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INSIDE

Outpatient therapy services: Medicare's trap for the unwary

By Lester J. Perling, MHA, JD and Barbara Viota-Sawisch, JD

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Billing the Medicare program for outpatient therapy services is often misunderstood. Although the rules changed in 2005, they are frequently not followed. If you or your practice bills Medicare for outpatient therapy services provided to patients directly as a covered benefit, or incident to the services of physicians or nonphysician practitioners, this article will provide you with a basic understanding of important Medicare reimbursement policies for outpatient therapy services. Becoming familiar with these policies is essential to avoid liability under the False Claims Act or the assessment of overpayments.

Background

Medicare policies that relate to outpatient therapy services have traditionally been confusing to providers, and that is still true. In May 2005, the Centers for Medicare and Medicaid Services (CMS) revamped the Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230 - the sections which contain the majority of Medicare's policies regarding coverage of therapy services and the qualifications of individuals who render such services. The changes, which were made in order to implement corresponding provisions in the 2005 Physician Fee Schedule Final Rule, became effective on June 6, 2005.[1]

Though intended, in part, to clear up the confusion on the part of physicians and others who bill Medicare for therapy services, the revisions have done little to demystify Medicare coverage policies on the subject. Because the revised manual sections also incorporate additional requirements, such as more stringent requirements for therapy services billed incident to the services of physicians and nonphysician practitioners, these policies continue to be a source of misunderstanding for those to whom they apply. To ensure Medicare payment for these services and to avoid liability under the False Claims Act or the assessment of overpayments, physicians and other suppliers who bill for therapy services should have a thorough understanding of Medicare requirements and effectuate procedures to ensure that Medicare is billed only for services that meet Medicare reimbursement requirements.

The following discussion does not represent a comprehensive list of Medicare policies relating to therapy services. Rather, this article highlights the more significant requirements for physicians, nonphysician practitioners, therapists, and other providers who bill for outpatient therapy services directly as a covered benefit, as well as for physicians and nonphysician practitioners who bill for therapy services incident to other professional services. For additional guidance on Medicare therapy policies, consult the Medicare Benefits Policy Manual, Chapter 15, Sections 220 and 230.

General Conditions of Coverage

Therapy services (also referred to as outpatient rehabilitation services) are a covered Medicare Part B benefit and include physical therapy, occupational therapy, and speech language pathology services when furnished on an outpatient basis. However, to qualify for coverage, these services must be provided in accordance with certain conditions discussed at length in the Medicare Benefit Policy Manual.

As with every Medicare benefit, therapy services must be reasonable and necessary. The revised sections of Medicare's Benefit Policy Manual include an extensive discussion of numerous conditions that must be satisfied for therapy services to be considered reasonable and necessary. For example, there must be an expectation that the patient's condition will improve in a reasonable period of time; the level of complexity of the services must be such that the services can be safely and effectively performed only by or under the supervision of a therapist; and the amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

Extensive documentation requirements must also be satisfied. The patient must be under the care of a physician or nonphysician practitioner before or during receipt of the services. The services must be provided according to a plan of care established by a physician or nonphysician practitioner, or, if established by the therapist providing the services, the plan must be reviewed periodically by a physician or nonphysician practitioner. The CMS manual sets forth the basic requirements of a plan of care; specifically, the plan must include a diagnosis, long-term treatment goals, and the type, amount, and frequency of the therapy services. Finally, the plan must be certified (i.e., approved) by a physician or nonphysician practitioner.

Therapy services are payable under the Physician Fee Schedule only when furnished on an

outpatient basis. A provider (or persons under arrangements with and under the supervision of providers) may furnish therapy services to its outpatients in the patient's home, to patients who come to the facility's outpatient department, or to inpatients of other institutions. A supplier (e.g., a physician, nonphysician practitioner, or enrolled therapist) may furnish therapy services in the office or in the patient's home.

Qualified Professionals or Personnel

To qualify for coverage, therapy services must be furnished by qualified professionals or personnel. For purposes of therapy services, qualified professionals include physicians, nonphysician practitioners (physician's assistants, nurse practitioners, or clinical nurse specialists), and physical therapists and occupational therapists in private practice who are licensed or certified to perform therapy services in their state. Doctors of medicine and osteopathy, podiatrists, and optometrists (for purposes of low-vision rehabilitation only) are considered physicians. Chiropractors and doctors of dental surgery, on the other hand, are not considered physicians for therapy services, and may not refer patients for therapy services or establish therapy plans of care. Qualified professionals may also include physical therapy assistants (PTAs) or occupational therapy assistant (OTAs) when working under the direct or general supervision (the applicable level of supervision varies depending on the setting) of a therapist and within the scope of practice allowed by state law.

Under limited circumstances, therapy services may also be furnished by "qualified personnel." Qualified personnel are individuals employed by a physician or nonphysician practitioner who have all the qualifications of therapists, with the exception of licensure. These individuals can perform therapy services only under the direct supervision of a physician or nonphysician practitioner, and only when their services are furnished incident to the services of a physician or nonphysician practitioner.

Therapy Services Provided "Incident To"

Therapy services can be billed directly as a covered benefit, or they may be billed as services incident to the services of a physician or nonphysician practitioner. "Incident to" services are provided in conjunction with a medically necessary service provided by the physician to alleviate or treat an illness or injury. They must be furnished by an employee or independent contractor of the supervising physician or the legal entity that employs or contracts with the physician, and are billed under the supervising physician's or practice's provider number as if they had been provided by that physician personally.

There is no Medicare coverage for services provided incident to the services of a therapist. In contrast, physicians and nonphysician practitioners, can properly bill for therapy services provided incident to their own services, subject to the same requirements that apply to therapy services furnished by physical or occupational therapists, with one exception. When therapy services are performed incident to a physician's or nonphysician practitioner's service, the qualified personnel who perform the service need not have a license to practice therapy unless it is required by state law. However, they must meet all of the remaining requirements. In effect, this rule requires that the person who furnishes the services be a graduate of a training program in physical or occupational therapy, but the person need not have passed the recognized credentialing examination.

Therapy services provided and billed incident to the services of a physician or nonphysician practitioner also must meet all requirements generally applicable to incident to services. Briefly, these include the requirements that:

- the service is one that is commonly furnished in the physician's office as an integral part of the physician's professional services, and
- in private practice, the services must be furnished under the direct supervision of a physician or nonphysician practitioner (i.e., the physician or nonphysician practitioner must be present in the office suite, but need not be in the same room, while the services are being performed).

So, for example, when therapy services are billed incident to a physician's or nonphysician practitioner's services, the requirement for direct supervision must be met, even though the service is provided by a licensed therapist who can perform the services without supervision under different circumstances.

With the 2005 revisions to the Medicare Benefit Policy Manual, CMS made clear that Medicare is authorized to pay only for services provided by persons trained specifically in physical therapy, occupational therapy, or speech language pathology. This is one of the more dramatic changes to take effect in the revised manual because, as a result, many of the services of practitioners who had in the past provided incident to services (massage therapists, recreation therapists, kinesiologists, and low-vision specialists, for example) no longer qualify for coverage.

Physical therapy assistants and occupational therapy assistants

The services of physical therapy assistants (PTAs) and occupational therapy assistants (OTAs) cannot be billed incident to the services of a therapist. When PTAs and OTAs work under the supervision of therapists, their services are covered under the benefit for therapy, and not under the benefit for services incident to those of a therapist. The applica-

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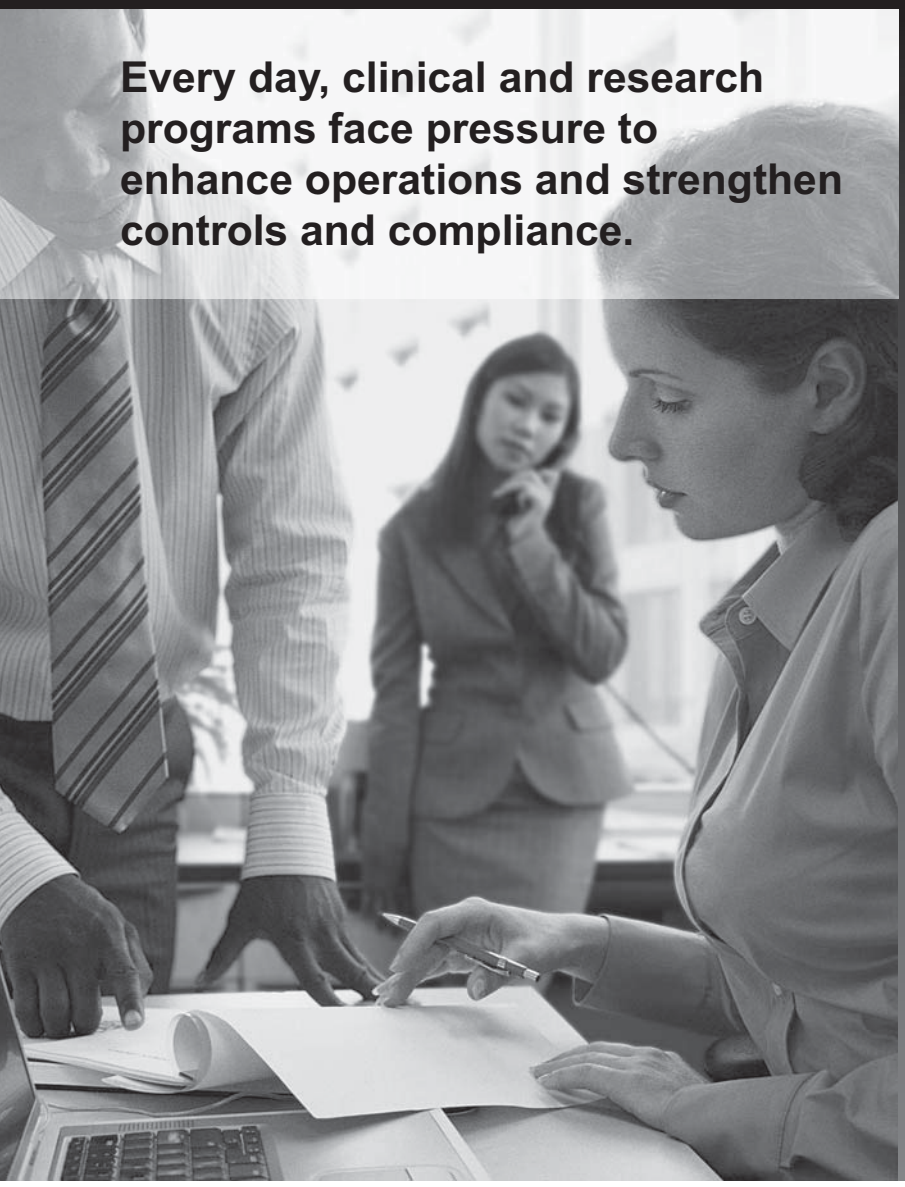

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ble level of supervision differs by setting, and state practice requirements apply if they are more stringent than Medicare's requirements. Generally, general supervision is required in all settings except private practice, which requires direct supervision.

The services of PTAs and OTAs also cannot be billed incident to those of a physician or nonphysician practitioner. However, if the physical therapist and the PTA (or the occupational therapist and the OTA) are both employees of a physician, the services of the PTA or OTA, when directly supervised by a therapist, may be billed by the physician's office as physical or occupational therapy services using the provider identification number (PIN) or national provider identifier (NPI) of the enrolled therapist.

The services of speech language pathology assistants are not recognized for Medicare coverage. Similarly, the services provided by aides, even if under the supervision of a therapist, are not therapy services for purposes of Medicare coverage, and are, therefore, not covered. Unskilled services, such as the services of aides, are considered not reasonable and necessary if they are billed as therapy services.

Physical or occupational therapists in private practice

To bill Medicare directly as a therapist, an individual in private practice must be enrolled as a private practitioner and employed by: 1) an unincorporated physician or nonphysician practitioner solo or group practice or partnership, if allowed by state law; 2) another enrolled physician, nonphysician practitioner, or therapist; or 3) a professional corporation or other incorporated therapy practice. Individuals working as employees of an institutional provider cannot enroll as therapists in private practice.

Therapists in private practice can furnish services in the therapist's or group's office, or in the patient's home. For therapy services to be properly furnished in a therapist's office, the space must be owned, leased, or rented by the therapist or the group by which the therapist is employed for the exclusive purpose of operating the practice, and the therapist must do so during the hours that he/she regularly engages in practice at that location. Medicare may also recognize a community center pool, for example, as part of the therapist's own practice. The practice must rent or lease the pool for a given period of time during which the use of the pool is restricted to the therapist's patients.

In a physician's or nonphysician practitioner's practice, the services of therapists who have their own Medicare PIN or NPI can be billed directly, with the therapist identified on the claim as the supplier of the services, or they can be billed by the physician or nonphysician practitioner as services incident to their own. As in any other setting, the services of PTAs or OTAs cannot be billed by a physician, nonphysician practitioner, or therapist as services incident to their own.

Conclusion

In recent years, the Office of the Inspector General of the Department of Health & Human Services has targeted outpatient therapy as an area of study and investigation, particularly with regard to the areas of medical necessity, documentation, and incident to services. For physicians, therapists, and others who furnish outpatient therapy services, this highlights the importance of developing effective procedures to ensure that therapy services are rendered and billed in accordance with Medicare's policies. ■

1 Note: Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005 was published in the Federal Register, Volume 69, No. 219, November 15, 2005.

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Inserted in this issue of **Compliance Today** is a quiz related to this article: "Outpatient therapy services: Medicare's trap for the unwary" by Lester J. Perling, MHA, JD and Barbara Viota-Sawisch, JD, beginning on page 4.

To obtain your CEUs, take the quiz and print your name at the top of the form. Fax it to Liz Hergert at 952/988-0146, or mail it to Liz's attention at HCCA, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435. Questions? Please call Liz Hergert at 888/580-8373.

Compliance Today readers taking the CEU quiz have ONE YEAR from the published date of the CEU article to submit their completed quiz.

Winds of change in reimbursement – Part 1

By Joy King, RHIA, CCS

Editor's note: Joy King is a Consultant with more than 13 years of inpatient coding and speaking experience. She can be reached at 205/612-4471 or by e-mail at jkinginc@charter.net.

Part II will be published in an upcoming issue of **Compliance Today**.

Not since 1983, when Diagnosis-Related Group (DRG) reimbursement was implemented, have such momentous changes faced the health care industry. The Final Rule for the Inpatient Prospective Payment System (IPPS) for Fiscal Year 2007 was published in the Federal Register on August 18, 2006. It included provisions that, along with the Budget Deficit Reduction Act of 2005, will have as drastic an impact on future Medicare reimbursement as DRG implementation.

CMS plans to align hospital payments with the cost of providing care and, eventually, to reflect the cost of care based on the severity of the patient's condition. All of this is done in the context of budget neutrality. Therefore, CMS must continue to re-distribute the money into different buckets to ensure that the dollars pay for the highest quality of care, for the greatest number of beneficiaries, for the longest time possible.

The Final Rule for FY 2007 included a two-part reform. Part 1 is a three-year transition from charge-based to cost-based DRG-relative weights beginning with October 1, 2006. Part 2 is implementation of a severity-adjusted DRG system on October 1, 2007. The move from a charge-based to a cost-based system is primarily aimed at eliminating the bias caused by markups for ancillary services. CMS has developed 13 cost centers, including 8 Ancillary centers, 1 Routine Day Cost Center, 1 Intensive Care Unit (ICU) Cost Center, 1 Anesthesia Cost Center, 1 Labor & Delivery Cost Center, and 1 Inhalation Therapy Cost Center. They plan to standardize charges for each cost center using a national cost-to-charge ratio to convert charges into cost. This would be done prior to setting the relative weights for the respective DRGs. An independent contractor has been hired to evaluate charge compression with the hospital-specific relative value cost center (HSRVcc) methodology that was proposed in April. (Charge compression means that high-cost items receive a lower markup than low-cost items, which particularly impacts high-cost devices in the cardiac DRGs). The three-year implementation phase is as follows:

- First year, 33% cost-based/67% charge-based
- Second year, 67% cost-based/33% charge-based
- Third year, 100% cost-based

The major impact will be a redistribution of relative weights (reimbursement) from surgical to medical DRGs, primarily because the ancillary markup for surgical DRGs is about 80% as compared with a markup of 64% for medical DRGs, per the Proposed Rule. The average increase in medical DRG relative weights will be 0.9% with an average decrease in surgical DRG relative weights of 1.2%. The biggest winners in medical DRGs could be pneumonia, sepsis, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF). Cardiology and cardiovascular surgery, orthopedic joint replacements, and neurosurgery will be most negatively impacted. The top 19 DRG losers would fall into Major Disease Category 5, in particular, coronary stents, implantable cardioverter defibrillator (ICD) implants, and pacemaker implants. On average, payments to all hospitals will increase about 3.5%. However, hospitals reporting on the 21 Quality Measures now being required will see an overall increase in operating expenses of 3.4%. Rural hospitals will see about 3.7% increase in payments, urban hospitals will see a decrease of about 3.4%. Cardiac hospitals will get a decrease of greater than 5%.

Hospitals will need to analyze their Case Mix Index, especially the percentage of surgical to medical DRGs. Determine what percentage of patients fall into the losers vs. winners, and look at specific DRGs within service lines that might be most affected. Look also at physician performance within service lines (such as current vs. expected revenue) for their patients in particular DRGs, as well as looking at physicians' current vs. expected revenue for all their patients. Compare revenue from the previous year to projected income under the new cost-based system. For example, 3M did some data analysis on a hospital, predicting a net overall decrease in reimbursement from charge-based to cost- based DRGs for FY 06 to FY 07 of more than $400,000. The net variance for medical DRGs was up $1,091,000, while the net variance for surgical DRGs was down $1,526,000.00.

For the past couple of years, CMS has required hospitals to report on 10 Quality Measures for acute myocardial infarction (AMI), pneumonia, and CHF, in order to receive their full market-basket share of reimbursement. The Final Rule for FY 2007 increased the number to 21, including additional measures on AMI, pneumonia, and CHF, plus the Surgical Infection Prevention measures. Hospitals receive a 2% reduction in payment for not

reporting. In addition, data validation of 80% reliability is required on the first three quarters of 2005 to receive the full market- basket share. Eventually, CMS also plans to include patient satisfaction survey data. The Hospital Consumer Assessment of Health Providers & Systems (HCAHPS) Patient Survey was to be implemented Octber 1, 2006, but participation will not impact this year's payment.

Public Law 109-17 included two important provisions that will greatly impact hospital reimbursement. CMS must develop a value-based purchasing program, effective October 1, 2008. By June 1, 2007 MedPAC must submit recommendations to Congress defining the structure of payment adjustments, including:

- defining thresholds in quality improvement that would justify payment adjustments,
- defining the size of payment adjustments, and
- identifying sources of funding for the value-based adjustments.

By August 1, 2007 the Secretary of Health and Human Services (HHS) must submit a plan to Congress for the value-based purchasing program, to include:

- an ongoing process for evaluating/developing quality measures;
- reporting of quality data by providers;
- the structure of the payment adjustments based on the recommendations by MedPAC; and
- provision for disclosure of information on hospital performance. Hospitals must be allowed to review their data before it is made public.

The value-based purchasing program means paying more for higher quality care and less for poorer quality care, as reflected by the Quality Measure reporting, as well as a new provision defined in Public Law 109-171. That law requires the Secretary of HHS to identify at least two high-cost or high-volume (or both) diagnosis codes that cause a case to group to a higher-weighted DRG when present as a secondary diagnosis and that reasonably could be prevented with evidence-based guidelines. The assignment of the lower-paid DRG would apply to discharges where the beneficiary did not have one of the identified diagnosis codes, (e.g., an infection, not present on admission, and therefore, hospital-acquired). This particular payment adjustment is not budget neutral, meaning that the total amount a hospital receives for discharges in a fiscal year could be changed as a result of such payment adjustments. The list of identified diagnoses can be revised periodically, as long as there are at least two conditions selected during any fiscal year. The Secretary of HHS is also required to consult with the Centers for Disease Control (CDC) and other appropriate clinical parties when selecting and revising the diagnosis codes.

In preparation for that, Public Law 109-171 has a provision requiring hospitals to report diagnoses that were present on admission (POA), effective October 1, 2007. This POA provision is also part of implementation of the claim form UB-04 for paper claims, which must be fully implemented by May 2007. The current version of the electronic claim format does not allow for reporting the POA information. The newer electronic version is not expected to be implemented prior to October 1, 2007. Therefore, work-arounds are being considered to provide for POA reporting. Coders must document POA information for all diagnoses reported on the claim. (Note: Guidelines on POA reporting will be published in Coding Clinic, but are currently posted at: www.cdc.gov/nchs/data/icd9/POAguideSep06.pdf. They include some diagnoses that will be exempt from POA reporting.)

Beginning October 1, 2008, CMS is scheduled to begin assigning higher-weighted or lower-weighted DRG payments based on the presence of those identified preventable conditions, when they are not identified as being POA. ■

TIMELINE

2006
- 2/06: Budget Deficit Reduction Act of 2005 (PL 109-171) Section 5001 Hospital Quality Improvements
- 10/1/06: First Year Transition from Charge-Based to Cost-Based DRG payments

2007
- 5/23/07: Form UB-04 implemented for providers submitting paper
- 6/1/07: MedPAC must submit recommendations for value-based payments
- 8/1/07: Secretary of HHS must submit plan to Congress for Value-based Purchasing Program for IPPS payments to acute care hospitals
- 10/1/07:
  1) Second Year Transition to Cost-Based DRG payments
  2) Implementation of Severity-Adjusted DRGs
  3) Secondary Diagnoses Present on Admission (POA) required by hospitals per Section 5001 PL 109-171
  4) Secretary of HHS must identify 2 high-cost/high-volume

2008
- 10/1/08:
  1) Third Year Transition—Completely Cost-Based DRG payments
  2) CMS assigns DRG payments based on presence of preventable conditions not designated as POA

2010
- Earliest possible implementation of ICD-10 and ICD-10-PCS

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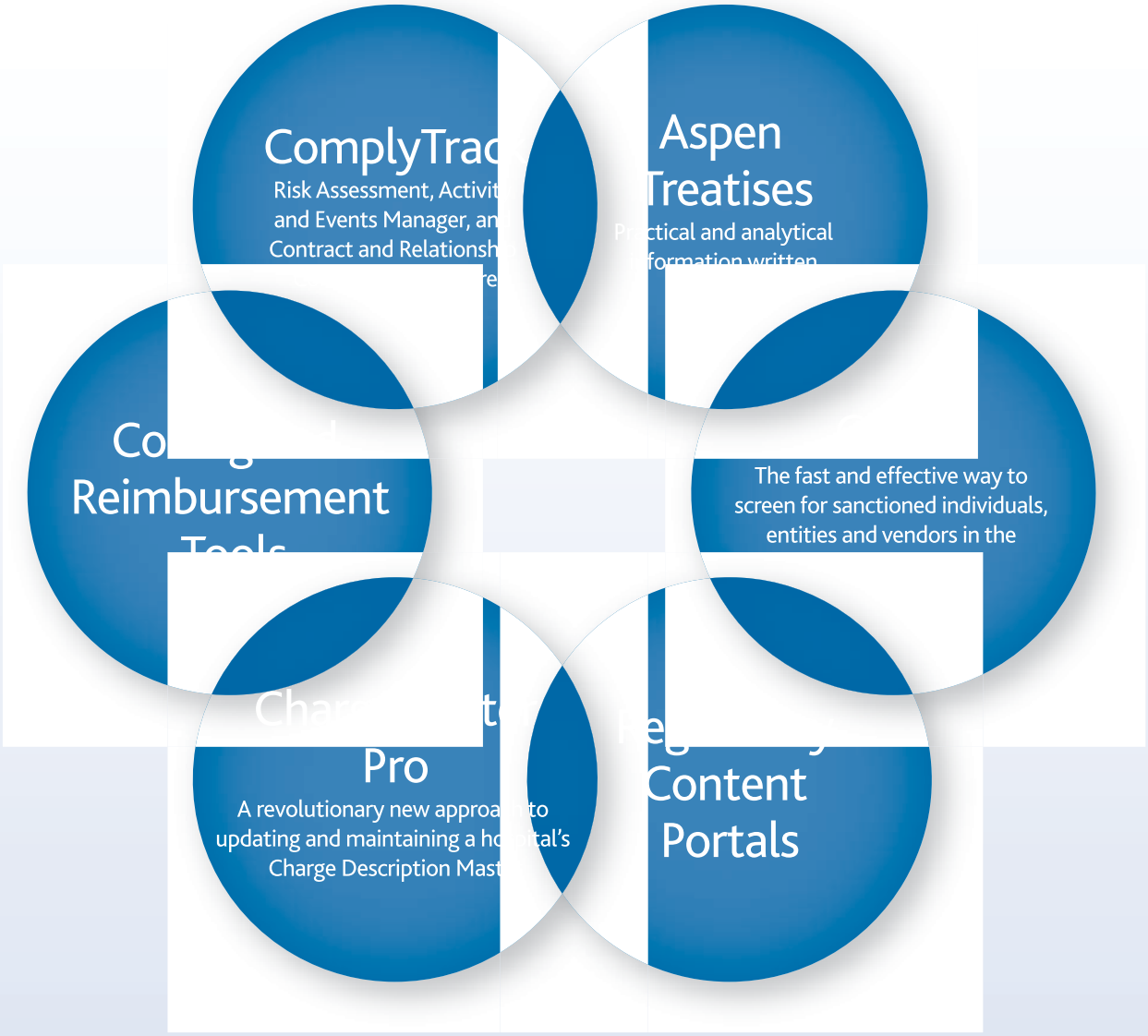

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Using statistical methods to meet fraud and abuse compliance requirements

By Jennifer Amato, MPH

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As the Office of Inspector General (OIG), Centers for Medicare and Medicaid Services (CMS), and other agencies collaborate to combat fraud, waste, and abuse (FWA) in the Medicare and Medicaid programs, many contractors try to prepare for these increasing efforts.

In particular, as a condition of participation in the Medicare Part D program, CMS requires Part D plan sponsors to implement a comprehensive fraud and abuse plan.[1] Self-reporting cases of potential fraud remains voluntary, but Part D sponsors are required to cooperate and coordinate with the Medicare Drug Integrity Contractors (MEDICs) who work with CMS to ensure program compliance. Specifically, the MEDICs are tasked to analyze and manipulate Prescription Drug Event (PDE) claims data to identify potential cases or areas of FWA.

Enforcement entities, MEDICs, and Program Safeguard Contractors are dramatically increasing their use of claims data to identify FWA. Some enforcement entities who use claims data to identify FWA are Zone Program Integrity Contractors (ZPICs), Medicaid Fraud Control Units (MFCUs), and Recovery Audit Contractors (RACs). As a result, Part D sponsors and other contractors and providers who receive funds from Medicare or Medicaid programs should be proactive and analyze their own claims data for potential cases of FWA before a government auditor finds the fraud.

Analysis of claims data

Part D sponsors and other payers of Medicare/Medicaid services should establish an in-house data team or hire a data analysis contractor to analyze claims data. This can be done in a number of ways, including producing descriptive statistics, predicting regression models, and performing clustering analyses that use a statistical package such as SAS.

Descriptive statistics. Descriptive statistics, such as frequencies and means, can be performed as a basic approach to locating areas in the data that might look suspicious. These suspicious areas, discovered by running frequencies and means on the data, could be flagged for deeper statistical exploration to determine if potential FWA exists.

A *frequency* is used to display the number of occurrences of an event. Examples include the number of times beneficiaries filled a Medicare covered prescription with a particular provider or pharmacist, the number of times a specific drug was prescribed, and the number of different product selection codes used.

Frequencies can provide general information on multiple aspects of the data that point to areas where problem areas may exist. For example, a plan may learn from a frequency analysis of the claims data that the drug most frequently prescribed also happens to be a highly addictive and expensive drug with lesser cost and risk alternatives. The plan should then explore this area further by counting the number of times individual providers prescribe this particular drug and identifying the individual providers with a high frequency of occurrence.

The *mean*, theoretically defined as the central location of the data, can be used to determine the average values of a quantitative field in the data, such as beneficiary payment amount. *Standard deviation* is a measure of how widely spread the values are in a data set. Locating the mean value (i.e., average) can give a payer a general idea of outliers, which are observations that are a set number of standard deviations from the mean. For example, the average beneficiary payment amount in the data is calculated to be $50 per claim. Three claims, though, are found to have payment amounts of $250, $435, and $1,375. These three claims should be flagged for further exploration, because their payment amounts are substantially higher than the average payment amount for this data set. *Outliers*, like frequencies, locate data points or areas that should be examined more closely to determine if any aberrant patterns or potential fraud exist.

Advanced statistical methods. To produce more detailed results of Medicare or Medicaid data, advanced statistical methods can be performed, such as regression models and clustering analyses.

Regression models are used to predict a given dependent variable.[2] For example, the dependent variable could be the amount of Medicare reimbursement made to a particular provider. The model is used to identify providers who received significantly more from Medicare than others. Fundamentally, regression analysis also identifies outliers, but it can incorporate factors (e.g., provider specialty, number of claims, type of drug) that might influence the amount of money made by a given provider.

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In practice, analysts should include all factors that might have some effect on the dependent variable in the model, and then remove factors that do not significantly predict the dependent variable. Variables are not significant in the model if their *P* value (i.e., the probability of obtaining the observed data) is > 0.05.

Regression models can be designed in numerous ways; however, the ultimate goal is to achieve a model that will significantly predict the dependent variable. R^2 is the proportion of variability in a data set that is accounted for by the statistical model. R^2 values range from 0-1, where the value of 1 accounts for all variability in a data set by a given model. The R^2 coefficient helps measure the overall predictability of the model. If the model yields a high R^2 value, the factors in the model are accounting for much of the change in the dependent variable.

Once a model is created that provides a good fit to the data, prediction equations are established for the included factors to see what produces a significant change in the dependent variable. For example, does issuing the drug oxycontin result in a significant increase in the amount of reimbursement to a provider compared to the drug codeine? Predictions can be made for all factors in the model, establishing hypotheses for the selected dataset. Overall, regression analysis is an advanced tool to assess problem areas at a deeper level than the descriptive statistical methods described previously.

Another advanced statistical method, cluster analysis, is used on claims data to ultimately locate areas of potential fraud or overpayment. Cluster analysis involves the classification of millions of data values into several 'like' data value groups.[3] The goal is to effectively organize the data into like or homogenous clusters (as decided by a number of factors included in the cluster analysis) to identify differences between or among clusters. For example, provider specialties could be organized into clusters where several like specialties are grouped into one cluster, such as general surgery, orthopedic surgery, and hand surgery. Inclusion of a specialty within a cluster would be mathematically determined by a number of factors with like values that are shared between each specialty in the cluster. This method permits the statistician to make statements about a larger group of elements that still share common characteristics. Cluster analysis is an effective method when dealing with several millions of claims records.

Conclusion

Health care organizations are facing increased scrutiny by CMS and other enforcement agencies to combat and prevent FWA in their claims. CMS already requires Medicare Part D sponsors to have a fraud and abuse plan as part of their compliance program and is moving toward implementation of fraud and abuse plans in other organizations as well. Incorporating some level of data analysis into the Medicare/Medicaid contractor organization is recommended to locate problem areas and make changes before an auditor or whistleblower finds a problem.

Statistical methods, including descriptive statistics, regression, and cluster analysis, can aid the organization in identifying problem areas. These methods do not specifically identify fraud, but they do indicate potential sources of fraud, thus enabling the organization to take the first step in assuring appropriate Medicare/Medicaid program payment. ■

1 42 C.F.R. § 423.504(b)(4)(vi)(H)
2 C. Warner: Automating Predictive Analysis to Predict Medicare Fraud. SRA International, 2005.
3 A.K. Jain, M.N. Murty, P.J. Flynn: "Data Clustering: A Review" ACM Computing Surveys, Vol. 31, No. 3 (September 1999).

feature article

Meet Paula J. Desio

Chair for Ethics Policy, Ethics Resource Center

Editor's note: HCCA Board Member Jennifer O'Brien conducted this interview with Paula J. Desio in January 2008. Ms. Desio may be reached by telephone at 571/480-4420 or by e-mail at paula@ethics.org.

JO: Tell us a little bit about Ethics Resource Center and your current role as Chair for Ethics Policy.

PD: Ethics Resource Center (ERC) is the oldest nonprofit organization in the United States devoted to organizational ethics—striving to advance organizational understanding of the practices that promote ethical conduct. ERC conducts research, measures ethics and compliance program effectiveness in individual organizations (particularly those in the workplace) and develops whitepapers and educational resources based on overall findings relating to ethics in the workplace.

I joined ERC as its first Chair for Ethics Policy in June, 2007. I am particularly interested in advancing ERC's efforts to share its extensive survey data, research, and analysis with policy makers at the state and federal levels, and also with non-governmental agencies that are in positions to shape and align policies that have an impact on business ethics in the workplace.

For example, last summer ERC responded to a request from the House Ethics Task Force to provide insights about a range of methods for reporting and screening internal complaints used by the public and private sector. In January, 2008, ERC submitted public comment to the FAR Councils as they consider some final changes and refinements to the recent rules requiring codes of business ethics and conduct for government contractors. ERC pointed out that while the government puts a great deal of emphasis on hotlines, such reporting mechanism are very rarely used by employees who prefer instead to talk to supervisors and ethics and compliance officers within their own organizations. As I learned from being on staff at the Sentencing Commission, public officials appreciate receiving empirical data that can better inform their policy choices and decisions, and I am working with ERC to bring more of this type of information to the attention of government and non-government offices that can use it in their deliberations.

ERC has important insights to contribute and I want to help make that happen. I will also be helping ERC augment its partnerships with other organizations, both national and international, that share our common objective of improving standards and awareness of ethical practices.

JO: Prior to your role with ERC, you were Deputy General Counsel for the United States Sentencing Commission for ten years, and before that you were Of Counsel to the white collar crime practice of the Washington, DC law firm of Crowell & Moring, LLP. Please share how your previous work compliments your current role at ERC.

PD: My ten years at Crowell & Moring

were spent on some of the leading cases involving the defense procurement and health care industries, along with other matters involving congressional oversight hearings and SEC enforcement investigations. I handled corporate internal investigations and disclosures to the government, and counseled companies and their employees on grand jury investigations. Some of the matters were complex and intricate, and involved cutting edge theories of criminal liability by the government.

That experience was a perfect spring board for moving to the U.S. Sentencing Commission, where I spent another ten years focused on policies relating to the Commission's consideration of penalties for economic crimes, particularly money laundering, fraud, and identity theft. I was also responsible for monitoring the effects

of the organizational Sentencing Guidelines that the Commission had promulgated in 1991. From 1997 to 2000, I spent a great deal of time studying our data and reaching out to the growing body of ethics and compliance professionals to understand how the Guidelines were working.

JO: What did you find most surprising about the organizational Guidelines at that time?

PD: What I learned was that the criteria for compliance programs had had such an unanticipated and unrivaled impact of probably any non-mandatory government policy. The reach of the Guidelines' influence was certainly beyond the Commission's expectations.

The program elements had essentially taken on their own life, were embraced by many of the leading companies, and fostered the growth of ethics and compliance organizations and related research. ERC's own business and workplace ethics surveys, conducted biennially since 1994, are based on these program elements.

I was even more amazed to learn of the influence of this aspect of the organizational Sentencing Guidelines beyond U.S. national borders. The Sentencing Commission was being looked to for policy guidance and innovation by regulators and enforcement officials in other countries, and in recent years Australia, South Africa, and Italy have all adopted some aspect of the guidelines into their legal system.

JO: What was the most rewarding professional opportunity at the Sentencing Commission?

PD: Besides the separate opportunity that I had to work on a new sentencing guideline for cultural-heritage resource crimes involving coordination with Native American tribes, museums, and archaeological and historical preservation associations, the most interesting and rewarding experience relating to the organizational Sentencing Guidelines had to do with the revision process from 2001 to 2004. At the tenth anniversary of the organizational Guidelines, the Commission appointed an expert advisory group of practitioners, academics, and government officials to study the effects of the compliance program criteria and recommend whether any amendments would be advisable. Just after the group was appointed, Enron broke, followed by a tidal wave of high-profile corporate scandals.

Congress's interest in the organizational Sentencing Guidelines as expressed in the Sarbanes-Oxley Act of 2002 dovetailed with the Advisory Group efforts that the Commission already had under way on its own initiative. Congress let that process continue, which consisted of a very thorough and comprehensive review. The Advisory Group solicited public comment and took testimony, wrote an in-depth report that still serves as a solid compendium of ethics and compliance information, and made recommendations to the Commission. The Commission in turn held its own hearings and then passed a number of changes to the Guidelines, including creating a separate stand-alone guideline for compliance and ethics programs that gives it the importance it deserves in federal policy.

Handling these matters and getting to know the experts on the advisory group and the practitioners in companies who have been working with ethics and compliance issues on the front lines of U.S. businesses was a terrific professional opportunity, as was the opportunity to be involved in changes with such profound public policy implications.

JO: What are you seeing as factors that are pushing organizations to commit resources to compliance and ethics initiatives?

PD: Both the Sarbanes Oxley Act of 2002, that has some requirements for ethics codes for publicly-traded companies, and the 2004 amendments to the organizational Sentencing Guidelines, have had a great deal to do with focusing attention on these matters and getting the attention of corporate management. The Sentencing Guidelines included specific language about devoting adequate resources and persons with sufficient stature and authority to make the ethics and compliance effort a viable one. The Department of Justice's 2006 McNulty Memorandum (providing guidance to prosecutors about charging decisions affecting companies) also has refocused attention in this area.

However, what probably has had an equally great impact as these government policies is the daily work of the professional ethics and compliance officers, individually and through their associations, to develop empirical data that demonstrates the value of ethics and compliance programs. Their interest and efforts have spurred the work of many researchers to produce ways of measuring ethics and compliance efforts. We all know that what gets measured in business gets attention, and I think the ethics and compliance professionals have done an admirable job of getting resources focused on this

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important effort.

I am thinking of some of the articles written by Linda Trevino of Penn State, who has studied the impact of ethical leadership. ERC's surveys that measure the impact of ethical culture and effective programs on preventing misconduct and reducing risk of wrong doing are another example. A survey conducted by the former Austin, Texas city auditor found a correlation between a department's ethics and its performance. These efforts are all extremely useful in demonstrating the viability of ethics and compliance as a business unit. They will also go a long way towards creating standards and benchmarks that enforcement officials will eventually have to consult when assessing the effectiveness of a program under government standards.

JO: How do you see compliance and ethics intersecting in the work place?

PD: I see them as vitally linked. That is one of the main conclusions that the Sentencing Commission came to when it revised the Guidelines to refer to both "ethics and compliance programs" and also added the objective of "promoting an organizational culture that encourages ethical conduct and a commitment to compliance with the law."

In my view, the Sentencing Commission got it very right when it identified culture as the foundation for ethical practices. Perhaps what is overlooked is the precision of the actual language in the Guidelines that stresses – not that culture will itself result in compliance with the law, because that can often be too technical and requires separate training and understanding – but, that culture will be the foundation of creating an attitude that values following the rule of law and seeking out advice on how to do the right thing. A strong culture helps to encourage doing the right thing and well implemented ethics programs teach employees how to recognize potential problems and red flags and where to seek information and advice. Getting information and advice will in turn promote compliance, because it will raise awareness and help prevent possible problems and misconduct from occurring in the first instance.

This very prescient policy approach, now embedded in the organizational Sentencing Guidelines, is empirically validated by ERC's 2007 national survey data. The National Business Ethics Survey® demonstrates that the strength of a company's enterprise-wide ethical culture has the greatest impact on misconduct, while the strength of a company's formal ethics and compliance program has the greatest impact on encouraging employee reporting. Together, culture and programs maximize ethical behavior and appropriate reporting in the workplace.

JO: What are some of the more common compliance and ethics issues ERC encounters when working with organizations?

PD: ERC's work with organizations in recent years has been primarily focused on benchmarking and resource allocation related to ethics risk and measuring well-implemented programs. What ERC is finding is that the most common wrongdoing is much more subtle than the financial fraud and document destruction that generally gets a great deal of media attention. Instead, we are learning that conflicts of interest, abusive behavior, and lying pose the most severe ethics risk to companies. The information we collect about what works in building an ethical culture and having a well-implemented ethics and compliance program helps us in turn inform the public and policy makers.

JO: What advice do you have for organizations struggling to create a strong culture around compliance and ethics?

PD: Get a really good handle on what the practical measures of an ethical culture are, in particular ethical leadership, supervisor reinforcement, peer commitment to ethics, and embedding ethical values. Push ethical leadership down to the mid-management and supervisory level to utilize these key employees in building your culture, given that most employees look to them for information and advice. ERC is finding that well implemented ethics programs help drive a strong culture, so your culture can only be as strong as these program elements that back it up. This preliminary research is going to be examined in greater depth in the coming months and should shed additional light on actual practices.

Also, recognize that your hotline statistics are telling only part of the story.

Inform employees about the outcome of reports of perceived misconduct and work to build up trust and confidence; elevate ethics and compliance professionals to real standing within the company and make sure that they have the clout to get things done.

JO: In your opinion, what is the most important component of a compliance and ethics program?

PD: It is assessment of the program. I agree with the decision of the Sentencing Commission to make it explicit in the 2004 amendments, because this decision was based on information from actual practitioners and their views of effectiveness.

If the compliance and ethics program is not assessed regularly, it is impossible to know if it is doing an effective job. Having this information is essential for several reasons. First, as a viable business unit that adds value to the company, an ethics and compliance office must be able to demonstrate that its work and message are having an effect throughout the workplace. Second, if an organization is ever scrutinized by a prosecutor or regulator, it will want to demonstrate how its program

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Letter from the CEO

Ideas for your Compliance and Ethics Program

Joe Murphy is writing a book that I think is quite interesting and effective. The title of his book will be 310, no, it's 345, no, wait, it's 368, no make that, "401 Ideas for your Compliance and Ethics Program". Actually we don't know how many ideas there will be when this is final because Joe is increasing the count on an hourly basis. I will be a co-author on the book, but I have to admit Joe is very hard to keep up with. Not only is he developing these short pearls of wisdom, but he is referencing the ideas to the document, article, book, etc. that generated the idea. That way, readers can follow up and get more information. Joe is already planning on following up with a second edition as soon as the first one comes out. Some of the compliance ideas will be accompanied by photos or illustrations.

The book is intended to be an easy read, inexpensive, and a refreshing way to get ideas for your compliance program. No analysis, no ponderous opinions, no rules you have to follow – just ideas and tips you can use or toss. It will surely be a much appreciated break from the arduous, lengthy, and sometimes dry compliance publications and regulations we all must sift through. It will be helpful to everyone in the Compliance department because it will cover all elements of compliance, such as education, auditing, monitoring, codes of conduct, discipline, etc.

Win a free registration to a Compliance Academy

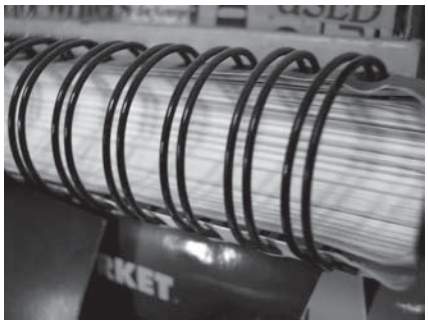
If you are interested in sending Joe an idea for the book, please forward it to him for his consideration (jemurphy@cslg.com). He is very interested in your ideas and if he uses them, he will include your name along with your compliance idea in the book (unless you want to remain anonymous). Be sure to add a reference if you have one, such as an article or page in a book where the idea was explained or applied. We will take all of the ideas Joe gets prior to publication and randomly select one. That person will receive a complementary registration to one of SCCE's or HCCA's Compliance Academies. (All other expenses must be covered by the recipient.) If you send 10 ideas you will have 10 chances to win.

If you would like to be notified when the publication is available, please send an e-mail asking to be notified about the release of the Compliance Ideas book to nancy.gordon@corporatecompliance.org. Here are a few examples from this upcoming book.

9. **Test comprehension**. Test the reading comprehension level of the code.

30. **Prevention consultants**. Have compliance and ethics professionals review new business proposals and operations to analyze where problems could occur and where control weaknesses might exist, and recommend controls tailored to the potential risks. See Roach & Davis, "Establishing a Culture of Ethics And Integrity in Government," 21 ethikos 1, 16 (Sept./Oct. 2007).

12. **Mail to homes**. Consider mailing the code to employees' homes. See Singer, "Bracing for Deregulation, AEP Boosts Ethics Training," 11 ethikos 1, 2 (July/Aug. 1997).



24. **HR manual**. If there is a separate HR or personnel policy, review this and ensure consistency with the code and the compliance and ethics program. ■

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Medicare program integrity efforts target high risk areas

By Michael Apolskis

Editor's note: Michael Apolskis is an attorney at MacKelvie & Associates, PC. He works with health care providers and suppliers on a variety of legal and regulatory issues, including Medicare compliance, reimbursement and enforcement matters. He may be reached by telephone at 312/332-0533 or by email at mapolskis@mackelvielaw.com.

In May 2007, the Department of Health and Human Services (HHS) announced that a Medicare fraud strike force had begun operations in March 2007, and had already made 38 arrests and indictments involving over $142 million in Medicare billings.

At the time of the announcement, HHS reported that the strike force efforts targeted infusion therapy providers and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in South Florida. The strike force used "real-time analysis of billing data" to identify and react to fraud schemes. HHS also suggested that steps were being taken by the Centers for Medicare and Medicaid Services (CMS) to increase accountability and decrease the presence of fraudulent providers and suppliers in the Medicare program.

Since May 2007, the strike force efforts have yielded a steady stream of arrests and indictments of individuals associated with certain DMEPOS suppliers and infusion therapy providers in South Florida. An examination of those efforts and recent CMS pronouncements reveals a Medicare program integrity initiative designed to identify and designate high risk areas and then rapidly deploy targeted integrity measures to combat potential fraud and abuse.

Designation of high risk areas

In July 2007, CMS revised the Medicare Program Integrity Manual (Manual) to charge Medicare Program Safeguard Contractors (PSCs), Medicare Administrative Contractors (MACs) and Affiliated Contractors (ACs) with the responsibility of identifying "high risk areas" for potential fraud and abuse.[1] According to the Manual, a "high risk area" may be identified by emerging or widespread anomalies that may lead to potential fraud and abuse in, for example, claim type, provider type, and geographic area.[2] In the Manual, CMS even supplies a non-exhaustive list of situations that may demonstrate areas of high risk, including:

- spike billing
- billing of inappropriate diagnoses
- increased beneficiary complaints
- high CERT (Comprehensive Error Rate Testing) rate
- beneficiary recruitment (capping), and
- billing for ordered services in which the ordering physician has no patient billing relationship.[3]

When a potential high-risk area is identified, PSCs, MACs and ACs are directed to request that CMS make a high-risk area designation.[4] If a particular area is designated as high risk, the Manual requires that PSCs, MACs and ACs develop an action plan to address the area, which must be approved by CMS prior to implementation.[5] The Manual also identifies a number of activities that may be proposed to address high risk areas, including:

- recommended edits
- selected or 100% auto-denials
- expanded beneficiary complaint acknowledgement, and
- increased frequency of Medicare Summary Notices (MSNs).[6]

Further, in the context of provider and supplier enrollment in the Medicare program, the Manual contains a list of actions that MACs and ACs may propose to remediate the problems that are identified in high risk areas. Those actions include:

- revalidation activities
- unannounced site visits
- verification and validation activities that include felony searches for individuals, owners, managing officials, and delegated officials; and
- risk assessments for newly enrolled providers and suppliers.[7]

The process of designating and addressing high risk areas for potential fraud and abuse is being tested in three new enrollment demonstrations that focus on DMEPOS suppliers, home health agencies (HHA) and infusion therapy providers in areas that CMS has designated as high risk. The demonstrations are similar in design and will include the waiver of certain Medicare enrollment rules in favor of some enhanced requirements. Further, Medicare contractors will be using the enhanced requirements to screen providers and suppliers, more closely monitor providers and suppliers that satisfy the enhanced requirements, and terminate unqualified providers and suppliers from the Medicare program.

DMEPOS demonstration project

In July 2007, HHS announced a two-year demonstration involving the reenrollment of DMEPOS suppliers in South Florida and the Los Angeles metropolitan area.[8] This demonstration follows program integrity initiatives in

which on-site visits and investigations of 3,472 DMEPOS suppliers resulted in 1,404 suppliers having their Medicare billing privileges revoked.

As part of this demonstration, DMEPOS suppliers in the demonstration locales are required to submit a Medicare enrollment application (CMS-855S) to the National Supplier Clearinghouse (NSC) within 30 days after the NSC requests such information. This demonstration also involves on-site visits, criminal background checks for owners and managing employees, and the revocation of Medicare billing privileges if a supplier:

- fails to submit CMS-855S within the 30 day time frame;
- fails to report a change of ownership or address at least 30 days prior to the effective date of the change;
- fails to obtain accreditation from an approved DMEPOS-accrediting organization within 90 days of notification from NSC to do so;
- has an owner or managing employee that had a felony conviction within the last 10 years; or
- no longer meets the requirements for enrollment as a DMEPOS supplier.

DMEPOS suppliers that do not have their billing privileges revoked during the reenrollment process will be subject to enhanced review. Under enhanced review, the NSC will apply a fraud level indicator to each DMEPOS supplier. DMEPOS suppliers with higher fraud-level indicators will receive more frequent on-site visits and greater overall scrutiny. In assessing fraud level indicators, the NSC is expected to consider such factors as:

- prior experience with Medicare and other payers
- specific supplier location
- fraud potential of products and services
- site visit results
- inventory observed and contracted, and
- accreditation of supplier.

Home health demonstration project

In July 2007, HHS announced a two-year demonstration involving the reenrollment of HHAs in Harris County, Texas and the Los Angeles metropolitan area.[9] Because of instances of fraud and abuse, the growth in the number of HHAs in Harris County, Texas, and the substantial increase in HHA billings in some Los Angeles area counties, these areas require immediate scrutiny.

Similar to the DMEPOS demonstration, this demonstration requires HHAs in the demonstration locales to submit a Medicare enrollment application (CMS-855A) to the applicable Medicare contractor within 60 days after the contractor requests such information. This demonstration also includes a state survey for HHAs that experienced a change in ownership within the last 2 years, criminal background checks for owners and managing employees, and on-site reviews to determine if HHAs are located at the addresses reported in their applications. Further, an HHA's Medicare billing privileges will be revoked if an HHA:

- fails to submit CMS-855A within the 60 day time frame;
- fails to report a change of ownership or address within 30 days;
- has an owner, partner, director, or managing employee who had a felony conviction within the last 10 years; or
- no longer meets the HHA conditions of participation or any other requirement for HHA enrollment.

Infusion demonstration project

In August 2007, HHS announced a new demonstration focusing on infusion therapy providers in South Florida, which may be expanded to other areas of the state if providers are found to be relocating to avoid detection.[10] This demonstration is similar to the DMEPOS and HHA demonstrations in that it involves reenrollment in the Medicare program.

In fact, as part of this demonstration, CMS will require that infusion therapy providers in demonstration locales submit a Medicare enrollment application within 30 days of CMS's notification. This demonstration also provides for the revocation of an infusion therapy provider's Medicare billing privileges if the provider:

- fails to submit a Medicare enrollment application within the 30 day time frame;
- fails to report a change of ownership or address as required;
- fails to report owners, partners, directors, or managing employees who had a felony conviction within the last 10 years; or
- no longer meets the requirements for enrollment as an infusion therapy provider.

Infusion therapy providers that successfully complete the reenrollment process will be subject to enhanced review, including site visits driven by established risk factors. CMS is also establishing a new toll-free Medicare infusion fraud hotline and issuing MSNs to beneficiaries in South Florida on a monthly (rather than quarterly) basis to generate more scrutiny of infusion therapy provider billings.

In 2004, CMS and Medicare contractors launched an initiative to address infusion fraud in South Florida after detecting a spike in billing. That initiative included site visits, prepayment edits, automatic denials of clinically unbelievable dosages, payment suspensions, and other activities. However, CMS believes that unscrupulous infusion therapy providers have continued their fraudulent billing practices, and hopes that this demonstration will provide additional tools for the removal of fraudulent providers from the Medicare program.

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Conclusion

Following the completion of the three enrollment demonstrations, CMS intends to evaluate each demonstration for its effectiveness and determine whether the demonstrations should be implemented in other parts of the country as a means of deterring fraudulent conduct.

Although some providers and suppliers have lauded the new enrollment demonstrations, others have expressed concern regarding the uncertainty surrounding the reenrollment process and the possible inadvertent impact that the demonstrations or similar initiatives may have on legitimate providers and suppliers that operate in high risk areas.

For instance, there has been concern regarding whether Medicare contractors and state survey agencies have the resources to take on the enrollment application review and survey responsibilities, without subjecting providers and suppliers to prolonged reenrollment periods. Other providers and suppliers have expressed concern regarding the methodology that CMS or Medicare contractors may use to assign fraud level indicators or risk factors to providers and suppliers, and the business disruptions that may result from inappropriate assignments.

Nevertheless, given the apparent success of the Medicare strike force efforts in South Florida, CMS may initiate similar demonstrations or other initiatives in high risk areas. Further, CMS recently established seven zones based on the newly established MAC jurisdictions and is creating new entities called Zone Program Integrity Contractors (ZPICs). ZPICs will perform program integrity functions for Medicare Parts A-D, DMEPOS, home health, hospice, and the Medi-Medi program in the zones. ZPICs are also expected to be actively involved in the fraud and abuse initiatives planned for high-risk areas, including the three new demonstrations.

Therefore, providers and suppliers should remain cognizant of the situations that may constitute areas of high risk (for their organization and industry), and consider whether any such areas are worthy of an organizational assessment. As always, providers and suppliers should also continue to maintain effective compliance programs and ensure that their compliance efforts are designed to establish a culture that promotes prevention, detection, and early resolution of conduct that does not conform to Medicare program requirements. ■

1 CMS Transmittal No. 210, June 15, 2007; CMS Transmittal No. 217, July 13, 2007.
2 Medicare Program Integrity Manual, CMS Pub. 100-08, Chapter 4, §4.32 and Chapter 10, §20.
3 Id. at Chapter 4, §4.32.
4 Id. at Chapter 4, §4.32; Id. at Chapter 10, §20.
5 Id. at Chapter 4, §4.32.1; Id. at Chapter 10, §20.1.
6 Id. at Chapter 4, §4.32.1.
7 Id. at Chapter 10, §20.1.
8 HHS Press Release, HHS Fights Durable Medical Equipment Fraud: Demonstration Project Targets Fraudulent Business Practices in South Florida and Southern California, July 2, 2007; HHS Fact Sheet, Medicare Provider Enrollment Demonstration Involving Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) in High-Risk Areas, July 2, 2007.
9 HHS Press Release, HHS Fights Home Health Agency Fraud: Demonstration Project Targets Fraudulent Business Practices in the Greater Los Angeles and Houston Areas, July 17, 2007; HHS Fact Sheet, Medicare Provider Enrollment Home Health Agency Demonstration in High-Risk Areas, July 17, 2007.
10 HHS Press Release, Department of Health and Human Services and Department of Justice Fight Infusion Therapy Fraud: Strike Force Prosecutions and Demonstration Project Target Fraudulent Business Practices in South Florida, August 20, 2007; HHS Fact Sheet, Medicare Integrity Program Demonstration for Providers of Infusion Therapy in High-Risk Areas, August 20, 2007.

Does your compliance training and education program need a checkup?

By Mike Falzano

Mike Falzano is Executive Assistant Dean at Albany Medical College. He is the Director of Research Compliance and Oversight, the Privacy Officer for the College and Research Program, Institutional Official and Regulatory Advisor to the Institutional Review Board. Mr. Falzano also oversees the Office of Research Affairs. He may be reached by telephone at 518/262-6008 or by e-mail at falzanm@amc.mail.edu.

One of the significant challenges we face as compliance professionals is developing, communicating, and sustaining effective compliance training and education programs. (For the sake of readability, I will use the word "training" to encompass both "training and education" from this point on. In some academic circles, there is a distinction between the meanings of the two words. Some argue that "training" is more about task-based skill development and that "education" is more about the process of understanding concepts, theories, and acquiring knowledge. Compliance needs to include both aspects.)

Some of the typical day-to-day concerns relate to keeping pace with frequent changes to laws, regulations, and related guidelines, which compete for time with other organizational priorities, including other training programs, and managing limited compliance training resources for maximum coverage and effectiveness.

What exactly are the government's expectations regarding compliance training and how do these expectations mesh with our organization's expectations, needs, and capabilities? What types of training and how much training is enough? As compliance professionals, regardless of our specific organizational niche in the healthcare world (i.e., hospital, health plan, academic health center, biomedical research center, etc.), we all face many of the same challenges when it comes to training. At the same time compliance training poses challenges, it also provides a critically important opportunity for compliance professionals to make a difference. As Mark Twain once said, "There is nothing training cannot do. Nothing is above its reach. It can turn bad morals to good; it can destroy bad principles and recreate good ones."

As you know, compliance training is one of the seven elements of an effective compliance program as defined by the United States Sentencing Commission (USSC) in the Federal Sentencing Guidelines. The seven elements have become the foundation of many health care compliance programs, and other types of compliance programs as well. I am not going to discuss each element here, because the seven elements have been an important topic addressed in past issues of *Compliance Today*. Suffice it to say, the seven elements are inextricably related. For example, how can your organization conduct training without having policies/procedures/standards, or without open lines of communication, or without a leadership commitment to do so? It can not.

If you take a look at Chapter Eight of the Federal Sentencing Guidelines manual [Part B, 2.1(b)(4)], you will find it does not prescribe exactly what an organization needs to do for compliance training. This is a good thing, because "one-size does not fit all" when it comes to compliance training needs. However, the manual does provide the following generic clues as to the government's expectations for compliance training programs:

- **Effective communication** - Take reasonable steps to periodically communicate in a practical manner the standards and procedures and other aspects of the compliance and ethics program.
- **Role based training** - Conduct effective training programs and otherwise disseminate information appropriate to individuals' roles and responsibilities.
- **Applicability** - Individuals are defined as the members of the governing authority, high-level personnel, substantial authority personnel, the organization's employees, and, as appropriate, the organization's agents

The Office of Inspector General (OIG) publishes Compliance Program Guidance for various healthcare organizations (e.g., hospitals, home health agencies). The OIG Guidance references the USSC Guidelines manual, and in some cases, the OIG provides supplemental guidance. One can tease out some general compliance training clues from the Supplemental Compliance Program Guidance for Hospitals just as we have done from the Guidelines manual:

- **Purpose of compliance training** - Ensure each individual (see above definition under "Applicability") is fully capable of executing his or her role in compliance with rules, regulations, and other standards.
- **Compliance trainers** - Trainers should be qualified to conduct annual training, both general and specific, based on staff responsibilities.

- **Annual review of content** - Content should be appropriate and sufficient to cover the range of issues and updated to reflect regulatory changes.
- **Audit findings** - Content should consider results from its audits and investigations, trends in hotline reports, and federal agency guidance of advisories.
- **Evaluation of training** - Format, methodology, and frequency should be evaluated for appropriateness.
- **Training feedback** - Feedback should be solicited to identify shortcomings in the training program. Post-training testing is needed to ensure attendees understand and retain the subject matter delivered.
- **Documentation** - Required training should be tracked to identify which individuals completed the training.
- **Sanction/incentives** - An assessment should be performed to determine whether to impose sanctions for failing to take required training or to offer appropriate incentives for completing training.
- **Governance** - The Board and other governing body should have undergone training on fraud and abuse laws.

I developed a training questionnaire or checklist from the information contained in the governmental references, as well as some of my compliance training practices and experiences over the years in various compliance roles. The checklist is in the form of simple questions to ask about our training programs and is included at the end of this article. The checklist is not intended to be exhaustive, but hopefully it will stimulate a re-assessment of your training program in terms of four key areas: content, frequency, trainers and methodology, and effectiveness. It may even help you make some adjustments where necessary.

Executive buy-in is critical to the success of compliance training programs. I assume and hope you have the support of the executive leadership in your organization. Without visible and active support (including funding), your compliance training program will likely fall short, no matter how hard you try. You can make the case that being proactive with a solid training program will save your organization money, protect the organization's reputation, and help it comply with the laws. Just ask any organization that has had to deal with a Corporate Integrity Agreement. I like to use the simple quip that "You don't build the firehouse, and hire and train the fire fighters after the fire has started."

Even in a supportive organization, I suspect it is somewhat unlikely that you will have all of the training resources you would like to have. Reality creeps in with concerns about how to sustain the existing level of training or conducting additional training with existing resources. I am not a magician, but I do feel that training efficiencies are possible. Here are a few ideas that may be helpful:

Leverage technology
Develop self-learning-programs (PowerPoint slide show or handbook format with built in post-test) and ask your IT/IS staff to make the program available for access and tracking on-line.

Use available Web-based training programs
Professional association, public, government, and commercial compliance sites offer solid training programs for free or at reasonable costs, so I suggest you evaluate them carefully and speak with some of their customers. If it turns out to be cost effective and a good fit for your program, consider using them, rather than creating your own, especially if you are in a large organization. Many public universities that have academic health centers include compliance and program-related policies, procedures, guidelines, and training material on their public Web sites.

Maximize size of training event
Some types of fairly basic compliance training can be delivered to large audiences effectively, so try to maximize attendance through small incentives (e.g., bagel breakfast, pizza lunch/dinner) and use of larger training rooms/lecture halls. In general, I do not recommend large audiences for more substantive and complicated compliance training content.

Communication platforms
Understand and use the full gamut of your organization's communication platforms (e.g., newsletters, Intranet, group e-mails, internal audio/video training media) to conduct various levels of training over the course of your training year.

Be a compliance champion and "inform" your manager that he/she is co-champion
Take advantage at every staff, operational, or other organizational meeting in which you, your staff, or your manager are on the agenda, to incorporate compliance training. Better yet, ask that you be put on the agenda for a specific time allotment and make it a mini training event. Keep it simple, and try to make it interesting and relevant to the particular audience. Of course, you will want to document attendees and the training that took place.

None of us is as smart as all of us.[1]
Identify which of your own training practices are most effective, conduct some research on best training practices on the Web, and then organize a small group of compliance professionals in other like organizations, and discuss and compare notes. You've just formed a compliance training "best practices" work group that will be of mutual benefit. Also, use professional organizations and professional

Continued on page 27

FYI FOR YOUR INFORMATION

Feds Recoup $2.2 Billion

On February 14, 2008 The Hill (Washington, DC) reported that "Federal investigators recouped $2.2 billion during fiscal 2006 by prosecuting companies and individuals who allegedly defrauded this week.

"A report, issued by the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and the Department of Justice, details efforts by investigators and prosecutors from both departments to root out scams and reclaim money improperly paid out under programs such as Medicare and Medicaid." For more: h*ttp://thehill.com/the-executive/federal-investigators-recoup-2.2b-in-healthcare-fraud-prosecutions-2008-02-14.html* ■

conferences and their resources to promote more "best training practices" workshops, forums, and presentations.

Conclusion

It is important to remember that "one size does not fit all" and that your compliance training program approach should fit your organizational needs. The checklist is just a tool to help you in assessing your training program. Regardless of what unique characteristics your training program may have, it should be carefully planned. Based on your organization's risk profile, training efforts should be prioritized, objectively evaluated, and refreshed as necessary.

My sense is that very few compliance professionals are completely satisfied with their training programs for a variety of reasons. No program is perfect, and there is always room for improvement.

In closing, it is worth emphasizing at every opportunity that compliance is a core business competency for your organization and for every member of your work force. Furthermore, an effective compliance training program not only helps each work force member perform their job better and gain competencies, it helps the organization achieve its overall business objectives while minimizing both business and compliance risk. ■

1 This quote is attributed to management guru, Ken Blanchard

Sample Compliance Training and Education Check List

Training Content

- Because content has to match the audience …first, do we know who our training audiences are from top to bottom and bottom to top?
- Have we determined what content areas are applicable to the groups or individuals, based on their roles and responsibilities (role-based training)?
- Have we asked our internal customers (e.g., our employees and other audiences) what they think their compliance training needs are?
- Do we know from past training programs what content was most needed, most helpful, and most pertinent?
- Have we prioritized our compliance training content based on internal business and compliance risk assessments and audits, OIG Work Plan red flags, known problem areas and complaints, other emerging audit areas?
- Have we identified the most appropriate content areas (i.e., institutional policies, procedures, standards, federal and state laws, regulations and requirements, accreditation requirements, trainee needs) that we need to address in our training programs?
- Have we stated specific learning objectives for each type of trainee audience?
- Have we included in our syllabus, training on our organization's overall compliance plan and our code of ethics or code of conduct?
- Have we developed accurate, current, and user-friendly training content and informational and educational materials for each content area?
- Are the written materials and other training content kept up to date and reviewed annually?
- Is there a specific training program for governance that covers, at least, the fraud and abuse laws?
- Is content sensitive, flexible, and scaleable to audience reading level, language, cultural, or other audience needs?
- Do we have a solid communication plan to get the word out about our compliance training program - who, what, when, where?

Training Frequency

- Are we taking reasonable steps to train on a periodic basis?
- Are we communicating training schedules in a practical manner?
- Have we communicated to our trainee audience the training requirements (e.g., minimum number of hours per year per content area)?
- Have we communicated to our trainee audience the disciplinary action for failure to comply?
- Have we identified areas for continual basic retraining and reinforcement of current personnel at all levels?
- Is some level of compliance training part of the annual employee evaluation process?
- Are new employees appropriately targeted for training early in their employment (e.g., part of initial orientation or on-the-job training)?
- What (if any) training is voluntary versus mandatory?
- Is all compliance training (by whatever method) adequately documented and tracked?
- Is the tracking system manual or electronic?
- Is it quick and easy to develop progress tracking reports and test scores where applicable?

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Compliance Today CEU Quiz Deadline

Compliance Today readers taking the CEU quiz have ONE YEAR from the published date of the CEU article to submit their completed quiz.

2008 HCCA Conferences

MARCH

Compliance Academy
March 10–13 | Dallas, TX

APRIL

HCCA's 12th Annual
Compliance Institute
April 13–16 | New Orleans, LA

MAY

Upper North Central
Regional Conference
May 2 | Grand Rapids, MI

Upper Northeast
Regional Conference
May 16 | New York, NY

JUNE

Compliance Academy
June 2–5 | Scottsdale, AZ

Pacific Northwest
Regional Conference
June 6 | Seattle, WA

Research Compliance Academy
June 9–12 | San Francisco, CA

Advanced Academy
June 16–19 | San Francisco, CA

West Coast Regional Conference
June 27 | Los Angeles, CA

JULY

Alaska Regional Conference
July 10–11 | Anchorage, AK

AUGUST

Compliance Academy
August 11–14 | Chicago, IL

SEPTEMBER

New England
Regional Conference
September 5 | Boston, MA

Upper Midwest
Regional Conference
September 12 | Minneapolis, MN

Midwest Regional Conference
September 26 | Kansas City, MO

Quality of Care
Compliance Conference
September 28–30 | Philadelphia, PA

Research Compliance Academy
Fall Date TBA | Location TBA

OCTOBER

Physician Practice
Compliance Conference
October 1–3 | Philadelphia, PA

North Central
Regional Conference
October 3 | Chicago, IL

AHLA/HCCA
Fraud & Compliance Forum
October 5–7 | Baltimore, MD

East Central
Regional Conference
October 10 | Pittsburgh, PA

Hawaii Regional Conference
October 16–17 | Honolulu, HI

Research Compliance Conference
October 20–22 | Chicago, IL

Advanced Academy
October 20–23 | Dallas, TX

Mountain Regional Conference
October 24 | Denver, CO

Audit & Compliance
Committee Conference
October 27–29 | Fort Lauderdale, FL

NOVEMBER

Compliance Academy
November 3–6 | Orlando, FL

South Central
Regional Conference
November 7 | Nashville, TN

Mid Central
Regional Conference
November 14 | Louisville, KY

DECEMBER

Compliance Academy
December 1–4 | San Diego, CA

Medicare Part D
Compliance Conference
December 7–9 | Baltimore, MD

HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

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HCCA offers first-class education, resources, and networking opportunities for everyone in the health care compliance field. Whatever your focus, HCCA has a conference for you.

For more information, visit www.hcca–info.org

- Does management receive progress reports on training for their respective areas of responsibility?
- Does management review and act on progress reports on training for their respective areas of responsibility?

Trainers and Methodology

- Who are the compliance trainers? Do they consist of staff, external consultants, or both?
- Do we utilize full-time trainers or use other compliance staff to train as part of their overall responsibilities?
- Are trainers experienced, knowledgeable, capable, interesting, and effective communicators?
- Is there a methodology to evaluate the effectiveness of your trainers?
- Do we use a "train-the-trainer" approach?
- Do we employ a variety of passive and active training methods?
  - Home-grown self-learning programs?
  - Didactic lecture-style training?
  - Interactive training with audience participation such as mock case scenarios, simulation exercises, role playing?
  - Commercial training software programs?
  - Compliance newsletter and other internal communication?
  - E-mail compliance reminders tips?
  - Intranet Web based training?
  - Conference calls?
  - Training manuals (paper or electronic)?
  - E-access to frequently asked questions (FAQs) repository
  - Training videos
  - Attendance and participation at professional conferences, meetings, etc.
- Do we think "outside the box" and to try to make the training not only informative but interesting …maybe even fun?
- Do we maximize use of training programs available from professional organizations (e.g., AHA, AAMC, HCCA, HCCS, NCURA, JCAHO) and government sources (e.g., HHS, CMS, NIH, state health departments) for our trainers and compliance professionals?
- Do we use a layered approach so training programs are not just one-time events, but an ongoing program over the course of a year?
- Do we leverage technology, where possible?
- In addition to formal training "events," do we maximize the opportunities to train when and where we can (e.g., operational meetings, staff meetings, management meetings)?
- Are training areas comfortable, convenient, and otherwise conducive to learning?
- Do we offer little incentives to attendance (e.g., bagel breakfast, pizza lunch, refreshments, etc.)?
- Are training sessions offered at the convenience of the trainees' work schedule and at multiple times to accommodate different shifts?
- Do trainees receive a certificate or CME credit or some other record of achievement?

Training Program Effectiveness

- What was the attendance/participation rate? Did everyone who was supposed to take the training do so? (basic effectiveness - no test)
- Do we have evaluative tools or a scorecard to measure the effectiveness of our training in terms of comprehension via post-testing test scores? (medium effectiveness)
- Do we have evaluative or monitoring tools or a scorecard to measure the effectiveness of our training on actual behavior change? (maximum effectiveness)
- Do we survey the trainees to rate or assess the program for its usefulness, relevance, ease of learning, clarity etc.?
- Do we survey the trainees to rate or assess the trainer?
- Do we review trainee surveys and adjust our training programs accordingly?
- Do we evaluate our overall training program content, format, methodology, and frequency as to appropriateness? ■

feature focus

Celebrating Corporate Compliance and Ethics Week

Plans and results at MJHS

By Anne Walsh

Editor's note: Anne Walsh is the Healthcare Compliance Liaison for the Metropolitan Jewish Health System. She may be reached by telephone at 718/921-7842.

When I joined the Compliance department at Metropolitan Jewish Health System in January 2007, one of my first assignments was to help plan and organize exciting activities to celebrate National Compliance and Ethics Week, coming up in May. Anne Dawson, Compliance Officer is committed to educating staff about our compliance program and was enthusiastic about using Compliance Week as an opportunity to promote compliance awareness. The goals were simple: to make sure that every employee across our system knows that we have a Compliance department and program, knows who we are, and knows how to contact us.

Two articles published in *Compliance Today* gave us valuable information and ideas: Celebrate Compliance Day and Week-Republished (June 2005), and Celebrate National Compliance & Ethics Week (April 2006). We started our campaign by ordering Compliance and Ethics Week posters and various promotional items, and designed a brochure for the compliance program, which we planned to distribute during Compliance Week and also include in all our future orientation packets.

To generate some excitement about the upcoming events, we distributed flyers for each of our programs during the week of May 13. The flyer listed the schedule of Meet and Greet sessions that were planned and announced that there would be contests and raffle prizes. We created a storyboard to take with us for our display table.

The storyboard was carefully designed to help us meet our goals. We posted color photographs of each member of the Compliance and Legal departments with their names, titles, and phone numbers. The anonymous hotline number took center stage in large numbers and a bright red phone. The seven required elements of a compliance program, with a brief explanation of each, were listed. We gave examples of situations that employees should report and reasons why corporate compliance is important to everyone.

Each day during Compliance Week, Anne and I packed up our storyboard, handouts, and promotional items and took our show on the road, visiting nine different sites that are part of Metropolitan Jewish Health System. We set up our display table in high traffic areas and engaged the staff in impromptu compliance education. At the same time, everyone who stopped by our table had the opportunity to enter the raffle. By the end of the week, close to 700 staff members had filled out raffle tickets. The lucky winner received a Motorola Q Phone.

Staff genuinely appreciated the various promotional items we were giving away. We had candy bars with compliance messages like "Do the right thing" and "Act with integrity" on the wrappers. Smiley-faced computer duster pens were engraved with "Compliance & Ethics: A Clean Sweep!" Also on hand were pocket-sized notebooks, pencil sharpeners, etc. We made sure staff picked up a compliance program brochure and a copy of the code of conduct as well.

As we greeted the staff, we encouraged them to enter the essay contest for a chance to win a $50 gift card. The topic was "What Corporate Integrity Means To Me." Other prizes were awarded to staff that successfully solved the Compliance Word Jumble and Crossword Puzzle, which we disseminated via the Intranet.

While we were traveling around, the privacy officers of our various programs were busy conducting telephone staff awareness surveys. They asked a few simple questions like "Who is the compliance officer?" and ""Do you know what the code of conduct is?" The informa-

tion collected from these surveys serves as useful baseline information for the program.

Employees at the manager level and above were sent a Compliance Program Evaluation Tool to complete via Interoffice mail. The data collected from these tools will be invaluable to us in assessing the effectiveness of the compliance program and in the identification of areas for improvement for our 2008 Work Plan. To thank them for completing the evaluation, we gave them a laminated card with tips on "How to Set Good Ethical Standards." The back of the card lists important phone numbers and resources for obtaining compliance-related information. Each of the members of our four Compliance Committees received a recognition letter from the compliance officer and a Corporate Compliance and Ethics Week pen to thank them for their participation.

Anne included details about the week's activities, copies of the handouts, give-aways, etc. in her report to the board of directors and brought the storyboard to the meeting. Finally, the Compliance department was featured in two of our internal newsletters, with highlights of Compliance Week. The winning essay and poem have been incorporated into the compliance presentation we use for orientation and annual staff training.

The combination of written, Intranet, and face-to-face communication, which took place every day for the entire week, created much needed exposure for the program. Staff awareness was raised, informal training and education was accomplished, the hotline number and code of conduct were widely disseminated, and valuable data was collected. Our first Compliance Week Celebration was a tremendous success, and we look forward to planning this year's activities.

Kaiser Permanente Northern California celebrates National Compliance and Ethics Week

Editor's note: Benisa Berry of Ethics, Integrity and Compliance Management Systems with Kaiser Permanente Northern California (NCAL) submitted the following article which outlines their 2007 National Compliance and Ethics Week activities. The write-up appeared in Kaiser Permanente's internal newsletter and was written by Elizabeth Schainbaum. For more information, contact NCAL Regional Compliance and Privacy Office at 510/625-2400.

The wheel of compliance

By Elizabeth Schainbaum

Compliance is necessary and important, but is it fun?

Judging by the noise makers, the smiles, and applause at Thursday's compliance fair in Oakland, it certainly can be.

There were candy, popcorn, a raffle, and a Wheel of Fortune game with a host bellowing out questions through a bullhorn. Kristin Chambers, the regional compliance officer and vice president, Compliance and Privacy, was also on hand to query contestants about their "compliance IQ."

The fair is part of an effort to raise employee and physician awareness around compliance, and following the laws, policies, regulations, accreditation standards, and ethics governing the workplace.

Compliance touches many areas: hiring, patient confidentiality, conflicts of interest, vendor relations and contracts, to name a few. Educating employees and physicians about compliance makes them more aware of their obligations and ethical standards, and demonstrates KP's commitment to regulators such as the Centers for Medicare and Medicaid Services, said Benisa Berry, ethics, integrity and compliance management systems leader.

On Thursday, the Compliance Department held a seven-booth fair at the 1800 Harrison St. building that the department hopes all facilities will replicate.

The fair coincided with National Compliance and Ethics Week, May 20 to 26, and the annual compliance training, which is beginning now. The region aimed to complete the training by Oct. 31.

Maria Mena, durable medical equipment coordinator, had to answer true or false: We all win if KP is in compliance. After saying "true," she walked away with a photo holder.

"It's important to get the message out there," Berry said.

Continued on page 32

The Compliance department will determine whether the awareness campaign and trainings work. In October, the department plans to survey employees and compare this year's results against ones from last year.

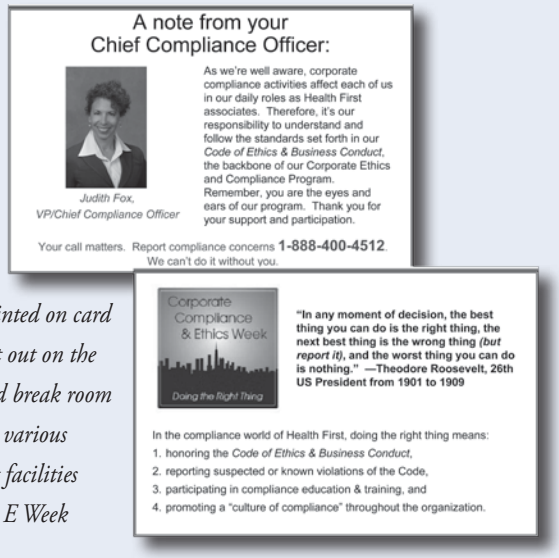
The highlight of the fair was the Wheel of Fortune. One by one, employees were tested on their compliance knowledge. If they answered correctly, they could spin the wheel for a mouse pad, key chain, picture holder, tote, T-shirt, or lanyard; or they could spin again.

She said the fair was a good idea because she has had questions about compliance. Before when she wanted answers, she had turned to a coworker. "It gives us awareness that there is help when you need it," she said. "There are a lot of people who don't know."

Jamila Gil, whose spin won her a new mouse pad after she correctly answered that you can get fired and sued for violating compliance, said the game was a fun way to educate employees.

"Everyone can hear the question and the answer," said the consulting manager with Management, Information and Analysis. "And the prize you get will always remind you of compliance."

Health First celebrates the third annual Corporate Compliance & Ethics Week



Tentcard printed on card stock and set out on the cafeteria and break room tables at the various Health First facilities during C & E Week

Compliance Sudoku and Scramlets distributed to associates at the various Health First facilities to do as a "just for fun" activity

Corporate Compliance & Ethics Week

Doing the Right Thing

We celebrated the 3rd annual Corporate Compliance & Ethics Week, June 4 - 14.

- The theme for this year's celebration was *"Doing the Right Thing."*
- We focused attention on the distribution of the new edition of the *Code of Ethics & Business Conduct* booklet and raising awareness about the new 24/7 Compliance & HIPAA Hotline.

Goals:

1. To increase familiarity with Compliance resources.
2. To widen exposure to the Compliance Program.
3. To provide exposure of Area Compliance Officers (ACOs) to associates.
4. To spur questions pertaining to compliance concerns.

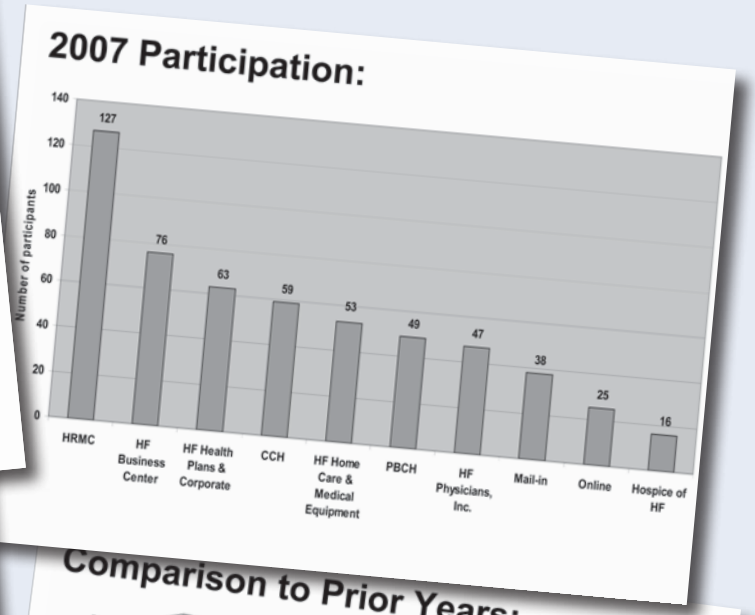
Plans:

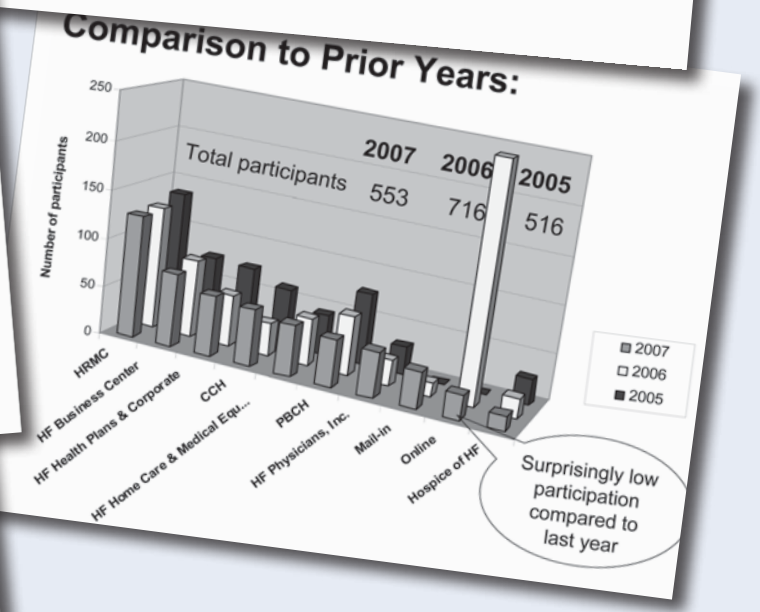
- Visited entities - Health Plans, PBCH, HFPI, Business Center, Hospice, HRMC, CCH, Home Care, Medical Equipment
- Mingled with associates – CCO, ACO & Sr. Compliance Analyst
- Set up display table - display board, poster, Inservice-to-Go, quiz, Sudoku & Scramlets, snacks, prizes
- Provided all information online via Inside Health First, including an online quiz

Schedule of events:

Doing the Right Thing

- **Monday, June 4th:**
  11 am - 1 pm
  PBCH Cafeteria
- **Tuesday, June 5th:**
  9 - 10 am
  Health First Health Plans
  11:30 am – 1 pm
  Health First Business Center
- **Wednesday, June 6th:**
  8:30 – 9 am
  Health First Medical Equipment
  11 am – 1 pm
  CCH Cafeteria
- **Thursday, June 7th:**
  8:30 - 9 am
  Hospice of Health First
  2 - 3 pm
  Health First Physicians, Inc.
- **Friday, June 8th:**
  11 am - 1 pm
  HRMC Cafeteria
- **Tuesday, June 12th:**
  Noon - 1 pm
  Health First Home Care – Melbourne
- **Tuesday, June 14th:**
  Noon – 1 pm
  Health First Home Care – Merritt Island





PowerPoint presentation to the Corporate Compliance Committee providing a summary of the Week's activities and participation

3RD ANNUAL CORPORATE COMPLIANCE & ETHICS WEEK
PRIZE DISTRIBUTION 2007

Online:
- 3 honeybaked ham $10 gift certificates

Mail-in:
- 2 honeybaked ham $10 gift certificate

PBCH:
- 1 month membership at Pro-Health & Fitness
- 1 beach chair

HFHP:
- 1 beach towel
- 1 beach chair

HF Business Center:
- 1 beach towel
- 1 bullet mug

HF Medical Equipment:
- 1 beach towel

CCH:
- 1 beach towel
- 1 bullet mug

Hospice:
- 1 honeybaked ham $10 gift certificate

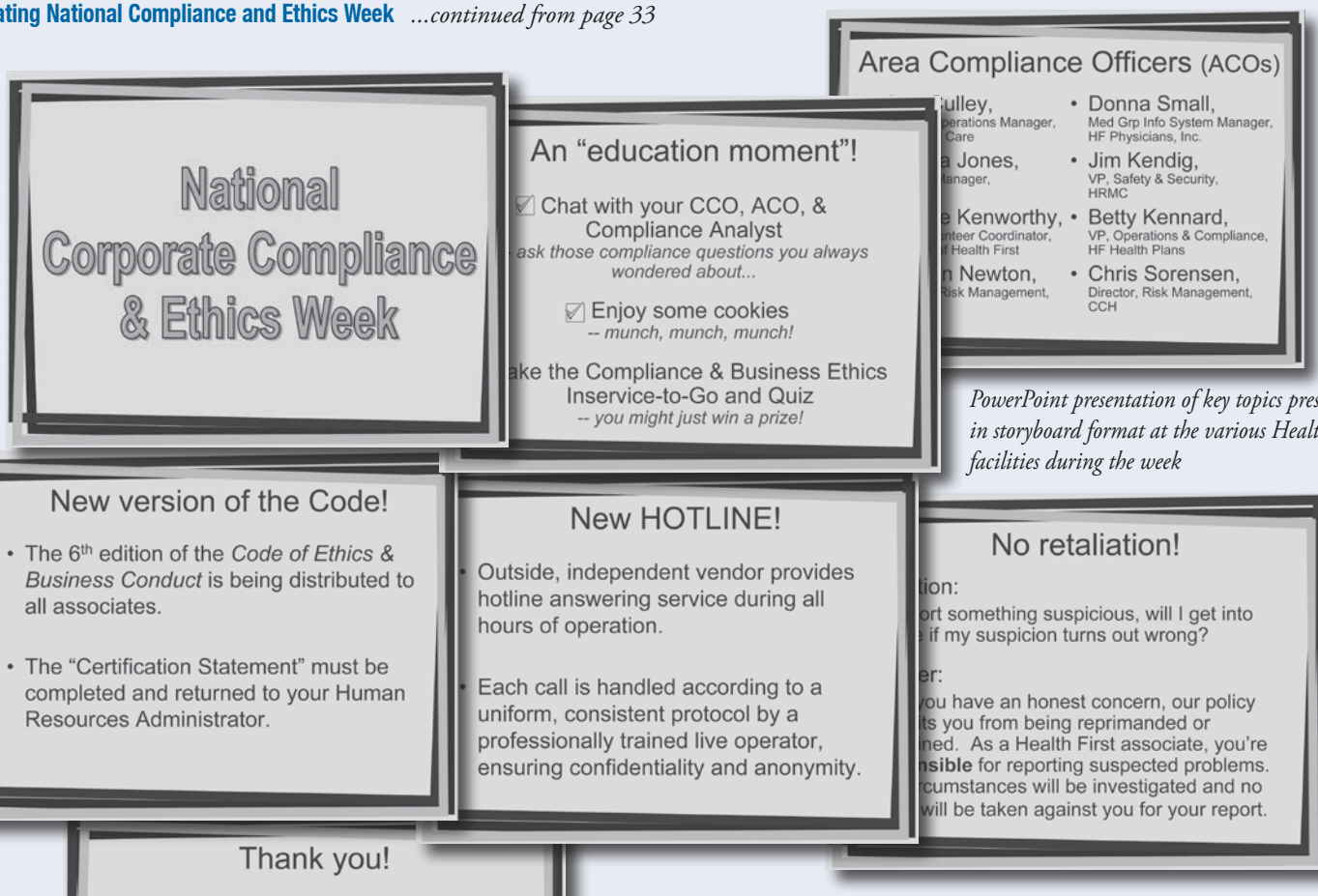
HFPI:
- 1 beach chair

HRMC:
- 1 honeybaked ham $10 gift certificate
- 1 basic manicure
- 1 beach chair
- 1 bullet mug

HFHC – Melbourne:
- 1 honeybaked ham $10 gift certificate

HFHC – Merritt Island:
- 1 bullet mug

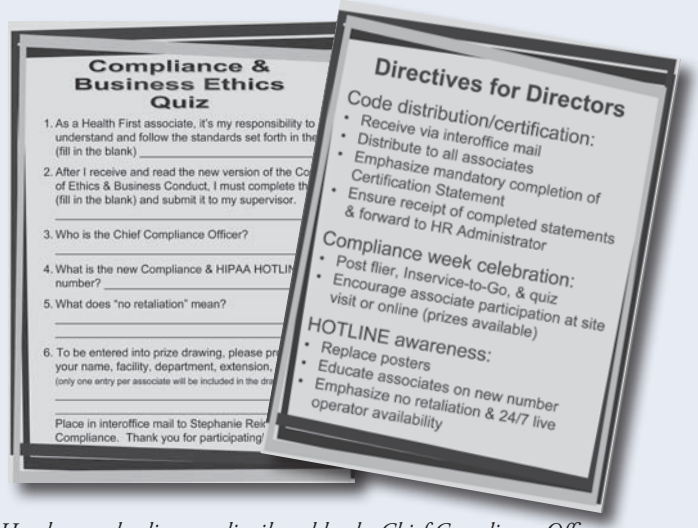
Prize distribution list



PowerPoint presentation of key topics presented in storyboard format at the various Health First facilities during the week

Quiz distributed to associates at the various Health First facilities to cover knowledge of key topics; served as entry in prize drawings at each facility; also available online; additionally, an online, electronically-formatted quiz was available via a link from the announcements section on the home page of Inside Health First

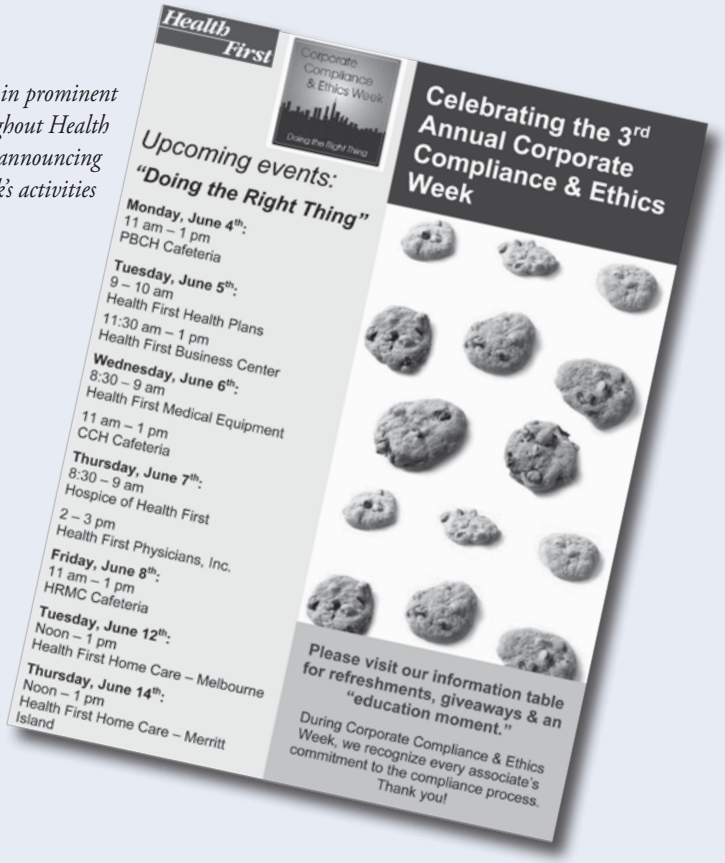
Inservice-to-Go displayed on the story-board and distributed at the various Health First facilities to cover key topics



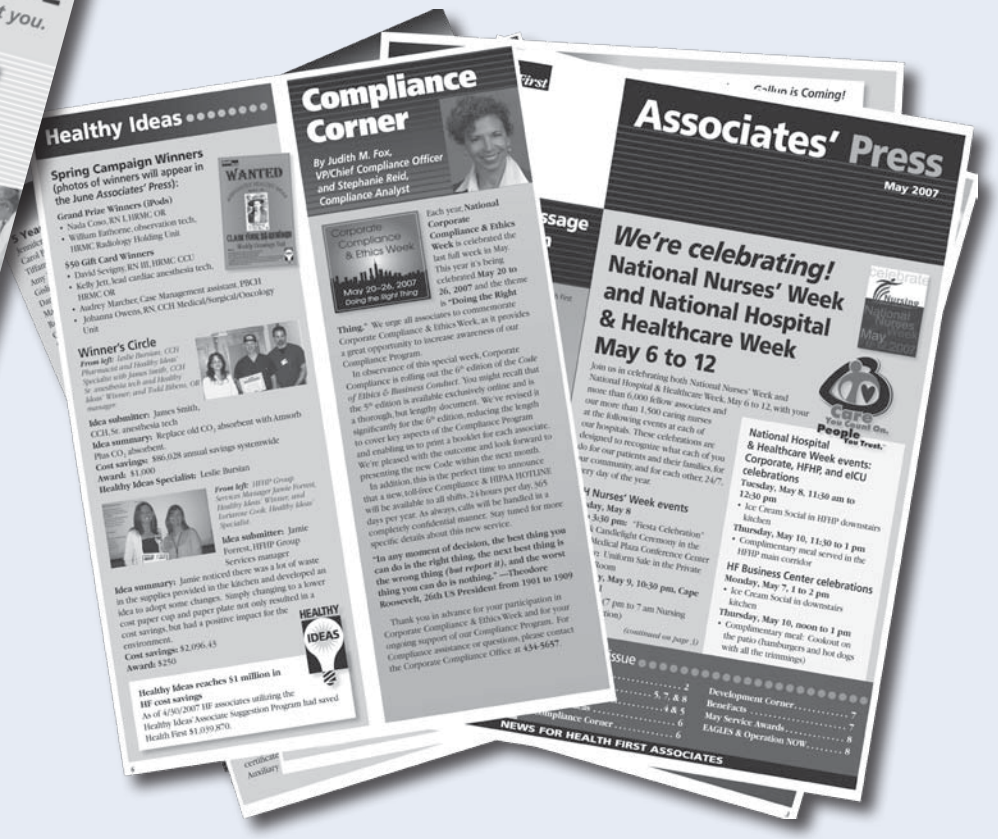
Handout to the directors distributed by the Chief Compliance Officer at the various facilities' department head meetings to engage the directors to encourage associate participation in the Week's activities

PowerPoint slide showing picture collage of 2006 display and associates participating in activities at one of the facilities

Flier posted in prominent locations throughout Health First facilities announcing C & E Week's activities



New compliance poster displayed on the story-board and distributed at the various Health First facilities



May 2007 edition of Associates' Press with Compliance Corner article on page 6 announcing C & E Week's celebration and key topics

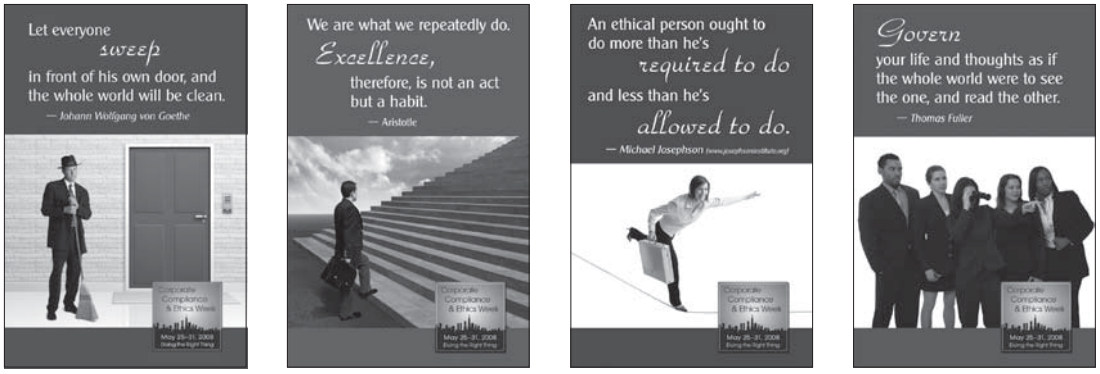
Corporate Compliance & Ethics Week

May 25–31, 2008

ORDER YOUR SUPPLIES NOW

Each year, Corporate Compliance & Ethics Week is celebrated the last full week in May. Co-sponsored by the Health Care Compliance Association (HCCA) and the Society of Corporate Compliance and Ethics (SCCE), the fourth Corporate Compliance & Ethics Week will be celebrated May 25–31, 2008.

HCCA has a number of items available for purchase to help spotlight compliance and ethics in your organization. **Place your order by Friday, May 9, to ensure delivery before this event.**



Four colorful glossy posters, 2 ft x 3 ft, each showcasing a different ethical message and including the Corporate Compliance & Ethics Week logo (1 each per 4-pack) $25 per 4-pack (min. order 3 packs)

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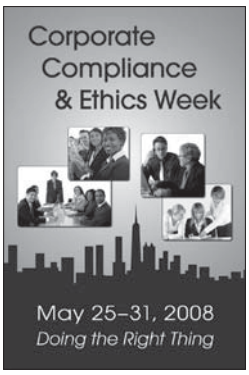

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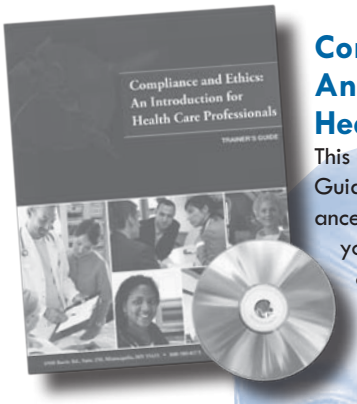
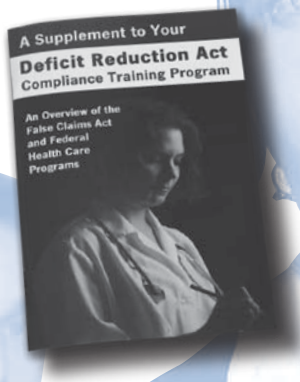


Compliance and Ethics: An Introduction for Health Care Professionals

This 23-minute video and Trainer's Guide covers seven common compliance topics and provides everything you need to conduct new employee orientations and staff refreshers.

Compliance Conscience and Conduct

This 17-minute video plus session leader guide offers an easy way to train employees in compliance basics. Seven dramatized scenarios cover key topics, including coding accuracy, workplace conduct, gifts and gratuities, patient information, patient charts, vendor relationships, and vendor gifts.



A Supplement to Your Deficit Reduction Act Compliance Training Program

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HIPAA Security Compliance

This 15-minute video plus 10 participant handbooks show how to meet the requirements of the HIPAA Security Rule. The program covers security basics, including protection from malicious software, device and media controls, log-in monitoring, technical safeguards, physical and facility access controls and more.

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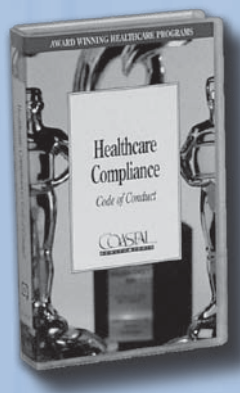

Healthcare Compliance: Code of Conduct

This 18-minute video plus 10 participant handbooks give an overview of compliance and its importance in today's health care environment. Topics include codes of conduct, compliance best practices, monitoring and auditing, education and training, enforcement and discipline, and more.

EMTALA 911: On Call!

This 15-minute video plus 10 participant handbooks review EMTALA requirements for any facility that has walk-in patients with urgent care needs. It explains a facility's legal obligations to provide health care for patients with an inability to pay, proper procedures for asking about financial status or health insurance, and more.

*The Health Care Compliance Professional's Manual is exempt from this offer

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Business tools for compliance

By Patrick Curry

Patrick Curry is Senior Manager, Compliance, OTN Companies located in South San Francisco, CA. He may be reached by telephone at 650/871-3357.

One of the greatest challenges for new compliance officers is a certain knowledge of the risk areas for the organizations they represent. Even if compliance officers are intimately familiar with the risk profile of the departments they are responsible for, this understanding tends to be time-limited if they are not plugged into the business and its processes as a whole.

The give and take between risk and process creates a constantly changing environment. Setting aside any potential complexity of working with a business process that may be outside the specific expertise of the compliance officer, an additional challenge is to have enough detailed knowledge of the work processes of managed departments or functions to be able to catch errors in process. One must also be removed enough have an overall picture of how the various component departments work together and to be able from this "balanced" picture to be able to appropriately label and categorize risk—a tall order!

This issue is not new for other business leaders. To be effective, leaders in one business silo need to understand what happens in the workflow, either upstream or downstream from them. For example, a contracts management function in a health care business works best when its leader understands where the contracts they manage come from (say, Business Development) and where the data that they gather and manage is used (say, Internal Audit or Accounting.) Business groups have developed various solutions to these types of issues. One surprisingly productive opportunity for the compliance officer is borrowing techniques and tools found in business process-focused disciplines such as Six Sigma and Lean Manufacturing.

Six Sigma is a process-centered methodology derived from manufacturing that focuses on the number of defects or production errors in a given production line, determines how to identify what's causing the issues, what can be done to correct the issue, and how to have the correction persist over time. In health care industries, Six Sigma can use other, less-manufacturing metrics, such as errors reported in charting, medication errors, or even less obvious metrics, such as number of calls to a medical "help" line. Lean, another manufacturer-based methodology, focuses on the speed and efficiency of any process as a key to streamlining workflow for the entire organization. Lean looks at "work in progress" as a key to figuring out which parts of a process cause rework or don't add value to the overall process. An excellent general reference for these topics is Michael George's suite of books, most specifically, *Lean Six Sigma for Service*.[1]

Borrowing tools from other departments by the compliance organization isn't new. Many articles have been written on synergies between Internal Audit and Corporate and Regulatory Compliance, not only in goals, but in audit methods (e.g., sample size determination, leveraging work performed by the other organizations). A full deployment of such "ways of working" requires the buy-in of the executive level and a fairly large training commitment. As such, some methods are likely out of the sole reach of the compliance officer, although the impact to return on investment capital and to costs should not be underestimated! A departmental use of such techniques may increase certainty around processes that the compliance officer oversees from a compliance/regulatory perspective, and thus decrease the likelihood of a sentinel event or another breakdown in process leading to a regulatory citation, fine, or worse.

A particular risk analysis tool borrowed from Six Sigma is the Failure Mode and Effects Analysis (FMEA), which allows a relatively precise gradation of risk based on agreed-on organization standards, and thus a prioritization of tasks. FMEA is useful for managing both the compliance officer's limited time and resources, as well as being a potential financial resource focus for the corporation.

However, in order to analyze and grade a process from a risk perspective, the compliance officer needs to understand what actually happens in the process itself. If the business process isn't personally known, and if there are no existing process maps to the flow of work in a given department, it's helpful to interview, briefly, several key people in the department. Several people's perspectives should be used in order to flatten out any specific skew to the responses given by any one individual.

Six Sigma methodology uses a process known as Define, Measure, Analyze, Improve, and Control (DMAIC).[2] FMEA is used in several different stages of a project:

- When a process is being considered for rework (in the Define phase)
- To understand critical process steps that need to be scoped (in the Measure phase), and

Continued on page 40

- To explore potential weaknesses created by new and improved processes (in the Improve phase).

Figure 1

Detectability rating

1	Pre-edit process identifies error and kicks out to suspense file 100% of the time
4	Pre-edit process identifies error 50% of the time, but review by supervisor catches remainder
10	Pre-edit process fails to identify invalid or inaccurate claims, no review occurs prior to submission

FMEA works by creating a series of rating categories that are agreed on by the organization. These categories are then used to score defects occurring in a business process, similar to the example shown above (Fig 1). Frequently, three categories are used:

- **Severity**, for the amount of damage, either to life and limb or to reputation, that an issue would cause;
- **Likelihood**, for the likelihood that a given issue might happen, and
- **Detectability**, for the chance that an issue might not be found prior to the process completing, or otherwise something that might not be seen (an example of this might be a claim error not caught prior to being sent to the Fiscal Intermediary, see below.)

Other categories are occasionally used as well; for example, cost of remediation of the issue might be used to give a financial scope.

Traditionally, the categories are given a rating of 1-10, where 1 is the least serious and 10 is the most serious. A severity of 10 might be patient mortality for a patient care organization, or it might be failure of a business line that affects patients for an insurance group, depending on what processes FMEA is being used to examine.

Figure 1 shows the highlights of a Detectability rating example for a hypothetical claims review process. For the sake of clarity, a claim "pre-edit" process is scored to better show how the Detectability rating works.

Figure 2 outlines the basics of a contract review process, where the Legal and Finance departments review a contract for their given focus areas. A very abbreviated process is shown, excluding reprocessing and decision loops, where Legal marks up the contract and returns it to the originating organization, for example. The bolded items are used in the FMEA example, figure 3.

The first line in the FMEA, figure 3, describes the case from figure 2 where the business team has used a contract provided by another organization, but which doesn't meet the requirements of the internal Legal department. An example of this might be where the contract's terms would create conflicts of interest in key organization stakeholders. The ratings are determined, as noted above, by organizational consensus. In terms of severity, this might rate a 9 if an organization is operating under a Corporate Integrity Agreement (CIA), or possibly lower if not. Likelihood of occurrence would be determined by how strictly, for example, the organization follows any sort of validation process, Detectability, in this case, might be very low (a high score, however) because the error might not be discovered until after the contract is signed by both parties.

The key to FMEA's effectiveness as a tool is that each number (in the case of our example, severity, likelihood, and detectability, scored on a scale from 1 to 10) is multiplied together to get an overall score, called a risk priority number, or RPN.

In figure 4, the RPN scores are filled in for two of the three process steps. In this example, the breakdown in the financial contract review process is more likely to happen (a likelihood of 7 vs. 4), but is also more likely to be noticed prior to the execution of the contract (a detectability of 5 vs. 4.) The RPN score for the contract capture from the outside company is 160, and the score for contract review internally is 168. The larger the RPN, the more urgently corrective action is needed, based on the organization's criteria. The higher the severity of the result, the more likely, or the more hidden, the problem is.

FMEA, when thoughtfully used, can provide a functional "common language" for an organization to decide how to prioritize fixes for impaired or broken process, or to decide on what timescale to appropriate resources or dollars to address issues.

Many other tools from the business side can be harnessed by the compliance officer to add rigor and certainty to their risk analyses. Future articles will look at other methods to assist the compliance officer in assuring compliance for his or her organization.

1 George, Michael L, Lean Six Sigma for Service (New York: McGraw Hill, 2003)
2 Chapter 11, Using DMAIC to improve Service Processes, in Michael L. George, Lean Six Sigma for Service (New York: McGraw Hill, 2003)

Figure 2

Figure 3

Process Step/Input	Potential Failure Mode	Potential Failure Effects	Severity	Potential Causes	Occurrence	Current Controls in place	Detectability	RPN
What is the process step and input under investigation?	In what ways can or does the step go wrong?	What is the impact on the process?		What causes the step to go wrong?		What controls and procedures are in place that prevent the event that causes the failure?		
Contract obtained from external company	Contract does not meet Legal specification	Legally not permitted language included in contract, violation of Safe Harbor requirement, etc		Boilerplate language used by other corporation; lower Safe Harbor sensitivity		Legal review for all contracts not using approved Legal template		
Contract forwarded for review	Contract not forwarded to Finance	Terms of contract do not warrant business		Revenue loss, unprofitable business		Financial review for all contracts over $10,000 (materiality threshold)		
Contract returned to business	Contract not approved by Legal	Unapproved language still in contract		Miscommunication; tentative approval of draft but not final		Initials of Legal department rep required		

Figure 4

Process Step/Input	Potential Failure Mode	Potential Failure Effects	Severity	Potential Causes	Occurrence	Current Controls in place	Detectability	RPN
What is the process step and input under investigation?	In what ways can or does the step go wrong?	What is the impact on the process?		What causes the step to go wrong?		What controls and procedures are in place that prevent the event that causes the failure?		
Contract obtained from external company	Contract does not meet Legal specification	Legally not permitted language included in contract, violation of Safe Harbor requirement, etc	8	Boilerplate language used by other corporation; lower Safe Harbor sensitivity	4	Legal review for all contracts not using approved Legal template	5	160
Contract forwarded for review	Contract not forwarded to Finance	Terms of contract do not warrant business	6	Revenue loss, unprofitable business	7	Financial review for all contracts over $10,000 (materiality threshold)	4	168

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Security breaches at the Department of Veterans Affairs

By Gabriel L. Imperato, Esq., CHC

Editor's note: Gabriel L. Imperato is the Managing Partner of the Fort Lauderdale office of Broad and Cassel. He is board certified as a specialist in health law and Chairman of the firm's White Collar Criminal and Civil Defense Fraud Group. Gabe is also a member of HCCA's Board of Directors. He can be reached by calling 954/745-5223 or by e-mail at gimperato@broadandcassel.com

The relationship between identity theft and health care fraud has taken a number of different forms during the past year, most notably in the Department of Veterans Affairs (VA) and in the submission of Medicare and Medicaid claims for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) and associated medications used with nebulizers and oxygen concentrators. The identity theft associated with the VA has involved a more traditional form of theft of personal health information and Medicare identification information for the purpose of submitting false and fraudulent claims. The schemes to defraud involving DMEPOS and aerosol medications and the payment of kickbacks for medically unnecessary prescriptions has taken on a more subtle form of identity theft and fraud in the Southern District of Florida.

This article will examine the incidents of identity theft and potential fraud against federal health care programs related to the VA and focus on the schemes to defraud that are reflected in the indictments of numerous individuals and organizations involved in the supply of DMEPOS and aerosol medications. These developments reflect the vulnerabilities and breaches of security that can be exploited by those who would commit health care fraud and convert federal dollars at the expense of not only Medicare and Medicaid beneficiaries, but all those who pay taxes to support these federal health care programs.

On January 22, 2007, a portable hard drive was reported missing by an employee at the Birmingham, Alabama VA. The hard drive held up to 1.8 million veterans and doctors' personal health information, including, but not limited to, billing information and codes for Medicare services. It was certainly a black eye for the government, but making matters worse is the repeated nature of these security breaches that occur on the watch of such organizations as the VA. Criminals set on defrauding Medicare have taken advantage of these transgressions, establishing various schemes intended to bilk the government. Fortunately, with the advent of real-time analysis of Medicare billing data and stronger collaboration between federal, state, and local enforcement agencies, investigators are becoming more adept at capturing those parties who are defrauding federal health care programs. The results of these efforts have already begun to materialize, evidenced by the numerous indictments handed down in South Florida this past year as part of an ongoing investigation of health care fraud in the DMEPOS and retail pharmacy business.

Theft at the VA

The January 2007 incident was just the latest in a long line of VA data breaches. In May 2006, a laptop and external hard drive containing 26.5 million veterans' and military personnel's private information were stolen from a VA data analyst's home in Maryland. The information was ultimately recovered without being accessed, but the scare prompted calls for the VA to tighten its lax security measures. Consistently ranking near the bottom of federal agencies in terms of computer security, the VA pledged $25 million to create a call center to handle veterans' concerns and promised to hire a data analysis company to monitor whether identities were being stolen.

Despite promises from the VA to improve their security measures, the agency weathered even more criticism for its lack of accountability and leadership. Inexplicably, it took the VA 13 days to notify the Secretary of the agency of the actual burglary, and even longer to contact potential victims of the theft. The security breach was a serious error, but the lack of a standard policy for dealing with such a breach was viewed by many as even more inexcusable. The incident mushroomed into a public relations disaster and reflected poorly upon not only the VA, but also the federal government in general.

The tipping point, perhaps, came with the January 2007 incident of data loss. Many of the same problems that arose during the fallout from the first theft (May 2006) resurfaced during the investigation of the 2007 theft. The most glaring example was that the VA waited three weeks after it was first aware of the loss to

Continued on page 48

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begin notifying veterans. When the VA agreed to provide one free year of credit monitoring to people whose information had been compromised, it was clear that even the solution to the problem hadn't changed since the first incident. In effect, very little progress had been made.

Arguably, this data breach could be considered a more egregious security lapse, because the information at stake included both veterans' and physicians' information. With physicians' billing information and Medicare codes, criminals theoretically have access to a wider network of patients that extends beyond veterans. The most patent difference between the two incidents is that the information from the second theft was never recovered. Therefore, someone presumably still has access to information that lends itself to fraudulent activity, if it finds its way into the wrong hands.

What is apparent is that the VA's system of monitoring data is porous enough to allow for multiple breaches over the course of eight months. Although the VA has been cited for its poor handling of notifying those who have been victimized and for its perceived lack of leadership, it is hard to apportion the blame entirely on the VA. Considering the limited resources given to them to combat a seemingly unlimited criminal demand for the information they are entrusted to protect, the VA and similar government entities are fighting from a disadvantaged position. The monitoring system may be difficult to improve, but another effective method would be to increase the deterrent factor. Once a security breach does occur, the criminals must be made aware that using the information for fraudulent purposes will not go undetected.

The role of CMS

In an effort to increase deterrence among criminals who seek to defraud Medicare or Medicaid with false information, a recent multi-agency collaboration is attempting to prosecute individuals and health care companies that are fraudulently billing these programs. At the forefront of this collaboration are the Department of Justice (DoJ), the Office of Inspector General of the Department of Health and Human Services (OIG) and the Centers for Medicare and Medicaid Services (CMS), whose purposes include ensuring quality health care for beneficiaries.

Prior to the January 2007 theft, CMS had been involved in attempting to strengthen compliance plans for providers and sponsors participating in the Medicare Program. These efforts to safeguard Medicare beneficiaries have resulted in only intermittent success, partly due to regulations that are difficult to enforce. In a recent review of 79 drug plan sponsors, OIG found that 72 did not address all CMS requirements regarding statutory compliance elements and that only 15 addressed the recommended procedures for fraud detection, correction, and prevention. Nevertheless, investigators have devised methods of ensuring compliance from various programs and organizations. Techniques, such as an increase in random compliance inspections and audits, have alerted Medicare providers that enforcement is nearby and is being increased.

Yet, this still has not proven to be enough. In January 2007, the Government Accountability Office (GAO) singled out CMS for their inability to capture unusual charges being billed out to Medicare. Between 2005 and 2006, it is estimated up to $700 million in fraudulently induced payments have been made to durable medical equipment companies alone. In fact, recent estimates suggest that one out of every ten dollars spent for Medicare and Medicaid is lost to fraud.

Several reasons contribute for this abundance of fraud. As mentioned, regulated supervision has not been a particular strength of governmental agencies such as the VA and CMS. In addition, it has proven to be rather easy to obtain access to Medicare provider numbers. When a company has obtained a provider number, it can then establish relationships with an endless number of companies and pharmacies, all of which have potential to become part of fraudulent enterprises.

Since the GAO admonished the CMS, the health care agency has attempted innovative and aggressive approaches to address the fraud and abuse that is running rampant in the Medicare program. In May 2007, CMS proposed substantive reform of compliance requirements for Medicare Advantage plans, including clarifications and refinements of program provisions and a streamlining of intermediate sanctions.

On June 28, 2007, CMS announced plans to put into operation a two-year project involving the enrollment of DMEPOS suppliers into Medicare. The enrollment plan is comprised of multiple compliance tools, increased ad-hoc site visits, and a newly instituted yearly reapplication policy as the centerpieces of the plan. In addition, CMS has taken a more active role in working with beneficiaries and in facilitating information exchange with law enforcement agencies.

Real-Time analysis in South Florida

The collaborative effort paid almost immediate dividends. On May 9, 2007, the DOJ announced 38 arrests resulting from a multi-agency strike force investigation which targeted individuals and health care companies that had established fraudulent Medicare billing schemes. The multi-agency teams, formed in March of 2007, are led by a Deputy Chief in the DoJ Criminal Division's fraud section in Washington DC and the head of the Criminal Division in the office of the United States Attorney in Miami. The individual teams were staffed with a mix of agents from the Federal Bureau of Investigation (FBI), OIG, and local law enforcement.

The federal indictments in the Southern District of Florida against DME suppliers and retail pharmacies involve the submission of false and fraudulent claims for nebulizers and oxygen concentrators and the medications that were compounded to use with them. These aerosol medications are generally covered under Medicare Part B, as long as they are medically necessary and ordered by a physician. The indictments in Miami allege that individuals associated with equipment suppliers and pharmacies conspired to submit false claims and to pay and receive kickback payments for medically unnecessary and unreasonable supplies, services, and medications. The allegations in the complaint state that individuals established relationships with Medicare beneficiaries for the purposes of obtaining their Medicare identification cards and personal information so that they could assign claims to the DME companies and submit claims to the Medicare program. The methods used to obtain this information were, allegedly, not as bold as the theft of Medicare information that occurred from the VA, but it did involve the conversion of the identity of these Medicare beneficiaries to facilitate the scheme for false and fraudulent claims. This supported federal charges, in some cases, of aggravated identity theft for knowing possession and use of another person's identity (i.e., Medicare beneficiaries) for purposes of submitting false claims to Medicare and Medicaid.

The indictments further alleged that the owners of the pharmacies provided the DME suppliers with a list of those medications that could be billed to the Medicare program if they were prescribed by a physician and if they were required to be individually compounded. This would require the physician to prescribe a quantity and concentration of the aerosol medication that was not commercially available, and therefore, required the mixing and making of the compound. The indictments also allege that the DME suppliers obtained the prescriptions for these compounded aerosol medications and would refer orders to various retail pharmacies in exchange for a kickback of approximately 50% of the Medicare payments that the pharmacies received for each medication. A further aspect of the allegations was that the aerosol medication was not medically necessary or reasonable, was not appropriately prescribed by a licensed physician, and certainly was not necessary to be compounded under any circumstances.

An incalculable aid to the investigation was the implementation of real-time billing analysis, a method that had not been previously available to investigators and prosecutors. Through collaboration with the Medicare Program Safeguard Contractors (PSCs), the strike force was more easily able to identify potential cases of fraud because of access to PCSs' database. By tracking billing information as it was being recorded, investigators caught criminals in the act, rather than risking a cold trail by waiting until the information was fully processed. It has long been suspected that executives

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Irregular billing patterns: Are they Indicative of payment errors?

By George Davis, PhD; Kathleen Terry, PhD; Andrea G. Goldstein, MS; and Monty Bodenheimer, MD

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Background

Pattern analysis and outlier identification are long-standing analytic techniques whereby measures of variation in key indices over time are used to monitor and evaluate performance. IPRO, the Quality Improvement Organization (QIO) for New York State (NYS), as part of a special Center for Medicare and Medicaid Services (CMS)-funded project, examined the validity of outlier billing patterns as predictors of payment errors. IPRO reviewed a random sample of outlier and non-outlier inpatient claims to detect payment errors of admission necessity/appropriateness and coding/DRG assignment. Study results indicate no significant difference in payment error rates between hospitals with disproportionate or proportionate billed claims. These findings are in contrast to currently held opinions about the intuitive relationship between outlier status and billing errors. Perhaps there was a type of "Hawthorne effect" in play, where providers whose claim submission tendencies classify them as outliers may have performed better, because of the positive effect of the increased attention and oversight. The findings suggest a need for alternative approaches to payment error prevention that expand beyond billing outliers. It is suggested that additional studies occur with regard to the relationship between disproportional billing patterns and payment errors on Medicare claims.

Introduction

Evaluating performance through pattern analysis is a long-standing technique used by providers and payers of health services. Routine medical data from patient records and medical claims forms for service providers is often analyzed quantitatively and comparisons are made over time, including benchmarks against themselves, other health care providers, or other group designations. Variations in these measures are frequently interpreted as a reflection of performance in the delivery of health care services, and statistical performance outliers identified through such methods are usually targeted for performance improvement interventions.[1]

The Agency for Healthcare Research and Quality (AHRQ) indicators, for example, have been employed in comparative analyses on hospital quality by organizations as diverse as the Texas Health Care Information Council and Anthem Blue Cross Blue Shield of Virginia. The indicators can provide a comprehensive picture of the level and variation of quality over several dimensions of health care quality.[2] In many instances, performance monitoring has greatly enhanced the ability of the health care industry to evaluate itself and improve services. It has also enabled individual consumers and large purchasers of health care services to make informed decisions among competing providers. One important caveat is that researchers caution that these methods and the implied assumptions about performance must be applied with care, taking into account such mitigating factors as case mix variation, validity and reliability of predictors, and chance variability.[1,3]

Another type of approach to monitoring and evaluation can be found in commercial business applications, particularly those specializing in financial services. Here, advanced analytic techniques such as neural networks, Bayesian inference, and a variety of statistical and artificial intelligence methods are used to detect unusual patterns and anomalous behavior in events and activities across customers and organizations. While these analytic methods have traditionally been utilized as sentinel systems to detect and respond to potential customer risk and fraud, it is easy to project how they could be extended to the health care industry with regard to monitoring billing patterns, even at the prepayment stage, to identify statistical outliers.[4,5] Clearly, the current trend in the health care industry is toward evidenced-based methods for monitoring and evaluating key indices of performance.

CMS recently funded a study to begin to evaluate one component of the validity of

billing trends as predictive agents of health care outcomes. Specifically, CMS funded a Hospital Payment Monitoring Program (HPMP) project that looked at proportional billing patterns for specific Diagnosis-Related Groups (DRG). As part of the HPMP ongoing effort to reduce Medicare payment errors, IPRO conducted a special project designed to reduce both inappropriate admissions and occurrences of incorrect coding/DRG assignments associated with the clinically related DRGs 174 (GI Hemorrhage with Complication Comorbidity [CC]) and 182 (Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders age >17 with CC).

Methodology

DRGs 174 and 182 were chosen based on a history of high payment error rates for both DRG/coding and admission necessity in IPRO's NYS Medicare case review process. Although the primary aim of the project was to reduce payment errors, a major project assumption was that those providers with disproportionate (or uneven) numbers of billed claims for DRG 174 as compared to DRG 182 would submit a higher percentage of claims with payment errors than those providers with claim frequencies that reflect a more even billing proportion between these two DRGs. The legitimacy of evaluating the latter assumption was further strengthened by the results of pattern analysis of paid claims in NYS. The results of the analysis indicated that, in general, DRGs 174 and 182 are billed in an even and consistent manner relative to one another. This suggests that under the currently utilized surveillance design, hospitals that bill one of these DRGs with much greater frequency than the other could well be considered noteworthy and merit further attention.

We looked at the validity of using disproportionate billing patterns as an indicator of potential claims payment errors. By comparing groups of hospitals with even and uneven billing patterns for DRGs 174 and 182 on their associated levels of payment errors, we determined the extent of the statistical association between these two measures. Among the hospitals selected for study, an association between billing patterns and payment errors would be thought to validate the use of statistical-outlier identification in selected target areas as a method of monitoring and preventing payment errors on claims. A negative finding, however, would indicate the practicality of considering alternative approaches to monitoring billed claims for indicators of systematic trends in payment errors.

Hypothesis

As part of the analytic plan for the HPMP special project on Reduction of Payment Errors for DRGs 174 and 182, IPRO examined the hypothesis that, for NYS acute care providers, the frequency of payment errors detected on the billed claims for these DRGs during retrospective case review is related to the proportion of Medicare claims billed for one DRG as compared to another. Specifically, it was postulated that those providers with disproportionate numbers of claims for DRG 174 as compared to DRG 182 would submit a higher percentage of claims with payment errors than those providers with claim frequencies that reflect a more even proportion between these two DRGs.

Study design, and sample

A random sample of 600 inpatient claims with DRGs 174 and 182 were selected from a pool representing all Medicare inpatient claims billed between the first quarter (Q1) through third quarter (Q3) of fiscal year 2006. These claims were stratified equally across two groups, each consisting of 10 short-term acute-care NYS hospitals selected for project participation. The hospitals were assigned to groups based on the proportion of claims they billed for DRG 174 as compared with DRG 182. One group consisted of 10 hospitals with a relatively even proportion of claims (i.e., a ratio of 174 to 182 claims ranging from approximately 1.25 to .79). The other group was represented by 10 hospitals with a more disproportionate mix of claims (i.e., a claims ratio of 174 to 182 ranging from 1.95 to 1.47 and .39 to .27 for either the high or low volume proportions). For the two groups, the percentage of total cases denied, as well as separate percentages for cases denied for admission necessity/appropriateness and for coding/DRG assignment, were compared to determine the existence and degree of any difference associated with the proportion of billed claims for DRGs 174 and 182.

Results

Denial rates overall. As indicated in Table 1 below, for all project cases, baseline review results indicate that there was no significant difference in the payment error rate between hospitals with a disproportionate or proportionate number of claims billed to DRG 174 and DRG 182.

To clarify our findings, we analyzed data for each DRG independently. That is, for

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Table 1. Fischer's exact results for proportional analyses

Denial Rates Overall				
Measure	Total Cases	Even Proportion Group	Disproportionate Group	*P* value
All Cases	11.67	12.67	10.67	0.53
DRG 174 Alone	7.3	8.0	6.67	0.82
DRG 182 Alone	16.0	17.33	14.67	0.64

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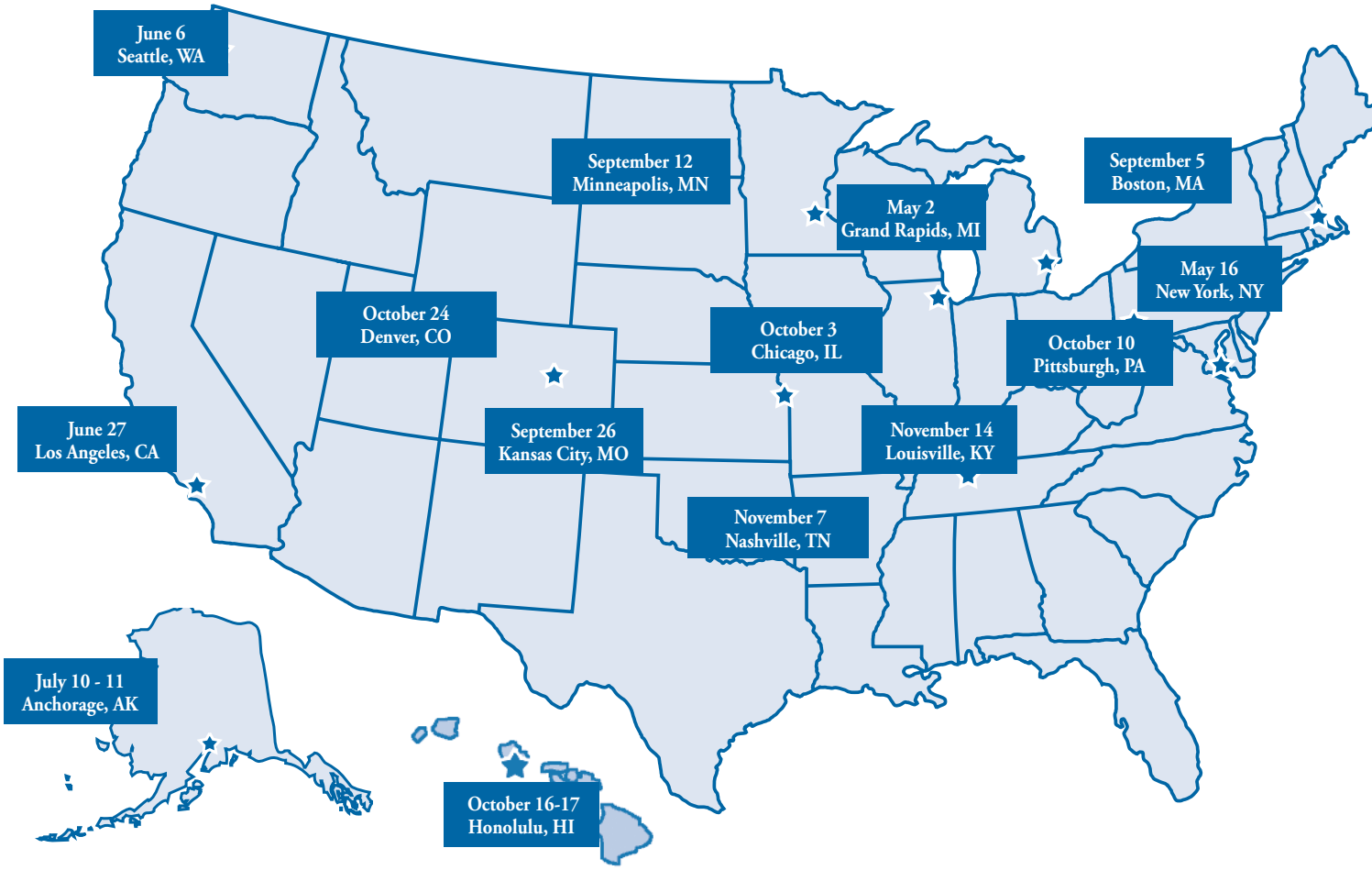

the same grouping of hospitals based on proportion of DRG 174 to 182 claims, we compared payment error rates for DRG 174 and DRG 182 independently. Again, Table 1 indicates no significant difference between disproportionate and even-proportion billing hospitals when payment error rates are determined separately for each of the two DRGs. In fact, in all comparisons, the even-proportion group had a higher overall percentage of cases denied than the disproportionate group, albeit a non-significant greater percentage.

Table 2. Error-type breakout for grouped DRGs 174 and 182

All Cases				
Measure	Total Cases	Even Proportion Group	Disproportionate Group	*P* value
Adm Denial Rate	7.2	7.3	7.0	1.0
DRG Denial Rate	4.8	5.3	4.3	0.7

Admission and coding/DRG denial rates. The counterintuitive findings described above necessitated a further breakdown of payment errors by type (i.e., DRG/coding or admission necessity) to evaluate the extent and depth of our findings. Table 2 again points to the findings that overall for the even-proportion group, the percentage of cases denied specifically for coding/DRG assignment and for admission necessity/appropriateness were higher than the corresponding denial percentages for the disproportionate group. However, the differences were not statistically significant. Further, analyzing each DRG separately did not lead to significant differences between DRGs or type of payment error.

Review results based on alternative groupings. One might reasonably argue that groupings based on billed claims proportions other than DRG 174 to 182 are more appropriate. For example, one might conceivably assume that disproportionate billing in the complication comorbidity (CC) companion DRG may lead to a different finding. IPRO tested this theory through post-hoc alternate groupings. In one analysis, hospitals were grouped according to the proportion of claims billed for DRG 182 to DRG 183, its non-CC counterpart, and denial percentages. These were examined for the sample cases considered relevant as far as expected impact (i.e., DRG 182 case reviews). As indicated in Table 3, all payment error percentage comparisons between the even and disproportionate groups based on DRG 182 to 183 claims proportions yielded non-significant results. Again, the non-significant trend points to greater errors in the even-proportion group.

Similarly, a subsequent analysis grouped providers according to their billed claims proportion for DRG 174 to its non-CC counterpart, DRG 175. The overall disproportionate group percentage was slightly higher than that of the even proportion hospitals, but the percentage comparisons did not yield statistically significant results (see Table 4).

Table 3. DRG 182-183 proportional billing analyses

Denial Rates Based on Disproportionate Billing for DRG 182 to DRG 183			
DRG 182 Cases Alone			
Measure	Even Proportion Group	Disproportionate Group	*P* value
Adm Denial Rate	14.8	9.7	.21
DRG Denial Rate	5.2	4.2	.79
Total	19.26	13.33	.20

Discussion

Baseline review results indicate that there is no significant difference in payment errors between disproportionate and proportionate (i.e., even) billing hospitals. Thus, the hypothesis of disproportionate billing as an indicator of increased payment errors is not supported. In fact, in many of the comparisons examined, although the differences were not statistically significant, it was the hospital in the even-proportion group that had noticeably higher denial percentages. This finding of non-significance for unevenly billed proportional hospitals seems to hold through comparisons based on billing of DRG 182 to its CC companion DRG 183 and DRG 174 with its CC companion DRG 175.

It could be argued that this finding is the result of a lack of consistency over time with regard to a hospital's degree of proportionality of claims among related DRGs. Additional analysis designed to clarify this issue, however, did not support the argument for a dramatic impact based on changes in billed claims proportions over time. When project hospitals were re-grouped according to their proportion of claims for DRG 174 to DRG 182 for an administrative claims period extended back through fiscal year 2005 (i.e., Q1 fiscal year 2005–Q3 fiscal year 2006), comparison of payment error rates for the revised disproportionate and even-proportion hospital groups continued to result in non-significant findings. It appears that billing proportions are not indicative of greater or fewer payment errors for the DRGs reviewed in this project.

One explanation for these findings may be found in the expectations and level of attention and resources that have been applied to each hospital's outlier status. Specifically, there are

Table 4. DRG 174-175 proportional billing analyses

Denial Rates Based on Disproportionate Billing for DRG 174 to DRG 175			
DRG 174 Cases Alone			
Measure	Even Proportion Group	Disproportionate Group	*P* value
Adm Denial Rate	3.1	.95	.43
DRG Denial Rate	4.1	6.7	.41
Total	7.2	7.6	1.0

ongoing initiatives that identify hospitals whose claims submission patterns classify them as outliers. Outlier hospitals are encouraged to investigate these outlier claim-submission patterns, and to identify and remediate potential sources of payment errors on billed claims. Perhaps the level of attention and resources devoted to these outlier providers in comparison to those providers with claims submission tendencies more consistent with statewide numbers, resulted in a kind of "Hawthorne effect" in which the attention offered to the outlier hospitals itself created a positive group climate and motivation, which then resulted in improved performance. Conversely, those providers who were more in line with statewide claims submission patterns may have regressed in their efforts to manage payment errors, because of a sense of satisfaction with the status quo and a perceived decrease in the level of external performance monitoring from CMS and/or its designated agencies.

It is worth noting that the intuitive concept of outlier status and billing errors is one that has existed for some time. As mentioned previously, it is used commercially in both performance monitoring and as the basis of some existing fraud programs and recovery audit efforts. This method can retrieve dollars paid in error, but this study implies that there may in fact be greater errors in areas that are not a focus of attention. Alternative approaches may be needed to supplement approaches that primarily focus on billing outliers The relationship between proportional billing distributions among claims and payment error rates should be further examined. Replicating our findings with additional target areas would assist in our understanding of associations between billing patterns and higher payment error rates. ■

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Accepting emergency transfers: Making compliance easier

By M. Steven Lipton

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It is an all too common scenario: a hospital calls the emergency department of another facility, requesting the name of an on-call specialist to accept an emergency transfer, and the on-call physician either accepts or denies the transfer, without coordinating the request with the hospital (which may be equally surprised if the patient arrives without prior notice, or if a surveyor later investigates the denial of the transfer by the on-call physician). In other cases, a nurse supervisor or a unit manager denies an emergency patient transfer for insurance reasons, not fully understanding the obligations to make these decisions without regard to financial status. In these examples and other typical cases, the decentralization of the emergency transfer process jeopardizes the hospital's compliance with the Emergency Medical and Treatment and Active Labor Act (EMTALA) regarding accepting hospital obligation.

This article is limited to the obligations to accepting emergency patient transfers under EMTALA. Hospitals should also consider philosophical, ethical, and industry standards, as well as contractual obligations, in making decisions on transfers, whether or not implicated by EMTALA.

The obligation of a hospital to accept emergency transfers is tucked away in the corners of EMTALA – a hospital with specialized capabilities must accept from a referring hospital an appropriate transfer of a patient who requires the services offered by the accepting hospital, if it has the capacity to treat the patient.[1] The accepting hospital obligation applies to all Medicare-participating hospitals, including facilities that do not have dedicated emergency departments. While all hospitals have operationalized the obligations for medical screening, stabilizing treatment, and making an appropriate transfer, many hospitals still approach the accepting facility obligation without a coordinated process.

In many parts of the country, hospitals are seeing the unintended consequences of limited on-call coverage, downsizing of programs, emergency department saturation, and other reasons that have resulted in an increase in the number of emergency patient transfers. In a 2005 report, the American College of Emergency Physicians found that 73% of responding emergency department directors said they had a problem with inadequate on-call coverage by specialists, an increase from 67% a year earlier.[2] Teaching, pediatric, and other regional full-service facilities are experiencing an increase in requests for transfers, with increasing uncompensated and Medicaid burdens. Some of these facilities face a daunting challenge to manage their tertiary or quaternary missions or trauma programs with the influx of patients who could easily be accommodated in other local hospitals. Some receiving facilities are receiving transfer requests from hundreds of miles away, with air or ground transport vehicles passing by a dozen or more hospitals that have refused to accept transfers. Receiving hospitals are also dealing with their own coverage physicians who are increasingly irate over the lack of specialty coverage at other hospitals and the feeling that they are shouldering an unequal burden.[3]

Five steps to a coordinated acceptance process

The growing demand on many hospitals to accept transfers requires centralizing the acceptance process with trained personnel who ask the right questions, manage the flow of information, and coordinate hospital personnel and coverage physicians to arrive at compliant and timely decisions. The solution will differ between hospitals depending on available resources and the frequency of requests to accept transfers. Many large hospitals have already established formal transfer centers. Smaller hospitals may want to centralize the process in an existing department, using available resources and cross-trained personnel.

Step One: Centralize the transfer process. Hospitals should designate trained personnel and a dedicated phone number to handle all incoming requests for transfers. The hospital should also inform its "frequent flyers" of the phone number and the process for requesting transfers. The hospital should advise sending facilities to communicate directly with the transfer unit and a determination will be made whether the receiving hospital has the capacity and capability to accept the patient. Sending facilities should be directed not to call the receiving facility's coverage physicians or the emergency department before they have spoken with the transfer unit. The receiving hospital should also inform its coverage physicians to refer to the transfer unit all calls that are received from other facilities seeking an accepting physician.

Step Two: Ask the right questions. The key to complying with EMTALA's accepting hospital

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obligation is to ask the right questions. Transfer unit personnel should receive in-service training on the EMTALA obligations and its lingo. For example, some hospital staff and physicians still do not understand that the focus of EMTALA is whether an emergency condition is "stabilized," which may differ from whether a patient's condition is "stable."[4] The hospital should develop a checklist to determine whether the transfer implicates EMTALA, and if so, whether the hospital has the capability or capacity to accept the transfer. See sidebars on pages 59-61 for a checklist of ideas to include in a sample script for employees to use.

Step Three: Manage the flow of information. The transfer personnel should document information relevant to the transfer from both accepting and receiving hospital personnel, and identify additional information that may be pertinent to accepting a transfer. In the absence of a centralized process and a convenient form to record information from in-coming calls, the information is often lost or misplaced. Some hospitals also record conversations with sending hospitals; facilities should review applicable legal requirements before initiating taped calls.

If additional clinical information is required, the transfer personnel should request pertinent portions of the patient record, if the request will not unduly delay the decision-making process or the immediate need to transfer the patient. Equally as important as asking the right questions is refraining from asking the wrong questions, especially the premature question of insurance status. The request for patient records should not be for the purpose of identifying the patient's insurance status unless the sending hospital has confirmed that the patient is an inpatient or does not have an unstabilized emergency medical condition.

In addition, transfer personnel must be careful not to request obligations or impose conditions of the sending facility that are not required. CMS has reaffirmed that accepting hospitals act at their peril if they seek to impose conditions on sending hospitals: "It is a violation of the EMTALA requirements for a receiving hospital to condition its acceptance of an appropriate transfer of an individual with an emergency medical condition upon the sending hospital's use of a particular transport service to accomplish the transfer."[5]

Step Four: Manage the acceptance process. The transfer personnel should coordinate with patient units, support service departments, and the emergency department (when relevant) in evaluating the hospital capacity to accept a patient. If capacity is confirmed, the transfer personnel should call the on-call physician and provide him/her with the information on the patient and hospital conditions, and coordinate a call between the accepting physician and the sending physician. If an on-call physician refuses a transfer for which he/she is available and qualified to accept, the transfer staff should trigger the hospital's chain-of-command process to expedite a timely review of the situation and a possible reversal of the decision. Similarly, the transfer staff should report to administration, risk management, or the compliance officer the actions by the transferring hospital or physician that may be an EMTALA violation. Upon accepting a transfer, the transfer personnel should document the decision, and alert hospital units and departments as to the expected arrival time and patient routing. If the transfer is declined, the transfer personnel should document the reasons for the refusal and communicate the reasons for the decision to the sending facility.

Step Five: Learn from experience. Having a roundtable discussion with transfer personnel to discuss cases, common problems, and repeat issues can be a very enjoyable and informative experience. Hospitals should also implement a formal review process for transfer decisions and documentation. Process improvement has to be continuous, and the experiences with transfers can be used to modify the checklist, enhance the internal and external communications processes, and trigger other actions that promote best compliance practices.

Transfer agreements

As a result of the growing demand on sending and receiving hospitals to make or accept emergency patient transfers, many facilities are developing or updating their transfer agreements to detail the transfer process and address issues that should not (or cannot) be first raised at the time of a transfer. Some transfer agreements have "take back" clauses, requiring the sending hospital to accept the return of the patient when he/she no longer requires the higher level of care that precipitated the transfer. Other common provisions include the respective financial obligations of the parties, transport arrangements, notification of changed conditions (such as a delay in implementing a transfer or the unexpected loss of capacity before the patient has departed the sending hospital), mutual review of disputed transfers, and special procedures for certain transfers (such as neonatal transport). If the hospital has signed transfer agreements, the contents of the agreements should be known to staff who are involved in making or accepting transfers.

Just as hospitals have focused on the front end of emergency services, the back side of EMTALA also requires careful attention. Centralizing the transfer acceptance process, designating a central point of coordination, having trained staff, using a checklist, and documenting the flow of information are all critical to meeting the EMTALA accepting hospital obligation. And hospitals may find a dividend in a happier medical staff that is relieved of taking unnecessary calls from other hospitals. ■

Accepting Emergency Patients

Inquiries/Documentation	Comments
Part 1. Collect Basic Information	
■ Date and time of the call ■ Name of transferring hospital ■ Name of the caller (position if known) ■ Telephone number of caller ■ Name of staff member receiving the call ■ Patient's name ■ Patient's age (gender optional) ■ Name of transferring physician ■ Other basic information	Do not ask for any insurance or financial information prior to determination whether the request is for an EMTALA or non-EMTALA transfer If an EMTALA transfer, do not ask for any insurance or financial information before final decision to accept or decline the transfer
Part 2. Is the Request for an EMTALA or Non-EMTALA Transfer?	
1. "Is the patient in an emergency department (or labor & delivery)?" ■ If an inpatient -- no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). **Go to Part 5 if transfer declined.** ■ If an emergency patient -- **go to Question 2**	Inpatients include patients admitted to the hospital who are boarded in the emergency department pending the availability of an inpatient bed or other treatment area
2. "Has there been a determination that the patient has an 'emergency medical condition?'" ■ If patient does not have an "emergency medical condition" -- no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers); **Go to Part 5 if transfer declined.** ■ If patient has an "emergency medical condition" -- **go to Question 3**	**"Emergency medical condition"** is a medical condition (including severe pain, psychiatric disturbances or chemical dependency abuse) manifesting itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in -- ■ placing the health of the patient (or un-born child) in serious jeopardy; or ■ serious impairment of bodily functions; or ■ serious dysfunction of any bodily organ or part, or A pregnant woman having contractions if there is inadequate time for a safe transfer to another facility or the transfer will pose a threat to the health of the mother/unborn child.
3. "Has there been a determination as to whether the emergency medical condition is "stabilized" or unstabilized?" ■ If "stabilized," no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers). **Go to Part 5 if transfer declined.** ■ If not stabilized, **go to Question 4**	**"Stabilized"** means no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient to another medic-cal facility (or woman having contractions has delivered the baby/placenta)
4. "What are the reasons for the transfer?" ■ If the reasons are not to access "specialized services" that are required to stabilize the patient's emergency medical condition (e.g., insurance purposes, physician preference, etc.), there is no EMTALA obligation to accept the patient (refer to Admission Policy for acceptance of non-EMTALA transfers) ■ If the reasons are to access "specialized services" that are required to stabilize the patient's emergency medical condition, document the reasons: ❑ Specialized care (NICU, neurosurgery, catheterization, etc.) ❑ Lack of capacity at sending hospital ❑ Diagnostic testing only (and return to sending hospital) ❑ Patient request for transfer ❑ On-call physician is unavailable (in surgery or at another hospital) ❑ On-call physician failed or refused to respond **Go to Question 5**	**Note:** The hospital may be required to accept a non-EMTALA transfer from another facility (e.g., the patient is insured by a plan that is aligned with the hospital or under a transfer agreement) **"Specialized services"** are any services provided by the receiving hospital that are necessary to stabilize the patient's emergency medical condition that are a higher level of care at the time of the transfer than the level of care available at the sending hospital at the time of the transfer A patient request for a transfer must be an informed request (after receiving risks and benefits, and alternatives) If on-call physician failed or refused to respond, and patient accepted, report the on-call failure to [insert appropriate department]
5. "Does the sending hospital have the present capability and capacity to provide those services?" ■ If the sending hospital has the present capability and capacity to provide the specialized services required for the patient, no EMTALA obligation to accept the patient (refer to Transfer Policy for acceptance of non-EMTALA transfers) ■ If the sending hospital does not have the present capability and capacity to provide the specialized services required for the patient, **go to Part 3**	Document the name of the person stating the lack of capability and capacity
Part 3. Determine Hospital Capability and Capacity to Accept the Transfer	
Note: In order to assess the clinical needs of the patient and the capability and capacity of the receiving hospital, the receiving hospital may ask for the patient's vital signs, test results and other clinical information that is pertinent to determining the hospital's capability to meet the patient's needs	
1. Does the hospital have an appropriately staffed bed that is expected to be available at the time of patient's arrival (or later, if the patient will be routed to surgery or other treatment area)? ■ If the patient requires an inpatient bed and an appropriately staffed bed is not expected to be available at the time of the transfer, there is no obligation to accept the patient. **Go to Part 5.** ■ If the patient requires an inpatient bed and an appropriately staffed bed is expected to be available at the time of the transfer, **go to Question 2.**	If the receiving hospital routinely boards inpatients in the Emergency Department or other overflow area, or holds an open bed for a later use, consult with unit personnel as to whether there is bed capacity to accept the patient

Continued on page 60

 ...continued from page 59

Inquiries/Documentation	Comments
2. Is the Emergency Department expected to have capacity to examine, treat and monitor the patient pending assignment of the patient to an inpatient bed, treatment or discharge from the Emergency Department? ■ If the patient requires the services of the Emergency Department and the Emergency Department is on diversion or saturation or otherwise does not have capacity to accept another emergency patient with an unstabilized emergency condition, there is no obligation to accept the patient. **Go to Part 5.** ■ If the patient does not require the services of the Emergency Department, **go to Question 3.** ■ If the patient requires the services of the Emergency Department and the Emergency Department has capacity to examine, treat and monitor the patient, **go to Question 3.**	

Inquiries/Documentation	Comments
3. Does the hospital expect to have service capacity at the time of the patient's arrival (or within clinically required timeframes) to provide the level of care required for the patient? ■ If the patient requires an operating room, cardiac catheterization or other treatment area, and the treatment area and staff are not expected to be available at the time of the transfer (or within clinically required timeframes), there is no obligation to accept the patient **Go to Part 5.** ■ If the special treatment area is expected to be available at the time of the transfer, **go to Question 4.**	

Inquiries/Documentation	Comments
4. Is there an appropriate medical staff physician who will accept the responsibility for the patient? ■ If there is no appropriate medical staff physician who is available and willing to accept the patient, there is no obligation to accept the patient. **Go to Part 5.** ■ If there is an appropriate medical staff physician who is available and willing to accept the patient, **accept the patient transfer and proceed to Part 4.**	If an on-call physician is available to accept the patient, but is unwilling to do so, report the decision to [insert appropriate department]

Part 4. Documentation if Transfer Accepted

- Date and time of acceptance
- Name of accepting physician
- Bed unit assigned to the patient (or route to emergency department)
- Mode of transport (ALS, BLS, air, private vehicle, other)
- Other information

Inquiries/Documentation	Comments
Part 5. Documentation if Transfer Not Accepted	
■ Not an emergency medical condition	
■ Emergency medical condition is stabilized	
■ Patient does not require specialized services at the hospital	
■ Hospital does not provide the specialized services required to stabilize the patient's emergency condition	
■ Hospital does not have bed, services or emergency department capacity (document the reasons)	
■ On-call physician is not available to accept the patient	
■ Transfer is for insurance reasons	
■ Transfer is a lateral transfer (level of care available at transferring hospital at time of transfer)	
■ Other (document the reasons)	

1 42 C.F.R. 489.24(f).
2 See "On-Call Specialists at Emergency Rooms Harder to Find, Keep," Washington Post, December 21, 2007 (p. A1).
3 See Howard Beale, movie Network (1976). Pop culture source of "I'm mad as hell and I'm not going to take it anymore."
4 See, St. Anthony's Hospital v. U.S. Department of Health and Human Services, 309 F.3d 660 (10th Cir. 2002).
5 CMS Memorandum S & C 07-20 (April 27, 2007

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ELECTION 2008: New Members of the HCCA Board of Directors

Marti Arvin, JD, CHC, CPC, CIPP/G, CCEP
Privacy Officer
University of Louisville
Louisville, KY

Marti Arvin, Privacy Officer for the University of Louisville, is an active member of the Health Care Compliance Association (HCCA), having served as the Compliance Focus Group chair for privacy. Ms. Arvin also serves on the Healthcare Compliance Certification Board and is a faculty member of the HCCA Academy. In 2007, Ms. Arvin was awarded the Compliance Professionals Compliance and Ethics Award by the HCCA.

At the University of Louisville, Ms. Arvin oversees the university privacy compliance program. She coordinates privacy efforts with affiliated entities and is a key individual in the university's efforts to establish a security compliance program.

Shawn Y. DeGroot, CHC, CCEP
Vice President of Corporate Responsibility
Regional Health
Rapid City, SD

Shawn Y. DeGroot is Vice President of Corporate Responsibility at Regional Health, an integrated health care delivery system in western South Dakota. Ms. DeGroot is Certified in Health Care Compliance by the Healthcare Compliance Certification Board and is a Certified Compliance and Ethics Professional by the Society of Compliance & Ethics. Ms. DeGroot has over 24 years of health care experience in both private and public health care, holds a bachelor's degree in organizational behavior and management, and has written several articles for various publications including Trustees, Compliance Today, Journal of Healthcare Compliance and MD News. Ms. DeGroot is a frequent speaker on corporate integrity agreements, compliance effectiveness, organizational ethics, compliance 101, and other compliance topics.

Sheryl Vacca, CHC
Senior Vice President/
Chief Compliance and Audit Officer
University of California, Oakland, CA

Sheryl Vacca is Senior Vice President/Chief Compliance and Audit Officer for the University of California. Prior to this, Sheryl was director in the Health Care and Life Science Regulatory Practice with Deloitte. With more than 28 years in the health care industry, Sheryl has a significant amount of experience in health care and life sciences compliance, regulatory, internal audit and dispute areas. She has been involved with the development of compliance and operational controls; quality assurance/improvement programs; HIPAA privacy programs; and has expertise in providing advice on regulatory compliance issues for health and life science clients focusing on internal control process; billing and coding system issues; financial and compliance due diligence; operational design and fraud and abuse investigations, including voluntary disclosures to enforcement agencies, fiscal intermediaries and carriers.

Angelique Dorsey
Research Compliance Officer
Tulane University
New Orleans, LA

In her capacity as Research Compliance Officer for Tulane University, Angelique Dorsey is responsible for creating, leading, and monitoring the university-wide compliance efforts involving human subjects, regulated biological materials, animals, radiation, and grants and contracts administration. Ms. Dorsey also oversees the operations of the Institutional Review Boards, the Institutional Biosafety Committee, and Radiation Safety Committee. Prior to this, Ms. Dorsey served as president of Axis Research & Consulting, Inc. where she provided research and writing services to private and governmental entities, wrote chapters in a state civil practice manual for a major legal publisher, and advised businesses on organizational structure, operations, and personnel compliance.

Frank E. Sheeder III, CCEP
Partner
Jones Day
Dallas, TX

Frank Sheeder's practice is focused on complex health care litigation and regulatory compliance. He represents health systems, hospitals, physician groups, DME suppliers, long-term care providers, ancillary providers and other members of the health care industry in defense of False Claims Act, whistleblower and class action cases, compliance matters, internal investigations, negotiations with federal regulators and prosecutors, voluntary disclosures, annual compliance certifications, and related litigation. He has dealt with many government agencies, including HHS-OIG, OCIG, CMS, DOJ, FBI, Texas OIG and MFCU, AUSAs in various federal districts, IRS, DOL, Secret Service, Postal Inspection Services, and DEA.

David J. Heller
Chief Ethics and Compliance Officer,
Vice President Risk Management, Qwest,
Denver, CO

David (Dave) Heller was appointed Chief Ethics and Compliance Officer for Qwest in December 2002. He is responsible for ethics, corporate and regulatory compliance, security, disaster preparedness, claims, environmental affairs, safety and industrial hygiene, and risk finance & insurance.

Previously, he was Vice President, Risk Management, and Chief Compliance Officer, as well as an attorney for US WEST, Inc. and Safety, Security and Industrial Hygiene Advisor for Mobil Oil. Mr. Heller is a regular speaker on risk management and compliance issues and has taught in the graduate curriculum at the University of Denver.

Dave received his Bachelor of Science in fire protection engineering technology from Oklahoma State University, his master's degree in environmental policy and management from the University of Denver and his Juris Doctorate from the University of Denver School of Law.

is working, that it has made improvements over time, and what those are. A regular assessment provides the foundation for creating and maintaining that record.

JO: How frequently should an organization assess its compliance and ethics program?

PD: Every two years would be reasonable. These are huge undertakings and financially costly, and may have to be coordinated with other audits and assessments in a company. It takes time to incorporate what is learned from one assessment into the operational components, and measuring too frequently will not allow visibility into that process. I would not hold to any hard and fast rule, but look to see what would be considered reasonable for the company's size, geographic locations, budget, and similar factors.

JO: What have you found to be the single biggest challenge in your role?

PD: Making the transition from a legal environment to a more research-oriented role and to a non-profit setting has been the greatest personal challenge.

Coming from the Sentencing Commission, the budget that determined our staffing was set by Congress and, while we didn't often get additional funding, it was a relatively stable financial environment where concerns about funding were not a high priority for a staff member like myself, and we could focus on our substantive projects. We had very dedicated staff and supervisors, and if you as a staff member had the willingness and energy to take out an extra project, you would get the support you needed.

In contrast, ERC, as a non-profit, has to raise funds to do its research and analysis. While I am not directly involved in this, I have come to learn the very different dynamics involved in taking on projects and to appreciate the fine leadership job that ERC President, Pat Harned, has done to re-focus ERC on using surveys and assessments to generate new knowledge and inform the public dialogue. ERC used to be involved in code development and training, but we have refined our focus so we can concentrate on effective evaluations and are mining our data to generate deeper understanding of what affects ethical conduct in organizations.

Learning all of the fine points of our survey and integrating our research data is a constant new challenge for me in preparing my policy analyses and speeches. ERC staff is very helpful and patient in training me and sharing their knowledge.

JO: Where do you see the compliance and ethics world going in the next five years? Ten years?

PD: I see compliance and ethics officers becoming even more established as a profession. The efforts to provide systematic training and certification through the SCCE and HCCA will start to bear fruit and inroads will be made with colleges and universities to introduce and cross-fertilize courses. U.S. based professionals will start to incorporate ideas and approaches from European and Asian-based enterprises and will become more active in what are now called "social responsibility" issues, although that terminology is fluid and likely to evolve as well. There will be a greater realization that ethics professionals, with their commitment to integrity, will be valuable internal allies for many of its responsibility issues. I think that universities and colleges will start to incorporate training for this curriculum – it will be interesting to see if business schools take the lead in this, or if the education departments perceive this next wave of innovation.

JO: What recommendations do you have for individuals looking to focus their careers in compliance and ethics?

PD: Obtain a sound grounding in actual operational work within various organizations in order to learn the ropes and the challenges of the workplace. Develop skills at being an effective communicator and negotiator, including persuasion and the ability to work with all types of people. Learn from setbacks to try another approach to your objective. Have an interest in some of the legal and philosophical bases for business ethics. Learn about and develop experiences in global social issues and trends. Maintain a strong backbone; have a serious commitment to integrity and a willingness to walk away from employment that threatens to compromise your personal commitment and reputation.

JO: What do you do to relax and have fun?

PD: I build and redesign and rebuild my garden, in one area trying to get English cottage garden plants to tolerate the Washington DC humidity and in another section, incorporating native plantings so I can balance my potential for success.

I like to hike and visit archaeological sites and wilderness areas. I also study and collect folk art and visit museums, particularly in smaller cities and towns, and am starting to do some research in this area. I probably need to improve my photography skills to accomplish this. ■

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New HCCA Members

The Health Care Compliance Association welcomes the following new members and organizations. Please update any contact information using the Member Center on the Web site, or e-mail Karrie Hakenson (karrie.hakenson@hcca-info.org) with changes or corrections.

Hawaii

- George Apter, Hawaii Health Systems Corp

Illinois

- Jedediah L. Cantrell, MBA, RHIA, Graham Hospital
- Bethany Martell, University of Chicago
- Meagan Walsh, Gateway Foundation, Inc.

Indiana

- Joe Wilson, BS, CIA, CGAP, AVANTAGE Health Solutions Inc

Kansas

- Eric V. Eliason, MBA AIRC, The Epoch Grp
- Sherry K. Scott, Ms., Via Christi Health

Kentucky

- Robert Benvenuti, III, Barnett Benvenuti & Butler PLLC
- Gwen H. Holland, Univ. Of Louisville
- Jami S. Hughes, Lifeskills, Inc

Louisiana

- Kelli M. Carpenter, Ochsner Health System
- Kathryn M. Covington, RT, Highland Clinic APMC
- Paula C. Cox, Benton,Benton & Associates
- Mary L. Kelly, BSN RN, Medical Cntr of LA
- Nina M. McCombs Hix, McKesson
- Mary Miller, Terrebonne General Medical Cntr

Maryland

- James M. Cesare, Parente Randolph LLC
- Lawrence Edward Levine, Howard University Health Sciences

Massachusettes

- Daniel Barzman, Blue Cross and Blue Shield of MA
- Lillian Hong, Masspro

Michigan

- Cynthia L. Bevelhymer, LBSW, Riverwood Cntr
- Feana S. Humphrey, Hospice of MI
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- Michelle Whittaker-McCracken, CPC, The Whittaker Group

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- Judy Kluver, PrimeWest Health
- Jane M. McGrath, BS, RHIT, CPHQ, Stratis Health
- Ms. Therese A. Stecher, Associated Anesthesiologists, P.A.

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- Dana Carlson, Pender Community Hospital
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- Kathy A. Corbett, Lincoln Surgical Hosp
- Melissa Kelly, Pender Community Hospital
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- Nancy Dean, UMDNJ
- Nancy La Vecchia, Trinitas Comprehensive Cancer Center (Aptium Oncology)
- Deborah Samuels, University of Medicine and Dentistry of New Jersey

Neveda

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- Ellen R. Parish, RN MPH, Isabella Geriatric Center
- Greg Radinsky, Northshore Univ Hospital
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- Wanda G. Scott-Cain, CPC, Duke University Hospital
- Sherrie Settle, Univ of NC At Chapel Hill

North Dakota

- Mrs. Amy J. Hornbacher, CHFP, St Alexius Medical Ctr

Ohio

- Diane L. Burns, Summa Health System
- Sue E. DeShetler, RN, Promedica Hlth Sys
- Craig Hemminger, Summa Health System
- Doneta M. Jenner, RN, Smith Clinic

Oklahoma

- Keith J. Kantner, RN, BSN, Cancer Treatment Ctrs of America

Oregon

- Steve Gasparich, CIA, Providence Health Sys
- Teresa M. McMeans, MPH, CHC, Kaiser Permanente
- Sheri Russell, RN,BSN,CCP, Portland VA Medical Center
- Lisa Wood, Salem Hospital

Pennsylvania

- John A. Beattie, CPA, CFE, Parente Randolph, LLC
- Steve Birek, Conemaugh Health System
- Delia S. Chrismon-Diggs, Cancer Treatment Ctrs of America

Security breaches at the VA: *...continued from page 49*

at medical supply companies would close shop at the first sign of government trouble, only to reopen under new identities. Since the inception of the strike force, real-time analysis and the claims data have helped investigators obtain indictments of both individuals and companies that have billed Medicare for over $142 million.

The task force efforts in South Florida are simply the first phase of a continuous operation aimed at curbing such egregious fraudulent activity. The Attorney General of the United States declared that South Florida was chosen as the starting point for this effort because of its reputation as a high-risk area for Medicare fraud. During the investigation, reports described blatant practices of fraud committed by several Miami medical equipment companies, whose vacant offices sometimes were furnished by little more than a single desk chair. The Attorney General further indicated that similar efforts will be employed in other high-risk areas around the country. Given the success of the new investigative techniques in its initial run in Florida, real-time billing analysis would seem to be a permanent thorn in the side of those who intend to defraud the Medicare program.

Conclusion

In the past, individuals or companies simply needed access to certain Medicare information, which originates from many sources, from legitimate patient interaction to security breaches like those experienced at the VA. With that information, individuals or companies can formulate schemes with patients, physicians, medical equipment companies, pharmacies, and others to create false claims that induce payment from federal health programs. After years of individual agency efforts with limited resources, a sharing of agency resources has commenced to capture those who would defraud federal health programs. The biggest impact can be felt through the introduction of real-time billing analysis, which can alert authorities of fraud as it is happening. This technique has already shown its effectiveness, and now there are plans to expand into high problem areas throughout the nation. ■

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