November 8, 1999

Ms. June Gibbs Brown
Inspector General
Department of Health and Human Services
Attention: OIG-7-CPG
Room 5246, Cohen Building
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Brown:

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing 115,000 physicians and medical students of internal medicine, is pleased to submit comments in response to the Office of Inspector General's (OIG) "Solicitation of Information and Recommendations for Developing OIG Compliance Program Guidance for Individual Physicians and Small Group Practices" as published in the *Federal Register* dated September 8, 1999. These comments are in furtherance of our letter to you dated September 10, 1999, in which we offered ACP-ASIM's time and resources to work with OIG in the development of a physician compliance guidance, to ensure that such a document has a high level of utility and acceptance in the physician community. We appreciate OIG's receptivity to ACP-ASIM's offer as expressed in your letter of September 28, 1999, and look forward to working with your staff in developing a physician compliance guidance that physicians who practice solo or in small groups can implement with minimal demand on resources and disruption to patient care.

First and foremost, physicians want a compliance guidance which is written in plain language and is easy to use, does not represent an overwhelming investment of time and resources, and which can be easily incorporated into the every day workings of a physician practice. Though the existing guidance for third party billing companies is a helpful starting point for developing a physician compliance guidance, OIG needs to be aware that:

- The vast majority of physicians do not know what a compliance plan is, and some may only have a vague idea of what OIG does.
- The target audience, solo and small group practices, rarely has even the most rudimentary elements of staff organization to address the complex compliance issues and responsibilities referenced in the third party billing company compliance guidance model.
- Most physicians do not have the time to read, absorb, and implement a compliance guidance the length (36 pages) and intricacy of the third party billing company model.

If the goal is to help physicians, then OIG needs to attract their attention by "thinking out of the box," i.e., create a radically different type of guidance which helps physicians in two key areas: (1) Identifying internal weaknesses in claims submission accuracy and

completeness; and (2) Providing up-to-date awareness of which program areas OIG has identified as most vulnerable to fraud and abuse, and for which it has established enforcement priorities. A more detailed discussion of these two areas follows.

1. **Identify internal weaknesses in claims submission accuracy and completeness.**

   One key component of a physician compliance guidance should be a mechanism for identifying patterns of problem billings, either an in-house tracking system for the nature and volume of rejected claims, or a profile of claims payment history for each practice generated by the carrier. The goal is to have claims' problems identified and rectified early, and to keep such problems to an absolute minimum.

   Such an internal system would:

   (a) Assure claims are accurately coded and adequately documented; and

   (b) Minimize the chance that the claims will be denied or returned for additional information, or lead to a physician being placed on pre-payment review by a carrier, or being reported to OIG for investigation.

   Vital to achieving the above, physicians must recognize their responsibility in assuring:

   - Those responsible for submitting claims are well trained and experienced in coding and documentation requirements; and
   - There is an open and ongoing dialogue between the physician's office and the Medicare carrier which is instructive and educational. Every practice should be made aware by the Medicare carrier of billing areas that cause the most frequent problems for timely payment, and be able to work closely and productively with carrier staff to identify key billing problems and develop effective solutions.

   **ACP-ASIM Recommendation:** It would be extremely valuable if OIG, working in concert with ACP-ASIM and other medical organizations, could develop and offer physicians a detailed tool—some type of checklist or monitoring template--for identifying and tracking key problem areas in terms of claims submission and payment, as well as instituting corrective action and follow-up. Another option would be to help carriers standardize reporting to physicians on specific claims coding and documentation problems, with possible remedies identified, supplemented by face-to-face physician/carrier educational sessions.

   **Benefits:** There are a number of reasons why most physicians would be supportive of having this type of diagnostic claims payment information available:

- Faster claims payment turnaround through improved coding accuracy;
- Diminished red tape and administrative delays in having to resubmit returned or denied claims; and
- Reduced chance they would be subjected to a carrier post-payment audit, be placed on pre-payment carrier review, or be referred to OIG for further investigation.

Clearly, the benefits of such a cooperative, educational approach between physicians and carriers would be many. Over time, the expectation for most physicians would be for steady improvement in claims submission accuracy, completeness, and consistency, which should translate to less administrative red tape and more time spent on patients. And it should become easier for carriers and OIG to identify those physicians whose errant billing patterns are, for whatever reason, not improving and thus truly deserving of closer inspection.

2. **Provide up-to-date awareness of what program areas OIG has identified as most vulnerable to fraud and abuse, and for which it has established enforcement priorities.**

   The second critical element a physician compliance guidance must have is a detailed listing of all program areas which OIG has identified as being high risk, i.e., extremely vulnerable to fraud and abuse.

   **ACP-ASIM Recommendation:** OIG would issue to all physicians an advisory notice listing identifying the most frequent and common instances of program non-compliance, including Medicare service and billing offenses, as well as violations of physician self-referral statutes. This listing should be comprehensive and inclusive of all OIG compliance enforcement initiatives and priorities, including those publicized through OIG Special Fraud Alerts, Medicare Advisory Bulletins, and Special Advisory Bulletins.

   To be truly helpful to physicians, the guidance should explain the nature of each type of program risk area, what historically has made them targets of fraud and abuse, and then provide checklists for each which physicians can use to make sure Medicare and OIG requirements are met. ACP-ASIM would be glad to assist OIG in the crafting of the advisory notice, so that it is easily comprehended by a physician audience.

## Other ACP-ASIM Suggestions

To further enhance its appeal and acceptance in the physician community, the physician compliance guidance should also:

- Emphasize its positive, educational orientation by using a title in the vein of "Helpful Tips for Properly Billing Medicare"—omitting or downplaying all references to the term compliance, which has a pejorative connotation

("submissive," "yielding" in Webster's), and substituting more constructive phrases such as, "Helping to assure your business practices and Medicare claims are consistent with Medicare laws and regulations."

- Be limited to 5 or 10 pages in length and be written in simple, non-legalistic language which recognizes the resource limits and time demands of a solo/small group practice audience. Such a guidance would **omit** reference to the seven compliance program elements which have appeared in every OIG guidance released to date, as the target audience is highly unlikely to go out and hire a compliance officer, establish a compliance committee, perform background checks on every staff member, conduct formalized compliance training, perform systematic internal audits and monitoring, institute fraud and abuse hotlines, or publicize disciplinary procedures and penalties. Although we strongly recommend that the OIG approach the physician compliance guidance without reference to these seven compliance program elements, we have attached an addendum with our recommendations on how to address these seven elements should they be retained by the OIG.
- Provide an appendix of technical reference resources which physicians could call to get help. This would include a listing of key websites to obtain important Medicare and OIG related information, and phone numbers for carrier professional relations staff, state carrier advisory committees, and local Peer Review Organizations. The OIG Fraud and Abuse Hotline number should also be provided, as well as information on how to obtain an OIG Advisory Opinion (relative to the Federal Anti-Kickback statute).
- Provide a brief appendix which summarizes governing Federal laws, such as the False Claims Act, and Civil Monetary Penalties and Anti-Kickback statutes, so that physicians have an awareness of the consequences associated with various forms of programmatic misconduct.

## Summary

As OIG fraud and abuse activities have escalated over the last few years, so has the anxiety level of the physician community. The morass of red tape and rules governing Medicare services and payment has become overwhelming, making it harder and harder for physicians to adequately care for their patients. Physicians are besieged and befuddled not only with the need to meet every governing Federal requirement, but also an inconsistent and ever changing array of local carrier medical review policies.

The honest physician wants to do what is right. But in a solo or small group practice, where time spent with patients is so precious, the extravagance and cost of a formal compliance program is totally unrealistic. What is reasonable, and we believe achievable, is an easy to use physician compliance guidance which gives doctors the basic tools they need to raise claims accuracy and turnaround to a much higher level, leaving more time for serving their patients, and which also helps them stand clear of those programmatic areas only the most flagrant of individuals would attempt to defraud.

We look forward to our continued collaboration with your staff in achieving this goal.

Sincerely,

Whitney W. Addington, M.D., F.A.C.P.
President

## Addendum: ACP-ASIM Recommendations on OIG's 7 Compliance Program Elements

As noted in the body of the foregoing letter, ACP-ASIM strongly urges OIG to develop a radically new approach for a physician compliance guidance which is **not** based on the seven compliance program elements which have appeared in every OIG health care industry compliance guidance issued to date. However, in the event that OIG chooses to retain these same seven compliance program elements for its physician compliance guidance, ACP-ASIM recommends that the following element-specific considerations, developed by the American Medical Association, be taken into account by the OIG:

1. **Development of Written Policies and Procedures**—Since the goal of this element is to demonstrate a clear commitment to compliance, OIG should recognize that there are many ways for a physician or small group practice to demonstrate this, and that putting such a commitment in writing is not, in itself, a demonstration of compliance. Thus, OIG should specify what a basic set of written compliance policies and procedures must contain to be acceptable—and then identify the types of observable behaviors/actions it would consider as demonstrative of a practice's commitment to good compliance conduct.
2. **Designation of a Compliance Officer and Other Appropriate Bodies**—In a solo or small group practice, the OIG should allow an internally respected and influential individual from within the practice to serve as the Compliance Officer, and to not require that this be a full time position. This role could be filled by a practice physician. In such a setting, OIG should eliminate any requirement for a compliance committee. OIG should also consider whether the individual serving as Compliance Officer could function in this role for more that one entity.
3. **Development and Implementation of Effective Training and Education Programs**—Given that formalized, ongoing training and education programs on compliance are unrealistic for a solo or small practice to organize and finance, OIG should provide guidance on what it considers essential for physicians and staff to know about compliance, including the key risk areas it has identified through carrier and Health Care Financing Administration (HCFA) data, OIG fraud and abuse hotline calls, and its annual Chief Financial Officer audit of HCFA. In our opinion, the mere presence or absence of a formalized training and education program cannot serve as a proxy for the actual level of compliance observed in a practice; as such, OIG should simply list those critical elements and risk areas that practices need to be aware of, and leave the form and method of training/education up to the individual practice.
4. **Development of Effective Lines of Communication**—In a solo or small group practice, due to the very small number of people involved, significant barriers to effective communication are much less likely, making the need for a formalized

reporting mechanism superfluous. The major issue here is that OIG make sure practices encourage their employees to quickly identify and surface possible areas of non-compliance to the appropriate party's attention, a subject which can be underscored in any in-house training and reiterated in in-house procedure manuals. Though it is unrealistic for OIG to try to define what constitutes "effective lines of communication" in such limited employee settings, OIG's physician compliance guidance can specify key warning signs of when internal education and/or communication isn't working well, e.g., high rates of rejected and/or suspended claims, the filing of a significant number of complaints with the OIG Hotline, and the placement of a practice on pre-payment review by a carrier.

5. **Enforcement of Standards through Well Publicized Disciplinary Guidelines**—In a solo or small group practice, inclusion of disciplinary guidelines in in-house training and procedure manuals should be considered sufficient by OIG for meeting the "well publicized" standard. OIG should also urge practices to be aggressive in counseling/retraining employees who are identified as being the source of compliance problems, and warn them of the consequences of continued poor performance.
6. **Use of Audits and Other Evaluation Techniques to Monitor Compliance**—OIG should provide clarification on what it considers an appropriate audit or other evaluation technique for a solo or small group practice, especially since this can be a very costly and time consuming work component. Consistent with our earlier statements, we believe that OIG should consider as acceptable any monitoring system which: (a) allows identification and correction of the bulk of a practice's claims coding problems, and (b) helps the practice steer clear of OIG identified risk areas.
7. **Development of Procedures to Respond to Detected Offenses and to Initiate Corrective Action**—We believe an ability to respond to detected offenses and to initiate corrective action is part and parcel of a good internal monitoring system. Just how formalized such a system must be in terms of written procedures is hardly as important as a practice's willingness to address and correct problems quickly. As such, OIG should make sure that a practice has the will and machinery in place to make necessary changes, recognizing each problem detected can have its own unique cure, and that the details of achieving the final positive result cannot be predicted or pre-ordained in a detailed procedures manual. It should be sufficient for practices to keep records of problems identified and the remedial action(s) taken, since this would serve as a valuable internal employee reference, as well as objective evidence of a commitment to compliance should an audit occur.