

**UW Medicine Board Review Committee  
Report**

**Achieving Excellence in Compliance**

**July 20, 2005**



## Chairman's Memorandum of Transmittal

To: UW Medicine Faculty and Staff  
President Mark Emmert  
Members, Board of Regents  
Dean and VPMA Paul Ramsey  
Members, UW Medicine Board

From: Chair, Review Committee of the UW Medicine Board

Date: July 20, 2005

Re: Achieving Excellence in Compliance: Final Report of the Review Committee

The well-publicized four and one-half year Federal billing investigation of UW Medicine resulted in criminal felony convictions of two nationally prominent physicians, a \$35 million settlement and the expenditure of \$27 million for legal and other costs. The purpose of the Review Committee's Report—Achieving Excellence in Compliance—is to help convert this traumatic series of events into the development of an excellent Compliance Program, which is supported by a culture of professionalism, ethics, and integrity at UW Medicine.

The Review Committee's mandate was to ascertain the "lessons learned" from the billing investigation, to determine the adequacy of UW Medicine's Compliance Programs and to make appropriate recommendations to prevent future billing problems. The Review Committee's Report is intended to help you, the faculty and staff of UW Medicine, understand how past mistakes happened and how they can be prevented in the future.

The subject matter of the Committee's Report, Achieving Excellence in Compliance, is exceedingly complex. It presents and addresses many close and difficult questions about medical organizations—their governance and accountability—and how to move UW Medicine forward in a very complex and changing regulatory and financial environment.

In the course of its work, the Review Committee found that the vast majority of UW Medicine providers and staff have been and are committed to performing their individual clinical billing responsibilities in an ethical manner and in full accord with the requirements of the UW Medicine Compliance Programs and applicable Federal billing regulations. While fully acknowledging this, the Committee must also observe that there were, in the 1990s, simply too many billing errors at UW Medicine. In terms of level of culpability, the errors were of all types: innocent mistake, negligent mistake, reckless error and some rare instances of deliberate fraud.

Most of you were not part of the problem, but all of you are part of the solution. Ensuring compliant billing practices is the responsibility of every UW Medicine faculty

member and employee. At the same time, UW Medicine has the responsibility to provide you with the tools and resources you need to be compliant. You must use them in the full spirit of professionalism, ethics, and integrity that drew you to the practice of academic medicine in the first place. In so doing, be mindful that compliance is a great leveler: it requires the same degree of diligence from the faculty, administrators, and staff alike, from the most senior to the newest. No one member of UW Medicine is greater than the whole of the institution. No single person's behavior can be allowed to tarnish UW Medicine's reputation for excellence and integrity in all that it does.

Going forward, it is your duty, as an important member of the UW Medicine family, to appropriately address improper billing practices, wherever you see them. The instances may be few, but they cannot go uncorrected. It is the UW Medicine Administration's obligation to ensure that every potential problem is pursued diligently and appropriate action is taken, so that you can all take pride in, and be confident in, the quality of the institution you have created. Only by moving forward together to further strengthen the culture of compliance will you protect UW Medicine. In this way, you will ensure that the institution within which you are pursuing your life's work is worthy of your talent, skill, and commitment.

The Review Committee's message is to continue on the course you have chosen at UW Medicine. Take pride in your adherence to the values of professionalism, ethics, and integrity. Be confident that your contributions, however small or large, are essential parts of the foundation upon which UW Medicine is built.

This foundation is critical to UW Medicine's future. It is important that all of UW Medicine's members share common institutional values of trust, transparency, and a strong commitment to a culture of compliance. These values are central to continuing to build a world-class medical institution with a focus on healing, reducing suffering, preventing disease, advancing science, and transmitting knowledge to the wider global community of world humanity.

*William J. Van Ness*

---

William J. Van Ness  
Chair, Review Committee  
July 20, 2005

## **Acknowledgements**

*As Chairman of the UW Medicine Board Review Committee, I want to acknowledge and express my gratitude to all those who contributed to the UW Medicine Board Review Committee's final Report, Achieving Excellence in Compliance. This Report grew out of the Federal billing investigation; it addresses the lessons learned from that experience and the adequacy of UW Medicine's Compliance Program today.*

*I want to thank my family and my law partners at Van Ness Feldman, P.C. who graciously acceded to my request in August 2004 to spend a substantial portion of my time as Chair of the Review Committee.*

*The preparation of this Report, its substance and organization benefited greatly from the work of three very outstanding and dedicated people, Diane Sanford, Esther Holt and Bill Kramer. Diane gave up a position at the UW Law School to serve as Project Manager for the Review Committee. Esther has extensive paralegal experience. Bill is a Senior Healthcare Consultant with over twenty-five years of executive management responsibility at large public and nonprofit medical organizations. Together, they constitute the Review Committee staff and are largely responsible for the excellent work that went into the preparation of the Report.*

*As Chair of the Review Committee, I had unlimited access to the time, counsel, and advice of what I consider to be one of the most qualified group of public citizen Committee Members ever assembled. They include UW Medicine Board Members:*

**Orin C. Smith** recently retired as the President and Chief Executive Officer of Starbucks Coffee Co. He joined Starbucks in early 1990 and headed all business functions from 1994 until his retirement in March of 2005. He previously spent 14 years with Deloitte and Touche in management consulting, and became Partner in Charge of the Northwest consulting practice. He also taught at the college level for several universities and served as director of the Office of Financial Management under Washington State governors Ray and Gardner. Mr. Smith currently serves on the Board of Directors of Nike and the SkinKlinik, as well as a number of community organizations, including Conservation International, the Seattle Foundation, the University of Washington Foundation and University of Washington Medicine. He also serves on the Advisory Boards for the Harvard Business School and the University of Washington Business School. In 2002, he received a Harvard Business School Alumni Achievement Award, becoming one of only one hundred and ten graduates to receive the School's highest honor. He is a graduate of the University of Washington as well as Harvard Business School. (Orin serves as the Review Committee's Vice Chair.)

**Michael D. Garvey** serves as Chairman of Saltchuk Resources, Inc., a holding company with investments primarily in the maritime industry. Formerly, Mr. Garvey practiced law with the firms of Preston Thorgrimson and of Garvey, Schubert & Barer, of which he was a founding member. He presently serves as Of Counsel for Garvey, Schubert & Barer. Mr. Garvey serves, or has served, on a number of boards, including Ste. Michelle Vintners, K-2 Ski

*Company, Columbia River Farms, Cascade Management, The Commerce Bank of Washington, Foss Maritime Company, and Tollycraft Yachts.*

**Sylvia M. Mathews** is Chief Operating Officer and Executive Director at The Bill & Melinda Gates Foundation. She is a 1987 graduate of Harvard University and was a Rhodes Scholar. Ms. Mathews served in a number of senior positions in the Executive Branch, including Deputy Director of the Office of Management and Budget, Deputy Chief of Staff to the President, Deputy Chief of Staff to the Secretary of the Treasury, and Staff Director of the National Economic Council.

**Brooks G. Ragen** is Chairman of McAdams Wright Ragen, Inc., brokers and investment advisers. Born and raised in Portland, Mr. Ragen received a scholarship to Yale University and after graduating went on to law school at Stanford. He also holds an MBA degree from New York University. He has been in the banking and investment business in Seattle since 1961. Mr. Ragen has served on several corporate boards, is also a leader in community service, and has been president of the boards of A Contemporary Theater (ACT), Bush School, the Seattle Art Museum, and the Seattle Foundation.

**Patricia Stanford** also serves on the board of The Fred Hutchinson Cancer Research Center, The United Negro College Fund Advisory Board and The USO of Puget Sound. She has recently served on The Seattle Cancer Care Alliance Board, the Higher Education Coordinating Board and Mothers Against Violence in America. She is still actively involved with the John Stanford Endowment Fund Committee, established in honor of her late husband, former Seattle Schools Superintendent John Stanford, through the Alliance for Education (resigned from the UW Medicine Board in December 2004 to move to North Carolina).

**Charlotte Guyman** earned both bachelor's and MBA degrees from the UW, was formerly general manager of MSN Internet sales and marketing for Microsoft, and has worked on MSNBC and several Microsoft consumer project lines. Her experience includes learning software for adults and children and the pioneering Internet application, Expedia. She has been general manager of Kids and Games software for Microsoft as well as director of international marketing and director of consumer division marketing. Since November 2003, she has served as a Director and Member of the Audit Committee for Berkshire Hathaway, Inc. (appointed to UW Medicine Board Review Committee in December 2004).

**William J. Van Ness Jr.** is a founding partner of the law firm Van Ness Feldman, with offices in Seattle and Washington, D.C. Before entering private practice, he served as chief counsel to the U.S. Senate's Interior and Insular Affairs Committee (now the Energy and Natural Resources Committee), under Senator Henry M. Jackson (from 1966 to 1977). He also directed the U.S. Senate's National Fuels and Energy Policy Study in the early 1970s. Mr. Van Ness is a graduate of Western Washington University and received his law degree from the University of Washington Law School, where he was articles editor of the Washington Law Review. He also serves in a pro bono capacity as President of the Henry M. Jackson Foundation.

*I deeply appreciate the many gifts this distinguished group of former and present CEOs and community leaders brought to the Review Committee and its very important responsibility in producing the analysis and recommendations contained in the Committee's Report.*

*The Report at page 23 acknowledges the excellent cooperation the Committee received from President Emmert, the Board of Regents, Dean and VPMA Paul Ramsey, the UW Medicine Administration, the entity Executive Directors, Compliance Program officials, faculty physicians and staff.*

*Not formally acknowledged in the Report, but acknowledged here, are the very important contributions we received from the faculty physicians we interviewed. The Committee Members and staff were deeply impressed by the dedication of faculty-physicians to an institution that permits them to engage in challenging acute patient care (at lesser financial rewards than are readily available in the private sector) and also provides the opportunity to teach the next generation of medicine's practitioners as well as to engage in research to advance the frontiers of medical knowledge.*

*The Chair was schooled as a young lawyer at the UW Law School. My secondary legal education was provided by Senator Henry M. Jackson. The Senator was a man of unequalled commitment to common sense, good judgment, candor and honesty.*

*Senator Jackson shared a unique relationship with two Members of the Board of Regents who were very active participants in the Board's governance responsibilities and involvement in the Federal billing investigation. The Senator held a high opinion of Regent Dan Evans. Though from different political parties, they shared many values and a highly personal approach to the political process. They also held in high esteem the importance of the tradition of public service. It is appropriate that the UW has two very excellent schools named after these two statesmen: The Henry M. Jackson School of International Studies and The Daniel J. Evans School of Public Affairs.*

*The second Member of the Board of Regents who had a long and close relationship with the Senator was Jerry Grinstein. Mr. Grinstein served as Chief of Staff to Senator Warren G. Magnuson before returning to Seattle to practice law and later embarking upon a successful career as CEO of a number of major corporations. Regents Grinstein and Evans played instrumental roles in the Federal billing investigation on behalf of the UW. They were in attendance at every critical juncture in the process. They represent the best of fully-informed and dedicated public servants. The members of the UW Medicine Board's special Review Committee are also part of this tradition.*

*In conclusion, I want to thank Dean Paul Ramsey for initially proposing this review and Ann Ramsay-Jenkins, Chair of the UW Medicine Board, and the Members of the full Board for commissioning this Report. Of particular importance was the care, thought and foresight that went into the crafting of the Review Committee's charter and mandate, the August 6, 2004 Statement of Purpose found at Appendix 3.*

## **Review Committee Note**

This Report consists of 11 Sections. It includes 19 Appendices. For the reader's guidance, Appendix 1 contains a list of Acronyms used in the Report and their meanings or reference. Appendix 2 contains a brief Chronology of significant events related to the Federal billing investigation, Federal regulations, and UW Medicine Compliance Program development.

The Review Committee's website, <http://depts.washington.edu/uwmbrc>, will contain a number of relevant documents that are too long to include in the Appendices. These will include a summary of press stories on the Federal billing investigation; the Settlement Agreement of April 30, 2004; the Corporate Integrity Agreement of April 30, 2004; the U.S. Department of Justice (DOJ) Presentation of December 6, 2003; Mark Erickson's (the Whistleblower) prepared statement submitted to the Review Committee on March 14, 2005; the Faculty Council Report of April 24, 2005; and other documents.

## Table of Contents

<b>Chairman’s Memorandum of Transmittal</b> .....	i
<b>Acknowledgements</b> .....	iii
<b>Review Committee Note</b> .....	vi
<b>Table of Contents</b> .....	vii
<b>Executive Summary</b> .....	1
A. Brief Executive Summary.....	1
B. Full Executive Summary.....	5
1. The Relevant History.....	5
2. Analysis and Assessment of the History.....	7
3. What Has Been Done: UW Medicine Compliance Programs Today.....	8
4. Organizational Culture .....	10
5. Review Committee Recommendations .....	10
6. Conclusion .....	11
<b>Report of the Review Committee</b> .....	13
I. Introduction.....	13
A. The Investigation and Settlement .....	13
B. Costs of the Investigation and Settlement.....	13
II. The Review Committee’s Work .....	15
A. Purpose of This Report .....	15
B. Committee Membership.....	15
C. Committee’s Independence.....	16
D. Scope of Committee’s Review.....	16
E. The Committee’s Expectations .....	17
F. Elements of Methodology.....	17
G. Sources of Information.....	19
1. UW Medicine Billing Investigation Documents.....	19
2. Meetings and Briefings with UW Attorneys .....	19
3. Key Personnel and Stakeholders.....	20
4. Government and Whistleblower .....	21
5. Review of Federal Regulations, Guidelines, and Academic Literature .....	22
6. Best Practices Study.....	22
7. Member and Staff Training.....	23
8. Committee Meetings .....	23
H. Cooperation of UW Medicine Administrators, Faculty and Staff .....	23
I. UW Medicine’s Compliance Program Initiatives.....	23
III. Overview of UW Medicine.....	25
A. UW Medicine and its Affiliated Entities .....	25
B. National Recognition .....	25
IV. Evolution of Medicare Billing Requirements - Summary.....	27
V. What Happened – Events and Causes.....	31
A. Summary of Developments in Compliance Programs at UW Medicine in the mid-1990s .....	31
1. Early Notice of Allegations of Improper Billing in the 1990s.....	32
2. Pre-Investigation Audits .....	37

B.	Summary of Investigation and Outcomes .....	38
1.	The Criminal Case .....	38
2.	The Civil Case.....	44
3.	The Settlement .....	46
C.	Causes of the Problems that led to the Federal Billing Investigation.....	50
D.	Developments in UW Medicine Compliance Programs: 1999-2004 .....	56
1.	Professional Billing Compliance - UWP and CUMG – 1999-2004 .....	56
2.	UWP and CUMG’s Compliance Program in 2005 .....	58
3.	HMC and UWMC Compliance Programs from 1999-present .....	58
4.	Committee’s Commentary.....	59
VI.	Summary Assessment of Current Compliance Programs .....	61
VII.	Organizational Culture and Physician Accountability.....	65
A.	Organizational Culture .....	65
1.	Findings.....	65
2.	Responsibility of Individual Providers .....	66
3.	Responsibility of Physician Leaders and Department Chairs .....	67
4.	Responsibility of Administrative Leaders .....	68
5.	Other Recommendations.....	69
B.	Expectations, Feedback and Incentives for Physicians .....	69
C.	Communications .....	70
VIII.	Governance .....	73
A.	Role of UW Medicine Board .....	73
1.	UW Medicine Board’s Role and Authority .....	73
2.	Board Level Compliance Committee.....	73
3.	Board Functions and Perceptions of its Role .....	73
4.	Considerations on Strengthening the Board’s Governance Role.....	74
B.	UWP Structure and Governance .....	78
IX.	Detailed Findings and Recommendations – UW Medicine Compliance Programs ....	81
A.	Management.....	81
1.	Management Accountability.....	81
2.	Risk Assessment and Compliance Planning .....	83
B.	Compliance Functions .....	85
1.	Structure and Oversight of Compliance Function .....	85
2.	Monitoring and Auditing .....	90
3.	Education, Training and Information for Physicians and Staff .....	91
C.	Business Infrastructure.....	93
1.	Information Technology .....	93
2.	Coding and Billing Functions .....	94
X.	Looking Forward.....	95
A.	Implementation of Review Committee Recommendations .....	95
B.	A Vision for Compliance .....	95
C.	Expectations and Outcomes.....	97
XI.	Conclusion .....	99

## Table of Contents – Appendices

Appendix 1	Acronyms .....	1-1
Appendix 2	Chronology.....	2-1
Appendix 3	Statement of Purpose – UW Medicine Board Review Committee .....	3-1
Appendix 4	Settlement Cost Recap .....	4-1
Appendix 5	Developments in UW Medicine Compliance Program: 1999-Present ....	5-1
Appendix 6	UW Medicine Compliance Enhancement Efforts.....	6-1
Appendix 7	Description of UW Medicine Entities and Growth.....	7-1
Appendix 8	June 8, 2005 Memorandum from Jack Johnson, Chief of the University of Washington Division of the AGO, regarding Governance and UW Medicine Board .....	8-1
Appendix 9	Evolution of Medicare Billing Regulations .....	9-1
Appendix 10	History of Compliance Programs at UW Medicine in the Mid-1990s ..	10-1
Appendix 11	Correspondence related to Early Notice of Improper Billing in the 1990s .....	11-1
Appendix 12	Correspondence between Dr. Paul Ramsey and Dr. William Couser, December 1996 – January 1997 .....	12-1
Appendix 13	April 23, 2003 letter from John McKay.....	13-1
Appendix 14	Dr. William O. Robertson Correspondence .....	14-1
Appendix 15	Summary of Federal Sentencing Guidelines.....	15-1
Appendix 16	List of Recommendations .....	16-1
Appendix 17	March 29, 2005 Letter to UW Medicine Faculty and Staff from Dean Ramsey on Professional Ethics, Integrity, and Compliance.....	17-1
Appendix 18	Expectations and Outcomes.....	18-1
Appendix 19	July 8, 2005 Memorandum from Steve Boerstler, UW Health Sciences Administration, regarding Review Committee Expenses .....	19-1



## Executive Summary

### A. Brief Executive Summary

For four and one-half years, beginning in August 1999 and ending on April 30, 2004, UW Medicine's faculty Practice Plans (University of Washington Physicians (UWP) and Children's University Medical Group (CUMG)) were the subject of a Federal criminal and later a civil investigation into allegations of fraudulent billing of the Medicare program. The investigation was launched by a "Whistleblower" lawsuit filed under the False Claims Act (FCA) by Mark Erickson, an employee who had worked at different times for UWP and CUMG. The criminal investigation concluded with felony criminal convictions of two nationally prominent UW Medicine physicians. The civil investigation resulted in a \$35 million settlement between the Federal government and the Practice Plans.

On August 6, 2004, the UW Medicine Board, in response to a request from Dean Paul Ramsey and with the endorsement of the UW Board of Regents and President Mark Emmert, announced the formation of a special independent Review Committee. Its goal was to ascertain the "lessons learned" from the billing investigation, determine the adequacy of UW Medicine's Compliance Programs and make appropriate findings and recommendations.

#### Review Committee Objectives

*Objective 1: Assess the structural, operational, educational, and communications weaknesses that contributed to the billing errors identified in the Federal investigation.*

#### Key Findings

- The billing problems in the 1990s were *serious and unacceptable*.
- The problems were of all types: *innocent mistake, negligent mistake, reckless error and some rare instances of deliberate fraud*.
- The vast majority of physicians and staff made *honest efforts to comply* with billing requirements.
- The ultimate accountability for UW Medicine is vested in the Dean/VPMA. Responsibility for the billing problems, however, is broadly shared – from those who intentionally overbilled to administrators at several levels who failed to exercise appropriate oversight.
- The Committee found *no evidence of a conspiracy* at any level to overbill the Federal government or to intentionally disregard potential problems; most errors were of omission rather than commission.
- Administrative personnel at UWP did *not consistently respond adequately to billing allegations* with investigations and disciplined enforcement to ensure compliance.

- UWP Administrators failed to *recognize the severity of the initial problems*, apparently did not bring them to the attention of UW Medicine Administrators, and did not take timely steps to strengthen the Compliance Programs in the 1990s.
- The following are the most important *systemic causes* of the problems that led to the Federal billing investigation:
  - *Complacency*, based on the belief that the existing Compliance Programs in the 1990s met or exceeded national industry standards;
  - *Under-valuing of business functions* in comparison to core missions of patient care, research and teaching;
  - *Limited governance and oversight* of UW Medicine’s clinical billing and compliance activities;
  - *Lack of rigorous risk assessment* and recognition of the patterns of billing problems; and
  - *Decentralized management structure*.

*Objective 2: Assess the adequacy of the UW Medicine’s evolving Compliance Program and identify any additional changes that may be needed.*

#### Key Findings

- UW Medicine has made *significant improvements* to its Compliance Programs in recent years. Despite this progress, *continued strengthening is needed*.
- Overall, virtually *all of the formal elements* of effective Compliance Programs described in Federal guidelines *are in place* today at UW Medicine.
- The current Compliance Programs for hospital services billing at UWMC and HMC are strong and well-developed. The physician billing Compliance Program at UWP/CUMG has made significant progress, but it still has *areas to strengthen, especially the audit function*.
- The administration of the Compliance Programs is largely decentralized, and there is *no full-time leader* in the Dean/VPMA’s office to monitor and provide *a comprehensive overview of Compliance* for all of UW Medicine.
- Continuing efforts are needed to promote and instill a *culture of compliance* throughout UW Medicine.
- *Significant risks* for the institution and physicians are present due to the size and complexity of UW Medicine, and increasing governmental oversight.

### Key Recommendations

- Create a full-time position of *Associate Vice President for Compliance and Risk Assessment* in the office of the Dean/VPMA to provide leadership and comprehensive oversight of these critical functions.
- Strengthen the *risk assessment* and compliance planning process by developing an integrated and long-range view of emerging risks.
- Upgrade business systems and processes – especially *billing, auditing, compliance-related training, and automated documentation tools* – to support compliance and make it more “physician-friendly,” i.e., to support providers’ efforts to document, code, and bill accurately and efficiently;
- *Rebuild the UWP/CUMG audit function* in order to meet the targets for Corporate Integrity Agreement (CIA) requirements and OIG guidelines, and to provide physicians and management with compliance performance data.
- Institute a disciplined process to *monitor the implementation* of the Review Committee’s recommendations and the effectiveness of the Compliance Programs.

*Objective 3: Assess whether the governance structure of UW Medicine and the physician Practice Plans provide the necessary level of oversight, and recommend any appropriate changes.*

### Key Findings

- The large size and the composition of the UWP Board of Trustees and the limited role of the UWP Board President detract from the Board’s abilities to effectively *direct and oversee UWP’s compliance functions*.
- The existing governance structure for UW Medicine and the advisory role of the UW Medicine Board *limit the Board’s ability to provide effective oversight*.

### Key Recommendations

- *Strengthen the governance of UWP* by reducing the size of the 24-member Board of Trustees, adding outside members with special experience or expertise, and creating the position of a permanent Physician Administrator to serve as President of UWP.
- *The governance and oversight of UW Medicine must be strengthened.* President Emmert and the Board of Regents should undertake a careful review of the “advisory” role of the UW Medicine Board and the appropriate oversight and governance structure for UW Medicine.



## **B. Full Executive Summary**

### **1. The Relevant History**

**Pre-1996.** UW Medicine and its constituent entities established policies and procedures to ensure compliance with the requirements of Federal billing regulations following the establishment of the Medicare program in 1965. UW Medicine was among the first Academic Medical Centers (AMCs) to employ Professional Fee Coordinators (PFCs)(in the early 1980s) and auditors (in the early 1990s) to ensure that physicians' billing documentation and coding were in compliance with regulatory requirements.

Beginning in 1995, a series of events signaled the increasing importance of billing compliance at AMCs. These included the \$30 million settlement of a Federal audit of teaching physician services by the University of Pennsylvania Healthcare System (Penn) in December 1995; the beginning of the Federal government's Physicians at Teaching Hospitals (PATH) audit program in 1996; and revised Medicare regulations for Teaching Physician Presence (1996); and for E&M documentation (1995 and 1997). UW Medicine was not subjected to a PATH audit, but did assess its Compliance Programs against the requirements of the Penn settlement. It was concluded that UW Medicine's existing Compliance Programs' structural elements met or exceeded these standards in most respects. UWP and CUMG adopted formal compliance plans in December 1996 and January 1997, respectively.

**August, 1999.** Mark Erickson, an eight-year billing staff employee at UWP and CUMG and an auditor at CUMG, filed a False Claims Act or "Whistleblower" lawsuit in Federal District Court on August 3, 1999. Mr. Erickson's lawsuit was under the seal of the Court, but made many allegations of improper and fraudulent billing activity, including an allegation of fraudulent activity in shredding previous "audit" reports. In 1997 and 1998, he had sent letters to the Inspector General of Health and Human Services (DHHS) providing information about alleged billing violations.

**November - December 1999.** The government responded to Mr. Erickson's lawsuit and information by initiating a large, aggressive, and secretive investigation of the Practice Plans. This investigation became public in November 1999<sup>1</sup> with the issuance of search warrants and subpoenas, interviews of UWP employees and physicians, and the convening of a Grand Jury. The purpose and targets of the government's investigation, however, continued to be largely secret until the partial unsealing of the "Whistleblower" complaint in December 2000.

**December 1999 – January 2000.** UWP and CUMG adopted updated Compliance Plans, and the new position of UWP Compliance Officer was filled by a former Assistant Attorney General. These steps had been in the planning process prior to UW Medicine's learning of the Federal investigation.

---

<sup>1</sup>These events made UW Medicine aware that the Federal government was in the process of launching a criminal case against UW Medicine. UW Medicine's understanding of the government's case increased gradually from this point on.

**2000.** A law firm, newly retained by UW, worked to organize defense counsel strategy and to open lines of communication with the U.S. Attorney and DOJ. A litigation oversight committee was formed with Board of Regents and UW Medicine participation. The government investigation focused on the Department of Neurosurgery and the Division of Nephrology. UW Medicine asserted a more active and informed role in the defense strategy.

**2001.** The UWAMC Board Compliance Committee was created at the request of Dean and VPMA, Paul Ramsey.

**2001 - 2004.** UW Medicine exercised increased control over the Practice Plans; it replaced UWP and CUMG administrators, provided additional resources and personnel for compliance, and undertook an internal reorganization of the Practice Plans. In addition, UWP and CUMG commissioned a consulting firm to evaluate UWP/CUMG coding and billing compliance, provided compliance training for all UWP and CUMG faculty, and created a Physician Education, Billing and Compliance (PEBC) Committee.

**2002 - 2003.** Dr. Richard Winn, Chairman of the Department of Neurosurgery and Dr. William Couser, Head of the Nephrology Division, entered plea bargain agreements and were convicted in Federal District Court of criminal charges. Significant controversy surrounded the financial arrangements under which Dr. Winn resigned from the faculty.

**2003.** The U.S. Attorney issued a declination letter that concluded the criminal phase of the government's investigation. The civil investigation continued and the parties began to discuss a possible settlement. UW Medicine and the government differed significantly on how much the Practice Plans would have to pay to achieve a settlement.

**June - December 2003.** UW Medicine commissioned an audit by Compliance Concepts, Inc. (CCI), which determined that UW Medicine owed the government \$3.5 million. Mediation sessions began before the Federal District Court. The government's attorneys alleged \$70+ million in overpayment, subject to treble damages and penalties and raised questions, concerns and serious allegations based on numerous subpoenas, search warrants, and information from Mr. Erickson.

The Federal Magistrate Judge facilitated settlement negotiations. UW Medicine increased its damage settlement offer to \$7.5 million. The government suspended negotiations, made a final demand of \$35 million and threatened to initiate litigation if this offer was not accepted. UW Medicine, with the support and involvement of UW Medicine Board representatives and the Board of Regents, concluded that a global settlement was preferable to years of distracting, uncertain and costly litigation.

**April 30, 2004.** The Settlement Agreement was signed. A Corporate Integrity Agreement (CIA) was also signed and put into effect. UW Medicine component entities paid \$35 million to the Federal government. Between April and September 2004, compliance training was provided to all UWP/CUMG physicians and staff to meet one of the key requirements under the CIA.

**June 10, 2004.** Dean Ramsey proposed, and President Emmert and the Board of Regents endorsed, an independent review to determine the “lessons learned” from the Federal investigation.

**August 6, 2004.** The UW Medicine Board created a special six-member Review Committee of Board Members to determine the lessons learned, to evaluate the adequacy of UW Medicine Compliance Programs and to make recommendations to strengthen the Compliance Programs.

**September 2004.** The Review Committee was organized, established its independence from UW Medicine, hired staff and a consultant, developed a work plan, established a protocol for securing access to documents under legal privilege, and initiated its inquiry.

**September 2004 - June 2005.** The Review Committee undertook an extensive review of documents, conducted interviews, and received briefings to gather information in furtherance of its mission. The Review Committee also commissioned a major consultant report on best practices in compliance at leading AMCs nationally.

**April - June 2005.** Review Committee Members considered an initial draft of the Report and held meetings on successive drafts of the Report.

**June 14, 2005.** The Review Committee approved in principle the final Report, entitled Achieving Excellence in Compliance with Appendices.

## **2. Analysis and Assessment of the History**

UW Medicine’s Compliance Programs were considered to be advanced and structurally sound in the mid-1990s, but there were serious and unacceptable patterns of billing misconduct and violations at a number of the clinical departments. The errors were of all types: innocent mistake, reckless error, and some rare instances of deliberate fraud. The vast majority of physicians and staff made honest efforts to comply with billing regulations. The Committee found no evidence of a conspiracy at any level to overbill the Federal government or to intentionally disregard potential problems. Most errors were of omission rather than commission.

The ultimate accountability for UW Medicine is vested in the Dean/VPMA. Responsibility for the billing problems, however, is broadly shared – from those who intentionally overbilled to administrators at several levels who failed to exercise appropriate oversight. Administrative personnel at UWP did not consistently respond adequately to billing allegations with investigations and disciplined enforcement. This included a failure to respond appropriately to concerns expressed by compliance staff about behavior that appeared to constitute violations of regulations. In addition, investigations of some reported abuses, though warranted, were not undertaken, and a pattern developed of UWP administration deferring to Department Chairs’ opinions about whether physicians’ actions were in compliance with applicable regulations. UWP Administrators failed to recognize the severity of the initial problems, apparently did not bring them to the attention of UW Medicine

Administrators, and did not take timely steps to strengthen the Compliance Programs' management in the 1990s.

With hindsight, it appears clear that the billing compliance problem at UWP was not the policies, structures or processes of the Compliance Programs, but complacent and inconsistent administration and insufficient prioritization of the compliance functions.

- The following were the most important *systemic causes* of the problems that led to the Federal billing investigation:
  - Complacency, based on the belief that the existing Compliance Programs in the 1990s met or exceeded national industry standards;
  - Under-valuing of business functions in comparison to the core missions of patient care, research, and teaching;
  - Limited governance and oversight of UW Medicine's clinical billing and compliance activities;
  - Lack of rigorous risk assessment and failure to recognize the patterns of billing problems; and,
  - Decentralized management structure.

Since 1999, UW Medicine has made significant improvements to its Compliance Programs, including hiring additional staff, revising compliance policies and plans, designating Compliance Officers for each entity, and providing training to physicians and staff. These improvements were reviewed by an external consultant in 2003. By this time, UWP had made substantial improvements to the Compliance Programs.

While there is no question that UWP has made great strides in its Compliance Programs since 1999, the Review Committee is particularly mindful of the absence of regular audits between 1999 and 2004. This has resulted in an inability to provide billing-related performance data to physicians, Practice Plan management, and UW Medicine leadership.

### **3. What Has Been Done: UW Medicine Compliance Programs Today**

Overall, virtually all of the formal elements of effective Compliance Programs described in the Federal guidelines are in place today at UW Medicine. The Compliance Programs for hospital services billing at UWMC and HMC are particularly strong. The physician billing Compliance Program at UWP/CUMG has made significant progress over the 2000 – 2004 period, and even more progress with the January 2005 hire of a new Compliance Officer and additional staff. It still has areas to strengthen, however, especially the audit function.

The current Compliance Programs have many strengths upon which to build:

- There is recognition that the ultimate accountability for ensuring compliant practices at UW Medicine lies with the Dean/VPMA; responsibility for compliant practices within each entity lies with the Executive Director (E.D.);
- A Compliance Officer exists within each entity with day-to-day operational responsibility for the compliance function;
- Formal training programs are in place at all entities; and,
- Appropriate Codes of Conduct, policies and procedures for discipline and enforcement, corrective action plans, follow-up audits and investigations, and reporting and refunds of overpayments are in place at all entities.

The most serious concern is in the area of auditing and monitoring at UWP/CUMG; this is one of the most critical elements of the Federal guidelines used to evaluate Compliance Programs. At UWP/CUMG, the appropriate structures, policies and processes are in place; thus, the Federal guidelines are formally met. UWP/CUMG has, however, conducted few audits of physician services in the past two years. In other words, the formal policies, structures and processes exist, but the necessary activities and desired outcomes are not yet being fully achieved. In recent months, UWP/CUMG has launched an ambitious plan to meet its auditing goals. Effective monitoring and auditing processes are in place for hospital services at UWMC and HMC.

Other areas of needed improvement include:

- The current structure of the Dean/VPMA's senior management team does not provide for full-time focus on compliance overview and risk assessment;
- The size and complexity of UW Medicine and increasing governmental oversight continue to present risks for the institution and physicians. UW Medicine would benefit from the development of an enterprise-wide Risk Assessment and Compliance Plan;
- The large size and the composition of the UWP Board of Trustees and the limited role of the UWP Board President detract from the Board's ability to effectively direct and oversee UWP's compliance functions;
- The existing governance structure for UW Medicine and the advisory role of the UW Medicine Board limit the Board's ability to provide effective oversight;
- The Department Chairs' and CUMG Department Directors' accountability for compliance are not yet sufficiently clear or endorsed as a priority;

- Current business systems and processes, especially billing and automated documentation tools need to be strengthened to make compliance easier to accomplish and less time-consuming for physicians; and
- Continued efforts to promote a “culture of compliance” would strengthen the Compliance Program.

#### **4. Organizational Culture**

The most important and fundamental change that will determine UW Medicine’s future success is how well a *culture of professionalism, ethics, and integrity* is instilled and adopted at UW Medicine. In general, the current organizational culture is much healthier than the culture of the 1980s and 1990s.

##### Responsibility of Individual Providers

Being an excellent physician in a leading AMC requires very high-level performance in all aspects of the institution’s systems for delivering quality patient care. There is no room at UW Medicine to permit some providers – regardless of the task at hand – to perform in a manner that is less than excellent.

UW Medicine’s standard is excellence in patient care, teaching, research, and compliance. Patient care and compliance are two areas in which individual failure, for lack of effort, commitment or dedication, cannot be tolerated. Inadequate patient care threatens human life. Inadequate commitment to compliance threatens institutional survival.

##### Responsibility of Physician Leaders and Department Chairs

The organizational culture of UW Medicine is driven by physician leaders. If UW Medicine is to fully incorporate compliance into its values of professionalism, ethics, and integrity, it must look to Department Chairs and physician leaders to take concrete actions to bring about this cultural change.

##### Responsibility of Administrative Leaders

The administrative leaders of UW Medicine – the entity E.D.s, senior officials in the Dean/VPMA’s Office, other directors, managers and supervisors – also play a critical role in moving the organization’s culture to fully embrace compliance. They must work with the Dean/VPMA and his leadership initiatives to set a tone that is consistent with the organization’s values of professionalism, ethics, and integrity. They must also ensure that the business and administrative infrastructure – policies, procedures, information systems, and other systems – provide support to individual physicians in their efforts and ability to comply with regulations and policies.

#### **5. Review Committee Recommendations**

The Review Committee has made a number of specific recommendations to improve the functioning of UW Medicine’s Compliance Programs. Although there have been major

improvements in recent years, a continuing process of focused quality improvement is needed to further upgrade the compliance function.

The following are the recommendations that the Review Committee considers to be the most important:

- Create a full-time position of *Associate Vice President for Compliance and Risk Assessment* in the office of the Dean/VPMA to provide leadership and comprehensive oversight of these critical functions.
- Strengthen the *risk assessment* and compliance planning process by developing an integrated and long-range view of emerging risks.
- *Strengthen the governance of UWP* by reducing the size of the 24-member Board of Trustees, adding outside members with special experience or expertise, and creating the position of permanent Physician Administrator to serve as President of UWP.
- *The governance and oversight of UW Medicine must be strengthened.* President Emmert and the Board of Regents should undertake a careful review of the “advisory” role of the UW Medicine Board and the appropriate oversight and governance structure for UW Medicine.
- Reaffirm and clarify the *Department Chairs’ and entity E.D.s’ accountability* for overseeing and ensuring compliance in their Departments.
- Upgrade business systems and processes – especially *billing, auditing, compliance-related training, and automated documentation tools* – to support compliance and make it more “physician-friendly, i.e., to support providers’ efforts to document, code, and bill accurately and efficiently.
- *Rebuild the UWP/CUMG audit function* in order to meet the targets for CIA requirements and OIG guidelines, and to provide physicians and management with compliance performance data.
- Continue to *strengthen training programs* and increase the provision of real-time feedback to physicians on documentation and coding.
- Institute a disciplined process to *monitor the implementation* of the Review Committee’s recommendations and the effectiveness of the Compliance Programs.
- Engage outside firms to conduct *periodic independent evaluations* of the compliance function.

## 6. Conclusion

UW Medicine is an outstanding, nationally recognized AMC with an enviable reputation for the quality and balance of its missions of teaching, research, and patient care. This reputation has attracted many extremely talented and dedicated physicians, researchers,

residents, students and staff to the institution. In the aftermath of the Federal billing investigation UW Medicine has both opportunity and incentive to build on its institutional values. The drive to achieve scientific advances must be matched by a commitment to duties of professionalism, ethics, integrity, and compliance.

This challenge must be addressed, physician by physician, department by department, and entity by entity. Compliance is and must be one of UW Medicine's core values. And unlike many other responsibilities, compliance is everyone's responsibility. As the Review Committee has seen, a relatively few acts of non-compliant behavior – whether intentional or otherwise – can threaten what UW Medicine holds dearest: its reputation for excellence and integrity.

The obstacles are not unique nor are they insurmountable. Many other large, successful, fast-paced organizations have overcome similar challenges and the Review Committee is confident UW Medicine will do the same.

This concludes the Executive Summary. The next section begins the detailed Report itself.

## **Report of the Review Committee**

### **I. Introduction**

#### **A. The Investigation and Settlement**

The Federal investigation was initiated by the filing of a False Claims Act (FCA) lawsuit in Federal District Court by a former UWP and CUMG employee, Mr. Mark Erickson, on August 3, 1999. This “Whistleblower” lawsuit was preceded by two letters written by Mr. Erickson to officials at the Office of Inspector General (OIG) at the Department of Health and Human Services (DHHS) on June 18, 1997 and February 16, 1998. In addition to allegations of illegal billing, Mr. Erickson included in the lawsuit allegations that audit documents had been improperly destroyed at UWP and CUMG in 1999. The filing of the “Whistleblower” lawsuit led to a very large, secretive, and aggressive Federal criminal investigation involving the FBI and other Federal agencies. This investigation became public in November 1999 when search warrants were served on nine UWP and CUMG offices. This was followed by subpoenas, threats of criminal charges and the initiation of Grand Jury proceedings.

Neither the University of Washington nor UW Medicine were named in the Whistleblower lawsuit. The named defendants were the two faculty Practice Plans, University of Washington Physicians (UWP) for physicians at UW Medicine’s clinical practice sites; and Children’s University Medical Group (CUMG) for physicians at Children’s Hospital (CHRMC).

The criminal case ended on April 23, 2003, when U.S. Attorney John McKay declined to prosecute anyone other than the two prominent UW Medicine physicians who had pled guilty to felonies in the course of the investigation: Dr. Richard Winn, Chair of the Department of Neurosurgery, pled guilty to obstruction of justice and left his position at UW Medicine in July 2002. Dr. William Couser, Head of the Nephrology Division, pled guilty to one count of mail fraud in connection with billing and resigned from his administrative and tenured faculty position at UW Medicine in July 2003.

#### **B. Costs of the Investigation and Settlement**

On April 30, 2004, the Federal government and the Practice Plans reached a civil settlement of all claims associated with the False Claims lawsuit. Included as Appendix 4 is a chart prepared by UW Medicine regarding the \$35 million settlement and the additional \$27 million of legal costs associated with the Federal billing investigation.



## **II. The Review Committee's Work**

### **A. Purpose of This Report**

Many associated with the University of Washington (UW) and UW Medicine hoped that, with the criminal convictions of a prominent Department Chair and Division Head and the \$35 million settlement, the Federal billing investigation would be put to rest. UW Medicine could then return to the pursuit of excellence in research, teaching and quality patient care.

Others, however, including Dean Ramsey, believed that there was a need for an independent, informed and careful review of what happened, why it happened, and what has been and is being done to address the issues presented in the billing investigation. They also saw a need for a thorough assessment of the adequacy of UW Medicine's Compliance Programs.

On August 6, 2004, the UW Medicine Board, in response to a June 10, 2004 request from Dean Paul Ramsey, and with the endorsement of the Board of Regents and President Mark Emmert, announced the formation of a special Review Committee to address issues related to the billing investigation and the Compliance Programs (see Appendix 3).

The Report of the Review Committee, Achieving Excellence in Compliance, is the product of an extensive ten-month review. It is the work of six citizen Members of the UW Medicine Board who agreed to serve on the Review Committee. The Report represents the Committee Members' observations, analysis, findings and recommendations.

### **B. Committee Membership**

The Review Committee consisted of the following Members of the UW Medicine Board:

- Bill Van Ness, Chair
- Orin Smith, Vice Chair
- Mike Garvey
- Charlotte Guyman (appointed in January 2005)
- Sylvia Mathews
- Brooks Ragen
- Pat Stanford (relocated to North Carolina and resigned from the UW Medicine Board in December 2004)

Staff and the senior consultant to the Review Committee are:

- Diane Sanford, Project Manager
- Esther Holt, Executive Assistant
- Bill Kramer, Senior Healthcare Consultant

### **C. Committee's Independence**

The Members of the Review Committee made a determination to conduct an independent evaluation of the billing investigation and the operation of the Compliance Programs, and not to be unduly influenced by the views of the Federal agencies that conducted the billing investigation, or by the views of UW Medicine's administrators, faculty, or attorneys.

The Committee's process was forward-looking; it had as its objective assisting UW Medicine in developing and implementing excellent Compliance Programs, in full accord with UW Medicine policies and Federal law and regulations.

### **D. Scope of Committee's Review**

The charter for the Review Committee's work is set forth in the August 6, 2004 "Statement of Purpose" that is enclosed as Appendix 3 to this Report. The major elements of this charter are set forth below:

The Review Committee was requested to:

- Assess the structural, operational, educational, and communications weaknesses that contributed to the billing errors identified in the Federal investigation.
- Assess the adequacy of UW Medicine's evolving Compliance Program and identify any additional changes that may be needed.
- Assess whether the governance structure of UW Medicine and the physician Practice Plans provide the necessary level of oversight, and recommend any appropriate changes.

In its initial meetings, the Review Committee Members further clarified the scope of the review and determined that the assessment would be defined according to the following:

- The review would focus primarily on billing and coding, not other compliance issues (e.g., Health Insurance Portability and Accountability Act (HIPAA), research).
- The review would focus on compliance policies and processes and rely on existing data regarding actual performance; it would not conduct new measurements of performance (e.g., a sample of bills to estimate error rates).
- The review would include all physician billing and coding issues (not just those identified during the Federal billing investigation).
- The review would include all UW Medicine clinical departments, not just Neurosurgery and the Division of Nephrology.

- The review would include all UW Medicine entities, not just the physician Practice Plans.
- The review would not undertake an overall performance assessment of UW Medicine Administrators or any individuals engaged in Compliance Program administration.

In developing the Committee's work plan in September 2004, Members of the Committee determined that they had to be informed about "what" happened and "why." This understanding was necessary before the Committee Members could make informed and knowledgeable judgments about the adequacy of UW Medicine's evolving Compliance Programs. As a result, the Committee undertook to gain an informed understanding of the problems behind the Federal billing investigation. This would leave the Committee better equipped to make appropriate recommendations for UW Medicine's Compliance Programs so that potential risks to the institution can be identified early and avoided wherever possible.

### **E. The Committee's Expectations**

As a result of its work and recommendations, the Review Committee's expectations are that UW Medicine will, on a continuing basis, achieve the following major objectives:

- Ensure full compliance with UW Medicine policies and Federal and state billing regulations and minimize the risk of compliance problems in the future;
- Establish excellent business systems to assist physicians in their documentation and billing; and,
- Strengthen UW Medicine's culture of professionalism, integrity, ethics, and compliance.

### **F. Elements of Methodology**

In order to thoroughly execute its charge, the Review Committee developed a methodology to capture the requisite information on the Federal billing investigation; the historical and current organization and administration of the UW Medicine's Compliance Programs; and UW Medicine and its component entities' governance processes and structures. The key elements and principles governing the Committee's approach were:

1. Independence and Objectivity: The review would be conducted in a manner fully independent of the UW Medicine administrators, faculty and attorneys. The Members of the Review Committee are independent Directors of the UW Medicine Board and the Members, staff and consultants have no other ties to UW Medicine.
2. Adequate Resources: The Committee would have a dedicated budget to fund the initiatives that the Committee determined needed to be undertaken.
3. Staff and Consultants: The Committee would maintain its own office and retain an independent staff and consultants, providing services and assistance necessary to the Committee's inquiry, review and recommendations.

4. Access to All Documents: The Committee would utilize the services of the University Division of the Office of the Attorney General in securing access to all relevant documents in the UW's and its legal counsel's custody.

5. Conduct of the Review: The Members of the Committee would be kept fully informed about how the Chair and staff conduct the review.

6. Best Practices: The Committee would seek to determine "Best Practices" in billing compliance at other leading AMCs through the engagement of a national consulting firm and by conducting site visits.

7. Privilege and Privacy: The Committee would have full access to all documents and would honor the Board of Regents' claims of legal privilege; it would not disclose any information in the Committee's Report that would improperly infringe upon the privacy rights of patients, faculty, physicians, providers or staff at UW Medicine.

8. Expert Feed-Back: In recognition of the fact that Committee Members are not physicians or experts in clinical billing practices, compliance programs, or the Federal billing regulations, the Chair, staff and Members would review the Committee's major recommendations with selected physician leaders, legal counsel, Compliance Officers, and others. The purpose of this review would be to obtain informed feed-back on factual matters, AMC best practices, and the Committee's Findings and Recommendations, while retaining the Committee's full independence of judgment and final decision-making authority.

9. Implementing Recommendations: The Committee would encourage UW Medicine and compliance personnel to act promptly to implement any of the Preliminary Recommendations of the Review Committee that would improve the effectiveness of the Compliance Programs.

10. Public Report: When completed, the Committee's full report would be presented to the faculty and staff, UW Medicine Board, President Emmert, the UW Board of Regents, UW Medicine's administrators, and to the public.

The Review Committee Members strongly endorse the importance of the values of transparency and trust at UW Medicine. We believe that these values are essential to build and strengthen a culture of professionalism, integrity and compliance. These values are also critical in the proper implementation and administration of the evolving billing Compliance Programs.

Committee Members recognize that developing and maintaining excellent compliance programs is a constant and ongoing process of quality improvement, one that is adaptive to regulatory, scientific, technological, economic and other changes to the environment in which academic medicine must function.

## **G. Sources of Information**

### **1. UW Medicine Billing Investigation Documents**

The record of the four and one-half year Federal billing investigation is immense. Included are more than one million pages of litigation-related documents.<sup>2</sup> Over half of these were produced in response to subpoenas and the balance of the document are subject to some form of confidentiality protection, such as patient confidentiality or “attorney-client privilege.” In gaining access to these documents, the Committee developed and followed a formal protocol to protect the status of the documents and the rights of patients.

The Chair of the Review Committee reviewed and read voluminous original documents and substantive materials identified as significant by UW Medicine’s attorneys and others, as well as numerous additional documents that he or others on the Review Committee requested. Committee Members and staff also reviewed many of these documents. During the course of the review process, key background documents were compiled into subject matter notebooks that were made available to Committee Members.

### **2. Meetings and Briefings with UW Attorneys**

The attorneys (the Attorney General’s Office (AGO) for the University of Washington, outside legal counsel serving as Special Assistant Attorney Generals, and UWP and CUMG attorneys) acting on behalf of their respective clients, including the Board of Regents (the University of Washington and UW Medicine), and UWP and CUMG, had day-to-day responsibility for the legal process and custody of the documents that constitute the relevant history of the investigation. The attorneys also interfaced with the Board of Regents and UW Medicine, with the Federal agencies conducting the billing investigation and with the “Whistleblower” (plaintiff) and the government on the lawsuit.

In initiating the Committee’s review of the Compliance Programs, the Committee arranged for a series of briefings with UW Medicine’s attorneys to gain an historical and chronological overview of the Compliance Programs, the billing investigation and the resulting changes that were made in the Compliance Programs by UW Medicine. These briefings addressed the following general subject matter areas:

- a. Department of Neurosurgery
  - i. billing improprieties
  - ii. Dr. Winn’s criminal plea to obstruction of justice
- b. Division of Nephrology
  - i. billing improprieties
  - ii. Dr. Couser’s criminal plea to fraud
- c. Other billing issues
- d. Applicable Federal regulations.

---

<sup>2</sup> UW’s attorneys initially reviewed more than four million documents.

In addition, Members of the UW Medicine Board attended executive session presentations made on at least three occasions to the UW Medicine Board by UW's attorneys during the latter stages of the billing investigation.

These briefings and meetings were useful in gaining an informed understanding of the billing investigation and the one million documents that reflect its history. To gain a written and chronological framework for the Review Committee's work and analysis, the Chair and staff sought to identify documents or accounts that provided a narrative history of this complex and important subject. It was determined that such a document or documents had not been prepared. The Chair addressed this lack of an historical framework, in part by having a short history compiled for the Committee's use, based upon newspaper accounts before, during and after the settlement of the billing investigation.<sup>3</sup>

### **3. Key Personnel and Stakeholders**

Over the course of the Committee's inquiry, more than 110 individual interviews and group meetings were conducted to understand the history of the Compliance Programs, their administration over relevant periods of time, and how they have been upgraded and refined since 2000. Some of the meetings listed below were large group meetings with between 20 and 100 participants. The Review Committee estimates the number of people with whom Members and staff met or communicated to gather information in the course of the Committee's inquiry to be approximately 500. For the purposes of describing the number of interviews and meetings conducted by the Committee, below, some meetings are included in more than one category.

a. Physicians. The Committee conducted 45 interviews and meetings with physicians, including all Department Chairs, both individually and in group settings.

b. Compliance Personnel. The Committee conducted 15 interviews and meetings with non-physician compliance personnel from UWMC, HMC, UWP, CUMG and UWSOM, both individually and in groups.

c. Entity Personnel.

i. UWP – The Committee conducted 24 interviews and meetings with UWP leadership and personnel, both individually and in groups.

ii. CUMG – The Committee conducted six interviews and meetings with CUMG leadership, both individually and in groups.

iii. UWMC – The Committee conducted six interviews and meetings with UWMC leadership and personnel, individually and in groups.

iv. HMC – The Committee conducted eight interviews and meetings with HMC leadership and personnel, individually and in groups.

---

<sup>3</sup> This document is included on the Committee's web page and was prepared by a Research Assistant, Quinn Tidaback, in the Chair's Seattle law offices.

v. UWSOM – The Committee conducted four interviews and meetings with UWSOM leadership and personnel.

vi. UWPB – The Committee conducted three interviews and meetings with UWPB leadership and personnel, individually and in groups.

d. UW Medicine Leadership. The Committee conducted eighteen interviews and meetings with UW Medicine leadership, including two meetings and interviews with Dean and VPMA, Dr. Paul Ramsey.

e. University Leadership. The Committee met with President Emmert to discuss its preliminary findings and the progress of the review.

During the review process, Committee staff attended the bi-weekly Compliance Group meeting for UW Medicine’s entity Compliance Officers, chaired and coordinated by John Coulter, the Associate Vice President for Medical Affairs (AVPMA) and E.D. for Health Sciences.<sup>4</sup>

#### **4. Government and Whistleblower**

##### **a) U.S. Attorney**

The Members of the Review Committee did not have access to the documents created or gathered by the U.S. Attorney, DOJ, OIG or other Federal agencies. The U.S. Attorneys’ files were largely unavailable to the public because of long-standing policies and rules governing the secrecy of any matter related to Grand Jury proceedings. The U.S. Attorney’s office did make available, at the Committee’s request, a slide presentation made by a U.S. Department of Justice Attorney and an Assistant U.S. Attorney at a December 6, 2003, Federal District Court mediation session that is posted on the Committee’s website.

The Review Committee met with U.S. Attorney John McKay and the Assistant U.S. Attorneys who led the billing investigation, in order to hear their views about the Federal billing investigation, related legal proceedings, the April 30, 2004 settlement between UW Medicine and the Federal government, and the adequacy of UW Medicine’s clinical practice billing procedures and Compliance Programs.<sup>5</sup>

##### **b) Mark Erickson**

The Review Committee also met with Mark Erickson, a former UWP and CUMG employee and the Relator or “Whistleblower” in the FCA lawsuit. Mr. Erickson was accompanied at this meeting by his attorney, Mr. Stephen Meagher.

---

<sup>4</sup> During the Review Committee’s process, the Member had an opportunity to read a Report from the Faculty Council on Faculty Affairs dated April 24, 2005. The report had been commissioned by the Faculty Senate to look into the settlement with Dr. Winn and related issues. Review Committee Members found the report to be a useful and informative analysis from the faculty’s perspective.

<sup>5</sup> Mr. McKay’s declination letter is enclosed as Appendix 13.

At the time he was interviewed by the Review Committee, Mr. Erickson provided the Committee with a lengthy written statement summarizing his observations and opinions concerning the Federal investigation and the kinds of problems that led up to it. This personal perspective was valuable, although the Committee was well aware that it included allegations, accounts and views with which others involved in the billing investigation strongly differ.<sup>6</sup>

The work of the Review Committee has not included the resolution of detailed factual disputes. The Committee is mindful of the fact that Mr. Erickson's views and evidence were presented by him to the Federal government, and that the U.S. Attorney evaluated and filtered that evidence before confronting UW Medicine with allegations that it judged to be significant and credible.

## **5. Review of Federal Regulations, Guidelines, and Academic Literature**

To gather information on prevailing Federal, industry and academic standards governing best practices in compliance program structure, operations and effectiveness, Committee Members and staff gathered and surveyed various sources. These included:

- OIG Compliance Program Guidance for Hospitals;
- OIG/AHLA Resource for Healthcare Boards of Directors;
- Baldrige National Quality Program criteria;
- Committee for Sponsoring Organizations of the Treadway Commission (COSO) Enterprise Risk Management report; and,
- PATH-related Settlement Agreement Terms.

## **6. Best Practices Study**

In February 2005, the Review Committee engaged PricewaterhouseCoopers to conduct a study of Best Practices in Compliance nationally. The aim of the study was to identify best practices in billing compliance at leading AMCs and to provide relevant information to guide further improvements in UW Medicine's Compliance Programs.

The five AMCs chosen for site visits by PricewaterhouseCoopers and the Committee staff were comparable to UW Medicine in size, academic status, and structure and possessed strong and well-regarded compliance programs. Committee staff also sought AMCs that had been the subject of a PATH audit or a FCA investigation.

The Committee invited physicians, administrators, entity E.D.s, Compliance Officers and others at UW Medicine to join in these visits. It was the Committee's judgment that exposure to how other AMCs developed and administered compliance programs and policies

---

<sup>6</sup> Mr. Erickson's statement is included in the Committee's website at <http://depts.washington.edu/uwmbrc>.

and the priority they attached to this important function would be an educational experience for these individuals.

Teams of seven to ten people, consisting of Review Committee staff, PricewaterhouseCoopers' consultants and UW Medicine Administrators, compliance personnel and physician leaders visited each of the five sites to conduct two days of detailed interviews and receive presentations from their counterparts on the operation of their respective Compliance Programs. The Committee understands that the participants found the visits valuable.

Because of concerns and agreements about confidentiality, the Committee has not disclosed the names of the institutions visited or any sensitive or specific information from the Best Practices in Compliance Study under preparation by PricewaterhouseCoopers. When this Study is completed, however, it will be made available under appropriate conditions for internal review and use by UW Medicine Administrators, compliance personnel and faculty physicians.

#### **7. Member and Staff Training**

All Review Committee Members and staff participated in a standard HIPAA training session and in the training required for all physicians and providers under the Corporate Integrity Agreement (CIA) of April 30, 2004.

#### **8. Committee Meetings**

The Committee met once a month from September 2004, to June 2005. In addition, Committee Members met in smaller groups and the Chair worked closely on a daily basis with Members and staff. The UW Medicine Board and the Board's Compliance Committee, on which some Review Committee Members also serve, met monthly during the period of the Committee's review activities.

#### **H. Cooperation of UW Medicine Administrators, Faculty and Staff**

UW Medicine Administration, faculty and staff have respected the independence of the Review Committee's inquiry into the causes of the Federal billing investigation and the adequacy of the Compliance Programs. The Committee has had the full cooperation of administrators, faculty, staff, and UW Medicine's attorneys in its inquiry.

#### **I. UW Medicine's Compliance Program Initiatives.**

UW Medicine has been actively responding to the need to strengthen and reform its entities' Compliance Programs since early 2000. This has included the investment of significant resources, hiring and training new Compliance staff and auditors, revising billing compliance plans and related documents, naming Chief Compliance Officers for each entity, retaining expert consultants to review and assist in refining the compliance process, and other important initiatives. (A detailed description of UW Medicine's initiatives may be found at Appendix 5: "Developments in UW Medicine Compliance Program: 1999 – Present." Appendix 6 contains a report prepared in May 2005 by UW Medicine at the Committee's

request that reviews compliance developments and provides information on funding and personnel.) Consequently, a great deal of important work had already been accomplished by UW Medicine and its related clinical practice entities before the Review Committee was created in August 2004. The Review Committee's recommendations build upon this work with the objective of ensuring that UW Medicine's Compliance Programs reach the same level of excellence already achieved in the institution's basic missions of quality patient care, teaching and research.

### **III. Overview of UW Medicine**

UW Academic Medical Center (UWAMC) was established in 1992 when the previously separate roles of the Dean of the School of Medicine and the Vice President for Medical Affairs (VPMA) were united in the person of then-Dean Dr. Phil Fialkow. UWAMC was renamed “UW Medicine” in January 2003.

UW Medicine’s mission is as follows:

“UW Medicine works to improve the health of the public by advancing medical knowledge, providing outstanding primary and specialty medical care to the people of the region, and preparing tomorrow’s physicians, scientists and other health professionals.”<sup>7</sup>

#### **A. UW Medicine and its Affiliated Entities**

UW Medicine is not a legal entity, such as a corporation, but rather represents the institutional collaboration of several legally separate, but affiliated, entities. The entities that make up the various elements of UW Medicine are markedly different. Some are academic public institutions that are part of the UW, such as the UWSOM. Others are non-profit corporations with their own governance and boards of directors, such as UWP, CUMG, UWPN and SCCA. The UWMC is a central part of UW Medicine whose governance authority for hospital accreditation, operations and quality of patient care is vested in the UW Medicine Board. The Board of Regents retains authority for some financial matters and capital plant expansion at UWMC. UW Medicine has a contractual relationship with CHRMC to provide physicians for the hospital through CUMG. Harborview Medical Center’s (HMC) capital assets are owned by King County, which provides an appointed Board of Directors. UW Medicine operates the hospital under a management contract and provides the hospital’s physicians through UWP. UW Medicine also provides physicians to area Veteran Administration hospitals, which are part of the Veteran’s Administration, a Federal agency.

The key element tying all of these entities together and to UW Medicine is that they are all staffed by UW Medicine physicians and research personnel and must meet UW Medicine standards for quality patient care, teaching, research and compliance. UW Medicine is a complex organization with multiple missions (patient care, teaching and research) a complicated corporate structure and funds flow. It operates in a highly regulated environment and serves multiple constituencies. One Committee Member has noted that UW Medicine and its many related entities was, by orders of magnitude, more complex than most large business corporations.

#### **B. National Recognition**

UW Medicine’s component entities have received consistent national recognition for the quality of their services: for twelve consecutive years, the UWSOM has been ranked first among all medical schools nationally by *U.S. News and World Report* for training in primary

---

<sup>7</sup> At <http://www.u.washington.org/Global/AboutUWMedicine/>.

care. UWSOM is ranked number one for its rural health program and in 2005, was the only medical school in the country to rank in the top ten in every category in the *U.S. News and World Report* rankings. UWSOM is also ranked first among public medical schools and second among all medical schools nationally for NIH research grant funding. UWMC is recognized by *U.S. News and World Report* as one of the top ten best medical centers in the United States. HMC is the area's designated White House receiving hospital and was ranked by *U.S. News and World Report* in 2004 as one of the top two rehabilitation providers in the country.

Appendix 7 contains an overview and description of each of these institutions. Appendix 8 contains a memorandum which reviews the historical and legal relationships of this federation of entities to UW Medicine and the University of Washington.

#### **IV. Evolution of Medicare Billing Requirements - Summary<sup>8</sup>**

The Medicare billing requirement for teaching physicians have evolved gradually since Medicare was created in 1965. Prior to the mid-1990s the regulations were somewhat unclear, inconsistently applied and largely unenforced by the government. In the mid 1990s, new regulations were promulgated that resolved, to a large extent, the ambiguity that had previously existed regarding two areas: what a teaching physician had to do in order to provide a billable professional service, and the documentation requirements to bill for that service. At the same time, the Federal government initiated its audit and investigation program, the Physicians at Teaching Hospitals (PATH) audits, enforcing adherence to the Medicare Billing Regulations for the first time. The administrative process of clarifying the regulations continues today.

##### Teaching Physician Rules

- In 1967, the Department of Health, Education and Welfare (DHEW, predecessor to the Department of Health and Human Services (DHHS), issued regulations intended to guide teaching physicians as to when they could legally bill for services delivered by residents<sup>9</sup> under their supervision.
- In general, the regulations (under Medicare Part B<sup>10</sup> for a service performed in the course of supervising a resident) stated that a teaching physician could bill if the physician had established an “attending” relationship with the patient, and provided “personal and identifiable” services to the patient. There was confusion as to the degree to which a physician had to be present and to personally supervise the delivery of care in order to bill. No explanation of billing documentation requirements was included in the regulations.
- In response to this confusion, two “Intermediary Letters” (ILs), IL-372 and IL 70-2 were released in 1969 and 1970, respectively.
- According to the ILs, the standard for major, complex and dangerous surgery was that the teaching physician had to be “present [when the procedure is performed] and ready to perform any service performed by an attending physician in a non-teaching setting.” The ILs explained that to be paid under Part B, all services must be “personal and identifiable” and “substantiated by appropriate and adequate recordings entered personally by the physician in the hospital...or outpatient clinic chart.” No further instructions were given as to what constituted appropriate and adequate recordings beyond a countersignature.

---

<sup>8</sup> For further details, please see Appendix 9.

<sup>9</sup> The terms are interchangeable and defined as “an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting” – Medicare Carrier’s Manual, 15016A. Medicare billing regulations use the term “resident” to connote residents, interns and fellows.

<sup>10</sup> Medicare Part A covers institutional costs, such as hospital facility expenses, as well as residents’ and interns’ salaries. Medicare Part B covers medical professional services provided to patients on a fee-for-service (FFS) basis, such as physician services, medical supplies and laboratory tests.

- In 1989, in the course of an attempt to clarify the Teaching Physician Presence Rules, HCFA<sup>11</sup> stated that documentation had to include reference to the degree of physician involvement in delivery of care. The 1989 standards were never adopted in final form.
- In the late 1980s and early '90s, HCFA began to back away from the concept of the “attending physician relationship” and moved toward requiring actual physician presence to bill under Part B.
- In December 1992, Charles Booth, then-Director of HCFA’s Office of Payment Policy, issued a memorandum stating that a teaching physician’s physical presence was required to bill for an identifiable service performed by a resident. The memorandum was widely protested, most notably by the American Association of Medical Colleges (AAMC).
- A new set of teaching physician regulations took effect on July 1, 1996. The Rules required that the teaching physician “be present for a key portion of the time during the performance of the service for which payment is sought.” Physical presence was defined as being located in the same room (or partitioned/curtained/subdivided area) as the patient and providing a face-to-face service.<sup>12</sup> The physician’s countersignature was no longer sufficient to attest to presence for billing purposes. The documentation must adequately reflect the services performed by the teaching physician. These rules are still operative today.

### E&M Guidelines

- The American Medical Association publishes an intricate, complex and evolving set of five-digit codes, known as CPT codes (Current Procedural Terminology). The coding system is designed to provide a uniform language that describes medical, surgical and diagnostic services. The Centers for Medicare & Medicaid Services (CMS) has largely adopted the CPT codes for Medicare billing purposes.
- A common type of CPT code for physician services corresponds to “evaluation and management” or “E&M” services. E&M services can be non-procedural physician office visits, consultations or hospital visits.
- In 1992, HCFA first promulgated guidelines on E&M coding.
- In 1995, HCFA adopted a new set of E&M coding guidelines, based on the 1992 version. These new guidelines were more extensive and precise than those used in 1992.
- In October, 1997, HCFA’s new E&M guidelines became effective. The guidelines were issued in response to criticism that the 1995 guidelines were ambiguous.

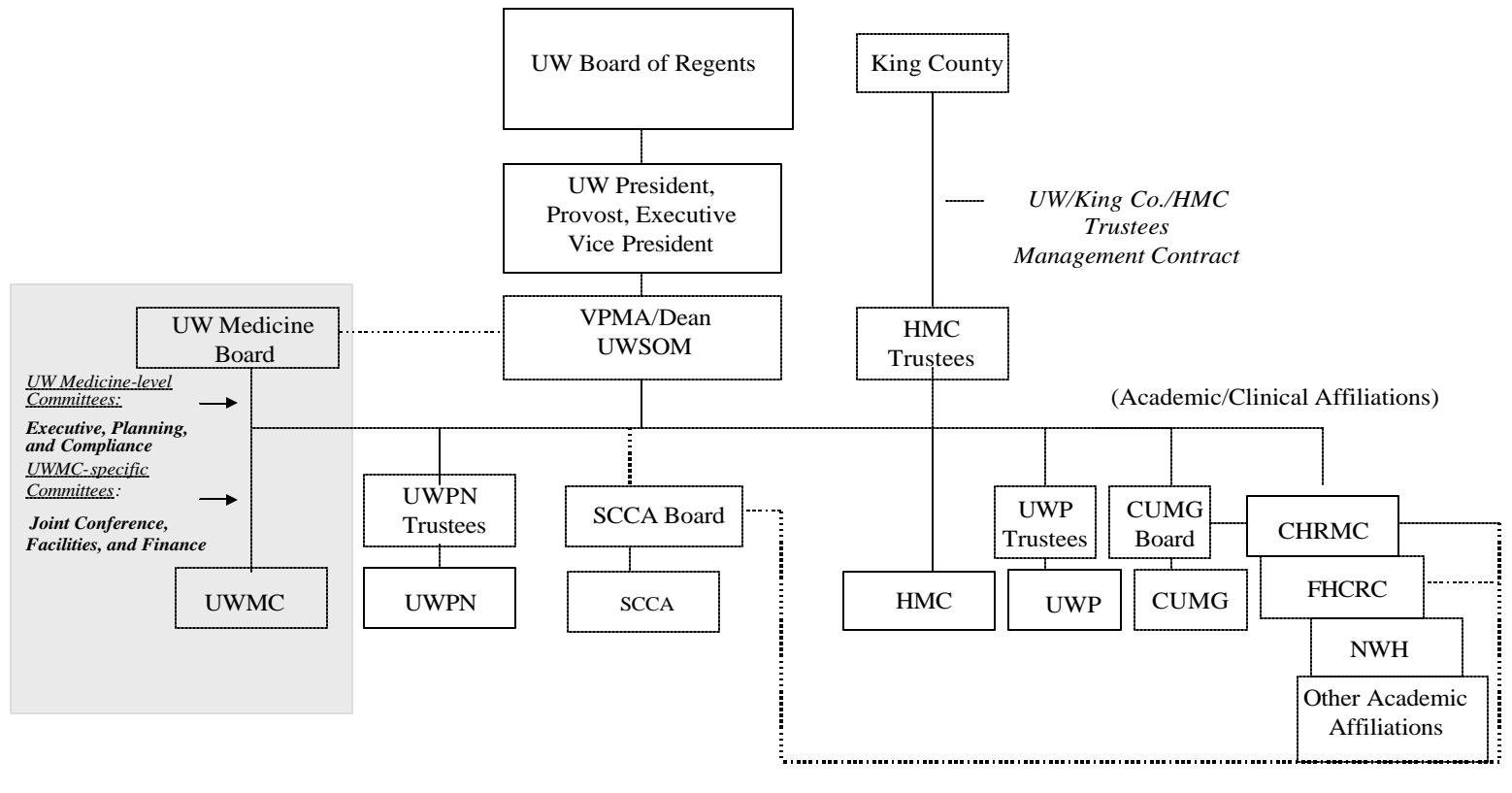
---

<sup>11</sup> In 1977, the Healthcare Financing Administration (HCFA) became the administrator of the Medicare and Medicaid programs .

<sup>12</sup> There are a limited number of exceptions to the “face to face” rule, such as pathology services.

- According to HCFA, either the 1995 or the 1997 guidelines can be used at each healthcare system's discretion.

# UW Medicine Organization



## V. What Happened – Events and Causes

### A. Summary of Developments in Compliance Programs at UW Medicine in the mid-1990s<sup>13</sup>

Prior to the mid-1990s, most AMCs, including UW Medicine, did not have formal, structured Compliance Programs. Beginning in 1995, however, a series of events signaled the increasing importance of well administered compliance programs:

- The University of Pennsylvania Healthcare System’s settlement of the Federal billing investigation for \$30 million in December 1995;
- The revised Medicare reimbursement regulations regarding Teaching Physician Presence that took effect on July 1, 1996;
- The revised Medicare reimbursement regulations regarding E&M (Evaluation & Management services) documentation (1995 and 1997);
- The beginning of the Federal government’s Physicians at Teaching Hospitals (PATH) audit program in 1996; and
- The issuance of DHHS’ Office of the Inspector General’s (OIG) Program Guidance for Hospitals in February 1998, which included details of a model compliance program for hospitals.

These events represented two significant changes: (1) the ambiguous requirements in existence prior to 1996 were clarified, and (2) the inconsistent government enforcement prior to 1996 was ended with the launch of the government’s PATH audits. The evolving standards and enforcement practices gave each AMC notice and an opportunity to reevaluate its compliance efforts.

#### UWP’s Compliance Program in the mid-late 1990s

- Prior to the mid-1990s, UWP had developed a centralized billing function and instituted the use of professional fee coordinators (profees or PFCs).
  - Inpatient and surgical services – PFCs “abstracted the charts” – i.e., assigned a billing code to each service based on the documentation in the medical record. All charts for inpatient and surgical services (more than 70% of UWP’s annual revenue) were abstracted. At this time, however, no one audited the PFCs for accurate code assignment.

---

<sup>13</sup> For further information, see Appendix 10.

- Outpatient services – Physicians signed a fee sheet attesting that they had coded and documented the procedures properly. The completeness and accuracy were checked by means of “spot check” audits.
- In 1996, the E.D. of UWP, Brian McKenna, and UWP’s President, Dr. Frederick Matsen III, jointly transmitted the new Teaching Physician Presence Rules to UWP Members, including an explanation of the rules. Physicians had to sign for the rules to acknowledge their receipt.
- UWP’s first Billing Compliance Plan took effect in November 1996. The Plan included standards of conduct; training of clinical, coding and billing staff; access to uniform coding advice; and internal and external chart and billing reviews. It set forth a process for reporting, investigating and taking corrective action in instances of potential non-compliance. Many aspects of the Plan, however, were not fully implemented, including access to uniform coding advice, training of coding and billing staff and external chart and billing reviews of most departments.
- Responsibility for implementation of the Compliance Plan was vested in the E.D. of UWP, who reported to the then AVPMA, Robert Gust.
- CUMG adopted a similar compliance plan in January 1997.
- In 1997, UWP trained physicians in the new E&M documentation standards.
- In 1998, the UWP E.D. presented to the UWP Board of Trustees a plan to enhance UWP’s audit function. The plan was not fully implemented.

The UWP Compliance Program in the mid- and late-1990s was generally a well-structured program on paper that did not function adequately in practice. Specific problems included insufficient auditing, limited training of physicians and staff, and inadequate investigation of allegations of impropriety. (The latter issue is discussed in more detail below.)

### **1. Early Notice of Allegations of Improper Billing in the 1990s**

News stories and Review Committee interviews with faculty and staff have raised the question of whether or not UWP and UW Medicine Administrators had notice of billing problems before the Federal billing investigation began in November 1999. The Review Committee’s assessment is that UWP Administrators had repeated and pointed notice and consistently failed to take effective action. The next issue presented is whether UW Medicine Administrators acted reasonably and responsibly in response to a number of allegations of improper billing received in 1993, 1995, and 1998.

The Review Committee Chair, some Committee Members and staff reviewed the files on the four matters discussed in this subsection. They also requested briefings by UW’s

attorneys, who had custody of the files. The letters discussed below may be found at Appendix 11.<sup>14</sup>

### Dr. Maier's Letter

The first notice or allegation was raised in a January 5, 1993 letter from the Acting Chief of Surgery (Dr. Ron Maier) to the Medical Director at Harborview Medical Center (HMC) and Associate Dean (Dr. James LoGerfo). Dr. Maier stated a "presumption," based on discussions and interactions with residents, that some neurosurgery attending physicians were improperly billing for procedures at which only a resident was present.

The issues raised in Dr. Maier's letter were handled by Dr. LoGerfo. He spoke to Dr. Maier and asked him to speak to Dr. Winn, the Chair of the Department of Neurosurgery. Dr. LoGerfo also spoke directly to Dr. Winn and received assurances that the "presence" rules were being followed in the Department of Neurosurgery. Dr. LoGerfo also sent two sets of memoranda to Clinical Service Chiefs reminding them about the attending's presence requirements for billing. The Committee was informed that this matter was also brought to the attention of Dean/VPMA Phil Fialkow, who asked Dr. LoGerfo to bring the problem to the attention of Brian McKenna, the E.D. of UWP and Robert Gust, AVPMA, the officials responsible for UWP and its Compliance Programs for clinical practice billing.

Dr. LoGerfo responded actively and responsibly to Dr. Maier's 1993 letter. The Committee recognizes, however, that in today's post-Federal billing investigation environment, allegations of this nature would require a significantly more rigorous investigation by UW Medicine's, UWP's and HMC's management and their Compliance Officers.

The Committee would like to commend Dr. Maier for the manner in which he raised his concerns. This is a model of how a physician or staff member at UW Medicine should bring a compliance concern forward to Compliance Officers and management. Dr. Maier's approach was responsible and appropriate. He stated his concerns and their basis, and he directed his concerns to senior management. The Committee commends all faculty and staff who have raised concerns in this way. UW Medicine employees have a responsibility and are encouraged to take a similar approach.

### Renay Bruner's Letter

The second allegation was contained in a seven-page letter of resignation, dated November 25, 1995, written by Renay Bruner (also known as "Swanee Rivers"), a UWP Support Coordinator. In her letter, she stated that Mark Erickson was collecting information showing evidence of "massive illegal billings that have occurred within the kidney dialysis area," including billings for physicians' services at times when they were documented to be on vacation. Ms. Bruner went on to note that others in the Department were worried about illegal billing and that Ms. Bruner's supervisor had given direct orders for PFCs to bill

---

<sup>14</sup> These letters, with the exception of Ms. Bruner's, are found in Appendix 11. Ms. Bruner's letter is not included as it contains information and accusations against individuals, which the Review Committee, on the advice of counsel, has chosen not to disclose.

illegally, for example, by directing a PFC to “sign a physician’s signature when it was missing.”

UWP’s Administrative Director, Patrick Murphy, and E.D., Brian McKenna, talked to Ms. Bruner’s supervisor about Ms. Bruner’s letter. The supervisor denied Ms. Bruner’s allegations. The Administrative and Executive Directors apparently did not conduct any further investigation into Ms. Bruner’s complaint. In addition, Dean Fialkow’s office was never notified about the allegations or follow-up investigation.

The response to Ms. Bruner’s allegations was clearly inadequate. UWP’s Administrators should have advised the Dean’s office when explicit allegations of fraud were made and undertaken a broader and more thorough investigation. Far more should have been done to review such serious allegations.

Certain facts may help to explain why the Administrative and Executive Directors did not conduct a more vigorous investigation, although they certainly do not justify the limited response. Ms. Bruner’s letter did not focus on billing allegations. Instead she devoted most of her letter to discussing complaints about her supervisor. The letter clearly reflected significant personal conflict between Ms. Bruner and her supervisor. It was only on page six of the seven-page letter that she made her claims about false billing. The allegations may have been perceived as simply an attempt to throw in one more accusation against Ms. Bruner’s supervisor. In addition, although Ms. Bruner had stated that Mr. Erickson was the individual compiling the records that demonstrated false billing, his note or letter (which arrived shortly thereafter) did not include the allegations to which Ms. Bruner referred.

#### Mark Erickson’s Letter

The third allegation was contained in a note sent December 11, 1995, from Mark Erickson, who later became the Whistleblower, to UWP’s Administrative Director, Patrick Murphy, complaining that nephrology charts were being returned to physicians for documentation up to one year after the procedure.<sup>15</sup>

The Administrative Director wrote back to Mr. Erickson, stating that he had spoken to Dr. Couser, the Chief of the Division of Nephrology, who contended that he and the other nephrologists understood the requirement for personal presence in order to bill for the dialysis procedure. The Administrative Director stated that UWP took these concerns seriously and that he wanted to know if this response resolved Mr. Erickson’s concerns. Mr. Erickson wrote again on February 13, 1996, stating that he interpreted the letter to mean that UWP would not route files back to the physicians for documentation. The Administrative Director responded to the second communication, stating that Dr. Couser had undertaken to encourage the physicians to document their services at the time of service, but that might not always occur. UWP would still give them an opportunity to document their presence later.

The first response to Mr. Erickson from the Administrative Director was copied to Dr. Ramsey (then Chair of the Department of Medicine), but Mr. Erickson’s original letter and the later correspondence were not. The document copied to Dr. Ramsey contained

---

<sup>15</sup> See Appendix 11.

assurances that the nephrologists understood the presence rules. It contained nothing to suggest that improper billing or falsified documentation was occurring, or even that the late documentation was as late as it in fact was. Given these facts, there was nothing to suggest to Dr. Ramsey that Mr. Erickson's concern was not being adequately addressed.

It is a close question whether the response to Mr. Erickson's concerns was adequate. Mr. Erickson did not allege that physicians were documenting services for which they were not present or that others were signing for them. He complained that documentation was occurring well after the fact (and there is nothing inherently wrong with accurately correcting an omission in the medical record within a reasonable time after the service is provided). Certainly, in today's environment a letter such as Mr. Erickson's would merit a far more probing inquiry; such an inquiry might have revealed some of the problems that were later the subject of the Federal billing investigation.

Finally, as noted elsewhere in this Report, it was improper to rely solely on the responses from Department Chairs or Division Heads in the investigations of allegations.

During the course of his employment, Mr. Erickson raised concerns to his colleagues and supervisors on numerous occasions, and on one occasion (the December 11, 1995 letter discussed above), to UWP and CUMG leadership about billing practices that he viewed as inappropriate. The responses Mr. Erickson received, however, were limited and unsatisfactory, and he did not see billing practices change as a result of his repeatedly expressed concerns. UWP's and CUMG's management's lack of responsiveness may have been in part due to the fact that, with the exception of the December 11, 1995 letter, Mr. Erickson does not appear to have expressed his concerns to UWP administrators, beyond his colleagues and supervisors. At any event, Mr. Erickson relates that the lack of responsiveness was a significant factor in his contacting DHHS and subsequently launching the FCA lawsuit as a "Whistleblower" (see Section V. B.1.a. below).

For at least some of the complaints he raised, Mr. Erickson's supervisors should have investigated his complaints in further depth. In at least some instances, had they investigated further, they would have discovered problems that were later the subject of the criminal investigation. UWP and CUMG should never discourage faculty or staff, at any level of operations, from coming forward with concerns, and should always accord the appropriate respect and procedural care to anyone's concerns. The chain of events involving Mr. Erickson should serve as a potent reminder of how important that commitment is. The elements of the institutional culture that permitted these events to occur were serious weaknesses; for the future, the culture must encourage faculty and staff to raise concerns so that the issues can be addressed constructively.

#### Dr. Spiess' Letter

The fourth allegation was raised by Dr. Bruce Spiess in an April 8, 1998 letter to Dean Ramsey raising a number of issues, including some related to his employment, but also concerns and allegations about staffing issues related to patient care, and improper billing activities of some physicians in the Department of Anesthesiology.

Dr. Spiess' 1998 allegations were the subject of multiple reviews over a substantial period of time. Each of the medical, legal, consultant and investigative reviews, conducted by different individuals at different points in time, arrived at the same conclusion: there was no credible information developed to support any of Dr. Spiess' allegations, and there was significant evidence contradicting his allegations. For example, Dr. Spiess alleged that after a particular liver transplant, one physician, although not attending the procedure, said he "would simply sign for the liver transplant 'so the department could bill.'" However, the billing records showed that this physician in fact did not bill for this procedure. A letter that Dr. Spiess claimed criticized him for not falsely signing billings for unsupervised fellows in fact criticized him for not supervising those fellows and then not co-signing the notes he would properly have co-signed had he supervised them. A billing clerk whom he claimed had asked him to sign a particular record denied having done so.

Dean Ramsey received Dr. Spiess' initial and other letters. He also met with Dr. Spiess and promptly directed his staff to examine the allegations. He was informed by Steve Milam, Assistant Washington State Attorney General, of the results of the multiple reviews and investigations.

The Review Committee believes that the extensive investigations into Dr. Spiess' allegations were sufficiently thorough and independent. The investigators concluded that there was a lack of corroborating evidence and the presence of clear contrary evidence. The reviews and investigative reports, however, should have been finalized more promptly.

The U.S. Attorney's Office reviewed the Spiess allegations as a part of the Federal billing investigation but apparently decided to take no action on the allegations. The Office also declined the UW's attorneys' offer to make a formal presentation on the Spiess matter.

#### **Correspondence between Dr. Paul Ramsey and Dr. William Couser, December 1996-January 1997**

As part of its review of early warnings of inappropriate billing practices, the Chair and staff of the Review Committee examined correspondence between Dr. Paul Ramsey, the Chair of the Department of Medicine (1992-1997) and President of UWP (1996-1997), and Dr. William Couser, Head of the Nephrology Division, on the subject of the causes of a sharp decline in the Division's revenue in the first quarter of FY 1997. The issue presented was not an allegation of improper practices, but potential inferences that could have been drawn from Dr. Couser's explanations for the decrease in gross fees collected. The Chair and staff of the Review Committee concluded that Dr. Ramsey acted appropriately and responsibly in pursuing the decreased revenue issue with Dr. Couser at the time. However, the correspondence between Dr. Couser and Dr. Ramsey does reveal missed opportunities on the part of UW Medicine to act to remedy coding and billing problems in the Nephrology Division. Further details of this matter are contained in Appendix 12.

#### **Commentary regarding the Role of Paul Ramsey**

Dr. Paul G. Ramsey is the Vice President for Medical Affairs and Dean of the School of Medicine at the University of Washington. After receiving his M.D. from Harvard Medical

School in 1975 and completing residency training in Internal Medicine at Massachusetts General Hospital, he came to the University of Washington in 1978. He served as Chair of the Department of Medicine from 1992 to 1997. He also served as President of UW Physicians from 1996 to 1997. In June of 1997 he was appointed Vice President for Medical Affairs and Dean of the School of Medicine.

The Committee has reviewed the record and interviewed Dr. Ramsey regarding his knowledge of and actions relating to allegations of billing problems in the 1990s, a period during which he held administrative positions of increasing responsibility. Ms. Bruner's allegations and Mr. Erickson's concerns, discussed above, occurred while Dean Fialkow was in office and before Dr. Ramsey became Dean. Dean Ramsey did receive Dr. Spiess' letters and promptly directed his staff to examine the allegations. He was informed of the results of the investigation. In the Review Committee's judgment, this investigation was thorough and complete and the Dean took appropriate action based on the information available.

A question remains in the minds of some people, however, as to whether the Dean was aware of additional billing problems and took appropriate action in response. The Dean has strongly asserted that he was not aware or made aware of additional problems and, if he had been, he would have taken steps to ensure they were being addressed. The Review Committee's view is that, prior to the launch of the Federal investigation in 1999, the Dean was largely insulated from knowledge about other billing problems by UWP management and the Dean's senior staff members responsible for compliance oversight. While he was aware of the Spiess allegations and that UWP Administration had looked into concerns about a billing issue in Nephrology – as noted above – these apparently isolated incidents provided an inadequate basis to believe or conclude there was false billing or to take specific administrative action.

Beyond the issue of the Dean's awareness, the Review Committee's view is that early in Dean Ramsey's administration, UW Medicine did not give a sufficiently high level of attention and priority to billing compliance. It was not until 1999 that compliance was made a higher priority and steps were taken to strengthen the Compliance Programs.

## **2. Pre-Investigation Audits**

In August 1996, UWP, through its legal counsel, Preston, Gates & Ellis, LLP, commissioned Arthur Andersen LLP to perform an initial risk assessment of billing and physician presence, following the University of Pennsylvania settlement in December 1995.

Through the Arthur Andersen work, UWP learned that Radiation Oncology had a patient tracking system that attributed services to the physician who developed the patient's treatment plan, rather than the physician who provided the care under that treatment plan. This system reported the wrong physician as the performing physician on the medical record. This billing system accounted for many of the high number of physician mismatches (initially 2504, but later reduced to 796 services) in the final Arthur Andersen report. However, because the Arthur Andersen report was designed to highlight risk areas rather than serve as a basis for repayment, UWP subsequently hired Ernst & Young to do a broader, more detailed audit of Radiation Oncology. Even prior to the engagement of Ernst & Young, Radiation

Oncology changed its billing system to report services by the physician actually providing the service. In 1999, UWP made a voluntary disclosure and, in 2000, repaid the Federal government for Medicare services that had been miscoded by Radiation Oncology. The repayment was followed by a detailed written disclosure to the Medicare carrier.

## **B. Summary of Investigation and Outcomes**

### **1. The Criminal Case**

The “Whistleblower” lawsuit was filed by Mark Erickson, an employee from 1991 to 1999 of both of UW Medicine’s Practice Plans. Mr. Erickson was employed first as a PFC at UWP, then at CUMG, and finally in an outpatient auditing capacity at CUMG.

#### **a) False Claims Act (FCA)(Whistleblower) Laws uit**

In 1997, Mr. Erickson sent a letter to the Inspector General of DHHS alleging billing fraud at UWP. He sent additional materials to DHHS in February, 1998. Mr. Erickson’s FCA lawsuit was filed on August 3, 1999. The suit was filed under Federal court seal, and, accordingly, was not formally made known to UW Medicine. UW Medicine’s attorneys inadvertently became aware of the existence of the complaint, but not of its substance. The Federal government launched a large criminal investigation and, in November 1999, executed search warrants at UW Medicine’s Practice Plans’ offices. The government sought interviews with faculty members, Practice Plan officials and hospital employees at their residences. The government’s secret and aggressive criminal investigation was based, at least in part, on Mr. Erickson’s allegations of improper shredding of audits.<sup>16</sup> This matter is discussed below.

#### **b) The Audit Shredding Allegations**

The government investigated Mr. Erickson’s allegation that UWP and CUMG had “eviscerated” their Compliance Plans through a number of mechanisms allegedly designed to hide the poor results in “audits” that were conducted subsequent to the 1996 Medicare rule changes. These mechanisms included: changing the audits from retrospective (i.e., auditing claims already billed) to prospective (i.e., auditing the bills before they were submitted to Medicare and other payors); changing the wording of the audit forms (e.g., calling them “reviews” rather than “audits”); and shredding hard copies of audits created before the wording changes were made.

#### **Committee Commentary on the Audit Shredding Allegations**

There is no question that the above changes were made and that some hard copy draft audits were shredded. The issue is whether these actions were taken in good faith or for improper purposes. The government asserted to the Review Committee that the changes and shredding were done to hide poor results. UW Medicine’s attorneys had contended to the government that there were numerous facts suggesting a good faith motivation for the changes. For example, the change from retrospective to prospective audits (which

---

<sup>16</sup> Under Federal Rule of Criminal Procedure 6(e), Grand Jury matters may not be disclosed except to a few authorized government attorneys/personnel or with court authorization under specific circumstances.

Mr. Erickson had alleged was done to avoid disclosing the incorrect billings) was a change adopted by many institutions across the country because it could identify coding and billing weaknesses and remedy the issues before inaccurate bills were submitted. Prospective audits were adopted nationally also because they provided educational feedback to physicians on their coding decisions while the services provided were still fresh in their minds.

As to the changes in the audit forms, UW Medicine's attorneys pointed out that none of the information on the original forms was omitted in the changed forms (except for a calculation of compliance/error percentages, and that this was evident from the remaining data on the forms). As to the wording, even though the changes made reports of poor results less threatening, they would not have kept outside auditors from readily discerning the rates of errors.

As to the shredding, UWP and CUMG contended that they frequently shredded draft audits and other work where it contained or was based on individual patient healthcare information. In addition, they retained in their files copies of most of the shredded audits, which the Practice Plans contend would indicate that they were not trying to hide results.

It is not up to the Review Committee to resolve this dispute. Whether the changes were done out of good intentions—to make the audit results less confrontational and thus more likely to lead to changes in behavior by the audited physicians—or out of a desire to make the results less obvious to the reader, we simply cannot say. There was no trial on these allegations and issues, so there is no record of judicial process and fact finding on which to base determinations.

Nevertheless, it is clear to the Review Committee that the manner in which these changes in audit policy were handled by UWP was hasty and clumsy, at a minimum. Without hearing a detailed justification for the changes, a disinterested observer could reasonably conclude from the manner in which these changes were implemented that there may indeed have been a heavy-handed and incompetent effort to hide or obfuscate poor audit results. This is apparently what Mr. Erickson concluded and it appears to have formed a significant basis for the government's initiation of their subsequent, aggressive criminal investigation.

In retrospect, the Review Committee has difficulty in understanding why such a series of significant changes in audit policies and procedures was not formally previewed and explained by memorandum, administrative notice or discussions with UWP personnel, and especially with compliance staff, auditors and physicians. This whole incident is exceedingly unfortunate because it helped trigger a highly adversarial criminal process between the DOJ and UW Medicine's Practice Plans that continued for two years. UW Medicine should take pains in the future to ensure that its related entities' actions, even if well-intentioned, cannot be interpreted as showing any intent to hide "bad news." This is an important example of where better documentation and oversight by the central administration of UW Medicine would have provided important benefits.

### c) Retention of Legal Counsel

UW Medicine reacted to the criminal investigation by retaining legal representation to deal with the Federal investigation as it unfolded. The University of Washington itself was never a target of the investigation, but the Board of Regents had to be kept informed of the progress of the litigation in order to respond to any problems that might be revealed. Due to the specialized nature of the case, the Washington State AGO, which is required by statute to represent UW Medicine, retained Richard Tallman, a very well-respected former Federal prosecutor with white-collar crime experience, to represent the University as a Special Assistant Attorney General. Within a few months, Mr. Tallman was nominated to become a Federal judge on the Ninth Circuit Court of Appeals. The University then retained Dan Dubitzky of Dubitzky & Zarky, P.S. UWP and CUMG were first represented by their long-time counsel, Preston, Gates & Ellis, L.L.P., and later by a law firm that specializes in healthcare litigation, Bennett Bigelow & Leedom, P.S.

Under the bylaws of the two Practice Plans, plan employees had to be furnished with legal representation. The plans are private 501(c)(3) not-for-profit corporations. No state or university funds were spent on obtaining legal representation for faculty. Some residents, who are not Plan employees, were provided with attorneys and those fees were paid by the University.

Much of UW Medicine's time in the initial phase of the investigation was spent trying to determine the scope and purpose of the government's investigation and obtaining appropriate legal representation for plan employees. The government did not allow UW Medicine access to its early criminal theory of the case or the information it had gathered; it subpoenaed considerable data and requested that UW Medicine turn over much more. UW Medicine decided to facilitate government interviews with employees, provide information that would be cumbersome for the government to access otherwise through subpoenas and brief the government on how UW Medicine, as a very large and complex institution, functions. To some extent, UW Medicine's decision not to share all information requested by the government was driven by the fact that it was not known if the Practice Plans were going to be criminally indicted on the basis of the information requested by the Federal government. The penalties associated with such an indictment were potentially extremely severe.

In total, approximately 175 Federal subpoenas were issued to UW Medicine's hospitals, related entities and the Practice Plans. UW's legal counsel reviewed over 4,250,000 pages of documents during the four and one-half-year period, retained one-half million of them in their custody, while generating many more. UW Medicine provided the government with over 563,000 pages of documents. UW's legal counsel learned of over 200 individuals who were interviewed by the government, and reinterviewed many of them as part of an ongoing effort to understand the government's theory of the case. By 2001, counsel for UW Medicine had ascertained the main areas of governmental interest in the investigation. With a few exceptions discussed below, the government concentrated on the Department of Neurological Surgery, the Division of Nephrology and the Interventional Radiology Section.

Allegations concerning the Department of Neurological Surgery included:

- “Bedside” procedures – allegations that the Department had billed for minor bedside procedures under Medicare Part B when the procedures had in fact been performed by a resident without attending physician presence or supervision;
- Billing for chief residents as attending physicians or assistants at surgery;
- “Back-dating” of medical records for billing purposes;
- Billing for a patient’s physician as a surgeon, even though he or she was not present for the surgery; and,
- Billing in the name of an attending surgeon who was not physically present for long enough during the surgery to satisfy the Teaching Physician Presence Rules.

**d) Dr. Winn’s Plea Bargain**

Many of the above allegations were leveled at Dr. Richard Winn, Chair of the Department of Neurological Surgery. UW Medicine Administrators, in conjunction with legal counsel, attempted to evaluate whether the allegations were sufficiently serious to warrant action being taken against Dr. Winn. After reviewing the evidence and Dr. Winn’s response to the allegations, UW Medicine Administration concluded the evidence acquired was equivocal enough that no action was warranted. Shortly thereafter, allegations came to the Dean/VPMA that Dr. Winn had been obstructing justice, principally by influencing residents’ testimony before a Grand Jury, a Federal offense. Neurosurgery is a very small field and the favor of a highly respected leader in the field, such as Dr. Winn, could greatly affect a resident’s long-term career objectives and success. The Dean/VPMA directed counsel to determine if there was corroborating evidence. When two witnesses confirmed the allegations, counsel advised the U. S. Attorney of the situation, and the Dean/VPMA asked Dr. Winn to step down from his administrative positions.

The government moved to indict Dr. Winn. Dr. Winn and his counsel then entered into lengthy plea bargain negotiations. Due to the complexities of the Faculty Code termination process for tenured faculty, UW Medicine was unable simply to terminate Dr. Winn, as would likely occur in a non-academic context. The Faculty Code provides for dismissal of a faculty member once convicted of a felony, but that had not yet occurred.

UW Medicine was very concerned about the impact of a lengthy trial, in financial and institutional terms, and on the already damaged Department of Neurological Surgery. UW Medicine was concerned that it would no longer be able to recruit highly qualified residents and would risk losing key faculty/physicians and residents in the Department, which would substantially damage the provision of quality patient care. In addition, UW Medicine was concerned that any residents forced to testify in a Federal District Court trial and/or before the Faculty Senate against Dr. Winn could risk serious damage to their future careers.

In July 2002, Dr. Winn pled guilty to a felony count of obstruction of justice. UW Medicine settled with Dr. Winn for \$3.5 million (contingent on Dr. Winn's future employment and the salary he was paid, which would be deducted from that amount). UW Medicine determined that the financial costs of a trial would exceed this amount, and concluded that avoiding the intangible costs and the time and uncertainty of a trial made the settlement reasonable and worthwhile. The Review Committee notes that the \$3.5 million settlement paid to Dr. Winn was very high and controversial. However, if UW Medicine had not settled with Dr. Winn, it would have been forced to pay him his very large salary throughout the period of the trial, in addition to legal fees for numerous individuals. That amount would likely have exceeded the amount paid in settlement. In addition, a trial would have seriously detracted from the provision of quality patient care and impeded UW Medicine's ability to concentrate on solving its compliance problems. For the aforementioned reasons, the decision to settle with Dr. Winn was, in the Review Committee's view, the right judgment for the well-being of UW Medicine. Further information on the allegations against Dr. Winn and the details of his plea agreement are available to the public through the Federal District Court. The Review Committee will not replicate that public record information in its Report.

e) **The Nephrology Division and Dr. William Couser**

Dialysis procedures are generally performed on an outpatient basis by nurses and technicians. When a patient is hospitalized, however, dialysis is provided in the hospital, and the hospital submits bills for the dialysis service. In such circumstances, the patient's physicians may or may not visit the patient during dialysis. The government was concerned with possible improper billing for a physician's services when the physician was not present.

The government investigated allegations that the Division of Nephrology and UWP administrative staff's practices would permit physicians to bill for dialysis services they had not provided. The system in place made it easy for a physician to bill for a dialysis procedure regardless of whether he or she had actually been present. When there had been dialysis but there was no documentation of physician presence, PFCs would send a request for completed documentation to the attending physician on-call at the time of the procedure. These requests were routinely sent weeks after the procedures had been completed. Among other things, there were allegations of physicians signing a stack of such documents without regard to their actual presence. It was to a practice such as this that the Head of the Division of Nephrology, Dr. William Couser, pled guilty when admitting that he had committed fraud.

Further information on the allegations against Dr. Couser and the details of his plea agreement are available to the public through the Federal District Court. The Review Committee will not repeat that material in its Report.

f) **Interventional Radiology (IR)**

During the criminal investigation, the government became interested in the IR Section, where a physician presence issue had arisen. It appeared that there was significant confusion among the physicians regarding the presence standards in force, as IR procedures are billed as both surgical and procedural services, for which the presence requirement is not the same.

The government investigated whether any physicians, rather than being confused, were knowingly billing for services provided by IR fellows when the billable physician did not meet the presence requirement. UW Medicine immediately ceased billing for IR. The Section proceeded to retrain the physicians and staff and later resumed billing under changed procedures.

The government did investigate and pursue one physician who had authored a memo that was on display in the Section, stating:

“At the beginning of every dictation, you will clearly state: ‘the Attending Interventional Radiologist, Dr. \_\_\_\_\_ was present during the case.’ Following this you can proceed with the dictation. If you do not do this, you will not dictate the case!”

There were allegations that the physician in question intended these instructions to apply whether the attending physician had in fact been present or not, but these allegations were never substantiated. Conversely, there was also evidence that the physician intended the suggested language to redress a persistent inaccuracy in IR residents’ charting of care – an omission that might have led services being billed by the Section when there was sufficient presence but insufficient documentation.

The physician in question resigned. The government later declined to prosecute the targeted physician.

#### **g) Surgery**

In General Surgery, the government investigated bills submitted by a foreign fellow, whose visa status limited his ability to practice in the United States. The Department Administrator and PFCs working for the Department of Surgery appeared to have identified instances when bills for the fellow were mistakenly submitted. The Chair of the Department of Surgery, Dr. Carlos Pellegrini, confirmed that as soon as the problem was identified all surgeons were made aware of the issue and agreed that the fellow would be adequately supervised and only appropriate billing would be submitted to UWP. The government did not pursue the investigation into this matter further.

In the course of the investigation, the government also took the position that the Operative Record, which is completed by nurses, was the most authoritative document regarding a physician’s presence during an operation. UW Medicine’s attorneys took the position that it was not a reliable indicator for this purpose, because it was never intended to be a record of physician presence and was never reviewed for accuracy; that the nurses had a different understanding of how the Record was to be filled out; and that some nurses were inconsistent in how they filled out the Record.

UW Medicine worked with the UWP Compliance Officer, outside experts and each of the facilities to create a simplified policy that would be uniform throughout the system.

## **h) Fee Cards**

Before the Federal investigation began, some CUMG inpatient fee cards did not list the lower levels of E&M service. A few fee sheets for surgical procedure areas at UWMC and HMC did not list the lower code levels. The government asserted that this contributed or even encouraged upcoding by the physicians. Those responsible for creating the forms denied that motivation, instead responding that they had tailored the forms to reflect only those levels most frequently used in the service areas in question. UWP, CUMG and the hospitals began including all levels of E&M code on the forms starting in the Spring of 2000.

## **i) Declination of Prosecution of UWP and CUMG**

By letter of April 23, 2003, the U.S. Attorney, John McKay, declined to prosecute UW Medicine's employees and entities further and brought the criminal phase of the investigation to a conclusion. Mr. McKay also praised the vast majority of physicians who were associated with UW Medicine and UW Medicine's accomplishments in the area of reforming the UWP Compliance Program (see Appendix 13).

## **2. The Civil Case**

### **a) Overview**

The civil component of the FCA case began in earnest in January 2003. Since neither the criminal nor the civil cases went to trial, none of the claims were tested, beyond the audit and extrapolation process discussed below. Under the relevant provisions of the FCA, treble damages could, and likely would, have been assessed had the matter gone to trial and the Practice Plans not prevailed.

UWP and CUMG entered into a settlement with the United States on April 30, 2004 in which the Practice Plans, with substantial funding assistance from other UW Medicine entities (see Appendix 4), paid the United States \$35 million and were required to enter into a five year Corporate Integrity Agreement (CIA).

Under the terms of the April 30, 2004 settlement, UWP and CUMG were released from all liability for improper claim submission for a nine year period (January 1, 1995 through December 31, 2003). In addition, the OIG released any claims that could have formed a basis for excluding UWP and CUMG from Federally-funded programs (Medicaid, Medicare and TRICARE/CHAMPUS). Among other terms, the CIA mandated that a sample of services provided by each of UW Medicine's clinical physicians be audited internally every two years, except for the Department of Neurological Surgery and Division of Nephrology, which must be audited annually. The CIA also included a mandatory six-hour training on the substance of its terms, for all physicians and practice plan employees within 120 days of the CIA taking effect as well as billing, coding and documentation training.

It merits recognition that by April 30, 2004 UW Medicine had significantly revamped its Compliance Programs, and the improvements required by the CIA beyond the changes already made were relatively minimal.

## **b) Scope and Extent of Federal Billing Violations**

As noted above in Section II.G., the Committee has concluded from its review of thousands of the relevant records, other materials and in excess of 110 interviews, that the vast majority of UW Medicine's physicians and providers made honest efforts to comply with applicable Federal billing regulations and guidelines before, during and after the four and one-half year Federal billing investigation.

### Informal Assessment of Departments

An informal review undertaken by the Chair and Committee staff concluded that, of the eighteen School of Medicine clinical Departments subject to the Federal billing investigation, there was no known government interest expressed in the billing practices of two of these Departments (Laboratory Medicine and Urology).

Minimal interest was raised by the government with respect to two other Departments (Neurology and Rehabilitation Medicine).

Minor concerns were raised by the government at four other Departments (Family Medicine, Medicine, Ophthalmology, and Psychiatry).

Some compliance concerns were raised by the government at six other Departments (Otolaryngology, Pathology, Pediatrics, Radiation Oncology, Obstetrics and Gynecology, and Radiology).

Significant concerns were raised at two of the Departments (Surgery and Anesthesiology).

Major concerns and substantial investigations, including criminal investigations by the government, were focused on some physicians and billing activities in three areas: the Department of Neurological Surgery; the Department of Medicine's Nephrology Division; and the IR Section of the Department of Radiology.

Concerns were expressed and investigated at one other Department (Orthopedics and Sports Medicine) about joint surgeries that physicians in that Department had conducted with surgeons from the Department of Neurosurgery.

It should be noted from this review that the more detailed focus of the government's inquiry was on relatively few Departments and Divisions and on a relatively small number of the physicians in UW Medicine's two faculty Practice Plans. Even in those Departments and Divisions where serious or major concerns were raised and extensive investigations were conducted, the government focused on only a few physicians.

While it might be theoretically possible to make a rough calculation of the number of alleged or suspected billing violations from a careful survey of the one million pages of documents relevant to this case, the Review Committee concluded that such an effort was not justified. The costs would far outweigh the benefits, especially given that, with much of the evidence unavailable, the Review Committee would have little confidence in the results.

It is clear, however, that there were serious and unacceptable patterns of billing misconduct and violations by some physicians at a number of the clinical Departments. Some errors were made innocently, some were made negligently and recklessly, and a few were made repeatedly and knowingly.

In a December 6, 2003 mediation settlement proceeding before Federal Magistrate Judge Martinez, the DOJ and the US Attorney's Office made a lengthy presentation on multiple alleged violations of Medicare regulations at UW Medicine and a compilation of the government's damage claims.

The government's presentation was clearly its "worst case" advocate's view and, was therefore, one-sided, especially on damage claims. The government's presentation consisted of numerous documents, prepared largely by UW Medicine Compliance and other personnel, on the subject of perceived or alleged billing violations occurring in some clinical departments by a number of physicians. These documents raised very serious allegations and questions about billing compliance at UW Medicine that were not adequately investigated or acted upon by UWP management.

The December 6, 2003 presentation is lengthy and will, with some other documents, be included on the Review Committee's website (<http://depts.washington.edu/uwmbrc>).

The scope and focus of the Federal billing investigation should, however, be kept in context and proportion. The records the Committee has reviewed indicate that while the four and one-half year investigation was aggressively pursued, little or only minor interest was expressed by the government in many of the clinical Departments' billing practices or in those of the very large majority of UW Medicine's physicians.

### **3. The Settlement**

#### **a) The Respective Damage Calculations**

UW Medicine and the Federal government differed greatly in their estimation of damages. UW Medicine, through Bennett Bigelow & Leedom, hired expert consultants, CCI, whose principals had designed the PATH audit protocol and performed PATH audits for both the government and other AMCs. CCI was retained to determine the extent of damages. They presented a \$3.5 million estimate over a 12 year period of time. In contrast, the government initially claimed that \$110 million was a conservative estimate over the same period. Through a series of discussion and concessions, the government's figure dropped to \$70 million and the Plans' damage estimate increased somewhat. The remaining gap, which involved complex issues of estimation methodology and interpretation of the relevant rules and regulations, was never resolved. In January 2004, with Magistrate Judge Ricardo Martinez as mediator, UW Medicine and the Federal government agreed in principle to settle for \$35 million dollars. Significantly, the settlement was the largest in teaching physician and AMC history, \$5 million more than University of Pennsylvania healthcare system in 1995. However, UW Medicine's settlement covered a nine year period, whereas the University of Pennsylvania's covered six. UW Medicine's settlement encompassed Medicare, Medicaid

and TRICARE/CHAMPUS claims, whereas the University of Pennsylvania's only included Medicare claims.

The Federal government did not conduct its own audit to calculate damages. Instead, the government's numbers were based upon its analysis of the CCI sample, with the government's own interpretation of "which" sample billings should be denied. The government presented its damage calculations in the December 6, 2003, DOJ presentation mentioned above. The government arrived at a figure of approximately \$70 million in overbillings to Medicaid and Medicare. Given the treble damages allowed under the FCA, the government's total figure was approximately \$210 million.

One limitation in CCI's analysis is that the audit and sampling assumed the truth and accuracy of the underlying documentation. Since there were some demonstrated instances of fraud, this assumption was not universally valid. UW Medicine contended that such instances were fairly isolated, while the government believed that instances of fraud were more widespread.

#### **b) Analysis**

UW Medicine's attorneys contended that there were significant flaws in the government's analysis. They were prepared to argue that the government: 1) did not take into account underpayments, only overpayments; 2) did not give credit for services that its own auditors had already agreed were correctly billed; 3) disallowed all radiology, pathology and electrocardiogram bills, based on an objection to electronic signatures, despite their being allowed under the regulations and despite investigation that suggested that they were being properly used and transparent to the auditor; 4) applied Medicare documentation requirements to Medicaid billings, even though Medicaid requirements differed in ways that would allow for billing when Medicare might not<sup>17</sup>; and 5) disallowed one neurosurgery billing (and, by extrapolation, all neurosurgery billings), because of their concern about that surgeon's practices, even though there was no evidence that the surgeon had been absent and significant evidence that he had been present. Correcting these errors alone, UW Medicine attorneys contended, would reduce the overbilling figure from the government's number of \$70 million to \$12 million.

The points made by UW Medicine's attorneys appear to the Committee to be well taken. However, the government may well have been correct that further litigation would have revealed more flaws in the documentation, increasing further any extrapolated overbilling amounts. But the settlement ended once and for all a deeper and adversarial inquiry into these issues. Based on the admittedly incomplete record at the time of the settlement, it appears to the Review Committee that the true amount of net overbilling is certainly higher than the original \$3.5 million figure resulting from CCI's audit, but that there is little basis, once the various contentions of the parties are carefully considered, for believing that the true number is close to the \$70 million figure or even trending somewhat towards the middle.

---

<sup>17</sup> For example, Medicaid did not have published standards, or documentation thereof, during the years covered by UW Medicine's settlement with the Federal government.

Beyond the question of “how much overbilling,” is the question of “was it worse than elsewhere.” The government’s anecdotal evidence does not show that UW Medicine’s error rate was worse than other institutions. No other institution was subjected to the intense, lengthy criminal investigation that UW Medicine faced, so the level of anecdotal evidence would naturally be higher at UW, regardless of the relative error rates. And UW’s settlement also covered a longer period of billing and more payment programs than did the other large settlements such as the University of Pennsylvania, so a larger settlement is not properly evidence of a greater degree of billing problems.

The Review Committee heard on numerous occasions from faculty physicians who had trained and/or practiced at other AMCs that billing practices at UW Medicine were no better or worse than at other institutions in the 1990s. By the same token, the Committee heard from a few faculty physicians that questionable billing practices adopted by some UW residents and physicians were a problem for a while after they transferred to other AMCs.

The Review Committee has also included as Appendix 14, a July 12, 2004 letter from Dr. William O. Robertson, former Medical Director of the University Hospital and Associate Dean, UWSOM, to the Chair of the UW Medicine Board. Dr. Robertson’s letter provides a very useful historical insight into how the “presence” requirement of Federal billing regulations was treated in practice at some UW Medicine entities and at other AMCs over the years.

Neither of the above points regarding the quantity of overbilling or how it compared to other institutions in any way undercuts the Review Committee’s conclusion that there were too many billing errors at UW Medicine. Some errors were a result of simple mistakes, some others were a result of negligence, some of recklessness, and some of fraud. But a valid conclusion of “too many” errors does not imply that we can, on the record of this matter, draw any definitive conclusion about “how many” errors or whether the level was better or worse than experienced at other institutions.

### **c) The Committee’s Views on the Settlement**

Some informal observers are of the opinion that, given the strongly held views of the parties, the fact that a settlement occurred at all is surprising. The Federal government contended it had evidence that would cast broad and serious doubts on the legitimacy of billing at UW Medicine and would support a very large financial recovery. While acknowledging the existence of some serious billing errors, the Board of Regents, UW Medicine’s leadership, and attorneys felt that many elements of their legal case were strong and they could prove that the extent of culpability and the scale of improper billing was a small fraction of that portrayed by the government.

The Federal government and UW Medicine held very different views about how pervasive the billing abuses were. The DOJ claimed overbilling of \$70 million<sup>18</sup>, and UW Medicine claimed \$3.5 million based on the CCI audit. There was no way to determine precisely or to estimate reliably what the actual amount was. This was due to the fact that the

---

<sup>18</sup> The government’s estimation of damages changed over time.

issues presented were never litigated or tested with the rigor of judicial process and the audit process could not easily or reliably address many of the U.S. Attorney's claims. Accordingly, the dispute could only be resolved by litigation or compromise. Regardless of which side was closest to correct, the billing problems they reflect were serious.

Toward the end of the mediation process in Federal District Court the government gave the Practice Plans an ultimatum. Their final proposal was a \$35 million offer of settlement, open for only two days, or the government would initiate civil litigation on the billing issues in the Federal investigation.

The University's representatives and attorneys fully recognized that, beyond the merits of their position on specific legal issues, they faced a daunting legal and procedural problem that overhung their planned defense of the case. The problem was that the FCA carries mandatory remedies for the government of treble damages and \$5,000 to \$10,000 in civil penalties (penalties for claims submitted after September 29, 1999, were increased to \$5,500 to \$11,000) per false claim knowingly submitted. Federal law defines the "knowing" element to include reckless disregard of the truth or falsity of the claims submitted.

The two Practice Plans submitted thousands of claims per month. If the government could show that over a ten-year period, the Practice Plans knowingly or with "reckless disregard" billed 350 or more claims per year – or one per day – then the civil penalty exposure would be \$35 million alone, before the assessment of treble damages. And it was very likely the government could show that significantly more than 350 such claims a year were incorrect in some respect.

In light of this damage assessment projection and the relevant legal considerations (and the additional fact that there was some criminal conduct), the government's \$35 million settlement offer was not outlandish, even when weighed against the modest CCI audit projection of \$3.5 million in damages. Further, because of the criminal guilty pleas, the bottom line evaluation for the UW representatives was not whether the Practice Plans would ultimately lose if the case was litigated, but rather how badly, in financial terms, the Practice Plans would lose. Given the likely penalties, a major loss could have been ruinous for the Practice Plans and had major impacts on UW Medicine.

In view of this analysis, the settlement was hardly "surprising."

While not an excuse for UW Medicine's billing problems, significant settlements have not been unusual with other academic medical institutions. Moreover, the problems identified at UW Medicine's Practice Plans were similar to those for which repayment was made by other AMCs as part of the PATH audits. PATH audit settlements to-date range from

\$800,000<sup>19</sup> to \$30 Million<sup>20</sup> and, in many cases, involve only one Federal program and cover a lesser period of time than UW Medicine's nine year settlement.<sup>21</sup>

In the end, the Federal government, through U.S. Attorney John McKay's leadership, ultimately concluded that the best interests of justice and of the regional medical care system, in which UW Medicine (through HMC, UWMC, Children's, SCCA and the VA Hospitals) played a very prominent role, would be best served by making a comprehensive settlement and concluding the long civil investigative process.

The Board of Regents and Dean Ramsey came to a similar conclusion: that the benefits of a settlement in terms of finality and institutional stability outweighed the risks and any potential benefits that might have been achieved by going through a long, uncertain and very complex civil trial.

It is the Review Committee's judgment that the April 30, 2004, settlement was the proper decision by both the Board of Regents and the Federal government. The settlement leaves many factual and legal issues open, which protracted civil litigation could, perhaps, have answered. But, the settlement decision permits UW Medicine, and all those who comprise it, to proceed – without the legal uncertainty, the continuing distraction of the investigation and a long, complex and expensive civil trial – in focusing on refining UW Medicine's Compliance Program's and on the institutional core missions of quality patient care, teaching and research.

### **C. Causes of the Problems that led to the Federal Billing Investigation**

It was critical for the Review Committee to understand not only what happened with regard to UW Medicine billing processes, Compliance Programs and the Federal investigation in the 1990s, but also why these things happened. Why did problems exist in the billing process? Why did UWP's and UW Medicine's management not identify and correct problems at an early date? Why did these problems become so serious that they resulted in Federal criminal and civil investigations, and a large financial settlement with attendant financial and institutional costs?

The focus of much of the publicity regarding these events has been on specific individuals, especially the two prominent faculty members who pled guilty to criminal charges (obstruction of justice and fraud). Problems of this scope, however, are seldom due solely to a small number of "bad actors." To fully understand the problems, it is necessary to examine systemic causes. Experts who have studied a wide variety of similar events believe that it is important to identify and understand the root causes that contributed to the problem. In order for UW Medicine to learn from the past and minimize the likelihood of similar problems in the future, it must ensure that these systemic causes are addressed.

---

<sup>19</sup>Made by Johns Hopkins University in February, 2003–  
[www.aamc.oeg/advocacy/library/teachphys/phys0022.htm](http://www.aamc.oeg/advocacy/library/teachphys/phys0022.htm)

<sup>20</sup> University of Pennsylvania, December 1995.

<sup>21</sup> For example, the University of Pennsylvania's settlement covered a six year period, involved only Medicare claims, and represented treble damages on an underlying claim of \$10 million in improper billing.

During the more than 110 individual and group interviews and meetings that the Committee conducted with UW Medicine physicians, nurses, staff and administrators, the Committee asked questions about the “causes” of the problems that led to the Federal billing investigation and its aftermath. In response to this question, the Committee received a wide range of opinions that are synthesized and summarized below. For each suggested cause, we have included representative quotations from the interviews and provided commentary based on our analysis. The Committee attaches significance to these responses and opinions because they reflect the complexity of UW Medicine, reveal the views of many of the talented people that make up the institution, and provide important insights into the structure, processes and culture of UW Medicine during the 1990s.

The issues discussed in this section do *not* provide a comprehensive description of UW Medicine’s organizational culture. This discussion focuses on aspects of the culture, some of them negative, which may have led to the billing problems. This focus might create the impression that the overall situation was dysfunctional. In fact, there were and are many positive elements of UW Medicine’s culture, and they have provided a foundation for the many successes and accomplishments that UW Medicine has achieved. The Members of the Review Committee have been impressed by the organization’s commitment to excellence in its missions – clinical care, teaching and research. The observations below are offered with the constructive intent of further strengthening a culture of compliance and excellence in what is already, in many respects, a healthy and productive organizational environment.

### **The Most Important Causes - Overview**

In summary, the Review Committee Members believe the following to be the most important causes of the problems that led to the Federal billing investigation. Each item is followed by representative quotations from interviews with faculty, staff, and administrators. The causes are described in more detail in the following section.

- Complacency. (“We thought we were ahead of the curve on regulatory compliance.” “We were not a part of a PATH audit.”)
- Under-valuing of business functions. (“We’re here to save lives and do research; the administrators are here to take care of the administrative stuff and keep the doctors out of trouble.” “Compliance is an administrative hassle that was laid on us by government regulators who don’t understand medicine.”)
- Limited governance and oversight. (“The UW Medicine Board had no real authority and wasn’t providing guidance or oversight.”)
- Lack of rigorous risk assessment. (“No one was looking out into the future to identify potential risks and the need to take preventive action.” “We were too slow to respond to the changing regulatory environment.”)
- Management structure. (“No one in the Dean’s office was providing direction on compliance; the compliance function was too decentralized.” “The entities and the

departments within UW Medicine operated independently, and there was insufficient communication as issues arose.”)

### **Other Factors That May Have Contributed - Overview**

- Rapid growth. (“We grew so fast; our business systems and infrastructure didn’t keep up.”)
- Confusing regulations. (“The complexity of the regulations was overwhelming; no one could be expected to keep track of everything.”)
- Inadequate knowledge. (“The physicians and staff weren’t given the training and information they needed to do the job right.”)
- Financial pressure. (“Everyone was under pressure to increase revenue.”)
- Naivety/Deference to physician leaders. (“It was hard to believe that any of our physicians could be breaking the law.”)
- Financial accountability. (“The UWP Board saw increased spending on compliance as taking money away from physician compensation.”)
- Power and status. (“The Professional Fee Coordinators were hesitant to challenge the physicians regarding questionable coding.”)
- Communications barriers. (“No one wanted to raise or hear bad news.”)
- Busy-ness. (“The physicians are so busy keeping up with the demand for patient care; they didn’t have time to focus on documentation and compliance.”)

### **The Most Important Causes - Discussion**

- Complacency (“We thought we were ahead of the curve on regulatory compliance.” “We were not part of a PATH audit.”)

As noted earlier, throughout the 1990s, UW Medicine operated on the assumption that it had an excellent, leading edge clinical billing Compliance Program in place at UWP and CUMG. UWP was formed as a centralized practice plan in the late 1970s, and it was among the first to employ Professional Fee Coordinators. UW Medicine’s evaluation of the 1995 Penn settlement and CIA requirements led UW Medicine to believe that the structural elements of the UWP Compliance Program were sufficiently strong. Furthermore, UW Medicine was not selected as a “target” in the initial wave of the PATH audits. In retrospect, a UW Medicine PATH audit might have been preferable to the trauma subsequently suffered through the billing investigation, in that a PATH audit would have led to an earlier evaluation and correction of the shortcomings in the clinical billing and compliance processes. As it stood, UW Medicine Administrators did not launch a major initiative to upgrade the Compliance Programs until late 1999. At the same time, however, the bar was being raised. The

Federal government was stepping up its oversight and enforcement activities, and some other AMCs were hastily engaged in making major improvements to their Compliance Programs.

- Under-valuing of business functions (“We’re here to save lives and do research; the administrators are here to take care of the administrative stuff and keep the doctors out of trouble.” “Compliance is an administrative hassle that was laid on us by government regulators who don’t understand medicine.”)

The 1990s culture at many AMCs and at UW Medicine did not make compliance with Medicare billing regulations a high priority. The training of physicians did not include much emphasis on billing compliance or other regulatory issues. Physicians at UW Medicine were focused primarily on mission objectives: patient care, research and teaching. Secondary areas of focus were contributing positively to Department revenue goals and objectives, institutional career advancement, and achieving recognition for research. Strict compliance with Federal billing regulations was, to many physicians, a time-consuming administrative matter that benefited auditors rather than patients; patients were always considered more important in the constant competition for physicians’ limited time. No awards or recognition were given to the physicians who read, understood and conscientiously followed the Medicare billing and documentation guidelines.

- Limited governance and oversight (“The UW Medicine Board had no real authority and wasn’t providing guidance or oversight.”)

In the 1990s, there was inadequate high-level formal governance authority for UWP and its billing Compliance Programs; the UW AMC Board was not created until 2000, and it had only advisory authority regarding UWP. From this point on, matters of importance were brought by UW Medicine Administrators to the Board. During the early stages of the billing investigation, the Board’s Chair, Vice Chair, and one other senior Member of the Board received briefings by UW Medicine and UW’s attorneys and participated in strategic meetings of a litigation oversight committee that included Members of the Board of Regents. Some information from these briefings was shared with the other Members of the Board. After information about the investigation became public, the UW Medicine Administration provided the full Board with briefings by UW’s attorneys about the investigation and allegations. The UW Medicine Board was not asked to provide oversight or guidance about the Compliance Programs until well after the investigation had been launched. In early 2001, Dean Ramsey recommended and the UW Medicine Board created a Board-level Compliance Committee which began active monitoring, review and oversight of the Compliance Programs.

- Lack of rigorous risk assessment (“No one was looking out into the future to identify potential risks and the need to take preventive action.” “We were too slow to respond to the changing regulatory environment.”)

Despite the warning signals from the Penn settlement, the 1996 Federal regulations regarding physician presence, and the launch of the PATH audits, there was little recognition of the growing level of risk. As a result, there was not a strong effort to upgrade UW Medicine's Compliance Programs between 1996 and 1999. During this period, some other AMCs realized that they faced serious risks and took steps to make needed improvements.

- Management structure (“No one in the Dean’s office was providing direction on compliance; the compliance function was too decentralized.” “The entities and the departments within UW Medicine operated independently, and there was insufficient communication as issues arose.”)

The management structure of UW Medicine has been relatively decentralized. Although the Dean/VPMA retained formal management authority, the individual entities (UWP, CUMG, UWMC, HMC, etc.) operated with a significant degree of autonomy, and the Dean/VPMA was largely insulated from day-to-day compliance issues. Each entity had its own Compliance Program; the organization at the Dean’s office was such that no one was formally designated as accountable for overseeing compliance until after the Federal investigation was launched.

### **Other Factors That May Have Contributed - Discussion**

- Rapid growth (“We grew so fast; our business systems and infrastructure didn’t keep up.”)

The systems and infrastructure of many organizations that grow as fast as UW Medicine are often inadequate to support such growth. UW Medicine has grown very rapidly in research funding and service volumes, and UWSOM depends much more on professional billing revenue than it did in the 1980s. There have, however, not been adequate investments in business systems, e.g., billing, documentation, automated medical records, and other systems, to accommodate this growth.

- Confusing regulations (“The complexity of the regulations was overwhelming; no one could be expected to keep track of everything.”)

The Medicare billing regulations have been complex and often inconsistent with the traditional practice of medicine. It is true that some of the requirements crucial to the outcome of this matter, such as pre-1996 physician presence requirements or the E&M documentation and coding standards were not clear. Many have pointed out, however, that most physicians are highly intelligent and capable of understanding the regulations relevant to their specialties. Other AMCs have found ways to clarify the regulations for faculty physicians, or at least instruct them regarding the appropriate interpretation of any vague requirements.

- Inadequate knowledge (“The physicians and staff weren’t given the training and information they needed to do the job right.”)

The Practice Plans and UW Medicine's education programs for physicians in the 1990s were insufficient. Other AMCs launched major training programs that were required for all faculty physicians.

- Financial pressure (“Everyone was under pressure to increase revenue.”)

At many AMCs during the 1990s, there was a preoccupation with increasing the Practice Plan's revenue that often overwhelmed the Compliance Program's requirements. For example, as recently as 1999, a respected consulting firm was retained to undertake a major evaluation of UWP's billing program. Even though Penn had made a very substantial settlement in the wake of its Federal billing investigation, and PATH audits were underway at other AMCs, the consultant study focused on efficiency and opportunities to increase revenue; it paid little attention to UWP's parallel responsibility for managing an effective Compliance Program. It should be noted that the potential direct financial benefits of overbilling were relatively minor when compared to the overall compensation of most individual physicians. Personal financial gain does not appear to have been a primary cause of the billing problems that led to the Federal billing investigation.

- Naivety/Deference to physician leaders (“It was hard to believe that any of our physicians could be breaking the law.”)

Some administrators and managers at UWP followed a practice of being overly deferential, and in some cases yielding final authority, to the Department Chairs and Division Heads in interpreting the Federal regulations. UWP administrators did not consistently respond adequately to verbal and written reports from compliance staff of improper or illegal billing activity. They also frequently failed to go beyond simple consultation with the Department Chairs in investigating an allegation. Part of the problem was that in the 1990s, many Department Chairs also served as the Chief Compliance Officers for their Departments. This authority gave the Chair the last word on whether a Department's billing practices met UW Medicine policy and billing regulations. In hindsight, this created potential and, on occasion, real conflict between the Chair's responsibilities for Departmental finances and the Chair's responsibilities for proper implementation of the Compliance Programs. It allowed the concentration of too much authority in the Department Chairs without countervailing checks and balances.

- Financial accountability (“The UWP Board saw increased spending on compliance as taking money away from physician compensation.”)

The UWP Board members – all of whom are UW Medicine faculty – have a financial conflict in the form of competition between budgets for: (1) billing, compliance and other business functions; and (2) funds for department administration and physician compensation. This may have led to under-investment in compliance-related functions in the 1990s.

- Power and status (“The Professional Fee Coordinators were hesitant to challenge the physicians regarding questionable coding.”)

The Review Committee heard anecdotes of instances of rude, impolite and unprofessional behavior by a number of physicians toward the PFCs and auditors in connection with staff efforts to provide feedback to providers regarding untimely, incomplete, improperly coded and/or undocumented bills. Some of these anecdotes indicate that among a few physicians, this type of behavior continued during and even after the settlement of the Federal billing investigation. It appears that today, however, incidents of such unacceptable behavior are rare.

- Communications barriers (“No one wanted to raise or hear bad news.”)

Some of those interviewed felt that the general UW Medicine culture, especially at UWP, discouraged people from raising problems. It also appears that job re-assignments and minor rebukes at UWP had the effect of discouraging some billing and compliance staff from reporting and bringing forward instances of non-compliant billing, documentation and coding activity.

- Busy-ness (“The physicians are so busy keeping up with the demand for patient care; they didn’t have time to focus on documentation and compliance.”)

It is true that physicians’ daily life was and is very busy, and this probably contributed to the lack of emphasis on compliance initiatives. This very busy-ness, however, may have contributed to the lack of awareness of the growing risks of audits and investigations.

## **Conclusion**

There is no single systemic cause for the billing problems that led to the Federal investigation. In combination, however, the factors discussed above created an organizational culture and climate that enabled some individuals to violate billing regulations for many years without being sanctioned. This placed the entire UW Medicine organization at a high level of risk.

### **D. Developments in UW Medicine Compliance Programs: 1999-2004**

#### **1. Professional Billing Compliance - UWP and CUMG – 1999-2004**

- In December, 1999, shortly after the beginning of the Federal investigation, UWP and CUMG hired their first Compliance Officer, Steve Milam, a former Assistant Attorney General.

- In January, 2000, UWP and CUMG adopted revised Billing Compliance Plans, including mandatory billing and compliance training upon hire and annual compliance audits of each specialty group.<sup>22</sup>
- In February, 2000, UWP and CUMG's Compliance Officer formed a Compliance Council to assist in the investigation and resolution of issues brought to the Compliance Officer's attention.
- In January 2001, a consulting firm was engaged to provide an assessment of the UWP/CUMG billing and coding functions and Compliance Plans.
- In June, 2001, UW Medicine administration formed a committee to implement changes to the Compliance Programs. These included the development of a more detailed Code of Conduct, the hiring of more billing staff to abstract all services, training for PFCs and the internal reorganization of the Compliance Program.
- In September 2001, the UW AMC Board Compliance Committee was formed. At the same time, the Dean/VPMA assigned one of his senior staff, John Pettitt, to oversee compliance.<sup>23</sup>
- In late 2001, UWP and CUMG created Physician Education, Billing and Compliance (PEBC) Councils.
- UWP's E.D., Brian McKenna, resigned in October 2001 and was reassigned to a position at UWSOM, where he had no billing or collections responsibilities. He was replaced in September 2002. A new CUMG E.D. was hired in January 2003. Robert Gust, Associate Dean of UWSOM and AVPMA, retired in August 2003.
- UWP instituted mandatory compliance training for physicians in 2002. Between May 2001 and December 2002, UWP conducted 83 group and individual training sessions.
- In Spring 2003, UWP and CUMG developed a detailed Code of Conduct that every new employee was required to sign and agree to uphold.
- In May of 2003, a consulting firm reviewed UWP's progress towards improving the compliance function. By this point, UWP had made substantial improvements to the Compliance Programs, including hiring many more staff members.
- A new Director of Regulatory Compliance for UWP and CUMG was hired in Spring 2004. She resigned in November 2004 and was replaced in early 2005 by the person who also serves as Compliance Director for UWMC.

---

<sup>22</sup> Actions to hire a Compliance Officer and revise the billing Compliance Plans were underway before the initiation of the Federal billing investigation.

<sup>23</sup> In January, 2000, the Regents had approved renaming and expanding the duties of the UW Medical Center Board. The Board was renamed UW Academic Medical Center Board and its expanded duties included advising the Dean/VPMA on many AMC issues. In January 2003, the UWMC Board was renamed the UW Medicine Board.

- In 2004, under the terms of the CIA, UWP and CUMG trained 2000 faculty and staff in billing and coding documentation requirements.

## **2. UWP and CUMG's Compliance Program in 2005**

- The compliance budget for Fiscal Year 2004 was approximately \$4 million for the two plans.
- UWP's Board of Trustees recently approved an increase of five analyst positions in UWP's Office of Regulatory Compliance. The compliance staff now totals 15 full-time positions.
- UWP and CUMG recently developed a revised billing review (audit) process that includes one-on-one educational feedback to each faculty member. Under the new process, all audit results will be shared with Department leadership.
- There are currently 18 UWP PFCs located at UWMC and 12 PFCs at HMC. All but eight are certified. Two additional PFC positions are vacant. Plans have been made to host three sessions of coding "boot camp" for PFCs over the Summer of 2005. CUMG employs ten PFCs, three of whom are certified.
- UWP's Compliance and Education Committee (formerly PEBC Council) and CUMG's PEBC Council continue to meet, oversee compliance activities, and receive reports from Compliance Officers regularly.

## **3. HMC and UWMC Compliance Programs from 1999-present**

- A full time Compliance Officer was hired in 1999-2000 at each medical center.
- In 2000, both medical centers established anonymous compliance reporting hot lines.
- In 2000, the medical centers established codes of conduct in the form of a publication titled "Integrity at Work" that communicated clear expectations for employees' adherence to regulatory requirements.
- In 2000, general compliance training was incorporated into the new employee orientation programs (including fraud and abuse concepts, confidentiality and security of healthcare information, conflicts of interest and other ethical issues) at both medical centers.
- In 2002, job-specific mandatory healthcare compliance training for both HMC and UWMC staff was instituted.
- Both medical centers have implemented annual compliance review training for staff that includes conflict of interest information.

- Between 2000 and 2002, HMC and UWMC implemented a billing audit process that includes educational feedback for staff and providers.
- During 2003-2004, the scope of the hospital Compliance Programs was expanded to include HIPAA and research compliance activities. The hospital Privacy Officer positions were moved to the HMC and UWMC compliance offices, and new positions were created to address research compliance needs.
- Today, the medical centers collectively employ 16 full-time compliance staff dedicated to investigating, training and auditing activities.
- The compliance officers report to the E.D.s of their medical centers. They receive guidance and oversight from their respective medical center executive compliance committees. They attend monthly UW Medicine Board Compliance Committee meetings and report quarterly to the Compliance Committee.

For information on the SCCA and UWSOM Compliance Programs, including HIPAA compliance, please see Appendix 6.

#### **4. Committee's Commentary**

Since 1999, UW Medicine has made significant improvements to its Compliance Programs. The Review Committee commends UW Medicine's initiatives and very real progress. At the same time, the Review Committee is mindful of three deficits in the 1999-2004 period: (1) the absence of regular audits and the resulting inability to share results with physicians, practice plan management and UW Medicine leadership; (2) inadequate and unsystematic follow-through on closure of investigations; and (3) inadequate specialty-specific training for physicians before 2002-2003. The strengths of the current Compliance Program, as well as areas for further improvement, are summarized in the next Section.



## **VI. Summary Assessment of Current Compliance Programs**

This section provides a summary assessment of the current Compliance Programs at UW Medicine, with a focus on physician and hospital services billing at UWP/CUMG,<sup>24</sup> UWMC, and HMC. The Committee’s review of UW Medicine’s current Compliance Programs is based on standards from the “seven elements” of the Federal Sentencing Guidelines (see Appendix 15). A more detailed assessment of selected elements can be found in Section IX – Detailed Findings and Recommendations, and Section VIII - Governance. The assessment relies on a variety of sources, including “scorecards” and other information produced by each of the entity Compliance Officers in response to requests from the Review Committee. The Committee staff clarified and confirmed the information provided by the Compliance Officers. As a result of this process, the assessment represents a blend of self-reporting and independent review regarding key elements of the current Compliance Programs.

### General Findings for UWP/CUMG, UWMC, and HMC

Overall, virtually all of the elements of effective Compliance Programs articulated by the Federal Sentencing Guidelines are in place in the Compliance Programs at UW Medicine. The Compliance Programs for hospital services billing at UWMC and HMC are strong, while the Program at UWP/CUMG needs further improvement. There has been an emphasis on ensuring that the formal elements of the Compliance Programs are in place; in general, there has been less focus on the “softer” elements, such as a supportive organizational culture. In addition, the emphasis has been on structural and process elements; the outcomes measures are less well developed. These deficits are not unusual in the process of developing and refining compliance programs, and UW Medicine’s Programs have not yet had an opportunity to reach full maturation.

### Element 1: Compliance Standards and Procedures

#### Existing Strengths to Build Upon:

- All entities have a Code of Conduct and Compliance Policies and Procedures that meet the Federal Guidelines for effective compliance programs.

#### Areas for Improvement:

- UWP/CUMG has identified a need to strengthen its Policies and Procedures to better identify risk areas and to communicate the benefits of a strong Compliance Program. HMC is in the process of revising and strengthening its “Integrity at Work” brochure and compliance policies.
- Many physicians do not view the Compliance Programs as a supportive or consultative resource.

---

<sup>24</sup> UWP provides compliance functions for CUMG.

## Element 2: Organizational Leadership

### Existing Strengths to Build Upon:

- The compliance roles, responsibilities and activities of the senior administrative managers of all entities meet the Federal guidelines. For example, the UW Medicine Board Compliance Committee receives regular reports from the Compliance Officers regarding their plans and activities.
- The role of the Compliance Officers within each entity regarding day-to-day operational responsibility is clear and strongly supported by senior management
- Senior management has taken steps to ensure the provision of adequate resources for Compliance Programs. As described above in Section V. D., there have been significant increases since 1999 in the number of staff devoted to compliance functions. It is also the opinion of Committee staff and consultants (although direct comparisons are difficult to make) that the total number of compliance-related personnel at UW Medicine is greater or equal to the number at comparable AMCs.

### Areas for Improvement:

- The UW Medicine Board's limited advisory role constrains its ability to oversee UW Medicine's clinical activities, including compliance.
- The large size and composition of the UWP Board of Trustees and the limited role of the UWP Board President weaken the Board's ability to direct UWP's compliance functions.
- Continued efforts to promote a "culture of compliance" are critical for strengthening the effectiveness of the formal Compliance Program.
- The Department Chairs'/Directors' accountability for compliance needs to be clarified and made a high priority.
- There is no full-time leader to provide a comprehensive overview of Compliance for all of UW Medicine.
- The current decentralized structure may lead to the following: lack of consistency across the entities; difficulty in coordinating activities; and duplication of effort.
- An annual compliance work plan at UWP/CUMG needs to be developed.

## Element 3: Employee Screening

### Existing Strengths to Build Upon:

- Processes are in place at all entities to screen new and current employees to exclude those with a history of violations.

#### Element 4: Training and Education

##### Existing Strengths to Build Upon:

- Formal training programs that meet the Federal guidelines are in place at all entities.
- The CIA training requirements for UWP and CUMG have been met.
- Compliance policies are accessible online by physicians and staff.

##### Areas for Improvement:

- Although the current training programs meet the formal Federal Guidelines, a further strengthening of compliance training, education and dissemination of compliance information throughout UW Medicine would enhance the effectiveness of the Compliance Program.

#### Element 5: Internal Monitoring and Auditing

##### Existing Strengths to Build Upon:

- Effective monitoring and auditing processes for hospital services billing are in place at UWMC and HMC.
- At UWMC and UWP, all of the compliance auditors are certified coders.

##### Areas for Improvement:

- As a result of limited auditing in recent years, management, physicians and other providers have not received adequate information regarding the accuracy of billing documentation.
- The audit function is being rebuilt at UWP. Achieving this, however, depends on improvements in productivity and filling existing vacant audit positions.
- There is limited use of statistical analysis to identify outliers and trends.
- At HMC, less than half of the compliance auditors are certified coders.

#### Element 6: Discipline and Incentives

##### Existing Strengths to Build Upon:

- Consistent disciplinary and enforcement policies are in place at all entities. Compliance competencies are part of the staff performance review process at some entities.

Areas for Improvement:

- Compliance expectations and standards are not consistently included in evaluations or performance incentives for all physicians and staff. All entities are in the process of reviewing job descriptions, evaluation criteria and performance incentive arrangements to consider including or strengthening references to compliance.

Element 7: Response and Prevention (Corrective Action)

Existing Strengths to Build Upon:

- All entities have appropriate policies and processes for corrective action plans, follow-up audits and investigations, and reporting and refunds of overpayments.

Comments on Risk Assessment

Existing Strengths to Build Upon:

- Risk Assessments are conducted by the Compliance Officers at each entity. UWMC has developed a tool to prioritize compliance activities that considers the level of effort required and the degree of potential risk.
- During the past three years, the UW Medicine Board's Compliance Committee has received reports on emerging compliance risk areas, including billing for clinical research trials, Sarbanes-Oxley, HIPAA, and other topics.

Areas for Improvement:

- UW Medicine would benefit from an enterprise-wide and long-range view of emerging risks.

## **VII. Organizational Culture and Physician Accountability**

### **A. Organizational Culture**

UW Medicine is in the process of emerging from a painful four and one-half year Federal billing investigation. This investigation cast a large cloud over the institution. Even as this cloud disperses, the institution still faces risks; UW Medicine cannot afford to be vulnerable to another Federal inquiry that finds shortcomings in the faculty's commitment to compliance with laws and regulations. The institution needs a process of constant quality improvement in its Compliance Programs.

It is the judgment of the Committee, based upon its review of the billing investigation, that many changes are in order. The Committee has proposed changes in UW Medicine's clinical billing Compliance Programs, which are found at Section IX and are discussed throughout this Report. But the most fundamental change that will determine UW Medicine's future success is how well its leadership promotes and maintains a culture of professionalism, integrity, and compliance at UW Medicine.

This subject is very important. UW Medicine's growing leadership role in national medical research, global health, and many other areas could be threatened unless all of its physicians, researchers, staff, and administrators make this commitment to a culture of compliance and abide by its obligations.

#### **1. Findings**

In general, the current culture is much healthier than the culture of the 1990s. There are several areas of concern, however, that are impediments to building excellent Compliance Programs at UW Medicine.

- The wake of the Federal billing investigation has left some faculty and staff with feelings of vulnerability to the severe consequences of not meeting professional billing regulations. This may cause some faculty and staff to be reluctant to raise compliance and other concerns.
- Some faculty, staff and administrators who feel vulnerable as a result of these events want to "put this all behind them." While understandable, this may frustrate constructive efforts to learn from past events.
- Some faculty and staff feel that the Dean/VPMA's office has a pattern of closed decision-making and a lack of open communications and transparency, which has contributed to a sense of anxiety and lack of involvement among the faculty that still persists in much of the organization.
- Some physicians, but increasingly fewer since the Review Committee's August 2004 creation, still do not fully accept that accurate documentation and billing are critically important functions.

- Some physicians still feel that compliance is a regulatory burden imposed from outside rather than an essential element of ethics, integrity, and professional conduct.
- Further effort is needed at all levels to instill and strengthen a culture of excellence in compliance.

## 2. **Responsibility of Individual Providers**

Being an excellent physician in a leading AMC requires very high-level performance in all aspects of the institution's systems for delivering quality patient care. There is no room at UW Medicine to permit some providers – regardless of the task at hand – to perform in a manner that is less than excellent.

No one questions the commitment of UW Medicine physicians and other providers to the ethics of the medical profession. As they enter the challenging and rewarding practice of medicine, physicians are trained to accept personal accountability for ensuring that their patients receive the highest quality of care. In the same way, physicians and other providers must also accept responsibility for ensuring that they comply with regulations and policies for documentation, coding, and billing. They must recognize that any non-compliant actions – even if committed by a few individuals – can threaten the ability of UW Medicine to carry out its missions of patient care, teaching, and research.

Maintaining excellence requires committed and responsible individual behavior. It also requires that individuals, when they witness irresponsible behavior, take action to prevent abuses. This will protect patients, colleagues, staff and the institution.

At the same time, providers cannot be expected to take on this responsibility alone. As described below, providers must be given support to enable them to fulfill their compliance responsibilities. They must be given:

- accurate and timely information regarding regulations, policies and standards;
- information technology and other administrative tools to improve documentation accuracy and efficiency;
- useful, relevant and real-world educational materials;
- frequent reports and feedback on their performance; and,
- tangible consequences, consistent across UW Medicine's entities for results that do not meet established standards.

Providers must also recognize that compliance is ultimately a team effort. The process of coding and billing for professional services relies on administrative staff such as PFCs and claims specialists. They are essential to the process of ensuring accurate and timely documentation, coding, and billing. There is neither room at UW Medicine for physician behavior that accords PFCs, claims specialists or compliance personnel impolite treatment,

nor for the venting of frustrations at administrative staff who are trying to assist in making physicians' billing accurate.

The Review Committee recognizes that in a large institution like UW Medicine, there are some gifted, talented and creative individuals who may be incapable of adapting their individual behavior to a culture of compliance. These individuals face a clear choice: Either get with the program of professionalism, integrity, compliance, and excellence at UW Medicine or find a more lax, less committed environment in which to pursue their career objectives.

The Review Committee recommends that UW Medicine adopt a clear and unambiguous policy with respect to compliance with UW Medicine policies and governmental regulations. For example, in the area of physician billing, any documentation or coding errors must be addressed immediately by a progressive process, beginning with individual feedback and coaching, but moving to mandatory pre-billing review and more serious sanctions if standards are not met within an appropriate time. It is essential to have predictable consequences: irresponsible behavior, continued errors and/or bad faith in compliance matters by anyone must not be tolerated and should be addressed promptly, decisively and severely by senior management through due process. At the same time, there should be positive incentives to promote good behavior: rewards and public recognition for compliance performance successes.

UW Medicine's standard is excellence in patient care, teaching, research, and compliance. Patient care and compliance are two areas in which individual failure, for lack of effort, commitment or dedication, cannot be tolerated. Inadequate patient care threatens human life. Inadequate commitment to compliance threatens institutional survival.

### **3. Responsibility of Physician Leaders and Department Chairs**

In the past, some physicians – a few in leadership positions – have acted on the mistaken belief that compliance with billing regulations is a bureaucratic intrusion into the “higher” obligations of a physician in providing quality patient care, teaching, and research. The Review Committee's view is that the mission of UW Medicine must be conducted with full respect for the values of professionalism, integrity, and compliance. UW Medicine's mission and these values are indivisible. Taken together, they constitute the essential building blocks for confidently moving forward in a changing and uncertain regulatory and financial environment for all Federal healthcare programs.

The organizational culture of UW Medicine is driven by physician leaders. If UW Medicine is to fully incorporate compliance into its values of professionalism, ethics, and integrity, it must look to physicians to provide leadership as agents of change. Department Chairs play a very important role in establishing their Departments' and the institution's culture. If they are “off message,” inconsistent or do not prioritize excellence in professionalism and billing compliance, UW Medicine's reputation for excellence will be threatened.

Department Chairs, Medical Directors, and other physician leaders must take concrete actions to bring about this cultural change. Specifically, they must:

- Lead by example, with actions being more important than words. They should set high standards, and they should make integrity in compliance a very high priority;
- Set clear expectations regarding documentation and billing, as well as other compliance requirements;
- Provide support to physicians and other providers, including arranging for feedback, and education as needed; and
- Enforce tangible consequences for not meeting standards.

The Review Committee recommends that the clinical Departments of the UWSOM provide a written report annually to the Dean on their progress in promoting a culture of professionalism, integrity, and compliance, including excellence in documentation and coding. The Dean should provide a high-level summary report annually to the UW Medicine Board.

#### **4. Responsibility of Administrative Leaders**

The administrative leaders of UW Medicine – the entity E.D.s, senior leaders in the Dean/VPMA’s Office, and other directors, managers, and supervisors – also play a critical role in moving the organization’s culture to fully embrace compliance. They must work with the Dean/VPMA and his leadership initiatives to set a tone that is consistent with the organization’s values of professionalism, ethics, and integrity. They must also ensure that the business and administrative infrastructure – policies, procedures, information systems, and other systems – provide support to individual physicians in their efforts and ability to comply with regulations and policies.

The administrative leaders’ responsibilities are similar to those of the Department Chairs and physician leaders. Specifically, they must:

- Lead by example, set high standards, and make compliance a high priority.
- Use formal and informal communications tools to articulate organizational values, emphasize that compliance is an important institutional goal and individual responsibility, and show how compliance is linked to the organization’s mission and financial results.
- Set clear expectations and performance targets for compliance.
- Ensure that business processes and IT systems support compliance and make it “physician-friendly,” i.e., to support providers’ efforts to document, code, and bill accurately and efficiently for the services they provide.

- Establish clear and well-understood consequences for not meeting compliance standards.
- Establish a comprehensive process for assessing the risks facing the institution, and develop programs and strategies for continuing assessment and mitigation of risks.

## **5. Other Recommendations**

- Continue to emphasize that compliance is one of the essential elements of professionalism; as leaders of the institution, physicians are accountable for and play a critical role in modeling professionalism, ethics, integrity, and compliance.
- Continue efforts to overcome the concerns that may cause some faculty and staff to avoid raising compliance issues; commend individuals who come forward with issues and concerns.
- Continue to foster open dialogue about compliance risks and solutions, and to increase transparency and strengthen the sense of trust throughout the institution.
- Keep alive – in a healthy and constructive way – the memory of what happened in the past. By thoroughly understanding what happened, UW Medicine can take full advantage of the “lessons learned” and strive for continuous improvement.

### **B. Expectations, Feedback and Incentives for Physicians**

As noted above, physicians have a central role in determining the culture of compliance at UW Medicine. Physicians deserve to have clear expectations for compliant behavior as well as feedback on their performance; these elements can provide strong support for achieving high performance in compliance.

#### Findings

- Current job expectations, performance and promotion documents and criteria, and incentive compensation arrangements at UW Medicine for administrators, managers, and physicians do not adequately describe and emphasize compliance responsibilities and expectations.
- One of the principles of the Faculty Code is the protection of independent research and teaching for tenured faculty. The physician/faculty members at UW Medicine, however, have clinical responsibilities involving patient care and compliance with Federal billing regulations that go beyond academic research and teaching. It is important to recognize the procedural issues that the Faculty Code may present when administrators find it necessary to take personnel actions in cases of violations of clinical policies and Federal regulations for compliance.

Under present regulations and UW Medicine policies there are procedures with appropriate due process protections to suspend or terminate medical staff “privileges” of physicians who are in violation of the requirements of the Compliance Programs or

whose actions pose threats to the well-being of patients. In those circumstances, a physician can have his or her privileges to practice clinical medicine at UW Medicine suspended. The physician's faculty appointment, however, can only be terminated under the provisions and procedures of the Faculty Code. The Review Committee has been informed that the termination process under the Faculty Code is arduous and can, in some contested cases, take years of extended legal process.

### Recommendations

- Clearly articulate physicians' job expectations, performance, and promotion criteria, and develop metrics and incentive compensation programs to explicitly measure and reward compliance performance; acknowledge highly compliant behavior with recognition and appropriate awards.
- Review and integrate employment agreements and bylaws – i.e., faculty appointments, hospital privileging and credentialing, and clinical appointments – to achieve consistency across UW Medicine entities. Provide for appropriate sanctions, including termination of privileges for non-compliant behavior.

As President Mark Emmert moves forward with compliance efforts in a number of subject areas and locations throughout the greater University of Washington community, it may be appropriate for him to engage the Faculty Senate in a discussion of whether Faculty Code provisions adequately support compliance efforts and discipline.

### **C. Communications**

As discussed above, communications are an important tool in shaping an organization's culture and support for the compliance program.

### Findings

- Prior to and after the April 2004 settlement of the civil case, the Dean/VPMA of UW Medicine sent emails and letters and spoke about compliance, professionalism, ethics, and integrity within UW Medicine. A continuation of strong and consistent communication would reinforce UW Medicine leadership's commitment to compliance, tie this message to institutional objectives and missions, and strengthen the compliance program's effectiveness.
- Also prior to the April 2004 settlement, the PEBC Council and its subcommittees helped develop website training, provided lectures on compliance and HIPAA training, and formed a Template Workgroup to survey, evaluate and improve standards for templates.
- Despite the work of the Dean/VPMA and other physician leaders on the PEBC Council, there remains a strong perception that there was inadequate public and internal communication by UW Medicine Administration, Department Chairs, and other Physician leaders about the importance of instilling a culture of compliance at UW Medicine.

- The label “Compliance” alone reinforces the feeling among physicians and staff that it is a burden imposed from outside rather than an essential element of “ethics, integrity, and professional conduct.”

### Recommendations

- Rename the Compliance Offices to incorporate the concepts of “professionalism, ethics, and integrity.”
- Continue the ongoing communications process, led by the Dean/VPMA and physician leaders, regarding institutional values for UW Medicine’s professional ethics, integrity, and compliance.
- Continue UW Medicine leadership’s meetings with physicians, compliance staff, and other key groups; make frequent public communications, including guest columns and speaking engagements, regarding the importance of professional ethics, integrity, and compliance at UW Medicine.
- Consider creating or designating a staff position in the Dean/VPMA’s office to assist in developing meaningful messages about values and goals.



## **VIII. Governance**

### **A. Role of UW Medicine Board**

#### **1. UW Medicine Board's Role and Authority**

Since 1976, the UW Medical Center (UWMC) Board has exercised governance authority over UWMC, and been responsible for the quality of patient care, the physical plant, finances, and other related matters. In 2000, the Board was renamed the “UW Academic Medical Center Board” (UW AMC Board) and was granted additional “advisory” responsibility over all of UW Medicine and its related enterprises by the Board of Regents. The UW AMC Board was renamed the UW Medicine Board in 2003. The Board’s advisory responsibility is to the Dean of the UWSOM and Vice President of Medical Affairs. Historically, the UW AMC Board’s responsibilities did not include the School of Medicine (UWSOM) or other academic functions of UW Medicine. The Board’s responsibilities have focused on UW Medicine’s delivery of medical care through the activities of a large number of related medical enterprises.

Each of the organizations that constitute UW Medicine – UWMC, HMC, UWP, and UWPN – is a separate legal entity. Some are publicly governed institutions while others are not-for-profit corporations with separate governing Boards. The essential institutional glue that ties all of these related entities together is the fact that all of the physician and the non-physician personnel for each of these entities are UW Medicine employees and are subject to policies established by the VPMA, President Emmert and the Board of Regents. They are also united by the three core missions of UW Medicine: patient care, teaching, and research.

#### **2. Board Level Compliance Committee**

In response to the issues raised by the Federal billing investigation, and at the request of Dean Ramsey, the UW Medicine Board, created in 2001 what is believed to be the first Board-level Compliance Committee at any national AMC. The Board Compliance Committee has been very active since that time. The Committee is currently chaired by Sylvia Mathews, and has six members. The Committee meets monthly and receives quarterly as well as special reports from the Compliance Officers, the E.D.s of UW Medicine’s component entities and affiliated institutions, and UW Medicine Administration.

#### **3. Board Functions and Perceptions of its Role**

The UW Medicine Board, over the years, has had very competent and dedicated members and leadership. The UW Medicine Board’s “advisory” role has meant that Board Members become engaged in issues facing UW Medicine when their advice is requested by the UW Medicine Administrators. Board Members have often been utilized to good advantage for their skills and experience. Members have committed significant time and energy to important institutional initiatives that UW Medicine has undertaken, such as the establishment of UWPN and SCCA. There is little precedent, however, for the Board or its Members to operate proactively in providing oversight or policy guidance.

There is a public and internal perception that the UW Medicine Board has the authority to operate as would a board of directors of a public corporation, exercising governance and fiduciary authority over all of UW Medicine's entities and activities. This is not the case under the terms of the delegation of "advisory" authority to the UW Medicine Board from the Board of Regents, nor does it reflect the operational history of the UW Medicine Board.

At the same time, however, the Committee learned in extensive interviews that the UW Medicine Board is seen and perceived by many of the physician faculty as a Board that does not address emerging problems until the UW Medicine administrators have requested the Board's advice.

#### **4. Considerations on Strengthening the Board's Governance Role**

One of the questions the Federal billing investigation raises for the University and the Board of Regents is whether UW Medicine should have a Board vested with governance and fiduciary authority for at least the Compliance Programs at UW Medicine, and, possibly, other aspects of its many related enterprises. Several factors are bringing this issue to the forefront:

- UW Medicine has grown rapidly in recent years. Net patient revenues have increased from \$310 million in FY 1990 to over \$1.2 billion in FY 2004. The number of inpatient admissions at UWMC and HMC has grown from 26,671 in FY 1990 to 37,006 in FY 2004, and the number of outpatient visits (including UWP and SCCA) has increased from 271,221 in FY 1990 to 842,082 in FY 2004. During this same period, research awards (UW-based and NIH) have increased from less than \$300 million to \$966 million.
- UW Medicine has evolved to become a very complex integrated care delivery system, including two major medical centers (UWMC and HMC), a large multi-specialty physician group (UWP), and a dispersed primary care delivery system (UWP). In addition, UW Medicine has developed affiliations and operating agreements with related entities, such as Northwest VA Medical Centers, SCCA, CHRMC, and CUMG. For some patients, services must be managed and integrated across the continuum of multiple care settings.
- Federal and state regulators expect healthcare systems to have an effective governance structure. Recent corporate scandals – both within and outside of the healthcare industry – have led to increased governmental scrutiny and higher standards.
- The UW Board of Regents is primarily focused on university-wide issues, and it is difficult for the Regents to exercise sufficient and detailed oversight of UW Medicine. In recent years, formal oversight has consisted of an annual report by the Chair and Vice Chair of the UW Medicine Board at a Board of Regents' meeting.

Many of the above factors are similar to those identified in 1976 when the UW Board of Regents delegated authority to the predecessor of the UW Medicine Board ("August 20,

1976 recommendation of the University Administration and the action of the Board of Regents to adopt a Resolution to establish a 12-member “University Hospital Board” to be charged with the governance of the University Hospital”).<sup>25</sup>

The 1976 justification for the Regents’ action to create the University Hospital Board is instructive on the issue of Board governance authority today. The 1976 justifications included:

- Federal healthcare regulations focused on the “role and performance of hospital trustees in the institution’s decision-making process” (pages 1 and 2).
- “. . . trustee functions cannot be fulfilled by a Board of Regents who must necessarily direct their attention to broad university-wide policy matters.” (page 2).
- Recognition of the trend of State universities giving “special attention to the matter of governance structure of their own teaching hospitals.” (page 2).
- Pre-1976, “. . . no single body has collectively been conversant with all the major issues, policies, plans and needs affecting the University Hospital.” (page 2).
- JCAHO’s concern that the University Hospital did not have a governing board “. . . to which the . . . medical staff and hospital administration were directly accountable.” (page 2 and 3).

Similar factors were cited in 2000 when the Regents created the UW Medicine Board to advise the VPMA. (January 21, 2000 Recommendation of the UW Administration to the Board of Regents that a Board should be established by Resolution to “Advise” the VPMA with Respect to the UW AMC (other than the UWSOM’s Academic Mission)).<sup>26</sup> This Resolution of the Board of Regents reaffirmed the expanded 1976 governance role of the UW Medicine Board with respect to UWMC and added the following new responsibilities to the Board in its “advisory” role to the VPMA for UWAMC. The Board was:

“. . . charged with advising the VPMA/Dean regarding the operation and governance of those aspects of the UWAMC relating to the development and strategic allocation of resources; strategic aspects of academic programs, including the development of off-campus research facilities; the planning and delivery of medical services, including oversight of the physician services provided through the UWP; and the management of extramural affiliation and operating agreements, including those executed by the University with Harborview, the Seattle Cancer Care Alliance (“SCCA”), and UWPN.” (page 2)

The relevant documents and history are on the Review Committee website.

In summary, the governance of UW Medicine has been evolving since 1976. Initially, authority was delegated to a Hospital Board for direction of UWMC, which at that time was

---

<sup>25</sup> This document is posted on the Review Committee’s website (<http://depts.washington.edu/uwmbrc>).

<sup>26</sup> This document is posted on the Review Committee’s website (<http://depts.washington.edu/uwmbrc>).

the dominant clinical entity. As other entities grew and became part of UW Medicine's integrated healthcare delivery system, the Board's scope was expanded in 2000 to provide advice to the VPMA regarding all elements of UW Medicine's clinical activities. The current situation warrants a policy consideration by the Regents of steps to further strengthen oversight and governance functions.

The Members of the UW Medicine Board recognize that this is a very complex question, especially in light of the multiple missions of UW Medicine – “academic functions” within the UWSOM, and the medical “enterprise” functions of the other entities. At the same time, there is no consensus among Board Members that governance structure based upon public or private sector corporate models would work well, given the complex and hybrid nature of UW Medicine. The significant issues here relate to oversight of a public enterprise, and the effectiveness and appropriateness of exercising governance over a chief executive who has both “academic” and “clinical enterprise” responsibilities.

The UW Medicine Board's role should be considered and carefully reviewed by President Emmert and by the Board of Regents. They should determine whether the UW Medicine Board brings independent value and serves a useful institutional purpose in oversight and informed governance. They should also consider the ramifications of potential regulatory actions based upon the currently ambiguous oversight and governance relationships. If so, they should also determine how UW Medicine Board Members' experiences and skills could be better utilized in assisting UW Medicine to fulfill its medical enterprise mission and serve the interests of the University, the public, and the nation.

#### Summary Findings

- The lack of effective governance and oversight was a significant factor in the slow development of strong and effective Compliance Programs at UW Medicine.
- Formal governance authority over UW Medicine lies with the UW Board of Regents. The leadership and effective oversight provided by the Board of Regents is limited by the Regents' broad scope of responsibility, finite time, and the growing complexity and size of UW Medicine's enterprises.
- The UW Medicine Board's limited “advisory” role and lack of broad formal governance authority constrains its effectiveness in providing clear direction to UW Medicine's medical enterprise and clinical activities, including the Compliance Programs.
- The fundamental problem is that the Board of Regents, as a practical matter, lacks the information needed to exercise effective oversight and make fully informed governance decisions. The UW Medicine Board has access to and the benefit of much of this information but lacks effective oversight capability backed by governance authority. This has potential implications for regulatory agencies and credentialing organizations, when governance structures and processes become an important issue in evaluating UW Medicine's operations and performance as they did for compliance during the billing investigation.

## Recommendations

- The governance and oversight of UW Medicine must be strengthened. The appropriate oversight and governance structure for UW Medicine, including the “advisory” role of the UW Medicine Board, should be reviewed carefully by President Emmert and the Board of Regents.
- In determining the appropriate governance structure for UW Medicine, the President and the Regents should use established governance principles, including the following:
  - The role, authority and responsibilities of the governing body should be clear and explicit.
  - Governance responsibilities should be aligned with timely access to information at the appropriate level of detail needed for effective oversight.
  - The governance structure and processes should meet the rising expectations of regulators and the public for effective guidance, oversight and exercise of fiduciary responsibility.
  - The governing body must be able to act with independence from the UW Medicine Administration. This is especially important for the audit and compliance functions. For example, the Internal Audit and Compliance Audit directors and staff must have a direct and independent line of communication to the governing body.
  - There should be a clear delineation between governance for “academic” functions and for medical enterprise and clinical activities.
- The President and Board of Regents should carefully consider the following range of readily available options:
  1. Grant the UW Medicine Board governance authority over *compliance* functions only, but across all entities; or
  2. Grant UW Medicine Board *broader* governance authority over UW Medicine’s medical enterprise and clinical entities (UWMC, UWP, and UWPN), as well as oversight of UW’s management contract with HMC and contractual or equity ownership relationships with other entities (e.g., CHRMC, CUMG, and SCCA) while retaining governance authority for academic functions in the Board of Regents; or
  3. Create a *new Health and Medicine Subcommittee* of the Board of Regents to provide effective governance and oversight; or
  4. Revisit the Board of Regents’ January 21, 2000 action in expanding the UW AMC Board’s “advisory” role to the VPMA and give *more precise meaning to the phrase “charged with advising the Dean. . .”* The options range from

“proactively advising” to “exercising delegated governance authority in some designated areas subject to periodic review by the Board of Regents.”; and/or

5. Consider other options that are consistent with the principles stated above and the emerging standards for oversight and governance for complex hybrid academic medical systems.

## **B. UWP Structure and Governance**

The effectiveness of the billing Compliance Programs at UW Medicine depends in large part on the effective governance of UWP. Currently, UWP has a Board of Trustees consisting of 24 members – the 18 faculty clinical Department Chairs, plus six at-large representatives elected by UWP’s members. The President of UWP is appointed by the Dean for a three-year term; this is not a full-time position. The Board has established a Compliance and Education Committee to oversee the Compliance Program functions at UWP.<sup>27</sup>

### Findings

- The large size of the UWP Board of Trustees (24 members) limits its effectiveness as a decision-making body and may result in diffuse and diminished accountability.
- The lack of outside members of the Board of Trustees limits the independence that is desirable for key governance functions, such as compliance.<sup>28</sup>
- The lack of a permanent Board President weakens the ability to provide leadership and oversight to compliance and other business functions of UWP.
- The large majority of the UWP Board of Trustees consists of Department Chairs who are appointed by the Dean, who also has the authority to approve UWP by-laws and budgets. Since formal legal authority rests with the Dean, many UWP Board Members consider their leadership positions to be symbolic. This may have limited the UWP Board’s sense of ownership and accountability.
- The costs of the Federal investigation and settlement were shared by all of the major UW Medicine entities. This also may have contributed to the limited sense of accountability at UWP for the events that led up to the Federal billing investigation and the consequences for these events.
- UWP Board Members – all of whom are UW faculty – have a financial conflict, i.e., competition between allocation of available revenue for: (1) billing, compliance, and

---

<sup>27</sup> The Review Committee’s findings and recommendations in the area of governance relate only to UWP, and not to CUMG, because the Committee’s concerns in this area do not apply to CUMG. CUMG is structured differently: it has a twelve-person Board of Directors. CUMG’s President, Bruder Stapleton, M.D., serves a three year term and is also Chair of the Department of Pediatrics. Dr. Stapleton has served as President of CUMG since 1998.

<sup>28</sup> The UWP Board Finance Committee does include two former UW Medicine Board Members. The Finance Committee is advisory to the UWP Board of Trustees.

other business functions and/or (2) funds for department administration and physician compensation.

- The location of the compliance function within UWP, which is primarily a billing agency, does not appear to provide sufficient independence between compliance/audit functions and management of billing activities.

### Recommendations

- Reduce the size of the 24-member Board of Trustees.
- Add outside public members to the Board. Outside Directors are especially vital for the composition of the audit/compliance committee.
- Create a position of permanent Physician Administrator to serve as President of UWP.
- Consider modifications to the UWP governance arrangements to strengthen the sense of accountability and ownership, e.g., hold UWP fully responsible for the costs of any future repayments, settlements or penalties for physician billing compliance violations. This would reinforce the need for the UWP Board and the faculty to take the steps necessary to ensure that documentation, coding, and billing comply with Federal regulations.
- The budget for UWP's Compliance Program and functions should be reviewed by the Chair of the UW Medicine Board Compliance Committee, and be reviewed and approved by UWP's Finance Committee (which includes independent ex-officio members), and the Dean/VPMA. This will help to avoid a conflict regarding allocation of funds for compliance versus department administration and physician compensation.
- Although the location of the compliance function within UWP may not appear to provide sufficient independence, the Review Committee recommends that the compliance function remain close to UWP operations, so that it can work closely with the physicians and billing staff. Independence can be maintained by a direct line of communication from the Compliance Department to the Dean/VPMA and to the UW Medicine Board Compliance Committee.



## **IX. Detailed Findings and Recommendations – UW Medicine Compliance Programs**

The following is a summary of the Review Committee’s findings and recommendations for improvements to UW Medicine’s billing Compliance Programs. Each is based on the observations and analysis that have been developed during the Committee’s review process. The findings and recommendations are grouped into three major categories: (A) Management, (B) Compliance Functions, and (C) Business Infrastructure. In each section, we have described the relevant sections of the Federal Sentencing Guidelines.

In considering these recommendations, the reader should be aware that there have been substantial investments in and improvements to the billing and Compliance Programs during the past four years. In particular, the Review Committee has seen a strong compliance commitment from UW Medicine’s senior leadership. Independent external assessments have been made of the Compliance Programs; resources and staff devoted to compliance have been expanded; comprehensive and clear policies, standards, and procedures have been developed; and the training for all physicians and staff under the CIA has been completed.

During the review, the Committee identified areas for further improvement and has developed recommendations to further strengthen elements of UW Medicine’s Compliance Programs. The recommendations set forth below are intended to be constructive for the further development of the Compliance Programs; they are not intended to criticize management or individuals, or to assign blame.

The Review Committee understands that its Report and recommendations – as important as they are – will not be sufficient to advance UW Medicine’s status as a leader in compliance. Achieving this goal is also contingent on how UW Medicine physicians, staff, and administration respond in developing, implementing and maintaining an excellent Compliance Program. It is imperative to move forward with urgency to implement these recommendations.

### **A. Management**

#### **1. Management Accountability**

It is important to distinguish between two key types of accountability for compliance:

a. senior management accountability for *ensuring that the organization is compliant* – this lies with the Dean/VPMA, the E.D.s of each entity, and the Chairs or Directors of each Department; and

b. functional accountability for the *performance of the entities’ Compliance Programs*, i.e., monitoring, training and providing the necessary support infrastructure – this lies with the Compliance Officers and the high-level personnel assigned responsibility for this function.

This section addresses the first item, i.e., senior management accountability. The compliance function is discussed in the following section.

Evidence of senior leadership's commitment to compliance is one of the key elements of the Federal Sentencing Guidelines, described in Appendix 15 and Section VI. and it is one of the most important elements of successful compliance programs. The ideal characteristics include:

- **“Tone at the top”** – strong support advocacy – in words and deeds – for doing the right thing at all times;
- **Strong governance** – compliance is directed by effective oversight committees and functional structures;
- **Healthy Organizational Culture and Communications** (as described in Section VII.A.4. above) -- Leadership from the Dean/VPMA is the most important factor in instilling a culture of compliance. Ideally, the Dean/VPMA should demonstrate visible leadership, personal engagement and prompt response to compliance issues.

The Review Committee expects the following from UW Medicine Administration regarding the management of the Compliance Program:

- High level attention by senior management;
- Clear accountability;
- Strong leadership and clear direction; and,
- Single point of responsibility for reporting and follow-up action.

### Findings

- There is widespread recognition that the ultimate accountability for ensuring compliant practices lies with the Dean and E.D. for each UW Medicine entity. The E.D. job descriptions have recently been revised to include this compliance responsibility explicitly.
- The Department Chairs' and CUMG Directors' accountability for compliance are not clear and are not uniformly regarded as a priority. Their job descriptions, performance evaluation criteria, and incentive compensation metrics do not include compliance. This is a potentially serious barrier to promoting a culture of compliance for faculty leaders and physicians.
- In the 1990s, Department Chairs served as Compliance Officers for their departments. This arrangement did not provide sufficient independence between Compliance Officers' responsibilities for Compliance Program integrity and the management of UWP business and revenue generation responsibilities.

### Recommendations

- Reaffirm that the ultimate management accountability for Compliance Program management and ensuring compliant practices lies with the Dean/VPMA and E.D. for

each UW Medicine entity; continue process now underway to update E.D. and other job descriptions, as appropriate, to include this compliance responsibility explicitly.

- Reaffirm and clarify the Department Chairs' and CUMG Department Directors' accountability for ensuring compliance in their Departments; modify their job descriptions, performance evaluation criteria, and incentive compensation metrics to include responsibility for compliance explicitly.
- Ensure that Department Chairs' management accountability for ensuring compliance in their Departments does not include the Chairs serving as Compliance Officers.

## **2. Risk Assessment and Compliance Planning**

The proactive assessment of potential risks and the development of plans to prevent problems have become increasingly important elements of compliance programs. Traditionally, compliance programs have focused on monitoring, investigation and enforcement processes; this is now changing to a focus on prevention and planning. The most recent revision to the OIG Guidelines (§8B2.1 (c) Effective Compliance and Ethics Program) states:

*(c) . . . the organization shall periodically assess the risk of criminal conduct and shall take appropriate steps to design, implement, or modify each requirement . . . to reduce the risk of criminal conduct identified through this process.*

Risk assessment and compliance planning are receiving increasing emphasis in general industry standards and in academic health systems. For example, COSO, which published in the 1990s an influential report on internal control processes, recently released a new report on “enterprise risk management.” In that report, COSO observed that there is increased emphasis on risk management, which is driving a need for organizations to develop a disciplined approach to assess and manage potential risks. In addition, the COSO report recommends that the governing board should be informed about major risks and the initiatives taken by senior management to address these risks.

Risk assessment and compliance planning is especially critical for AMCs. They are often on the cutting edge of research, and, every day, they handle life and death situations. The size and complexity of UW Medicine, its multiple missions (clinical care, teaching and research), the thicket of Federal regulations, the increasing oversight by payors, and reductions in Federal healthcare programs, and the government's increasing focus on pursuing healthcare fraud in an aggressive manner, create a very high degree of risk.

In addition to billing, the Review Committee believes that there are other functions at UW Medicine that, by their nature, represent areas of potential risk. These areas include:

- the financial interest of drug and device manufacturing companies in UW Medicine clinical trials, research and development of intellectual property;
- issues addressed by the Institutional Review Board (IRB) relevant to the UWSOM and other UW Medicine entities;

- review of “medical necessity” in physician and hospital billing; and
- use of investigational or experimental drugs, devices and procedures.

The Review Committee raises these issues to point out that UW Medicine is involved in many activities that make it subject to a very high degree of risk. This situation calls for a comprehensive risk assessment and compliance planning process for the whole enterprise.

### Findings

- Risk assessment and annual compliance planning is done primarily within each entity at UW Medicine. Inputs include the OIG Work Plan, Fraud Alerts, and Advisory Bulletins, as well as new or updated OIG Compliance Guidance publications, trade journals, newsletters, and reports of Federal enforcement activities.
- UWMC has developed a tool to prioritize compliance activities that considers the level of mitigation effort required and degree of potential risk, but in recent years compliance priorities have focused on operational improvements rather than long-range planning. It is often difficult for the entity Compliance Officers – who are appropriately focused on day-to-day operations – to take a long-range view of potential risks and develop strategic plans for compliance.
- During the past three years, the UW Medicine Board’s Compliance Committee has received a number of reports and recommendations on emerging compliance risk areas, including:
  - Faculty Effort Reporting
  - Clinical Trials Billing
  - Research-related Conflicts of Interest
  - Resident Duty Hours
  - Interactions between Providers and Pharmaceutical Manufacturers
  - Sarbanes-Oxley
  - HIPAA.
- In addition to the assessment of entity-specific and topic-specific risk areas, UW Medicine would benefit from a more comprehensive, integrated, and long-range view of emerging risks.

### Recommendations

- Continue to strengthen the annual risk assessment process by expanding the sources of internal and environmental data used. Use a consultative process to solicit ideas from

line managers, faculty, and staff on their perceptions of the key risk areas for the organization, as well as prior audit findings, other indicators of historical risk profiles, and relevant external benchmarks.

- Rigorously evaluate potential regulatory and financial risk areas using a formal framework. The key parameters should be the likelihood of a hazard and the potential magnitude of possible adverse events.
- Expand the use of the prioritization tool to develop annual compliance plans and deploy resources efficiently.
- Strengthen the long-range risk assessment and compliance planning process. Present an integrated Risk Assessment Report and Compliance Plan—summarizing the entity-specific plans—at least annually to the UW Medicine Board.

## **B. Compliance Functions**

This section discusses the *compliance function*, with a focus on three critical elements: (1) structure and oversight, (2) monitoring and auditing, and (3) education training information. The responsibility for the performance of the compliance function lies with the Compliance Officers and the high-level personnel assigned responsibility for compliance.

One key to success is the philosophy of the Compliance Programs at UW Medicine. Ideally, the Compliance Program is seen as working in partnership with physicians rather than simply enforcing rules. The focus is on *supporting the physicians and staff* with training, information, and performance feedback to enable them to comply with regulations and policies.

The primary purpose of the Compliance Program is to help people code and bill appropriately, thereby enhancing their economic results and avoiding penalties for non-compliance. While acting as part of the organization's internal control system, the Compliance Program is also in a position to be an enabler of performance by avoiding hazards and appropriately capitalizing on opportunities.

### **1. Structure and Oversight of Compliance Function**

#### **Findings**

- The compliance function at UW Medicine is structured primarily according to entity, i.e., each entity (UWMC, UWP, HMC, UWPN, UWSOM) has a full-time Compliance Officer reporting to the E.D. of that entity. (Note: the Compliance Officer roles for UWMC and UWP have recently been combined. UWP also provides compliance functions for CUMG. In addition, while full-time, the UWPN Compliance Officer is responsible for many other director-level functions at UWPN including accreditation, quality improvement, physician credentialing, etc.).
- Within each entity, the Compliance Officer is responsible for multiple compliance areas (billing, clinical trials, Stark & Anti-kickback, Medicare cost reporting, HIPAA, and some aspects of Faculty Effort Certification).

- Each entity Compliance Officer is also responsible for conducting an annual Risk Assessment Report and developing a compliance plan.
- There are also compliance functions that reside within other areas, i.e., a Vice Dean oversees Conflict of Interest and Scientific Misconduct, and another Vice Dean oversees Accreditation Council for Graduate Medical Education (ACGME) Standards and Resident Work Hours. The HIPAA Compliance Officer reports directly to one of the AVPMAs. (See organization chart on page 89.)
- At the UW Medicine level, the responsibility for compliance has been assigned to one of the AVPMAs (J. Coulter) as part of his extensive and broad management role. He is expected to coordinate the efforts of the entity Compliance Officers, each of whom has a “dotted-line” reporting relationship to him. The Compliance Officers’ group meets twice monthly for one hour for the purposes of sharing information, coordination, and collaboration. There is no full-time dedicated Chief Compliance Officer for all of UW Medicine.

#### Analysis/Assessment

- The current Compliance Officers within each entity are well-known and respected within their entities, and they have developed strong working relationships with entity managers and staff.
- The structure is consistent with and reinforces a strong sense of management accountability for the E.D. of each entity.
- There is, however, no member of the Dean/VPMA’s senior management team who is focused exclusively on compliance issues. Given the wide range of the current AVPMA’s responsibilities in addition to compliance, it is difficult for him to devote sufficient time to lead and oversee the compliance function. Current arrangements, under which the AVPMA “coordinates” compliance through bi-monthly meetings with entity Compliance Officers, are inadequate given the recent history of UW Medicine’s Federal billing investigation and settlement. Coordination is welcome, but, in the Committee’s view, full-time leadership and senior management attention are required.
- There is no enterprise-wide Risk Assessment and Compliance Plan, and there is no comprehensive overview of UW Medicine compliance provided to the Board; furthermore, it is difficult for the entity Compliance Officers – who are appropriately focused on their entity’s day-to-day operations – to take a long-range, cross-entity view of potential risks and to develop strategic plans for compliance.
- In addition, the current structure has the following potential disadvantages:
  - lack of consistency in approach, resources and strength of compliance functions across the entities;
  - limited ability to shift resources between entities as needed;

- difficulty in addressing issues that involve multiple entities;
- duplication of effort, e.g., in the development of training programs and communications materials; and
- less opportunity to develop specialized knowledge and expertise for each type of compliance.

### Recommendations

The Review Committee believes that the UW Medicine Board should be explicit about its expectations regarding the compliance function, without being overly prescriptive regarding structural decisions that are rightly the responsibility of management.

#### Board Expectations:

- The UW Medicine Board's Compliance Committee should regularly receive a comprehensive, integrated overview of UW Medicine's Compliance Program, to include the following:
  - An annual enterprise-wide Risk Assessment identifying the most serious areas of potential risk;
  - An annual enterprise-wide Compliance Plan that addresses anticipated risk areas;
  - Semi-annual reporting of progress on implementing the Compliance Plan; and
  - Quarterly reporting of allegations, investigations, findings and corrective action plans;
- There should be a high degree of consistency and standardization across all UW Medicine entities, e.g., common compliance policies and procedures, educational materials, audit processes, and communications.
- The structure should minimize duplication of effort and maximize the efficiency of the Compliance Program.
- The structure should leverage specialized knowledge and expertise among compliance staff. It may be more effective to build the structure according to type of compliance, e.g., clinical billing functions across all entities.
- The Compliance Officers must have an independent and direct line of communication to the Board for routine reporting and serious allegations. (The Board Compliance Committee may want to consider adopting the Internal Audit model and hold a quarterly closed session for Compliance Officers and Committee Members only.)

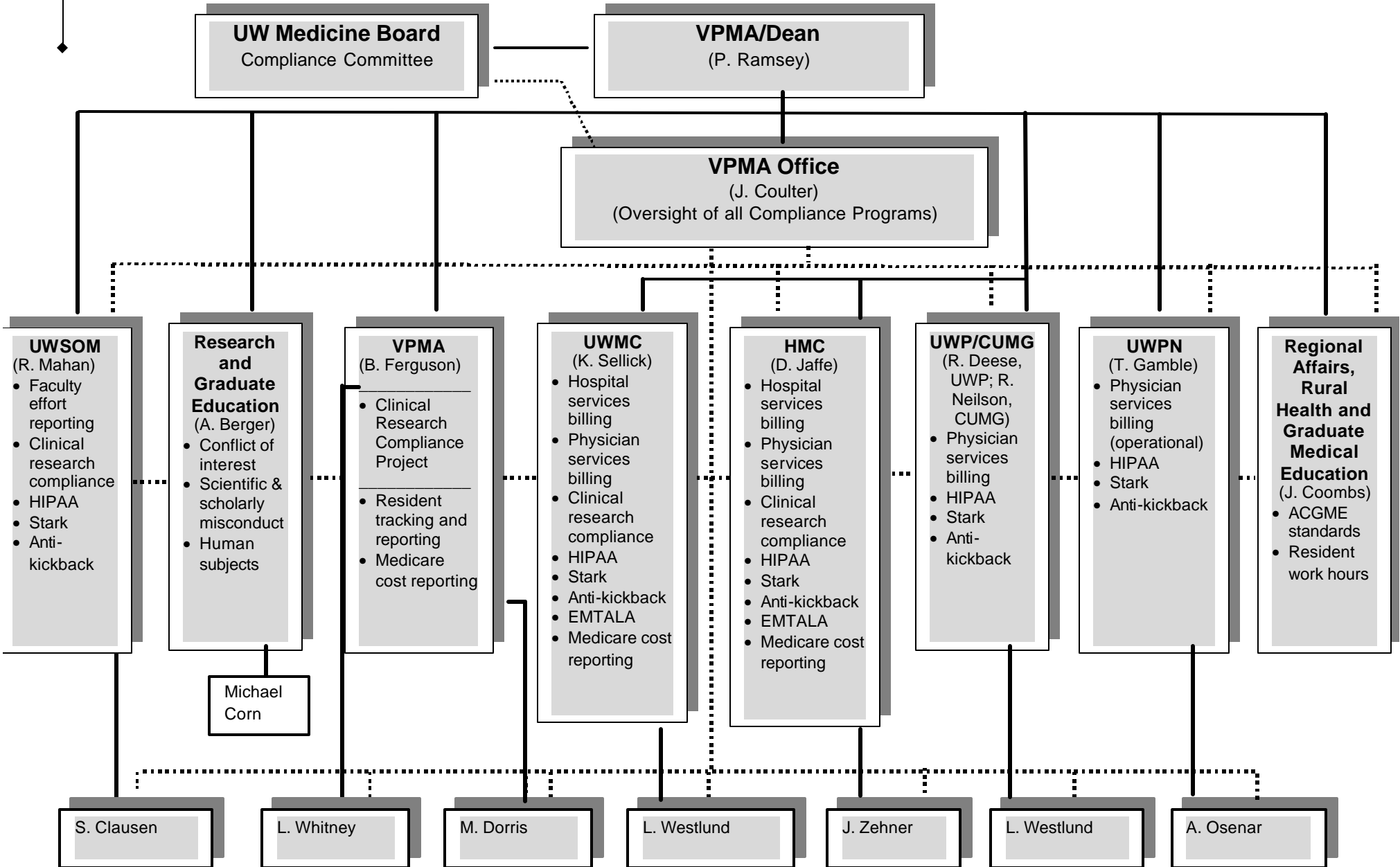
*The Review Committee believes that these goals are more likely to be achieved by the creation of a new full-time position of Associate Vice President for Compliance and Risk*

*Assessment for UW Medicine in the office of the Dean/VPMA, with direct access to the Dean/VPMA and the Compliance Committee of the appropriate governing Board.* The compliance function needs focus and oversight at a senior level in the Dean/VPMA's office. The Review Committee believes that this can be achieved within existing resources; if this is not the case, the additional investment would be relatively small when compared to the benefit, and it would serve as an insurance policy to minimize the risk of future problems. In the latter half of the 1990s, the Compliance Program went from being leading edge in its structure to being found deficient in the manner in which it was administered. The problems that led to the Federal billing investigation would have been less likely to occur if there had been focused and clear responsibility for oversight of the Compliance Programs at a senior level of UW Medicine's management. Looking forward, this administrative action would provide important insurance for the institution "if or when" there is another billing or other significant compliance problem, which the Committee believes is likely to occur in an organization of UW Medicine's size and complexity.

In considering any changes in compliance leadership and structure, care should be taken to ensure that enhancing the visibility and leadership for the compliance function in the Dean/VPMA's office does not undercut UW Medicine's dominant management philosophy, which is to emphasize the accountability of entity and department management. "Ownership," i.e., line management responsibility for *ensuring that the organization is compliant*, appropriately lies with the E.D. of each entity and the Chairs or Directors of each department. The *Compliance Program itself*, i.e., monitoring, training, investigation, and providing the necessary support infrastructure, however, would be strengthened by full-time leadership in the Dean/VPMA's office and a consistent approach enterprise-wide.

# UW Medicine Compliance Organization

6/1/05



## 2. Monitoring and Auditing

One of the essential elements of a strong compliance program is monitoring and auditing. According to the new OIG Guidelines (§8B2.1 (b) (5), Effective Compliance and Ethics Program):

*The organization shall take reasonable steps—*

*(A) to ensure that the organization’s compliance and ethics program is followed, including monitoring and auditing to detect criminal conduct;*

*(B) to evaluate periodically the effectiveness of the organization’s compliance and ethics program; and*

*(C) to have and publicize a system, which may include mechanisms that allow for anonymity or confidentiality, whereby the organization’s employees and agents may report or seek guidance regarding potential or actual criminal conduct without fear of retaliation.*

In addition, the Corporate Integrity Agreement states that:

*“Each physician and non-physician provider (“Provider”) under whose name bills are submitted through the Plans [UWP and CUMG] shall be audited to assure compliance with all documentation, coding and billing requirements of the Federal healthcare programs.”* (See Review Committee website: <http://depts.washington.edu/uwmbrc>)

The CIA also specifies the sample size, the qualifications of the audit staff, and the specifics of the audit and reporting process.

The compliance audit function is the primary control mechanism for identification of and defense against adverse compliance risks in daily operations. Ideally, the Compliance Program should use a rigorous audit methodology, similar to that typically seen in many excellent corporate Internal Audit departments. Furthermore, a regular detailed review of the error rates is the best means through which management can develop reasonable assurance that the overall compliance program is functioning effectively.

### Findings

- An effective audit process is in place for hospital services billing at UWMC and HMC.
- As a result of the limited auditing at UWP in recent years, physicians and other providers are not receiving adequate feedback regarding the accuracy and completeness of billing documentation. (Ideally, this feedback would include real-time information and coaching, as well as routine audit reports.) Furthermore, senior management does not have the information from audit results that is needed to evaluate the effectiveness of the billing compliance program.

- The audit function is being rebuilt at UWP. Only a small percentage of providers were audited in 2003-04. This was due primarily to the emphasis on training required by the CIA and to turnover among UWP/CUMG Compliance Department management and staff. As a result, UWP and CUMG are not meeting the original CIA milestones for auditing. When this became apparent earlier this year, UWP/CUMG management requested an extension of the CIA audit schedule, for which the OIG has given informal verbal approval. The UWP Compliance Department has developed a plan to meet the CIA requirements by April 2006, which is four months prior to the new deadline. Achieving this, however, depends on improvements in productivity and filling existing vacant audit positions.
- There is limited use of statistical analysis to identify outliers and trends, especially at UWMC, HMC, and UWP. The data are generally available, but the existing staff is focusing most of their time on auditing and training.
- There appears to be limited use of the confidential “Hot Line” for reporting potential violations. This may be due to low awareness among some faculty and staff, that faculty and staff rely on direct and informal communications with the Compliance Officers, or that they are not witnessing problems.
- At HMC, only three of the seven compliance auditors are certified. According to the Compliance Officer, HMC has a planned program to encourage certification.

#### Recommendations

- Rebuild the UWP/CUMG audit function in order to meet the targets for CIA requirements, OIG guidelines, and to provide physicians and management with compliance performance data.
- Expand the use of statistical analysis to determine outliers and trends.
- Provide real-time feedback to physicians from PFCs regarding the accuracy and completeness of billing documentation.
- Adopt administrative strategies to encourage UW Medicine personnel to use the anonymous hot line, contact Compliance Program staff, and access other means to report compliance questions, concerns, and problems.

### **3. Education, Training and Information for Physicians and Staff**

Education is one of the foundations of an effective compliance program. While monitoring and auditing are important in evaluating performance and identifying problems, education is important in *preventing* errors. Proper use of codes by providers depends on UW Medicine providing information and effective education on how to code accurately. In addition to generalized classroom training, an ideal education program includes (1) modules that are customized for specialties and sub-specialties using recent audit results, (2) individual real-time feedback, and (3) easy access to billing documentation and coding information through a variety of vehicles such as a “help line,” website, newsletter, and/or reference library.

According to the new OIG Guidelines (§8B2.1 (b) (4). Effective Compliance and Ethics Program):

*(A) The organization shall take reasonable steps to communicate periodically and in a practical manner its standards and procedures, and other aspects of the compliance and ethics program. . . by conducting effective training programs and otherwise disseminating information . . . .*

The Corporate Integrity Agreement (CIA) requires the Practice Plans to provide at least two hours of initial General Training and four hours of specialized Billing and Coding Training to all new providers. The plans must also provide one hour of General Compliance Training and three hours of initial Specialty Specific Training annually to current providers.

### Findings

- All physicians and staff received the initial compliance training within the past year under the CIA requirements, and all new physicians receive training within 30 days of their start date.
- Most of the training is done classroom-style in medium or large groups. Very few physicians receive individual real-time feedback or coaching.
- The effectiveness of the education programs has not been routinely assessed.
- Many faculty and staff feel that they receive inconsistent and unreliable information and guidance from PFCs and compliance auditors.
- Comprehensive information regarding UW Medicine’s Compliance Programs is not easily accessible to providers on the intranet.
- UWP and HMC have coding “help lines;” UWMC does not, due in part to structural differences between UWMC and the other entities.

### Recommendations

- Continue to develop and refine customized training programs for physicians for each specialty and subspecialty.
- Use actual audit results (with specific cases appropriately marked) as a key educational tool.
- Increase the provision of real-time feedback and coaching to physicians.
- Enhance and formalize resident and student education about compliance.
- Continue to monitor the effectiveness of training programs by routinely auditing and/or testing physician and staff knowledge and awareness of billing regulations and processes.

- Consider instituting formal annual compliance training and recertification programs.
- Clarify and strengthen the process for faculty and staff to obtain authoritative answers to billing and coding questions and dilemmas. Establish a coding “help line” at UWMC.
- Upgrade and implement a readily accessible, single, integrated “Professional Ethics, Integrity, and Compliance” website for all entities at UW Medicine.

### C. **Business Infrastructure**

The success of the Compliance Program depends in large part on the strength of the general business infrastructure at UW Medicine.

#### 1. **Information Technology**

Information technology (IT) is a critical part of the infrastructure of any large and complex modern organization. The ability of UW Medicine to strengthen its Compliance Programs depends on the effectiveness of IT. The Review Committee has not attempted to undertake a comprehensive review of IT systems at UW Medicine, but it has made some observations regarding IT, as it relates to the compliance functions.

#### Findings

- UW Medicine has invested significantly in new IT systems in recent years, but their upgrading process has not always gone smoothly; at least one major project is over budget and delayed. Further, some basic business systems are antiquated. In particular, the billing systems at UWMC and HMC lack the functionality to support a strong and efficient compliance function.
- For most physicians at UW Medicine, the documentation and coding process is largely manual. Many departments have developed templates to assist physicians in the documentation process for E&M services, but the use of templates varies significantly by individual provider in some of the largest departments (Medicine, Surgery and Orthopaedics at UWMC and HMC). Other AMCs make extensive use of automated templates and believe them to be critical to the success of their billing compliance programs. At UW Medicine, documentation templates are effectively integrated into the Electronic Medical Record only at Hall Health and UWPN, which make up approximately one-third of total E&M charges.

#### Recommendations

- Review all current and planned IT systems to identify opportunities to strengthen Compliance Programs; move these items, e.g., Electronic Medical Records, to the highest priority and accelerate implementation if feasible.
- Continue with the development, refinement, and use of documentation templates as appropriate to improve accuracy and efficiency; ensure that templates meet the needs of specialty departments. (Note, however, that the use of templates is coming under

increasing scrutiny from regulatory agencies. In implementing templates, care must be taken to ensure that they do not cause systematic upcoding or otherwise create additional regulatory liability.)

## **2. Coding and Billing Functions**

Effective billing compliance depends on strong billing and revenue collection processes. Billing for professional services needs to be timely, accurate and efficient. In the billing process, the PFCs play a critical role. They review the documentation to ensure it is complete, and they code the records for billing purposes. They also are a key communication link between physicians and the billing staff.

### **Findings**

- The PFCs' technical skills and knowledge need to be upgraded. While some PFCs are well-trained and experienced, some require additional training and experience to achieve a high performance level.
- The roles and communication lines between the PFCs and the compliance staff are not clear and effective. In general, the PFCs feel that they operate in an atmosphere of isolation both from UWP and from their colleagues. The unclear roles, weak communication links and lack of information from the Compliance Department make it more difficult for PFCs to obtain needed information and guidance.
- The current Physician Presence Policy allows retrospective amendments of the medical record for billing purposes for an extended period. Some other AMCs do not allow this.

### **Recommendations**

- Continue to upgrade the professional status of the billing and coding staff by increasing training, requiring certification, and assuring appropriate levels of compensation.
- Finalize revision of the Physician Presence Policy to place appropriate time limits on retrospective amendment of the record for billing purposes. Conduct further training for providers on this policy and the correct use of the presence statement.

## **X. Looking Forward**

### **A. Implementation of Review Committee Recommendations**

In order to ensure that the Compliance Programs meets the desired standards of excellence, the UW Medicine Board should institute a disciplined, continuing process to monitor the implementation of the Review Committee’s recommendations. The process should include the following:

1. UW Medicine Administration should develop a detailed Implementation Plan for review and approval by the UW Medicine Board Compliance Committee. This plan should specify what actions will be taken, what objectives will be achieved, who is accountable for accomplishing the objectives, and when they will be achieved. The plan should be developed and approved within 90 days of the publication of the Review Committee Report.
2. UW Medicine Administration should provide quarterly reports to the UW Medicine Board Compliance Committee, charting progress in implementing plan objectives.
3. UW Medicine Administration should periodically engage an outside firm to conduct a formal independent evaluation of the Compliance Programs; the report and the administration’s response should be provided to the UW Medicine Board Compliance Committee.

### **B. A Vision for Compliance**

In order to “achieve excellence in compliance,” UW Medicine should have a clear vision of what constitutes “excellence.” The Review Committee recommends that the Board’s Compliance Committee work with UW Medicine senior management to develop a clear and compelling vision statement that will be a guide for future action. The Review Committee recommends that the vision statement should include the following elements:

- UW Medicine will be in full compliance with billing regulations:
  - rigorous monitoring of results
  - clean audits and no government penalties.
- Compliance accountability is clear for individuals and management;
- The organizational culture – trust, safety, and openness of communication – supports compliance;
- Compliance concerns are respected and immediately addressed, investigated, and where necessary, resolved effectively;
- Business systems and processes should make it easy for faculty and staff to document and code accurately and efficiently;

- The organization has the ability to anticipate and prevent problems through strong Risk Assessment and Compliance Planning processes;
- The Compliance function is integrated for all of UW Medicine, and leadership comes from the Dean/VPMA; and
- UW Medicine is seen as a national leader in ethics and compliance, comparable to its leadership position in research, teaching, and patient care.

### **C. Expectations and Outcomes**

Once the vision for compliance is developed, it would be beneficial for the Board's Compliance Committee to work with UW Medicine senior management to translate the vision into concrete expectations. This set of explicit expectations should include clear descriptions of what constitutes "success" as well as the tools to measure success. The most effective compliance programs have performance measures that are used by Board members, senior administrators, managers, faculty, and staff. The disciplined use of measures clarifies accountability and drives performance. The Review Committee has developed a prototype (See Appendix 18) for consideration and further refinement by the Board's Compliance Committee and UW Medicine Administration. The Committee believes that this will provide discipline and clarity to the efforts to further improve the Compliance Programs.



## **XI. Conclusion**

It is the judgment of the Review Committee that the implementation of these recommendations with this report will enable UW Medicine to achieve excellence in its Compliance Programs for physician coding, documentation, and billing. Success in this area fundamentally depends on *an organizational culture of compliance, the availability of well-designed business systems to support physicians' efforts to be compliant, and physician assumption of accountability and leadership for compliance*. Ideally, all UW Medicine physicians, providers, and staff should embrace compliance as part of a broader commitment to professionalism, ethics, and integrity. They will also see that accurate and complete documentation and billing will lead to tangible benefits, such as increased revenue, and support improved quality of care for patients. In the end, this will enable UW Medicine to achieve sustained excellence in its Compliance Programs and other business functions.

The Review Committee recognizes that UW Medicine is an institution yet to emerge fully from a significant crisis. All who have chosen to be a part of this institution have seen and experienced a series of events associated with the Federal billing investigation that challenge long-standing institutional perceptions of who they are, their values, and leadership. The challenge is real and clear.

For the future, the key is how each individual responds. The Members of the Review Committee believe that UW Medicine must respond with the same dedication to its mission and fundamental values that created this institution. UW Medicine must comply with Federal and State regulatory mandates with the same rigor and commitment it applies to its central missions. The goal must be to become the leading national AMC in terms of effective compliance with Federal, State, and private sector clinical billing requirements.

UW Medicine is an outstanding, nationally recognized AMC with an enviable reputation for the quality and balance of its missions of teaching, research, and patient care. This reputation has attracted many extremely talented and dedicated clinicians, researchers, residents, students, and staff to the institution. In the aftermath of the Federal billing investigation, UW Medicine has an opportunity and the incentive to build on its institutional values. The drive to achieve scientific advances must be matched by a commitment to the duties of professionalism, ethics, integrity, and compliance.

This challenge must be addressed, physician by physician, department by department, and entity by entity. Compliance is and must be one of our core values. And unlike many other responsibilities, compliance is everyone's responsibility. As the Review Committee has seen, a relatively few acts of non-compliant behavior – whether intentional or otherwise – can threaten what we all, as members of UW Medicine, hold dearest: our reputation for integrity and excellence in all endeavors that we and the institution with which we choose to associate seeks to achieve.

The obstacles are not unique nor are they insurmountable. Many other large and successful organizations have overcome similar challenges, and we are confident UW Medicine will do the same.

###