

**UNIVERSITY OF ROCHESTER
MEDICAL CENTER
BILLING COMPLIANCE PLAN**

Revised December 31, 1998

INTRODUCTION

This plan is an integral part of the University's ongoing efforts to achieve compliance with federal and state laws relating to billing for clinical services. The Plan creates a comprehensive and centralized system of oversight for bill coding, education, chart review, reporting and discipline ("Discipline," as used throughout this policy shall include all steps described in the Human Resource policy manual and faculty policies and regulations including, without limitation, termination and tenure revocation). This Plan provides for oversight by a Compliance Program Medical Director and Compliance Officer. Although the intent is to encourage compliance through a centralized audit system, it remains the responsibility of each individual involved with the billing process, from physicians and other providers to clerical staff, to comply with the law.

The purpose of this Plan is to ensure that clinical services are adequately documented and that properly coded bills are submitted only for documented services. This Plan is to be read in conjunction with and is an integral part of the University of Rochester Medical Center Compliance Plan, which is set forth in a separate document. In addition, it is anticipated that individual departments of the University will create specialty-specific billing compliance plans, which will be subject to review by the Compliance Program Medical Director and Compliance Officer.

The University acknowledges that this plan is only the beginning of its efforts to institute a program and oversee compliance with applicable laws and regulations. The key to success, in which all employees play a part, is ongoing adherence to the highest standards of conduct and the development of a workable system in which employees are educated about compliance and participate in ongoing review of their success in that regard.

PLAN OVERVIEW

Recent changes in the laws and regulations affect how clinical providers may bill Medicare for their services. This Plan has its origin in the new laws, but is intended to set standards for billing of all services to all payors.

Under the Medicare system (with a few minor exceptions), clinical professional services may be billed only under Medicare Part B, and then only if there is documentation to support personal and identifiable services to the patient. Providers may not bill Medicare for teaching residents; Medicare Part A pays for the cost of instruction and other hospital costs.

The significant requirements for Part B billing fall into two broad categories: the requirement of teaching physician "presence" when providing services with a clinical trainee, and the need to code bills properly depending on the level of service provided and documented. Proper documentation of both provider involvement and the level of service rendered is essential and is the overriding feature of billing compliance. The goal of this

Plan is to ensure that clinical services are properly documented and accurately billed and that services rendered but not properly documented are not billed.

A. Presence

To bill for services performed with a clinical trainee, teaching physicians must perform the services themselves or must be present when the trainee does so. However, for surgeries or complex procedures, the teaching physician must be present only during the critical portion of the procedure. To bill for evaluation and management (E&M) services, the teaching physician must personally perform or confirm the key elements of the service (e.g. history, exam, medical decision making) that determines the level to be billed.

B. Coding

Bills are coded according to the complexity of a procedure or service, as measured by established components. The Health Care Financing Administration (HCFA), a division of the U.S. Department of Health and Human Services responsible for administering the Medicare program, has developed guidelines which identify proper coding for bills submitted to Medicare for payment. At the time of this writing, these guidelines are being revised by HCFA and are due to be piloted in 1999.

STRUCTURE

There shall be appointed a Compliance Officer who reports to the Compliance Program Medical Director. These individuals report to the Vice President and General Counsel for Strong Health Affiliates and to the Vice President of Finance for Strong Health. To avoid any issues related to a conflict of interest regarding legal or financial matters associated with compliance, the Compliance Program Medical Director and Compliance Officer have direct access to the Senior Vice President and Vice Provost for Health Affairs-Medical Center and Strong Health System Chief Executive Officer and the University of Rochester Medical Center Board.

Compliance Office Leadership includes the following: Senior Vice President and Vice Provost for Health Affairs-Medical Center and Strong Health System Chief Executive Officer, the Vice President and General Counsel for Strong Health Affiliates, Vice President of Finance for Strong Health, Compliance Program Medical Director, Compliance Officer and others as designated by the Senior Vice President and Vice Provost for Health Affairs-Medical Center and Strong Health System Chief Executive Officer.

The Compliance Officer employs a staff whose functions include: (1) review of guidelines for documentation and coding of clinical services, (2) development and/or delivery of general and specialty-specific inservice training of physicians and other providers, residents, and billing staff on coding and proper documentation of evaluation

and management (E&M) services, and (3) coordination of system-wide, department-specific audits of inpatient and outpatient medical records on an ongoing basis. Following any audit, results of the chart analysis are discussed with the care provider(s) involved. The staff also communicates to care providers, via newsletter or other written communication, changes to the laws and regulations regarding billing.

Each individual department will appoint a Physician Compliance Liaison whose function is to interface with the Compliance Program Medical Director and the Compliance Officer on behalf of the department. The Compliance Liaison should be a member of the clinical faculty and is responsible for assisting the Compliance Program Medical Director and Compliance Officer in coordinating training, information gathering and dissemination, and audits. The compliance liaisons will meet with the Compliance Program Medical Director and the Compliance Officer no less than quarterly, as a group or individually.

CODE OF CONDUCT/PROCEDURES

Billing will be done in compliance with all applicable state and federal laws and regulations. Specifically, no bill will be issued for a clinical service unless it was actually performed and documented by the teaching physician or the teaching physician was present and such presence has been properly documented. Bills for clinical services shall be coded accurately according to the documentation of the services provided.

Each department is responsible to develop its own billing compliance procedures, specific to its area of practice. Such procedures are subject to approval by the Compliance Program Medical Director and the Compliance Officer.

When claiming payment for hospital or professional services, the Medical Center has an obligation to its patients, third party payors, and the state and federal governments to exercise diligence, care and integrity. The right to bill Medicare and Medicaid programs, conferred through the award of provider or supplier number, carries a responsibility that may not be abused. The Medical Center is committed to maintaining the accuracy of every claim it processes and submits. Many people, throughout the Medical Center, have responsibility for entering charges and codes for clinical services. Each of these individuals is expected to monitor compliance with applicable billing rules. Any false, inaccurate, or questionable claims should be reported immediately to a supervisor or to the Compliance Office.

False billing is a serious offense. Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made any false statement or representation of a material fact in an application for benefits or payment. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. Examples of false claims include:

- Claiming reimbursement for services that have not been rendered
- Filing duplicate claims
- “Upcoding” to more complex procedures than were actually performed
- Including inappropriate or inaccurate costs on hospital cost reports
- Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not
- Billing for a length of stay beyond what is medically necessary
- Billing for service items that are not medically necessary
- Failing to provide medically necessary services or items
- Billing excessive charges

Medical Center employees and agents who prepare or submit claims should be alert for these and other errors. It is important to remember that outside consultants only advise the Medical Center. The final decision on billing questions rests with the Medical Center.

In compliance with federal law, the Medical Center does not permit charging for any Medicaid service at a rate higher than that approved by the state or accepting any payment as a precondition of admitting a Medicaid patient to the Medical Center.

The Medical Center carefully follows the Medicare rules on assignment and reassignment of billing rights. If there is any question whether the Medical Center may bill for a particular service, either on behalf of a provider or on its own behalf, the question should be directed to the Compliance Officer for review. Medical Center employees should not submit claims for other entities or claims prepared by other entities, including outside consultants, without approval from the Compliance Officer. Special care should be taken in reviewing these claims, and Medical Center personnel should request documentation from outside entities if necessary to verify the accuracy of the claims. [31 U.S.C. § 3729(a)] In addition to the criminal penalties, the Federal False Claims Act permits substantial civil monetary penalties against any person who submits false claims. The Act provides a penalty of triple damages as well as fines up to \$10,000 for each false claim submitted. The person (as well as the Medical Center) may be excluded from participating in the Medicare and Medicaid programs.

Numerous other federal laws prohibit false statements or inadequate disclosure to the government and mandate exclusion from Medicare and Medicaid programs.

It is illegal to make any false statement to the federal government, including statements on Medicare and Medicaid claim forms. It is illegal to use the U.S. mail to scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government.

The Medical Center promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity, and accuracy in all its financial dealings. Each employee and professional, including outside consultants, who is involved in submitting charges, preparing claims, billing, and documenting services is expected to maintain the highest standards of personal, professional, and institutional responsibility.

EDUCATION

The Compliance Officer's responsibility is to ensure that every employee involved with the billing process is educated about the applicable laws and regulations governing provider billing and documentation. It is the responsibility of the compliance liaison for each department to identify those employees who should be educated and trained.

The Compliance Officer supervises staff who develop, oversee and/or provide inservice training on billing and documentation requirements. Such training and education may include presentations, video tapes, pocket cards and newsletters. Every employee involved with the billing process must attend a compliance training session no less than annually.

Attendance or viewing by employees involved in billing, as identified by their departments, is mandatory. The Compliance Officer oversees a system that tracks attendance, and he/she has the authority to discipline for non-attendance. Discipline may include required supervision, review of charts for some period of time or sanctions. The Compliance Officer shall also maintain, personally, or through his/her designee, a record of each employee's attendance.

The Compliance Officer will ensure that the Compliance Office trainers work with individual departments to acquire information specific to their specialties that will make the training more concrete, specific, and therefore, more effective.

REPORTING AND INVESTIGATION

A. Reporting

Every employee in this institution has the responsibility not only to comply with the laws and regulations but to ensure that others do, as well.

Employees must report non-compliance to their supervisors, the Compliance Officer or the Compliance Integrity Hot Line. Supervisors are required to report these issues through established channels in Human Resources/Personnel and/or the Compliance Office. Calls may be made anonymously, although the University encourages employees to provide their name and telephone number so that reports may be more effectively investigated.

Employees uncertain about whether some conduct constitutes non-compliance should contact the Compliance Information Line or the Strong Health Integrity Hot Line.

Every attempt will be made to preserve the confidentiality of reports of non-compliance (and, with regard to those reports made anonymously, the caller's name cannot be identified). All employees must understand, however, that circumstances may arise in which it is necessary or appropriate to disclose information. In such cases disclosures will be on a "need to know" basis only.

B. Investigation

The Compliance Officer will, personally or through his/her designee, investigate every report of non-compliance as soon as practicable. Investigation may include interviewing employees and/or reviewing documentation (subject to laws on patient confidentiality). Each employee must cooperate with such investigations and may be disciplined for failing to do so.

Once the Compliance Officer completes an investigation, he/she will make a report to Compliance Office Leadership. The report will be the basis for the Compliance Officer's plan or recommendation of corrective action or discipline. Reports will be retained for six years.

C. Non-Retaliation

It is the policy of the Medical Center that no person shall retaliate, in any form, against a person who reports in good faith an act or suspected act of non-compliance (although employees may be disciplined for making intentionally false reports of non-compliance). Any person who is found to have retaliated for such a report in violation of this policy shall be subject to discipline.

CORRECTIVE ACTION/SANCTIONS

In order to make this compliance plan effective, the Compliance Officer will have authority to impose corrective action and/or discipline for single or repeated instances of non-compliance.

If a provider or other employee is found to be non-compliant in a single instance or relatively insignificant percentage of cases over a short period, the Compliance Officer may require that person to undergo a session of education or training.

If a provider or other employee fails to comply with billing or documentation requirements repeatedly, sanctions may be more severe. The Compliance Officer will review the recommended corrective action or discipline with Compliance Office Leadership (convening a meeting on an as needed basis to address these issues). Before the imposition of sanctions, the department Chair and/or the Chief Medical Officer will be informed of the disciplinary actions.

Plans of correction and discipline may include but are not limited to: (1) a requirement to undergo training; (2) a period of required supervision or approval of documentation before bills can be issued; (3) expanded auditing, internal or external, for some period of time until compliance improves; (4) self-reporting of violations; and (5) in sufficiently egregious cases, discipline. In addition, the Compliance Officer may recommend to Compliance Office Leadership some other appropriate course of action to correct non-compliance.

AUDITING/REVIEW

Monitoring of compliance with billing rules is a central feature of this Plan. The Compliance Officer must be able to ensure compliance through an understanding of current regulations and overall levels of compliance throughout the Medical Center at any given time.

Under this Plan, there will be both internal and external (i.e. by an independent consultant or other professional) auditing of proper coding and chart documentation. Internal auditing is done by the professional staff of the Compliance Office, who will conduct periodic chart reviews. Each clinical provider of the Medical Center who bills for services will be subject to annual chart reviews for proper documentation and coding of clinical services. The Compliance Office analysts will communicate the results of their reviews to the clinical provider and to the Compliance Officer. If the level of compliance is found to be low, the Compliance Officer will implement a plan of correction and/or education (see Sanctions).

The Compliance Officer may engage an external auditing firm as deemed necessary to assess the University's overall compliance. All employees must cooperate fully with this effort, by making themselves and/or any pertinent documents available, and may be disciplined for not doing so.

The external auditor will report to the Compliance Officer concerning the results of its investigation. The Compliance Officer will report, in turn, to the Compliance Program Medical Director and to Compliance Office Leadership.

ONGOING ASSESSMENTS

The Compliance Officer will make an annual assessment of the success of the Billing Compliance Plan. That assessment will be based on the examination of results of internal audits and investigations, reports of any outside audits that may have been conducted and on his/her own personal experience with the functioning of the Plan over the previous year. The report will be submitted to the Compliance Program Medical Director, Compliance Office Leadership and the University of Rochester Medical Center Board. The Compliance Officer may propose and implement changes to the Plan in light of the conclusions of the report.