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PROTECTOR

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MEDICAL PROTECTIVE

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Medical Protective introduces *Protector* Reader Continuing Education Program

Medical Protective is pleased to announce a free resource for Continuing Education (CE) hours for our insureds. *Protector* is published three times each year. In order to obtain one hour of free CE, you must read the most recent *Protector* and then complete the applicable on-line test – which can be accessed 24/7 using your Medical Protective policy number to log on at http://www.medpro.com/protector-ce.

Allow sufficient time to complete the test in one sitting, as information that is not submitted cannot be saved. Upon submission of a test, you will immediately receive a pass/fail notification. If you pass with a minimum score of 80 percent, you will also receive a certificate that you should retain in your CE file. If you fail, you cannot retake that particular test. Each test will be available for approximately four months, until the next issue of *Protector* is published. Osteopaths, non-physician doctors, and advanced practice healthcare professionals can submit certificates to their professional associations for review. If you pass two tests within one year, you also may be eligible to earn a one-year risk management premium credit which will be applied automatically at your next policy renewal.*

Medical Protective is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Medical Protective designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This activity was planned and produced in accordance with the Essentials and Standards of the ACCME.

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The Medical Protective website is best viewed in Internet Explorer 7 and higher or Firefox 3.5 and higher. If you have questions, please contact the Clinical Risk Management Education team at: (800) 463-3776.

Dear Medical Protective healthcare provider:

2011 is a hallmark year for *Protector*. For the first time, Medical Protective is accredited to provide Continuing Education (CME or CDE) hours for both physicians and dentists. This achievement allows us to broaden the scope of our educational offerings – beginning with the availability of CMEs or CDEs for MedPro insureds who read *Protector*.

Online access will make it easy for you to complete the test that will accompany each issue. MedPro insureds who successfully complete two tests, in the same year, may also earn premium credits. For more information, see the announcement on the inside cover of this issue of *Protector*. Or, visit our website at www.medpro.com.

As you know, Medical Protective welcomes input from our insureds about the topics and issues you find most interesting – or frustrating. This year, we have responded to your requests for more information about business challenges that healthcare professionals find confusing, and sometimes contentious. Perhaps the topic that has caused most concern for practice-based healthcare professionals is corporate compliance. In this issue of *Protector*, we hope to eliminate some of the misunderstanding about this "bridge" between sound clinical practice and honest financial dealings.

By reading the Spring 2011 *Protector*, you should be able to:

- explain the business ethics rationale behind many corporate compliance requirements,
- appraise the standing of your current corporate compliance plan, and
- give examples of ways in which you and your group/practice can improve corporate compliance, while at the same time improving clinical safety.

As always, thank you for sharing your ideas, questions, and concerns with us. The innovations in our Continuing Education programming – and the selection of topics – are our way of saying that we appreciate your input and hope the Spring 2011 *Protector* will be truly useful to you.

Sincerely,

Kathleen M. Roman

Kathleen M. Roman
Editor

Avoid Corporate
Zero in on corporate com

Confusion and Consternation
The phrase "corporate compliance" generates a lot of angst in the healthcare professions these days. It isn't popular–and it's frequently misunderstood.

Physicians and dentists, along with other healthcare providers, are dedicated to taking good care of their patients. This includes a commitment to engage in honorable business practices. Assumption of this duty goes all the way back go the Hippocratic Oath which first defined the healer's duty to patients. So, corporate ethics isn't a novel concept in healthcare. And, most doctors and their staffs assert that their business processes meet both legal requirements and ethical expectations.

But, healthcare has become more technology-driven, more hectic, and more expensive. In this high-stress environment, the line between acceptable and unacceptable business processes can easily become blurred. Now, instead of having distinct "checks and balances," the business function is sometimes subsumed by the billing function. When these wobbly financial processes become embedded in the business plan, they create a fertile ground for questionable decisions and actions. Further, ethical and legal actions may be relegated to non-essential status, while priority is given to filing claims and making speedy collections by staffers who believe, or who have been instructed, that this is their primary duty.

"...the business function is subsumed by the billing function,... when wobbly financial processes become embedded in the business plan."

Confusion Results in Problems
Oversight by the federal government – which pays roughly 50 percent of all U.S. health dollars – adds an additional layer of confusion and complications for healthcare professionals when it comes to billing and submitting claims. Because taxpayer dollars are the ultimate funding source for these reimbursement claims, the government has a duty to ensure that claims filed for payment are timely, accurate, and complete – one of the toughest compliance areas for healthcare professionals. Although concerns about the accuracy of healthcare billing procedures have been around for a long time, dating back to 1863 under the False Claims Act, new technologies have now given the federal government the ability to analyze claims submissions and to identify outlier claims submission filings.

Confusion–
pliance

In fact, numerous studies by the federal government, which used these new data mining techniques, were conducted in various states – and the results were astonishing. Billions of dollars were hemorrhaging out of the healthcare system due to improperly filed claims, the reports said. The media were flooded with stories about healthcare fraud, criminal activity, and fines – huge fines. For example, in January 2010, Secretary of Health and Human Services, Kathleen Sebelius, announced that, during fiscal year 2009, the government recovered over $4 billion in a combination of administrative findings and courtroom trials, based on fraudulent healthcare transactions.

Many doctors and providers were dismayed that apparently fraudulent activities could tarnish the reputation of the healthcare professions. "That could never happen in our practice," doctors and their staffers claimed. But, the data were compelling.

So – What is Corporate Compliance?
In light of the fact that many healthcare professionals are unaware of their corporate compliance responsibilities, it begs the question "What is corporate compliance?" Corporate compliance is a process by which an organization monitors its internal processes in order to ensure that they are efficient, effective, and honest. No different from a commitment to provide safe clinical care, corporate compliance hones in on the business processes by which care is provided– and subsequently paid for.

Once a healthcare practice understands the components of a corporate compliance plan, it is imperative that they analyze their practice for gaps. Until they begin this process, many practices do not even realize that they have gaps in their corporate compliance plans.

In a recent risk management webinar, Medical Protective asked participants from throughout the country about their corporate compliance plans. The following survey results show that, on average, nearly half of the participating medical and dental practices reported significant gaps in their corporate compliance plans.

The webinar is the first of a two-part series. It can be accessed by logging on to the Medical Protective website at www.medpro.com, and entering the insurance policy number, selecting risk management library, and the selecting webinars. The webinars were designed to help office-based practitioners assess any gaps in their corporate compliance plan and revise their business practices accordingly.

Importance of Compliance when Facing an Audit

As claims-reporting structures become more sophisticated, outside oversight will most likely continue to expand. As such, healthcare corporations may find themselves on the receiving end of a variety of oversight or audit functions – and the ability to demonstrate compliance will be of the utmost importance. For example, federal and state statutes authorize numerous audits:

- Quality Improvement Organization (QIO)
- Comprehensive Error Rate Testing (CERT)
- Medicare Area Contractor (MAC)
- Recovery Audit (RAC)
- Program Safety Control (PSC)
- Zone Program Integrity Contractor (ZPIC)
- Office of the Inspector General (OIG)
- Federal Bureau of Investigation (FBI)

In addition, business-focused audits of healthcare entities can be initiated by private (non-government) entities. For example, the sale or purchase of a medical or dental practice typically includes, as part of its due diligence review, an audit of the organization's financials. During this review, auditors will hone in on any signs of billing or coding violations, as well as other non-standard accounting practices. From a

Pre-webinar Survey

1. Our practice has a written corporate integrity mission statement.	52%
2. Our practice has a designated corporate compliance officer/team.	43%
3. Our practice utilizes a written corporate compliance program.	51%
4. Everyone in our practice has received corporate compliance training.	53%
5. Our practice provides periodic (at least annual) corporate compliance updates.	56%
6. We regularly audit our financial transactions correcting and reporting them when necessary.	18%

clinical perspective, managed care plans or utilization reviewers may also want to have a look at providers' financial interactions with their patients and third party payers. Their audits look for patterns of contradiction between billing and coding documentation and the clinical record.

" It ain't what you don't know that gets you into trouble. It's what you know for sure that just ain't so."

– Mark Twain

When Does an Error Become Fraud?

Some healthcare professionals acknowledge that errors do sometimes occur but that they aren't synonymous with criminal intent. In response, the government contends that every business, including healthcare organizations, should engage in ethical business practices. Audits by the federal government or other third parties can identify gaps in compliance. They also can identify whether the gap is an unintentional error or a more purposeful action, such as fraud. An error, if corrected, is an error. An ongoing pattern of erroneous billing or claims filing, uncorrected, becomes fraud, intentional or not.

Here's an example of how human error in the form of misunderstanding of corporate compliance, can turn into fraud. A practice's billing clerk upcoded many of her employer's Medicare claims. After a billing fraud complaint was filed with the state, the clerk admitted in her testimony that she was trying to do her employer a favor. It never occurred to her, she said, that she was doing anything wrong, only that she was helping him increase his well-deserved income.

One might argue that this employee was acting on her own but sound business principles suggest otherwise. The practice and this employee specifically failed with regard to corporate compliance in many respects. First, the leadership of her

On a very basic level, (see Corporate Compliance Spot Check on pg. 8-9 for a more detailed overview), a corporate compliance plan consists of:

1. A corporate commitment, from the highest level of management, and throughout the organization, to detect and correct improper procedures or activities and, if necessary, to report them.

2. A formalized plan, including written policies and procedures and designated corporate compliance leadership.

3. Training programs to ensure understanding and acceptance of personal accountability for every individual associated with the organization, regardless of rank or title.

4. Appropriate and adequate internal auditing to detect breaches, and take steps to address them.

5. A plan for dealing with those who violate the rules.

6. Diligence in preventing the organization from dealing with or placing in a position of authority, individuals who have previously engaged in corrupt business practices.

organization had a duty to provide training that would have ensured accurate filing. Second, corporate integrity principles – personal and corporate responsibility for one's own actions and for the actions of the organization – were virtually unknown to her.

Third, there was no oversight of her claims coding and filing activities. As long as the money arrived, the faulty process

was allowed to continue. This practice of business-by-default most often occurs when practice leaders have neither a head for business nor an interest in the details. Without oversight – a key component of sound business management – the stage was set for a wobbly system, one that may have appeared to be working, but was illegal as well as inefficient.

And, unfortunately, a fourth factor must also be included, and that is the possibility that there may actually have been a corporate intent to defraud. In light of the current economy and the actions of certain corporate entities, personal integrity has come into the limelight of public discourse. Few things can destroy a healthcare venture more quickly than loss of reputation.

In an attempt to force businesses to take greater accountability for their financial dealings, several types of legislation have been enacted to punish those who engage in such activity and to support those who report the same. For example, the Federal Sentencing Guidelines (1991) provided impetus for many of the new regulations including the increase in financial penalties for organizations that engage in unlawful conduct. Further, legislation has been enacted to hold corporate leadership accountable for the actions of employees – even if leadership claims to have been unaware of the purportedly illegal activity. In addition, and potentially most impactful, "whistleblower" legislation has been enacted to allow substantial financial incentives for employees who report persistent illegal activity.

With the enactment of this legislation, the repeated message from CMS, OIG, and HHS, is that corporate America – and this includes the healthcare professions – should consider corporate compliance a priority.

" An error, if corrected, is an error. An ongoing pattern of erroneous billing or claims filing, uncorrected, becomes fraud."

Ideally, oversight of corporate integrity would emanate from within the healthcare professions. To add motivation, external auditing powers have repeatedly stated that significant reductions in fines are possible when an organization can show that it has examined its own internal processes and corrected errors, or reported them without delay.

Benefits of Corporate Compliance
Corporate compliance can do more than just improve financial transactions. It can also identify breakdowns in clinical processes (e.g., poor documentation, lack of informed consent, prescription errors) and can encourage the organization to fix them before they cause injury to a patient or cause liability for the practice. Such corporate compliance activities are recognized in any industry as part of a quality assessment function and can change the entire culture of a group, reducing negatives such as:

- Inefficiency and associated waste of resources.
- Clinical errors that may trigger patient injury, litigation, censure, disciplinary action, or loss of privileges.
- Staffing disruptions caused by poor morale, employee turnover, or disruptive behavior.
- Administrative malfunction, including violation of corporate policies and procedures, censure/disciplinary action, loss of privileges, public relations embarrassment, and financial failure.

A sound corporate compliance plan can help a practice establish a sense of integrity, which is compatible with the clinically valued concept of "just culture." Such a plan helps an organization fulfill its duty to provide quality care and to also be an upstanding corporate citizen. ■

Corporate Complia

Do you feel that you're trying to play catch-up in the corporate compliance arena? Perhaps, in an informal way, you already abide by a corporate ethics philosophy? If that's the case, then formalizing the process may not prove as difficult as you might suspect. Aside from reducing your fear of regulatory oversight and intervention, you might attain some additional benefits, including: a) more efficient processes; b) fewer errors; c) improved communication; d) better team morale; and d) a feeling of being in control of your day-to-day activities.

Take a few minutes to complete the self survey below. Ask yourself if your practice is in sync with the key elements of a corporate compliance plan. The survey isn't comprehensive – but it identifies several areas where healthcare practices often misunderstand the purpose or intent of key components of these plans.

1. In our group/practice, an organizational commitment to corporate compliance and ethics is set forth in a written statement that:

a. Relies on standards of fairness and ethical behavior in all business dealings;

b. Recognizes that the commitment applies to any/all employees, associates, or affiliates of the organization, regardless of rank, title, seniority, or work schedule;

c. Commits to the development and use of policies and procedures that will assist the organization in accomplishing its corporate compliance objectives; and,

d. Acknowledges a duty to respond to reports of perceived improper conduct and to make efforts to avoid hiring, promoting, or contracting with individuals or corporate entities that have engaged in unethical or illegal dealings.

2. Our group/practice has a designated corporate compliance officer (and, if necessary, a corporate compliance committee) to:

a. Assume responsibility for implementation and ongoing operation of the corporate compliance activities of the organization, including the duty to stay abreast of, and to respond to, regulatory changes;

b. Operate from the authority and accountability established in a written job description;

c. Ensure that education, periodic review and internal audits, corrective actions, and appropriate documentation are in place; and,

d. Lead in the identification of and correction of errors, including: a) responses to reports of potentially illegal activities; b) corrective steps, when appropriate; c) prevention of retaliatory actions aimed at those who, in good faith, report suspected violations; d) prescribed (and documented) follow-up, including disciplinary actions and, if necessary, reporting to regulatory bodies.

nce Spot Check

3. Our practice/group has implemented written policies and procedures that set forth the operational aspects of corporate integrity. As examples, these include:

a. Personal accountability;

b. Work functions, such as coding, billing, refunds, fee discounts, internal audits and reviews, preparation for external audits, and documentation;

c. Reporting of non-compliance and appropriate response, including, corrective action, documentation, and disciplinary action; and,

d. Plans to ensure prompt and adequate responses to complaints and/or regulatory notices of impending audits.

4. A formalized education process is used by our group/practice to explain the ethical and legal elements of corporate compliance and its interplay with the clinical aspects of patient safety and satisfaction. We have educational components that address:

a. Education for new employees, for temporary employees or locum tenens staff;

b. Adequate allotment of resources to ensure the time, materials, and needed expertise are available when needed;

c. Periodic review and updates (at least once a year and, additionally, as needed) required for all practice associates (including boards of directors) about any changes in regulations in the law(s) or about changes in the team's policies and procedures. Signed re-commitment is obtained at this time; and,

d. Re-education, as may be necessary for inadvertent, non-egregious violations of compliance policies. Disciplinary action may or may not be required, based on the occurrence and its outcome. Regardless, dispositions of these actions are documented and retained.

Work with your compliance officer and staff to fine-tune the various components of your plan. Be sure to document these meetings and discussions. Keep track of successful changes, updates, and actions. If you decide that you need to go outside your practice for expert advice, seek an attorney who is competent in this specific area of corporate law. Hopefully, this survey will give you some good ideas and help you formulate the questions you want to ask your attorney.

(Continued on page 16)

Preventing Common Corpo

Building a bridge between clinical excel

As a service to its insureds, Medical Protective monitors many of the regulatory issues that relate to healthcare. For this reason, corporate compliance, with its potential challenges to the accuracy and reliability of health services, has become a topic of ongoing interest.

From a clinical perspective, several aspects of corporate compliance pose professional liability exposures for healthcare professionals. These risks may occur separate from, or in conjunction with, business process failures. In order to address both types of risks, Medical Protective interviewed business consultant and coding expert Joy Newby, president of Indianapolis-based Newby Consulting. This article examines several recurrent corporate compliance misunderstandings that occur in medical and dental practices. It also offers suggestions for how these challenges can be rectified.

"Our practice doesn't accept government money, so we don't have to worry about a compliance plan."

This is not a safe assumption, for several reasons. First, healthcare practices are finding it increasingly difficult to sign up with non-government programs if they can't provide corporate compliance data and documentation requested by payers' quality assurance plans, utilization review, or patient safety programs. So the economic incentive is clear: if you don't implement these systems, you won't be allowed to participate.

A second concern arises if your practice is accused of negligence (clinical malpractice) or fraud (violation of civil law). Regardless of the allegations, poor documentation or flawed business processes may hamper your ability to defend yourself. They may prevent you from proving that you engage in the same kind of quality practices as other practitioners in your area. And, according to Joy Newby, documentation gaps that impact both the clinical and business aspects of a practice are not all that uncommon.

Suggestion: If you don't have a corporate compliance plan, you may want to contact your state medical or dental association. Usually they will have a compliance advisor available for consultation. In some cases, a fee may be associated with their services. However, it might be worth the added cost in order to come away enlightened and motivated.

"Documentation of clinical care doesn't really have anything to do with our business practices."

Documentation is of the utmost importance in a practice setting. Aside from the obvious risk of clinical error, disorganized or inadequate clinical records also pose compliance challenges for medical or dental providers who rely on their records to support their reimbursement transactions.

Joy Newby says that she's seen numerous examples of gaps between clinical care and billing processes. These gaps can occur in any kind of healthcare environment. For example, when handwriting is difficult to read, or is completely missing, it may be difficult to support the care provided – from a liability perspective as well as from a billing perspective. "Lack of signatures and illegible handwriting are at the top of the (risk) list for (paper) records," Newby

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says. Further, she warns doctors not to "squeeze" words onto the bottom of a page. "Go ahead," she says – "it's OK to start a new page." Another writing problem occurs if notes are written outside the margins, cutting some information off when it is copied. Unfortunately, illegible or missing documentation has been identified as a factor in occasional high-loss litigation as patient injuries can be severe when critically important diagnostic information is not included with copied records.

Not only does documentation influence clinical care, it can also impact billing and claims submissions in the way it verifies proper coding. "Hospital progress notes also can be challenging," Newby says. "'Doing well; home tomorrow' is not going to support *any* visit code or a treatment decision!" she warns. Not only might this impact clinical care, but the physician may not be paid for the visit.

Poor documentation of medical necessity may make it difficult to substantiate the rationale for the care provided. As a result, questions will arise about the appropriateness of the care provided and the way in which a procedure or visit was coded, and ultimately paid. Newby also gets nervous when she sees that "the review of systems and examination performed aren't specific to the patient's presenting problem. For example, it can be difficult to figure out the medical necessity when a physician documents a ten-point review of systems and an exam of eight organ systems for a patient who presents with pain in his right index finger because it was slammed in a door during a wind storm."

Another challenge in paper records is some clinicians' bad habit of using the assessment portion of the progress note as a problem list. "If all pre-existing problems are lumped into the assessment, then there's no indication in the history or exam that the problems actually were assessed," Newby says. In addition, the treatment plan may not even refer to the problems. "Sometimes," she adds, "the problem isn't identified even in the chief complaint or in the history of the present illness." This can be equally problematic whether the practice is trying to submit a claim or defend a malpractice lawsuit.

Lack of clinical justification for the proposed treatment plan is also a common problem in dentistry. Without adequate assessment of the patient's condition and a summary of proposed treatment options, dentists may face the same challenges that beset their physician colleagues.

Suggestion: If you're still using a paper system, conduct a quick audit to see if any of the problems listed above appear consistently in your charts. Look for additional potential problem areas and

outline a game plan for ways you might improve your documentation processes, thus reducing your liability exposure. Do some re-education for your staff. Some medical and dental societies offer documentation training classes for their members.

"I'm too busy for all of this corporate compliance work. I went to school to learn how to take care of my patients. My staff should take care of these things."

When a physician or dentist is sued, the practice manager is rarely named in the lawsuit. Or the receptionist. Or the billing clerk. Right or wrong, the public presumes that doctors and other clinical providers will look out for them and ensure their safety. As one defense attorney succinctly pointed out, liability follows the license. So physicians and dentists can't be "too busy" to engage in the business aspect of their practices. Nor, can they be too "thrifty" to invest in the necessary tools that enable sound business practices.

For example, one major concern that all healthcare organizations should be planning for is the required transition to the ICD-10-CM coding system. In order to be compliant, practices must implement the new coding system by October 1, 2013. This new system will have a significant impact on the claim submission processes for hospitalized patients. Physicians need to understand the difference between the old and new systems. Think about this: a) the current system, ICD-9-CM, contains 13,600 codes; however, b) the ICD-10 system will contain 69,000 codes. To the extent that the ICD-10 system may affect your coding processes, you should be working with your staff and with the hospital(s) where you have privileges to make sure that you understand your role and, to whatever extent necessary, the possible implications for the coding staff in your practice.

Dentists also need to be sure that the way they submit billing information is compliant with applicable standards, which, in the case of dentists, is the 8th edition of *Current Dental Terminology*, 2011-2012. This manual contains the Code on Dental Procedures and Nomenclature, and is designated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as the official resource for terminology to be used when reporting dental healthcare services and is the required clinical reference for dental third-party payers.

Suggestions: If you're like the doctor quoted above, there are many resources that you can look to for assistance. Talk with other doctors and groups. Find out how they are tackling their compliance issues.

Consider establishing an internal "advisory council" of members of your medical or dental team to research, to share information, to help introduce business process changes, and to help enforce them. Greater cooperation and compliance may occur if members of the staff feel that they participated in, or "own," the process rather than being force-fed a new system. This group may function within the authority of your corporate compliance officer's oversight or even serve as a standing committee. You can design it in the way that best fits your practice and the types of challenges you need to address.

In some instances you may want to bring in an outside consultant, an independent organization that has expertise in the specific areas where you need help. Often, they can help you cover a lot of ground. Be sure to check references and be sure you understand the scope of services provided.

A few other recommended sources of information may include:

- The American Academy of Professional Coders (AAPC) at http://www.aapc.com. Physicians should check for updates, resources, and sound advice. Among services AAPC provides to its members is a Personal Progress Tracker in which healthcare organizations can plot their target dates for various stages of readiness. Other healthcare professionals may also find the AAPC resources useful. For more information about this service, go to: http://www.aapc.com/ICD-10/training.aspx.

- The American Dental Association (ADA) at (800) 947-4746, or by visiting www.adacatalog.org, for information about the CDT 2011-2012 manual, 8th edition.

"We have an electronic health record, so we're all set."

While this may be the goal, from Joy Newby's experience, it isn't always true. No matter how well it is designed, if an EHR (electronic health record) is not used correctly, you may have even more trouble than you might with a paper system.

Regardless of whether you are using a paper system or an EHR, the procedures performed in the office must have sufficient documentation. And what does that mean? Well, from a clinical perspective, it means that any other healthcare provider could pick up the record and, having reviewed it, be reasonably up to speed in his or her ability to provide ongoing care for the patient. From a business enterprise perspective, "sufficient" means that the medical necessity of the treatment is well documented, in the correct section of the EHR.

At a minimum, documentation for a procedure, which might occur in either a dental or a medical office, should include:

1. Medical necessity.
2. Informed consent, including separate consent for anesthesia.
3. Description of procedure location.
4. Prep, including anesthesia.
5. Description of the procedure, including excision diameter.
6. Report on the patient's tolerance to the procedure.
7. Patient post-procedure instructions, including warning signs to look for, introduction of water, light foods, meals, pain medication, implementation of prescription medications, and an emergency contact telephone number.

From a business process perspective, perhaps one of the most dangerous actions an EHR may trigger is misguided or inappropriate upcoding. Be wary if a consultant or advisor tells you that there are "secrets" you can use to upcode or ways to work around the system. The software used by government programs and by commercial payers has become very sophisticated and reliable, and inflexible when it comes to determining the appropriate codes.

If an EHR's codes have been properly set, it can save valuable time for the provider. But additional training may be necessary to ensure that the codes are being properly used – and some of this training may be time-intensive. All members of the team need to complete it. One doctor cannot be "too busy" to participate. Neither can she delegate her coding duties to a subordinate,

thus defeating one of the most beneficial aspects of EHR use.

From a clinical care perspective, an EHR can also facilitate organization and documentation. However, Newby wants physicians and dentists to be aware that electronic systems sometimes reveal contradictory information. "It's certainly going to draw attention if the ROS (History and the Review of Systems) disagree," Newby says. "How do we know which is accurate if one entry says that the patient arrived complaining of chest pain but the other entry says, 'denies chest pain'?"

"When this happens, we are immediately suspicious about the ROS. Was it really done or was it pulled into the note from a previous encounter? Does the progress note clearly indicate the physician personally reviewed the ROS and PFSH (Past Medical Family and Social History) on new patients?"

Along the same lines, "we look for 'cloned' documents," Newby says. "Do all the visits for a particular patient look exactly alike? What if we compare progress notes for different patients? Will the History and Exam components of their current progress notes be exact replicas of earlier notes?" All of these issues can be impactful when trying to submit a claim for reimbursement or when trying to respond to an allegation of negligence. In either scenario, conflicting documentation, or documentation that seems contrived, can be an obstacle.

Further, the EHR can't correct forgetfulness or human error. If you gave the patient an inoculation, but didn't document it in the record, the bill itself is not sufficient to verify the service. Likewise, if your record shows that you extracted Tooth #30 but the bill says that you extracted Tooth #20, it may be difficult to prove that you're entitled to payment and it may be difficult to defend a claim.

Suggestions: In addition to the audit procedures that every practice should have in place as discussed above, and because EHRs encompass so many nuances and potential errors, Medical Protective and Joy Newby offer several other suggestions that doctors and their staffs can use to improve their clinical and business function processes:

- A good electronic system should be able to print out complete and accurate post-procedure instructions for every treatment performed in the office. This saves time for the doctor and his or her staff and prevents lapses by ensuring that the patient has needed information and support. Note: Such forms should also include a blank space for the doctor's sign-off and "special" instructions that should address the patient's *specific* health issues, e.g., diabetes, Coumadin dose, etc.

- Avoid the temptation to bill as though the physician or dentist provided a service that was actually provided by an allied health professional. By their very nature, these miscodings are difficult to defend. Rarely do they occur in the inverse order – coded as though a midlevel professional provided the care when a physician or dentist actually did. Fines can be stiff and, depending on the types of violations, they can be financially devastating.

- If you find overpayments, you should refund the money for the specific claims. However, what do you do if you find a consistent pattern of ongoing billing problems? Examples might be a long-term policy of:

  a. Billing nail debridement services as "covered," when the provider actually provided routine foot care or
  b. Billing all pediatric dental extractions as emergencies.

In such instances, Newby tells doctors they should immediately contact their attorneys and begin planning self-disclosures – which might involve refunds for inappropriate payments dating as far back as six years! So – it's not just the fines that have the potential to be financially devastating. The corrective process itself can be intensive and painful.

"I've practiced all these years without having a corporate compliance plan, and I'm not going to start now!"

This refusal to accommodate change is a risk that Newby finds all-too-often in practices where an older or founding partner is still seeing patients. In her example, these

founding doctors often built their practices into large and successful organizations. The number of employees has increased and the group now has several partners and other doctors on the partnership track. Yet, Newby says, "in many instances, these older doctors refuse to recognize the need for compliance plans and believe that the way they ran the practices 20 years ago is still the model they should be using today.

Refusal to part with outdated clinical processes poses risks for *all* of the doctors associated with the practice. In addition to the risk of regulatory audits that may expose the practice to significant financial risk, non-compliance with one required business policy is often associated with non-compliance in other areas as well.

This type of practice often has problematic gaps in its corporate compliance plans – the exclusion of corporate compliance agreements being one such example. Typically, corporate compliance agreements should require completion of training and a signed agreement to cooperate. The signed commitment forces each provider to acknowledge that refusal to comply with a compliance plan, may result in suspension or termination of employment. Without these kinds of employment agreements, the uncooperative doctor has no "skin in the game," and continues to ignore the compliance (and sometimes other) policies. As a result, Newby has seen instances in which the other partners in the practice may not have sufficient leverage to force their colleague's cooperation.

Conclusion

This article has focused on examples of corporate compliance problems that also can have a negative effect on the quality or safety of patient's clinical care. The range of corporate compliance tools, systems, and training can help physicians and dentists and other healthcare professionals get a better handle on their business processes and improve the quality of clinical care. ■

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Corporate Compliance Spot Check

(Continued from page 9)

Corporate compliance and business ethics are not static in nature. The regulatory environment is becoming even more vigilant and it is unlikely that expectations of business transparency will become less stringent over time. Check out the resources listed below and seek additional information from professional associations, specialty organizations, state medical/dental boards, local health systems, etc. In an area where non-compliance can play havoc with a business's ability to survive, it's very important that you stay informed and give yourself adequate time to respond. ■

Resources

AAFP (American Academy of Family Physicians) Guide for Physicians: a series of practice management articles that include information on oversight, controls and governance. http://www.aafp.org/online/en/home/practicemgt/codingresources/recoveryauditcontractors.html

CMS Medical Learning Network (MLN) on RAC (Recovery Audit Contractor) Numerous advisories from the Centers for Medicare and Medicaid. CMS updates should be a regular part of corporate compliance oversight. http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf

CMS RAC Overview Explanations of Recovery Audit Contractors and their role in CMS corporate compliance and ethics administration. http://www.cms.gov/RAC/01_Overview.asp

Corporate Responsibility and Corporate Compliance: A Resource for Health Care Boards of Directors. Although the targeted reader is a board member, the information is comprehensive enough for a single practitioner or small group trying to get a handle on how to manage a compliance program on a small scale. http://oig.hhs.gov/fraud/docs/complianceguidance/040203CorpRespRsceGuide.pdf

Gafner, R. Focus on Medical Compliance: Preventing Health Care Fraud and Abuse, 3rd Ed. Medical Risk Management. Houston. 2010. Overview of a corporate compliance plan for the office-based healthcare practitioner. Provides Continuing Education.

RAC Preparation – 7 Key Steps and Best Practices. Sound explanation of how the RAC audit process works and how healthcare professionals can be prepared to deal with them. http://www.mcguirewoods.com/news-resources/news/3874.asp

RAC Toolkit: AHIMA (American Health Information Management Association) http://www.ahima.org/downloads/pdfs/resources/RACToolkit.pdf

Society of Corporate Compliance & Ethics (SCCE) www.corporatecompliance.org Has an annual membership fee of $295 but also publishes free articles and other information. And, has a social networking resource: http://community.corporatecompliance.org

Top Ten Compliance Challenges for Hospitals. On a different scale, many of these same challenges also apply to office-based care settings. http://www.racsummit.com/top10.html

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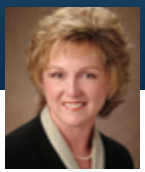

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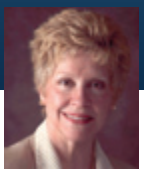

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