

# Physician Practices – Reimbursement, Risk, and Recommendations

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In July of 1997, the US Department of Health and Human Services' ("HHS") Office of the Inspector General ("OIG") reported that nearly \$5 billion in "improper" Medicare fee-for-service overpayments had been made to physicians in 1996– a whopping 21.68% of the total Medicare fee-for-service overpayments reported. And even though the report stated that the OIG had no idea what portion of this amount was due to fraud, this figure and the persistent estimates of 3-10% of the total national health costs spent in overpayments due to "waste, fraud and abuse" was enough to focus Federal fraud initiatives on physician providers, clinics, and system-owned practices.

As a result of the 1997 report, Federal anti-fraud legislation has proliferated, not only providing the Government with more ways to get at potential healthcare fraud, but also systematizing the funding to expand the searches in more ways than before.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") had already greatly expanded the federal government's capacity to recoup inappropriate payments made under Medicare by creating the Medicare Integrity Program which not only doubled the number of OIG auditors and investigators but also permitted both the Federal Bureau of Investigation ("FBI") and the Department of Justice ("DOJ") jurisdiction over investigations of potential Medicare fraud and abuse and allowed HHS to contract with private entities (including fiscal intermediaries) to review and audit all activities where Medicare covers payments, to determine whether a Medicare payment should have been made, and to initiate recovery of payments. HIPAA also created a Health Care Fraud and Abuse Control Account with yearly authorizations dedicated to the pursuit of potential offenders and slated to grow from \$104 million in FY 1997 to \$240 million b FY 2004. At the same time, HIPAA permitted the OIG to receive a portion of its recovery and use it to make the funding of the OIG investigations – if not the office itself - self-sustaining.

While the numbers of physicians actually prosecuted for fraud is still small according to the American College of Physicians, physicians and their practices are not immune to investigation, nor are they immune to enforcement and or recoupment actions under the older "and more often used" False Claims Act (FCA) which has civil liabilities, treble damages, and stiff mandatory civil sanctions.

Civil sanctions may be imposed where a physician (or office staff) "knowingly" submits a claim that he knows - or should know - will fall into a prohibited category. Such sanctions may be imposed for each inappropriate claim - and each sanction may be as high as \$10,000 (\$50,000 for anti-kickback violations) plus an assessment for up to 2 to 3 times the amount improperly claimed.

Criminal Penalties may be imposed where an individual "knowingly and willfully" defrauds

Medicare or the other federal health care benefits programs, including Medicaid. Even one claim fraudulently submitted, may lead to penalties that include imprisonment for up to five years, a fine of up to \$25,000 per claim, and/or a five-year exclusion from participation in Medicare and Medicaid programs (lifetime exclusion after a 3rd conviction).

Particularly galling to physicians is the campaign with the American Association of Retired Persons (AARP), named “Who Pays? You Pay!” urging Medicare beneficiaries to scrutinize their physician bills and report to the government hotline suspected instances of “improper billing”. The initiative promises the reporting patient up to one-third of the amount recouped. AARP is strongly backing this initiative with literature urging its members to call the Medicare fraud hotline if they can’t answer a resounding “yes” to the following questions.

“Did you receive the service or product for which Medicare is being billed?”

“Did your doctor order the service or product for you?”

“Is the service or product relevant to your diagnosis or treatment?”

Anyone submitting a claim for payment as a Medicare provider must first be alert to the potential liability resulting from an inappropriately submitted claim. Once it (or its fiscal agent) receives a claim, the federal government (or agent) has the authority to investigate the claim's propriety. If that investigation finds a problem with the claim, which can range from an inadvertent mistake to an intentional misrepresentation, the government has the authority to impose either criminal or civil sanctions against the provider, and the agent has the authority to instigate a sampling review and carry out immediate recoupment based on their findings.

While all Medicare-provider physicians are at risk of having patients contact the Medicare “hotline,” practices in internal medicine, cardiology, ophthalmology and orthopedics may be especially vulnerable because of their larger numbers of Medicare patients. These specialties have been the focus of fraud and abuse initiatives by Medicare investigators in the past. But, in fact, the bigger the practice (the more Medicare or Medicaid patients it has) the greater the risk a patient will call the “hotline.”

With all these Federal investigators, private entities, and Medicare patients seeking “suspicious” claims, knowledgeable healthcare consultants are strongly recommending that physicians, practice groups, clinics, and entities that own or manage practices take some necessary steps to protect themselves against potential fraud investigations, recoupments, or charges. Physicians and practice-owning entities need to do more than remain passive and hope their patients don't misinterpret or fail to understand their bills, their diagnosis, or their course of treatment – and then reach for the telephone. They need to adopt some basic strategies to lessen the risk of being called on the carpet by HCFA.

## **Basic Strategies for Protecting the Practice and the Physician**

### **Strategy One: Know the High-Risk Areas**

There are several billing areas being monitored by Medicare, Medicaid, and many insurance companies through reimbursement claims. These are the ones that physician practices need to pay scrupulous attention to in order to avoid potential fraud difficulties: medical necessity; upcoding; overbilling; and unbundling. “Oh, we don’t do that!” your physician clients will say. “We wouldn’t do that.” But add the phrases “than your documentation will support” or “coding definitions different than you and/or your staff understand” and the picture changes. Physicians who claim they are too busy to fully document every chart will find their arguments get short shrift during a Medicare audit. The old saying, “If it isn’t charted, it didn’t happen!” has never been more true than it is in these situations. Physicians need to know that the requirement to submit the supporting documentation now routinely occurs in as many as 10% of all claims from physician offices – under a variety of computer-identified claim processing “suspensions for Medical Review.” Commonly, the physician’s billing staff simply photocopy the chart for that date and visit and forward it to the claims processing entity.

#### *Medical Necessity*

In the issue of medical necessity, the physician’s documentation must show that the service being rendered to a patient is warranted, given the patient's condition. The key is in proper charting, that includes complete documentation of diagnosis and symptoms, as well as legible handwriting. The chart must show a complete “snapshot” of the patient’s condition at that point in time – and it must be clear to a reviewer who does not know either the patient or the physician’s thinking. The fact that the physician believed the service rendered to be medically necessary must be clearly supported in the chart. Physicians who are of the opinion that “These are my office charts. They’re for me. I can understand the chart and why the care was necessary - surely the Medicare auditor will,” are taking serious risks. Those with the “I’ve always done it this way, why should I change” philosophy are putting themselves and their practices at significant risk.

#### *Upcoding*

Upcoding is a common source of fraud accusation. Briefly defined as “coding at a higher level of service than the documentation will support,” specialty practices dealing with more complex cases are particularly vulnerable to review on this issue. The computers that “red flag” practice patterns look for exceptions to bell-shaped curves in coding levels. If a physician’s claims are predominantly coded at Levels 3 and 4, the computer will identify that provider number and mark claims under that number for Medical Review. And, if the documentation justifying each level of service is not adequately supported by the requested documentation, the “flag” will remain for further investigation.

## *Overbilling*

Overbilling may also include double billing errors and billing for services not rendered. These may be perfectly innocent office errors and misunderstandings, but ignorance of the reimbursement processing system at the other end and not knowing Medicare guidelines causes physicians problems. For example, a physician may determine that it is medically necessary to see a patient in a skilled nursing facility three or four times a week for a brief period. However, if Medicare only permits two visits, the physician could be accused of overbilling. It doesn't matter if the physician thought he or she was just practicing good medicine any more than it matters if the billing clerk believed that no response to a claim sent 4 weeks ago means that it went astray – and so the clerk sends it again.

## *Unbundling*

Unbundling is another area in which physicians run afoul of Medicare regulations. It is the practice of maximizing reimbursement by billing separately for actions routinely done under the same overriding procedure. Practice patterns are studied to seek out this sort of violation. For example, most surgeons do not charge Medicare separately for abdominal exploration during a choecystectomy. A surgeon who does routinely sticks out like a sore thumb and is easily identified.

## **Strategy Two: Practice Assessment**

In the competitive health care environment, bringing in an experienced consultant to conduct a practice assessment can identify trends, suggest process improvements and provide recommendations to improve cash flow, reduce costs for a medical practice and point out ways to increase patient satisfaction. But an even more pressing reason for a Practice Assessment today is to review billing practices, collection systems – and the documentation supporting claims – in order make changes that head off investigations and audits.

A competent Practice Assessment consultant will look long and deeply at documentation issues from a number of perspectives in addition to the fee-for-service issues highlighted by Medicare/Medicaid billing. Attorneys know that clear and complete documentation make cases much easier to defend. Jurors have come to expect that important information will be documented. To them, unclear records seem haphazard and indicate a lack of attention to patient care. There is, however, another significant, reason that documentation and documentation systems have become vital - allegations of healthcare fraud that come in the prepaid or capitated care system. Claims have been made that if needed care was prepaid or paid for through a capitated arrangement and not provided, fraud has occurred. Further, and perhaps more frightening, is the question as to whether fraud has occurred when there is a prepaid or capitated payment arrangement and the patient claims that the level of care provided does not meet appropriate standards.

## **Strategy Three: Compliance Plan**

The number-one item on many practice management consultants' lists right now is the

establishment of a compliance plan as recommended by the American Medical Association (AMA) in both large and small practices. Moreover, where compliance plans are in place, they need to be regularly revisited to assure that they are both up-to-date and operating well. Long recommended for hospitals and home-healthcare agencies, hospices, and other community-based providers, compliance plans that focus on documentation and billing procedures, will most likely soon be needed for medical practices, as well as for individual physicians.

A compliance plan represents comprehensive documentation that the practice is aware of all Federal and state laws affecting it. It indicates that proper protocols and operating procedures, are in place and that efforts toward compliance with all regulations are continuous and systematic. Additionally, it demonstrates to an auditor that the practice follows Medicare regulations and shows that there is no intent to defraud.

A physician or practice group that can prove that there is a working compliance plan in place and that the rules and regulations are followed, have a basis for asserting “substantial compliance” and the auditor may be satisfied to address the isolated cases as errors rather than asserting fraud and abuse based on a few bills. And, of course, a compliance plan may not only help protect the practice from charges of fraud and abuse (or at least lessen such charges); it may also identify revenue lost as a result of work that has gone unbilled, been inadequately followed-through on, or has been incorrectly coded.

#### **Strategy Four: Rapport with Patients**

Patients with realistic expectations are more satisfied, less litigious, and more eager to speak well of a physician and rate him or her highly on satisfaction surveys. Studies show that they also take less time, are more likely to be compliant with agreed-upon treatment plans and to refer others.

Physicians should not overlook the power of good doctor-patient rapport. Malpractice prevention strategies work here, too. The time-honored reiteration that physicians who enjoy good rapport with their patients get sued less often than those with bad rapport holds true when it comes to accusations of Medicare fraud. It is the frustrated and disgruntled patient who sees the hotline number on the Medicare Explanation of Benefits and reaches for the telephone.

Patients should know what to expect when they are undergoing treatment. Protocols should be explained in advance. Patients are more satisfied when they see their clinician following the protocols they expect. Patients should be involved in problem-solving where there are requirements of them that must be followed. Considering how they will resolve the inconvenience makes the patient and family more willing, more compliant, and more confident in their physician.

Patients and their families need information. Such things as a pamphlet on the practice’s billing procedures help patients understand the reimbursement requirements faced by the practice and prevent misunderstandings and frustration. Practices should keep patients from being surprised and unsettled by unsuspected limitations. Limits, especially regarding access to care, or reimbursement coverage by payors, need to be understood as early in the relationship as possible.

Patients and their families need response to unmet expectations. When expectations aren't met, patients often call to ask questions. When the support staff is not informed and empowered enough to explain and resolve the question, the patient may feel that the practice is indifferent to them. Since much of patient satisfaction with care is related to perceptions of caring, these calls are occasions that forge relationships -- both positive and negative.

Physicians and their staffs are fielding more patients questions than ever before about billing. The Medicare-fraud initiatives have given patients both permission and incentive to question. How physicians and their staffs handle these questions is critical. The AMA recommends that a good compliance plan include a practice "hotline" to the billing department – with a trained, knowledgeable designated person to call – and that name and number should be on all statements. Once the designated person is called, however, that person must be trained in how to handle such calls and how to resolve the patient's concerns.

### **Strategy Five: Educate Everyone**

Formal educational sessions on the requirements of reimbursement need to be at least annual for all staff – and that includes all clinicians as well. Everyone must understand the critical relationship between medical-record documentation and billing records. And the maintaining of that relationship requires different behaviors as reimbursement rules and regulations change. Moreover, the reimbursement rules, regulations, processes and issues in physician practices are different than they are for acute care or long-term care facilities, so that reimbursement knowledge gained in one environment may or may not successfully transfer to another.

Routine assessment of procedures and records can point out areas of needed education and training. The days of hiring a competent bookkeeper or even an accountant and having the business office run smoothly are long over. Today's reimbursement environment requires billing personnel to be experts in reimbursement rules and regulations (and the procedures that must be followed) – something not taught in regular business curricula. Practice consultants can help physicians get their staff up-to-date and keep them there with focused, regular proper training and information. It is far too common to find office staff who are unfamiliar with medical procedures and protocols doing coding – and sending off support documentation that they do not understand.

The present reimbursement environment is one that hold a significant amount of risk for the unprepared physician, practice group, clinic, or system-managed practice. Urging healthcare providers to carry out basic protections of themselves and their practices can assist them in being prepared if problems come their way and provides a good platform for advice of counsel.

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