

Compliance Guidance for Physicians: Blustering About Clustering

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Introduction

After exploring the extremities of healthcare compliance in its previous eight statements of voluntary compliance program guidance (see [Sidebar A](#)), the Office of Inspector General (OIG) finally reached the heart of the matter by focusing on physicians in its Compliance Program Guidance for Individual and Small Group Physician Practices (Physician Guidance), released on September 25, 2000 <http://www.dhhs.gov/progorg/oig/modcomp/webcpg.txt>. The Physician Guidance identifies a new risk area associated with physician billing called "clustering," and invites physicians to fall into a compliance trap. This article will explain how physicians can guard against clustering and avoid the compliance trap.

Physician Specific Risk Areas

Like prior statements of compliance guidance, Physician Guidance lists specific risk areas that the compliance program should address:

- coding and billing;
- reasonable and necessary services;
- documentation; and
- improper inducements, kickbacks and self-referrals.

Within the broader category of coding and billing, Physician Guidance highlights the most frequent subjects of investigations and audits by the OIG:

- **billing for items or services not rendered or not provided as claimed;**
- **submitting claims for equipment, medical supplies and services that are not reasonable and necessary;**
- **double billing resulting in duplicate payment;**
- **billing for non-covered services as if covered;**
- **knowing misuse of provider identification numbers, which results in improper billing;**
- **unbundling (billing for each component of the service instead of billing or using an all-inclusive code);**
- **failure to properly use coding modifiers;**
- **upcoding the level of service provided; and**
- **clustering.**

The OIG had discussed all of these specific risk areas in prior compliance guidance or fraud alerts with the exception of the practice of clustering. Clustering did not even appear in the draft Physician Guidance released in June 2000, just three months before the issuance of the final Physician Guidance.

What is Clustering?

Physician Guidance defines clustering as "the practice of coding/charging one or two middle levels of service codes exclusively, under the philosophy that some will be higher, some lower, and the charges will average out over an extended period (in reality, this overcharges some patients while undercharging others)."

This actual practice stems from the complex documentation and coding burdens on physicians in order to receive federal reimbursement for their services. Physicians must comply with either the 1995 or 1997 version of HCFA's Documentation Guidelines for Evaluation and Management Services (E&M Guidelines). HCFA announced a new set of draft E&M Guidelines in June 2000 which are not in current use. The E&M Guidelines require detailed documentation on each patient's history, physical exams and medical decision-making to support five different levels of physician service. HCFA recognizes that it is not unusual for well-intentioned physicians to code as much as two levels apart for identical services because of varying interpretations of histories, physicals, and medical decision-making. Another factor contributing to clustering is physicians' fear resulting from the government's crackdown on alleged fraud and abuse. Some physicians believe that if they conservatively bill for level 2 E&M services across the board then they will avoid government scrutiny, even though they actually provide higher levels of service for many patients.

No Credit for Under-Billing

Physician Guidance announces that the OIG has targeted these well-intentioned physicians for the practice of clustering. The Social Security Act prohibits the "practice of presenting or causing to be presented a claim for an item or service that is based on a code that such person knows or should know will result in a *greater payment* to the claimant than the code such person knows or should know is applicable to the item or service actually provided." The statute only covers claims in which the provider received greater payment, and the provider receives no credit for claims in which the provider received lesser payment than was due.

Physicians may be tempted to code conservatively to avoid attention in the current environment of **heightened concern over**

coding issues. Nevertheless, a physician may violate the statute if he/she has a few instances (a practice) of receiving greater payments than actually applicable to the services provided even if there are hundreds or thousands of instances in which the physician received lesser payments than actually applicable to the services provided. For example, a physician billing level 2 E&M services across the board is violating the statute for all claims that really should be charged as level 1 E&M services, but the physician receives no credit for all claims that really should be charged as levels 3, 4 or 5 E&M services. The statute is entirely one-sided in favor of the government.

Suggested Order of Compliance Steps

Physician Guidance reiterates the now familiar seven elements of a healthcare compliance program, but with a new wrinkle. The OIG now suggests a particular order to follow in developing a physician compliance program. See [Sidebar B](#).

Physician Guidance suggests that physicians first perform the compliance step of auditing and monitoring both practice standards and claims submission. Specifically, the OIG recommends that physicians use a baseline, or "snapshot," to enable a practice to judge over time its progress in reducing or eliminating potential areas of vulnerability. After the internal audit identifies the practice's risk areas, the next step is to develop a method for dealing with those risk areas through the practice's standards and procedures. After the audits have been completed and the risk areas identified, ideally one member of the physician practice staff needs to accept the responsibility for developing a corrective action plan, if necessary, and overseeing the practice's adherence to that plan.

The Compliance Trap

Education is the next logical step, according to the OIG, after the problems have been identified and the practice has designated a person to oversee educational training. The OIG's advice that physicians perform a baseline audit before they receive education about the special compliance risks of clustering sets a trap, especially for those well-intentioned physicians that have been billing level 2 E&M services across the board to avoid government scrutiny. The OIG offers no amnesty for voluntarily reporting violations that might be discovered in the process of taking the snapshot and expects restitution for any noncompliant claims discovered in the audit. For example, a snapshot of the physician billing level 2 E&M services across the board would likely disclose some claims that should have been billed as only level 1 E&M services, and the physician would be expected to make restitution for those claims.

The government can also extrapolate the discovered violations over the entire six year limitations period and recover the extrapolated amount, plus up to triple the extrapolated amount, plus up to \$11,000 per claim (current sanction under the False Claims Act, as increased for inflation effective September 29, 1999). In fact, federal regulations declare that, absent extraordinary mitigating circumstances, the aggregate penalty should never be less than double the amount of the claim. Thus, the process of taking the snapshot before physicians receive education about clustering puts physicians at extreme risk for restitution plus exorbitant sanctions, particularly for innocent violations that might be prevented on a going-forward basis by an effective compliance program.

The Difference Between "Erroneous" and "Fraudulent"

Providers have complained that the government has been over-zealously enforcing fraud and abuse laws in a manner that punishes honest billing mistakes. As a result of this criticism, the OIG has been emphasizing the legal differences between innocent "erroneous" claims on the one hand and "fraudulent" (intentionally or recklessly false) claims on the other. Physician Guidance recognizes that the applicable enforcement tools cover only offenses that are committed with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim. The statutes do not cover mistakes, errors, misunderstanding of the rules or even negligence. As applied to the widespread and innocent practice of clustering, physicians may conclude that clustering is only an honest misunderstanding of the rules or at worst negligence, but the practice does not constitute the fraudulent or recklessly false conduct prohibited by the law.

How to Avoid the Trap

From the physician standpoint, it is far too dangerous to take a snapshot that might result in restitution plus sanctions up to triple an extrapolated amount over six years plus \$11,000 per claim. The benchmark is already clear without an historical snapshot: zero instances of fraud and abuse. The physician should act on a prospective, not retrospective basis. The physician should first educate all employees, contractors and agents to understand

their compliance obligations and the applicable legal and ethical requirements, particularly documentation of E&M services and the practice of clustering; and only then begin using auditing and other monitoring techniques to assess compliance with the fairly articulated standards.

Physician Guidance even supports the advice about making education the first step: "The OIG recommends that claims/services that were submitted and paid during the initial three months *after* implementation of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness."

Delivery of Physician Compliance Training

Physicians are trained to provide clinical care, not documentation. Nevertheless, the current reimbursement scheme for healthcare requires that physicians become aware of and comply with complex documentation requirements or else risk severe sanctions. Most physician practices do not employ a professional coder, and the physician is often primarily responsible for all coding and billing. How can individual physicians obtain the required compliance training in an economical manner?

The OIG encourages physician practices to participate in other providers' compliance programs, such as the compliance programs of the hospitals or other settings in which the physicians practice. Physicians and their practice employees may attend training programs offered by hospitals, third party billing companies, local medical societies and insurance carriers. Collaborative training provides a means to promote the desired compliance objective without imposing excessive burdens on the physician practice or requiring physicians to undertake duplicative action. This sort of collaborative effort is an excellent way for the physician practice to meet the desired training objective without having to expend the resources to develop and implement the in-house training.

Anti-Kickback and Self-Referral Concerns

If a hospital provides compliance education without charge to physicians, a 1992 OIG Special Fraud Alert suggests that such training may be considered an illegal remuneration under the Federal Anti-Kickback Statute if the intent to induce referrals is present. In addition, the suggestion that free compliance training is remuneration may also implicate the Federal Physician Self-Referral Statute (a/k/a Stark), for which lack of intent is no defense. Physician Guidance specifically confirms that the OIG encourages collaborative compliance training and will not consider free compliance training to be remuneration implicating either Anti-Kickback or Stark. However, to prevent possible Anti-Kickback or Stark issues, the OIG recommends that physicians consider limiting their participation in a sponsoring provider's compliance program to the area of training and education or policies and procedures.

Conclusion

Physicians should first receive education and training about documentation of E&M services and the practice of clustering before undertaking the other compliance steps suggested in Physician Guidance. Collaborative compliance efforts with hospitals and other providers enable physicians to economically obtain such training. The OIG will not consider free compliance training to be remuneration implicating either the Federal Anti-Kickback or Self-Referral Statutes.

BIOGRAPHY

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NOTE: This site includes a summary of certain compliance issues facing healthcare providers today. This site does

not, and is not intended to, give legal advice. Reference should be made to full text of the statutes and regulations for complete analysis. Consultation with competent counsel is strongly recommended.