Corporate Compliance

What's the Risk?

The U.S. Department of Health & Human Services' Office of Inspector General (OIG) expects individual practitioners and group practices to voluntarily implement a compliance program that will help prevent unlawful conduct and submission of erroneous claims. Practitioners are responsible for keeping apprised of current Medicare rules and regulations; monitoring adherence to applicable statutes, regulations, and program requirements; and ensuring that staff members are educated and continuously updated on Medicare guidelines related to coding and billing for services. Failing to meet these responsibilities could lead to acts or omissions that may expose the physician practice to civil and/or criminal sanctions and penalties.

When Is This Risk an Issue?

Medicare fraud typically includes any of the following:

- Knowingly submitting false claims or causing them to be submitted, or misrepresenting fact to obtain a federal healthcare payment for which no entitlement would otherwise exist.
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal healthcare programs.
- Making prohibited referrals for certain designated health services.

As the Centers for Medicare and Medicaid Services states:

> Defrauding the federal government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal, civil, and administrative liability, and may lead to imprisonment, fines, and penalties.
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> Criminal and civil penalties for Medicare fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate intervention. Providers and health care organizations involved in health care fraud risk being excluded from all federal healthcare programs and losing their professional licenses.[1]

Medicare abuse describes practices that may result, directly or indirectly, in unnecessary costs to the Medicare program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care. The difference between "fraud" and "abuse" depends on facts, circumstances, intent, and knowledge.

Examples of Medicare abuse include:

- Billing for unnecessary medical services.

- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a practitioner assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

Medicare abuse can also expose practitioners to criminal and civil liability.[1]

Several federal laws address Medicare fraud and abuse, including:

- Federal Civil False Claims Act.
- Anti-Kickback Statute.
- Physician Self-Referral Law (Stark Law).
- Criminal Health Care Fraud Statute.
- Exclusion Statute.
- Civil Monetary Penalties Law.

Compliance Program Guidance

The OIG offers compliance guidance. The purpose of a compliance program is to minimize errors when submitting claims and to prevent unlawful and undesirable activities. The OIG recognizes that innocent mistakes are made and that such mistakes are very different from the problems arising from reckless or intentional conduct. Nevertheless, even innocent mistakes are a drain on federal healthcare programs. Practitioners are expected to be able to identify and correct these errors in a timely manner and implement steps/processes to prevent future occurrences.

How Can I Reduce Risk?

The implementation of an effective compliance program reflects a good faith effort to eliminate inadvertent and inappropriate practices. Additionally, an active compliance program, along with stringent policies, procedures, and practices, minimizes the risk of exposure to civil and/or criminal sanctions and penalties.

Implement a Corporate Compliance Program	
Develop policies and procedures	• Develop written policies and procedures for each of the key elements, as recommended by the OIG.
Perform internal audits and monitor claim submissions	• Develop an auditing process that evaluates the main areas of potential risk for physician practices, including coding and billing, documentation, improper inducements, kickbacks, and self-referrals. Include audits to evaluate whether documentation: ○ Is complete and supports the care/treatment.

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- Includes the reason for visit, history and physical, test assessment, clinical impression/diagnosis, and care plan.
- Supports the billed CPT codes.
- Identifies appropriate health risk factors and charts progress, response to treatment, changes in treatment, and diagnosis revisions.

- Establish the frequency of monitoring and auditing for the practice. Consider performing baseline audits followed by periodic audits to evaluate the compliance program's effectiveness. Determine if the practice's standards and procedures are accurate and up to date and if individuals are submitting claims appropriately. Increase the frequency of audits and monitoring when issues are identified.

Appoint a compliance officer

- Designate a compliance officer (or compliance contacts when using more than one employee) and address their responsibilities in writing. Consider including the following responsibilities:
  - Implementing the compliance program.
  - Establishing a method for conducting audits.
  - Updating the program as needed.
  - Providing training and education.
  - Monitoring HHS-OIG excluded individuals.
  - Investigating reports of unethical or improper business practices.
- Outsourcing all or part of the functions and responsibilities of the compliance officer is a possibility, but to be effective, the outsourced individual must have sufficient interaction with the practice and staff members.

Implement a training program

- Develop a training and educational program that is specific to the practice. A written policy should address who is to be trained, the type of training, and when and how often training will be held.
- Include fraud and abuse laws and a review of your office-specific policies, procedures, and standards of

Implement a Corporate Compliance Program	
	conduct that address compliance in your staff orientation. Educate staff on Medicare guidelines, especially those related to billing and coding. Provide staff ongoing education to reinforce current standards and apprise staff members of changes and updates.
Allow confidential internal reporting	• Develop a way to facilitate confidential internal reporting of situations involving suspected fraud and/or abuse. Consider utilizing a hotline or some other mechanism for anonymous reporting. Establish a process to address possible violations.
Investigate complaints and/or violations	• Investigate and respond to compliance concerns, complaints, and violations. Develop a written investigation and response process that addresses the following: o Internal review of all reports. o Developing and implementing a corrective action plan. o Disciplinary actions, as appropriate. o Prompt referral and/or disclosure of potential criminal violations, as required.
Enforce policies and procedures as outlined in the compliance program	• Develop and implement a process to enforce compliance with the policies and procedures of the program. • Ensure that the compliance program is regularly reviewed and updated to remain current.

Address Problem Areas	
Examine corporate practices and implement steps to address areas of concern	• Examine practices and audit results. Identify areas of concern/problems that need to be addressed as soon as possible. These include: o Providing or accepting incentives for unnecessary services or referrals. o Upcoding services provided or a patient's diagnosis to receive a higher payment. o Unbundling tests/services to receive higher payments.

Address Problem Areas	
	○ Billing for medical supplies or services not provided or not needed. ○ Billing practices for services provided by nurse practitioners, physician assistants, and other physician extenders. ○ Improper referral practices. ○ Improper discounts/professional courtesy discounts. ○ Paying or receiving kickbacks. ○ Joint ventures not created to raise legitimate investment capital (improper patient solicitation, falsified documentation, and falsified cost reporting data).
Prohibit offering inducements	• Implement measures that prohibit offering inducements to patients, such as writing off balances.
Develop a corrective action plan as needed	• Correct identified problems as soon as possible. Determine the level of response needed based upon the circumstances and the identified problem. The response may be as simple as making a repayment along with an appropriate explanation to Medicare. Other situations may require consultations with coding experts and/or legal counsel. In all cases, preserve the response and pertinent records.
Retain records	• Ensure that your written policy includes a section on retaining records. Consider retaining the following records: ○ Documents related to education provided. ○ Internal investigations and audit results. ○ Documents regarding investigations of potential violations and actions taken.

References:

1. Centers for Medicare and Medicaid Services, Medicare Learning Network. *Medicare Fraud & Abuse: Prevent, Detect, Report*.; January 2021. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf. Accessed June 23, 2021.