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On the Front Lines

Do No Harm: Consultants and Compliance

By Allan P. DeKaye, MBA, FHFMA

In June 2001, the Office of Inspector General (OIG) issued a Special Advisory Bulletin addressing concerns over the "Practices of Business Consultants."[1] While OIG does not suggest that consultants as a whole have committed compliance infractions, it does note that some have engaged in questionable, misleading or illegal actions–most notably associated with the advice or instructions they present. The issuance of such an article should make all consultants pause and ask themselves whether their clients could possibly misconstrue the meaning of their advice, and if the advice could be misleading or questionable. Consultants are well advised to tell clients "what they need to know, not what they want to hear!"

In the areas of healthcare financial consulting and corporate compliance, there are some areas that should be clearly delineated "black or white," while others are "shades of gray." Although there is unlikely to be a debate as to what goes into specific demographic and financial fields on a UB-92 claim form, local medical review policies (LMRPs) may require that certain codes or values be used to denote variations of clinical conditions. In some instances, these instructions will vary between governmental and nongovernmental payers. The result will likely be disparate rules and instructions that are open to interpretation. In reality, trying to achieve the data and procedural uniformity necessary to prevent errors is compromised, especially when the rules become anything but "uniform." The balance of this article will examine some examples of both, and how the consultant and client can avoid harmful situations.

Responding correctly: Is there only one answer? Standardized tests purport to have only one correct answer for each question. Preparation on how to take the exam may result in a higher score. This result is the basis for preparatory programs' willingness to guarantee that students taking their course will score higher.

Although the standardized test has one correct answer per question, many of us will recount of the five multiple choice answers listed, 1-2 could be eliminated, 1 almost certainly could be discarded, and the remaining two might both sound good. For some tests, leaving an answer "blank" was rewarded. In some instances, you were better off guessing. But, bottom line, you were either right or

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wrong. In health care, the wrong answer, whether on a bill, cost report, or even a statement may now subject the provider (or individual) to civil or criminal penalties.

On the other hand, around April 15th of each year, news organizations tend to run features on how tax professionals differ in preparing a "specific return." A taxpayer's files are given to five tax preparers, who in turn generate five different bottom line returns. It has been reported that five calls to the Internal Revenue Services' (IRS) tax help line with the same scenario resulted in five different responses.

The tax preparer may be able to present reasonable justification for recording a specific transaction. While a favorable ruling may not always result, penalties will be proportional, as long as criminal intent was not suspected or proven. There is no room on the claim form or cost report to explain these alternative rationales or justifications.

Let's see how those examples would work in the world of healthcare compliance.

Generating clean claims (dotting the "i" and crossing the "t"). To generate "clean 'compliant' claims," blank fields and guessing *a la* the standardized test is not recommended. While provider manuals delineate regulations and procedures, local medical review policies (LMRPs), and contractual provisions or procedures may contradict the manual. These exceptions may vary from payer to payer, making programming logic more difficult.

Difficulties in programming. A notable example is an ambulatory surgical procedure that some payers want billed in an inpatient format, while others want the procedure billed as an outpatient. While many billing applications support these types of conditions, programming and executing too many "if/then" clauses becomes unwieldy. Customized programs often fail due to the multitude of clinical conditions that occur. Providers usually settle for programming and procedures that capture most of the patient conditions, relying on "workarounds" to handle the exceptions.

Once exceptions are provided for, breakdowns in patient, paper and systems flow can occur. This leads to potential error conditions. Even if the system editing functions could fully protect a process, there are further complicating matters. For example, human intervention is required to determine if a service is billed the same way for the payer's preferred provider organization (PPO) vs. point of service (POS) products. The difficulty arises when the staff is unable to distinguish the attributes of a PPO vs. POS identification card or there is little or no electronic eligibility verification access to clarify the matter. Providers must then rely on their best efforts to interview and collect information from patients. As a result, preparing clean claims can sometimes can be "hit" or "miss." Those with billing responsibility should keep in mind whether an "errant" or "fraudulent" claim has been submitted.

Cost saving strategies. In *The Travel Detective*, Peter Greenberg, a travel editor, discusses strategies to achieve the lowest possible fare for various forms of travel. In a most interesting segment, he discusses how "back-to-back" ticketing is legal (as it doesn't violate the terms of the tariff), but that "hidden city" ticketing does. He notes the risks and potential penalties of both strategies.[2]

Healthcare providers may be faced with a similar dilemma: "how to save on costs legally?" While negotiating better rates and seeking preferred pricing may be acceptable forms of doing business, "kickbacks" and other forms of prohibited behaviors should not tempt a provider to achieve its goal in such a way. Providers should strive to reach organizational goals, but must exercise good, sound judgment, to ensure that goals are achieved in an ethical and legal manner. While the OIG bulletin has focused on consultants, even attorneys have been held to these standards, with some facing prosecution for being part of a scheme.[3]

- Consultants and other healthcare professionals (including attorneys and accountants) are often asked by clients to determine if alternative approaches to achieving a provider's objectives exist. While loopholes in rules and regulations can be examined, all players must be cognizant that these exceptions are often closed with subsequent legislation and regulation.
- When applying codes of ethical standards, such terms as "reasonable" and "justifiable" should be applied.
- In healthcare billing, consultants—as well as clients—should rely on payer instructional manuals, as well as any regulatory issuance that guide the process. Provider "corporate compliance" guidelines generally will echo that requirement.
- Consultants may be called upon to assist with the procedural design or workflow implementation. Depending on the assignment, consultants may have limited involvement.
- Consultants often feel they must have the answer to every question. "I don't know" should not be construed to diminish the consultant's ability (although if used too often, it will). A client may wish to have an answer (even an "off-the-top-of-my head"), simply to be able to say, "but the consultant said...."

In today's billing environment, "getting it right" is of paramount importance. Consultants must stress this with clients. Consultants are challenged in advising clients how to deal with limited resources. While it is not uncommon to suggest "80/20" rules to encompass most conditions, issues of patient care, customer service and provision of efficient workflow patterns, must be weighed to simultaneously ensure "compliance" with billing requirements. Consultants should point out these weaknesses in process, especially if they contribute to potential exposure issues. Ensuring proper workflow and data integrity makes good business sense, and is an essential compliance building block.

Coding: Art or science? Coding is another area of provider vulnerability. All too often, there are insufficient numbers of credentialed coders to meet all of a provider's demands. While superbill formats, and lists of the most common occur-

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rences may suffice, any patient that presents a condition that deviates from the norm may result in coding guesswork.

Subtle differences in when to use a specific code or modifier, as well as when to request physician input or clarification can increase exponentially a provider's exposure to coding errors. These errors, often identified in audits, or even on billing edits, can trigger more extensive reviews, audits and investigations. Independent internal or external reviews often provide management with baseline and comparative performance. Using the results to take corrective and preventive actions should be a staple of a consultant's recommendations.

Some years back, it wasn't uncommon to use these types of reviews to generate more revenue (largely based on errant coding). Today, chief executive officers (CEOs) and chief financial officers (CFOs) should be content to know that their coding was correct! While the industry is acclimating to ambulatory patient classification (APC) changes, there is no reason why we still read about inpatient coding errors and penalty assessments. Consultants would do well to recite this adage to clients, "If it isn't written–it wasn't done."

Reducing risk: "Getting it right". While most healthcare providers will have recited a pledge to "follow the rules," conscientious consultants will deliver a reminder message to reinforce the concept that "compliance is required, not optional." Consultants must have their radar operating with greater sensitivity to serve as a value-added resource to warn clients when errors are present, as well as how to prevent them.

The types of examples that have been discussed are real and occur throughout the industry. Healthcare regulations are complex and often require hours of study. Providers will rely on consultants to assist them in interpretation and implementation efforts. In all assignments, consultants would do well to remember to "do no harm!" To achieve that level of correctness and reliability upon which clients depend, their knowledge and commitment to compliance must be evident in both their character and communication. By achieving that higher standard, consultants will avoid the OIG's "warning" label and instead be more closely associated as a resource to "safeguard" the process.

Allan P. DeKaye, MBA, FHFMA, is President and CEO of DEKAYE Consulting, Inc. (www.dekaye.com), located in Oceanside, New York. He is a member of the CCH Advisory Board for the Healthcare Compliance Letter. The analysis and opinions expressed in this article are solely the author's.

[1] "Practices of Business Consultants," Office of Inspector General, Special Advisory Bulletin, June 2001, (http://www.dhhs.gov/oig/frdalrt/consultants.htm).

[2] Peter Greenberg, The Travel Detective, (Villard Books 2001) pp. 111-122. "Back-to-back" ticketing creates the appearance of a Saturday night stay by booking two travel itineraries using the same cities but with different dates. "Hidden-city" travel attempts to take advantage of lower pricing between an originating and final destination when a "stop-over" city is added to the itinerary. The "stop-over" city is the intended destination, the traveler does not continue on to the final destination.

[3] United States v. LaHue, 10th Cir., Aug 17, 2001.