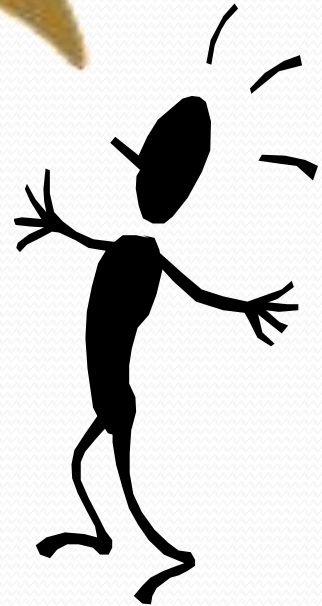
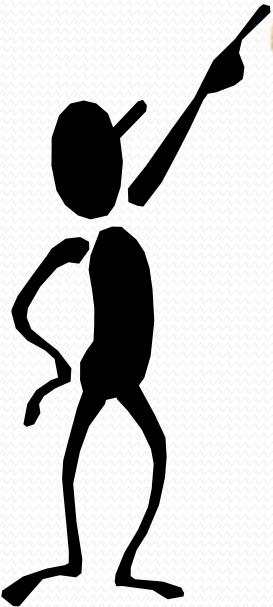


How to develop and implement a...

“COMPLIANCE PLAN!”

BY
DENISE M.
SHOEMAKER
CPC-A, CPMA



“The success of your presentation will be judged not by the knowledge you send, but by what the listener receives.”

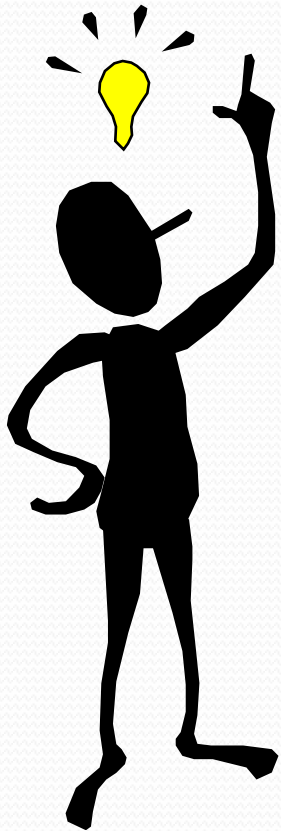
-Lily Walters ~ author, motivational speaker

In my opinion ~

“There really is no wrong or right way on how we “interpret” coding and documentation rules. Each decision that a coder or an auditor can make is based on knowledge that is true to them...our coding world has so many shades of gray and we as coders have the right to choose which shade of gray works for us.”

-Denise M. Shoemaker CPC-A, CPMA

First of all get familiar with...



- Medicare rules and your local carrier (IE. Noridian, Palmetto, etc.)
- RAC (Recovery Audit Contractors) and their website
- Coding trends
- Coding rules
- Your local coding chapter (Great for networking and obtaining new knowledge)
- Online coding resources (AAPC, NAMAS, E/Muniversity.com, etc.)

Seven Steps for a successful compliance plan

“Here are the seven steps the OIG suggests solo and small group practices use to create an effective compliance program as well as practical tips for incorporating each of them.” - Mark S. Kennedy, JD

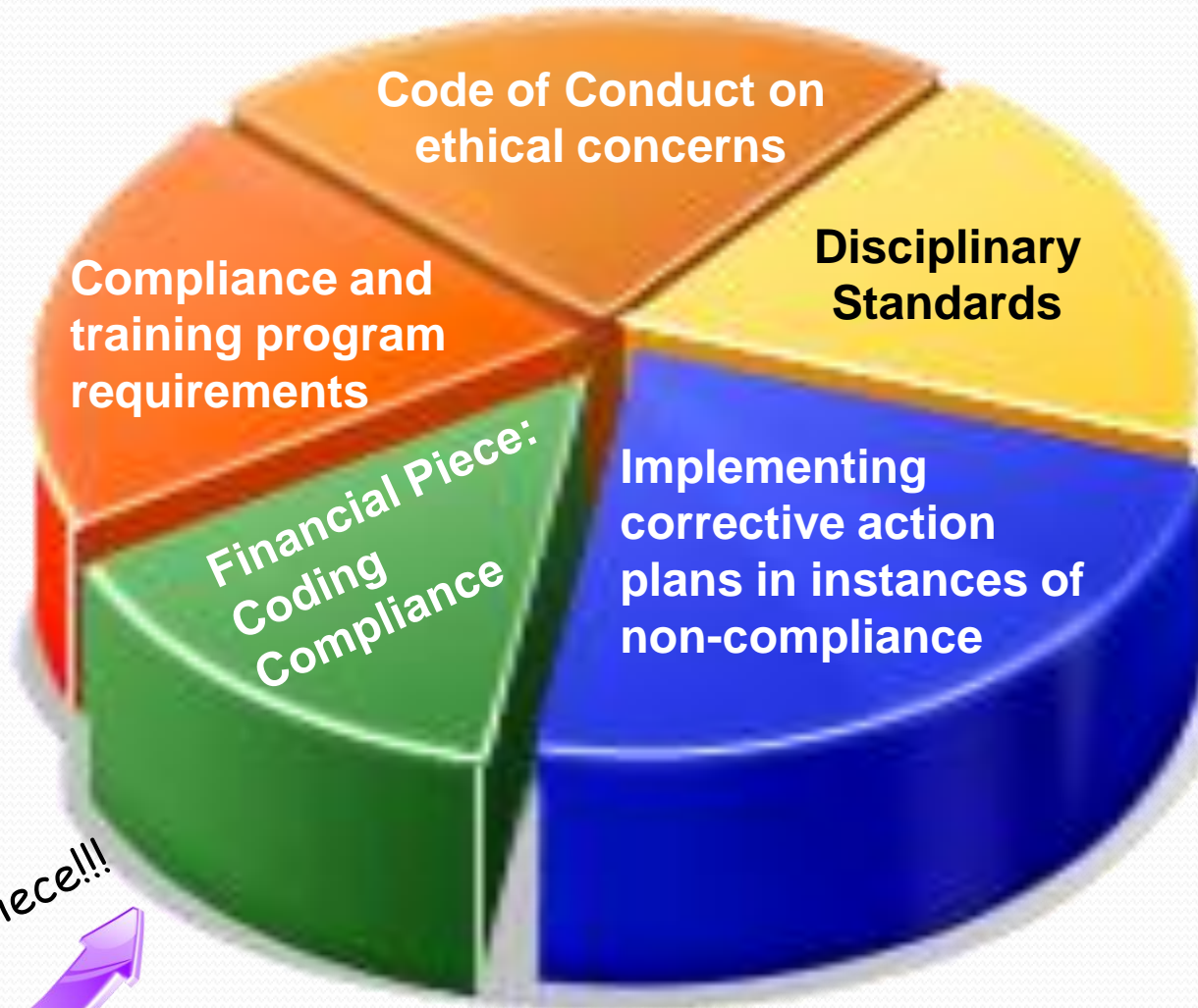
Mark Kennedy is a lawyer in the Dallas law firm of Cochran & Cochran, PC, and represents physicians in a variety of compliance, reimbursement and fraud-and-abuse matters. Before entering private practice, he was agency counsel for the Inspector General and HCFA in matters involving Medicare, Medicaid and other health care programs.



According to Marc S. Kennedy's article:

“A compliance program doesn't have to be perfect, but it must be effective -- and each practice has the burden of demonstrating its effectiveness to obtain the benefit of reduced culpability.”

“The slices of a corporate compliance plan.”



This is our piece!!!

The seven steps that we are going to cover...

1. **Develop standards of conduct** ✓
2. **Establish a method of oversight** ✓
3. **Conduct staff training** ✓
4. **Create lines of communication** ✓
5. **Perform auditing and monitoring functions** ✓
6. **Enforce standards and apply discipline** ✓
7. **Respond appropriately to detected offenses** ✓



1. Claims are processed through A/R dept.

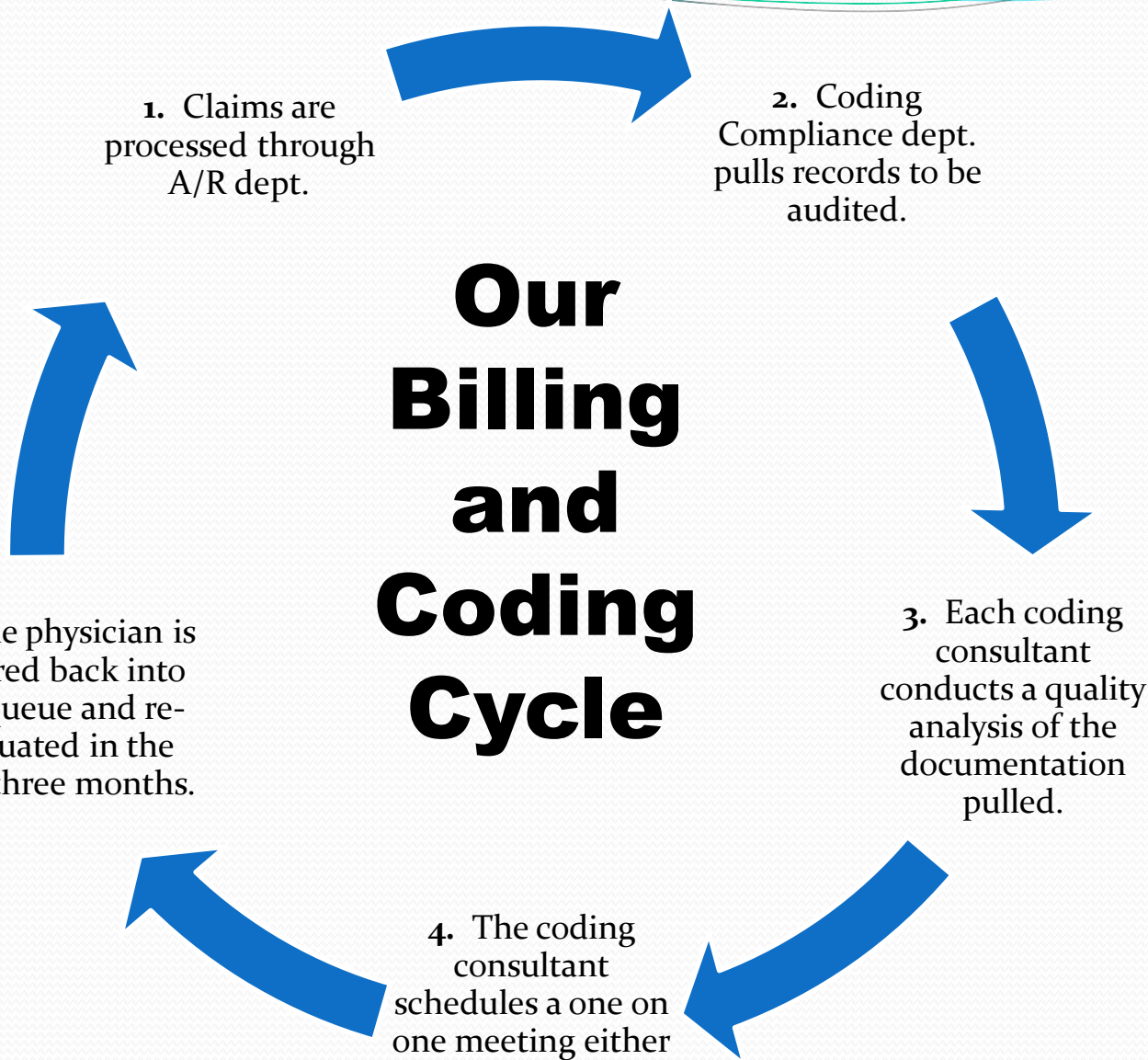
2. Coding Compliance dept. pulls records to be audited.

3. Each coding consultant conducts a quality analysis of the documentation pulled.

4. The coding consultant schedules a one on one meeting either face to face or over the phone to discuss findings.

5. The physician is entered back into the queue and re-evaluated in the next three months.

Our Billing and Coding Cycle



1. Develop standards of conduct. The first step to building your compliance program is to determine the types of fraud-and-abuse issues that might arise in your practice. The OIG guidance identifies risk areas that can serve as a starting point for an internal review of potential vulnerabilities. The OIG also suggests reviewing its current work plan and semiannual reports to identify additional risk areas. This information is available on the OIG's Web site at www.oig.hhs.gov/readrm/index.htm.

Once you've pinpointed your risk areas, identify employee responsibilities and expectations for each area and clearly state them in a code of conduct. The code should set forth your practice's commitment to compliance, and it should be supported by written policies and procedures that clearly explain how the compliance measures will be incorporated into your practice.

In our plan... "Our slice of the pie"

- ✓ *Start off with an internal coding/documentation audit of your practice.*
- ✓ *Get a good idea on which of your physicians tend to down code or over code.*
- ✓ *Analyze their coding and documentation patterns.*
- ✓ *Find out which set of documentation guidelines works best for them.*
- ✓ *Determine which physicians need continuous coding education.*

Coding/Documentation compliance tracker


<i>Office - D</i>	<i>#</i>	<i>Style</i>	<i>Audit Date</i>	<i>Audit Type</i>	<i># Correct</i>	<i>Accuracy %</i>	<i>Pattern</i>	<i># of charts</i>	<i>Method</i>
Doctor A	42	D - 97	12/10/2009	Office/95	6	60%	PFSH	10	FTF
Doctor B	50	D - 97	11/20/2009	Office/95	4	40%	HPI, ROS, PFSH, ICD-9	10	FTF
Doctor C	14	D - 97	12/17/2009	Office/95	0	0%	ROS, PFSH, EXAM	10	FTF
Doctor D	62	D - 97	TBS	Office/95	0	0%	Incomplete dictation	10	FTF
Doctor E	123	D - 97	11/30/2009	Office/95	5	50%	HPI, PFSH	10	FTF
Doctor F	61	D - 97	12/17/2009	Office/95	0	0%	HPI, PFSH	10	FTF

Key

Pattern - HPI, ROS, PFSH, EXAM, MDM, ICD-9 codes not supported by dictation

FTF - Face to face TBS - To be scheduled WFR - Waiting for records

NTY - Not time yet

 Need to schedule a follow up one on one

2. Establish a method of oversight. An elaborate set of rules is impractical if there's no mechanism for making sure the rules are followed. One alternative is to distribute the oversight responsibilities among several employees designated as "compliance contacts." For example, this responsibility could be shared between the office manager, who might be responsible for the written standards and procedures, and the primary biller, who might handle the arrangement of audits. Another alternative is to have a third party, such as a consultant or billing company, act as the compliance officer.

If a practice chooses to have one person or one group handle the oversight of the compliance program, the OIG suggests assigning the following duties to that person(s):

- Monitoring the compliance program implementation,
- Improving the efficiency and quality of services through auditing and other methods,
- Periodically revising the compliance program,
- Coordinating a compliance training program,
- Investigating allegations of improper conduct and monitoring corrective action.

No matter which method you choose, it's critical that all those involved in performing the compliance-officer function be sufficiently independent, free from conflicts of interest and not swayed by their other operational duties.

In our plan...

We have 3 people in our coding compliance department...

Denise M. Shoemaker CPC-A, CPMA
Coding Compliance Coordinator

I oversee auditing protocol and
physician education

Nancy Hove R.N. CPC-A
Certified Coding Consultant

Nancy oversees the clinical aspect
of coding and auditing.

Karina Valenzuela
Coding Assistant

Karina provides support to the coding
compliance department.

Each of our physicians get the following services and tools:



1. We start of with a welcome letter to our new physicians that explains what our department does and it also gives them a point of contact to refer to (Coding Consultant) if they have concerns or questions.
2. We give them our company Documentation Guidelines Reference Manual that contains coding tools, coding reference materials and examples of proper documentation.
3. We give them a company laminated pocket Coding Guide to carry with them to each office visit or in the hospital.
4. We give them a laminated Level of Risk table based on our specialty, that helps to eliminate the guess work when determining the level of risk.
5. We have an online MS Power Point Coding Class, that goes over basic E/M principles and how they can apply those principles in their documentation. They can review it as many times as they need to and at their convenience.

3. Conduct staff training. The written compliance standards should be effectively communicated to your staff. **This can't be accomplished through the mere distribution of instructional literature.** At a minimum, all employees must be made aware of the basic risk areas. All employees should understand how to properly do their jobs and realize that their compliance is a condition of employment. They must also understand how the compliance program works, their role in ensuring compliance and the consequences for violating the standards of conduct.

A compliance program doesn't have to be perfect, but it must be effective.

Specifically, those employees involved in coding and billing should receive extensive instructions on their responsibilities. The OIG suggests that coding and billing training cover the following: coding requirements, claim development and submission processes, the signing of physician forms without the physician's authorization, proper billing and documentation of services, and the legal sanctions for fraudulent billing. The OIG guidance is flexible as to how training of other employees should be conducted. It encourages the use of the most effective educational tools to communicate what is required of employees in the performance of their jobs. All training should be current, continuous, personalized to the needs of each employee and documented in each employee's personnel file.

In our plan...

We have a billing manager that oversees all Medicare and Commercial Plans, the coding compliance department works hand in hand with billing to ensure all coding and billing coincide with one another.

We audit based on post claim-submittal. When we educate our new physicians we conduct a one hour consultation after 30 days of clinic and hospital time. We bring their audit analysis along with the audited documentation. We go over every intricate detail in their dictation to show how we determined the level of service audited. We go over their documentation weak points and educate them on how to meet the level of service based on **Medical Necessity.** We audit every three months on office and hospital.

Audit and Analysis Sheet

Med Record number	Date of Service	Selected Level of Service	Documentation Supports	Missing key element(s) to support level of service billed	Chief Complaint	HPI / ROS	Past, Family and Social History	Exam
123456	4/1/2010	99291 Critical Care	99291 Critical Care	Coded accurately! No documentation requirements except time needs to be documented and the patient is in critical condition	Yes	4/10	3	Comp - 95
789101	5/12/2010	99255 Level 5 hosp consult	99255 Level 5 hosp consult	Coded accurately!	Yes	4/10	3	Comp - 95
121314	5/12/2010	99255 Level 5 hosp consult	99253 Level 3 hosp consult	The review of systems is what brought the level of service down, for a level 5 consult you need 10+ systems reviewed	Yes	4/5	3	Comp - 95
151617	6/18/2010	99233 Level 3 hosp progress note	99233 Level 3 hosp progress note	Coded accurately!	Yes	Brief/10+	Not required	Comp - 95
181920	5/13/2010	99233 Level 3 hosp progress note	99232 Level 2 hosp progress note	Medical complexity met at a more moderate level	Yes	Brief/10+	Not required	Comp - 95

A: Number of problem points	B: Level Of Risk	C: Amt and/or data to be reviewed	Medical Decision Making	Non-Supported ICD-9 Codes	Comments
4	High	1	High	Supported	Note met requirements for Critical Care
4	High	3	High	Supported	One or more chronic illnesses w/ severe exac or progression
4	High	3	High	Supported	One or more chronic illnesses w/ severe exac or progression
4	High	1	High	403.10 Benign hypertensive renal disease w/ out renal failure	Responding inadequately, one or more chronic illnesses w/ severe progression
4	Moderate	1	Moderate	Supported	One or more chronic illnesses w/ mild progression

4. Create lines of communication. A compliance program relies on enabling employees to report fraud and other improper conduct without fear of retribution. Because formal, high-tech communication procedures, such as hotlines, may not be practical for solo or small group practices, the OIG guidance suggests using simple and readily available procedures, such as an anonymous "drop box," to report instances of questionable conduct. In some cases, establishing an "open-door" policy between physicians, compliance personnel and employees may be adequate.

In our plan...

We are currently working on a "Hotline", for now we have an "open-door policy".

Our department does have a spreadsheet that keeps track on insurance denials and anonymous reports that are reviewed. Our goal is to educate, educate, educate. When you educate, you're being proactive on how to resolve issues in a positive way, also it keeps track on repeat offenders. This is a sample of what our spreadsheet looks like:

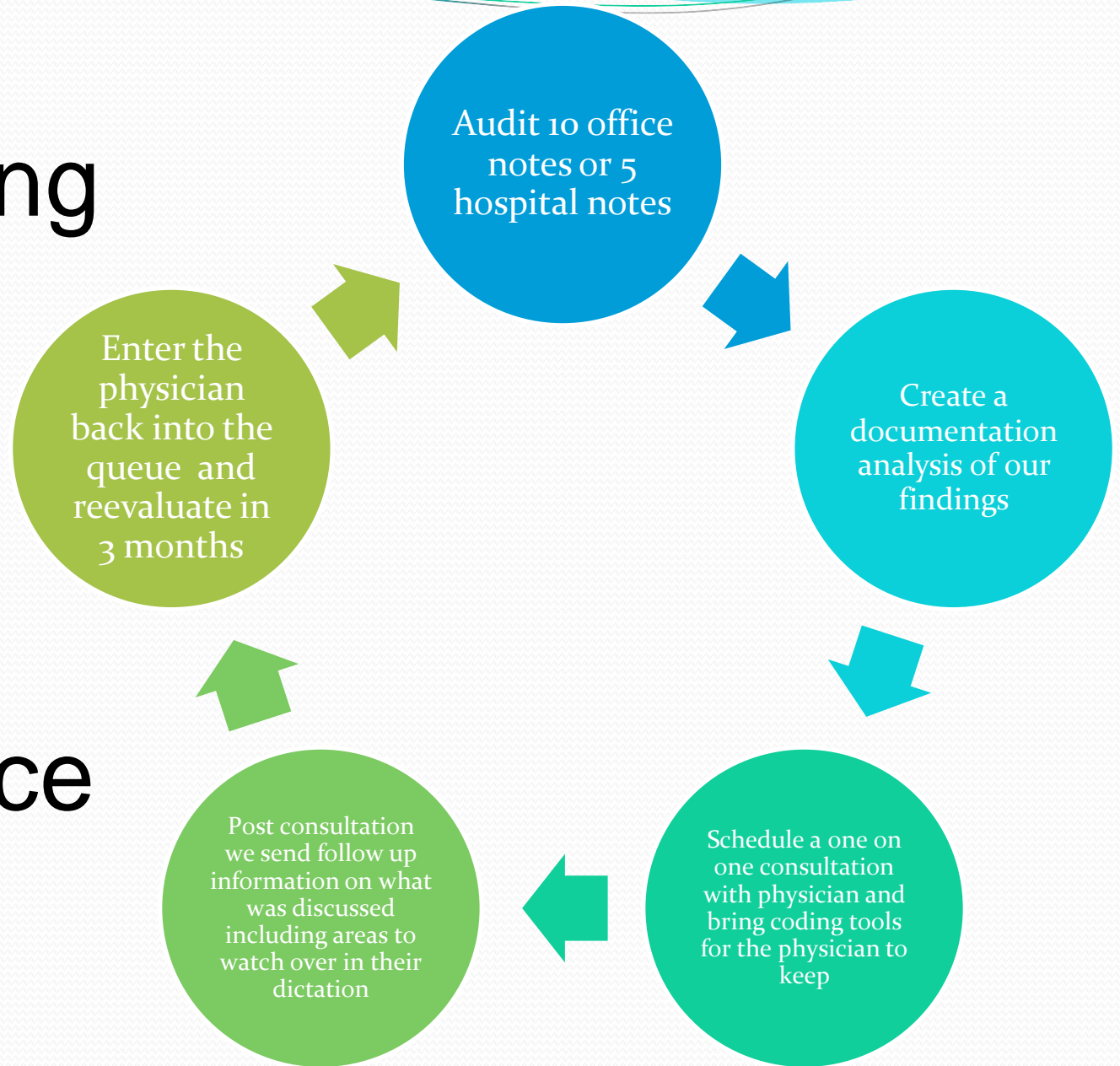
COMPLIANCE CONTROL LOG												
<i>Control number</i>	<i>Physician</i>	<i>#</i>	<i>Sector</i>	<i>Report date</i>	<i>Incident</i>	<i>Interviewer</i>	<i>Witness</i>	<i>Confidant</i>	<i>Interview date</i>	<i>Interview time</i>	<i>Report on file</i>	<i>Remedy</i>
1	Dr. Jane Doe	2	Central	1/1/2010	2				1/5/2010	2:30pm	Yes	4

5. Perform auditing and monitoring functions. A compliance program should continuously evaluate the standards to which it holds employees accountable. It should also assess whether employees carry out their responsibilities and whether claims for payment are proper and accurate. This should be done at least once a year by reviewing your practice's policies and procedures to ensure accuracy, timeliness and completeness, and conducting self-audits to determine if claims are accurately coded and services billed are reasonable, necessary and adequately documented. As a guide, the OIG suggests reviewing five or more medical records per federal payer or five to 10 records per physician. For more information about self-audits, see [“Using Peer Review for Self-Audits of Medical Record Documentation, “FPM, April 2000, page 28](#)

In our plan the philosophy is...



Our Coding and Auditing Cycle to ensure compliance



6. Enforce standards and apply discipline - Enforcement of standards and disciplinary actions are the "teeth" of a compliance program. Your practice should use consistent and appropriate sanctions and, at the same time, be sufficiently flexible to account for mitigating or aggravating circumstances. Employees who fail to detect or report violations should also be subject to disciplinary action. The range of disciplinary actions taken may include warnings, reprimands, probation, demotion, temporary suspension, discharge, restitution and referral for criminal or civil prosecution. All disciplinary actions should be well documented.

Let's look at an example on the following slide...



In a perfect world, this is what an ideal disciplinary hierarchy would look like...currently we have a open-door policy, on a case to case basis

1st.
Offense

- Verbal warning from Compliance Board
- Along w/ Coding and documentation education

2nd.
Offense

- Written warning by Chief Compliance Officer
- Along w/ Coding and documentation education

3rd.
Offense

- Probation (For 3 months code all visits pre-submittal)
- Along w/ Coding and documentation education

Final
Determination

- Monetary Penalty (Pay a fine towards offenses)
- Along w/ Coding and documentation education

7. Respond appropriately to detected offenses - According to the Healthcare Disclosure Statute, a provider can be prosecuted for his or her failure to disclose a known overpayment to the Medicare carrier even if the payment was not fraudulently obtained. Overpayments or errors that are not believed to be fraudulent should be reported directly to the entity responsible for handling those claims. However, fraudulent claims that have occurred in a provider's own organization can be disclosed to the OIG through its Provider Self-Disclosure Protocol. Instructions on how to submit a voluntary disclosure under this protocol can be downloaded from the OIG's Web site at

www.hhs.gov/oig/oigreg/selfdisclosure.pdf **The OIG points out that providers may want to consult an attorney prior to disclosing information.**

Although voluntarily disclosing fraud and abuse does not preclude prosecution, the OIG considers the act of doing so a "mitigating factor in [its] recommendations to prosecuting agencies." Expect closer scrutiny by the government if you refund a large overpayment. A May 2000 program memorandum from HHS to intermediaries and carriers indicated that any repayment equal to or greater than 20 percent of a practice's total annual Medicare payments would prompt further inquiry.

HR 4872 ENR Reconciliation Act portion:
SEC. 1303. FUNDING TO FIGHT FRAUD, WASTE, AND ABUSE.

“(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

“(1) IN GENERAL.—If a person has received an overpayment, the person shall—

“(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

“(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

“(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—

An overpayment must be reported and returned under paragraph (1) by the later of—

“(A) the date which is 60 days after the date on which the overpayment was identified; or

“(B) the date any corresponding cost report is due, if applicable.

“(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

“(4) DEFINITIONS.—In this subsection:

“(A) KNOWING AND KNOWINGLY.—The terms ‘knowing’ and ‘knowingly’ have the meaning given those terms in section 3729(b) of title 31, United States Code.

“(B) OVERPAYMENT.—The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

“(C) PERSON.—

“(i) IN GENERAL.—The term ‘person’ means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)),

H. R. 3590—638

Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D-41(a)(13)).

“(ii) EXCLUSION.—Such term does not include a beneficiary.

Piecing together the Compliance Plan

Develop standards of conduct

Establish a method of oversight

Perform auditing and monitoring functions

Streamlined

Full understanding of compliance protocol

Respond appropriately to detected offenses, re: overpayments

Safe guarded

Timely filing

Plan of action

Increased revenue

Create lines of communication

Decreased risk

Enforce standards and apply discipline

Conduct staff training

Peace of mind

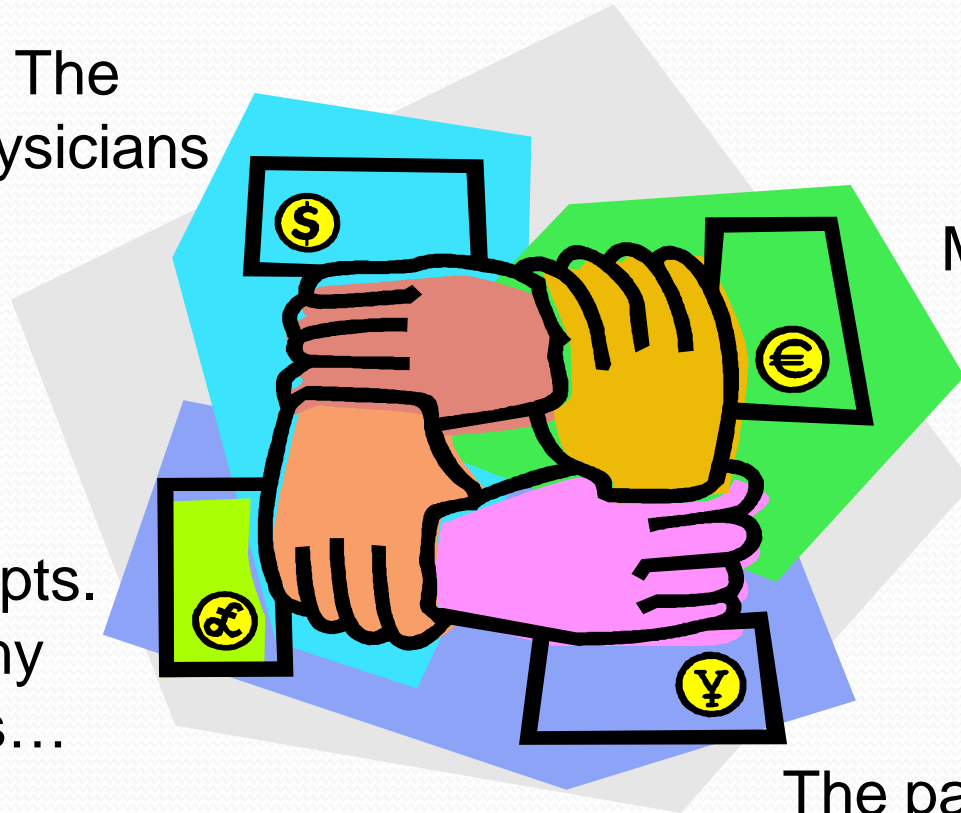
United as a company

So when you have a well functioning compliance plan we all benefit from it's success!!!

The
physicians

Medicare/RAC

Billing and
Coding Depts.
All company
employees...



The patients



Thank You!