COMPLIANCE, RACs AND ZPICs

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NAMAS 5th Annual Auditing Conference 2013
December 9, 2013
Atlanta, GA

DELIBERATE IGNORANCE IS NOT A DEFENSE!

RECOVERY AUDIT CONTRACTOR

- Responsibilities
  - Identify improper Medicare overpayments and underpayments
  - Detect and correct past improper payments
  - Implement actions to prevent future improper payments
- Paid on contingency fee basis

Background

The national Recovery Audit program is the product of a successful demonstration program that utilized Recovery Auditors to identify Medicare overpayments and underpayments to health care providers and suppliers in randomly selected states. The demonstration ran between 2005 and 2008 and resulted in over $900 million in overpayments being returned to the Medicare Trust Fund and nearly $38 million in underpayments returned to health care providers. As a result, Congress required the Secretary of the Department of Health and Human Services to institute (under Section 302 of the Tax Relief and Health Care Act of 2006) a permanent and national Recovery Audit program to recoup overpayments associated with services for which payment is made under part A or B of title XVIII of the Social Security Act."

RAC Regions

Current RAC Targets

- Inpatient hospital
- Outpatient hospital
- Ambulance providers
- DME suppliers
- Physician groups

Medicare Fee for Service National Recovery Audit Program

- (October 1, 2011– December 31, 2011)

	OVER PAYMENTS COLLECTED	UNDER PAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: DCS	$69.6	$8.2	$77.8	$77.8
Region B: CGI	$65.6	$6.5	$72.1	$72.1
Region C: Connolly	$117.5	$2.6	$120.1	$120.1
Region D: HDI	$145.1	$7.6	$152.7	$152.7
Nationwide Totals	**$397.8**	**$24.9**	**$422.7**	**$422.7**

TOP ISSUE PER REGION

*Based on collected amounts through December 31, 2011

Region	Issue
Region A:	**Neurological Disorders: (Medical Necessity)**
Region B:	**Cardiovascular Procedures: (Medical Necessity)**
Region C:	**Neurological Disorders: (Medical Necessity)**
Region D:	**Minor Surgery and other treatment billed as Inpatient: (Medical Necessity)**

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2012Medicare-FFS-RecoveryAuditProgram-1st-Qtr.pdf

RAC ISSUES

- **Claim Unbundling**
- **High Cost Drug Billing Errors**
- **Incorrect Reimbursement Rates on Medicare Fee-for-Service**
- **Outpatient Cardiac Catheterization**
- **Incorrect CPT Codes**
- **Surgical Codes Determined as Bundled Codes**

Claims Review

Review claims on post-payment basis

- Uses same Medicare policies as FIs, Carriers, and MACs including LCDs, NCDs and Medicare Manuals
- Areas of focus chosen based on data mining techniques, OIG / GAO reports, CERT reports, and experience and knowledge of staff
- Approved audit issues posted on RAC contractor website

Automated Review

- Uses data analysis to determine improper payments
- Does not involve a review of medical records
- Contacts providers directly to collect any overpayments or repay any underpayments
- Consumes less resources than a complex review and conducted more frequently

Complex Review

- Uses medical records to further analyze the claim when data analysis is insufficient
- Identifies discrepancies between the medical records and the claim
- Provider has 45 days to submit medical records
- Review must be completed within 60 days of receipt of medical records
- Sends the hospital a determination letter with its findings

Complex Review Examples

- Acute Respiratory Failure: MS-DRG 189
- Coronary Bypass Procedures MS-DRG 234, 236
- Heart Transplant DRG 103 MSDRG 002
- Human Immunodeficiency Virus (HIV) Disease
- Major Cardiovascular Procedures MS-DRG 238
- Simple Pneumonia DRG 089, MSDRG 193, 194, 195

ZPICs

Zone Program Integrity Contractors (ZPICs)

- Consolidation of PSCs and Medicare Drug Integrity Contractors (MEDICs)
- Coordination of claims processing and benefit integrity activities
- 7 ZPIC zones based on MAC jurisdictions

ZPIC Zones

- **Zone 1**
  - Safeguard Services (SGS)
    - California, Hawaii, Nevada, American Samoa, Guam, and the Mariana Islands
- **Zone 2**
  - AdvanceMed
    - Washington, Oregon, Idaho, Utah, Arizona, Wyoming, Montana, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, Alaska
- **Zone 3**
  - Cahaba
    - Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky

- **Zone 4**
  - Health Integrity
    - Colorado, New Mexico, Texas, and Oklahoma
- **Zone 5**
  - AdvanceMed
    - Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, North Carolina, South Carolina, Virginia, West Virginia
- **Zone 6**
  - Under Protest
    - Pennsylvania, New York, Delaware, Maryland, D.C., New Jersey, Massachusetts, New Hampshire, Vermont, Maine, Rhode Island, Connecticut
- **Zone 7**
  - Safeguard Services (SGS
    - Florida, Puerto Rico, Virgin Islands

ZPIC Responsibilities

- Ensure integrity of ALL Medicare related claims
  - Parts A, B, C, D, Home Health, DME
- Hospice and coordination of Medi-Medi data matches
- Use "innovative data analysis methodologies" for early fraud detection and prevention

- ZPIC analysis of data should:
- *Identify those areas of potential errors (e.g., services which may be non-covered or not correctly coded) that pose the greatest risk;*
- *Establish baseline data to enable the recognition of unusual trends, changes in utilization over time, or schemes to inappropriately maximize reimbursement;*
- *Identify where there is a need for (a) an LCD and (b) targeted education efforts;*
- *Identify claim review strategies that efficiently prevent or address potential errors (e.g., prepayment edit specifications or parameters);*
- *Produce innovative views of utilization or billing patterns that illuminate potential errors;*
- *Identify high volume or high cost services that are being widely overutilized. This is important because these services do not appear as an outlier and may be overlooked when, in fact, they pose the greatest financial risk;*
- Chapter 2, Section 2.2 of the Medicare Program Integrity Manual.

ZPIC analysis of data should:

- *Identify program areas and/or specific providers for possible fraud investigations; and*
- *Determine if major findings identified by RACs, CERT, and CMS represent significant problem areas in the AC's or MAC's jurisdiction.*
- *This data analysis program shall involve an analysis of national data furnished by CMS as well as review of internal billing utilization and payment data to identify potential errors. The goals of the data analysis program are to identify provider billing practices and services that pose the greatest financial risk to the Medicare program.*
- Chapter 2, Section 2.2 of the Medicare Program Integrity Manual.

ZPIC Responsibilities

- Fraud case development
- Fraud complaint processing
- Provider education related to fraud investigations

ZPIC Responsibilities

- Identify potential fraud within service
- Compare billings with similarly situated providers
- Authorized to initiate administrative sanctions
- Provide support to law enforcement

ZPIC Audits

- Unannounced or limited notice
- Review of claims
  - Prepayment or post payment
  - Probe sample or statistical sampling and extrapolation
- May review small number of records to determine if there is a fraud concern
- May use a statistician
- May conduct interviews with beneficiaries or provider's employees, *etc.*

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- ZPIC reviews are NEVER random
- ZPICs initial request
- On-site inspections

ZPIC Audit Triggers

- Improper or inaccurate billing
  - High claim rejection rates
  - High claim recoupment rates
- Utilization screens
  - Higher utilization than neighboring providers
    - High clinical case mix assignment
    - Medicare admission patterns
- Claim mismatch with physician record
- Lengths of stay outside industry norm
- Use of data mining

Audit Results

- Referral to law enforcement
- Forward of findings to MAC for appropriate overpayment recoupment action
- Provider education

Duty to Refund Overpayments

- Under 6402 of PPACA, provider must report (notify contractor in writing of reason) and return Medicare and Medicaid overpayments within 60 days from the date identified or a date the corresponding cost report was due
  - Open questions:
  - When is an overpayment "identified?"
  - Does 60-day rule require identified overpayment to be reported if amount unknown?
  - Must overpayments arising prior to 3/23/2010 be reported and refunded within 60 days?
  - How does 60-day rule apply to interim payments?
- Retention after deadline results in potential liability under the False Claims Act

Preparing for an Audit

- Maintain complete, accurate, and timely documentation of patients' clinical conditions
- Encourage high level of collaboration between physician and facility departments
- Establish record management protocols
- Unless entity specifically requests to interview an employee, all communications go through designated individual
- Involve legal counsel

Responding to Record Request

- Responses must be timely and complete –track all deadlines
- Provider must be prepared for large volume of requests
- Keep a complete record of who has sent what to whom
- Keep copy of all records and correspondence
- Designate a point of contact, perhaps the compliance officer, to communicate with requesting entity
- Notify legal counsel

- Implement document management system
  - Scan duplicates, cover letter with filings
- Compile documentation immediately
  - Work on referral sources to obtain all clinical documentation
  - Instruct all personnel, in writing, that no records are to be destroyed

How To Respond To An Audit Request

- Make certain government has your correct mailing address – mail delay is not an excuse for an untimely response.
- Designate one person to whom all audit letters will be given when received by the provider and open immediately.
- If representatives of a government entity shows up at your door, take their cards and immediately contact the individual designated for such matters.
- Designate one person to coordinate a response.
- Contact health care counsel for guidance.

- Make sure that all information requested is gathered If the document is missing, find it. If the document does not exist, DO NOT CREATE IT.
- Number each page of all documentation sent to the government (bates stamp).
- Respond by the deadline noted in the audit request.
- Send the response to the correct entity at the correct address.
- Timely respond to any requests for additional information.
- Submit a road map or clinical chronology of medical record

Establish an Audit Response Team

- Compliance Officer
- Documentation Manager
- Administrator –oversees deadlines
- Registration/Admissions
- Discharge Planner
- Billing and Coding
- Clinical, Financial, and Legal Expertise

Medicare Appeal Process

- Redetermination from the Intermediary/Carrier
- Reconsideration from a Qualified Independent Contractor
- Appeal to an administrative law judge
- Appeal to the Medicare Departmental Appeals Board
- Appeal to a federal district court

The Medicare Appeals Process

1. MACs must explain clinical and scientific basis for decision.
2. Providers may pursue appeals on behalf of patient
   a. Beneficiaries and providers, participating suppliers, and nonparticipating suppliers who accept assignment of claim have standing to appeal.
   b. Beneficiaries can assign their appeal rights to a provider or supplier.
   c. Must use form available at: www.cms.hhs.gov/forms or provide a letter with all required information
   d. With few exceptions, a party may appoint anyone to act as their representative
3. CMS AND MAC can participate in ALJ hearings.
4. OIG Report OEI -02-10-00340, November 2012
   Recommended increased CMS Participation in ALJ Appeals
5. There is a process to expedite an appeal in certain circumstances

The Medicare Appeals Process

- The Initial Determination (ID):
  - 42 C.F.R. § § 405.920-928

1. Contractor must review a "clean" claim within 30 days or interest runs to be paid to patient
2. 45 days to review non-clean claim. No interest.
3. A clean claim has no defect or impropriety requiring special treatment for payment.
4. Denied claim must explain reason, if LCD OR NCD used, and how to apply for Redetermination

The Medicare Appeals Process

- Redeterminations:
  - 42 C.F.R. § § 405.940-958

1. Request within 120 days of receipt of ID plus 5 days for mailing if date of receipt not established.
2. No Amount in Controversy (AIC).
3. Request for Redetermination must contain:
   a. Summary of facts and clinical evidence supporting claims.
   b. Explain how laws, regulations, coverage rules and CMS policies apply
   c. Explain why disagree with ID and include any new evidence.
4. Redetermination by same MAC, but not individual(s) involved in the ID

The Medicare Appeals Process (cont'd)

5. MAC has 60 days to issue a redetermination. If evidence is submitted after request, extra 14 days.
6. Redetermination decision by MAC must contain:
   a. How to apply for Reconsideration.
   b. Statement that all evidence must be submitted with Request to QIC.
   c. At next level, ALJ will not accept additional evidence unless good cause shown, or beneficiary not represented.
   d. MAC can add new issues relevant to claim.

The Medicare Appeals Process (cont'd)

Reconsideration:

42 C.F.R. § § 405.960-978

1. 180 Days to request Reconsideration – 5–day mail rule.
2. Reconsideration is an independent, on-the-record review of an ID, redetermination, and all issues related to the claim made to Qualified Independent Contractor (QIC), on CMS Form, or in writing with certain required information.
3. Request should include all new evidence and explain why disagree.

The Medicare Appeals Process (cont'd)

Reconsideration (cont'd)

4. QIC reviews evidence already submitted and new evidence submitted with Reconsideration, as well as evidence the QIC develops on its own. QIC has 60 days to issue reconsideration decision, but if evidence presented after request, additional 14 days.
5. If issue is whether service or item is "reasonable and necessary" under § 1862(a)(1)(A) of SSA, the Reconsideration must consider recommendation from panel of physicians or appropriate health care professionals, and be based on clinical experience, the patient's medical, record, and medical, technical and scientific evidence of record.

The Medicare Appeals Process (cont'd)

- 6. Reconsideration decision must include:
  - a. Favorable or not.
  - b. Summary of facts including clinical and scientific evidence.
  - c. Explanation of how law, regulations, coverage rules and CMS policies apply to facts.
  - d. If issue is reasonable and necessary, explain medical and scientific rationale.
  - e. If missing documentation, explain how impacted decision.
  - f. How to apply for ALJ hearing and $140 AIC – index for inflation.

The Medicare Appeals Process (cont'd)

ALJ Hearings:

42 C.F.R. §§ 405.1000-1064

4. CMS or MAC/RAC may be a "Party" and there may be "Participation" by CMS or MAC/RAC at its request or ALJ request. Appellant must be given notice within 10 days after receipt of Notice of Hearing.
   - **42 C.F.R. § 405.1010 and 42 C.F.R. § 405.1012.**
   - **OIG REPORT OEI-02-10-00340**
5. Evidence must be submitted with request for hearing or within 10 days after receipt of Notice of Hearing. Late submission tolls 90 Days adjudication period. Must have a statement explaining why evidence was not previously submitted to QIC, but it is not applicable to oral testimony at hearing or for an unrepresented beneficiary. ALJ decides if there is good cause to admit evidence or exclude it or remand to QIC for consideration.

The Medicare Appeals Process (cont'd)

ALJ Hearings:
42 C.F.R. §§ 405.1000-1064

1. Within 60 days, request ALJ hearing-usually via telephone or by video conferencing. Can request an in person hearing, but must demonstrate good cause. Can also request a decision on-the-record (without hearing). AIC of $140 indexed for inflation. ALJ has 90 days to issue decision with certain exceptions.
2. If the QIC does not issue Reconsideration within 60 days, file request to escalate to ALJ hearing. QIC has 5 days to issue Reconsideration after escalation request.
3. Request for ALJ hearing must include:
   - a. Reason disagree with QIC's Reconsideration
   - b. Statement of additional evidence to be submitted, and when.
   - c. Appellant must send copy of its request for ALJ hearing to all other parties.

The Medicare Appeals Process (cont'd)

- 1. MACs are bound by the statute, regulations, CMS rulings, NCDs, LCDs, CMS manuals, and other program guidance.
- 2. QICs, ALJs, and the Medical Appeals Council are bound by the statute, regulations, CMS Rulings, and NCDs.
- 3. QICs, ALJs, and the Medical Appeals Council must give substantial deference to LMRPs, LCDs, CMS manuals, and other program guidance if they are applicable to a particular case.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review:

42 C.F.R. §§ 405.1100-1134

1. Request Medicare Appeals Council review within 60 days from receipt of ALJ decision. No AIC. Medicare Appeals Council may decline review. Medicare Appeals Council has 90 days to issue decision.
2. Request for Medicare Appeals Council Review must:
   a. Be on CMS standard form or written with required information.
   b. Identify parts of ALJ decision, dismissal or other determination disagree with and explain why. Why ALJ inconsistent with statute, reg., CMS ruling, etc.
   c. MAC/RAC's review is limited to issues raised unless beneficiary is not represented.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review (cont'd)

3. Medicare Appeals Council conducts a de-novo review (on its own) motion or at request of CMS or MAC/RAC. The Medicare Appeals Council will only consider the evidence that was before the ALJ if it is reviewing an ALJ decision.
4. If hearing decision decides a new issue that the parties were not given an opportunity to address before ALJ, Medicare Appeals Council will consider evidence on that issue submitted with the request for Medicare Appeals Council review.

The Medicare Appeals Process (cont'd)

Medicare Appeals Council Review (cont'd)

5. Medicare Appeals Council will accept case if there is an:
   a. error of law material to the outcome,
   b. an abuse of discretion by the ALJ,
   c. decision is not consistent with the preponderance of the evidence, or
   d. there is a broad policy or procedural issue that may effect the general public interest.
6. CMS or MAC referral to Medicare Appeals Council, parties notified.
7. Medicare Appeals Council will consider all documents, evidence and transcript of oral testimony before ALJ relevant to issues, briefs may be submitted, but oral argument only if there is an important question of law, policy or fact that cannot be resolved on the written record

The Medicare Appeals Process (cont'd)

Judicial Review:

42 C.F.R. §§ 405.1136-1140

1. Appeal to Federal District Court where the beneficiary resides or where the provider has its principal place of business.
2. Complaint filed within 60 days. The AIC is $1,400 indexed for inflation.
3. No time limit within which the Court must issue a decision.
4. The standard of review is substantial evidence. The Court reviews the administrative record below and no new evidence is permitted.

The Medicare Appeals Process (cont'd)

Escalation:

1. Advance to the next level of appeal if an adjudicator fails to issue its decision within the time limits.
2. The appellant must request the escalation in writing, or the appeal remains at the current level until decided.
3. The adjudicator has an extra 5 days to issue its decision before the appeal is sent to the next level.
   - Recoupment will begin when a request for escalation is made and favorable decision is not issued within 5 days.
4. Appellant waives right to obtain a decision within the specified number of days from the QIC or the ALJ. Also forgo benefit of level of review skipped.

The Medicare Appeals Process (cont'd)

Expedited Access to Judicial Review:

42 C.F.R. § 405.990

1. A party to the appeal may request expedited access to judicial review if there are no material issues of fact in dispute, and a review entity certifies that the MAC does not have the authority to decide the question of law.
2. A review entity consists of three reviewers who are ALJs or members of the Department Appeal Board DAB) as determined by HHS.
3. The issue must be a challenge to a statute, or regulation as unconstitutional, or a NCD or CMS ruling is invalid.

Reopening

42 C.F.R. § 405.980

1. A reopening is a remedial action taken to change a final determination or decision. QIC, ALJ or MAC may reopen its decision.
2. Clerical errors include human and mechanical errors on the part of a party or contractor such as:
    a. Mathematical or computational mistakes;
    b. Inaccurate data entry; or
    c. Denials of claims as duplicates

Reopening (cont'd)

3. Within 1 year from date of initial determination or redetermination for any reason.
4. Within 4 years from date of initial determination or redetermination for good cause (defined in 42 C.F.R. 405.486)
5. At any time if there is reliable evidence that the initial determination was procured by fraud or similar fact.
6. At any time if the initial determination is at all unfavorable, but only to correct a clerical error on which the determination was based.
7. At any time to effectuate a determination under the coverage appeals process.

Rebuttal Statement and Discussion Period

42 C.F.R. §§ 405.374-375

1. Rebuttal – 15 days from the date of the demand letter to submit a rebuttal statement.
2. Rebuttal statement should explain why recoupment should not be put into effect.
3. MAC must consider rebuttal evidence to decide if overpayment should be reduced or reversed.
4. The MAC will advise you of its decision in writing within 15 days of receipt of your rebuttal quest.
5. Discussion Period – Call MAC immediately for a discussion of why overpayment is wrong. Can request additional time for discussion period, but appeals deadlines are not stayed. Recoupment begins 41 days from date of denial letter.

Stay of Recoupment

"Recoupment is the recovery by Medicare of any outstanding Medicare debt by reducing present or future Medicare payments and applying the amount withheld to the indebtedness."
42 C.F.R. § 405.370

- Recoupment is stayed during first two levels of appeal (if filed within appropriate time frames), redetermination and reconsideration, but interest continues to accrue.

Time Deadline for Stay of Recoupment

You Can Stay Recoupment of an Overpayment

- A provider has 120 days from receipt of the Demand Letter (5 days from mailing) to file a request for redetermination to the MAC.
- Recoupment begins on the 41st day after the date of the Demand Letter, unless the MAC receives a request for redetermination within 30 days from the date of the Demand Letter (not 30 days from the date of receipt).
- If the redetermination decision is not favorable, a provider has 180 days to file a request for reconsideration with the QIC.

Time Deadline for Stay of Recoupment (cont'd)

- The MAC can begin recoupment on the 61st day after the unfavorable redetermination notice, unless the provider files a request for reconsideration within 60 days.
- If the reconsideration decision is not favorable, a provider can appeal further, but recoupment cannot be stayed during the appeal.

Adopt a compliance program or update existing program

- Provide for regular assessments
  - Self-audit of potential risk areas
  - Keep track of denied claims and look for patterns
- Monitor problem areas
- Training (including testing) and outreach
- If improper claims submitted, correct problem and refund overpayments
- Establish a point of contact

- Appeal adverse determinations
- Establish a systematic appeals process,
- Need to track status of appeals and all due dates
- Presumption of receipt of notices within 5 days of document
- Documents sent are deemed filed when received by addressee
- Consider all defenses, including waiver of liability and "without fault"

What is Fraud, Waste and Abuse?

- **Fraud** is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist - includes obtaining a benefit through intentional misrepresentation or concealment of material facts.
- **Waste** includes incurring unnecessary costs as a result of deficient management, practices, or controls.
- **Abuse** describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally, includes excessively or improperly using government resources.

A provider has a duty to have knowledge of the statutes, regulations and guidelines regarding coverage for Medicare services including:

a. reasonable and necessary medical services furnished to beneficiaries.

42 U.S.C. § 1395y(a)(1)(A)

b. economical medical services and then, only when, and to the extent medically necessary.

42 U.S.C. § 1320c-5(a)(1)

c. clinical record must be *"legible, clear, complete, and appropriately authenticated and dated…" in accordance with accepted* professional standards.

Fraud and Abuse/Compliance

- Increased Funding to Fight Fraud
- PPACA -$10M each year 2011-2020
- Budget Reconciliation –added another $250M from 2011–2016
- Possible goal to offset cost of Health Reform
- Many important changes

HTTPS://OIG.HHS.GOV/FRAUD/ENFORCEMENT/CMP/FALSE_CLAIMS.ASP

- 07-08-2013
- After it self-disclosed conduct to the OIG, Sonora Regional Medical Center (SRMC) California, agreed to pay $597,193 for allegedly violating the Civil Monetary Penalties Law. SRMC contracted with a physician to provide professional services at SRMC's medical oncology outpatient center. The OIG alleged that SRMC submitted claims containing CPT codes 99204, 99205, 99214, and 99215, that it submitted for services provided by the physician that were upcoded and that the physician engaged in a pattern or practice of coding at a higher level that he knew or should have known would result in a greater payment than the code applicable to the services he was actually providing.

- 05-17-2013
- Dr. Matthew James Britton and C.F. Health Management, Inc. d/b/a Gainesville Pain Management (Gainesville), Georgia, agreed to pay $1,577,597 for allegedly violating the Civil Monetary Penalties Law. The OIG alleged that Gainesville submitted false or fraudulent claims: 1) by inappropriately using Modifiers 76 and 59, to submit claims for payment for multiple units of Healthcare Common Procedure Coding System (HCPCS) codes G0431 and G0434 when only a single unit may be billed per patient encounter; and 2) by inappropriately using Modifier QW and billing for HCPCS G0431 when the less expensive services represented by HCPCS code G0434 were actually provided.

Seven Elements of Compliance Programs

1. Written policies, procedures and standards of conduct
2. Compliance Officer and Committee
3. Effective training and education
4. Effective lines of communication
5. Enforce standards through well publicized disciplinary guidelines
6. Conduct internal auditing and monitoring
7. Respond promptly to detected offenses and develop corrective actions

1. Written Policies, Procedures and Standards of Conduct

Code of Business Ethics and Conduct:

- Commitment to compliance with Federal and State health care program requirements.
- Expectation that associates will comply.
- Right and requirement to report to Compliance Officer or Committee suspected violations of any Federal/State law or regulation or company policies.
- Commitment to non-retaliation.
- Confidentiality of disclosing employee

COMPLIANCE AS AN ELEMENT OF EMPLOYEE PERFORMANCE PLAN

- Written Policies and Procedures:
  - Comprehensive and comprehensible
  - Distributed /available to all employees
  - Frequently updated
  - OIG Risk Areas – (Eligibility, Anti-Kickback, Medical Necessity, Plans of Care, Stark)

- Records and Documentation:
  - Medical Record and Billing Process/Records
  - Compliance Program Documentation:
  - Training, Hotline calls, corrective action plans, self-disclosures, audit and monitoring results, program modifications

2. Compliance Officer and Compliance Committee

Integrity, Independence, Authority

- Oversee/monitor the compliance program
- Report to Governing Body, Board of Directors, CEO and Compliance Committee
- Updates changes in requirements
- Develops and participates in training
- Independent Contractors
- OIG/ZPIC/RAC/MIC checks
- Investigations

Compliance Committee:

- Senior management, drawn form all departments
- Assist and support the compliance officer
- Analyze and review legal requirements
- Review/revise existing policy
- Determine strategy
- Monitor internal and external reviews

3. Effective Training and Education

- All Company Associates: corporate officers, senior management, nurses, other clinical staff, administrative, marketing and financial services
- Annual, mandatory, post-tests & employee attestations
- Business Ethics and Compliance
- HIPAA
- Regulations, statutes and COP's – Program Integrity
- Eligibility and Coverage Requirements
- Billing Requirements
- Patient rights
- Duty to comply and report misconduct
- Marketing

4. Develop Effective Lines of Communication

Access to the Compliance Officer

- Unfettered access to the compliance officer
- Non-retaliation
- Confidential and anonymous Hotline and Other forms of Communication
- Confidential Hotline
- Confidential and anonymous
- Readily available
- Distributed to all
- Appropriate follow-up to calls: log, investigations, reports
- E-mail, suggestion box, newsletters, etc., can also be used

5. Enforce Standards through Well-Publicized Disciplinary Guidelines

Effective Disciplinary Policies and Actions

- Well disseminated
- Effective
- Fair and equitable
- Enforced

New Employee Policies

- Background checks
- OIG/GSA Exclusion Lists
- State Medicaid exclusion lists

6. Auditing and Monitoring

- Pre-bill Audits
- Internal Review
- Admission, Eligibility Audits
- Certification and Plan of Care Audits
- Plan of Care Audits
- Investigation of Hotline calls and other complaints
- Patient/family complaints
- Collate data – review trends – provide feedback
- Act on findings – education, plan of correction, discipline

7. Respond to Detected Offenses and Develop Corrective Action Initiatives

- Report misconduct within a reasonable period
- Demonstrates good faith
- Failure to do so might be construed as a deliberate attempt to conceal findings from the government
- Provide evidence of the violation and estimate of the overpayment that resulted from it
- Return the overpayment (See return of overpayments)
- Demand plan of correction
- Implement corrections to practices and required disciplinary action
- Evaluate effectiveness of corrective actions

Five Practical Tips for Creating A Culture of Compliance

1. Make compliance plans a priority now.
2. Know your fraud and abuse risk areas.
3. Manage your financial relationships.
4. Just because your competitor is doing something doesn't mean you can or should. Call 1-800-HHS-TIPS to report suspect practices.
5. When in doubt, ask for help.

https://oig.hhs.gov/fraud/enforcement/cmp/false_claims.asp

REMEMBER

- Your best line of defense for any audit is a GOOD COMPLIANCE PLAN.

- **Get the Facts.** Understand the law and the consequences of violating it.
- **Make a Plan.** Cultivate a culture of compliance within your health care organization.
- **Know Where To Go.** Learn what to do when a compliance issue arises.

QUESTIONS?

THANK YOU!

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