-on to the hospital’s diagnosis-related group payment. Factors considered when counting IME FTEs are generally the same as the GME factors above, except the following:

- Time spent doing research can count for IME only when it relates to the direct care of a hospital patient.
- Residents must work in a hospital’s prospective payment system portion, a hospital’s outpatient department, or in a nonhospital setting (provided that a written agreement exists between the hospital and the nonhospital provider).

### Graduate medical education audit plan

Audit the accuracy of the resident full-time equivalent (FTE) counts your hospital uses for claiming graduate medical education (GME) and indirect medical education (IME). To ensure that your hospital bills appropriately for medical education, do the following:

1. Review the results of past GME/IME audits completed by your organization.
2. Obtain copies of your hospital’s Medicare cost report and supporting intern and resident information system file.
3. Identify all residents the hospital claimed on the Medicare cost report for GME and IME.
4. Reconcile the FTE counts to the Medicare cost report, Worksheet E-3, Part IV for GME and Worksheet E, and Part A for IME.
5. Review your hospital’s residency programs. Determine whether an appropriate accrediting body has approved the programs. One of the following organizations must approve residency programs:
   - American Medical Association’s Accreditation Council for Graduate Medical Education
   - American Osteopathic Association
   - American Dental Association
   - American Podiatric Medical Association
6. Identify all foreign medical school graduates. Determine whether these residents should be included in the FTE count.
7. Determine the length of the initial residency period (IRP) per specialty and verify that the FTEs were properly weighted. Hospitals may count residents in their IRP as 1.0 FTE. After the IRP, hospitals must count residents as 0.5 FTE.
8. Obtain the rotation schedules for all claimed residents and verify whether the hospital properly computed individual FTE time. Then verify that the hospital claimed this time in compliance with Medicare regulations.
9. Determine whether each resident’s time spent in clinical research is allowable. For GME FTEs, residents must perform research as part of an approved residency program. For IME FTEs, time spent doing research may count for IME only when it relates to the direct care of a hospital patient.
10. Determine the net dollar effect of audit adjustments to the GME and IME FTE counts. To do this, recalculate the hospital’s Medicare cost report Worksheets E-3, Part IV for GME and Worksheet E, and Part A for IME.

*Source: Adapted from Office of Inspector General audit programs.*
Eleven steps for HIPAA audit planning

You devote countless hours and resources to bringing your organization into compliance with the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Over time, the “HIPAA hype” will wear off, but you still need to ensure compliance. Auditing and monitoring will help your organization do that and adapt your current HIPAA practices to meet the changes ahead.

Why do a compliance audit?
The privacy, security, and transactions and code sets rules do not contain a specific standard for a compliance assurance program or for ongoing auditing and monitoring.

However, in addition to the compliance deadline dates that signal the start of enforcement for compliance, several specific standards require covered entities to ensure that “uses and disclosures are consistent with the notice of privacy practices,” and that you review and modify security measures as needed to reasonably protect information.

In addition, your transactions must conform to the ASC X12N standards.

HIPAA audit plan
Do the following to begin your HIPAA auditing and monitoring process:

1. Identify focus for the HIPAA privacy and security rule audit.
   Perform an overall assessment of the privacy and security program to identify an audit focus. An event may also trigger an audit. For example, your risk manager may receive several complaints about disclosures made without authorizations.

You may want to institute an internal audit of the entire HIPAA compliance process, including the privacy officer’s role in policy development, training, and monitoring.

2. Notify the department subject to audit.
   Make your work force aware that you are performing ongoing compliance assurance. This will help you avoid any potential claims of unfair practices and help elicit support and provide reassurance that the organization values compliance.

3. Develop an audit plan.
   Planning the audit is very much like setting up a formal research study.
   Follow these six steps:

   • Establish audit objective: The objective of the audit may be posed as a hypothesis. An example: “Staff members are thoroughly trained on information system disaster recovery.”

   Or, pose the objective as a research question. An example: “Are staff members thoroughly trained on information system disaster recovery?”

   The internal audit will help you find out whether you can prove the hypothesis or answer your question.

   • Identify and select data sources: As with a research study, an internal audit will establish precise means to collect and analyze data.

   Identify sources of data that will test the hypothesis or answer the question.

   • Develop a sampling plan: The sample should indicate how much data, from whom, and around which parameters to collect the data. Make sure the data collected is statisti-
cally valid and reliable.

- **Design a data-collection instrument**: Select the most suitable tool or instrument with which to collect the data, such as a survey, focus group, or interview.

- **Develop an analysis plan**: Include various statistical analyses that present the results using the most appropriate means and that also help you determine root cause and the validity and reliability of the data itself. Some examples include control charts and decision-tree diagrams.

- **Develop the audit schedule**: Conduct the audit when it will reveal the most indicative results. For example, don’t conduct it immediately after a massive training effort.

4. **Collect and analyze data**
   Carry out the audit.

5. **Draft a report for the audit’s subject department to review. Include a time frame for corrective actions and follow up review.**

6. **Let the subject department review the report for differences of fact, interpretation, and appropriateness of corrections.**

7. **Develop a final report, including identification of any disagreements.**

8. **Have organizational authority (e.g., board of directors, chief executive officer) review the report and resolve conflicts.**

9. **Develop the final report.**
   Generally, the organizational authority that reviews the audit report will return it for finalization. Incorporate any amendments in the report. If there are no changes, consider the report final.

10. **Review auditee actions taken.**
    The audit team is often the group that receives evidence of corrective actions or conducts re-audits.

11. **Deliver the report of review, with any non-compliance and recommendations.**
    If after the designated period of time the auditee has not taken corrective actions or the corrective actions aren’t working, deliver a report of non-compliance to the organizational authority. In it, include recommendations. At this point, the cycle begins again.

Editor’s note: This article is adapted from the book Guide to HIPAA Auditing. Written by HIPAA expert Margret Amatayakul, RHIA, CHPS, FHIMSS, the Guide to HIPAA Auditing is a step-by-step book and CD-ROM resource for auditing and monitoring your HIPAA compliance program. Designed to work in a variety of health care settings, it is a tool that quickly and accurately helps you audit specific practices. Go to www.hcmarketplace.com/Prod.cfm?id=2206 for more information or to order.
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Physician contracts

Monitoring
Regularly review the quality of physician’s work, says McGinty. Look at performance standards and records proving the physician performed the required services. Make sure your hospital has procedures to end a contract.

Also maintain a database of all physicians the hospital pays, says Breighner. Monitor these on a monthly basis for compliance with contracts. “Our database has a synopsis of each contract and lists all payments and hours worked by each physician,” Breighner says. “Our operations department monitors this and notifies the compliance department of any problem areas. Internal auditors review this area annually.”

If you find a potential problem during the audit, phrase recommendations as best practices, says Kozik. Use the following two examples of possible audit findings and best practice recommendations:

1. Physicians do not submit weekly time sheets:
Recommend that physicians complete weekly time sheets and send them to a hospital manager, who will verify and sign off on them.

2. Contracts do not include signatures: Develop a process to ensure that hospital administrators and physicians sign all contracts, forward them to legal counsel for review, and maintain them in a database for tracking.

Audit best practices
Perform a comprehensive review of all payments your hospital makes to physicians and identify corresponding contracts with those physicians, Breighner says. For your first audit, try reviewing all physician contracts. In subsequent audits, review a sample of payments. Consider reviewing all contracts at the same time, says McGinty. This allows you to compare formats and look for consistency of language.

Follow your instincts. “If it looks like the contract was established just to reward referrals, you are probably correct. Each contract contains terms and conditions, so your goal as an auditor is to find evidence to support all the terms and conditions,” says Kozik.