Compliance:
What You Should Know

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STANDARDS AND GUIDELINES

In this chapter, we use the Centers for Medicare and Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) rules, manuals and guidelines. One may ask, "Why Medicare?" and "Why the OIG?" The reasons are numerous:

1. The profession wants recognition from CMS, the Agency that administers Medicare.

2. CMS guidelines are one of the most widely and publicly published guidelines in the health care arena. CMS is often referred to as the "gold standard."

3. The majority of commercial health insurers follow Medicare guidelines and the CMS fee schedule already; however, some claim not to follow Medicare guidelines because either they do not understand them or choose not to follow them.

In any case, if you are Medicare compliant, you are virtually compliant with every payor. If you are an athletic trainer (AT) working in a clinical setting, chances are your supervising physician deals with Medicare. If you know what your physicians do, how their clinical reasoning works, **and** understand and apply Medicare guidelines, you become value-added as an employee and greatly increase the chances of successfully defending your physicians when they are audited or reviewed by payors.

When payors do not provide you with guidelines or parameters for dealing with them, if you apply Medicare guidelines, the results of internal audits will be consistent, verifiable and reproducible. Even if your organization is audited by Medicare or the OIG, if their teams see you have strived to start, stay, and remain compliant with Medicare guidelines, you may be in a better place from an audit standpoint.

HEALTH CARE STANDARDS - WHAT THE GOVERNMENT EXPECTS!

HIPAA (Health Insurance Portability & Accountability Act of 1996) & the OIG

Pursuant to HIPAA, health care fraud is a crime. HIPAA also contains a provision for the OIG to increase aggressive action to reduce health care fraud and abuse in the United States.

Trends Found by the OIG

As the OIG performs audits on annual claims, the OIG finds trends that result in overpayments to providers. Overpayments due to claims submitted for services not medically necessary, services inadequately documented or services not documented at all, and coding errors are the top three (3) trends, listed in order of priority. These findings make it evident that health care providers are not utilizing Local Medical Review Policies (LMRPs)/Local Coverage Determinations (LCDs) and neglecting to perform internal audits to ensure quality of documentation and accuracy of billing procedures.

Is there guidance to help providers? Yes! Errors made in filing accurate and appropriate claims according to medical necessity, documentation, and coding guidelines is of concern to the OIG. Coding, documentation, and billing errors are concerns for all payors. Pursuant to the following regulations, payors are permitted to pursue prosecution of providers that file false or fraudulent claims:

- Civil False Claims Act
- HIPAA
- Racketeer Influenced and Corrupt Organizations (RICO) Act
- Mail Fraud (mailed claims)
- Wire Fraud (electronically submitted)
- Civil Monetary Penalties Law
- Anti-Kickback Statutes

Compliance Guidance

In 1996, as the OIG initiated reviews and investigations in 1996, the OIG observed that health care providers strive for excellence in the delivery of services. Interestingly enough, the OIG noted the opposite regarding business operations:

- Policies and procedures were not written or followed
- Measuring performance and accuracy were minimal to nonexistent
- Competency and experience lacked in critical areas of compliance

The OIG made a decision to assist health care providers by publishing ***compliance guidance materials***. These guidance materials provide instructions for health care organizations to develop an infrastructure for business operations. It is not mandatory for providers to implement these guidances. The OIG states, however, that if the provider organization chooses not to implement the compliance guidance, it must have something in place to ensure appropriate business operations, which result in accuracy in coding and billing. Since 1996, the OIG has published compliance guidance documents (below). To find the compliance guidance, click ***Compliance*** on the HHS OIG main web page, and then click on the heading of ***Compliance Guidance***. The following guidance documents can be found there:

1. Nursing Facilities
2. Research Awards
3. Hospitals
4. Pharmaceutical Manufacturers
5. Ambulance Suppliers
6. Individual and Small Group Physician Practices *(please note the word "physician" applies to any practitioner in health care who can obtain a provider number and bill directly to CMS)*
7. Medicare+Choice Organizations
8. Hospices
9. Durable Medical Equipment, Prosthetics, Orthotics, and Supply Industry
10. Third-Party Medical Billing Companies
11. Clinical Laboratories
12. Home Health Agencies

OIG Compliance Steps

Step 1: Auditing and Monitoring

An ongoing evaluation process is important to a successful compliance program. This ongoing evaluation includes not only whether standards and procedures are in fact current and accurate, but also whether the compliance program is working, *i.e.*, whether individuals properly are carrying out their responsibilities and claims are appropriately submitted. Therefore, an audit is an excellent way to ascertain what, if any, problem areas exist and focus on the risk areas that are associated with those problems.

There are two types of reviews that can be performed as part of this evaluation: (1) A standards and procedures review; and (2) a claims submission audit.

A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution. This audit will establish a consistent methodology for selecting and examining records; this methodology then serves as a basis for future audits.

There are many ways to conduct a baseline audit. The OIG recommends that claims/services submitted and paid during the initial three months after implementation of the education and training program be examined, so as to give the physician practice a benchmark against which to measure future compliance effectiveness. Following the baseline audit, a general recommendation is that periodic audits be conducted at least once each year to ensure that the compliance program is being followed. Optimally, a randomly selected number of medical records could be reviewed to ensure that the coding was performed accurately.

Although there is no set formula as to how many medical records should be reviewed, a basic guide is five or more medical records per Federal payor (*i.e.*, Medicare, Medicaid), or five to ten medical records per physician. The OIG realizes that physician practices receive reimbursement from a number of different payors, and we would encourage a physician practice's auditing/monitoring process to consist of a review of claims from all Federal payors from which the practice receives reimbursement. Of course, the larger the sample size, the larger the comfort level regarding results.

Step 2: Establish Practice Standards and Procedures

After the internal audit identifies the practice's risk areas, the next step is to develop a method for dealing with those risk areas through written standards and procedures. Written standards and procedures are a central component of any compliance program. Such standards and procedures help to reduce the prospect of erroneous claims and fraudulent activity by identifying risk areas for the practice and establishing tighter internal controls to counter those risks, while also helping to identify any aberrant billing practices.

Step 3: Designation of a Compliance Officer/Contact(s)

After the audits have been completed and the risk areas identified, ideally, one member of the staff needs to accept the responsibility of developing a corrective action plan, if necessary, and oversee the practice's adherence to that plan. This person can either be in charge of all compliance activities for the practice or play a limited role to solely resolve the current issue.

Step 4: Conducting Appropriate Training and Education

Education is an important part of any compliance program and is the logical next step after problems have been identified and the practice has designated a person to oversee educational training. Ideally, education programs will be tailored to the physician practice's needs, specialty, and size, and will include both compliance and specific training. There are three basic steps for setting up educational objectives:

- Determining who needs training (both in coding and billing and in compliance);
- Determining the type of training that best suits the practice's needs (e.g., seminars, in-service training, self-study, or other programs); and

- Determining when and how often education is needed and how much each person should receive.

Training may be accomplished through a variety of means, including in-person training sessions (i.e., either on site or at outside seminars), distribution of newsletters, or even a readily accessible office bulletin board. Regardless of the training modality used, ensure that the necessary education is communicated effectively and that employees come away from the training with a better understanding of the issues discussed.

Step 5: Responding To Detected Offenses and Developing Corrective Action Initiatives
When a facility/practice determines it has detected a possible violation, the next step is to develop a corrective action plan and determine how to respond to the problem. Violations of a compliance program, significant failures to comply with applicable Federal or State law, and other types of misconduct threaten a provider's status as a reliable, honest, and trustworthy provider. Consequently, upon receipt of reports or reasonable indications of suspected noncompliance, it is important that the compliance contact or other employee investigate the allegations to determine whether a significant violation of applicable law or the requirements of the compliance program has indeed occurred, and, if so, take decisive steps to correct the problem. As appropriate, such steps may involve a corrective action plan, the return of any overpayments, a report to the Government, and/or a referral to law enforcement authorities.

Step 6: Developing Open Lines of Communication
In order to prevent problems from occurring and to have a frank discussion of why the problem occurred, providers need to have open lines of communication. Guidance previously issued by the OIG has encouraged the use of several forms of communication between the compliance officer/ committee and provider personnel, many of which focus on formal processes and are more costly to implement (e.g., hotlines and e-mail). A compliance program's system for meaningful and open communication can include the following:

- The requirement that employees report conduct that a reasonable person would, in good faith, believe to be erroneous or fraudulent;

- The creation of a user-friendly process (such as an anonymous drop box for larger practices) for effectively reporting erroneous or fraudulent conduct;

- Provisions in the standards and procedures that state that a failure to report erroneous or fraudulent conduct is a violation of the compliance program;

- The development of a simple and readily accessible procedure to process reports of erroneous or fraudulent conduct; and

- If a billing company is used, communication to and from the billing company's compliance officer/contact and other responsible staff to coordinate billing and compliance activities needs to be in place.

Step 7: Enforcing Disciplinary Standards Through Well-Publicized Guidelines
Finally, the last step that a provider may wish to take is to incorporate measures into its practice to ensure that practice employees understand the consequences if they behave in a non-compliant manner. An effective compliance program includes procedures for enforcing and disciplining individuals who violate compliance or other practice standards. Enforcement and disciplinary provisions are necessary to add credibility and integrity to a compliance program.