Errors in compliance with federal rules and regulations relating to healthcare benefits programs: the University of Washington Department of Neurological Surgery experience

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This article details the errors in compliance with federal rules and regulations relating to the healthcare benefits programs at the University of Washington Department of Neurological Surgery from 1996 through 2002. University faculty members, regardless of the organization to which they belong, will be identified by the federal government as the individual responsible in healthcare finance inquiries. A full understanding of all regulations and an active compliance program are necessary to avoid problems, including criminal prosecution.

KEY WORDS • compliance program • professional liability • faculty practice plan

On October 28, 2002, after a 3-year intensive federal investigation, I pleaded guilty to one count of obstructing "the communication of information to a criminal investigator," as outlined in the transcripts of the court proceedings.9 The US Attorney’s Office (and subsequently the federal judge) agreed that "the evidence gathered during the investigation is subject to a reasonable and good faith interpretation that although claims for professional services were submitted by the University of Washington Physicians (UWP) in conjunction with professional services provided by the Department of Neurological Surgery, these claims were not intended by the Defendant to be fraudulent and were instead the product of mistake and confusion as to the meaning and application of the rules and regulations that controlled the submission of claims to the Medicare, Medicaid, and TRICARE programs."

This federal investigation, which began as a whistleblower lawsuit, is still in progress and continues to be focused on other aspects of the UW School of Medicine, the UWP, and other faculty members in other departments. (Subsequent to the submission of this article, as reported in The Seattle Times [March 27, 2003], the head of the Nephrology Section of the Department of Medicine at UW pleaded guilty to a single felony count of mail fraud in submitting a $124 bill for a dialysis treatment at which he was not present. The plea agreement also called for $100,000 restitution for overbilling. The UW, rather than the individual physician, agreed to pay the entire amount because, the prosecutors noted, a significant portion of the funds derived from overbillings had benefited the UWP.) As part of the plea agreement, I agreed and was subsequently ordered by the court "to publicize through a professional medical journal a declaration regarding the errors in compliance with federal rules and regulations relating to health care benefits programs at the UW Department of Neurological Surgery." This article is in response to that agreement. To enable the reader to understand the context of the investigation, I will provide background information before reviewing issues of compliance.

Background Information

General Background

The federal government and the individual states now expend billions of dollars each year to pay for healthcare through a variety of programs such as Medicare, TRICARE (military health system sponsored care), and Medicaid. Until recently, auditing of these expenditures to AMCs and university faculty members was conducted as a routine accounting procedure, with overcharges and payments being subject to negotiated resolution between the payer and the payee. In the early 1990s, however, the federal government instituted PATH audits, which were a more aggressive approach to evaluating healthcare expenditures to AMCs. To date, more than thirty AMCs have been investigated, with civil (that is, noncriminal) resolutions in all cases. Settlement amounts have reached as high as $30 million per institution.

In addition to PATH audits, the federal government has used the legal principle of qui tam. Qui tam is part of the federal False Claims Act, originally enacted in 1863, which allows any person (that is, the whistleblower) to bring a lawsuit on behalf of the federal government against anyone...
who uses government funds in a fraudulent manner. Qui tam also allows the whistle-blower to receive a portion of the recovered funds resulting from a successful lawsuit. Several AMCs have been involved in qui tam cases with settlements of as much as $17 million.

The Federal Investigation

As stated in the plea agreement:

Beginning in approximately the summer of 1999 and continuing through the date of July 2002, law enforcement officers conducted an extensive criminal investigation relating to certain claims for professional services of UW School of Medicine faculty physicians submitted to health care benefit programs including the Medicare program. The investigation was aimed, in part, at ascertaining whether any of the UW School of Medicine faculty physicians had violated any federal criminal laws, including federal health care offenses.

Beginning in January 2000, a federal grand jury investigation of the same subject matter commenced. Additionally, the US Department of Justice and the US Department of Health and Human Services began a related civil investigation. In succeeding months, numerous administrative and grand jury subpoenas were served in furtherance of the criminal investigation and the parallel civil investigation. Some of these subpoenas were served on the University of Washington and called for the production of documents relating to claims for professional services rendered by UW faculty physicians. The subpoenaed documents included records that might tend to establish or disprove the presence of physicians during surgical procedures for which claims had been submitted and records that might relate to the eligibility of resident physicians practicing at the University of Washington to submit claims for professional services. Additional subpoenas were served to compel the appearance of witnesses, including a number of attending physicians and resident physicians practicing at the University of Washington, to testify before the grand jury.5

Administrative Structure and Governance of the UWP

Beginning in the early 1970s throughout the US, many medical schools centralized the management of clinical entities, bringing departmental clinical activity under the purview of the dean’s office. With time, such centralized faculty plans provided US medical schools with significant additional financial resources in an era of diminishing state and federal support.2 Because such arrangements usually involved a tax on clinical revenues (that is, a dean’s tax), these faculty practice plans had the additional benefit of allowing deans of schools of medicine to shift resources from one department to another, to create new programs, to expand existing programs, and to increase salaries of faculty. At public institutions, faculty practice plans allowed medical school administrators to have more discretion over the expenditures of these revenues, and, in some cases, to avoid the usual mechanisms of review by the state.

The faculty practice plan at UW was begun in the early 1960s. In the early 1980s, however, the UWP was incorporated as a 501-C3, that is, a nonprofit entity. Prior to this incorporation, each clinical department had managed its clinically generated revenues through a partnership arrangement that operated within the context of the UW School of Medicine. Currently, the UWP is a unified practice plan that encompasses all UW clinical faculty, including physicians and other healthcare providers (that is, nurse practitioners and psychologists) practicing at the UWMC, the HMC, and the Fred Hutchinson Cancer Research Center. Pediatric physicians have a separate practice group called the Childrens University Medical Group. The Office of the Dean of the School of Medicine is consolidated with the Office of the Vice President for Medical Affairs. The UWP governance structure consists of officers appointed by the dean/vice president and a board of directors, mainly consisting of the clinical department chairs. There are no outside (non–School of Medicine) members on the board. Decisions of the board are advisory to the dean/vice president. The chief administrative officer of the UWP (who was granted immunity during the federal investigation, as reported in The Seattle Times on June 14, 2002) is responsible for the day-to-day management of the UWP and for overseeing a staff of approximately 200 employees (many of whom were also reported to have been granted immunity).

Departmental administrators were focused on the academic (that is, grant budgets) and human resource issues and, by design, were not responsible for the day-to-day oversight of departmental UWP activities. Thus, a wall existed between the administrative elements of the UWP and the departments (“administrative wall”). During the most recent fiscal years, the total clinically derived revenues for the UWP have been in excess of $120 million per year, with the Department of Neurological Surgery contributing approximately 6%. (As outlined in the plea agreement,6 “the defendant shall pay or cause to be paid” to Medicare, Medicaid, or TRICARE programs the sum of $500,000 as a result of the submission by the UWP of incorrect claims for professional services provided by the defendant and by other attending physicians in the Department of Neurological Surgery. Thus, this $500,000 was a global, department repayment and secured the release from further prosecution by governmental agencies [federal and state] for both criminal and civil charges. To put this $500,000 in perspective, between 1996 and 2002 [the government subpoenaed records from this time period], the Department of Neurological Surgery billed approximately $90 million and received revenues of approximately $40 million. Thus, the $500,000 repayment represented 0.5% and 1.3% of the billings and revenues, respectively. This percentage is below the threshold for investigation according to most auditing standards.) During the period of the federal investigation (between 1996 and 2002), the dean’s tax was 11% of the total revenues per year and there was no requirement for reporting expenditures of these funds to the UWP Board.

House staff funding at all UW-associated hospitals was brought into the purview of the School of Medicine and was assigned to the direction of the dean for clinical affairs. Funds to support residents’ salaries were mainly derived from Part A of Medicare, although the School of Medicine, the hospitals, and the departments provided additional support. The use of funds from Part A of Medicare precluded billing under Part B, the latter being the usual source of revenues for fees generated by physicians caring for Medicare-funded patients.

Prior to the onset of the federal investigation, the compliance program of the UWP included “a corporate policy regarding professional fee billing, communication of that policy to its employees and insuring [sic] that billing is conducted in compliance with policy.”10 There were no (or limited) faculty educational compliance programs and no
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mandatory training sessions for existing or new faculty or other employees.

In late 1996 an expanded compliance program was initiated, with the responsibility for the plan being assigned to the executive director of the UWP. Under this revised plan, each department assigned a UWP faculty member to serve as a compliance officer (as of December 2002, this plan had not been fully implemented). Each faculty member was sent a copy of the “Members Guide and Corporate Policies.” The 1996 compliance plan placed significant responsibility on individual faculty members despite the following acknowledgment in its opening paragraph: “Compliance in this area is challenging, however, because the regulatory requirements governing such reimbursements are complex and changing.” Department chairs and service chiefs did not receive formal compliance training; neither were they assigned responsibility for compliance oversight.

In 2000 after initiation of the federal investigation of the UWP, additional components were added to the UWP compliance program with the appointment of a director of regulatory compliance (a position that required a juris doctor) and the initiation of educational training sessions for UWP staff and faculty. The latter involved mandatory yearly review of UWP billing compliance policies. Department chairs and service chiefs were required to attend educational programs. In addition, all UWP members were given a statement on UWP billing policies and were required to sign a statement of acknowledgment. Similar requirements were made of all incoming, new UWP members.

**Compliance Concerns in the Department of Neurological Surgery Investigated by the US Attorney’s Office From 1999 Through 2002**

The US Attorney’s Office and the FBI investigated five areas in the UW Department of Neurological Surgery: 1) eligibility of CRs in neurosurgery to submit claims for professional services; 2) retrospective documentation by CRs; 3) radionurology; 4) bedside procedures; and 5) operating room presence. Outlined hereafter are these five areas and related compliance concerns. The factual information outlined as follows was gathered and assembled from the public record and by my counsel and others in response to the federal investigation.

**Eligibility of Neurosurgery Resident Physicians to Submit Claims for Professional Services**

**Residency Requirements.**

The ABNS Requirements. Prior to 1974, the ABNS required a minimum of 48 months for completion of a residency. (For purposes of discussion in this article, residency durations follow 12 months of fundamental clinical training or internship.) After 1974 the minimum duration of a residency was increased to 60 months, with a requirement that the resident spend at least 36 months in core clinical neurosurgery training at the parent institution.

Residency at UW Before 1983. Prior to 1983, residents were rotated through three hospitals: University Hospital (subsequently renamed UWMC), HMC, and The Puget Sound Veteran’s Administration Medical Center. After 1974 and prior to 1983, the length of the residency was a minimum of 60 months. In 1981/1982 the Department of Neurological Surgery performed a combined total of 550 operative cases, with some faculty members conducting as few as 35 cases per year. The number of students accepted to the residency program had been reduced from two residents to one resident per year by the Residency Review Committee for Neurological Surgery, and according to reports I received in 1982, the program was threatened with probation status.

Residency at UW After 1983. The residency program at UW was lengthened to a total of 84 months to allow for an additional 12 months of laboratory training and a 12-month rotation in clinical neurosurgery at Atkinson Morley’s Hospital in Wimbledon, UK. This latter rotation in the UK would loom large in the subsequent concerns of the government. The Children’s Hospital Regional Medical Center in Seattle was also added to the rotation.

The residency rotations after 1983 consisted of 12 months as a junior resident at UWMC and HMC; 6 months of combined neurology (subsequently moved into the internship year), neuropathology, and neuroradiology; 12 months as CR at The Puget Sound Veteran’s Administration Medical Center and Children’s Hospital Regional Medical Center in the UK; and 30 months in laboratory research; yielding 72 months of residency training. The last 12 months were then spent as CR at UWMC and HMC. Thus, prior to becoming a chief resident at UWMC and HMC, the usual trainee had completed more than 60 months of residency training.

**Appointment of Residents to the Faculty.** Beginning in the 1960s, my predecessors (one of whom had been chairman of the ABNS) routinely promoted the CRs to faculty status as As. In doing so, the CRs/AIIs were able to submit fees for professional services under Medicare Part B. In some cases, this appointment occurred prior to the fulfillment of the minimum ABNS residency requirements. The process of appointment to the faculty involved gathering at least three letters of support from existing faculty and submitting the appointment package to the dean’s office for review and approval. In some cases, despite their billing status under Part B, the CRs/AIs continued to be erroneously included in the university’s cost report (Medicare Part A).

After my arrival in 1983, the process for the appointment of a CR/AI to faculty status remained the same. As noted earlier, however, the residency was extended to 84 months. On my arrival, I received no formal orientation or training from either the medical school or the UWP concerning Medicare/Medicaid regulations. Thus, I sought advice and direction from the associate dean for clinical affairs and, with time, his successors. My priorities were primarily focused on building the department by recruiting new faculty and being an operating neurosurgeon, a National Institutes of Health–funded investigator, and a residency program director. Unfortunately, at the time of my appointment, I did not make myself familiar with the residency guidelines of the ABNS.

The associate dean for clinical affairs determined that the threshold for billing eligibility was 60 months of clinical training, and no resident was promoted to the faculty prior to fulfilling 60 months of clinical neurosurgery training. Although there were several instances, due to the vagaries of the residency rotation, in which individuals became CRs
at UWMC and HMC before completing the 60 months of clinical training, none of these individuals were submitted for faculty appointment.

Although the associate dean for clinical affairs reviewed1 "several times the booklet of information published by the American Board of Neurological Surgery," 60 months of clinical training is not the sole criteria of the ABNS. In fact, there are other clear requirements, such as fulfilling 36 months in the core clinical experience. The rotation to the UK was an elective clinical experience; thus our residents, despite having performed 60 months of neurosurgical training, did not fulfill the criteria of completing 36 months of core clinical neurosurgery (which, by definition, must occur in the parent institution and not as part of any elective time). Both the associate dean for clinical affairs and I erred in our assessment of what constituted eligibility for promotion to faculty approval. In a letter to the university counsel in September 2002, the Medicare fiscal intermediary agreed that the individual in question was not eligible for faculty appointment.

Retrospective Documentation by the CR/AI

In 1998 these negotiations resulted in a contractual agreement between the university and its Medicare fiscal intermediary in 1998 after all parties, including the CMS, were made aware of the billing practice (this agreement civilly resolved the issue dating back to 1985 and established that it was completely acceptable to exclude those individuals from medical education payments [that is, Part A], but to leave intact physician payments [Part B] for such services); and was subject to ongoing approval. In a letter to the university counsel in September 2002, the Medicare fiscal intermediary agreed that the very practice that was under criminal investigation, in fact, had been approved by the responsible government agency and its agent.

Compliance Issues and Recommendations. Despite a multiyear investigation conducted by the US Attorney's Office and the FBI (vide supra), which involved subpoenaing thousands of pages of documents and files from the department, the UW School of Medicine, the UWP, and the ABNS, neither the US Attorney's Office nor the FBI was aware of the contractual agreement between the government agent (Premera Blue Cross) acting on behalf of the CMS and the UW School of Medicine and the hospitals. Furthermore, they had not seen the letter1 from the associate dean for clinical affairs until the documents were disclosed to them in February 2002 by my attorney, Cyrus R. Vance Jr. His contention of a lack of criminal intent in the appointment process was not subsequently challenged.

Nevertheless, this experience does raise potential compliance issues. For example, I recommend that medical schools have a structured orientation process for all new chairs of clinical departments, which should rigorously cover regulations governing the CMS and residency programs as well as research funding (a potential area of future federal focus). All new residency program directors should be familiar with and review on a regular basis specialty board residency guidelines and requirements. In this regard, the Society of Neurological Surgeons has educational seminars at meetings focused on these issues. Moreover, even experienced chairs and program directors will benefit by attendance at such seminars. Perhaps, the Residency Review Committee for Neurological Surgery could make attendance at such seminars a requirement for reaccreditation of a residency program. In addition, given that these regulations are subject to change, follow-up educational programs are needed.

Retrospective Documentation by the CR/AI

Background. In 1996 the HCFA issued changes in the regulations concerning documentation for billing under Part
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B of Medicare. These new regulations were complex and, as noted by the US Attorney’s Office, were subject to “confusion as to the meaning and application of the rules and regulations that controlled submission of claims to Medicare, Medicaid, and TRICARE programs.” Included in these modified regulations were new guidelines dealing with the submission of a fee for an operative assistant (Modifier 82). Modifier 82 allows an individual who assists the primary surgeon to submit a professional fee as part of the surgical fee. In an academic setting, however, the use of Modifier 82 requires fulfillment of the following two criteria: the case must be complex and an appropriately trained and experienced resident must be unavailable. Moreover, the new HCFA regulations required that, to qualify for payment, the operative report must state that these two criteria had been fulfilled. Prior to 1996, such documentation was not required, and in complex procedures during which the AI assisted the attending, an assistant fee could be charged.

Retrospective Documentation. Several months into the 1996/1997 fiscal year, our departmental administrator noted that no fees were being generated by the CR/AI at UWMC. As previously discussed, these individuals were faculty members and thus their salary was derived from professional fees (Part B). Consequently, our department administrator met with the individuals within the UWP to determine whether retrospective documentation could be performed in appropriate (that is, complex) cases. After evaluating the situation, the UWP administration indicated that such retrospective documentation and subsequent billing was permissible.

Unfortunately, individuals from UWP responsible for assembling the appropriate materials instead collected the charts of all patients—not just those of complex cases—who had undergone treatment during the time period, and the CRs then added the required language to all charts, even for minor procedures. Moreover, after initiating this retrospective documentation process, there was no administrative oversight by the UWP or the department. As indicated earlier, an administrative wall existed to a considerable extent between the UWP and the departmental administration.

Compliance Issues and Recommendations. Approval of retrospective documentation of surgical assistance in complex cases was sought from and approved by our faculty practice plan administration. An error in the process of collecting the patient charts resulted in inappropriate cases being documented. The lack of feedback to or review by the department administrator (that is, the administrative wall) prevented recognition of inappropriate chart documentation. A rigorous compliance program (not introduced by the UWP until 2000 and still a work in progress in 2002) with a strong departmental component would have most likely alerted both the UWP and the department to these operational problems and inappropriate billings. Furthermore, the faculty and residents had received no formal education from the UWP regarding the appropriate use and indication of Modifier 82.

The existence of an administrative wall between the central practice plan and the departmental administration impeded daily oversight and mid-course corrections of UWP/department activities. In this regard, the UW and the UWP have recently altered the job description of department administrators to encompass aspects of UWP activities and to increase the administrators’ abilities to access UWP financial information and other data.

In today’s litigious and bureaucratically complex environment, there is an absolute requirement for a rigorous compliance program in a faculty practice plan. The optimal organization and the degree of effectiveness of compliance programs are unclear, however. An example of the challenges and complexities facing a compliance program are illustrated by the use of Modifier 82 in ventricular shunt cases treated at HMC and UWMC (Fig. 2). This is an operation that, in most circumstances, would not require an experienced assistant and hence should not generate a Modifier 82 except in a minority of cases. At HMC, the initial (1997–1999) rate of use of Modifier 82 was 20.7%, but decreased to less than 1% in the period between 2000 and 2001. In contrast, during the same time period at UWMC, the use of Modifier 82 was higher and did not decrease, although a downward trend (which did not reach a statistical significance) occurred between 1997 and 2000. Note that the same compliance plan existed at both institutions and that a strengthened compliance program was introduced by the UWP in late 2000. The decrease that occurred at HMC was observed before the introduction of a rigorous compliance program (2000) and before the public disclosure of the federal investigation (1999). A longer follow up may reveal the effectiveness of the existing compliance program. Alternatively, modification of the existing compliance program together with the introduction of more effective tools of education and oversight as well as periodic evaluations of index cases may be required.

Frame Placement for Radiosurgical Treatment

Background. Billing for radiosurgery can be conducted with the aid of a comprehensive code for frame placement and radiosurgical treatment or by billing separately for placement of the frame as well as the neurosurgical aspect of the treatment plan (targeting the lesion). At the UW, a comprehensive fee was used.
University of Washington Experience. At UW, in the majority of cases, the junior resident applied the frame. The attending always created the treatment plan. The government contended that frame placement was the more important component, and because the attending did not place the frame in most cases, a fee was inappropriately submitted for radiosurgery cases. After an educational discussion, the government dropped this aspect of its investigation.

Bedside Procedures

Background. Beginning in the late 1980s and with the approval of the UWP, bills were generated by our department for bedside procedures such as performing lumbar punctures and inserting intracranial pressure monitors. Prior to 1996 and the changes in HCFA guidelines, there was no requirement for faculty to be physically present during these procedures. A mere presence in the vicinity (“vicinity” not being clearly defined) qualified as an attending presence. In 1996 the regulations changed, requiring an attending to be physically present (“shoulder-to-shoulder, elbow-to-elbow”). Confusion about these new regulations persisted, and consequently fees continued to be generated in some cases in the absence of a shoulder-to-shoulder, elbow-to-elbow attending presence.

Compliance Issues and Recommendations. In 1996 there was no office or individual in the UWP whose sole responsibility was compliance and compliance oversight. Such an individual and the development of an effective compliance program may have prevented the generation of fees for bedside procedures conducted in the absence of an attending. Indeed, with the creation in 2000 of the position of the UWP director of regulatory compliance, the inappropriate billing was identified and our department ceased billing for bedside procedures performed without a faculty presence.

As noted earlier, the presence of an active compliance office is an absolute necessity in today’s world of complex and frequently changing Medicare and Medicaid regulations. The organization of a compliance program within a faculty practice plan must be carefully considered, however. Its effectiveness may be hindered by being too centrally directed. A compliance program that is focused on simply evaluating the numbers and is too removed from the “shop floor” and not out in the field may miss inappropriate billing practices. On the other hand, a peripheral compliance effort (that is, at the departmental level) may be compromised by friendships and collegial interactions. Regardless of the mechanism of organization and financing, there may be a tendency to skimp on the financial support necessary to make these programs effective. Central planners may

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**TABLE 1**

<table>
<thead>
<tr>
<th>Nurse Response</th>
<th>No. of Nurses Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>never list faculty as surgeon or assistant</td>
<td>1</td>
</tr>
<tr>
<td>scrubbed attending listed as surgeon or assistant</td>
<td>13</td>
</tr>
<tr>
<td>nonscrubbed attending listed as surgeon or assistant</td>
<td>3</td>
</tr>
<tr>
<td>nonscrubbed attending listed only as attending</td>
<td>9</td>
</tr>
<tr>
<td>inconsistent about listing attending as surgeon or assistant</td>
<td>2</td>
</tr>
<tr>
<td>exceptions/own policy</td>
<td>2</td>
</tr>
<tr>
<td>total</td>
<td>30</td>
</tr>
</tbody>
</table>

* Nurses responded to the question, “How do you record the faculty surgeon’s presence?”
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adopt an attitude of “don’t ask, don’t tell,” whereas many faculty at the department level in this era of diminishing reimbursements and salaries may be decidedly unenthusiastic about supporting another bureaucratic effort. The faculty, staff, and department administration must be given incentive—both positive and negative—to cooperate with such a compliance program. Although some faculty may be hard pressed to think of positive incentives, the federal investigation of the UWP is certainly an example of a negative incentive and the need for an effective compliance program in all faculty practice plans and departments.

Operating Room Presence

Background. The government contended that there were many surgical fees submitted for operative procedures performed in the absence of an attending surgeon. The government’s contention was mainly based on the nursing operating room record. The nursing record (Fig. 3) has blank spaces for listing the names of physicians under the following categories: attending, surgeon, or assistant surgeon 1, 2, and 3. The government contended that only the designation “surgeon” indicated an operating room presence by a physician, whereas “attending” did not. In addition, the government had concerns about the accuracy of the dictated operative notes and the use of the term “attending.”

The UWP Response. The following data were developed in response to the government’s concerns and contentsions.

Nurses Education. On review, it was determined that the OR nurses had never received an in-service educational program that defined the terms “attending” and “surgeon.” When 30 nurses were queried, there was wide variation regarding what constitutes an attending and what constitutes a surgeon (Table 1). The nurse manager at HMC concurred that there was no uniformity on this issue. Moreover, when a variety of different surgeons (mainly non-neurosurgeons) at UW were questioned, the distinction between attending and surgeon was unclear.

In a review of 1500 procedures performed by one neurosurgeon, this individual was listed as an attending 50% of the time and as either a surgeon or an assistant in addition to an attending the other 50% of the time. In another 746 cases in which Modifier 82 was used because of the complexity of the procedure, the primary surgeon was listed as the attending only and not the surgeon. When queried, all nurses stated that in such complex cases the attending (that is, the faculty member) was always present. Clearly, the government had concerns about the accuracy of the dictated operative notes and the use of the term “attending.”

DICTATION GUIDE FOR UWP PHYSICIAN PRESENCE

Fig. 4. Example of Dictation Guide for UWP Physician Presence.

Dictated Operative Reports. It has been the custom at UW (and in many other university medical centers and training sites in the US) that dictated operative notes include the term “attending” as well as “surgeon.” The former term was, in many cases, placed into the operative notes by the hospital transcriptionist, based on hospital-derived demographics. Thus, irrespective of the actual individual performing the surgery, the name of the attending of record would appear in the typed operative notes, unless the individual dictating the operative notes (frequently not the attending surgeon) indicated the contrary. Within this system, in some cases the attending, the surgeon, and the individual who dictated the notes were three different people. Similarly, this dictation/transcription practice led to the mistaken inclusion into the operative record, without their knowledge, of the names of attendings who had not actually been present in the operating room.

Generation of Surgical Fees. In a number of cases, bills were erroneously generated by the central billing agency (the UWP) in the absence of an appropriate faculty OR presence. There was no clear consistency among surgical departments in regard to the threshold and criteria for generating a surgical fee. Beginning in the mid-to-late 1990s, a fee sheet was introduced at the Department of Neurological Surgery. After being completed by the faculty member, this sheet was submitted to the professional fee coordinator (a UWP employee) and a fee was then generated. Several of the faculty refused to use this method, believing that this paperwork was the responsibility of the professional fee coordinator. Alternatively, the coordinator could generate a fee if there was a handwritten operative note from the attending, indicating a physician presence. Some attendings set both of these conditions as the threshold for fee generation. Despite the absence of either of these methods of documentation, the professional fee coordinator mistakenly generated fees. Moreover, individual faculty members were not routinely able to review their billing records until a considerable length of time after cases had been actually treated. Consequently, the individual faculty member often dealt with financial information concerning patients treated several months previously. Such out of date billing information did not allow the individual faculty member to perform an appropriate oversight of the correctness of the fees being generated in his or her name.
Compliance Issues and Recommendations.

Nursing Documentation. Intensive education of the nurses must be ongoing and comprehensive. At all UW hospitals, the terms “attending” and “surgeon” have been clarified to nurses and other OR personnel through a series of mandatory educational lectures and updated on a regular basis in OR staff meetings. Moreover, the operative record form is presently being revised to distinguish clearly between the entries for attending and surgeon.

Surgeon Documentation and Dictation. The rules concerning documentation of an OR presence by the faculty must be clear and uniform. The following changes were initiated at UW in 2002. A uniform OR documentation/dictation policy was developed by the UWP after full discussions with all surgical departments. This policy was widely disseminated within the OR, with written guidelines prominently displayed there and proximate to all dictation sites. Faculty and residents in surgical departments were required to attend meetings to review these policies on documentation and were specifically instructed to include in the OR dictation only those individuals present in the OR at the time of the operation. Guidelines for multiple procedures, “critical and key portion(s)” of operative procedures, and faculty presence were clarified. Perhaps most importantly, a new form (Fig. 4) and a basis for generating a surgical fee was introduced by the UWP. This form (or a comparable handwritten note in the hospital chart) required the signature of the faculty member and consisted of five key statements attesting to an OR presence. Only after completion of this form could a professional fee coordinator submit a surgical fee.

Faculty Practice Plan. A faculty practice plan must be responsive to the needs of the individual faculty member. The large size of many comprehensive plans may make them too unwieldy to allow timely and appropriate review of individual fees charged by the central organization in the name of the individual faculty member. Concern in this regard is evident in a review of the responses of UW clinical faculty to the February 2002 questionnaire generated by the medical director at UWMC. This survey indicated that the majority of the faculty had considerable criticisms about the UWP, especially in regard to financial information and training. For example, when asked to rate their satisfaction with UWP support of faculty, 55% indicated that they were either very dissatisfied or dissatisfied. In response to the question, “Which would be your top areas for improvement?” 70.9% indicated a desire for charge capture/coding support and feedback, and 62.1% indicated a desire for reimbursement feedback. When asked for their comments, 60.5% made negative comments about practice plan support, communication, and leadership; 30.2% responded that billing and collection processes needed improvement; and 30.2% also noted that faculty needed improved education and feedback about billing. These negative comments contrasted with more positive responses to non-UWP-related questions elsewhere in the survey.

Despite any shortcomings in a faculty practice plan, faculty members must be aware that they as individuals will be held responsible for their own billing errors as well as those made by others acting on their behalf. They can be subject to prosecution and are not shielded by their practice plan and universities. As noted by an Assistant US Attorney in Seattle, “Dr. Winn will be an example to others who may have previously believed that their preeminence as physicians will shield them from criminal prosecution . . . and Dr. Winn will further be an example to physicians at teaching hospitals who may have otherwise believed that teaching physician issues should be pursued only as civil matters against their parent institution.”

Recognition that the government may hold individual faculty members responsible for errors rather than universities and practice plans is a strong inducement for faculty to reevaluate the governance of faculty practice plans. A conflict of interest may exist in plans that are organized with a strong central administration (dean as CEO) and board of directors made up of clinical department chairs who are appointed by the dean. Given that chairs usually serve at the pleasure of the dean, independent decisions by board members may be in conflict with their position as departmental chief administrator. In industry, some observers have attributed the lack of independently appointed board members to the recent financial misbehavior of CEOs. Although the exclusion of clinical chairs from the board of trustees of practice plans (perhaps the most important standing committee in medical schools today) is not a politically viable option, an alternative way of dealing with this perceived conflict of interest is to appoint outside (that is, non–medical school or nonuniversity) trustees to the board. Alternatively, some practice plans do not have the dean/vice president as CEO, but instead rotate this responsibility.

Another potential conflict of interest arises from the increasing dependency of medical schools on clinical revenues to support the dean’s discretionary fund. Such increasing central funding requirements may conceivably lead to corporate incentives that are in conflict with individual physician activities and compliance responsibilities. Compliance programs are mainly focused on the individual practitioner, whereas these central funds and their expenditures are usually not part of a compliance program. It is thus mandatory that accountability exists in the financial activities of the practice plan and the dean’s fund. As noted earlier, at UW, the faculty has considerable concerns about the UWP and there is no review of the dean’s fund by the UWP Board of Trustees.

Last, having transparency in the central management of these organizations can enhance compliance of the practice plan. Such openness in administrative activities is likely to ensure more rigorous adherence to federal and state regulations and the avoidance of any impropriety. In any investigation involving multiple individuals and parties, prosecutors aim to “divide and conquer.” In the event of an investigation focusing on both the practice plan and individual faculty members, both the faculty and the practice plan must therefore be observant of all regulations. The lack of any improprieties within the central organization is a laudable goal in itself (as is similar behavior by individual faculty members), but has the added benefit of avoiding the possible success of the “divide-and-conquer” tactic. For example, as reported in The Seattle Times and subsequently denied by a UW spokesperson, the US Attorney’s Office, as part of its investigation, developed evidence indicating that the UWP and Children’s University Medical Group undertook efforts to destroy audit reports that revealed billing irregularities. Thus, the faculty billing agency and their associated staff and officers became vulnerable to criminal
prosecution. Nevertheless, as reported in the press, most of the UWP staff were granted immunity (“divide and conquer”) and the criminal investigation was then focused on the faculty. In neurosurgery, however, as noted earlier from the plea agreement and the court transcript, "the evidence gathered during the investigation is subject to a reasonable and good faith interpretation that although claims for professional services were submitted by the [UWP] in conjunction with professional services provided by the Department of Neurological Surgery, these claims were not intended by the Defendant to be fraudulent and were instead the product of mistake and confusion as to the meaning and application of the rules and regulations that controlled the submission of claims to the Medicare, Medicaid, and TRICARE programs."

Summary

A faculty practice plan provides the important benefit of a flexible and augmented revenue source to medical schools and deans, to departments and chairs, and to faculty members. An ideal plan must be responsive to the individual needs of the faculty and based on a fundamental level of trust between the faculty and the administration of the plan. Nonetheless, as with international armament treaties, “trust but verify” is an important concept to guide the management of faculty practice plans and emphasizes the need for transparency in the activities of these organizations. In a similar fashion, in today’s complex bureaucratic and litigious environment and as part of this “trust-but-verify” concept, all practice plans need a comprehensive compliance program. Without an effective, well-organized compliance program, institutions and their faculty practice plans will remain vulnerable to government investigation.

In regard to the vulnerability of an individual, criminalization of health care is now a reality and the federal government may identify a faculty member as the responsible party in any health care investigation. Moreover, universities may not shield their faculty from these inquiries, especially if the universities and practice plans are also targets of an investigation. Consequently, faculty members must acquire a comprehensive understanding of health care regulations or face personal peril.

Acknowledgments

I thank Margaret Connolly for her editorial assistance. In addition, I am indebted to Cyrus R. Vance Jr. and Robert Sulkin of McNaul, Ebel, Naurot, Helgren & Vance in Seattle; Howard Pearl of Winston & Strawn in Chicago; and Richard O. Prentke of Perkins Coie in Seattle for their review of the manuscript and wise counsel.

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Manuscript received January 30, 2003. Accepted in final form September 2, 2003.