Inspecting Your Compliance Program

By Jackie Davis-Willett, CHBME

Implementing written policies, procedures, and standards of conduct is the first component the OIG listed in identifying the seven fundamental elements of an effective compliance program. Have you inspected your program lately in the area of operational policies and procedures?

The OIG recognizes the implementation of an effective compliance program, though policies and procedures may not entirely eliminate fraud, abuse, and waste from an organization. However, a sincere effort by billing companies to comply with applicable federal and state standards, as well as the requirements of private health care programs, through the establishment of an effective compliance program significantly reduces the risk of unlawful or improper conduct.

Most of us have heard the words PREVENT, DETECT, AND CORRECT in regard to Compliance. Policies and procedures should *prevent* fraud, abuse or mistakes, *detect* fraud, abuse or mistakes and *correct* fraud, abuse and mistakes. The OIG believes that the use of internal controls is essential to more efficiently monitor applicable regulations and program requirements.

Many billing companies have not developed all of the policies and procedures they need to support their compliance program. Many policies and procedures are not adequate to meet the billing company's compliance needs.

As you have been made aware by HBMA in the past, your policies and procedures should begin by addressing all the published risk areas that apply to your business and that have been identified by the OIG. Below are the suggested policies and procedures to address known risk areas as identified by the Health & Human Services Office of Inspector General.

While this checklist contains suggested areas for core policies and procedures for billing companies, it does not represent a complete model that will fit all sizes and specialties exactly. Each company must take the scope and nature of its business into account in formulating its own policies and procedures, and should take care that all relevant risk areas and regulatory requirements are covered.

HBMA does not warrant the completeness or accuracy of this listing, or make any representation as to its sufficiency or applicability to a particular company.

Be sure and register you and your staff to attend the next HBMA Webcast-Policies & Procedures on December 7th, 2005 and learn how to write effective policies and procedures. Participants will obtain several complimentary Operational Procedure and Policies and Audit Tools. It is one Webcast your key management people will not want to miss!

Checklist for Addressing Billing Company Risk Areas in Policies & Procedures

A. RISK AREAS

Among the risk areas the OIG has identified as particularly problematic are:

- Billing for items or services not actually documented
- Unbundling
- Upcoding, such as, for example, "DRG creep"
- Inappropriate balance billing
- Inadequate resolution of overpayments
- Lack of integrity in computer systems
- Computer software programs that encourage billing personnel to enter data in fields indicating services were rendered though not actually performed or documented
- Failure to maintain the confidentiality of information/records
- Knowing misuse of provider identification numbers, which results in improper billing
- Outpatient services rendered in connection with inpatient stays
- Duplicate billing in an attempt to gain duplicate payment
- Billing for discharge in lieu of transfer
- Failure to properly use modifiers
- Billing company incentives that violate the anti-kickback statute or other similar Federal or State statute or regulation
- Joint ventures
- Routine waiver of co-payments and billing third-party insurance only
- Discounts and professional courtesy.

Among the risk areas that billing companies who provide coding services should address are:

- Internal coding practices
- "Assumption" coding
- Alteration of the documentation
- Coding without proper documentation of all physician and other professional services
- Billing for services provided by unqualified or unlicensed clinical personnel
- Availability of all necessary documentation at the time of coding
- Employment of sanctioned individuals.

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(Checklist continued from page 15)

B. POLICIES AND PROCEDURES

With respect to claims, a billing company's written policies and procedures should reflect and reinforce current Federal and State statutes. The policies must create a mechanism for the billing or reimbursement staff to communicate effectively and accurately with the health care provider. Policies and procedures should:

- Ensure that proper and timely documentation of all physician and other professional services is obtained prior to billing to ensure that only accurate and properly documented services are billed
- Emphasize that claims should be submitted only when appropriate documentation supports the claims and only when such documentation is maintained, appropriately organized in legible form and available for audit and review. The documentation, which may include patient records, should record the time spent in conducting the activity leading to the record entry and the identity of the individual providing the service
- Indicate that the diagnosis and procedures reported on the reimbursement claim should be based on the medical record and other documentation and that the documentation necessary for accurate code assignment should be available to coding staff at the time of coding. The Health Care Financing Administration Common Procedure Coding System (HCPCS), International Classification of Disease (ICD), Current Procedural Terminology (CPT), any other applicable code or revenue code (or successor code(s)) used by the coding staff should accurately describe the service that was ordered by the physician
- Provide that the compensation for billing department coders and billing consultants should not provide any financial incentive to improperly upcode claims
- Establish and maintain a process for pre- and post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation and are in conformity with any applicable coverage criteria for reimbursement
- Obtain clarification from the provider when documentation is confusing or lacking adequate justification.

O&M 2005

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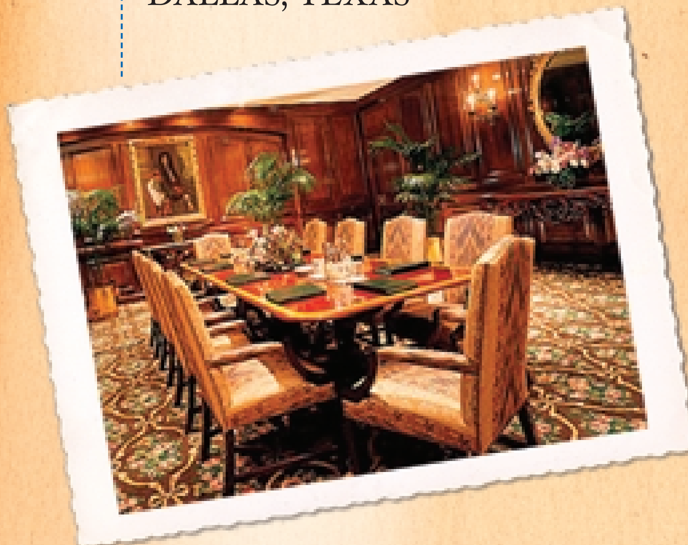

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