Academic Medical Center & Faculty Practice:
Building the Continuum of Compliance

REGINA F. GURVICH, MBA, CHC
CHIEF COMPLIANCE OFFICER
UNIVERSITY PHYSICIAN ASSOCIATES OF NEW JERSEY

APRIL 13, 2011

Academic Environment

- Why are AMC different?
- Interest – points of co-dependencies and impacts
- Incentive alignment or misalignment
- Financial pressures and perceptions
- Business Model of Academia
Major Challenges Facing AMCs

- Healthcare Reform
- Government Focus
- Financial/Economic Issues
- Top Compliance Risks
- Conflicts of Interest
- Government Funding: M/M, ARRA
- Medical Record Issues
  - EMR
  - Privacy
  - Data Sharing

Faculty Practice: Affiliation Agreement & Board

- Affiliation arrangement
- Board
  - Composition
  - Election periods
  - Independence
  - Affiliation Agreement
  - Effect of profitability and business deftness
- Impact
Follow the money...

- Financial inter-dependencies
- Profit sharing arrangements
- Impact of historical trends
- Impact of the budget
- Prognosis

Compliance Control “Owners”

- Custodian of Medical Records
- Electronic vs. Paper
- Responsibility for Coding
- Responsibility for Billing
- IT controls or ‘who stole the beef’
  - Are 16 systems better than 25
  - Asymmetry of implementations
- Financial controls
- Faculty Appointments
Lay of the Land or Map of Compliance Organization

- Top-heavy
- CIA impact –
  - Under microscope
  - Ongoing extensive reporting
  - Self-disclosures
  - Liability & culpability
- Faculty Practice Impact and Liability
- Collaboration
  - 

Mission Impact

- “to promote and foster the clinical activities of the Faculty”:
  - Support the missions Medical School in post-graduate, undergraduate and public education;
  - Advance the body of knowledge in both the clinical and basic science of medicine through research;
  - Offer the school's patients state-of-the-art, competent, compassionate, and cost-effective medical care.
Program Focus

- Quality of Care and Compliance Program
- Education
  - Faculty
  - Staff
  - Residents & Fellows
  - Board of Directors
- Background of Compliance team
  - Financial, legal, clinical, or ‘home-grown’
- Why do you have a program in place?

Stage: Post DPA, under CIA

- Physician Buy-in:
  - “I am saving lives”
  - “I thought I was supposed to practice medicine!”
  - “Who came up with this coding scheme nonsense?!?”
  - “The issues were resolved. It were just a few bad apples”
  - “I do not have time for THIS!”
  - “What’s the CPT code for stressed out?!?”
  - “I do not have time to write all that nonsense. That is what students and residents are for!”
  - “Look at all these abbreviations. I don’t recognize any of them!”
  - “My documentation is EXCELLENT!”
Realigning Compliance

- Fitting Patient Care and Quality into your Compliance Program
  - Why?
  - Where?
  - How?

- Business approach
  - Part of business operations
  - Compliance = Risk Management
  - Mitigation of potential adverse effects
  - Patient care resource

- “Selling” to the audience
  - Benefit
  - Organizational buy-in
  - Physician buy-in
  - Compliance ‘at large’

Creating Shared Sense of Purpose

- Physicians are in the business of improving the quality of life/care for their patients
- High quality
  - increased patient safety;
  - patient satisfaction
- Quality of care as a viable market strategy
- Leveraging shared sense of purpose
Seven+ Circles of Compliance

- Designation of Compliance Officer & Compliance Committee
- Developing Effective Lines of Communication
- Creation and Retention of Records
- Conducting Effective Training & Education
- Compliance as an Element of Employee Performance

Seven+ Circles of Compliance

- Enforcing Standards through Well-Publicized Disciplinary Guidelines
- Internal Auditing & Monitoring
- Responding to Detected Offenses & Developing Corrective Action Initiatives
- Assessing Effectiveness of a Compliance Program
- Policies & Procedures
  - Statement of Corporate Philosophy
  - Code of Conduct
Identifying Risks

- Inter-relations between the Faculty and AMC
- What you know?
  - OIG Audits
  - RAC Targets
  - MIC Reviews
  - CERT Targets
  - Changes to the CMS IOM Manual
- Publications & Research
  - MMIS Instructions
  - Medicare Bulleting
  - “Educational” letters from Carrier/FI/MAC
- What you do NOT know....
  - Rejected claims
  - Data-mining
  - Audits
  - Word of mouth
  - Complaints data

Risks: Actual vs. Perceived

<table>
<thead>
<tr>
<th>Actual</th>
<th>Perceived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational letter</td>
<td>Department Director concerns about inadequate patient registration</td>
</tr>
<tr>
<td>External audit results</td>
<td>Physician’s unspecified concern regarding colleague's billing practices</td>
</tr>
<tr>
<td>Audit of a local hospital</td>
<td></td>
</tr>
<tr>
<td>100+ CMS record requests for 99233</td>
<td></td>
</tr>
</tbody>
</table>
Risks of Non-Compliance

- Overuse or misuse of devices
- Rising healthcare costs
- Patient safety
- Quality of Care
- Credibility of medical and scientific research
- Violation of terms of grants or research contracts
- Potential for decreased public trust
- Fear of regulatory and legal action
- Scandals and negative media/PR
- Loss of respect in the medical and academic community
- Loss of funding

Research Billing

- Why focusing on Clinical Trial Billing?
- Federal monitoring of billing irregularities and inaccuracies
- FCA arising from research billing:
  - Major fines and unwanted scrutiny
  - Double-, over-, and irregular-billing as subject of OIG and DOJ investigations
  - Loss of research grants as a result of lax controls
  - Improper billing of routine care services
  - Sponsors accountability
    - proper budgeting
    - Billing for routine & non-routine care charges
    - Disbursing unspent grant funding
- DHHS’s OIG’s draft research compliance program guidance
  - risk management through a formal compliance process
Research Billing: Major Challenges

- **Probability of correct billing**
  - Debiting a study account vs. third-party billing
  - Investment in infrastructure (operations, financial management & compliance oversight)
  - Infrastructure vs. staffing

- **Stakeholders:**
  - Varied (mis-aligned) priorities
  - Time
  - Interest

Reimbursement Issues: Supervision

Physician Supervision Levels

- General - procedure furnished under the physician’s overall direction and control; physical presence is not required during the performance of the procedure. The training of the non-physician personnel who actually performs the procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

- Direct (office setting) - the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Does not mean that the physician must be present in the room when the procedure is performed.

- Personal - physician must be in attendance in the room during the performance of the procedure.
PATH Supervision

- Kaiser California (December 2009)
  Paid $3,752,000 under voluntary self-disclosure protocol
    - Services performed by residents without the presence of teaching physicians
- University Pediatricians Detroit (December 2009)
  Paid $92,000 under voluntary self-disclosure protocol
    - Teaching physician failed to supervise fellows
    - Use of preprinted, pre-signed forms

Safe Harbor in Stark for AMC’s

- Designated health services (DHS) furnished by an academic medical center are excepted from the Stark Law’s prohibition on self-referrals if the referring physician:
  - is a bona fide full-time or substantial part-time employee of a component of the academic medical center;
  - is licensed to practice medicine in the state;
  - has a bona fide faculty appointment at the affiliated medical school; and
  - provides either substantial academic or substantial clinical teaching services for which the faculty member is compensated as part of his or her employment relationship
- No corresponding Anti-kickback safe harbor
Stark/Anti-kickback

University of Medicine and Dentistry New Jersey (UMDNJ)

- Paid over $8 million to settle kickback case related to cardiology program
- Sham teaching, research and coverage contracts
- Double damages on all improper referrals to UMDNJ
- DOJ also pursed claims against eleven of the cardiologists; nine settled $30,000 to $1.4 million

Consultation Codes

- Inpatient and outpatient consultation codes no longer recognized by Medicare
- Utilization of E&M codes across the board
  - Understanding documentation subtleties
  - Operational difficulty
  - Effect on collections
- RVU’s increased 6% (0.3% for hospital and nursing facility visits) to compensate for loss of revenue
- Use of AI modifier to distinguish principal physician of record E&M from consulting specialists E&M
Faculty Billing Issues

- In-sourcing vs. out-sourcing
  - Vendor oversight
  - Liability
- Significant fraud cases
  - “Revenue cycle management” includes
    - Tracking of third-party payers
    - Rebilling of unpaid claims
    - (illegal) balance billing of Medicaid enrollees for claims unpaid by Medicaid
      fee for service or managed care
- Third-party oversight
  - Audits
  - Quality reviews
  - Recoveries/off-sets
  - Effect of FERA
- ABN conundrum

Billing Company Investigations

- Handle With Care, Inc. - "lost charge" audits for nursing homes
- Gottlieb Financial Services, Inc. (GFS) provided emergency department physician billing services, allegedly used an automated coding software system that routinely up-coded emergency room visits.
- Medaphis Corporation—multiple claims for the same service to the same patient on the same date of service; used incorrect or inapplicable diagnosis codes in resubmitting claims which had been denied based on the diagnosis originally stated.
- Emergency Physician Billing Services, Inc (Dr. J.D. McKean)—coders “abstracted” 40 charts per hour. No coder at EPBS ever attended training or any other informational meeting regarding emergency department coding other than in-house EPBS training, and no coder ever contacted a physician with questions regarding a chart. In a video introduced at trial, McKean said documentation of services rendered to patients for reimbursement by Medicare and other health programs was "just a red tape crap issue."
"Guidance for Third-Party Medical Billing Companies"
63 FR 70138-70152 (December 18, 1998)

- billing for items or services not actually documented;
- unbundling and up-coding of claims;
- computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented;
- knowing misuse of provider identification numbers which results in improper billing in violation of rules governing reassignment of benefits;
- billing company incentives that violate the anti-kickback statute;
- percentage billing arrangements.

EHR pitfalls

- “To Dr. Macro, From OIG 2011 Work Plan”
  - “Medicare contractors have noted an increased frequency of medical records with identical documentation across services. We will also review multiple E&M services for the same providers and beneficiaries to identify EHR documentation practices associated with potentially improper payments”

- Templates
- Consistency of utilization/ filing schemes
- Auditor’s perspective
Data-Driven Compliance Strategies

- Process of extracting patterns from data in order to transform the data into actionable marketing tactics
- In healthcare, data mining can help us build scoring models of for:
  - High-risk (for a service, procedure, or sub-specialty)
  - High-value
- Testing & Using Control Groups

Apples to Oranges or Value of Data Mining

- Who owns the data – who analyses the data
- Comparing apples to Oranges:
  - ensuring your data is ‘clean”
- Looking for trends over time
- Differences/ skew by practice, specialty
- Present data for discussions
- Educational component
  - part of audit de-briefing
Corrective Actions:  
From Perspective of Compliance Continuum

- Impact by area
- Impact by oversight responsibility
- Corrective Actions:
  - Who takes ‘the first shot’
  - ‘Closing the loop’
  - Communicating findings
  - Documenting the process
  - Reporting the outcomes
- Communicating findings to Physicians
- Self-disclosure, if applicable

Pitfalls

- Bridge Burners
  - Buy-in from the top is necessary;
  - Credibility through consistency
- Know your audience
  - Faculty & Board
  - Counterparts & their respective Board(s)
- United front – cohesive message
  - Alternative undermines everyone’s effort
  - Mixed message causes ‘interpretive’ compliance
  - Loss of trust from physicians & leadership
Physician compliance education outside of hospital environment

- Training on documentation guidelines:
  - Documenting for billing
  - Mitigating audit risk
  - Quality of Care implications
- Is training “helpful or mandatory”? 
- Incorporation of “Compliance perspective”
- Connecting audit outcomes to training
- Coordination with institutional Compliance Team
- “Sweetening the pill”

Strategies of Maintaining Compliance Continuum

- Focus
  - Develop rational, focused mission, and objectives
  - Support the mission across all levels of organization
  - Resolve central weaknesses & improve infrastructure
  - Develop core product lines
  - Don’t try to solve everything at once
- Trust
  - Create reciprocity relationship
  - Reality confrontation
  - Present facts on both sides of key issues
  - Redirection and distraction via new joint projects
- Take Charge
  - Present a plan & take control
  - Anchor behavior by focusing on beneficial but restricted outcome
  - Focus on the organizations real purpose for existence
  - Dampen swings through directive leadership
The Upside of AMC Idiosyncrasies

- Good knowledge of threats and opportunities inside and outside.
- Strategies for reduction of risk such as diversification
- Compulsive perfectionism as precursor of good internal controls and efficient operation
- Enthusiasm creates momentum for start-up and revitalization
- Brilliance & intellect can bring a variety of views to the table

Fall Out: Welcome to “Under the Microscope”

- Media, federal agencies, accrediting agencies, regulatory committees, prime contractors/awardees
- Formulating your response
- What you don’t know will hurt you – fact gathering and document review
- Response team -- affected units; subject matter experts; legal counsel; communications, etc.
- Faculty involvement in response
- Ongoing policy review and development
What Have We Learned

- We are all in this together
- Value of good and timely communication
- Occurrence reporting coordination
- Correlation between clarity of methodologies and compliance target
- Analysis & trending of data
- Expectations & reporting deadlines must be spelled out
- We are in this for a long haul!