Building a Partnership for Effective Compliance

A Report on the HCCA - OIG Physician's Roundtable
Held July 24, 2000, Philadelphia, PA

BACKGROUND
On July 24, 2000, the Office of Inspector General (OIG) of the Department of Health and Human Services and the Health Care Compliance Association (HCCA) co-sponsored a roundtable for physicians to discuss the role of compliance in their practices. The roundtable discussions were an opportunity for the physicians to inform the OIG of issues surrounding the implementation and maintenance of compliance programs and comment on the OIG's proposed compliance program guidance for physician practices. The meeting was also an opportunity for the HCCA to receive input from the physician perspective regarding the types of products and services required to develop and administer compliance programs in the practice setting.

Twenty physicians representing a variety of practice types and sizes were selected through an application process administered by the HCCA. These physicians were joined by officers of the HCCA, staff from the OIG's Office of Counsel, a representative from the OIG Office of Investigations, and a representative from the Health Care Financing Administration.

Participating physicians completed a pre-event survey in which they were asked to evaluate the current draft of the OIG Compliance Program Guidance for Individual and Small Group Physician Practices ("Guidance") and identify compliance areas of concern to them. The agenda for the roundtable was structured to address three main discussion themes raised in the pre-event survey:

* The OIG draft Guidance for physician practices,
* Resources needed for effective compliance in physician practice settings, and
* Methods in which the Government can communicate with physicians and assist in compliance program development and administration.

These themes were discussed by small groups that reported back to the larger group throughout the day, allowing all participants to gain from the collective knowledge of the group.

Thanks to the collective efforts of all of the participants, the roundtable was judged to be a success by the great majority of the participants. The free exchange of ideas and differing opinions was constructive and took place in a positive atmosphere. Since the objective of this collaboration was to share perspectives on creating and implementing an effective compliance program in the setting of a physician practice, no attempt was made to reach consensus on the many issues that surround compliance with health care program requirements. However, all of the participants gained new insights into the challenges facing physicians when creating effective compliance programs in their practices.

In order to share these insights with a larger audience, the presentations of the small groups to the collective audience of all participants were audiotaped and transcribed. The following report summarizes the presentations of these groups and comments raised by all participants. The views expressed in the following summaries of the discussions do not necessarily represent the views of the OIG or the HCAA.

INTRODUCTION

Seeking to engage the private health care community in discussions about preventing and combating fraud and abuse, the HHS/OIG issued, on June 7, 2000, a draft compliance program guidance for individual and small group physician practices and invited comments from all concerned parties. The draft Guidance contains seven elements that, based on the Federal Sentencing Guidelines, have been determined to be fundamental to an effective compliance program:

* Implementing written policies;
* Designating a compliance officer/contact;
* Conducting comprehensive training and education;
* Developing accessible lines of communication;
* Conducting internal monitoring and auditing;
* Enforcing standards through well-publicized disciplinary guidelines; and
* Responding promptly to detected offenses and undertaking corrective action.

The draft Guidance was designed to assist individual and small group physician practices in developing and implementing internal controls and procedures that promote adherence to statutes and regulations. The seven elements included in the Guidance are also contained in previous guidances issued by the OIG, and this Guidance, like previous

ones, is not mandatory or binding. The draft OIG Guidance also includes 6 appendices addressing additional risk areas, criminal statutes, civil and administrative statutes, OIG-HHS contact information, carrier contact information, and Internet resources. As previously noted, the discussions were focused on:

*   The structure and practicality of the OIG draft Guidance and suggestions for change
*   Resources needed for effective compliance in physician practice settings
*   Methods in development and administration of a compliance program

STRUCTURE AND PRACTICALITY OF THE OIG GUIDANCE

The language of the draft Guidance was identified early on in the roundtable discussions as a serious concern. There is, in general, a perceived "language barrier" between medicine and Government. Roundtable participants recognized that compliance will affect everyone in the physician practice office, so the language or terminology of the Guidance should be understandable by all parties involved, including - and perhaps especially - by office staff. It was also noted that the education levels of staff in the individual and small group physician practice might be widely divergent. Some participants opined that the Guidance employs language that may not be commonly understood. "Benchmark", for example, is a term used in the document and one that is open to multiple interpretations. The phrase "reasonable and necessary" is another. There was a suggestion that a practicing physician help write the Guidance to make sure the language is appropriate for the practicing physicians and their office staff or that the OIG conduct focus groups comprised of physicians and office staff to assist in drafting the language of the Guidance. It was further suggested that any compliance program should be made "accessible to the people who work in a real office." A document that is user-friendly will be better understood and hence more effective.

It was noted that a significant portion of program violations relates to billing and coding. Therefore, the role of the coder cannot be underestimated. Coders are directly or indirectly responsible for nearly all of a practice's Medicare/Medicaid revenue. One physician participant noted that he still does his own coding, but it was agreed that physicians who do their own coding are now in a distinct minority. Most coders do not have a degree higher than a bachelor's degree and virtually no medical training, per se. Yet it is the coders, dealing daily with the most complex of statutes, laws and regulations that must have the best grasp of compliance-related issues.

It was also emphasized, however, that coders are increasing their recognition and professionalism by obtaining certifications from programs offered by organizations such as the American Academy of Professional Coders. Some participants suggested that while credentialed coders are not yet the norm and can mean additional payroll dollars, the importance of qualified coders should not be underestimated. Regardless of their qualifications, the participants agreed that the Guidance must be accessible to this group. Participants noted that the draft Guidance is well organized, but not "visually impacting enough to be readable for an individual." Potential problems included poorly delineated paragraphing and the lack of spacing between paragraphs. The footnotes were described as very helpful in terms of specificity and depth, and there was a suggestion to expand the footnotes, especially to explain or elaborate on more technical terms. Appendices, especially those with examples, were also identified as helpful.

It was suggested by some that the overall structure of the document could be streamlined. Policy goals could be presented in a bulleted format with shorter descriptions to balance generalities and details. Explanations and backup information can be provided in an appendix. There is no mechanism for oversight described as part of the policies and this was targeted as an area for discussion. The challenge will be to make it accessible to practices of varying sizes and different specialty configurations. Ways of determining risk areas were also discussed and the OIG representatives urged those concerned about risk areas to review the OIG annual *Work Plan* which identifies areas targeted for special attention in the coming year.

In summary, physician participants complimented the "positive tone to the document" but also noted that there were opportunities to make the document more user friendly" in the final version.

RESOURCES NEEDED FOR EFFECTIVE COMPLIANCE
All agreed that education and training resources would be a key factor in implementing an effective compliance program. The group concurred that Web-based technology and interactive CD-ROM programs could be enormously helpful. For example, one participant advocated an ".EDU" Website for credentialing and CME [continuing medical education] requirements. There was strong encouragement by physician participants for the Government to expand its compliance-related Websites, making them as user-friendly as possible. One suggestion urged that the OIG create a button or icon on its Web page that will link directly to a physician-specific compliance page.

Educational opportunities via this Website would also be helpful. Quarterly on-line newsletter updates from HCFA highlighting trends and perspectives were also suggested as a potentially valuable resource. HCFA and the OIG were encouraged to seek feedback from physicians on their Websites to foster an interactive dialog and mutual understanding. A faster, easier to manage search engine for the regulations database was identified as desirable.

The physician participants exhibited an eagerness to know and understand what resources are necessary to implement and maintain a compliance program. They called for a basic resource, perhaps downloadable at no charge from HCFA that provides an implementation template for the small physician practice. It was encouraged that the template include specialty specific encounter forms, and that paperwork for coding, billing, and payment be separate from medical communication forms. This template would also include forms, guidelines, and tools for record keeping. It might also have a checklist of questions, such as sample issues to discuss with the billing department. A "turn key" audit sheet was suggested as part of the template. There was a question about whether all physicians would find this sort of pre-packaged compliance program attractive and user-friendly, and it was added that some flexibility in the template is desirable. As noted earlier, the template should be specialty specific, but it should also be adaptable for a multi-specialty practice.

While the discussion on educational resources was enthusiastic, it was noted that some physicians, especially in individual and small group practices, are not technologically savvy. Physicians working in the inner city may not have financial resources available for the latest computer equipment or even have computers at all. The needs of these groups must also be considered. There was also a call for starting compliance-related education earlier in a physician's career. Residency programs sometimes offer training in this area, but not consistently. Compliance would best be incorporated into the third or fourth year medical school curriculum.

It was noted that one source of educational programs on compliance is the individual medical specialty organization. It was also noted that many specialty societies are also offering compliance education and that choice and variety in educational options is desirable. There was a suggestion from the physician participants that HCFA or OIG provide an example of a model compliance plan for small group physician practices, which physicians could then adapt for their own practices. A

list of resources available on the Internet would also be helpful. In addition, there was discussion about how to measure the effectiveness of training and quantify the "return on investment" for training efforts. However, no concrete suggestions arose from this dialogue.

METHODS IN DEVELOPMENT AND ADMINISTRATION
The physician participants identified designing internal audits as one of the major challenges of developing and administering a compliance program. Audits were generally recognized as important, and there was a call for more guidance from the Government on this topic, especially on what factors may contribute to the Government's decision to initiate an audit of a provider. The OIG was encouraged to provide on its Web site sample audit protocols to assist physicians in designing an internal audit.

The participants also discussed how to prioritize issues for audit and compliance assessment. The OIG representatives took this opportunity to describe in detail the OIG annual *Work Plan.* This document, available at oig.hhs.gov highlights those areas on which the Government will devote its audit and evaluation energies. It was also mentioned that not all physicians have computers with access to the Internet. Moreover, the *Work Plan* is a "static" document, which is published in the fall and presumably not modified. It was felt that there needs to be a way for physicians to gain a sense of what issues are evolving and what new trends are emerging.

There was much discussion about auditing since the physician participants felt that auditing poses many challenges. There is, some noted, an inherent conflict of interest in conducting internal audits; yet not everyone can afford to hire outside objective consultants. It will be important to the physician practice to have consistent and accurate feedback from the Government on compliance questions if audits are to be effective compliance tools. Because internal audits can raise many questions, there was a strong recommendation from some of the physician participants that the Government take great care to ensure that Fiscal Intermediaries understand the issues and that there are no regional variations in interpretation and enforcement. It was encouraged that Fiscal Intermediaries be subject to compliance standards also, including regular monitoring.

The question arose among the physician participants as to what happens when an internal audit identifies a potential problem. There was an active debate about the value of auditing retrospectively and going back in time in search of mistakes. The Government

representatives encouraged physicians to use the audit for prospective corrective action, but not to ignore past problems that might have resulted in overpayments. Physicians were urged to talk with intermediaries and/or the Government when potential problems arise. In an effort to encourage "self-reporting," OIG participants will continue to explain what the Government views as innocent error as opposed to outright fraud. Descriptions of hypothetical situations and case examples were suggested as ways to achieve this goal.

The OIG participants also explained that self-disclosure can be of interest and benefit to both the Government and the physicians. It was noted that of the more than 75 recent self-disclosures, many were resolved as single incidents with simple one time repayment. Corporate integrity agreements and penalties are not necessarily the norm.

There were questions about specific punishment or disciplinary action a practice should take if a mistake is found. The draft Guidance does not specifically outline recommended disciplinary actions that a practice should take against an offending individual. The consensus was that such decisions belong in the hands of the physicians running the practice.

It was noted that many individual and small group physician practices outsource their coding and billing operation. These third-party billing companies are entirely separate from the physician practice. Questions arose about physician practice responsibilities concerning a third-party billing company's compliance activities. There was general concern that such outside billing companies may not maintain appropriate types of records or do regular auditing. An OIG representative identified this as a critical issue and advised physician practices to ensure, through the contract between the physician practice and the third-party billing company, that the contracted third party billing company have in place appropriate policies and procedures related to compliance. It was noted that the OIG issued a Compliance Program Guidance for Third-Party Medical Billing Companies in January 1999. Physicians using third party billing companies should insist that any contractual arrangement clearly state that the third party billing company must abide by all applicable statutes and regulations and that the company follow the OIG Third-Party Billing Guidance. As an OIG representative pointed out, "you can't contract away the false claims act liability."

Documentation was also identified as a potential problem area. Physician participants described the process of note taking and

explained the difficulty in putting all relevant medical points into the chart. A physician's notes may seem perplexing to some, especially non-physicians or even non-specialists. There was a plea that weight be given to a physician's informed decision and that the physician's judgment be respected when coding questions arise. When implementing a compliance program, one physician suggested an approach that emphasizes "optimizing physician billing," rather than the "compliance" or regulatory aspect. By emphasizing the business aspect, the goal is accurate coding. Both upcoding and down coding are bad business practice.

The question of gauging severity of condition when coding was also discussed. Determining severity can be tricky, and here again, it was strongly recommended by the physician participants that the physician's informed judgment be given weight. It was noted that the new E&M Guidelines have included more vignettes to assist in determining severity—a model the OIG might adapt for the Guidance. One participant, an experienced coder, noted that in most cases if a physician documents a condition as complex and posing a serious threat to the patient's well being or life, the physician's decision will be accepted.

There was concern expressed that today's physician is making notes in the chart with an eye toward reimbursement instead of focusing foremost on the patient's medical or health care issues. To many participating physicians, practicing medicine today seems to be more about collecting data and generating reports than caring for patients. The roundtable participants agreed that compliance is a quality issue; physicians want to provide high quality patient care and have a high quality business office. Some physicians expressed concern that compliance activities take time, and that time, ultimately, is taken away from patient care. Most physicians want to—and should—spend as much time as possible reading related specialty journals to keep up to date. Focus groups or town hall meetings were suggested as outreach efforts. The physicians also felt that in the spirit of dialog, HCFA and the OIG could build better lines of communication by acknowledging the considerable time and effort compliance entails for the physician practice and by making a commitment to reducing the time and effort needed.

It was noted that there is some fear that compliance will create another layer of bureaucracy that will take away from patient care. While there is no evidence-based medicine to show that a compliance program has a direct effect on a medical outcome, compliance must

not be perceived as a resource commitment that will put the patient in second place. These care related issues, the physician participants added, might make some small group physician practices reluctant to take compliance seriously.

In summary, a critical goal of an effective compliance program is to ensure that the patient gets appropriate care and the physician practice gets appropriate reimbursement.

CONCLUSION
The outcome of this collaborative effort between the OIG and representatives of the physician community was a positive one. At the roundtable, participants addressed many of the issues confronting physicians and their staff. Participants gained new insights into the challenges of creating effective compliance programs and had the opportunity to experience perspectives on compliance from both the Government and other physicians. We believe that the outcome of the roundtable discussions will give all of us greater understanding of how the Government and physicians can work together to protect the integrity of the health care system.