Corporate Compliance
Thoughts Behind the Rules

January 27, 2017

McLaren Bay Region

Presented by:

Heather McAllister, RHIA

Director of Regulatory Compliance

What is Corporate Compliance?

"A culture within an organization that promotes prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and federal, state and private payer health care program requirements, as well as the organization's ethical and business policies."

Federal Register/Vol.63,No.35/Monday, February 23, 1998/Notices

Department of Health and Human Services, Office of Inspector General, Publication of the OIG Compliance Program for Hospitals

What is Corporate Compliance?

- A program designed to ensure an organization's efforts to prevent fraud and abuse.
  - Fraud is an intentional deception or misrepresentation of fact that can result in unauthorized benefit or payment.
  - Abuse means actions that are improper, inappropriate, outside acceptable standards of professional conduct or medically unnecessary.
- Reduces our risk of liability.

What is Corporate Compliance?

- We can function without JCAHO or any other accrediting agency, but we cannot provide care to our patients if found not to be following CMS guidelines, resulting in elimination from the Medicare system.
- Negative impact on our patients and our community.
- Therefore, having a robust Compliance Program in place is the right thing to do.

OIG's Required Compliance Program Elements

1. Written Standards
2. Education and Training
3. Designation of a Compliance Officer
4. Effective Communication
5. Discipline and Enforcement
6. Auditing and Monitoring
7. Response and Prevention

1. Written Standards

- **Commitment to Providing Patient Care**
  - Provide thorough and complete medical record documentation.
  - Effective Communication: Phone etiquette, eye contact, smile, friendly greeting
- **Commitment to Our Community**
  - Even when not wearing your name badge, be mindful of conduct and set a good example.
- **Commitment to Ongoing Monitoring**
  - Be proactive and vigilant
  - Periodic audits
- **Commitment to Environmental Health and Safety**
  - Follow all OSHA, FDA, CDC regulations.
  - Question those you don't recognize in your work area.
  - Appropriately respond to difficult situations.

1. Written Standards

- **Commitment to Proper Employment Practices**
  - Ensure the work environment is free of discrimination and harassment.
  - Do not accept anything of monetary value from patients, their family members, or from vendors or anyone else.
- **Commitment to Ethical Business Conduct**
  - Outside business/employment activities must be limited to off-work time.
  - Report any Conflict of Interest.
- **Commitment to Assets and Financial Transactions**
  - Use honesty when completing financial and productivity reports, travel expenses.
- **Commitment to Accurate Coding and Billing Transactions**
  - Stay current with insurance provider billing rules and guidelines.

1. Written Standards

- **Commitment to Confidentiality and Electronic Security**
  - Patients should expect that we will keep their information safe.
  - Patients have rights regarding their PHI:
    - To confidential communication of PHI.
    - To access or receive a copy of their medical records.
    - To request a restriction of how their PHI is used.
    - To request amendments (changes) to their medical record.
    - To receive an accounting of disclosures when requested.
- **Commitment to Laws and Regulations**
  - Anti-Kickback (Can't accept/offer payments to induce/reward referrals)
  - Stark Laws (Physician Self Referral Law for Medicare patients)
  - Federal and State False Claims Act (Knowingly filing a false claim)
  - EMTALA (Emergency Medical Treatment and Active Labor Act)

2. Education and Training

- All employees must receive a minimum of one hour Compliance and HIPAA training annually.
- Coders and billers are required to receive three hours of education annually.
- Track education efforts for consistency and reporting.

3. Designation of a Compliance Officer

- Must be a high-level official with direct access to the governing body, CEO and senior management.
- Oversees and facilitates the Compliance Program and all related activities.

4. Effective Communication

- Reporting: Make sure employees know what to report, how to report, who to report to, and that it is their obligation to report. You want them to report!
- Compliance Hotline
- Get concerns to the right people for quick action.

5. Discipline and Enforcement

- We want to ensure discipline is fair, equitable and consistent.
  - Any identified problems or concerns are investigated.
  - Recommendations are communicated and acted upon.
  - Education is provided when deemed necessary.
  - Follow up monitoring is performed when appropriate to ensure ongoing compliance.

6. Auditing and Monitoring

- An important component of the Compliance Program is the use of audits and other evaluation techniques to monitor ongoing compliance.
- Internal Audits: coding and billing accuracy audits
- External Audits: Plante Moran
- Surveys: Accrediting agencies such as JCAHO
- Risk Assessments: HIPAA walkthrough audits, security audits

7. Response and Prevention

- **Record:** Determine the who, what, where, when and why of a reported concern, situation or event.
- **Evaluate and Analyze:** How could things have been done differently? Are there conditions that contributed to the situation that need to be changed?
- **Address:** Take action. Make changes to a process, investigate other alternatives, provide guidance and discipline when warranted.
- **Educate:** Communicate to those involved to ensure the same issue is not repeated.
- **Monitor:** Re-audit to make sure the change is being followed and is still working. Make adjustments as necessary.

Risk Areas for Compliance Violations

- Provision of patient care
- Patient confidentiality
- Environmental Health and Safety
- Conflict of interest
- Business ethics
- Financial Transactions
- Employment
- Miscellaneous or job specific

60-Day Overpayment Rule

- Issued by CMS February 11, 2016, effective March 14, 2016, implementing the overpayment and repayment provisions of the Patient Protection and Affordable Care Act.
- Applies only to Medicare Part A and B providers and suppliers.
- Requirements are meant to support compliance with applicable statutes, promote the furnishing of high quality care, and protect the Medicare Trust Funds against improper payments, including fraudulent payment.

60-Day Overpayment Rule

- Section 1128J(d)(1) requires a person who has received an overpayment to report and return the overpayment to the Secretary, the state, an intermediary, a carrier, or a contractor, as appropriate, at the correct address, and to notify the Secretary, the state, an intermediary, a carrier, or a contractor to whom the overpayment was returned in writing of the reason for the overpayment.
- Section 1128J(d)(2) requires an overpayment to be reported and returned by the later of A) the date which is the 60 days after the date on which the overpayment as identified, or B) the date any corresponding cost report is due, if applicable.
- Section 1128J(d)(3) specifies that any overpayment retained after the deadline for reporting and returning an overpayment is an "obligation". Per the FCA, obligation means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment.
- Section 1128J(d)(4) specifies the provisions of this rule, including clarification of the meaning of overpayment identification, the required lookback period for overpayment identification, and the methods available for reporting and returning identified overpayments to CMS.

Compliance Triggers/Potential Red Flags

- Blatant disregard to updates, rule changes, software changes or upgrades
- Changes in staff – loss of expertise.
- Does staff have all of the tools they need?
- Lack of consistency in performance of job functions.
- Change in practice patterns, both employee- and task-related.
- Sudden changes from the norm – increase in denials from a particular payer, increase in phone calls reporting payroll issues, missing items which delay bill submission.
- Cheat sheets – if being used, keep them updated!
- You don't want staff guessing – are there important billing elements missing that you should be providing for them or regularly monitoring? For example, coding is often interpretation.
- Potential "whistleblowers" – listen and be sure to weed out the chronic complaints from real issues.

Be proactive in identifying potential problems

- We don't want external reviewers/auditors finding errors for us.
  - Make sure staff have the most up-to-date education, rule changes, etc. and ensure that they are taking the time to review it.
  - Provide clear expectations to staff.
  - Perform regular audits (don't have to be big or time-consuming).
  - Be aware of practice patterns.
  - Communicate findings to the team and those departments that create the charges.
  - Educate other departments creating the charges so you have a clean bill from the beginning – will stop delays in the billing process.
  - Maintain systems and software that directly impact processes.

Ways to be Proactive

- Open door policy – welcome reporting of concerns – use employee's expertise to your advantage.
- When there are changes in staff (retire, terminate, etc.) be sure to determine any gaps they have left to ensure there are no holes in your process.
- Identify potential whistleblowers – are there employees on your team that are chronic complainers? Listen to their concerns!
- Ensure that you are receiving the most up-to-date publications and rule changes and communicate those immediately.

Questions?

References:

Federal Register/Vol.63,No.35/Monday, February 23, 1998/Notices

Department of Health and Human Services, Office of Inspector General, Publication of the OIG Compliance Program for Hospitals

CMS.gov/CMS 6037-F Final Rule

31 U.S.C. 3729: False Claims

Health Law News by Hall Render February 12, 2016