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Health Care Program Compliance Guide™

Chapter 1045
Management and Third-Party Billing Companies

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Exh. 1 Billing Company Compliance Checklist

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Chapter 1045
Management and Third-Party Billing Companies

Overview

Over the years, the need for, and prevalence of the use of, management and billing companies has increased dramatically. With the strict regulatory environment within which health care providers practice, the need and desire to turn to a third party to manage the non-clinical aspects of practice becomes appealing and, at times, essential. When health care providers turn to such third party management and billing companies, they are presented with a menu of service options from which to choose, ranging from processing bills to managing the business aspects of a particular practice to leasing and staffing space and personnel.

However, engaging third parties to alleviate the administrative burden that has become far too integrated into the practice of medicine comes with it a price reaching beyond the monthly management or billing fee. Engaging a third-party billing or management company carries with it certain compliance risks. Likewise, third-party billing companies and management companies also expose themselves to risk in contracting with health care providers. For instance, billing companies face potential liability for unlawful billing practices perpetrated by the company itself, such as upcoding or unbundling performed by its coders. Additionally, billing companies may be held liable for submitting claims based on information supplied by the health care provider that the billing company knows to be false or is unsupported by appropriate medical documentation.

This chapter examines the risk areas associated with management and third-party billing companies and gives examples of court cases and settlement agreements arising from government enforcement actions against such companies. For information on criminal prosecution and civil monetary penalties, see *Chapter 210, Penalties*.

1045.10 General Issues

1045.10.10
Introduction

Companies that perform billing services for health care providers face potential liability for two distinct categories of billing practices:

- unlawful billing practices perpetrated by the company, such as upcoding or unbundling performed by the company's coders; and
- the submission of claims to the government based on information supplied by the health care provider that the billing company knows to be false or is unsupported by appropriate medical documentation.

While the first scenario is the most egregious and, therefore, most likely to incur government scrutiny, the second type of liability is receiving increased attention under government fraud and abuse prevention efforts. Providers and management or billing companies alike should understand that blind acceptance of the other party's assurances will certainly come to haunt them in the future. More often than not, courts have found that if a party claims it did not know of fraudulent activity, it *should have known.*

Management companies with extensive management authority over provider operations are likely to have the type of knowledge that can trigger liability under the False Claims Act and other intent-based statutes.

Health care attorneys advise such companies against acting like an "ostrich with its head in the sand," or

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"turning a blind eye," essentially ignoring false claims information that they know or should know is not true. Management companies, especially those that provide more comprehensive services that go beyond simple claims processing, have the ability to be aware of the veracity of claim information. For example, if a management company has staff in a physician's office who have personal knowledge that a physician is making false claims, the management company could be held responsible by the U.S. Dept. of Health and Human Services (HHS) Office of Inspector General (OIG) for knowingly filing false claims with the government.

As stated previously, the risk not only rests on the billing and management companies; providers, too, must be careful. Wrongdoing by a billing or management company can expose providers to civil and criminal liability by relying uncritically on the billing company's expertise and its assurances of an effective compliance program. Providers should remember the golden rule of claims submission: you are responsible for **everything** that is submitted under your National Provider Identifier (NPI) number, regardless of who completes or submits the claim on your behalf. The OIG clearly made this point in its compliance guidance for individual and small group physician practices:[1]

> Physicians should remember that they remain responsible to the Medicare program for bills sent in the physician's name or containing the physician's signature, even if the physician had no actual knowledge of a billing impropriety. The attestation . . ., i.e., the physician's signature line, states that the physician's services were billed properly. In other words, it is no defense for the physician if the physician's billing service improperly bills Medicare.[2]

Thus, it is in a provider's interest to ensure that its billing and management companies not only have effective compliance programs, but also stay abreast of, and adhere to, all pertinent health care compliance laws, regulations, and guidance.

1045.10.20
Types of Billing and Management Companies and Services

Billing companies and management companies provide an array of service options for their clients. Typically, third-party billing companies receive clinical documentation, code and process that documentation into claims submitted to payers. Sometimes, third-party billing companies also provide other related functions, such as bookkeeping, accounting, and debt collection on behalf of their clients.

On the other hand, management companies, such as a management services organization (MSO) and physician management companies, provide more comprehensive business services to medical groups and other providers for a fee. Such services may include billing-related services, as well as some, or all, of the following:

- facilities management, including management of the business premises, utilities, building services, supplies, equipment, furniture and furnishings, repairs, maintenance, and signs; and
- other management services, such as management of marketing and public relations, information systems, and managed care contracting.

For the purposes of this chapter, the term "billing company" or "entity" generally is used to describe any organization that provides billing services, whether it is organized as a third-party billing company or a management company. Additional requirements or risk areas specific to management companies are discussed where appropriate.

1045.20 Assignment of Payments

1045.20.10
Law and Regulatory Summary

The Social Security Act limits who can receive payments due a provider or supplier of services.[3] In general, Medicare does not pay amounts due to a provider or supplier to any other person or entity.[4] However, payment to an agent that furnishes billing and collection services is permitted provided that the agent satisfies the following conditions:[5]

- receives the payment under an agency agreement with the provider or supplier;
- receives compensation for services that is not related in any way to the dollar amounts billed or collected or dependent on the actual collection of payment;
- acts under payment disposition instructions that the provider can modify or revoke at any time; and
- acts only on behalf of the provider or supplier in receiving the payment.

Notably, payment to an agent will always be made in the name of the provider, supplier, or the employer, facility, or system.[6] Failure to comply with the afore-

[1] Compliance Program Guidance for Individual and Small Group Physician Practices, 65 Fed. Reg. 59434, 59447 (Oct. 5, 2000).

[2] *Id.*

[3] Social Security Act §§ 1815(c) [42 U.S.C. § 1395g(c)], 1842(b)(6) [42 U.S.C. § 1395u(b)(6)].

[4] 42 C.F.R. §§ 424.73(a), 424.80(a).

[5] 42 C.F.R. §§ 424.73(b)(3), 424.80(b)(6).

[6] 42 C.F.R. § 424.73.

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mentioned requirements could result in the Centers for Medicare and Medicaid Services (CMS) terminating the provider agreement.[7]

1045.20.20
Industry Compliance Guidelines

1045.20.20.10
General Issues

With certain specified exceptions, CMS allows payment by a fiscal intermediary of assigned benefits to be made only to the physician or supplier of services.[8] However, CMS permits payment to be made to an agent that furnishes billing or collection services, provided that the conditions outlined above are met (see *Law and Regulatory Summary*, § 1045.20.10).[9]

Specifically, CMS clarifies that an agency is an entity providing computer and other billing services to prepare claims, and receive and process Medicare benefit checks for the provider, supplier, physician, or other practitioner.[10]

The purpose of the conditions (*i.e.*, the regulatory requirements set forth above) is to ensure that the agent has no financial interest in how much is being billed or collected and is not acting on behalf of someone who has such an interest, except for the provider or supplier itself.[11] However, these conditions do not apply if the agent merely prepares bills for the physician and does not negotiate the checks payable to the physician.[12] They also do not apply to an entity receiving payment in the physician's name if the entity qualifies by law and regulation to receive payment in its own name for the physician's services.[13] For example, a hospital that is entitled to bill and receive payment in its name for a physician's services can bill and receive payment in the physician's name, even though its compensation is related to the amount billed.

Agents are allowed to use part of the assigned payment as compensation for their billing and collection services.[14]

1045.20.20.20
Documentation

CMS instructs its carriers that if payment is made to an agent, the carrier can assume that the conditions for such payment are met in the absence of evidence to the contrary.[15] If there is evidence to the contrary, the agent must submit a copy of the written agreement between itself and the provider or supplier.[16] Written agreements can range from a formal legal document to an exchange of correspondence between the parties.[17]

In the absence of a written agreement or if all the required conditions for payment are not clear in the agreement, carriers are instructed to obtain a statement from the agent describing the pertinent terms of the agreement or those provisions that need to be clarified. The carrier will verify the agent's allegations with the provider.[18]

1045.20.20.30
Enforcement

In the past, the OIG has included billing and staffing companies in its Work Plan. In its work plans for fiscal year 2002[19] and 2003,[20] the OIG observed that hospitals often contract with billing and staffing companies to handle administrative functions and that more than 50 percent of hospitals use practice management or staffing companies to administer the daily operation and coverage of emergency room departments. The OIG stated it would investigate the practice of using staffing companies for emergency room (ER) physician services and also would identify any problems the use of such companies creates in relation to Medicare reassignment rules. For example, according to the OIG, under such arrangements, ER physicians work for the staffing companies as either employees or independent contractors. These physicians may then reassign their Medicare benefits to the staffing company only if they are its employees.

In fiscal years 1999[21] and 2000,[22] the OIG stated it planned to evaluate reassignment of physician benefits to clinics. Clinics that employ more than one doctor can accept a reassignment of the physicians' billing numbers. This practice allows the clinic to handle all billing and keep all fees for services provided by the physicians, usually in exchange for paying a flat fee or salary to the physicians, and provides considerable convenience to both physicians and the clinic business offices. However, under this model, the physician never sees what is billed under his or her physician number, and accountability and liability for billing abuses is shifted away from the physician to the clinic, the OIG said.

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[7] 42 C.F.R. § 424.74.
[8] Centers for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Medicare Claims Processing Manual (Pub. 100-04), ch. 1 § 30.2.
[9] *Id.* at ch. 1 § 30.2.1.
[10] *Id.* at ch. 1 § 30.2.4.
[11] *Id.* at ch. 1 § 30.2.4B.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.* at ch. 1 § 30.2.4C.
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 2002 Work Plan at 14.
[20] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 2003 Work Plan at 15-16.
[21] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 1999 Work Plan at 14.
[22] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 2000 Work Plan at 12-13.

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1045.30 Billing and Coding Risk Areas

1045.30.10

Law and Regulatory Summary

Congress has not passed a "billing company false claims act" or other statute that applies solely to companies that perform billing services. In general, however, billing companies are subject to attack under many of the same statutes as those applicable to health care providers themselves, that is, the civil and criminal False Claims Acts[23] and other intent-based statutes (*see Chapter 210, Penalties.*

The civil False Claims Act prohibits any person from knowingly presenting, or causing to be presented, a false or fraudulent claim.[24] It also prohibits any person from knowingly retaining an overpayment.[25] "Knowingly" is defined as the person either (a) had actual knowledge of the information; (b) acted in deliberate ignorance of the truth or falsity of the information; or (c) acted in reckless disregard of the truth or falsity of the information.[26] Importantly, "knowing" does not include proof that there was a specific intent to defraud the government.[27] In other words, the only intent that must be proven is the intent to submit the claim or retain monies. Violation of the civil False Claims Act could result in fines of up to three times the government's loss plus $11,000 per claim.[28] The criminal False Claims Act imposes criminal fines and imprisonment for the submission of claims knowing that the claim is claim false, fictitious, or fraudulent.[29]

1045.30.20

Industry Compliance Guidelines

The OIG's Compliance Program Guidance for Third-Party Medical Billing Companies (OIG's Compliance Guidance) sets forth seven fundamental elements to an effective billing company's compliance program:[30]

1. implementing written policies, procedures and standards of conduct;

2. designating a compliance officer and compliance committee;

3. conducting effective training and education;

4. developing effective lines of communication;

5. enforcing standards through well-publicized disciplinary guidelines;

6. conducting internal monitoring and auditing; and

7. responding promptly to detected offenses and developing corrective action.

Importantly, the seven elements for billing companies mirrors the elements required for physician group practices.

1045.30.20.10

Preventive Measures, Generally

While the OIG's guidance for third-party medical billing companies merely *encourages* the design and implementation of effective compliance programs, stating adoption is "strictly voluntary," the OIG identifies a number of billing practices that can present problems for contractors that provide billing and coding services.[31] Each of these risk areas is discussed below.

Billing companies sometimes attempt to avoid potential liability by contractually limiting their responsibilities when services are coded by their provider-clients. Their contracts stipulate that the provider is solely responsible for ensuring the maintenance of appropriate and timely documentation that clearly supports each code assigned. The OIG advises billing companies that do not code for their provider clients to incorporate in their contracts an acknowledgment by the provider that it is responsible for instituting coding compliance safeguards.[32]

In addition, the OIG stresses the importance of timely and proper documentation and urges billing companies to:[33]

- obtain documentation of all physician and other professional services prior to billing;

- submit claims only when supporting documentation exists;

- base the diagnosis and procedures reported on reimbursement claims on the medical record and documentation;

- refrain from providing financial incentives to coders and billing consultants for improperly upcoded claims;

- establish a process for pre- and post-submission review of claims; and

- obtain clarification from the provider when documentation is confusing or lacks adequate justification.

For further protection, many billing companies require their clients to indemnify them for False Claims Act and other liabilities arising from inappropriate coding.

For more information on this and other general compliance program topics, see *Chapter 207, Compliance Program Basics*.

[23] 31 U.S.C. § 3729, 18 U.S.C. § 287.
[24] 31 U.S.C. § 3729.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 18 U.S.C. § 287.
[30] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998).
[31] *Id.*
[32] *Id.* at 70143 (§ II.A.2.a).
[33] *Id.* at 70144 (§ II.A.3).

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1045.30.20.20
Billing for Undocumented Items or Services

Billing for undocumented items or services[34] presents a minor risk for billing companies that provide billing services only, provided that the service agreement clearly stipulates that the health care provider bears the sole responsibility for ensuring that proper documentation is maintained.

However, companies that provide coding services face exposure for improper coding and submitting claims that are not adequately supported by medical record documentation. For example, in *United States ex rel. Semtner v. McKean and Medicare Consultants d/b/a Emergency Physicians Billing Services*,[35] the judge noted that a video tape of a training session of EPBS employees showed McKean making various statements about coding, including the statement, "The documentation is purely a red tape crap issue."[36] The judge wrote that liability under the False Claims Act cannot be avoided "when there is a pattern of taking shortcuts and ignoring the rules and submitting claims that are not appropriately documented."[37] The company agreed to a $15 million settlement (see *Emergency Physicians Billing Services (September 1999)*, § 1045.70.20.60).

Additionally, management companies providing more extensive management services, such as records management, are, typically, familiar with widespread documentation problems. Nevertheless, if they submit claims on behalf of providers known not to adequately document services, the PPM or MSO itself can face liability.

1045.30.20.30
Unbundling

Unbundling—the practice of billing for each component code of a larger, single procedure code to maximize the reimbursement amount—is primarily a risk area for billing companies that provide coding services.[38]

But even billing companies that do not provide coding services should have an internal mechanism for catching commonly unbundled services—for example, a system edit to catch claims for office visits occurring within the 90-day post-operative period following a surgery.

For a more comprehensive discussion of unbundling as a billing risk area, see *Chapter 635, Unbundling*, especially *Chapter 635, Unbundling*, § 635.20.90.

1045.30.20.40
Upcoding

Upcoding—the practice of using a billing code that provides a higher reimbursement rate than the code applicable to the service furnished—is a clear risk area for billing companies that provide coding services.[39] For example, in *United States v. McKean* (see *Billing for Undocumented Items or Services*, § 1045.30.20.20), the judge found that billing company coders were discouraged from using Level 1 or 2 billing codes—which provide a lower reimbursement rate than higher level codes—and, in some instances, were required to obtain permission before assigning these codes.

Management companies that track statistics such as the numbers of patients seen per physician per hour or day also could theoretically face liability for routinely billing Level 4 or 5 evaluation and management (E&M) codes when they know that physicians typically spend less than the requisite amount of time with patients.

Upcoding has become a more pertinent issue in recent years. Specifically, the OIG indicated that it will be reviewing inappropriate E&M payments during CY 2013.[40] Moreover, CMS' auditors have listed E&M coding as a focus area of review (*e.g.,* Connolly, Inc.).

For a more comprehensive discussion of upcoding as a billing risk area, see *Chapter 620, Upcoding*, especially *Chapter 620, Upcoding*, § 620.20.100.

1045.30.20.50
Inappropriate Balance Billing

The compliance guidance lists inappropriate balance billing as a potential risk area for billing companies.[41] Inappropriate balance billing refers to the practice of billing Medicare beneficiaries for the difference between the total provider charges and the Medicare Part B allowable payment.

In addition to Medicare's prohibition against balance billing, many states have their own laws prohibiting, or limiting, the practice.

1045.30.20.60
Inadequate Resolution of Overpayments

The OIG cites inadequate resolution of overpayments as a billing risk area.[42] Overpayments are improper or excessive payments made to health care providers as a result of patient billing or claims processing errors for which a refund is owed by the provider. Examples of Medicare overpayments include instances where a provider is paid for:

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[34] *Id.* at 70142 n.27.

[35] *United States ex rel. Semtner v. McKean and Medicare Consultants d/b/a Emergency Physicians Billing Services*, 31 F. Supp.2d 1308 (W.D. Okla. 1998).

[36] 3 BNA's Health Care Fraud Rep. 30 (Jan. 13, 1999).

[37] *Id.*

[38] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998) (§ II.A.2.a, n.28).

[39] *Id.* at 70142 n.29.

[40] Office of the Inspector Gen., U.S. Dep't of Health and Human Servs., Fiscal Year 2013 Work Plan, at 25.

[41] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998) (§ II.A.2.a, n.28) at n.31.

[42] *Id.* at n.32.

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- the same service twice, either by Medicare or by Medicare and another insurer or beneficiary;
- services planned, but not performed; or
- noncovered services.

In general, it is not a billing company's responsibility to make restitution for overpayments—unless, by contract, it is responsible for doing so. However, the OIG advises billing companies to establish a system to identify and resolve credit balances.[43] Among other things, the OIG recommends that billing companies assign responsibility for tracking, recording, and reporting credit balances to at least one individual and ensure their information systems can print out individual accounts with credit balances.[44]

A provider's known retention of overpayments could constitute a false claim. For a more comprehensive discussion of overpayments constituting false claims, see *§ 1045.30.10.*

Additionally, for a more comprehensive discussion of overpayments as a billing risk area, see *Chapter 640, Credit Balances/Failure to Refund.*

1045.30.20.70
Computer System Risks

The OIG believes it "essential" that billing companies develop policies and procedures to ensure the integrity of the information they process. In that regard, the OIG advises billing companies to:[45]

- make sure that records can be located easily and accessed within a well-organized filing or alternative retrieval system;
- have a backup system to ensure the integrity of the data; and
- provide for a regular system backup to ensure that no information is lost.

The OIG also warns billing companies against using computer software that encourages billing personnel to enter data in fields indicating services were rendered, even if they were not actually performed or documented.[46]

1045.30.20.80
Failure to Maintain Confidentiality of Information/Records

The OIG advises billing companies to "develop, implement, audit and enforce" policies and procedures to ensure the confidentiality and privacy of sensitive information in their possession, whether in electronic or hard copy form. The policies should address financial, medical, and personnel information.[47]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA[48] was enacted in 1996 as a vehicle to share health information securely. However, since its enactment, HIPAA has transformed from a vehicle to share information into a barrier. In 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009,[49] which included the Health Information Technology for Economic and Clinical Health Act (HITECH). HITECH amended HIPAA, most notably to increase penalties for HIPAA violations as well as made changes to Business Associates' use, disclosure and handling of Protected Health Information.

HIPAA and its regulations established standards by which Covered Entities must comply to ensure the privacy and security of Protected Health Information. A "Covered Entity" is defined as a health plan, health care clearinghouse or a health care provider that transmits health information in connection with a HIPAA Standard Transaction (as such term is defined in the statute).[50] Protected Health Information (PHI) is defined as individually identifiable health information transmitted through any medium.[51]

Covered Entities, such as health care providers, often contract with third parties, such as third-party billing companies, to perform certain functions on behalf of the health care provider, such as coding and billing services. Such third parties are called "Business Associates" if their functions or services involve the use or disclosure of PHI. When a health care provider contracts with a third-party billing company to perform certain billing and collection functions, the Privacy Rule requires the Covered Entity to enter into a Business Associate Agreement (BAA) with the third-party billing company.[52] BAAs typically set forth the obligations of the Covered Entity and the Business Associate, the permissible uses and disclosures of PHI by the Business Associate and the privacy and security safeguards the Business Associate must have in place to ensure the privacy and security of the PHI it receives from the Covered Entity.

1045.30.20.90
Knowing Misuse of Provider ID Numbers

The knowing misuse of provider ID numbers is a particular problem for management companies providing broad-based management services, because such companies commonly are involved in performing the administrative tasks associated with obtaining and maintaining provider numbers for their clients.[53]

If reassignment-of-benefits principles are violated (see *Assignment of Payments*, § 1045.20), such compa-

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[43] *Id.* at 70144 (§ II.2.B.4).
[44] *Id.*
[45] *Id.* at 70143 n.33.
[46] *Id.*
[47] *Id.* at n.34.
[48] Pub. L. No. 104-191.
[49] Pub. L. No. 111-5.
[50] 45 C.F.R. § 160.103.
[51] *Id.*
[52] 45 C.F.R. § 164.502.
[53] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998) (§ II.A.2.a, n.28) at n.35.

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nies could be hard-pressed to maintain they were unaware when a provider number was being misused.

Examples of potentially problematic practices involving the misuse of provider numbers include:

- using a physician group billing number to bill for the services of independent contractor physicians provided in a hospital or other nonoffice setting;
- billing nonphysician services under physician numbers, such as the services of physical therapists when the physician's physical presence or other "incident to" requirements are not satisfied (for example, see *Medical Rehabilitation Support Services (June 1997)*, § 1045.70.20.20); and
- billing the services of new physicians who do not yet have their own identification number under the number of an established physician.

Providers should be cognizant of their potential liability in connection with erroneous Medicare claims submitted using their provider number(s). In 2000, the OIG issued a Report entitled *Medical Billing Software and Processes Used to Prepare Claims,* wherein it identified that billing companies, their employees, and employees of providers have access to patient and provider information that can be used (without a provider's knowledge) to generate false claims.[54] CMS relies on provider reviews of remittance notices to identify misuse of provider numbers. However, according to the report, such notices can be re-routed to a billing company, or another address, and providers may never see them. Thus, the OIG recommended (and CMS concurred) providers need to be made aware of their responsibility to review remittance notices as a further check on fraud and abuse.

1045.30.20.100
Outpatient Services Rendered in Connection With Inpatient Stays

According to the OIG, billing companies that submit claims for nonphysician outpatient services that were already included in the hospital's inpatient payment under the Prospective Payment System (PPS) are, in effect, submitting duplicate claims.[55]

Billing companies with hospital clients that do not have a mechanism, such as a system edit, for detecting and rejecting claims for nonphysician outpatient services that are included in the PPS reimbursement rate can be subject to prosecution under the theory of deliberate ignorance or reckless disregard.

For a more comprehensive discussion of outpatient services provided in connection with inpatient stays, see *Chapter 1002, Hospitals—Outpatient Services*, especially *Chapter 1002, Hospitals—Outpatient Services*, § 1002.30.

1045.30.20.110
Duplicate Billing in an Attempt to Gain Duplicate Payment

Duplicate billing is the practice of submitting more than one claim for the same service or submitting a claim to more than one primary payer at the same time.[56] Although duplicate billing can result from an unintentional error, the OIG warns that billing companies that intentionally double bill—which is sometimes evidenced by systematic or repeated double billing—can create liability under criminal, civil, or administrative law, particularly if any overpayment is not promptly refunded.[57]

Billing companies that do not have safeguards in place to prevent duplicate billing risk liability under the theory they acted in deliberate ignorance or reckless disregard of the truth.

For a more comprehensive discussion of duplicate billing and failure to refund, see *Chapter 630, Duplicate Billing* and *Chapter 640, Credit Balances/Failure to Refund.*

1045.30.20.120
Billing for Discharge in Lieu of Transfer

Billing for discharge in lieu of transfer is a risk area limited to companies that bill on behalf of hospitals.[58] The OIG's guidance explains that under Medicare regulations, when a PPS hospital transfers a patient to another PPS hospital, only the hospital to which the patient was transferred can charge the full amount for the patient's diagnosis-related group (DRG), while the transferring hospital should charge Medicare only a per diem amount.[59] However, the guidance offers no additional advice on how to avoid this risk area.

In general, if the hospital is responsible for maintaining documentation and telling the billing company what to bill, the transfer/discharge issue should not be a major risk for the billing company so long as the billing company is not acting with reckless disregard for the truth. Otherwise, the billing company should require the hospital to document whether a patient has been transferred to or from another hospital.

For a more comprehensive discussion of billing for discharge in lieu of transfer, see *Chapter 1001, Hospitals—Admissions and Discharges*, especially *Chapter 1001, Hospitals—Admissions and Discharges*, § 1001.10.

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[54] Office of Evaluation & Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medical Billing Software and Processes Used to Prepare Claims (No. OEI-05-99-00100, March 2000), p. 10.

[55] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998) (n.36).

[56] *Id.* at n.37.

[57] *Id.*

[58] *Id.* at n.38.

[59] *Id.*

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1045.30.20.130
Failure to Properly Use Modifiers

As defined by the *Physicians' Current Procedural Terminology, Fourth Edition* (CPT-4), modifiers allow providers to indicate that a performed service or procedure has been altered by some specific circumstance, but not changed in its definition or code. For example, the addition of the -59 modifier to a procedure code indicates that the procedure represents a distinct procedure or service from another billed on the same date of service, such as a different session, surgery, or anatomical site.[60]

Assuming the modifier is used correctly, the specificity provides the justification for payment for these services.[61]

1045.30.20.140
Routine Waiver of Copayments

The OIG guidance states that billing companies should encourage providers to make a good faith effort to collect copayments, deductibles, and payments for noncovered services from patients.[62] Routine waivers of copayments and deductibles could result in State and/or Federal Anti-Kickback Statute (AKS) and False Claims Act (FCA) exposure.

In a special fraud alert, the OIG notes that a provider, practitioner, or supplier that routinely waives Medicare copayments or deductibles is misstating its actual charge, which causes Medicare to pay more than it should.[63] The OIG gives the example of a supplier that submits a claim for a piece of equipment for $100, but waives the $20 copayment, thereby accepting Medicare's 80 percent payment ($80) as payment in full. According to the OIG, the supplier is misstating the amount of the claim for that equipment and, instead, Medicare should pay 80 percent of $80—or $64—rather than 80 percent of $100—or $80. As a result of the provider's misrepresentation (and, potentially, false statement or claim), the Medicare program is paying $16 more than it should for this service.

As is explained in more detail in § 1045.40, the AKS prohibits a person from paying remuneration to another to generate business paid by federal health care programs. The OIG warns that routine waivers of copayments and deductibles rise to the level of "remuneration." However, an important exception to the definition of "remuneration" is the non-routine waiver of copayments and deductibles after the provider or supplier has made an individualized determination of need. However, the OIG warns that the hardship exception can be used only occasionally to address the special financial needs of a particular patient.[64]

In general, a billing company is unlikely to be held responsible for waiving copayments and deductibles because it cannot bill without provider authorization. However, a management company providing comprehensive management services could be held responsible if it is involved in the development of policies that allow for the routine waiver of copayments and deductibles.

For a more comprehensive discussion of waivers, see *Chapter 1435, Waiver or Payment of Copayments, Deductibles, or Premiums*.

1045.30.20.150
Coding-Related Risk Areas

In addition to the billing practices discussed above, the OIG advises billing companies that provide coding services to be particularly vigilant in guarding against certain suspect coding practices.[65] Problematic areas for such companies include the following:

- *Internal coding practices.* The OIG recommends that internal coding practices, including software edits, be reviewed periodically to make sure they are consistent with applicable federal, state, and private-payer requirements.[66]
- *Assumption coding.* Coding a diagnosis or procedure without supporting clinical documentation is known as assumption coding. The OIG stresses the importance of making coding personnel aware of the need for documented verification of services from the attending physician.[67]
- *Documentation practices.* The OIG warns against altering documentation and coding without proper supporting documentation. Although proper documentation is the responsibility of the health care provider, the coder should be aware of proper documentation requirements and encourage providers to document their services appropriately. All necessary documentation should be available at the time of coding.[68]
- *Unlicensed or unqualifed clinical personnel.* The OIG identifies billing for services provided by unqualified or unlicensed clinical personnel as a risk area.[69]
- *Employment of sanctioned individuals.* Billing companies should ensure that they do not employ or contract with individuals who have been sanctioned by the OIG or barred from federal procurement programs.[70] The OIG's List of Excluded Individuals/Entities (LEIE) is available on the OIG's website. For more information, see § 1045.50.

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[60] Centers for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., Medicare Claims Processing Manual (Pub. 100-4), ch. 23, § 20.9.1.

[61] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138, 70143 n.39 (Dec. 18, 1998) (§ II.A.2.a).

[62] *Id.* at n.42.

[63] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Special Fraud Alert: Routine Waiver of Copayments or Deductibles Under Medicare Part B (May 1991) *reprinted in* 59 Fed. Reg. 65372, 65373 (Dec. 19, 1994) (§ II.C).

[64] *Id.*

[65] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. at 70143 (§ II.A.2.b).

[66] *Id.* at 70144 n.48.

[67] *Id.* at n.49.

[68] *Id.* at n.50.

[69] *Id.*

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1045.40 Anti-Kickback Risk Areas

1045.40.10
Relevance of Anti-Kickback Statute

The AKS provides criminal penalties for individuals or entities that "knowingly and willfully" solicit, receive, pay, or offer remuneration as an inducement to generate business payable by Medicare or Medicaid.[71] Importantly, since the enactment of the Patient Protection and Affordable Care Act (ACA), one does not have to have a specific intent to violate the statute for a violation to occur. Moreover, claims submitted pursuant to an AKS violation are also violations of the civil False Claims Act.[72] It is important to note that many state laws have anti-kickback prohibitions similar to, and at times more restrictive than, the federal prohibition.

While a relationship between a third-party billing company or a health care management company may implicate the AKS, the statute includes a number of exceptions.[73] Moreover, the OIG has promulgated a number of regulatory safe harbors.[74] For a greater discussion about the AKS, the exceptions and the safe harbors, please see Section 1800, *Anti-Kickback—Industry Specific Risk Areas.*

Some of the anti-kickback risk areas applicable to billing companies, including financial incentives (see *Financial Incentives*, § 1045.40.20), joint ventures (see *Joint Ventures*, § 1045.40.30), routine waiver of copayments (see *Routine Waiver of Copayments*, § 1045.40.40), discounts (see *Discounts*, § 1045.40.50), and gifts (see *Gifts*, § 1045.40.60), are discussed below.

For information about anti-kickback risk areas applicable to health care providers in general, see *Chapter 1410, Joint Ventures and Acquisitions*; *Chapter 1415, Personal Services and Management Agreements*; *Chapter 1420, Discounts and Free Items*; *Chapter 1425, Equipment and Space Rentals*; *Chapter 1430, Marketing Practices*; and *Chapter 1435, Waiver or Payment of Copayments, Deductibles, or Premiums.*

1045.40.20
Financial Incentives

Billing companies that are compensated by their clients based on a percentage of revenue, net income, or collections risk anti-kickback exposure. The OIG believes that financial incentives might increase the risk of upcoding and other abusive practices.[75]

In one case that involved a percentage compensation arrangement, the billing company marketed durable medical equipment to physicians and beneficiaries. The OIG advised that the proposed percentage compensation arrangement could be deemed a kickback violation.[76]

Further, the OIG has taken the position that management companies that provide marketing services might run afoul of the anti-kickback prohibition if they are compensated on a percentage basis.[77]

As a result, some management companies have chosen to eliminate marketing services altogether (see *Chapter 1430, Marketing Practices* and *Chapter 1415, Personal Services and Management Agreements*). Others have decided to curtail their marketing services to "passive activities"—such as assisting health care providers in the development of advertising campaigns and media placement—and avoid activities that are easily construed as "recommending" the provider's services—such as outreach to potential referral sources. In addition, some management companies have adopted flat fee arrangements that qualify for the management agreement safe harbor.

However, the direct solicitation of potential referral sources by management companies paid on a percentage basis remains a high risk proposition in the event of a government investigation.

1045.40.30
Joint Ventures

Although joint ventures can take a variety of forms, the term generally refers to a contractual arrangement between two or more parties to cooperate in providing services. The creation by the parties of a new legal entity to provide such services, such as a limited partnership or closely held corporation, is another form of joint venture.[78]

In its guidance for billing companies, the OIG states that it is "troubled" by the proliferation of business arrangements that might violate the anti-kickback statute and notes that such arrangements generally are established between those in a position to refer business, such as physicians, and those providing items or services for which a federal health care program pays.[79] The OIG goes on to say that it currently has a number of investigations and audits under way that focus on those concerns.[80]

For a more comprehensive discussion of joint ventures, see *Chapter 1410, Joint Ventures and Acquisitions.*

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[70] *Id.* at n.51.

[71] Social Security Act § 1128B(b) [42 U.S.C. § 1320a-7b(b)].

[72] *Id.*

[73] *Id.*

[74] 45 C.F.R. § 1001.952.

[75] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. at 70143 n.40 (Dec. 18, 1998) (§ II.A.2.a).

[76] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Advisory Op. No. 98-1 (March 19, 1998).

[77] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Advisory Op. No. 98-4 (April 15, 1998).

[78] OIG Special Fraud Alert: Joint Venture Arrangements (August 1989), *reprinted in* 59 Fed. Reg. 65372, 65373 (Dec. 19, 1994) (§ II.B).

[79] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. at 70143 n.41 (§ II.A.2.a).

[80] *Id.*

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1045.40.40

Routine Waiver of Copayments

Although the routine waiver of copayments generally is considered a billing risk area (see *Routine Waiver of Copayments*, § 1045.30.20.140), in some instances that practice also can raise anti-kickback concerns. For a more comprehensive discussion of waivers of copayments as an anti-kickback risk area, see *Chapter 1435, Waiver or Payment of Copayments, Deductibles, or Premiums*.

1045.40.50

Discounts

In general, discounts and professional courtesy are not appropriate unless the total fee is discounted or reduced.[81] The OIG third-party billing company guidance advises that in such situations, the payer—Medicare, Medicaid, or private payer—should receive its proportional share of the discount or reduction.[82]

The OIG was concerned that unless the total fee was discounted or reduced, the provider might discount the fee for one item or service to induce the purchase of another item or service. The agency was particularly concerned with situations where the non-Medicare billable service is discounted, but the Medicare billable service is not, or where different reimbursement methodologies apply.[83]

However, the revised discount safe harbor allows one item or service to be discounted or given away to induce the purchase of another good or service under specific circumstances.[84] To fit under the safe harbor, the goods and services must be reimbursed "by the same Federal health care program using the same methodology" and the reduced charge must be fully disclosed to the program and accurately reflected where appropriate to the reimbursement methodology.

Given the access billing companies typically have to the client-provider's fee schedule, they generally are presumed to know when services are being discounted. Such billing companies are unlikely to avoid liability under the False Claims Act and other intent-based statutes by simply claiming to follow client orders.

Providers of comprehensive management services have even greater potential exposure because they almost always have extensive knowledge of patient scheduling and fee schedules, which typically are tracked on company information systems. It also is presumed that management companies know when both discounted and entirely free care are provided.

Risk is greatest where a management company plays a role in strategic planning and the plan includes offering discounted or free care to actual or potential referral sources. Discounted and professional courtesy services can be particularly problematic when the recipient of the discounted or free care is a physician who is a potential referral source or the physician's family member, which raises anti-kickback risks (see *Relevance of Anti-Kickback Statute*, § 1045.40.10).

For a more comprehensive discussion of discounts and professional courtesy, see *Chapter 1420, Discounts and Free Items*.

1045.40.60

Gifts

The OIG warns that billing companies should not confer gifts on the client-provider because it could raise anti-kickback concerns.[85] However, the federal AKS applies only to payments and inducements for business that are reimbursable under state and federal health care programs. Thus, the statute most likely would not be implicated by gifts to clients from a company that performs only billing services.

In *United States v. Metzinger*,[86] for example, the court rejected an anti-kickback claim arising from the coding/consulting company's payment of a fee to individuals who referred additional hospital clients, holding that the anti-kickback law did not extend to suppliers of services that were not reimbursed by Medicare. However, a settlement agreement covering other allegations, including upcoding and unbundling, was later negotiated (see *Metzinger Associates*, § 1045.70.20).

The AKS might be implicated if a management company that itself owns health care facilities, such as ambulatory surgical centers, provides gifts to provider-clients. Such gifts might be viewed as an inducement to refer patients to the management company's facilities. The statute also might be implicated if a management company provides gifts to referral sources or patients as a means of inducing business for client-providers.

1045.50 Excluded Providers

The OIG has authority to exclude individuals or entities from participation in Medicare, Medicaid, or other federal health care programs.[87] Federal health care programs may not pay for items or services furnished,

[81] *Id.* at n.43.

[82] *Id.*

[83] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute, Final Rule, 64 Fed. Reg. 63518, 63530 (Nov. 19, 1999) (§ II.B.4).

[84] 42 C.F.R. § 1001.952(h).

[85] Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. at 70143 n.41 (§ II.A.2.a).

[86] *United States v. Metzinger*, No. 94-7520 (E.D. Pa. partial settlement Dec. 30, 1996).

[87] 42 C.F.R. Part 1001.

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directed or prescribed by an excluded physicians.[88] Moreover, "Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries."[89] In its Special Advisory Bulletin, the OIG lists a number of examples of items or services that are reimbursed by federal health care programs that, if provided by an excluded individual or entity, would violate the prohibition, including services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a federal health care program.[90]

A provider contracting with an excluded person or entity will be subject to civil monetary penalties of up to $10,000 for each item or service furnished by the excluded individual or entity, treble damages for the amount claimed for each item or service and, in some cases, exclusion from federal health care programs. The OIG has an electronic database on its website[91] that allows a person or entity to search the list of excluded persons or entities.

1045.60 *Qui Tam* Actions

Under 31 U.S.C. § 3730, private persons may bring civil actions on behalf of the government seeking recovery of government funds obtained fraudulently or obtained by submitting false claims. Such actions are called *qui tam* actions and, if the government is successful in its prosecution of health care providers, *qui tam* relators (or whistleblowers) receive a percentage of the government's total recovery.

Health care providers should be aware that the government not only utilizes its own administrative and prosecutorial tools, but it also encourages private citizens to bring actions against alleged bad actors. Such private citizens may be employees, compliance officers, board members, or other outside parties.

1045.70 Enforcement

1045.70.10
Enforcement Priorities

Although management companies and other billing services have not been a major focus of government prosecution, it would be unwise to assume they are exempt from scrutiny.

The OIG's guidance for third-party medical billing companies [92] clearly indicates a focus on the role played by billing companies in the submission of potentially false or inaccurate claims. As the Inspector General observed:

> [b]illing companies are providing crucial services that could greatly impact the solvency and stability of the Medicare Trust Fund. Health care providers rely on billing companies to assist them in processing claims in accordance with applicable statutes and regulations. Additionally, health care professionals are consulting with billing companies to provide timely and accurate advice with regard to reimbursement matters, as well as overall business decision-making. As a result, the OIG considers this compliance program guidance particularly important in the partnership to defeat health care fraud.[93]

One way the OIG seeks to promote compliance in the third-party billing industry is through the imposition of corporate integrity agreements (CIAs) on billing companies that have engaged in fraudulent conduct. CIAs are part of global settlement agreements the government offers companies in lieu of excluding them entirely from participating in Medicare or other federal health care programs.

According to congressional testimony by then-Assistant IG Lewis Morris, "CIAs are imposed on companies to help reorient a corporate culture that may have previously been prone to fraud and abuse. In this way, the OIG attempts to directly affect change in third-party billing entities. Such CIAs may also serve as admonitory examples for others within the industry."[94]

CIAs typically set forth specific requirements that the government believes a provider must meet in order to ensure it is complying with health care laws and regulations (see, e.g., *Medaphis Physician Services Corp. (June 1999)*, *Brandler* (August 2006)). CIAs imposed on third-party billing companies in the past, for

[88] 42 C.F.R. § 1001.1901.

[89] OIG Special Advisory Bulletin: The Effect of Exclusion from Participation in Federal Health Care Programs (Sept. 1999).

[90] *Id.*

[91] http://exclusions.oig.hhs.gov/.

[92] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Compliance Program Guidance for Third-Party Medical Billing Companies, 63 Fed. Reg. 70138 (Dec. 18, 1998).

[93] OIG news release dated Nov. 30, 1998.

[94] Testimony of Lewis Morris, HHS Assistant Inspector General for Legal Affairs, before the House Committee on Commerce, Subcommittee on Oversight and Investigations, U.S. House of Representatives, April 6, 2000, *available at* http://oig.hhs.gov/reading/testimony/2000/00406fin.htm.

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example, have required them to establish and maintain an effective compliance program including establishing a compliance officer function, a code of conduct, specific policies and procedures addressing billing and coding issues, a training program, and annual audits and reviews. The companies also must make annual reports to the OIG on their progress in complying with all provisions of the CIA.

In the past, the OIG has also described specific projects relating to third-party billing company compliance in its agency work plans for each fiscal year. In its Work Plan for fiscal year 2005,[95] the OIG said it would identify and review the relationships between billing companies and the physicians and other Medicare providers who use their services. It also planned to identify the various types of arrangements physicians and other Medicare providers have with billing services and determine the effects of these arrangements on the physicians' billings. The OIG's Fiscal Year 1999 Work Plan called for a review of billing service companies to determine whether:[96]

- Medicare claims prepared and submitted by billing service companies are properly coded, and
- agreements between providers and billing service companies meet Medicare criteria.

The cases discussed below illustrate the fraud and abuse exposure billing companies face in connection with improper billing and coding of reimbursement claims.

1045.70.20

Settlement Agreements

Settlement	Alleged Misconduct	Resolution/Penalties
United States ex rel. Brandler v. MSO Washington Inc., No. 3:06-cv-05437-RJB, (W.D. Wash., settlement announced Jan. 7, 2011).	A billing company program sent providers on unnecessary and over-frequent visits to patients, billed Medicaid and Medicare for services that were never rendered, and failed to properly document visits and services. In addition, it mislabeled or "upcoded" diagnoses and treatments to maximize Medicare and Medicaid reimbursements, and used an electronic medical record system with customized features that "fostered and enabled" the fraud.	The company and its owner agreed to pay $565,000 to resolve the whistleblower lawsuit. (15 *BNA's Health Care Fraud Rep.* 76, Jan. 26, 2011).
United States ex rel. Semtner v. Emergency Physicians Billing Servs., No. CIV 94-617-(c) (W.D. Okla. agreement concluded Sept. 23, 1999).	A billing company committed various improper billing practices, including upcoding, on behalf of physician groups.	EPBS entered into a corporate integrity agreement (CIA) and agreed to pay a total of $15 million to the federal government and 28 state governments to settle the allegations. In addition, EPBS's founder is excluded from participation in all federal health care programs for 15 years.
United States ex rel. Robinson v. Medaphis Inc., No. 1:95CV857 (W.D. Mich. agreement concluded June 22, 1999).	A company that provides business management services to physicians and health care organizations upcoded claims and billed for services more extensive than those actually provided by physicians.	It entered into a five-year, 150-day CIA and agreed to pay a total of $15 million to the federal government and 35 state governments to settle the allegations.
United States v. Royal Geropsychiatric Services Inc., No. 4:97-CV-218 (N.D. Ohio agreement concluded July 7, 1998).	A company that provides psychiatric services to nursing home residents submitted claims to Medicare for psychotherapy services as if physicians were performing services, when the services were provided by social workers with little or no supervision from the physicians.	Royal; the billing company, Nursing Home Services Inc.; two physicians; and two owners of the billing service agreed to pay the government $200,000 to settle the allegations.

[95] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 2005 Work Plan at 10.

[96] Office of Inspector Gen., U.S. Dep't of Health & Human Servs., Fiscal Year 1999 Work Plan at 14.

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Settlement	Alleged Misconduct	Resolution/Penalties
United States v. Metzinger Assocs., No. 94-7520 (E.D. Pa. agreement concluded April 21, 1997).	A Medicare billing consulting company devised and implemented a scheme called "CPT-4 Maximization" in which hospitals participated by using improper coding methods, including upcoding, unbundling, and rebundling, to gain increased Medicare reimbursement.	The two principal executives agreed to cooperate with the government by each providing 250 hours of consulting time to the U.S. Attorney. In addition, they agreed to provide the government with existing documents, records, computer runs, and other information relating to consultants, hospitals, and coding of billing techniques.They also agreed to be excluded from Medicare and Medicaid for three years and pay $60,000 in fines.

1045.70.30

Court Rulings

Facts	Outcome
An academic hospital and a billing company created and disseminated materials falsely representing that Stereotactic Body Radiosurgery (BRS) was a successful treatment for many forms of primary and metastatic cancers, including lung, liver, bladder, pancreatic, and colon cancers. The defendants offered cancer patients free consultations, during which they provided false information concerning the effectiveness of BRS. During the relevant time periods, the surgery was approved only for treatment of diseases above the neck. Two local coverage determinations (LCDs) and AMA's code book advised physicians of certain codes to use for stereotactic radiosurgery and for cerebral lesions, but no CPT code covered BRS during the period relevant to this action.	The court approved a settlement agreement in which the hospital agreed to pay the United States $25 million plus interest, of which the relator's share was $3.8 million. The billing company owners then filed a third-party complaint seeking contribution from billing and coding experts, which was dismissed. *United States ex rel Ryan v. Staten Island University Hospital, et al,* E.D. New York (No. 04-CV-2483, order to dismiss filed May 13, 2011). (15 *BNA's Health Care Fraud Rep.* 482, June 1, 2011).
A financial manager for an osteopathic hospital and other codefendants conspired to defraud the government by creating a network of Medicare provider companies, including five clinics in Florida, associated with the hospital from 1996 through 1998. The financial manager designed the network to benefit the hospital, but the network produced profits to the defendants through inflated costs charged to Medicare. The trial court found that each of the entities was controlled by the manager, making him a "related party" under Medicare regulations, and his relationship to the clinics was not disclosed to Medicare, enabling him to charge huge management fees. He was also charged with money laundering based on the transfer of funds to the Florida clinics as a result of the Medicare fraud. The conspirators were also charged with wire fraud.	The manager was sentenced to 90 months' imprisonment, two years of supervised release, and ordered to pay $7,290,202 in restitution. *United States v. White,* N.D. Ohio (No. 4:03-CR-00001-PAG, verdict announced Mar. 31, 2004). (8 *BNA's Health Care Fraud Rep.* 372, Apr. 28, 2004.) (15 *BNA's Health Care Fraud Rep.* 447, May 18, 2011.)

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