Coding, Documentation, and Billing: Introductory Guidance

Background

Coding, documentation, and billing of claims submitted to federal health care programs for payment or reimbursement for health care services rendered constitute one of the most significant risk areas for any health care provider. Coding, documentation, and billing fraud and abuse, generally consisting of the intentional or deliberately ignorant misrepresentation of information resulting in an increase to the amount paid or reimbursed by the government or commercial third party payor to the provider or resulting in a decrease of the amount owed by the provider to a governmental or commercial third party payor, is highly scrutinized by federal and state enforcement agencies as well as by commercial third party payors.

Fraud

Federal False Claims Act

The primary mechanism used by the Federal Government for penalizing fraudulent billing and coding practices is the Federal Civil False Claims Act ("FCA").[1] The Federal False Claims Act ("FCA") forbids knowingly and willfully:

- Presenting or causing the presentation of, a false claim for reimbursement by a federal health care program, including Medicare or Medicaid;
- Making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- Repaying less than what is owed to the government;
- Making, using, or causing to be made or used, a false record or statement material to reducing or avoiding repayment to the government; and/or
- Conspiring to defraud the Federal Government through one of the actions listed above.

Note that false statements on applications or reports related to grant funding from the Federal Government could also give rise to a false claims action.

In general, a billing error or honest mistake does not constitute a false claim under the FCA. Typically, a false claim requires actual knowledge that the claim or statement is false. However, the definition of "knowledge" is also met when the claim is made with deliberate ignorance or reckless disregard of the claim's truth or falsity. For example, if a health center assigns a billing function to an untrained clerk, fails to instruct practitioners on proper coding practices, or lacks regular billing and coding audits, the health could be said to have acted in reckless disregard of

[1] 31 U.S.C. §§ 3729- 3733.

the claim's truth or falsity. The lack of intent to make a false claim does not excuse the provider from liability.

Examples of billing and coding schemes that constitute false claims include, but are not limited to:

- Billing for services not furnished;
- Billing for services rendered by a provider which are outside the scope of that provider's license;
- Billing for a service not furnished as billed, i.e., upcoding or downcoding;[2]
- Misrepresenting the diagnosis to justify payment;
- Unbundling or "exploding" charges; and
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify a payment.

Because of the broad reach of the FCA, the Act is arguably the Federal Government's most potent weapon in combating fraud and abuse. Under the Act,

1. A health care provider may be fined up to $11,000 per claim, plus damages calculated as three times the amount that was falsely claimed;[3] and,
2. The provider can be excluded from participating in federal health care programs.

Fraud Enforcement and Recovery Act of 2009

On May 20, 2009, President Obama signed Public Law No. 111-21, the Fraud Enforcement and Recovery Act of 2009 ("FERA"). FERA significantly expanded the scope of the FCA. FERA removed the threshold for liability under the FCA requiring that the false claim be submitted to a federal employee or officer and the requirement that a false record or statement be made to obtain money from the government. Under FERA, the threshold for liability for a false record or statement is that the false record or statement be "material" to a false claim.

In the health care context, whereas the FCA previously applied to any request or demand for money or property that the Federal Government wholly or partially provides—which includes claims for reimbursement from federal health care programs, including Medicare, Medicaid, and grants under Section 330 of the Public Health Service Act ("Section 330")—the changes effected by FERA mean that the FCA reaches requests for payment or reimbursement submitted to

[2] Understandably, a physician may be tempted to undercode to reduce the cost of care to self-pay patients. Despite good intentions, the practice would violate Section 330 requirements if it resulted in uninsured or underinsured patients at or below 200% of the Federal Poverty Line receiving discounted or free services. Health centers are prohibited from using Section 330 funds and/or grant-related funds (such as program income) to support or subsidize the costs of services provided to such individuals and families and, with certain exceptions, health centers are required to charge and use best efforts to collect from such patients the full payment amounts in accordance with their fee schedules, without taking into account any discounts.

[3] 31 U.S.C. § 3729(a)(1); see also 64 Fed. Reg. 47099, 47104, (Aug 30, 1999).

intermediaries, such as Medicaid Managed Care Organizations, Medicare Advantage Organizations, and Medicare Prescription Drug Plans. FCA liability may even attach if the record or statement is material to a claim for which the Federal Government would pay in part, even if the person or entity did not know that the claim would be submitted for payment by the Federal Government.[4]

FERA also codified FCA liability for "reverse false claims," imposing liability for knowingly concealing or improperly avoiding a debt owed to the government.[5] As a result, the FCA now subjects individuals or entities that knowingly fail to repay obligations owed to the Federal Government to liability.

Although the person making a false record or statement material to a false claim need no longer know that such actions will defraud the Federal Government, the FCA continues to apply only in cases where the claimant has knowledge that the claim, record or statement is false or fraudulent. In general, a billing error or honest mistake does not constitute a false claim under the Act. Rather, a false claim typically requires actual knowledge that the claim or statement is false. However, a false claim can also exist when the claim is made with deliberate ignorance or reckless disregard of the claim's truth or falsity.[6]

For example, a health center manager who certifies that a claim for payment or a cost report is accurate, where the claim or cost report was prepared by an untrained clerk and not otherwise verified, may be said to have acted in reckless disregard of the claim's or cost report's truth or falsity. The lack of intent of the health center manager to make a false claim does not excuse the health center.

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act") codified that health care providers that do not report and return overpayments in a timely manner have an obligation to the Federal Government for purposes of the FCA. This law defines an overpayment as Medicare or Medicaid funds to which, after applicable reconciliation, the provider is not entitled, and requires the provider to return and report such overpayment by the later of sixty days from identification of the overpayment or the date the applicable cost report is due.

The Affordable Care Act does not define when an overpayment is considered "identified." It can take a couple of months for the existence of an overpayment to be confirmed and the amount of an overpayment to be quantified. In some cases, it can take even longer to calculate the amount that could have been appropriately paid and deduct that amount from the overpayment. It is not

[4] This provision overturns the Supreme Court case, Allison Engine Co. v. United States ex rel. Sanders, 128 S. Ct. 2123 (2008), where the Court held that FCA liability did not attach where the person submitting the false claim intended only to defraud a government contractor, not the government.

[5] 31 U.S.C. § 3729(a)(1)(G).

[6] 31 U.S.C. § 3729(b)(1).

clear whether the clock starts running for the sixty day time period at the point the potential overpayment is identified or at the point the overpayment amount is confirmed and quantified.

The Affordable Care Act also codified that claims resulting from violations of the Anti-Kickback Statute are false claims for purposes of the FCA. In some cases, claims related to transactions that violate other laws related to federal or state health care programs (e.g., the physician self-referral prohibition (the "Stark Law"), beneficiary inducement prohibition) have been considered false claims.

Health care providers are increasingly at risk under state false claims laws for making a false claim or statement to any state employee or officer to obtain money. Moreover, state false claims laws would apply to claims involving the Medicaid program as well as to health care programs exclusively funded by states, such as state health care programs that provide insurance coverage to uninsured adults who do not qualify for Medicaid or state pharmaceutical assistance programs.

Qui Tam Actions

The Federal Government can expect help in bringing FCA cases. Unlike other laws, the FCA allows private individuals to bring false claims actions in the name of the government. This type of action is known as a qui tam action, and the people bringing the actions are known as relators, or whistleblowers.

Under the FCA's qui tam provisions, a private individual, including, but not limited to, any health center employee, contractor, patient, or agent who has knowledge of a violation can initiate an action under FCA. Under the standard set forth by the Affordable Care Act, a whistleblower may bring suit if:

- S/he voluntarily provides information to the government prior to public disclosure of that information and
- If the relator's knowledge is independent of, and materially adds to, publicly disclosed information.

When a whistleblower suit is filed, the Federal Government may decide to take over the case, but, if it declines to do so, the whistleblower still may pursue the suit. A whistleblower who prevails may qualify for 15 to 30 percent of the amount recovered on the government's behalf, depending on whether the government intervened in the case, as well as attorney's fees and costs.

The FCA has long prohibited employers from retaliating against employees who file or participate in the prosecution of a whistleblower suit. FERA further extends the FCA's whistleblower protections to contractors and agents who suffer retaliation as a result of their filing or participating in the prosecution of a whistleblower suit. Relief from retaliation can include: "reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay,

and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees."[7]

Established by Congress in 2013, the "Pilot Program for Enhancement of Contractor Employee Whistleblower Protections" ("the Pilot Program") requires all federal grantees and contractors to include whistleblower protection requirements in any agreement made with a subcontractor or subgrantee.[8] Such protections must inform employees working on any federal award of their whistleblower rights and remedies as well as provide written notice of employee whistleblower protections in the predominant language of the workforce. Employees may not be discharged, demoted, or otherwise discriminated against as a reprisal for whistleblowing.

Under the Pilot Program, whistleblowing involves an employee making a report that he or she reasonably believes is evidence of any of the following:

- Gross mismanagement of a federal grant or contract;
- A gross waste of federal funds;
- An abuse of authority relating to a federal grant or contract;
- A substantial and specific danger to public health or safety; or,
- A violation of law, rule, or regulation related to a federal grant or contract (including the competition for, or negotiation of, a grant or contract).

The Pilot Program is scheduled to end in 2017.[9]

Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed into law the Deficit Reduction Act of 2005 ("DRA"), which contains three provisions of significance to a health center's compliance program. Two of the provisions strengthen government enforcement of healthcare laws by (1) rewarding states for passing state versions of the Federal False Claims Act by providing states with an additional percentage of any amount recovered under such laws[10]; and by (2) providing additional funding and staffing to establish the Centers for Medicare and Medicaid Services ("CMS") Medicaid Integrity Program.[11]

Most important to health centers, the third provision requires certain entities that receive more than $5 million in Medicaid payments (on an annual federal fiscal year basis—October to September) to take specific actions to prevent fraud, waste, and abuse. Failure to comply with this requirement may put all Medicaid payments for the health center at risk.

7 31 U.S.C. § 3730(h).
8 41 USC § 4712.
9 For more information on the Pilot Program, including a sample policy and procedure and sample language for contract/subgrant clauses, see Developing open lines of communication: Introductory guidance.
10 Section 6031 of the Deficit Reduction Act.
11 Section 6034 of the Deficit Reduction Act.

The $5 million threshold is calculated for each organizational unit that furnishes Medicaid health care items or services, and includes all sub-units of that organizational unit that furnish Medicaid health care items or services, even if the components are separately incorporated or located in different States.

> If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the [DRA requirements] apply if the aggregate payments to that entity meet the $5 million annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.[12]

In the context of health centers, this generally means that all health center sites would be included as part of the organizational unit that constitutes the "entity." Entities meeting the $5 million threshold must:

1. Establish written procedures and policies to protect against fraud, waste, and abuse;
2. Inform all health center employees, agents, and contractors of these policies and procedures;
3. Provide detailed information on state and federal laws regarding false claims (specifically, the Federal False Claims Act, state laws regarding false claims, and federal and state laws that protect whistleblowers); and
4. Include this information in an employee handbook, if one exists.[13]

Program Fraud Civil Remedies Act

The Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812, is a set of federal statutes which provide additional penalties separate from the Federal False Claims Act for improper claims and improper statements. A person violates the Program Fraud Civil Remedies Act if they know or have reason to know they are submitting a claim that:

- Is false, fictitious or fraudulent;
- Includes or is supported by written statements that are false, fictitious, or fraudulent;
- Includes or is supported by a written statement that omits a material fact; the statement is false, fictitious or fraudulent as a results of the omission; and the person submitting the statement has a duty to include the omitted facts; or
- Is for payment for property or services not provided as claimed.

A violation of this provision of the Program Fraud Civil Remedies Act carries a penalty of $5,500 for each such improper claim. In addition, an assessment of two times the amount of the

[12] CMS State Medicaid Director Letter #06-024 (Dec 13, 2006); see also CMS State Medicaid Director Letter #07-003 (Mar 22, 2007) at FAQ 5, 6.

[13] Section 6032 of the Deficit Reduction Act.

claim may be made, unless the claim has not actually been paid.[14] A person also violates the Program Fraud Civil Remedies Act if they submit a written statement which they know or should know:

- Asserts a material fact which is false, fictitious, or fraudulent; or,
- Omits a material fact and is false, fictitious or fraudulent as a result of the omission. In this situation, there must be a duty to include the fact and the statement submitted contains a certification of the accuracy or truthfulness of the statement.

A violation of the provision for submitting an improper statement carries a civil penalty of up to $5,500.[15]

Civil Monetary Penalties

The Civil Monetary Penalties ("CMP") Law[16] enables the Department of Health and Human Services ("DHHS") to assess administrative remedies for false and fraudulent conduct related to federal health care programs or beneficiaries of the programs. Examples of such conduct include submission of a claim for services that the person knows or should know is for an item or service that was not provided as claimed or is false or fraudulent, or submission of a claim for services by someone who had been excluded from a federal health care program. Although the amount of and nature of the penalty depends on the type of the violation, the OIG can impose up to $50,000 for fraudulent claims and three times the amount improperly claimed. The OIG also can seek to have the provider excluded from participation in the Medicaid or Medicare program.

Beneficiary Inducements

Section (a)(5) of the CMP statute (commonly known as the "beneficiary inducement prohibition") prohibits the offering or transferring of remuneration and/or inducements to beneficiaries of Medicare, Medicaid and other state health care programs receiving federal funds from Maternal and Child Health programs, Social Services programs, or State Children's Health Insurance Program, which are likely to influence the beneficiaries to choose goods or services from a particular supplier or provider, paid for in whole or in part by such programs. [17]
The statute defines "remuneration" broadly to include, without limitation, waivers or reductions of coinsurance and deductible amounts and transfers of items or services for free or for any

[14] 31 U.S.C. § 3802(a); see also 64 Fed. Reg. 47099, 47104, (Aug 30, 1999).
[15] 31 U.S.C. § 3802(b); see also 64 Fed. Reg. 47099, 47104, (Aug 30, 1999).
[16] 42 U.S.C. § 1320a-7a.
[17] The scope of the beneficiary inducement prohibition is narrower than that of Federal Anti-Kickback Statute. The Anti-Kickback Statute prohibits the knowing or willful offering, paying, soliciting or receiving of remuneration in exchange for referrals or business paid for, in whole or in part, by any "Federal health care program" (including Section 330). For more information regarding the Anti- Kickback Statute, see Fraud and abuse considerations for contracting in the health care industry: Introductory guidance. Under current federal statute, regulation, and guidance, the restrictions on providing beneficiary inducements do not apply to uninsured or commercially-insured individuals.

amount less than fair market value. The statute also includes a few limited exceptions to the prohibition, including any remuneration permitted under a safe harbor to the Anti-Kickback Statute.[18]

The Affordable Care Act also added four new exceptions that will broaden health center's abilities to provide items and services to beneficiaries for free or at reduced cost. Certain of these new exceptions are broadly worded. Under the new exceptions, the following are not prohibited forms of remuneration:

- Remuneration that promotes access to care and poses a low risk of harm to patients and federal health care programs;
- Offer or transfer of items or services for free or less than fair market value by a person if items or services consist of coupons, rebates, or other rewards from a retailer; items or services are offered or transferred equally to the general public, regardless of health insurance status; and offer or transfer not tied to the provision of other items or services reimbursed under Medicare or Medicaid;
- Offer or transfer of items or services for free or less than fair market value by a person if 1) items or services are not offered as part of any advertisement or solicitation; 2) items or services are not tied to the provision of other services reimbursed under Medicare or Medicaid; 3) there is existence of a reasonable connection between the items and the medical care of the individual; and 4) the health center makes a good faith determination that the recipient was in financial need; and
- Waiver by a prescription drug plan sponsor of a prescription drug plan under Medicare part D or an MA organization offering an MA-PD plan under Medicare part C of any copayment for the first fill of a covered part D generic drug for individuals covered by the prescription drug plan.[19]

In October 2014 the OIG issued a notice of proposed rulemaking that would amend the civil monetary penalty rules pertaining to beneficiary inducement and gainsharing. No final regulations have been published clarifying DHHS' interpretation of these exceptions.

A violation of the beneficiary inducement prohibition can subject a health center to civil monetary penalties of up to $10,000 for improper inducements and three times the amount improperly claimed for services rendered as a result of such improper inducements. The OIG also can seek to have the provider excluded from participation in the Medicaid or Medicare program.

The amounts charged by health centers for health care services rendered are generally regulated by Section 330. However, health centers need to be mindful that providing gifts and incentives to patients who are beneficiaries of Federal health care programs, such as Medicare and Medicaid,

[18] 42 U.S.C. § 1320a–7a(i)(6).
[19] Id.

has been an area of increasing awareness and activity by federal regulators such as the DHHS, Office of the Inspector General ("OIG"). How one reconciles Section 330 and related requirements with the beneficiary inducement prohibition is a significant compliance risk.

Gifts and Inducements to Patients

In August 2002, the OIG issued a Special Advisory Bulletin addressing the scope of acceptable practices with respect to the offering of gifts or other inducements to Medicare and Medicaid beneficiaries.[20] The Special Advisory Bulletin states that the following gifts may be offered to beneficiaries without exposing the provider/supplier to prosecution under the beneficiary inducement prohibition:

- Inexpensive ("de-minimis") gifts or services (other than cash or cash equivalents) that have a retail value of no more than $10 individually, and no more than $50 in the aggregate, annually, per patient;
- More expensive items or services that fit within certain statutory exceptions codified at 42 C.F.R. § 1003.101:
  - Non-routine, unadvertised waivers of cost-sharing amounts based on individualized determinations of financial need or exhaustion of reasonable collection efforts;
  - Properly disclosed differentials in a health plan's copayments or deductibles;
  - Incentives to promote the delivery of preventive care, defined as items or services (other than cash or cash equivalents) that are covered by Medicare or
  - Medicaid and are either pre-natal / post-natal well-baby services or services described in the Guide to Clinical Preventive Services;
  - Any practice permitted under the Anti-Kickback Statute; of particular relevance here, the waiver by health centers of coinsurance and deductible amounts for patients who qualify for the center's sliding fee scale (i.e., uninsured or underinsured individuals or families with annual incomes at or below 200% of the Federal Poverty Guidelines);
  - Waivers of copayment amounts that exceed the minimum copayment amount under the Medicare hospital outpatient fee schedule.

Practices that do not fit within one of the defined exceptions may be acceptable if the party secures a favorable advisory opinion from the OIG regarding the particular transaction. Receipt of a favorable advisory opinion allows the health center to insulate itself from liability related to that specific arrangement. Advisory opinions, however, are limited only to the particular requesting parties and bind only the OIG (and not other governmental agencies) and only with regard to the specific circumstances considered in the advisory opinion. That said, even though advisory opinions cannot serve as precedent for similar transactions by other parties, they can

[20] *Publication of OIG Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries* (Aug 30, 2002), 67 Fed. Reg 55856.

provide valuable insight into the OIG's expectations and enforcement priorities regarding such arrangements.

Gift Cards

The OIG has issued a couple of favorable advisory opinions for arrangements under which patients were awarded gift cards as a means of resolving service complaints or for rewarding compliance with treatment plans.[21] The facts and circumstances of each arrangement differed. However, the OIG findings included a few common criteria, which may be instructive for health centers unable to satisfy one of the defined exceptions:

- Each arrangement included safeguards to ensure that the gift cards could not be redeemed for cash or used to purchase items paid for by Medicaid, Medicare and/or other Federal health care programs (whether from the provider or from another health care-related provider / entity).
- The gift cards were not advertised, marketed or used for promotional purposes—rather, they were distributed to promote good health (one opinion included motivational incentives to comply with clinically appropriate treatment plans).

Federal Criminal Health Care Fraud Statute

The Federal Criminal Health Care Fraud Statute prohibits the knowing and willful execution, or attempts to execute, a scheme or artifice—

1. To defraud any health care benefit program; or
2. To obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services.[22]

This prohibition applies to all health care benefit programs, including public and private third party payors. Penalties for violation of the Federal Criminal Health Care Fraud Statute include a fine or imprisonment for not more than ten years, or both. If the violation results in serious bodily injury, the prison sentence may increase up to twenty years and/or a fine. If the violation results in death, the guilty party shall be fined and/or imprisoned for any term of years or for life.[23]

In addition to the Federal Criminal Health Care Fraud Statute protection of commercial third party payors, many such payors often have fraud departments that review claims to identify

[21] The most recent OIG Advisory Opinion No. 12-21 (issued Dec 27, 2012) is available at: https://oig.hhs.gov/fraud/docs/advisoryopinions/2012/AdvOpn12-21.pdf.
[22] 18 U.S.C. § 1347.
[23] Id.

improper billing and coding procedures. Commercial third party payors that identify improper billing and coding may bring civil legal action against the provider and may withhold future payments in order to recoup what they deem to be overpayments resulting from the identified improper coding, billing, and documentation.

Coding, Documentation, and Billing

Like any health care provider, health centers rely upon appropriate and timely submission of claims to third party payors to ensure steady cash flow. Since most health centers serve patients with a variety of types of insurance—Medicaid Fee for Service, Medicaid Managed Care, Medicare, commercial carriers, etc.—as well as "self-pay" patients without insurance, it is incumbent upon the organization to have comprehensive systems in place to be able to bill and collect from all of these payors.

A cornerstone of health center service delivery and business practice is coding and documentation of services provided. Ensuring accurate and proper coding is essential for many facets of a health center's business, including appropriate and timely claims submission, quality improvement and other initiatives that may rest upon data documented in the patient's chart, and, most importantly, patient care, which also requires accurate medical record documentation.
This section addresses principles of coding, documentation, and billing that apply to all payors, as well as specific billing issues related to Medicare. Health centers should consult with qualified legal counsel regarding the specific billing requirements of their state's Medicaid program and of other payors.

<u>Documentation Guidelines</u>

Accurate documentation, coding, and billing are the three major components of the claim submission process. In order to submit claims to the Medicare and Medicaid programs, each of the aforementioned must be done in accordance with regulations issued by CMS. These regulations specifically outline documentation requirements of a medical record. Guidance is also issued by CMS and its contractors on coding and billing issues.

The following principles guide proper documentation of medical records:

- Medical records should be clear, comprehensive, and legible.
- The following information should be included on every encounter form / medical record where applicable:
  - Date;
  - Reason for encounter;
  - Appropriate history and physical examination;
  - Review of lab, x-ray data, and other ancillary services;
  - Assessment, and plan for care;
  - Past and present diagnoses;

  - Reasons for and results of ancillary services;
  - Relevant health risk factors.
- Patient progress should include response to and change in treatment, change in diagnosis, and patient non-compliance.
- A written plan for care should include treatments and medications, specifying frequency and dosage, referrals and consultations, patient / family education, and instructions for follow-up.
- Documentation should coincide with level of patient evaluation and/or treatment, including complexity of medical decision making.
- Entries on the record should be dated and signed.
- Medical record documentation should support CPT/ICD Codes.

Advice and Recommendations[24]

Deficit Reduction Act of 2005

Health centers should determine whether, as an organizational unit, they receive $5 million in Medicaid payments during a federal fiscal year in order to establish whether they must comply with the DRA's Section 6032 requirements regarding written policies and procedures.

The Authors believe that, regardless of whether a health center meets the $5 million threshold, the health center should establish, disseminate, and maintain policies and procedures to protect against fraud, waste, and abuse as part of an effective Compliance Program. Such policies and procedures should provide health center Board and staff members with information about their rights and should direct them with regard to appropriate communications and reporting of potential concerns.

- Standards of conduct and compliance program: Sample policy and procedure

Such policies and procedures can help to reduce a health center's risk of liability under false claims and other fraud and abuse laws by helping the health center's senior management to learn about and appropriately respond to potential compliance concerns in a timely manner.

Civil Monetary Penalties

With regard to the beneficiary inducement prohibition, because health center patients (including children) often fluctuate between being uninsured and being insured by federal health care programs, particularly Medicaid / CHIP, and because consistently applying a single policy and procedure to all patients is less administratively burdensome (and less complicated, and therefore

[24] The Authors of these materials include attorneys at the law firm of Feldesman Tucker Leifer Fidell LLP. The advice and recommendations consist of general guidance based on federal law and regulations and do not necessarily apply to all health centers under all facts and circumstances. Further, these materials do not replace, and are not a substitute for, legal advice from qualified legal counsel

less likely to result in non-compliance), the Authors advise health centers to develop a patient incentive policy that applies uniformly to all health center patients, regardless of payor source.

To ensure compliance with the beneficiary inducement prohibition, each health center that provides gifts to patients (actual or potential) should satisfy either the inexpensive (de- minimis) gift definition—i.e., the gift should have a maximum retail value of $10 individually and no more than $50 in the aggregate annually per patient—or one of the statutory exceptions discussed above.

To minimize exposure from an arrangement that falls short of an exception, health centers should, at a minimum, satisfy the following guidelines:

- For gift cards, the health center should:
  - Not allow the gift cards to be redeemed for cash or for services or items provided by the health center;
  - Provide gift cards only for stores or vendors that are not operated by other health care providers, and/or that do not contain health care good and services (or limit redemption to non-health care items); and,
  - The health center should not provide gifts (other than de-minimis gifts) to market or promote the health center organization.
- The health center should provide gifts that are used in conjunction with medically necessary and appropriate treatment plans or clinical programs as a means to reward compliance and good health outcomes (i.e., as motivational incentives).
- The gifts should be related to the treatment received and should not be disproportionate in value (e.g., providing diapers for following a pre-natal care regimen could be acceptable; providing a flat screen television for the same care would not be acceptable).
- If possible, the gifts should be a component of a recognized plan or program, such as a requirement of a federal or state grant-funded program (e.g., emergency food assistance program that is funded under Ryan White Part A).

Coding, Documentation, and Billing

The area of coding, documentation, and billing is a principal focus of government auditors and a challenging area for many health centers. Establishing a Compliance Program, as described by OIG Compliance Program Guidance documents and this Toolkit is a good step toward avoiding fraud and abuse. All individuals acting on behalf of the health center, particularly those involved in coding and claims submission, should be aware of what constitutes fraud and abuse, should be trained on accurate coding and billing practices, should understand the consequences of violating the Compliance Program, and should recognize the critical role each of them plays in ensuring compliance.

It also is critical that health centers ensure that periodic audits of high-risk areas are conducted and that findings are addressed. The Compliance Guideline documents allow for flexibility in designing an auditing program that is appropriate to the size and resources of the organization. Nonetheless, health centers that do not believe they have the internal resources or expertise to conduct coding, documentation, and billing audits are encouraged to identify outside resources that can provide this assistance.

- Ensuring proper and accurate coding and documentation: Sample policy and procedure
- Ensuring proper billing: Sample policy and procedure