AHIMA Census Results: Focus on Compliance

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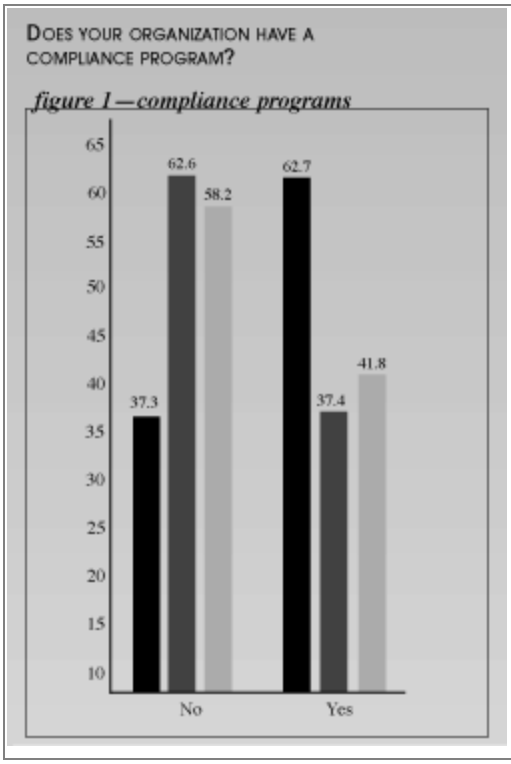
by Daniel P. Lorence, PhD

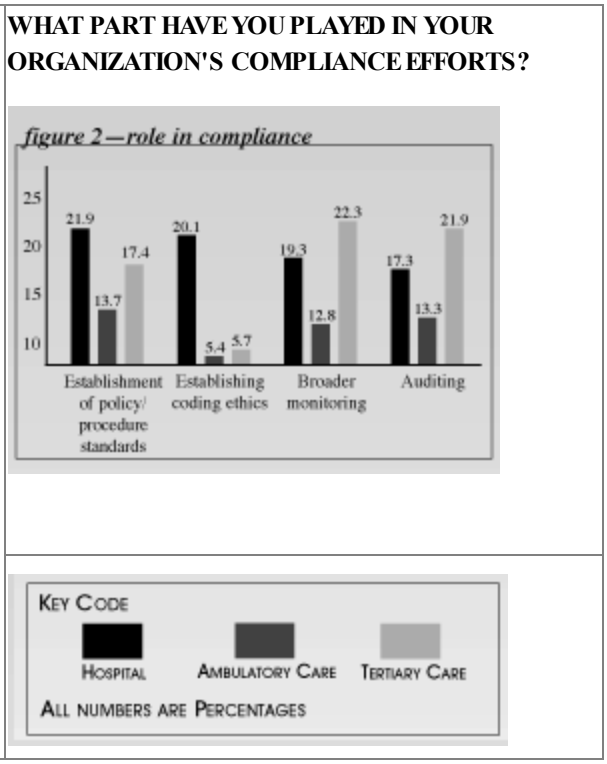
The Office of the Inspector General (OIG) has instituted compliance guidelines for medical laboratories, hospitals, and home healthcare agencies. Within this framework, these guidelines provide at least some compliance direction for individual providers and group practices who have contractual arrangements with these entities. The OIG has also indicated its intent to move into other practice settings.[1] Likewise, the Health Care Financing Administration (HCFA) has proposed a compliance plan for implementation of more extensive and detailed E&M documentation that individual providers must follow.[2] Regardless of the practice-specific labels imposed upon these guidelines, the message is clear: Healthcare compliance programs are a necessity in any practice setting that provides healthcare or conducts business with a healthcare provider.

Healthcare delivery settings however, possess many unique characteristics that do not provide easy analogies for other practice environments. Managers within these settings must therefore work to distinguish between aspects of model compliance programs that easily translate to their practice setting and those that do not.

The 1998 AHIMA census collected information on compliance practices and related health information perspectives within specific practice settings. What follows is a summary of reported compliance practices as reported by managers in hospitals, ambulatory and group practice settings, and tertiary care (long term care and rehabilitation) facilities.

Hospitals continue to lead the way in terms of compliance program development (figure 1). 62.7 percent of hospital-based respondents reported that they had established a compliance program, compared to 37.4 percent of ambulatory care respondents and 41.8 percent of tertiary care respondents. It is likely that the publicity surrounding large-scale investigations of hospitals has influenced managers in hospitals. This has occurred despite the fact that an increasing number of investigations and prosecutions are being brought against small groups or individual providers. Alternatively, it may indicate a perceived risk evaluation by providers: with more than 6000 hospitals available for investigation, compared to approximately 700,000 physicians who may be targeted, the perceived chances of investigation may appear small for clinics or group practices. Managers must bear in mind, however, that investigators may focus increased attention on the small practice environment as they gain additional resources and more sophisticated data-driven fraud detection tools.





HIM professionals are assuming more active compliance roles beyond their traditional domains. While most were previously involved in establishing coding ethics, this was not the primary role of information managers in organizational compliance, according to the data. Key HIM roles cited include setting policy and procedures, monitoring, and auditing.

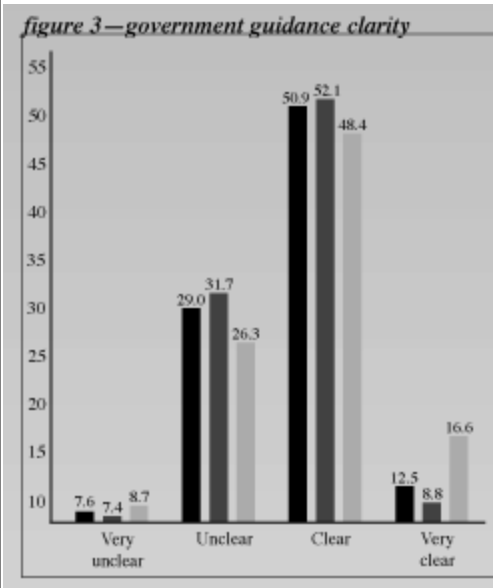
Information managers appear to have slightly different roles in organizational compliance programs, depending on their practice setting (figure 2). In hospitals, the major role of the information manager was establishing policy and procedure standards (21.9 percent). In the tertiary care setting, it was about equally divided between performing audits (21.9 percent) and more broadly performing monitoring and quality improvement functions (22.3 percent). In the ambulatory care setting, the HIM role was evenly divided between establishing standards (13.7 percent), broader monitoring (12.8 percent), and auditing (13.3 percent). This variance is likely due to a decreased ability to specialize in groups and clinics, where managers usually assume more diverse responsibilities and tasks. Most managers had at least some involvement in training and education. There was little reported involvement by managers in developing the organization's complaint system.

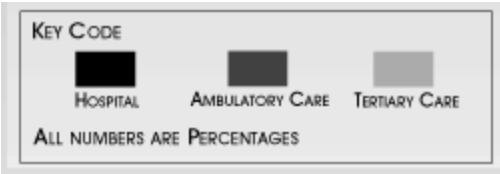
HIM professionals are likely to see increased responsibilities in the compliance area. The OIG notes, "by separating the compliance function from the key management positions of general counsel or chief hospital financial officer...a system of checks and balances is established to more effectively achieve the goals of the compliance program."[3] Few other members of the hospital management team possess the right combination of coding skills, legal knowledge, and auditing experience, outside of reimbursement and legal departments. The HIM professional, at least by training, is the likely choice to fill the compliance needs of most organizations.

Government-provided information regarding compliance remains problematic (figure 3). More than one-third of managers surveyed reported that government guidance related to compliance was either "unclear" or "very unclear." Ambulatory care managers were most dissatisfied with government guidance, with 39.1 percent indicating the information was unclear or very unclear. Thirty-five percent of tertiary care managers indicated a similar level of dissatisfaction. How managers will respond to this dilemma remains to be seen, but for now they are best served by aggressively seeking clarification and more definitive guidance from government sources.

HOW CLEAR IS COMPLIANCE GUIDANCE PROVIDED BY THE GOVERNMENT?

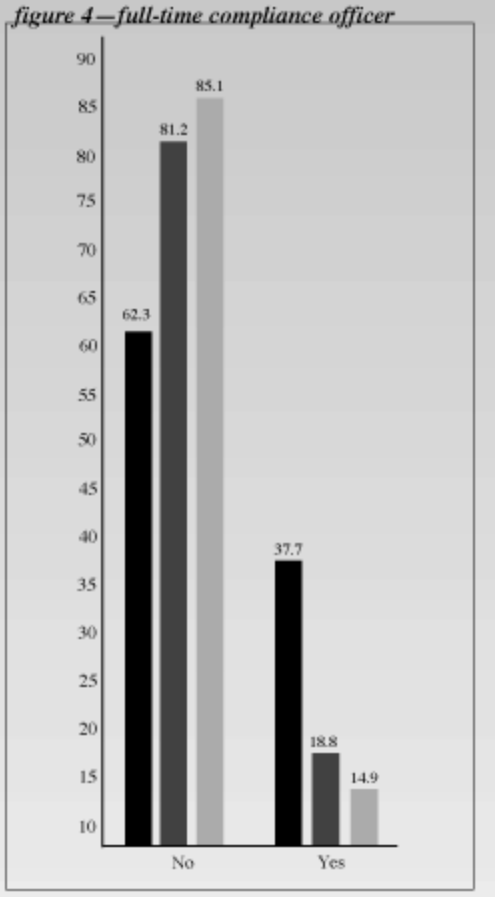
figure 3—government guidance clarity





DOES YOUR ORGANIZATION HAVE A FULL-TIME COMPLIANCE OFFICER?

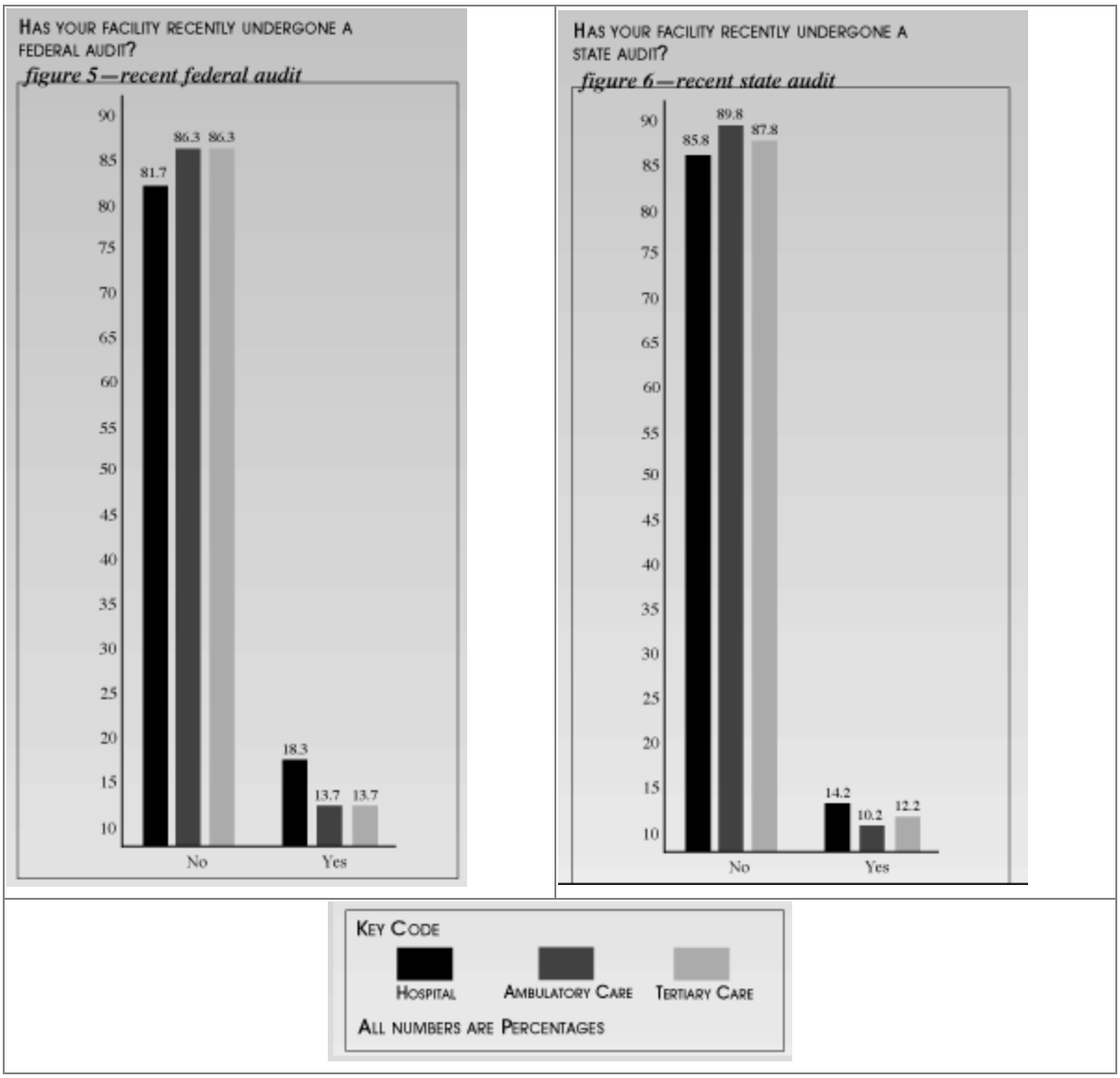
figure 4—full-time compliance officer



How committed are healthcare organizations to dedicating resources to compliance (figure 4)? OIG guidelines recommend that a compliance officer be authorized to oversee and coordinate compliance activities. But only 37.7 percent of hospital managers surveyed indicated that such a full-time position has been allocated in their organizations. In the ambulatory care setting, this figure dropped to 18.8 percent. In tertiary care, only 14.9 percent had designated a full-time compliance officer. This may be a result of problems finding qualified personnel for such positions or simply a timeliness issue, as many organizations prefer to establish a compliance program structure before hiring a full-time officer to run it.

As a risk management concern, it remains to be seen whether investigators will selectively target organizations who fail to install full-time compliance personnel in accordance with the spirit of model compliance program guidelines. The OIG guidelines do not explicitly mandate that compliance must be the officer's "sole duty," but they do state that officers should have sufficient funding and staff to perform their responsibilities fully, that they should have access to the hospital's governing body and the CEO, and that organizations will incur some risk in establishing an independent compliance function if that function is subordinate to the hospital's general counsel, comptroller, or similar hospital financial officer.[4] Within the typical hospital organizational structure, at least, these parameters seem to leave little room for anything except a full-time compliance officer in most settings. The Health Care Compliance Association (HCCA) has likewise identified the structuring of the compliance officer role other than as a single, dedicated responsibility as a "potential problem."[5]

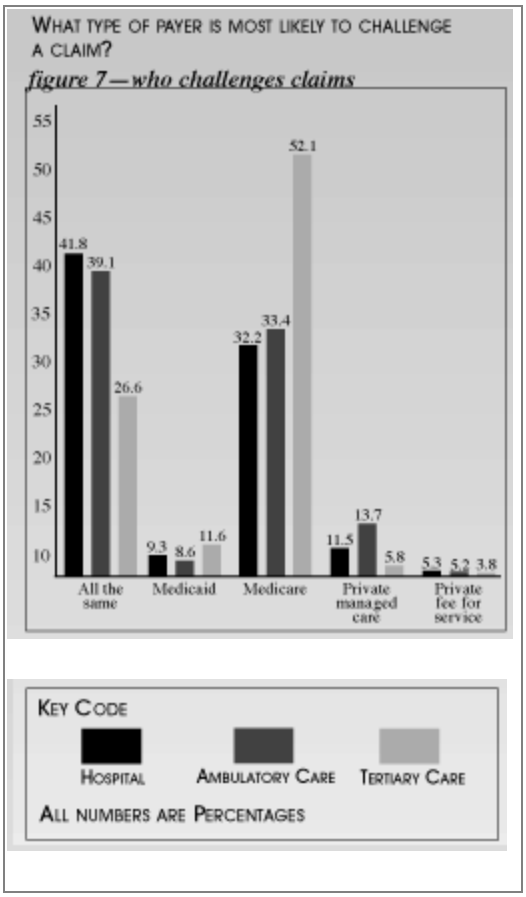
Hospitals are slightly more likely to undergo a federal government compliance audit or investigation than are ambulatory or tertiary care facilities (figure 5). 18.3 percent of hospital managers surveyed indicated that they experienced such a review in the past two years. Ambulatory and tertiary care managers were equally likely (13.7 percent) to have undergone an audit or investigation during the same time frame.



The chances of a state compliance audit were somewhat smaller for hospitals (figure 6). 14.2 percent of hospital managers indicated they had undergone a recent state compliance investigation. For ambulatory care managers, 10.2 percent had undergone a state investigation, and 12 percent of tertiary care managers reported a recent state compliance investigation.

Managers should remain wary of the risk involved in noncompliance, despite the seemingly small odds of being investigated. More commonly, noncompliance or billing or reimbursement irregularities are settled without any formal criminal or civil prosecution and without a full-blown investigation of the organization itself. Specific claims, rather than organization-wide policies, are the usual contested grounds of noncompliance. As such, compliance is more aptly portrayed as a mechanism for minimizing specific instances of noncompliance, rather than avoiding organizational schemes, since the initiation of an investigation is more often than not based on the discovery of an already existing pattern of reimbursement irregularities. The lesson for managers: assume you are being watched, even in the absence of any formal investigative action.

While conceptually compliance may include adherence to all legal and regulatory guidelines, practically speaking it is most commonly defined within a context of reimbursement and claims fraud. In hospitals and outpatient care settings, most managers indicate little distinction regarding what type of payer organization is likely to challenge a claim (figure 7). Where there is a perceived difference, long term care facilities seem to fare the worst and hospitals the best in regard to challenges from Medicare billings. 52.1 percent of long term care managers indicated they were most likely to be challenged by Medicare on a claim. Approximately 33 percent of hospital and ambulatory care managers indicated they were most likely to be challenged by Medicare. Surprisingly, long term care was the least likely to be challenged by private managed care payers (5.8 percent).



Conclusion

With compliance performance measures and tracking methods still being developed, compliance is an emerging science. Presently the OIG offers model plans in laboratory, hospital, and home healthcare compliance but provides no "safe harbor" for other settings. While compliance varies by work setting, it is needed in all settings.

Compliance is fast becoming data driven, yet data analysis methods are still somewhat primitive. In a recent look at compliance assessment software, the OIG found that at the case level, commercial data analysis products did not detect more than 40 percent of upcoded cases. Also, only 10 to 20 percent of cases these products identified as upcoded were actually upcoded. So while analysis of commercial data assessment methods provides some basis for optimism about the role that such products can play in detecting DRG upcoding, the OIG cautions against overreliance on current commercial data analysis tools and emphasizes the need to couple their use with other measures in the detection and prevention portfolio.

The products examined showed modest success in identifying hospitals with a high rate of upcoding and upcoded cases within a narrowly defined group of DRGs that exhibited the most frequent upcoding. Thus they could be used to identify hospitals that may need close scrutiny either before or after Medicare pays them. As these products were less successful for most other DRGs, the OIG recommends only a limited role for them at present.[6]

It is likely that computer-based assessment resources will continue to develop, and that commercial products will become more sophisticated and useful as part of a fraud detection strategy. No doubt HCFA will want to stay abreast of opportunities that this technology may present.

Notes

1. Remarks by June Gibbs Brown, Inspector General, US Department of Health and Human Services, for press briefing on OIG's compliance program guidance for home health agencies, August 4, 1998.
2. Health Care Financing Administration. *Documentation Guidelines for Evaluation and Management Services.* Washington, DC: 1998.

3. Department of Health and Human Services. *Compliance Program Guidance for Hospitals*. Washington, DC: Office of Inspector General, 1998.
4. *Ibid*.
5. Snell, Roy. "Message from the President." *HCCA Focus*, 1, no. 2 (1998).
6. Yessian, Mark. "Using Software to Detect Upcoding of Hospital Bills." *OIG Office of Evaluation and Inspections Report*. Washington, DC: 1997.

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