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IN THIS ISSUE

Follow OIG Advice on When and How to Audit Effectively 1
The OIG has provided some helpful advice about effective claims auditing procedures—following it could increase your practice's efficiency, besides keeping you out of trouble.
▶ When to Consider Consulting an Attorney About an Audit (p. 3)

Give Continuous Training to Billing and Coding Personnel to Help Ensure Compliance. 5
Keeping your billing and coding staff up-to-date is worth the effort. We'll show you how to get started.

Get Plans to Pay for Services by Uncredentialed Providers 7
Here are two steps to help you clear this hurdle.

Dos & Don'ts 9
▶ Include Human Resources Manager in Your Compliance Committee
▶ Keep All Bulletins from Your Carriers and Fiscal Intermediaries
▶ Don't Make General Counsel Your Compliance Officer

Show Your Lawyer 10

IN FUTURE ISSUES

- HCFA Issues New Stark II Regulations
- Tips for Serving Hearing-Impaired Patients Without Violating the ADA
- How to Do a Credentials Check of New Physicians

Follow OIG Advice on When and How to Audit Effectively

Do you know if your practice's billing and coding is being done promptly and properly? If it isn't, a payor may sometimes mistakenly pay you for an improper claim. If you don't find out that an error was made until months later, you may have made the same error repeatedly. You'll not only have to repay a lot of money, but you could be in legal hot water. So it's crucial to find problems soon after they occur (or even before they occur) and have an opportunity to correct them quickly. A comprehensive and consistent periodic auditing program can help you do this. It may also make your practice more efficient and more profitable.

Surprisingly, some of the most useful advice on setting up an auditing program for small medical practices comes from the OIG. When the OIG released its final small physician practice compliance program guidance in September, it included a very detailed section on auditing procedures it recommends for smaller medical practices. "The OIG did a nice job as far as the auditing advice goes," says New York health care attorney Matthew Kupferberg. "A medical practice that sets up an auditing program that mirrors what the OIG suggests is likely to discover most problems early while they're still easy to correct. And a thorough auditing program is the meat and potatoes of an effective compliance program—once you've got that, the rest is just gravy." Plus, he adds, an auditing program like the one the OIG recommends shouldn't be too expensive to implement or too cumbersome to run.

We'll show you how to set up an auditing program using the OIG's suggestions. We'll tell you what to look for when you audit, and we'll point out some pitfalls to avoid. Plus we'll tell you how to respond when your audit uncovers a problem.

Adopt Formal Program

Many practices don't have a formal auditing program. They may decide to audit only if a problem arises, or if the practice is adding a partner or is for sale. But it's prudent to have a formal program that calls for regular audits, Kupferberg explains. First, the OIG emphasizes auditing in its compliance program guidance. If you don't have an auditing program and you get caught submitting incorrect claims, you may be treated more harshly than you would if you had a system in place to detect and correct violations.

Second, it's just a good business practice, Kupferberg says. A system of regular audits means that employees won't be as tempted to bend the rules because they know they'll be caught sooner rather than later. And a system of regular audits will help you if you ever have to fight a payor over an improperly denied claim, or defend a request for repayment. If you audit regularly and can show comprehensive audit records, you'll have a much easier time documenting your side to payors.

(continued on p. 2)

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FOLLOW OIG ADVICE (continued from p. 1)

Do Baseline Audit to Identify Problem Areas

Start your audit program with a baseline audit. It's a very effective tool to identify problem areas and let you know where you stand, says Ann Zeisset, coding practice manager of the American Health Information Management Association. The OIG recommends conducting a baseline audit three months after your practice implements a compliance program. Even if you don't have a formal compliance program and don't plan to implement one, a baseline audit is an effective way to find out how your practice is doing and where it needs improvement.

The baseline audit should review claims submitted during the previous three months by looking for problems throughout the claims preparation and submission process. Look at every step from patient intake to assuring proper documentation to timely submission of claims, Zeisset says. When performing your baseline audit, do the following:

Designate an auditor. You don't need to hire an outside auditor for your internal audit program—that would be overkill. Instead, assign the job to a responsible person in your office. The person needs to be familiar with coding and billing requirements, and ideally would have some medical training. For some practices, that generally means that responsibility for conducting the audit must be shared by two people—for example, the billing office manager and a senior RN. If no person or persons are available in your office who meet these criteria, then designate the most responsible person who's familiar with billing and coding rules. And make sure that person has access to someone with medical expertise when questions arise about medical necessity, etc.

Take a random sampling of claims. There are several ways to do this. Zeisset advocates randomly choosing a date and auditing the chart of every fifth patient in the appointment book for that date. But if some physicians or coders in your practice aren't working on the chosen date, this method may not give you all the information you need. Instead, you could try selecting a certain number of patient charts (five to 10) for each of several days.

There are other ways to compile a sample. For example, in a multi-physician group, choose a certain number of charts per physician—say, every third patient seen by each physician on a particular day—until you have 10 charts per physician. Just make sure that the sample is random and not chosen, Zeisset stresses. An example of choosing is selecting only small charts, or the charts of just one physician, or the charts for a single diagnosis. Document the way you compile your sample, and do it the same way every time.

Scrutinize each chart carefully. When conducting your baseline audit, you're looking for any flaw in your practice's handling of the patient and his chart, says Zeisset. Go through each chart with a fine-tooth comb and make sure it contains everything that should be there. So, for example, check each patient's intake form to make sure that it's complete.

Other questions to keep in mind when looking at each chart include:

- Are referrals from the primary care physician recorded in the patient chart, if applicable?
- If tests were ordered, are the results in the patient's chart, and is there an indication that the patient was informed of the result?

■ Does the chart contain thorough documentation of every patient visit?

■ Is the time frame for follow-up noted in the chart?

■ Is there a system to note phone conversations or e-mail between your practice and the patient in the chart?

Evaluate services. For this step you need someone with medical background to look at the patient charts and confirm that the services performed were reasonable and medically necessary. Sometimes this evaluation will show that a particular physician habitually orders certain tests or services when confronted with a given set of symptoms. If the evaluation shows a pattern like this, it's important that you caution the physician about rote ordering. Every test or service ordered for a patient must be supported by the patient's clinical condition as documented in the patient's chart.

Analyze billing and coding. Finally, you need to check to ensure that your practice's billing and coding procedures are complete and accurate. Go through each patient's chart carefully, and make sure that every test, service, or procedure that you billed for was actually ordered, performed, and documented.

Next, look at the way the claims are coded. Is there support for the diagnosis code in the chart? If the chart contains a differential or rule-out diagnosis, are signs and symptoms documented? If your practice uses evaluation and management (E/M) codes, does the documentation adequately support the level of code selected? Are all your coding choices specific enough? Practices should always code to the highest level of specificity the documentation supports. Finally, look at modifiers and assignment codes to ensure that these are used correctly.

Make Adjustments Based on Audit Results

If you find any problem areas during your baseline audit, you need to develop procedures to correct them. No matter how minor a problem seems, immediately consider what caused it, how it can be remedied, and how you can prevent its recurrence, says Zeisset. For example, if you've found that several patients' intake forms were incomplete, put a system in place that prevents patients from seeing a physician until the intake form is complete. The most thorough and well-done baseline audit is a waste of time if you don't use the information it provides you to improve your practice, Zeisset says.

After the audit, the compliance officer, the office manager, or other responsible employees should use the information gleaned in the audit to establish corrective procedures. And don't procrastinate—the OIG's compliance program guidance recommends implementing corrective action within 60 days of discovering a problem.

***Insider* Says:** Make sure you document any corrective action you take, says Zeisset. If you develop a new policy or procedure to correct a problem, make sure all affected employees get a memo about it. If you send an employee to continuing education to address a problem, document his or her attendance. This could help you in the future if you're ever audited or investigated by third-party payors or the government, says Kupferberg.

Monitor Problem Areas

Once you've done your baseline audit, identified problem areas, and taken steps to correct them, you need to make sure the problems don't recur. You also want evidence that your compliance program is effective, and if not, you want to identify where it's failing and take steps to find a solution. Monitoring problem areas or high-risk areas can help you accomplish these goals.

To monitor problem areas, you select criteria associated with the

(continued on p. 4)

▶ *When to Consider Consulting an Attorney About an Audit*

In general it's unnecessary to have an attorney supervise a routine internal baseline audit or periodic audits, says New York health care attorney Matthew Kupferberg. Regular auditing to ensure that procedures are followed correctly and your compliance program is working effectively doesn't require outside legal guidance, he says. But there are some situations when you'll save yourself a lot of grief, and may ultimately save money, by bringing in an attorney to supervise an audit:

- If the practice initiates an audit in response to a complaint by a patient, payor, or other party with knowledge (such as a former employee). If there's any likelihood that the complaint has some merit, the practice's attorney should be involved in the audit from the earliest possible moment, as well as in determining how you'll respond to the complaint.
- If the audit is initiated by a payor or a government agency. Even carrier audits, although not unusual, carry enough risk, Kupferberg says, that he likes to be involved from the beginning.
- If your audit uncovers systemic problems, or large payment discrepancies or reimbursement errors, consult your attorney before deciding your next step. Returning a large overpayment to a Medicare carrier may trigger a carrier audit, for example. And some systemic problems may trigger self-disclosure obligations, which require an attorney's help.

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FOLLOW OIG ADVICE (continued from p. 3)

problems you've found. You review any chart that meets the criteria at the time of the patient's treatment. For example, maybe your baseline audit turned up an E/M code that a particular physician habitually misuses. You'll "flag" that physician and that code, and every time the physician assigns that code, the chart is reviewed to ensure the documentation supports the code choice.

Also monitor low-volume or high-risk areas whether you've noticed a problem or not, Zeisset says. And the OIG suggests that each practice periodically look at the practice's top 10 categories of claims' denials or top 10 services performed. The monitoring criteria you establish will depend on your resources and the particular risk areas for your practice. Some other examples of situations that may call for close monitoring:

- New procedures or services;
- Situations that have been the subject of OIG Special Fraud Alerts;
- Procedures or services that the OIG has targeted for investigation in its work plan (for example, E/M coding, diagnosis coding, nursing home visits); and
- Use of CPT codes that have a disparate impact on reimbursement.

Schedule Periodic Audits

After the baseline audit, you should conduct an audit regularly—in its compliance program guidance, the OIG says at least annually. But quarterly or monthly is better, depending on the size and resources of your practice and whether your baseline audit turned up any systemic problems. If your baseline audit turned up serious problems, monthly audits are a good idea. You can see whether the solution you devised is working and fine-tune any corrective action with the information you get from the monthly audits.

When setting up your periodic audit program, make sure you:

Choose prospective or retrospective audits. You must decide whether you'll audit prospectively (before you submit claims) or retrospectively (after they're paid or denied). A prospective audit means you're most likely to catch the problem before anyone else does, but it can cause delays in accounts receivable. If you choose to do a retrospective review, it's imperative that any problems you find be immediately corrected, Zeisset cautions. That means promptly returning any overpayments and implementing corrective procedures to avoid any recurrence of the situation that led to the overpayment.

Cover wide range of charts in your samples. Unlike your baseline audit, your periodic audit doesn't have to cover a *large* random sample. But you should make sure your sample includes charts from all physicians in your practice. You also want to include charts that every coder worked on. And your sample should include a few charts for every payor your practice routinely deals with.

Focus on problem areas. Do a thorough review, but focus particularly on those areas that have been troublesome in the past—for example, problems uncovered by the baseline audit, Zeisset advises. Also look closely at areas the OIG has identified as high risk, such as proper use of ABNs and adequate documentation for services billed under an E/M code.

Document deficiencies and improvements. Be sure to document areas of great accuracy and of improvement, as well as deficiencies, she says. Thorough documentation of all results and any corrective measures will help you in the event of an audit by a third-party payor or the government. It's an indication of a well-run practice with an effective compliance program. It also will help you to run a more efficient and profitable practice, because it will show you what your practice does well and what sort of corrective action is most effective in your practice.

Disseminate results. Once you've done your analysis, it's important to distribute the results to selected employees who can learn from them, says Zeisset. Certainly the physicians and the coders need to know the audit results, and the office manager should be told, too. Depending on how responsibility is allocated in your office, there may be others who should be told. The important thing is to make sure that the results are used in concrete ways to improve performance, says Zeisset.

***Insider* Says:** You can get a copy of the OIG's final guidance at <www.hhs.gov/oig> (click "electronic reading room"). Or call the OIG's public affairs office at (202) 619-1343 for a copy. ■

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Give Continuous Training to Billing and Coding Personnel to Help Ensure Compliance

An efficient billing and coding department staffed by knowledgeable personnel who are up-to-date on all the latest rules and regulations is crucial to your practice's success. It helps your practice get paid promptly and appropriately and reduces the risk of audits, investigations, or worse. But the rules on reimbursement are changing all the time, and it's tough to keep up. That's why the OIG emphasizes training of billing and coding personnel in its small physician practice compliance program guidance issued in September 2000. You can get a copy of the final guidance at the OIG Web site <www.hhs.gov/oig>.

We'll explain what the OIG says about the training of billing and coding personnel—which should begin when new hires first come to work and continue throughout their employment. And we'll offer you some suggestions from experts about establishing a continuous training program like this in your practice.

What OIG Says About Training

The draft compliance program guidance for small physician practices offers many specific suggestions about training billing and coding personnel, says Ann Zeisset, coding practice manager for the American Health Information Management Association. Although you're not required to adopt a compliance program or to follow the suggestions the OIG makes in the guidance, it's prudent to do so, she says. Plus the OIG offers good suggestions that make sense to follow, Zeisset explains.

The guidance includes these key suggestions for training billing and coding personnel:

- Offer training within 60 days of employment and have new hires work under the supervision of experienced personnel until training is complete;
- Make all billing and coding personnel understand that compliance is a condition of continued employment;
- Train continuously; and
- Include specific information about coding standards, documentation requirements, claim development and submission, proper billing standards and procedures, and the legal, ethical, and financial ramifications of submitting improper or inadequately documented claims.

How to Establish Training Program

Establishing a training program that includes all the OIG's suggestions doesn't have to be difficult or time-consuming, says Georgia billing consultant Melody Mulaik. The time and effort you put into your training program will be repaid, she believes, because you'll have fewer pended or denied claims, and your billing and coding department will be more productive and operate more efficiently. Zeisset agrees and notes that even if the OIG hadn't recommended continuous training for billing and coding personnel in its recent guidance, it's worthwhile for its own sake.

Here are suggestions from the *Insider*'s experts to help you get started.

Prepare training materials for new hires. When someone new joins your billing and coding department, it's important to get that person up to speed as soon as possible. So it's worthwhile to compile appropriate training materials for new hires ahead of time—and give them to the new hire as soon as he or she begins working for you. At a minimum, this training material should contain:

- A copy of your practice's policies and procedures;
- A copy of your practice's compliance plan;
- Important coding information, like updates from your carrier; and
- A description of the documentation requirements most applicable to your practice—for example, in a radiology practice, that an order from a primary care physician is required, or in an ophthalmology practice, what documentation is needed to assign evaluation and management codes.

***Insider* Says:** Don't consider the job done once you hand a package of written material to a new hire. Instead, give the new hire a few days to review the material and then have an experienced employee—preferably the new hire's supervisor—review it with the new hire. They should also discuss any questions the new hire may have.

Set a schedule for new hire training. Depending on your practice, you may want to formally train new hires soon after they begin working. Or you may want to use a more informal process, such as having them work under someone else's close supervision for a while until they're used to the way you do things. What's important is that you develop a training schedule that works for your practice and stick with it. If you're ever investigated, the OIG wants to see that you've consistently tried to keep all your employees up-to-date about compliance issues. A consistent training schedule—whether the training is formal or informal—is one way to do this.

(continued on p. 6)

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GIVE CONTINUOUS TRAINING
(continued from p. 5)

If you want to conduct formal training for new hires, you have several choices, says Zeisset.

■ Have the head of the coding department or your compliance officer or office manager conduct the training, making sure to cover essential elements such as documentation assessment, correct coding guidelines, and proper use of standard coding resources;

■ Arrange for new hires to attend programs sponsored by specialty societies, professional organizations, and even local colleges on these topics;

■ Direct new hires to training on Medicare fraud and abuse rules that are available online at www.medicaretraining.com; or

■ Outsource this responsibility, and hire a consultant to provide training assistance.

***Insider* Says:** Whichever method or combination works best for your practice, make sure to document that new hires have received training, as the OIG recommends, within 60 days of beginning work, says Zeisset.

Create an environment that encourages continuous learning. Almost every week some legal or regulatory development or some change in payor policy will affect your practice. You need to make sure that your billing and coding personnel are informed promptly of these developments. And from time to time your practice will have claims denied or pended. By investigating the reason for this, you'll get a clue about areas where additional training is needed.

Have your billing and coding personnel meet at least quarterly, Mulaik suggests, to discuss changes in law, regulation, or payor policy and to correct any problems in their performance that have become apparent. Or, depending on your practice, try a less formal approach. For example, at Mulaik's company, billing personnel meet once a week to discuss these issues. And many physician practices have monthly meetings where coding and compliance issues are discussed, Zeisset says. The crucial point is that employees have regular opportunities to learn about developments that affect the way they do their jobs, she says.

Maintain a library for billing and coding personnel. Payors regularly send out updates about reimbursement rules or changes in the way they want you to code a certain procedure. This information needs to be available to your billing and coding personnel. They also need access to other sources of information, such as the HCFA Carrier's Manual, a current CPT manual, a current ICD-9 manual, AHA and AMA official coding guidelines, and various publications and newsletters.

These resources should be kept in one place, and the billing and coding personnel should be encouraged to review them regularly, not just when a specific question arises, suggests Mulaik. It's essential that you tell billing and coding personnel that the latest information is available and that keeping current with payor requirements is a condition of their continued employment. You might consider having them sign a form acknowledging their requirement to keep current and keeping the acknowledgment on file, Zeisset suggests.

Encourage credentialing. The OIG guidance doesn't require that your coders be certified, but you should consider encouraging them to become certified, says Zeisset. There are several professional organizations that give competency tests and certify coders. These organizations provide educational materials, including online training programs, publish periodicals, and hold continuing education meetings. Membership in one of these organizations can provide your coders, and your practice, with access to excellent, up-to-date news about developments in coding.

Consider using professional meetings as rewards. Professional organizations frequently hold meetings about important compliance issues at resorts and other appealing locations. Paying your employee's way to one of those meetings can be a way to reward a good employee and further your compliance goals at the same time. The employee will enjoy her time away from the office, but also will pick up important information to share with colleagues. And the written materials from these professional meetings make an excellent addition to your compliance library.

***Insider* Says:** Even if you outsource your billing and coding, it's important that someone in your practice keep up with developments in reimbursement policy. Your practice is ultimately responsible for the claims your billing service submits, and someone in the direct employ of the practice must be competent to oversee the billing service's work. ■

Insider Sources

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Get Plans to Pay for Services by Uncredentialed Providers

Like most physicians, you may add employees (as well as partners and other staff) to your practice or facility after you sign a plan contract. But even if your contract says that new employees and partners will "automatically" be included on the plan's physician panel, you must still clear another hurdle. Most plans require that these new employees and partners be individually credentialed by the plan before they can start treating plan members, and will refuse to pay claims submitted by uncredentialed physicians. This can be exasperating for you and severely cut your revenues.

But you can avoid this problem, experts say. We'll tell you how to do that.

How Credentialing Process Burns Practices

Plans often will add your new employees and partners to their provider panels, especially if your contract says they must be included automatically. Even so, you're not home free. Most plans will insist that these new staff members be individually credentialed—that is, meet the plan's quality requirements—before they can treat plan members. Before approving a new physician and adding her to the panel, plans will confirm that the physician has a license to practice her specialty, malpractice insurance coverage, and appropriate academic credentials—and fulfills other criteria, says Texas attorney Robert Wolin. "Plans don't want to be sued by members for letting unqualified people treat them," he explains.

But the plan's credentialing process may be agonizingly slow, warns Maryland attorney Randi Kopf. "Some plans take from six to 12 months to credential physicians," she says. So your new employees or partners will be considered out-of-network by the plan until they're credentialed. This means that you may be reimbursed less by the plan for their services—or not at all. And if you can't schedule plan members to see your new uncredentialed employee or partner, it restricts member access to your group and causes members to wait longer for treatment, which can undermine member satisfaction with your services, notes Virginia consultant Brant Kelch.

Some practices will try to get around the problem by having the new physician see the plan member but billing the service under the provider number of a physician that the plan has already credentialed. But if you use the physician number of another employee or partner, you're falsifying a claims submission. "If a plan finds out that an uncredentialed physician treated the member and that you filed a claim under a different physician's name, the plan can accuse you of fraud," Kopf says. "It can terminate your contract and go after you for damages." And if you try this with a member covered under a federal managed care health program, such as a Medicare or Medicaid plan, you could be violating the federal *False Claims Act*. The penalties for that are severe and include hefty fines, exclusion from participating in the Medicare and Medicaid programs, and even prison, warns Wolin.

Other practices may try to get around the problem by letting the new physician see plan members before he's credentialed and holding off submitting claims on those services until after he's been credentialed. But then you may be submitting claims too late—after the submission deadlines have passed—and the plan may refuse to pay the claims.

Even if some plans initially pay these claims because they don't spot the discrepancy between the date of service and the date the new employee or partner was credentialed, you still can't rely on the payment. A plan may discover and retroactively treat the claims as services performed by a nonnetwork physician. It may demand that you repay the money—or offset it against money it owes you for other services, warns Kopf.

How to Protect Yourself

The *Insider* recommends two protective steps—and suggests taking both of them, if possible.

Step #1: Speed up credentialing process. The best protection is to avoid the problem entirely by getting your new employee or partner credentialed by the plan before she sees plan members, says Missouri attorney Jill Rubin Hummel, who recommends this strategy to her clients. "Submit the new physician's application to the plan's credentialing committee as soon as she agrees to join your practice or facility," Hummel says. If your group has sufficient resources, Kelch suggests credentialing the physician yourself, just as the plan would, prior to adding the physician to the practice. This can serve as a trial balloon and let you know if there's something in the physician's background that may cause problems or delays in credentialing, he says.

To speed up the credentialing process once the application has been submitted, ask the plan to expedite the application. Experts say this is a realistic request. Many plans are willing to expedite the credentialing

(continued on p. 8)

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GET PLANS TO PAY FOR SERVICES
(continued from p. 7)

process on a case-by-case basis, especially if you explain that faster credentialing will let you shorten members' waits for appointments, says Kopf.

To make your request, contact your provider relations representative and ask the representative to hand-deliver or overnight the application to the various plan personnel who need to review and approve it, says consultant Thomas P. Gordon, former head of network development for a major regional plan.

Step #2: Add contract clause. Even if the plan is willing to speed up credentialing for you, that doesn't mean that a new employee or partner will be credentialed by the time he starts working. To cover this possibility, put a protective clause in your contract that entitles you to get paid while your new employee's or partner's application is wending its way through the credentialing process. Here are two options.

▶ *Best protection: Plan agrees to pay while application pending.* Your best protection is to include a clause in your contracts that says you can use new employees or partners and bill for their services while their credentialing application is pending, says Wolin. Many plans will agree to add this clause, he says, since the plan must pay the claims only if the new employee's or partner's application is ultimately approved. "There's no financial risk for the plan," he says. "If the applicant doesn't meet the credentialing standards, your practice eats the bill." It means also that the plan can delay paying the bills until the new physician is actually credentialed.

You can use the following clause, based on one used by Wolin, to cover new employees and partners. The clause is geared toward physicians being added to a physician network, but can be used for any type of provider. The clause acknowledges that you can submit the claims for a new employee or partner while the credentialing application is pending and says you can expect payment once the application has been approved. You still must adhere to the deadline set elsewhere in the contract for submitting claims. The clause here assumes a deadline of 180 days, but that will vary. The clause also says that if a new employee or partner isn't credentialed before he treats a member, he's still subject to the plan's utilization review and other applicable procedures. And the plan isn't obligated to credential a new employee or partner who doesn't meet its credentialing criteria.

Insert the clause in the section that addresses recruiting and credentialing new physicians, if there is one, or in a separate section:

Model Contract Clause

New Physicians. Practice and Plan recognize that from time to time new physicians will become partners or employees of Practice ("New Physicians") and that such New Physicians may be treating Plan Members. Practice recognizes that Plan will not pay for any items or services provided or ordered by a New Physician until such New Physician has been credentialed in accordance with section [*insert section #*] of this Contract. Notwithstanding the foregoing, if a New Physician is credentialed in accordance with Plan's policies and procedures, Practice will be paid in accordance with the terms of this Contract for any services or items provided or ordered by such New Physician from and after the date such New Physician has applied to Plan for credentialing, provided all such claims have been submitted to Plan within 180 days of the date on which New Physician's items or services were rendered. Nothing herein shall obligate Plan to credential a New Physician except in accordance with its usual and customary policies and procedures.

If a New Physician provides services to a Plan Member prior to becoming credentialed, such New Physician shall be subject to the Utilization Review, Quality Improvement, and other applicable procedures specified in this Contract.

***Insider* Says:** If you're going to use this clause, check your contract for a "third-party beneficiary" clause. If you find one, ask the plan to delete it. This clause gives third parties, such as plan members, the right, among other things, to sue your practice and the plan for "negligent credentialing" or trying to bypass the plan's established credentialing standards, notes Wolin. This clause could make it easier for a member to argue that your practice and the plan violated the contract by allowing the new physician to see members while the application was pending, even if the member hadn't been harmed.

▶ *Alternative: On-call coverage.* If a plan is hesitant about saying outright in the contract that your new employees and partners may treat and bill for members before the credentialing process has been successfully completed, there's a more roundabout way to achieve the same result. Review the contract's on-call coverage section to see if any physician can be used to take calls—in other words, that you're not barred from using on-call physicians from within your own practice or facility, explains Hummel.

If the clause limits on-call coverage to physicians unaffiliated with you, ask the plan to remove that limitation. Most plans will waive their credentialing requirements and reimburse for on-call coverage if the on-call physician accepts the contract rate, she notes. While the new physician may actually be at work and not technically be on-call when asked to treat a plan member, many plans are willing to overlook that technicality.

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"Plans understand and are willing to accommodate the realities of medicine," says Gordon.

Try Informal Avenue if Plan Balks

Sometimes a plan can't negotiate a contract change for political or other reasons. For instance, the National Committee for Quality Assurance (NCQA), which accredits many plans, doesn't recognize any form of provisional or temporary credentialing, according to NCQA spokesperson Brian Schilling. So an HMO that's about to be surveyed by NCQA might not want its contracts to expressly say that it allows uncredentialed or out-of-network physicians to treat plan members, even though most plans do allow it. The AAHCC/ORAC—the other body that accredits managed care plans—doesn't recognize temporary or provisional credentialing either, says Kelch.

But the plan may still be willing to work with you. If you ask, it may agree informally to let you hold off submitting claims—or to pay claims submitted for services provided by new employees or partners whose credentialing applications are pending, says one practice administrator. The administrator got all of the plans that the practice contracts with to agree to pay claims submitted by uncredentialed physicians whose applications for credentialing were pending, even though none of the contracts expressly granted that right.

The administrator contacted the physician representative at each plan and explained that the medical group had just added new physicians and couldn't juggle their schedules to ensure that the physicians whose applications were pending could avoid treating plan members, especially members who needed emergency care. Each plan agreed to pay the claims for the uncredentialed physicians. The administrator then documented each conversation in a memo and faxed it to the provider representatives. To date, the group has run into no problems—and all of the claims have been paid. (Some plans may agree to help you out, but will pay at a lower fee schedule.)

This method is particularly effective if you've discovered that you've already submitted bills for services provided by uncredentialed physicians—without the plan's permission, says Mildred Johnson, compliance officer for a Midwest university. "Plans will often try to help a practice that has discovered a mistake and takes steps to try to correct it," she says. Just make sure you confirm any conversation in writing so the plan can't later claim that the conversation never occurred and come after you for fraud and/or contract violations. ■

Insider Sources

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DOS & DON'TS

✓ *Include Human Resources Manager in Your Compliance Committee*

Include a manager from your human resources department on the team of people appointed to your compliance committee, suggests health care compliance expert L. Stephan Vincze, a health care compliance expert with Vincze & Frazer in Atlanta. Employees often raise compliance issues that involve human resources problems, such as discrimination and harassment. So you'll want someone on the compliance committee who has the necessary experience and knowledge to deal with these matters.

Having a human resources manager on the compliance committee has other benefits: It will keep the human resources department in the loop about employee concerns, and it's a great way to conserve resources, notes Vincze. The OIG says that employee education and training are significant elements of an effective compliance program. Your human resources department is likely to have training programs that can be adapted to focus on compliance issues, saving you the time and expense of starting from scratch. The department's prior training experience and teaching tools can also be of great value and assistance to your compliance committee's efforts. Including a human resources manager on the compliance committee lets you build upon what already exists, saving your practice time and money.

(continued on p. 10)

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DOS & DON'TS (continued from p. 9)

✓ Keep All Bulletins from Your Carriers and Fiscal Intermediaries

Be sure to keep all the bulletins you get from your carriers and fiscal intermediaries. They may be helpful years later to show that you followed the instructions you got at the time. If the government claims that you billed Medicare improperly but you have a bulletin from your carrier or intermediary telling you to do it that way, you may be able to avoid fraud charges, explains Washington, D.C., attorney Jeffrey F. Boothe.

For example, in one instance a hospital association got the government to back down in its investigation of the association's billing practices by showing old intermediary bulletins, Boothe says. The government was conducting a nationwide probe called "Project Bad Bundle"—looking into the labs' failure to bundle certain tests under a single CPT code when billing Medicare.

But, Boothe explains, when Project Bad Bundle reached several hospitals in Illinois, their association was able to persuade the government to curb the probe by demonstrating that their intermediary hadn't properly instructed them to bundle. The bulletins proved that the intermediary failed to explain HCFA rules. Without the old bulletins, these hospitals would likely have paid a high price to settle improper billing charges.

Medicare requires you to keep carrier and intermediary bulletins for five years. But Boothe says it's safer to keep them for 10 years because the government can potentially bring charges under the *False Claims Act* for that time period.

✗ Don't Make General Counsel Your Compliance Officer

Don't designate your general counsel to be your facility's compliance officer, recommends attorney L. Stephan Vincze, a health care compliance expert with Vincze & Frazer in Atlanta. Although the OIG says in its various compliance plans that providers should appoint a high-level official with direct access to their facility's president or chief executive officer and board of directors, it also cautions against appointing the general counsel or the chief financial officer as the compliance officer. It's like the fox watching the hen house—neither position has the necessary independence needed for credible oversight, notes Vincze.

The general counsel's primary role is to defend your practice against accusations of wrongdoing. The compliance officer's role is to be an independent, objective person who implements and monitors compliance efforts and to whom people can express their genuine concerns or complaints. If your general counsel gets potentially damaging information, she may have a tough time removing her defender hat to investigate and possibly expose suspected fraud or other improprieties. Designating someone other than your general counsel will reassure your employees and the government that your facility is committed to detecting wrongdoing and to taking corrective action, says Vincze. ■

Insider Sources

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SHOW YOUR LAWYER

Here are the court cases and/or laws referred to in this issue.

- False Claims Act: 31 U.S.C. §§3729 *et seq.*

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