Objectives

- What elements should a comprehensive physician compliance program include?
- Strategies for engaging physicians in the process
- How to pass the ‘effectiveness’ test and stay out of trouble with the regulators
About Me

- Focus = contract negotiations
- How does that make me an ‘expert’ on Compliance? . . . .

Terms of a Payor Contract

Confidential Information. Any information that identifies a Member and is related to the Member’s participation in a Plan. The Member’s physical or mental health condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, “individually identifiable health information”, as defined in 45 C.F.R. § 164.514 and “protected health information” as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act. Confidential Information may be shared by Payor for the purpose of securing or effectuating a Plan, obtaining and using information about a Member to determine the existence of a Plan, obtaining and using information about a Member to determine the plan benefit to which a Member is entitled, for the purpose of billing a Member, or for any other purpose related to the administration and payment of a Plan.

Covenant. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Participating Group Physician.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

Covering Physician. A Participating Provider designated by a Participating Group Physician to provide Covered Services to Members when a Participating Group Physician is unavailable (e.g., out of the office or on vacation).

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member’s Plan before benefits will be paid.

Emergency Services. Those services necessary to treat a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her fetus, in danger; (b) serious dysfunction of any bodily organ or part; or (c) serious disfigurement of any bodily organ or part; or such other definition as may be required by applicable law.

Group Physician. A duly licensed and qualified physician who is employed by, or who is a partner or shareholder of, Group.

Medical Necessity. Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) medically appropriate, in terms of type, frequency, extent, site and duration, and consistent with standards of care prevailing at the time the services are furnished; (c) necessary to the diagnosis or treatment of patient’s illness, injury, disease or condition(s); (d) provided in a medical facility to a patient or other health care provider, and not more costly than an alternative service or level of service at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient’s illness, injury, disease or condition(s). For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed literature and that are either (i) recommendations of recognized physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Policies. The policies and procedures promulgated by Payor which relate to this Agreement, including but not limited to: (a) quality improvement/management, (b) utilization management, including, but not limited to, pre-certification of elective admissions and procedures, concurrent review of services and referral processes or protocols, (c) pre-admission testing guidelines, (d) claim payment review, (e) medical necessity/abuse and inappropriate use, (f) nonparticipation/termination, (g) plan change, (h) fraud and abuse, (i) complaint resolution, (j) changes in benefits, (k) plan termination, (l) any applicable Participation Criteria as set forth in the Participation Criteria Schedule attached hereto and made a part hereof. Policies also include those policies and procedures set forth in the Payor’s existing internet website, which is available via a password-protected website located at www.Payor.com, and other policies and procedures, written or oral, that are available via a password-protected website.
More terms of a Payor Contract

• Call coverage
• Handicap access
• Accommodations or interpreters for *no habla Inglés* or hearing-impaired patients

All this “compliance” for:

• A typical office visit that reimburses:

  $70.29

• Or, for Medicaid providers:

  $51.32
**Private Practice Physicians in Colorado**

Last data I had from AMA in early 2000s:
In Colorado there are 11,420 licensed physicians:

Of the total physicians, 9,672 or 85% are actively practicing medicine in Colorado (entire PIE).

Of those, there are 7,360 (or 76%) who are office-based (not teaching, residents, research) (red piece of pie).

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**Where does Compliance fit into your overall practice planning:**

- **Majority of survey respondents “It’s my job.”**
Compared to other Practices, I believe our Compliance Efforts are:

Does your Practice have a Mission Statement?

Yes 47%
No 53%
Does your Practice have a Compliance Officer?

- Yes: 79%
- No: 21%

Does your Compliance Officer have a Position Description?

- Yes: 33%
- No: 67%
My practice has written policies and procedures.

Written Policies & Procedures

Yes 53%
No 47%

Everyone in the practice knows where the written compliance policies and procedures are located.

Everyone knows where the Policies and Procedures are located

Yes 43%
No 57%
To the best of my knowledge, “compliance” was last addressed in my practice in this year:

When Compliance was Last Addressed

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2012</td>
<td>40%</td>
</tr>
<tr>
<td>2011</td>
<td>5%</td>
</tr>
<tr>
<td>2010</td>
<td>10%</td>
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<tr>
<td>2009</td>
<td>15%</td>
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<tr>
<td>2008</td>
<td>20%</td>
</tr>
<tr>
<td>2007</td>
<td>25%</td>
</tr>
<tr>
<td>Greater than 6 years or Never</td>
<td>30%</td>
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</tbody>
</table>

To me, “compliance” means:

- “following the rule”
- HIPPA [sic]
- “more work”
- “compliance = OIG”
- “doing the right thing”
The formal training I’ve received on compliance was:

- Mix of local conferences and webinars
- HIPAA (2001)
- “Spotty”
- “None” (25% of respondents)

For my practice, “compliance” efforts should be allotted an annual budget of:

For the practices that gave a dollar amount, the annual average was:

$1,215
For my practice, “compliance” efforts should be allotted an annual budget of:

- 37.5% of respondents said “0” or “no budget.”
- 1 wrote, “It really isn’t budgeted and really can’t afford it. We can’t hire someone to just worry about compliance. Ridiculous.”

I care about “compliance:”

- Every day
- Once a month
- When something happens, like an employee quits or a patient complaints
- Never
“When something happens . . .”

- Disgruntled employee
- Unhappy patient
- EquiClaim letter

WHAT ELEMENTS SHOULD A COMPREHENSIVE PHYSICIAN COMPLIANCE PROGRAM INCLUDE?
Summarizing the Big Payor Agreement only, a “comprehensive” program would have to include (in alphabetical order):

- Business & Profession Code (fraud & criminal activity)
- CLIA
- Collecting copayments, deductibles, etc.
- Collection policies for pursuing bad debt
- Continuing education
- Correct coding: CPT, ICD-9, HCPCS, NDC
- Credentialing, such as current licenses
- Credit balance resolution on overpayments

Summarizing the Big Payor Agreement only, a “comprehensive” program would have to include:

- DEA
- Disabilities
- Each payor’s unique policies (QM, UM, precert, referral, claims, access, continuity of care, etc.)
- Electronic claims & remittance advice & funds transfer
- Emergency treatment
- False claims
- FDA
- Fraud & abuse
Summarizing the Big Payor Agreement only, a “comprehensive” program would have to include:

- Generally accepted standards of medical practice for the specialty
- Health & Safety
- HIPAA
- Hospital privileges
- Insurance (malpractice, general, auto, D&O, workers’)
- Internal auditing & monitoring
- Language assistance program
- Medical records (documentation, retention, copies, access)
- Non-discrimination

Summarizing the Big Payor Agreement only, a “comprehensive” program would have to include:

- Patient written consent & authorizations
- Peer review
- Prohibition of kickbacks
- Radiology
- Rules around use of Non-Physician Providers
- Self-referral
- Staff education
A sampling of PCMH Standards:

- Access during office hours & after-hours
- Electronic access to patients
- Continuity of care
- Medical home responsibilities (coordination)
- Culturally and Linguistically Appropriate Services (CLAS)
- A practice “team”
- EHR for patient demographic & clinical data
- Comprehensive health assessment, etc.
Not to mention Meaningful Use

- For a small practice this can mean a significant investment of time and resources with barriers including:
  - Hardware, software, and interface costs
  - Slowdowns in productivity due to staff training
  - Limited physician time to devote to meaningful use project management

- Providers must certify that they’re in compliance
  - Compliance/False claims issues if they’re not?!

- Providers will be penalized for not achieving MU in future years

<table>
<thead>
<tr>
<th>Asthma pharmacologic therapy</th>
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<tbody>
<tr>
<td>Asthma assessment</td>
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<tr>
<td>Appropriate testing for children with pharyngitis</td>
</tr>
<tr>
<td>Oncology breast cancer: Hormonal therapy for stage II-IV estrogen receptor/progesterone receptor (ER/PR) positive breast cancer</td>
</tr>
<tr>
<td>Oncology colon cancer: Chemotherapy for stage II-IV colon cancer patients</td>
</tr>
<tr>
<td>Prostate cancer: Avoidance of overuse of bone scans in low risk prostate cancer patients</td>
</tr>
<tr>
<td>Smoking and tobacco use cessation, medication, and tobacco use cessation medications</td>
</tr>
<tr>
<td>Diabetes: Eye care</td>
</tr>
<tr>
<td>Diabetes: LVSD</td>
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<tr>
<td>Diabetes: Retinopathy</td>
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<tr>
<td>Diabetes: Glaucoma</td>
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<tr>
<td>Diabetes: Hearing loss</td>
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<tr>
<td>Coronary artery disease: Oral anticoagulant therapy prescribed for patients with CAD</td>
</tr>
<tr>
<td>Heart Failure: Beta-blocker therapy for LVSD</td>
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</tbody>
</table>
| Anti-hypertensive medication management:  
  - Effective acute phase treatment;  
  - Effective continuation phase treatment |
| Primary open angle glaucoma: Cataract nerve evaluation |
| Diabetic retinopathy: Documentation of presence or absence of macular edema and level of severity of retinopathy |
| Diabetic retinopathy: Communication with the physician managing ongoing diabetes care |
STRATEGIES FOR ENGAGING PHYSICIANS IN THE PROCESS

What is Compliance?

- Practical definition:
- We should all follow the rules & regulations
- But how?
What is Compliance?

• ... to conform, submit or adapt (as to a regulation)

• Compliance happens in every organization, as employers strive to comply with employment and labor law guidelines for safe workplaces and a responsible organization, including:

What is Health Care Compliance?

• Health care industry has to comply with the federal government’s expectations for participating in and receiving payment from its Medicaid and Medicare health insurance programs
Health care Compliance

**Fraud & Abuse Laws**
(for billing and reimbursement)
- Physician Self-Referral Law (STARK)
- Anti-Kickback Statute
- False Claims Act
- Civil Monetary Penalty Laws
- Exclusion Authorities

**Also:**
- HIPAA
- EMTALA
- PPACA (Healthcare Reform)
- ADA
- OSHA
- Human Resource Law
- Personnel policies’
- CLIA
- Etc.

Who cares about Compliance?

- **Uncle Sam cares about compliance if a physician accepts payment for health care services paid for by Uncle Sam**

- **Commercial payers are getting in the game as well**
Why YOU should care about Compliance?

• Tangible benefits
  – Abide by applicable laws and regulations
  – Reduce exposure to civil damages, criminal sanctions, and administrative remedies, such as program exclusion
  – Demonstrate commitment to good corporate conduct

Why care about Compliance?

• Tangible benefits of complying
  – Identify & prevent criminal and unethical conduct
  – Procedures for prompt, thorough investigations of alleged misconduct
  – Initiate immediate and appropriate corrective action
Why care about Compliance?

• Tangible benefits of complying
  – Centralized source of information on health care regulations
  – Methodology encouraging employees to report problems
  – Improve quality of patient care

Why care about Compliance?

• Intangible benefits of complying
  $Good investment in your practice
  – Peace of mind that rules are being followed
Why care about Compliance?

- Intangible benefits of complying
  - Decrease the risk of whistleblowers
  - Clear and consistent message to employees

THE 7 ELEMENTS
I am aware of the OIG Individual and Small Group Voluntary Compliance Plan from 2000.

What is a Compliance Plan?

- There is not a “One Size Fits All” Compliance Plan

- However, the OIG believes any Compliance Plan has 7 basic elements...

- ...and they’ve recently (informally) added one more to total 8
Compliance Plan – Basic Elements

1. Written Policies & Procedures
2. Designating a compliance officer or contact
3. Conduct appropriate training and education
4. Effective lines of communication

Compliance Plan – Basic Elements

5. Internal Monitoring
6. Enforcement of Standards
7. Prompt Response
8. ENSURE IT IS EFFECTIVE—periodically reassess the compliance program and make necessary changes
FIRST – CREATE A CODE OF CONDUCT

Does your Practice have a Code of Conduct?

- Yes: 47%
- No: 53%
Start with a Snapshot

- OIG suggests at inception of a Compliance Program, a review “snapshot” of operations be done to judge later progress in reducing or eliminating potential areas of vulnerability

Baseline Audit “How To”

- OIG Work Plan issues
- Any previous audit findings
- Existing policies
  - Are they appropriate? Followed? Missing?
- Analysis of current education & training
  - Attestation & attendance forms?
- Government regulations
  - Updates?
- Professional association insights into current issues/trends
- Professional liability carrier newsletter of potential risk areas
- Interview staff
  - Write-up & let them review
- Minutes of Board or Compliance Committee
Physicians want to know . . .
“What’s being enforced?”

Recent Enforcements

- Phoenix Cardiac Surgery
- Online schedule (unsecured)
- E-mails from internet site to staff that contained ePHI
- Like most private practices:
  - NO implementation of HIPAA Privacy (since 2003)
  - NO implementation of HIPAA Security (since 2005)
  - Few P&Ps, no training, no security official, no risk analysis, no business associate agreements
False Claims Act

Federal government’s #1 tool for fighting fraud & abuse
- $5,000 to $10,000 for each false claim
- 3 x damages to federal programs

• Violations of other fraud & abuse laws can result in a “false claim” to the government, triggering False Claims Act liability

False Claims Act

• Celebrated 25th birthday this January
• In 25 years – OIG has returned $30 billion dollars to government*
• 638 “whistleblower” cases in 2011 alone
  – Up from average of 300/year
• ROI: for every $1 government spent on enforcement, government received $7 in return**
Medicare/Medicaid Exclusion status

✧ Look up all providers against:
  ✧ OIG’s List of Excluded Individuals and Entities
  ✧ GSA’s “List of Parties Debarred from Federal Programs”


✧ Do this for all new hires – and at least quarterly for all others! DOCUMENT IT!

“Mandatory” Compliance Programs Coming “Soon”...

Patient Protection and Affordable Care Act (PPACA)

PPACA provisions mandate compliance programs for Medicare and Medicaid providers

– § 6401 applies to ALL Medicare and Medicaid providers

– CMS HAS NOT FINALIZED THE REQUIREMENTS!

– THERE IS NO DEADLINES FOR THESE ACTIONS YET!
I am aware that the Patient Protection and Affordable Care Act will require all Medicare and Medicaid providers to have mandatory compliance plans in the future.

**Documentation of Your Program**

- Corporate Compliance Plan
  - The “binder”
  - Include 8 elements
- Code of Conduct
- Policies relating to operation of compliance program
- Policies addressing organization’s principle legal (substantive) risks
- Employment policies
HOW TO PASS THE ‘EFFECTIVENESS’ TEST AND STAY OUT OF TROUBLE WITH THE REGULATORS

Effectiveness

● 1\textsuperscript{st} create the “plan”
● Long-term goal:
  “Prevent & Detect”
Dedicate Resources:

- Compliance Expertise (full-time employee, part-time employee, outside consultant, etc.)
- Staff education (in-house)
- Printing & distributing of “Code of Conduct”
- Time to review & revise Policies & Procedures

More Budget Items for Physicians

- Legal assistance/review
- Coding education/books
- Conference for compliance officer/physicians
- Compliance organization membership and publications
- External chart auditor – every 3 years?
- Facility/food expense for trainings/meetings
- Confidential hotline
- Annual retreat for Management to ensure updates
Evaluating Effectiveness Ideas

Possible Metrics of an effective Compliance Program:

- Staff knowledge
  - Pre & post tests
  - Quizzes
  - Skits/role play
- Educational sessions
- # hrs. logged on compliance
- # policies & procedures reviewed
- # charts audited
- % of denials in claims
- # mtgs with compliance on Agenda (Staff, RN, BoD, Compliance Cmte, finance, billing)
- # of CPCs on staff/MDs
- # of CHCs on staff/MDs
- # of Networking contacts for compliance related questions/issues in contacts database

Sentencing Guidelines
“mitigating factors”

1. Compliance reports to Board
2. Uncovers criminal conduct before likely to be discovered
3. Promptly reports
4. No compliance officer participated in or condoned
WHERE DO WE GO FROM HERE?

Open Ended Survey Comments:

“"I know it’s a valuable and necessary thing, but in rural, small practice groups, we don’t always have the money, time or resources to be up to date on all issues. Especially when the Security Officer, Compliance Officer, and Practice Administrator are all the same person.”
Open Ended Survey

Comments:

“Compliance is ridiculous for small physician practices we don’t have the money or staff to have full-blown Compliance Plan. Should we have some guidelines in place – yes. Just too much brain damage and I want a life outside the office.”

I would be interested in a step-by-step manual that is geared to physicians to help walk my practice through creating a Compliance Plan.

![Pie Chart]

- Yes: 73%
- No: 17%
Master’s Degree in Health Administration

According to the accreditation standards for higher education in the field of health administration, you can get a Master’s degree with the following Domains:

1. Business Knowledge & Skills, such as Investment & Financing
2. Management in the Healthcare Environment, such as population health, medical terminology
3. Professionalism, such as communication skills

Where is “Compliance”?

Better Survey Now Available

www.physicians-ally.com
CMGMA Partnership?

• 12/5 Board meeting
  – Proposing a seat on the board for “Compliance”
  – 400 members, 5,000 physicians
  – Future collaboration with HCCA
Resources

- OIG website (www.oig.hhs.gov)
- OIG Provider guidance for physicians: oig.hhs.gov/authorities/docs/physician.pdf
- OIG Provider guidance for 3rd party medical billing companies: oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf
- Medicare Learning Network (MLN) at www.cms.gov/MLNGenInfo
- Fraud specific: www.stopmedicarefraud.gov
- Compliance 101 2nd Edition, Debbie Troklus & Greg Warner