Medical Practice Compliance

News, tools and best practices
to assess risk and protect physicians

ALERT

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Impaired ophthalmologist convicted of billing fraud; raises colleagues' compliance risk

Warning: Your best efforts to ensure your practice is billing and coding correctly can be undermined when your compliance program has holes in it. And don't expect any slack if the improper billing was caused by one of your physicians with a personal problem.

Joseph Kubacki, MD, a pediatric ophthalmologist and the former chair of the Department of Ophthalmology at Temple University School of Medicine in Philadelphia was convicted August 22 of causing thousands of false claims to be submitted to payers for patients whom Kubacki did not personally see or evaluate, totaling more than $1.5 million in false claims.

At Kubacki's direction, staff employees would stack charts of patients seen by other physicians outside his office door. He made

*(see **billing fraud**, pg. 4)*

When revenue rises unexpectedly ask questions before you celebrate – or spend – the windfall

When you hire a new employee and see a sudden spike in revenue, don't just assume you hired a star. Verify that you can properly account for the new money flowing into your coffers.

Bangor Women's Health Care, a solo physician practice in Maine, serves as a case in point. The practice hired Dawn Zehrung in 2006, according to a statement from the Maine district of the U.S. Attorney's Office. In 2008 the practice put her in charge of its billing.

The practice didn't suspect anything was wrong until it received a report about billing irregularities in 2009. This prompted an independent audit with devastating findings: A 90% error rate that resulted in more than $300,000 in overpayments from Medicare, Medicaid and private payers, which the practice had to repay.

Zehrung had been regularly upcoding claims and submitting claims for services the practice hadn't performed, as well as stealing cash payments and giving herself unauthorized bonuses, officials said.

*(see **unexpected revenue**, pg. 8)*

Beware of private payers that offer deals too good to be true – result could be fraud

Most allegations of illegal kickbacks involve relationships between physicians and other providers or vendors such as pharmaceutical manufacturers. But with the rise of Medicare managed care, be on the lookout for private payers offering you money in violation of the anti-kickback law.

United Healthcare and its subsidiary, AmeriChoice New Jersey, are embroiled in a whistleblower lawsuit brought by two former United employees who claim sales representatives from United provided $27,000 in illegal kickbacks to Reliance Medical Group, a New Jersey physician practice. The employees claim the physicians were paid to switch some eligible patients to Medicare and Medicaid managed care products offered by United and its subsidiary and to provide names of potential new enrollees eligible for Medicare and Medicaid.

The lawsuit also alleges False Claims Act violations for filing claims to Medicare relating to these patients.

The physicians are not named in the lawsuit, but because they are implicated in the case, they could be targeted by the government for violating both the criminal anti-kickback law and the civil False Claims Act, according to attorney Stephen Sozio, with Jones Day in Cleveland, Ohio.

Neither United Healthcare, Reliance Medical Group nor the attorneys for the whistleblowers responded to requests for comment.

It may seem odd for private payers, long known for their stinginess when it comes to paying physicians, to suddenly pay for what seems like a marketing push. But it's not innocent – by enticing the physicians to induce these patients into their plans, the private payers will make far more in payments under the subsidized Medicare Advantage program.

It's not an isolated incident, says attorney Scott Oswald, with the Employment Law Group in Washington, D.C., who represents whistleblowers and claims that CMS knows a lot of this type of conduct is occurring.

Note: Expect this activity on the part of payer sales representatives to increase, as more private payers delve into the booming senior business by launching or expanding Medicare managed care products. Enrollment in Medicare Advantage is projected to increase 10% in 2012, according to a Sept. 15 HHS announcement.

In addition, HHS will allow payers with high quality scores to continuously market and enroll beneficiates into their Medicare-managed care plans throughout the year, not just during open enrollment, as an extra incentive for high quality performance.

What this means to you: Be prepared for more pressure from payer representatives to encourage your

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Medicare-eligible patients into their Medicare managed care plans, warns Bo-nnie Burns, training and policy specialist for patient advocacy group California Health Advocates in Sacramento.

This type of arrangement with a private payer may implicate the anti-kickback law and False Claims Act, even though your practice isn't billing Medicare or Medicaid directly. Oswald recommends as a best practice to refuse to accept these inducements if approached by a private payer representative. "Even small [payments] are a violation," he warns.

"Check with counsel at a minimum. This is fraught with risk," warns Sozio. — *Marla Durben Hirsch (mhirsch@decisionhealth.com)*

Four steps to reduce liability when dealing with an impaired or problematic physician

While it may not be pleasant to deal with a colleague with a substance abuse, health, or other problem affecting performance, inaction can seriously impact everyone else in the practice *(see story, pg. 1)*. Here are four tips to avoid or reduce liability when dealing with a physician or other provider whose conduct may create liability for your practice:

1. Have, and use your compliance plan. Make sure you have an effective compliance plan that attempts to prevent, detect and correct offenses, including these offenses by the physicians in your practice, and regardless of the reason for them, says consultant Reed Tinsley, CPA, In Houston.

2. Make sure physicians and others know that inappropriate conduct will not be tolerated and could have an adverse effect on the practice. Employees may be subject to the practice's disciplinary policies *(MPCA 7/12/10)*; licensed practitioners may be subject to legal and ethical reporting obligations to your state licensing board.

3. Provide employees with the ability and support to report suspicious behavior to superiors and to the OIG if the practice doesn't respond to the report, says Patty Hartman, public affairs specialist for the U.S. Attorney's office in Philadelphia *(MPCA 4/5/10)*.

4. Be prepared to take legal or other action. Your practice may end up providing counseling for a physician, putting a colleague on leave of absence or even terminating one from the practice, says Tinsley. If you are ethically or legally obligated to report inappropriate behavior, do so. — *Marla Durben Hirsch (mhirsch@decisionhealth.com)*

Make sure your practice isn't upcoding with improper place of service codes

Double check box 24B of your claims and remind staff that selecting the right place of service (POS) code is as important as selecting the correct procedure and diagnosis code. You can be certain Medicare Administrative Contractors (MACs) are taking a closer look at physician selection of POS codes even as they gear up to issue overpayment demands for past mistakes.

POS errors are a favorite OIG target, because doctors keep making mistakes and those mistakes add up. This year OIG released two audits which looked at claims submitted in 2008 and 2009, respectively. The OIG estimates errors during the two-year period resulted in a total of $28.8 million in overpayments. Previous audits tell the same story. OIG's 2009 POS audit found mistakes in 2007 triggered $13.8 million in overpayments. In 2008, the OIG found errors in 2005-2006 that sparked $20.2 million in improperly paid claims.

TIP: Remind your staff that selecting the wrong POS code can result in upcoding. Medicare pays more for services performed in a non-facility setting such as a physician office, urgent care center or independent clinic, to account for the practice's increased overhead expense. "However, when physicians perform these same services in facility settings, such as hospital outpatient departments or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate," OIG says in both audit reports.

Example: According to the 2008 audit report, a doctor received a $598 overpayment when he billed a balloon angioplasty with the office place of service code. OIG found the service had actually been performed in a hospital's outpatient department and the hospital had been reimbursed for the overhead costs. If the claim had been coded correctly, the physician would have received a payment of $239, OIG says in the report.

Note: The OIG catches mistakes by matching doctors' claims for services with non-facility POS codes to claims from hospital outpatient departments or ambulatory

surgery centers (ASCs) for the same patient, procedure and date of service. As MACs become better at conducting real-time comparisons of Part A and Part B claims, it will become easier for payers to catch errors when the claims are submitted.

RACs are also looking for POS errors. All four Recovery Audit Contractors have added place of service errors to their approved target lists and it appears they are using automated review to locate the mistakes. This means your only warning that you have a POS selection problem will be an overpayment demand letter from the RAC.

Don't repeat other practices' mistakes

Multi-million dollar overpayments aren't the only thing the OIG always finds when it reviews POS selection. The reasons providers give for these mistakes stay the same as well. As it has done in past years, the OIG interviewed the audited providers to find out what triggered the mistakes and received the following responses:

- The doctors, billing staff or billing agents didn't understand the definition of a physician office or other non-facility location, or were simply following an established practice of applying a non-facility code to all services.
- The practice's billing agency didn't know POS codes affected payment.
- Personnel made isolated data errors.
- An electronic billing system automatically assigned a non-facility POS to the claims.

While the reasons given for these mistakes are no doubt sincere, the OIG has heard them every time it has conducted a POS-selection audit. Auditors likely have become a bit skeptical by now. Even occasional errors could raise a red flag if they only occur for services where the wrong POS triggers a much larger payment.

Bottom line: You should not expect "I didn't know," "My billing service did it," or "It's a computer glitch," to block an overpayment demand. To make sure everyone in your practice understands the importance of proper POS selection, remind them:

1. No matter who – or what – made the mistake, the provider who signed off on the claim is responsible for its accuracy and returning the money to Medicare.

2. In the audit report, the OIG states doctors used the wrong POS *"even though they knew, or should have known, that the service was performed in a facility location."* In other words, the OIG assumes doctors know the rules and expects doctors to follow them.

3 more tips to clean up your POS process

1. Distribute CMS's definition of an office (POS 11) to everyone who prepares claims for your practice: "Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis." **Remember:** You can find a complete list of POS codes along with the pay rate (facility or non-facility) for each POS in the Medicare Claims Processing Manual, Chapter 26, Section 10.5.

2. Disable any auto-fill function on your billing software. If your billing service uses software, make sure it manually enters the POS.

3. Remind staff that services performed in the office's ASC should be billed as ASC services (POS 24). According to CMS, "The regulatory definition of an ASC does not allow the ASC and another entity, such as an adjacent physician's office, to mix functions and operations in a common space during concurrent or overlapping hours of operations." — *Julia Kyles (jkyles@decisionhealth.com)*

Official resources:

- OIG POS report 2008: *http://oig.hhs.gov/oas/reports/region10/11000513.asp*
- OIG POS report 2009: *http://oig.hhs.gov/oas/reports/region10/11000516.asp*
- *Medicare Claims Processing Manual,* Chapter 26, Section 10.5: *www.cms.gov/manuals/downloads/clm104c26.pdf* (POS list begins on pg. 19)
- CMS's ASC website: *www.cms.gov/CertificationandComplianc/02_ASCs.asp*

billing fraud

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notations in the charts, falsely indicating he had evaluated the patients and turned in pay slips that his physician practice, Temple University Physicians, then billed to payers, including Medicare. He also created false statements in the patients' medical records solely for the purpose of submitting fraudulent billings.

This went on for five years.

He faces more than 87 months in prison, a fine of up to $36 million and mandatory restitution.

Medicare's teaching physician rules allow payment for an attending physician for services provided by medical residents only if the physician either personally furnishes the services or is physically present during key portions of the service provided by the resident.

The government found Kubacki wasn't present during the cases he billed and sometimes he wasn't even in Pennsylvania.

Fraudulent billing covered drinking problem

The FBI's statement doesn't elaborate on the circumstances surrounding Kubacki's fraudulent billing. But a little digging into the indictment reveals that because Kubacki regularly abused alcohol, he was unable to see and treat as many patients as he otherwise would have been able to. The residents did not ask him to serve as their attending physician; other physicians would not send their patients to him either. He falsely inflated his billings in part to hide his impairment and to make himself look more productive so he could keep his position as chair of the department.

There is no indication that Kubacki actually treated any patients while impaired, according to Patty Hartman, public affairs specialist for the U.S. Attorney's Office in Philadelphia.

But what is sobering – and problematic for those around Kubacki – is that Temple's Ophthalmology Department's compliance program failed to prevent the fraud. The indictment lists the dates that Kubacki attended compliance training sessions, demonstrating that he should have understood the documentation requirements. There was also evidence that the compliance officer advised Kubacki directly that if he signed charts for patients he didn't see, he'd be committing fraud and could go to jail.

So while it looked like the compliance program was working, physicians and/or staff members were delivering charts and pay slips, looking the other way when he abused alcohol in the department and allowing him to violate the law. The sordid situation only came to an end when interns reported him to higher authorities at Temple, according to Hartman.

"The compliance plan failed. Obviously there was some major communication breakdown in the hospital," notes consultant Reed Tinsley, CPA, in Houston.

One physician can bring the whole practice down

The case highlights the significance that the personal problems of one of your physicians can have a broad, long lasting effect on not only the other physicians in the

Physician impairment often unreported by peers

Enabling an impaired physician colleague is not unique: According to a 2010 study in the Journal of the American Medical Association (JAMA), one-third of physicians who knew of an incompetent physician didn't report it to a relevant authority. Reasons cited included the belief that someone else would report it, the concern reporting it would be fruitless, and fear of retribution. According to JAMA, 8%-12% of physicians will develop a substance abuse problem; that figure does not include physicians with other problems that can impair their performance.

Not reporting a troubled colleague can create compliance problems for the witnessing physician. Many states have legal requirements to report physicians that may be incompetent or practicing while impaired. However, they vary as to who is obligated to report and how to go about it. Virtually all state medical societies and licensing boards do have treatment programs for dealing with impaired physicians.

"Physicians have to police themselves but they don't," warns Maxine Lewis, CPC, president of Medical Coding Reimbursement Management in Cincinnati, Ohio. "They don't realize that they're being watched [by the government] these days, and that impairment or other problems can lead to compliance problems, like false billing," she adds.

In addition, physicians have an ethical obligation to report colleagues who are impaired, incompetent or unethical, according to the American Medical Association, which has issued guidelines on the subject.
— Marla Durben Hirsch (mhirsch@decisionhealth.com)

On the Internet:

- JAMA study: *http://jama.ama-assn.org/content/304/2/187.short*
- AMA's ethical guidelines: *www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9031.page*

practice but also on the other providers with which the practice is affiliated.

Temple University appears to have acted appropriately once Kubacki's billings were reported. After investigating concerns about his conduct, Temple severed its relationships with him and promptly reported its findings to the HHS Office of Inspector General.

"The University has since implemented additional measures to safeguard against such misconduct from recurring and cooperated fully with the government in its investigation," according to Rebecca Harmon, director of public relations and communications, Temple University Health System. Harmon would not elaborate on the additional measures.

But this doesn't mean that Temple University or Kubacki's physician group is off the hook. "The case is still active," says Hartman.

The case also flags a little-discussed issue in physicians' offices: An impaired colleague can be a major compliance liability. It's unknown how often substance abuse is a cause of false billing. "It has not been a common theme in most of the overbilling cases we have charged," says Hartman.

But the government was able to show Kubacki's alcohol abuse made it more probable that he committed the billing fraud, because the alcohol abuse caused him to see fewer patients, giving him the motive to submit false claims. "There was strong circumstantial evidence that the two [fraud and alcoholism] were connected," says Colin Miller, Esq., associate professor at John Marshall Law School in Chicago.

A physician doesn't need to have a substance abuse problem to bill improperly; he could have a gambling problem, dementia or other behavior problem that could lead to other compliance issues, such as medical malpractice. "All of the doctors can get sucked in for aiding and abetting [the problematic physician]," warns Tinsley.

Many physicians don't want to confront or turn in a colleague with a substance abuse or behavior issue, especially when he's a high producer, notes Tinsley. And it can be exceedingly difficult for a subordinate to report an impaired or difficult boss. "Dr. Kubacki's staff [delivering the charts] was following his orders," points out Miller. — *Marla Durben Hirsch (mhirsch@decisionhealth.com)*

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Physician compliance nightmares: Confession by intimidation

The below is another of an occasional series of actual compliance mistakes encountered by your peers, and how the nightmare could have been avoided (*MPCA 9/19/11*).

The warning: Don't confess to improper coding just because the government tells you to. A dermatologist received a visit in his office one Friday from two government agents, one from the FBI and one from the OIG. They waited in his reception area until after all patients and staff had left. The agents told the dermatologist that they had evidence he had been upcoding for the removal of lesions. After two hours of interrogation, the physician agreed to handwrite a confession admitting that he had upcoded, which the agents dictated to him. The confession ended with a statement that the dermatologist knew what he did was wrong and promised not to do it again. The agents left, taking the confession with them.

However, there was a slight problem: The dermatologist never engaged in upcoding, according to attorney Steven Kowal, with K&L Gates in Chicago. "He [wrote the confession] because he was terrified. He thought that if he told them what they wanted, they'd go away," he explains.

"He had no idea what his rights were and felt like he was a hostage," Kowal adds.

What happened: A month later, the dermatologist received a subpoena from a grand jury for his records. Only then did he enlist legal counsel. "[The physician] was going to be indicted," says Kowal.

Kowal obtained a copy of the handwritten confession from the government, and was able to show the grand jury that all of the factual statements in it about coding were untrue, so the dermatologist was never charged. But he still had to go through the ordeal, and incur the legal costs.

What he should have done: While you can certainly talk informally to a government agent, you are not obligated to do so when agents show up unannounced at your office. In this case, the dermatologist should have asked for the agents' business cards and said he'd get back to them to talk further. "This would have given him some control over the situation, given him time to get an attorney involved, and perhaps some advance warning of the issues so he could prepare [for an interview]," says Kowal. — *Marla Durben Hirsch (mhirsch@decisionhealth.com)*

From the
DECISIONHEALTH® PROFESSIONAL SERVICES
Case Files

Case 68: The case of the blurry HPI and A/P

The client: A large multi-specialty group in the Southeast.

The audit: Random chart audit for all providers, focused on proper code selection and documentation of E/M services. The auditors were tasked with drilling deep into the documentation and looking for training opportunities to improve the notes physicians took during the encounters to justify the services billed.

The audit result: Overall, the practice fared well on the audit, but we found training opportunities in the precision used when documenting the history of present illness (HPI) and the assessment and plan (A/P) done by the physician during the encounter.

These are two of the most important areas of the service documentation because the HPI really helps to address the underlying severity of the patient's condition when it comes to driving treatment decisions and clarity in the A/P is a key way to demonstrate the work the doctor did during the encounter. In some cases in this audit, it was hard to differentiate between the HPI and the A/P.

Lessons learned:

- **State a clear HPI specific to that visit and include the status:** Try to avoid an HPI that simply says something to the effect of "patient here to be treated for x" or "follow-up visit for treatment of x." Your HPI is the best place to include statements about any current flare-up of the condition that prompted the patient to come in on this specific date. It will help justify the use of higher level codes when medically necessary.

- **Set a clear A/P that doesn't overlap with the HPI:** The HPI is not the place to discuss the physician's treatment plan for the patient or for the condition. Make sure your A/P has clear evidence of management. In this case, one chart had "all problems stable continue same meds" rather than individual management documented. When coding 99214 based on the breadth of management, i.e. at least three stable chronic problems evaluated and managed, be certain that the Dx, status of the problem and the Tx/Rx of each problem is spelled out for clarity of MDM. If it is a case of acuity or worsening problems, be sure the A/P area contains descriptive terms such as 'mild to moderate exacerbation progression' or 'significant progression.'

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On the Internet:

- Kubacki indictment: *www.justice.gov/usao/pae/News/2011/Jan/kubacki_indictment.pdf*

unexpected revenue

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In August, Zehrung was sentenced to more than three years in prison, followed by three years of supervised release. In addition she was ordered to pay more than $355,000 in restitution.

Zehrung's actions had a larger impact, according to an article in The Bangor Daily News. "Because of her lies and falsehoods, we committed ourselves to unrealistic long-range contracts," said practice owner Dr. Robert Grover during the trial. "We bought equipment that we can't afford, and we made promises that we will be hard-pressed to keep."

Embezzlement at small practices is more common than many people believe, says Jay Malik, managing member of Doctors' Finance LLC in Allentown, Pa. "A doctor in a small practice doesn't have the time, training or ability to manage their finances so they hire someone else and trust them."

These same time and budget constraints also mean the practice is unlikely to hire an accountant to review its finances, much less question a sudden increase in revenue.

Proactive oversight is among the many steps your practice can take to prevent compliance-related problems caused by embezzlement *(MPCA 2/21/11)*:

- Consider hiring an accounting firm to perform a test Medicare audit and ensure your billing process is correct, suggests Gregory R. Piché, proprietor of Singularity Health Law PLLC in Denver. "If you have a sudden spike or drop in revenues, you want to know the reasons why," Piché says.
- Create a budget or forecast at the beginning of the year that correlates to what you've done in the past, so if numbers start varying greatly it can serve as an alert to figure out what's going on, says Michael Fabrizius, board chairman of the Association of Healthcare Internal Auditors in Wheat Ridge, Colo. "Physicians can only see so many patients in a day," Fabrizius says. When your patient population stays the same but your revenue rises suddenly, this should trigger a look into where the extra money wis coming from.
- Routine compliance audits, including taking a sampling of claims that have not yet been submitted and having a second biller or other practice employee verify the coding, can ensure agreement with the assigned coding, says Jessica Gustafson, founding shareholder at The Health Law Partners P.C. in Southfield, Mich.
- When receiving your revenue from insurance companies, divide the revenues by the amount of visits so you get a good idea of what each visit means in terms of reimbursement from the insurance company, according to Fabrizius. "It can help you narrow it down and find out if it's the insurance company or a certain patient – it can help isolate the cause of that big fluctuation," Fabrizius says.

TIP: Have a meeting between your doctor(s) and your accountant at least once a quarter and go over your practice's finances, Malik says. "Discuss and compare your numbers to the previous year."

If your employees realize that your physicians are going over the numbers themselves and asking questions, then employees may not commit acts such as embezzlement, Malik adds.

Note: The number of claims your practice has filed for one day of patient visits should correspond with the number of patients who visited the practice that day, according to Fabrizius. "If you're filing 25 claims, then you should have treated 25 patients," he says.

Scrutinize your numbers, Fabrizius says. Implement a system of "checks and balances" at your practice as well, because "too many responsibilities should not belong to one person," he says.

TIP: Ask accounting firms to evaluate and analyze your practice's numbers and report anything unusual or out of the ordinary, Fabrizius says. "Tell the firm 'I need to know when things don't work out'," he says. "Help me understand my numbers." — *Chris Huntemann (chuntemann@decisionhealth.com)*

On the Internet:

- DOJ press release: *www.justice.gov/usao/.../20110314_grover_dawn_pleads_guilty.pdf*
- Bangor Daily News: *http://bangordailynews.com/2011/08/22/news/court/woman-ordered-to-serve-more-than-3-years-for-health-care-fraud*

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