Meet Rachael Kurzer Givens, CHC

Vice President of Compliance, ResCare
The Health Care Compliance Association has moved to its new headquarters, located at:

6500 Barrie Road, Suite 250
Minneapolis, MN 55435

While our address has changed, our telephone and fax numbers remain the same:

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And you can always reach us via e-mail at info@hcca-info.org or on our Web site at www.hcca-info.org

HCCA’s Compliance Institute
Call for Speakers

The Health Care Compliance Association (HCCA) will hold its 11th Annual Compliance Institute in Chicago, IL, at the Sheraton Chicago Cityfront Center, April 22–25, 2007.

The program is designed for compliance professionals from a variety of health care backgrounds, including compliance officers, billing and coding professionals, auditors, nurses, risk managers, ethics officers, privacy officers, and health information professionals.

If you would like to be considered as a speaker for the program, please visit our Compliance Institute Web site at www.compliance-institute.org to view more details and submit an online proposal. Submissions will be accepted until Wednesday, August 2, 2006.
John asks the leadership your questions

Editor’s note: This column is provided by John Falcetano, Chief Audit/Compliance Officer for University Health Systems of Eastern Carolina and a long-time member of HCCA. He knows that members frequently have good questions that they would like to ask leadership. This column has been created to afford them that opportunity. Members may submit their questions to John by e-mail at Jfalcetano@cox.net and he will contact members of HCCA leadership for their response.

I am trying to determine an appropriate sample size using Rat Stats. I do not understand what to select or what to enter for sample size determination. Please explain using the following example: Lets say my probe sample of 30 claims has a 20% error rate and I want determine how many of 50,000 claims I need to look at to be 90% confident of the results. What do I select, variable or attribute? Unrestricted or stratified? What is desired precision range?

Leadership response provided by Shawn DeGroot

There are several considerations and assumptions that need to be made in the course of answering your question. I will try to provide guidance in a chronological format that will ultimately lead to the answer of your question.

First of all, it is important to have a common understanding of the RAT-STATS statistical terms. The following terms and definitions are intended to aid in that understanding.

**Universe:** The quantity of items from which the sample was drawn.

**Probe Sample:** Items randomly selected and evenly distributed from the data universe.

**Mean (average):** The average value for the sample items appraised.

**Standard Deviation:** A measurement of the variation of the sample items about the average value (mean).

**Point Estimate:** A single estimate for the universe total based on the sample mean multiplied by the universe size.

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**2006 CONFERENCES (BY STATE):**
- Anchorage, AK
  - Alaska Area Meeting
  - July 13-14
- San Diego, CA
  - West Coast Area Meeting
  - July 28
- Denver, CO
  - Mountain Area Meeting
  - August 25
- Orlando, FL
  - Compliance Academy
  - November 6-9
- Honolulu, HI
  - Hawaii Area Meeting
  - October 19-20
- Chicago, IL
  - North Central Area Meeting
  - October 6
- Baltimore, MD
  - Medicare Part D
  - September 10-12
  - Fraud & Compliance Forum
  - September 25-27
- Boston, MA
  - New England Area Meeting
  - September 8
- Minneapolis, MN
  - Upper Midwest Area Meeting
  - September 15
- Kansas City, MO
  - Midwest Area Meeting
  - August 4

**Las Vegas, NV**
- 3rd Annual Research Conference
  - September 17-19
- Advanced Academy
  - October 23-26
- Pittsburgh, PA
  - Mid Atlantic Area Meeting
  - September 29
- Nashville, TN
  - South Central Area Meeting
  - November 10

**2007**
- Chicago, IL
  - Compliance Institute
  - April 15-18

**Continued on page 44**
On April 25, 2006, the Office of Inspector General of the Department of Health and Human Services (OIG) issued “An Open Letter to Health Care Providers” (Open Letter) offering helpful, but limited, guidance to providers on Stark enforcement. The Open Letter is a step in the right direction that, unfortunately, addresses only a subset of the enforcement issues raised by Stark violations.

Stark is the name commonly used for the federal physician self-referral law, which prohibits physicians from referring Medicare patients to entities for certain “designated health services,” if the physician (or an immediate family member of the physician) has a financial relationship with the entity, unless an exception applies. The designated health services affected by Stark are clinical laboratory; physical therapy; occupational therapy; radiology (including MRI, CT and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.

The basic penalty for Stark violations is the health care provider is not entitled to payment (and must refund payments previously received) for services provided pursuant to prohibited referrals. This penalty applies even if the provider has no wrongful intent, and even if the provider is not even aware of the Stark violation. Jurisdiction over this penalty, as well as primary jurisdiction over Stark generally, rests with the Centers for Medicare and Medicaid Services (CMS).

To date, one of the biggest hurdles with self-disclosing Stark violations to CMS has been that CMS takes the position that it does not have authority to negotiate a settlement that reduces the amount of the health care provider’s non-payment/refund obligation. Accordingly, a minor and inadvertent Stark violation can result in an enormous repayment obligation, especially if the violation involves many physicians, expensive services and/or the violation lasted for awhile before being discovered and corrected.

In addition to this basic non-payment/repayment penalty, Stark provides that for “knowing” violations, anyone submitting or causing the submission of claims for Medicare services provided pursuant to prohibited referrals may be subject to civil money penalties of up to $15,000 per service billed. Penalties for “knowing” violations are under the OIG’s jurisdiction. Unlike CMS, however, the OIG has been, for some time, taking the position that it can negotiate reduced settlement amounts with providers who self-disclose violations.

The Open Letter confirms the OIG’s willingness to negotiate settlement amounts, and suggests that providers use the OIG’s “self-disclosure protocol” when reporting Stark violations. The self-disclosure protocol provides basis directions on how to self-disclose violations to the OIG. For example, the disclosure must include basic information on the provider and its related entities, as well as a full description of the Stark violation, based on the provider’s internal investigation into the violation.

The disclosure should contain a narrative reflecting the nature and extent of the violation, including the potential causes, and its impact on, and risks to, health, safety and quality of care. The disclosure should identify the corporate officials, employees or agents who “knew of, encouraged, or participated in the matter” or “who should have known of, but failed to detect” the violation. The report should discuss the provider’s discovery of the violation and the steps taken to address the problem and prevent future violations. Finally, the provider must certify that the information provided is truthful and accurate, and is brought to the government’s attention for purposes of resolving the matter.

In terms of resolving the Stark violation, by far the most hopeful aspect of the Open Letter is a statement that those who self-disclose (depending on the circumstances) will generally be able...
to settle the violation by paying the OIG an amount based on the amount of remuneration paid to the physicians, rather than one based on the amount of Medicare payments received by the self-disclosing provider. This potentially means much lower settlement payments with the OIG, especially if the Stark violation itself was minor (e.g., the remuneration paid to the physicians was relatively modest), yet substantial Medicare payments were received by the provider.

In addition to requiring a settlement payment, the OIG generally will require the provider to enter into a corporate integrity agreement (CIA) or a certification of compliance agreement (CAA). The latter is a more recent offshoot of CIAs, and is preferable from the provider’s standpoint. This is because CCAs are typically shorter in duration (e.g., three years instead of five for CIAs) and do not require an outside compliance review organization to conduct or verify audits or claims reviews. Rather, the provider is permitted to self-monitor and certify its compliance.

Unfortunately, because the Open Letter comes from the OIG alone, the basic non-payment/repayment penalty (which is under the jurisdiction of CMS), is not addressed in the Open Letter and without that piece, substantial uncertainty remains regarding a provider’s ability to achieve a complete resolution of its Stark violations by disclosing to the OIG. Furthermore, as the Open Letter points out, the Department of Justice (DOJ) has jurisdiction over the False Claims Act and the anti-kickback statute, both of which potentially may be implicated in situations involving Stark violations, and the OIG does not have authority to settle on behalf of the DOJ.

Accordingly, although the Open Letter perhaps signals greater flexibility by the OIG in resolving self-disclosed Stark violations, uncertainty remains regarding the roles of DOJ and CMS. In the near term, providers who self-report Stark violations may very well go to the OIG first, in hopes of taking advantage of its seemingly more flexible policies. However, pending guidance by CMS and DOJ, providers should proceed with caution, because deciding whether and how to self-disclose Stark violations remains a difficult and sensitive area, calling for a careful and well-considered approach. These decisions require careful consideration of many factors, and should be made in consultation with legal counsel, with due consideration to issues of attorney-client privilege, and only after a thorough internal review and analysis of the facts and circumstances.

1 This article is an adaptation of Law Watch 06-5, titled “OIG Offers Stark Guidance: CMS/DOJ Keep Mum,” authored by Charles B. Oppenheim, published by Foley & Lardner LLP, and is adapted with permission.
2 The Open Letter can be found on the OIG’s website at http://www.oig.hhs.gov.
3 42 U.S.C. § 1395nn
4 This protocol can also be found on the OIG’s website at http://www.oig.hhs.gov.
Factors considered in determining exclusion

By Cindy Shields

Editor’s note: Cindy Shields is the Compliance & Privacy Officer with MCBS, LLC located in Augusta GA. She may be reached by telephone at 706/737-4575 ext 406 or by e-mail at CindyShields@mcbs.com

On July 23, 2004, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule delineating the procedures for pursuing exclusions. On August 4, 2005, CMS published a proposed rule to add a section entitled Waivers of Exclusions. (42 CFR Part 402; Medicare Program; Revised Civil Money Penalties, Assessments, Exclusions, and Related Appeals Procedures) CMS intends to respond to the public comments for both proposed rules in a single final rule. As of this writing, the final rule has not been published. This Proposed Rule from CMS is based on the procedures that the OIG has published for civil money penalties, assessments, exclusions, and under the OIG’s delegated authority.

CMS will consider certain aspects of an incident of noncompliance when it is deciding whether to exclude a person from the Medicare program and the length of exclusion (the maximum is five years). In general, CMS will look at the types of claims and the circumstances under which they were filed, intent, history of prior offenses, person’s financial condition, total number of claims involved in the violation, dollar amount at issue (both to Medicare Trust Fund and beneficiary expense), prior history of person’s willingness or refusal to comply and correct violations, seriousness of the person’s misconduct, and any other items that would serve to make a just decision.

CMS will look at both aggravating circumstances and mitigating circumstances.

Aggravating

■ There were several types of incidents and they occurred over an extended period of time.
■ The type and number of incidents indicate a pattern or target a specific group of people.
■ The person has previously been held liable for criminal, civil, or administrative sanctions regarding health care programs.
■ There is proof of other wrongful conduct in connection with delivery of health care items or services.
■ The wrongful conduct had a financially adverse effect on the Medicare program or its beneficiaries.
■ The person was the subject of an adverse action by another federal, state, or local government agency or board that was based on the same set of circumstances as the basis for this exclusion.
■ The noncompliance caused a financial loss of at least $5,000 to the Medicare program.
■ Full, accurate, and complete disclosure was not made as required or provided as requested.

Mitigating

■ The incidents were few and were of the same type, occurred within a short period of time, and the claims totaled less than $1,500.
■ The claims resulted from an unintentional and unrecognized processing error, and corrective steps were taken promptly after the error was found.
■ The person previously cooperated with law enforcement or regulatory agency which resulted in penalties against other persons.
■ The person at issue is the only source of the health care specialty to the Medicare population in the immediate area.* (See Waivers of exclusions)
■ The person took prompt corrective action upon learning of the noncompliance from his or her employee or contractor or Medicare.
■ The person had a documented mental, emotional, or physical condition prior to or during the commission of the noncompliant act which affected his or her ability to comply.
■ The person made a complete and prompt refund to the Medicare Trust Fund or Medicare beneficiaries.
■ The person was not directly responsible for the failure to provide timely and complete refunds.

Waivers of exclusions

If CMS determines that a hardship (something that negatively affects Medicare beneficiaries and results from the imposition of an exclusion because the excluded person is the sole community physician or sole source of essential specialized services in the Medicare community) results from an exclusion, CMS may consider and may make a recommendation to the Inspector General for waiver of the Medicare exclusion. An excluded person must submit a written request for waiver of exclusion to CMS which includes documentation that proves the person is the sole community physician or sole source of essential specialized services. The proposed rule does not limit or suggest the type of documentation to include with the request.
The alphabet soup of compliance: A real witch’s brew.

“Double, double, toil and trouble…” Even without reading Macbeth, you know the outcome. It’s a recipe for disaster. You confront a myriad of daily changes in regulations from the courts, congress, 50 states, plus nine different federal agencies. It’s too much for one person. One false step and you’re in hot water. The answer? ComplyTrack™ with the Regulation & Reimbursement Suite from MediRegs – the single-source for every regulatory and compliance citation. No more time-consuming searches. Or heartburn, worrying about the latest updates. Plus, with MediRegs you have tools to automate, track and manage communications, investigations, agency interactions, compliance audits, and more. Register now for a complimentary 30-day trial and discover what one compliance officer claims is her “administrative assistant in a box.”
In an effort to ensure and monitor compliance with Medicare requirements and to prevent abuse of the Medicare program, on April 21, 2006, the Centers for Medicare and Medicaid Services (CMS) issued new regulations which detail the requirements for initial enrollment in, and maintenance of billing privileges under, the Medicare program. The regulations apply to all providers and suppliers (other than physicians and practitioners who have opted out of the Medicare program) (hereinafter, “providers”) seeking initial enrollment in Medicare, as well as existing providers wishing to maintain their billing privileges. Effective June 30, 2006, all providers will be required to have certain enrollment information on file with CMS, to certify the accuracy of the information and to revalidate the information periodically. Such enrollment information must be submitted on form CMS 855—Provider/Supplier Enrollment Application. Providers need to be aware that new versions of these forms were released by CMS shortly after the issuance of the new regulations. In addition to the requirements regarding enrollment information, the new regulations contain provisions, such as CMS’ right to conduct unannounced site visits, which are designed to ensure that Medicare providers are appropriately qualified to provide health care services.

Background
In order to be eligible to receive payment for Medicare covered services, providers must enroll in the Medicare program and meet other federal requirements. Therefore, issuance of a Medicare identification number does not automatically entitle the provider to bill Medicare; the provider must also meet all Medicare requirements. In recent years, CMS has increased its efforts to impose more stringent controls on provider enrollment in Medicare. In furtherance of these efforts, the new regulations supplement existing regulations, consolidate and clarify CMS’ current policy on enrollment requirements, and highlight CMS’ enforcement authority.

The CMS 855 Enrollment Forms
The original CMS 855 form was released in 1996 and the prior approved versions (before the current ones dated 04/06) are dated 11/2001. Only providers who enrolled in Medicare since 1996 or otherwise had a need to file one since that date (e.g., in connection with a change in control) had previously been required to file the form. There are several versions of Form CMS 855, depending on the type of provider enrolling:

- CMS 855A—for providers billing fiscal intermediaries (e.g., hospitals, nursing homes and home health agencies)
- CMS 855B—for supplier organizations billing carriers (e.g., clinics and group practices)
- CMS 855I—for individual health care practitioners billing carriers (e.g., physicians)
- CMS 855R—for individual health care practitioners to reassign benefits to an organization
- CMS 855S—for suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)

The new CMS 855 forms are available online at http://www.cms.hhs.gov/CMSForms/CMSForms/ list.asp. While there has been some confusion about the transition from the old to the new forms, CMS has advised that as of June 2, 2006, it is no longer accepting the 11/2001 versions of the CMS 855 forms. Therefore, to avoid complications and/or potential delays, providers should begin utilizing the new forms immediately.
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Lisa Murtha, 646-277-8810
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The new CMS 855 forms are intended by CMS to be more user-friendly and easier to complete than the old forms.

However, the forms include two notable changes that may not be viewed by providers as user-friendly. First, providers must now include their National Provider Identifier (NPI) and must provide a copy of the NPI notification provided by the National Plan and Provider Enumeration System (NPPS) with each enrollment application. Second, the new forms require providers to accept their Medicare payments by electronic funds transfer (EFT) and to complete the Authorization Agreement to EFT (form CMS 588) if they have not done so already. If providers do not have an NPI or are not receiving Medicare Payments by EFT, the CMS 855 form will be rejected. It is also noteworthy that the new 855 forms require the provider to:

- Agree to inform CMS within 90 days of any changes to the enrollment information contained in the form, or risk penalties (as discussed in more detail below)
- Agree to permit Medicare to recoup over-payments by withholding future payments
- Certify that neither the provider nor anybody else listed on the enrollment application is currently under sanction, suspension or exclusion from Medicare or any other federal health program

Some of the changes that should make the CMS 855 forms more user-friendly are:

- Solo practitioners can now obtain a group number for their incorporated practice by utilizing a CMS 855I form. Previously, the solo practitioner had to fill out forms CMS 855I, CMS 855B, and CMS 855R to obtain a group number and reassign benefits to that group number
- Sections 9 (Electronic Claims submission information), 10 (Staffing Companies), and 11 (Surety Bonds) were removed

**Reporting changes in enrollment information**

Form CMS 855 requests detailed information about the provider. While called an “enrollment” application, the CMS 855 form serves a much broader purpose. It serves as CMS’ ongoing record of information about each provider. Among the information requested by the CMS 855 form, in addition to the NPI as discussed above, is the tax identification or Social Security number of the provider, identification of, and the tax identification or Social Security numbers of, persons with ownership or control interests in the provider, practice locations and billing services information, if applicable. Following enrollment, providers must report changes to the information submitted on the application within 90 calendar days of the change (other than DMEPOS suppliers who are otherwise required to report changes within 30 days and changes of ownership or control, which also must be reported within 30 days). CMS has advised that going forward, even if a provider is merely reporting a change of information, the provider must include its NPI and a copy of the NPI notification from the NPPES with the submission.

The new regulations impose significant penalties, including sanctions, deactivation or revocation of billing privileges, if providers fail to timely notify CMS of the change of information. In the preamble to the final rule, CMS notes “[w]e are . . . adopting a position to require deactivation of a billing number if we discover changes to the information provided on the provider or supplier’s enrollment application that were not reported within 90 days of the change. This includes, but is not limited to, changes in billing services, a change in the practice location, or a change of any managing employee.” 71 Fed. Reg. at 20,769.

Changes of ownership or control of a provider must be reported within 30 calendar days. However, if the change of ownership or control is of the type described in 42 C.F.R. § 489.18 (e.g., the merger of the provider into another corporation), both the current owner and the new owner must submit a CMS 855 before the change in ownership is complete. Failure of the current owner to timely complete the form may result in sanctions and penalties, even after the change of ownership is completed. Failure of the new owner to timely complete the form may result in deactivation of the billing number until the CMS 855 form is submitted. Generally, a change of ownership that changes the tax identification number of the provider requires that the new owner submit a CMS 855 form.

The CMS 855 form must be signed by the applicant in the case of an individual practitioner, or an authorized official, such as the general partner, chairman of the board, chief executive officer, president or person in a similar position in the case of an organiza-

*Continued on page 12*
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tion. Such person must have authority to bind the applicant. Providers, other than individual practitioners, may also delegate authority to another official who may sign updates or changes to the enrollment form. These requirements are designed to ensure accountability for the accuracy of the information and that the provider is committed to taking the necessary steps to comply with the requirements.

Implementation of new enrollment forms and revalidation of enrollment information

While a provider may submit a new CMS 855 form when it so chooses, and should report changes to existing filings as discussed above, the requirement for all providers to complete the new CMS 855 form will be phased in over the next several years. CMS, through its contractors, expects to contact existing providers in writing to advise them when they must submit the new CMS 855 form. When contacted, providers will be given 60 days to submit the required information. CMS has advised that when providers are contacted, they will be provided with a new enrollment form that is already populated with the information CMS has on file regarding such provider. Providers will then need to add any missing information and verify that the information included is accurate and complete.

In connection with phasing in the new forms, CMS has advised that over a five-year period, starting mid-2007, it plans to begin contacting the approximately 1,000,000 providers. The providers with the least information on file will be contacted first, and those with more information on file will be contacted later. Unless a provider has previously filed a CMS 855 form and such information is required to be updated in the interim in accordance with the new regulations, providers need not proactively file the new CMS 855 form until contacted by a CMS contractor.

As previously mentioned, a new requirement imposed on providers (other than DMEPOS suppliers and ambulance service suppliers, who are subject to separate requirements) by the new regulations is the requirement to resubmit and recertify the accuracy of the information on the enrollment application every five years. Each provider’s five year revalidation cycle will run from the time the provider is initially required to submit the new enrollment application after being contacted.

CMS also may request a provider to revalidate its enrollment information outside of the revalidation cycle. These off-cycle revalidations may be triggered by random checks, information indicating local health care fraud problems, national initiatives, complaints, or other reasons that cause CMS to question whether the provider is compliant with Medicare’s enrollment requirements. The rationale for the revalidation process is to ensure that CMS has complete and current information on file about all providers and that beneficiaries are receiving services only from legitimate providers.

Unannounced site visits and inspections

CMS has included, as part of its enrollment validation process and general program oversight activities, the possibility of unannounced site visits and inspections when deemed necessary to ensure compliance with the enrollment requirements. While certain providers, such as hospitals and nursing homes, are already subject to site visits, CMS may now make site visits to inspect other provider locations as well, such as physician offices. As CMS states in the preamble to the final rule, such site visits and inspections are necessary to ensure compliance with Medicare enrollment requirements and are unrelated to site visits already being conducted by the U.S. Department of Health and Human Services Office of Inspector General (OIG) and site visits performed for establishing conditions of participation.

Rejection of an enrollment application

CMS may reject an enrollment application if the provider fails to furnish any missing information within 60 days of request or all required supporting documentation (e.g., articles of incorporation and billing agreements) within 60 calendar days of submitting the enrollment application. The 60-day period may be extended in CMS’ discretion if CMS determines that the provider is actively working with CMS to resolve any open issues. If an application is rejected, a provider wishing to enroll must submit a new application with all supporting documentation.

Denial and revocation of enrollment

Enrollment in Medicare may be denied or revoked if the provider fails to comply with Medicare’s enrollment requirements, if the provider or certain persons having a control or ownership interest in the provider or who are reported on the enrollment application engage in certain inappropriate conduct, such as commission of certain felonies within the past 10 years, if false or misleading information is provided on an enrollment application, or if as a result of a site visit, CMS determines that the provider is not operational or has failed to furnish services as required by Medicare. Providers whose enrollment is either denied or revoked may appeal the decision in accordance with existing regulations.

In considering whether to revoke billing privileges, CMS considers the severity of the offense, mitigating circumstances, Medicare program, and beneficiary risk if enrollment were to continue, possibility of corrective action plans, beneficiary access to care and...
any other pertinent factors. Before billing privileges are revoked due to a failure to comply with enrollment requirements, such as the failure to timely report a change in enrollment information, a provider is entitled to an opportunity to correct the compliance defect. If billing privileges were revoked because certain health care personnel were excluded, debarred, or convicted of a felony, the revocation can be reversed if the provider terminates its business relationship with such personnel and submits proof of such termination within 30 days of the revocation notification.

In addition to the penalties outlined above, a concealment or misrepresentation of enrollment information may be referred to the OIG for investigation and possible criminal, civil, or administrative action. Providers should be aware that the impact of the revocation may reach beyond the provider whose privileges were revoked. As a result of a revocation, CMS must now automatically review all Medicare enrollment files with which the revoked provider has an association to determine whether adverse action against other providers is warranted.

Deactivation of enrollment

CMS may deactivate a billing number if no claims are submitted for 12 consecutive calendar months or changes in information on CMS 855 are not reported within 90 days of the change. When a provider’s billing number is deactivated, billing privileges are suspended, but may be restored upon submission of updated or recertified information. If a provider is deactivated for a reason other than nonsubmission of a claim, a new enrollment application must be submitted to restore billing privileges. If a provider is deactivated because of nonsubmission of a claim, the provider must recertify that the enrollment information currently on file is correct, provide any missing information, and the provider must meet all Medicare requirements in place at the time of reactivation. Reactivation does not require execution of a new provider agreement or the certification by the provider by a state survey agency.

While many of the requirements of the new regulations were already in place, enactment of the regulations and the release of the new CMS 855 forms demonstrate that CMS is serious about maintaining accurate provider information on file. To this end, CMS has the authority to impose penalties to ensure compliance.

The Compliance Professional’s Certification

The Healthcare Compliance Certification Board (HCCB) announces that the following individuals have recently successfully completed the Certified in Healthcare Compliance (CHC) examination, earning CHC designation:

Sandra L. Baseman
Betty Joyce Baber-Kinsey
Baker Patricia Anne
O’Neil Sean Kennedy
Cynthia D. Argentine
Cindy Ray Bartlett
Sandy L. Bell
Helen Amelia Bizunman
Ray Breuning
Ruth Ellen Brook
Brenda K. Burns
Ronald L. Bukirk
Pamela Anne Casey
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Tammy Agnes Thomas
William N. Whaley
Jerylyn Ann Williams
Wanda Teresa Ziemba

Congratulations on achieving CHC status! The Health Care Compliance Certification Board announces that the following individuals have recently successfully completed the Certified in Healthcare Compliance (CHC) examination, earning CHC designation:
Editor’s note: This interview was conducted in early May 2006 by Julene Brown, HCCA Treasurer and Billing Compliance Manager, with MeritCare Health System. Rachael Kurzer Givens, CHC, is Vice President of Compliance with ResCare, Inc., located in Louisville, Kentucky. She may be reached by telephone at 800 866 0860 ext.2136 or by e-mail at rgivens@rescare.com.

**JB:** First off, I want to thank you for taking the time to interview with me. Tell me about ResCare; the services provided, size of the organization, etc.

**RKG:** ResCare is a human service company providing residential, therapeutic, job training and educational supports to people with developmental or other disabilities; education and training to youth in the Job Corps program; one-stop employment and training services for people experiencing barriers to employment; and supports to older people in their homes. It currently offers services in 36 states, Washington D.C., Puerto Rico and Canada. ResCare employs more than 38,000 people and is headquartered in Louisville, Kentucky. We’ve been around since 1974.

We’re a publicly traded company primarily funded by local, state, and federal government contracts—largely Medicaid funds. ResCare has three operating segments: Community Services Group, Job Corps Training Services, and Employment Training Services. We operate in tough regulatory environments, face changes in funding streams based upon federal and state governmental actions and have employees working in thousands of sites across the country 24 hours a day, 7 days a week. Needless to say, we face numerous challenges in implementing and maintaining an effective compliance program and we’re not your typical “healthcare organization.”

**JB:** Please tell me about your background and the work that you do. How did you get into compliance? How long have you worked in compliance?

**RKG:** As Vice President of Compliance, I’m responsible for the day-to-day operations of ResCare’s compliance program. I’ve been in the compliance field since 2001 when the company formalized its compliance efforts and created our initial compliance program. Prior to compliance, I was Director of Quality Management for our Community Services Group and had a similar position at another company that was acquired by ResCare. I worked in various clinical and administrative roles at a state institution in Georgia before moving to Kentucky in 1996.

I have a graduate degree in Rehabilitation Counseling from Virginia Commonwealth University and an undergraduate degree in psychology from North Carolina State University.

**JB:** What do you find most challenging about your job?

**RKG:** A challenge we face is that we grow through acquisitions—as we acquire new companies we are faced with implementing our compliance program. Some companies have had comprehensive compliance programs while others have had components of a compliance program or less formal activities in this area. Sometimes you find yourself in discussions that you thought were over years ago: “compliance is important because...”, “yes, they have to have HIPAA training again because we are the covered entity now”, “no, we are not internal affairs”...”yes, we can come to your operation even when you are too busy for us...”

Talented, mission driven employees join our company each year as part of an acquisition—it’s how I joined the company. Eventually everyone understands the role of compliance and its importance within an organization.
How do you keep yourself up-to-date in the compliance field?

We stay up-to-date on compliance issues by attending seminars and conferences put on by HCCA, AHLA [American Health Lawyers Association], SCCE (Society of Corporate Compliance and Ethics), ACCE (Association of Certified Fraud Examiners), IIA (Institute of Internal Auditors) and various regulatory bodies. We take full advantage of web calls, list serves and compliance magazines and journals. We also use MediRegs, Lexis Nexis and Web searches by key phrase such as: Medicaid fraud, healthcare, applicable business line terms or phrases to provide us with up-to-date information on regulatory issues or providers in the news.

How is your compliance program organized?

The chief compliance officer is also general counsel. We currently have a centralized compliance department with staff who have general compliance knowledge and business line expertise. Most departmental staff have graduate degrees and various certifications related to the compliance field, audit field, or company business line (CHC, CFE, CPA, CIA).

All staff conduct reviews and training, though one staff is primarily responsible for training development and implementation. Another staff member has the primary responsibility for triaging calls from the outsourced action line, though several departmental members may be involved in reviewing and investigating an allegation. Our administrative assistant provides tremendous support to all.

In your opinion, what is the most important part of a compliance program?

I think that both education and a reporting process are the most important parts of a compliance program. Educated employees are more likely to do the right thing.

The reporting process is an integral part of the compliance program. It allows employees to seek clarification on business practices. It also allows employees the opportunity to report suspected inappropriate activity within the company. Compliance is everyone’s job at our organization—each of our personal and professional reputations depends on fellow employees doing the right thing. If there is wrongdoing within the company—it impacts all of us. We want to know about it in real time so that we can address it immediately.

How do you prioritize what is most important in your work?

We look at risk areas to the organization as a whole, as well as business line specific risks. We also consider any compliance trends within the organization when prioritizing our work.

Of course, we always accommodate emerging priorities identified by leadership or the Board of Directors.

How is your internal audit function structured? Is it part of the compliance program or separate?

Internal Audit is part of our compliance department structure. We have a Director of Internal Audit for Finance and a Director of Internal Audit for Operations. The Directors report directly to the Chief Compliance officer. Both Directors have an auditor reporting to them. The financial auditors review financial processes within the organization. They were heavily involved in Sarbanes- Oxley (SOX) compliance efforts and should be able to expand their audit scope beyond internal control testing as SOX compliance is an integrated business process. The operational auditors review business processes and identified risk areas at the field business unit level.

The auditors provide reports to the Board of Directors Audit Committee, Ethics and Compliance Committee, and the Company’s Compliance Committee.

The audit department recently had a quality assessment review from an outside party as recommended by the Institute of Internal Auditors. We were pleased with the outcome of this process.

Have you integrated quality issues into your compliance program?

We work closely with the operational departments monitoring and measuring quality. We have incorporated key elements of the compliance program into the quality management system—Best In Class utilized in our Community Services Group. We look for quality of care issues and follow up on critical incidents when we are in the field. We are alerted of punitive actions proposed for any field operation. We also educate about the importance of quality of care and explain that failure to provide quality care could potentially end up as an allegation of a false claim.

I am a member of the Quality Management Committee.

How does your organization keep compliance education and training interesting, motivating, and effective?

Making compliance exciting is always a challenge. We utilize a variety of avenues to educate our employees and keep compliance at the top of the mind: Electronic newsletters highlighting fraud and abuse, online training, face-to-face training, training disks with topical information sent to the field, risk area specific information such as fraud, topical training at internal conferences and regional meetings.

We find that employees like the use of

Continued on page 16
“on the job” scenarios for training and are especially interested in hearing about compliance issues that we substantiated.

It’s a continual process of updating existing materials or creating new materials altogether.

JB: What do you consider important information to give to the board of directors?

RKG: Our board committees receive detailed information regarding compliance allegations on a quarterly basis or more often if the need arises. We provide individual and aggregate information. The board receives reports from the internal auditors and compliance review findings.

We try to keep the board up-to-date on regulatory or legislative changes which impact the organization from a compliance perspective such as the language in the Deficit Reduction Act regarding False Claims Act training and incentives for state False Claims acts.

It really is an age of transparency—no one likes surprises. We inform the board of any nonroutine contact from a governmental agency.

JB: What do you see in the future for the compliance field?

RKG: The future for compliance is only getting brighter! Compliance will be an integral part of most businesses.

JB: What advice do you have for other compliance professionals?

RKG: Several years ago, I believe Roy Snell wrote an article on the Self Righteous Compliance Officer, which says it all. Everything is not a crisis, the sky is not always falling and mole hills should not be turned into mountains.

Use the red flags sparingly so that when a red flag needs to be raised, you’ll immediately get the attention it deserves. Conversely, bad news does not get better over time—inform management immediately when there is a potential problem.

Lastly, and I am sorry to be so cliché, is to realize that people will surprise you—both in a good way and in a bad way. When an issue arises, focus on the issue, not the individual, in order to remain as objective as possible.

JB: Do you have any best practices to share with others?

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Lastly, and I am sorry to be so cliché, is to realize that people will surprise you—both in a good way and in a bad way. When an issue arises, focus on the issue, not the individual, in order to remain as objective as possible.
Auditing and Monitoring are some of the biggest priorities for compliance officers. The Health Care Compliance Association has produced a manual designed to help officers deal with these two important tasks.

HCCA has compiled a trove of tools, policies, procedures, and job descriptions into one manual: Health Care Auditing & Monitoring Tools. Approximately 40 HCCA members contributed more than 100 documents to the manual. These documents are included on a CD-ROM. The manual includes a copy of the 107-page legal primer, Monitoring & Auditing Practices for Effective Compliance, edited by John Steiner, Jr.

The contributions range in size and kind. One contributor donated more than 150 pages of documents from an organization’s program to audit nursing home facilities. Other tools and policies are a single page. Documents address such issues as:
- Planning and conducting audits
- Billing and coding
- HIPAA
- Evaluation/Management
- Job descriptions

Emma Wollschlager Schwartz wrote the manual’s introduction. Emma, who is president of W Consulting, LLC in El Paso, Texas, also helped review the submissions. “The submissions were excellent attestations of the knowledge, experience, insight, and creativity of HCCA members in formulating standards and guidance in the ever-growing and evolving field of compliance,” Emma said.

The manual will be updated twice a year to reflect new regulations and compliance concerns. Subscribers will receive more auditing and monitoring tools, policies, and advice to strengthen their compliance programs. The first two updates are free. The subscription for subsequent updates is $195.

The manual is intended to help compliance officers with the high-priority responsibilities of auditing and monitoring. In HCCA’s 8th Annual Survey, compliance officers identified auditing and monitoring as the top goals they hope to achieve in their program in the next three years.

As a consultant who is familiar with the compliance efforts of many organizations, Emma knows firsthand about the importance of auditing and monitoring. “Based on this experience,” she said, “I have found that the auditing and monitoring functions of a compliance program are essential to ensure both the effectiveness of a compliance program and the retention of compliant policies and processes whether operational, billing, scope of practice, documentation and coding, contractual or any other type.”

The importance of auditing and monitoring to a compliance program means the manual can be especially useful to new compliance officers. “This manual will help to lay the foundation for auditing and monitoring programs, including plans and schedules, for new compliance officers,” Emma said. “It will serve as a guide for the new compliance officer to determine the types of auditing and monitoring plans needed, as well as the types of tools needed to perform the auditing and monitoring functions. In addition, it will provide insight to the compliance officer into the type of assistance and resources he or she will require to complete the auditing and monitoring functions within adequate time frames.”

Of course, veteran compliance officers can also benefit from the manual as well, according to Emma.

“For the experience compliance officer, this manual will provide fresh ideas, guidance in areas the experienced compliance officer may have had difficulties with in the past, and confirmation of and enhancements to existing auditing programs,” she said. “Experienced compliance officers may also look to compare the tools/plans they are currently using with the tools/plans in the manual to determine how effective their auditing and monitoring program may be. The comparison may indicate to the compliance officer that an update of the organization’s auditing program is in order, or it may confirm the program’s effectiveness for the department itself and to the organization’s board. An opportunity to review and improve should always be taken, especially in the world of compliance.”

To order, go to the HCCA’s Web site at www.hcca-info.org.
Sarbanes-Oxley suggests rotating auditors. There is also some language about rotating partners or technical review partners within the same firm. The intent of these recommendations is to maintain auditor independence. HCCA has had the same auditors for about six years, and because “we are the compliance association” we are going to put the audit out for bid. Even though SOX doesn’t apply to nonprofits, we support the intent of SOX. There is an eagerness to change so we can say we follow the highest standards. Ironically, though I support this process whole heartedly, I am very worried that we may not end up with an effective audit next year. Oh the humanity.

I am very concerned about the independence of our audit. I look at audits a little differently than some. I would rather the auditors be very critical and give me their best shot every year. I want to deal the little problems now rather than “the big one” years from now. I don’t want to have a problem go undetected and grow into something that could hurt my reputation or the organization. I want our CFO (Charlie) and our auditors to develop an accurate and informative set of numbers so people will think we are worthy. I really support the “spirit of SOX.” However there are many ways to mess up an audit other than a lack of independence.

The following are ways an audit firm can be ineffective:
- Lack of audit experience
- Lack of experience with your type of business
- Lack of knowledge of key risk areas
- Lack of independence
- Lack of effort
- Staff turn over
- Lack of ability to question business decisions

I believe that our current auditors are independent. They report to the audit committee directly. I am sure they find me to be bright, witty and charming, however, when it comes to finding and reporting problems they are independent. I have worked for, and with many audit firms in my day. I have seen cases where the audit was not effective because there was a lack of experience, knowledge or commitment. Ironically, experience, knowledge and commitment may be more frequently the reason for a ineffective audit than a lack of independence. I think auditors that are not independent overlook problems but more importantly some auditors are unsuccessful because they do not have the necessary experience, knowledge or commitment.

What if we switch auditors to maintain independence and end up with a firm that is not as effective technicly? What if we have independent and technically effective auditor now? We will end up with just the opposite of what the authors of SOX wanted. I want to comply with the spirit of SOX. SOX wants independence so the audit is effective. The ultimate “spirit” of SOX is to have an effective audit. I want an effective audit every year. I don’t want to find out 3 years from now that we and our auditors missed a costly mistake that would not have been costly if we had caught it right away.

Independence is important for detecting and reporting fraud and abuse. Switching auditors is not intended to help find run of the mill accounting errors. I never want fraud and abuse, however I am more concerned about mistakes that could cost us money or cause us to make a bad decision. I worry about independence but I am more worried about the mistakes that have nothing to do with independence. If our numbers are wrong and it goes undetected serious damage could be done. It is more popular to worry about fraud and abuse but I worry more about undetected run of the mill mistakes which generate bad numbers and have a negative financial impact or cause bad decisions to be made.

Let me tell you another thing about our auditors. They talk to me all the time about how I make decisions and run this association. They question my decision making constantly. They often tell me other ways to mange our organization. They share experience that they have had in the many other organizations they have done work for. They are actually good business people too. What if I loose that critical review of my business decisions?

The great irony is that I am concerned our annual audit will not improve. If we have a good auditor now that is independent, changing audits can only increase our chances for failure. Although, we will be able to say we changed auditors to comply with SOX, there is a chance that we could end up worse off. Here is an interesting question. What if we change to an auditor that does not want to report bad news for fear of loosing the job? What an irony that would be. It could happen. I don’t want to take a
Having just completed my first year in Compliance, I have some tips on surviving a compliance career!

1. **Join Health Care Compliance Association (HCCA)**
   Their website and annual Compliance Institute offers an incomparable opportunity to network and learn about Compliance!

2. **Sign up for listservs from CMS, Code Correct and your Fiscal Intermediary**
   These daily e-mails will help you stay current on changes in regulations.

3. **Read, read, read**
   Read everything you can on Compliance! Use the Internet, books, and articles. Get acquainted with Compliance Today and Journal of Healthcare Compliance

4. **Get acquainted with your hospital’s policies**
   Become familiar with all policies, especially those concerning Compliance.

5. **Collaborate, collaborate, collaborate**
   Identify key individuals within your organization (like the Hospital Attorney, Chief Financial Officer, the Director of Patient Financial Services, Hospital Administrators, Clinical Managers, Director of Health Information and Director of the ChargeMaster).

6. **Network, network, network**
   Having met other Compliance professionals at the HCCA Compliance Institute, share materials and e-mail them to stay in touch and discuss issues.

7. **Assess risk**
   Using risk assessment tools on the HCCA website, or developing your own, you will need to assess risk within your organization.

8. **Market compliance**
   Take your business card everywhere! Get invited to Manager meetings, Mission/Value Committee, and critically review Compliance information on your website.

9. **Write about compliance**
   Identify newsletters within your organization. Write a regular feature about Compliance or start your own Compliance newsletter!

10. **Take a break to refresh**
    Compliance is a tough job! Plan time off to refresh and regroup!
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In 1999, the OIG published an advisory compliance program guide for Durable Medical Equipment companies, which provided the basic information needed to start an effective program. The government’s intent in presenting this program guide is to prevent unnecessary expenditures of federal and state funds. In addition, the program guide provides an outline of good business practices, sets the framework for a profitable operation and greatly reduces the risk of fines up to $10,000 per claim and treble damages.

While the cost associated with a first class compliance program can be expensive, most of the DME companies throughout the country are relatively small operations serving local communities or health systems. Many organizations look at the task of starting an effective compliance program and may take a few steps in the right direction, but are they doing the right thing? With limited resources and little training, is the “good faith effort” going to achieve the goal of keeping the government’s large shadow from gracing their doorway? It can if they take the right steps. A logical, progressive approach can be utilized to build a strong program while keeping costs to a minimum. The key to starting an effective program is to thoroughly read the OIG’s DME Compliance Program Guide, prioritize the risk areas as established in the guide and develop a progressively strong plan based on realistic timelines for the organization.

There are seven elements to an effective DME compliance program as presented by the OIG:
1. Writing policies and procedures
2. Designating a compliance officer and a compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Auditing and monitoring
6. Enforcing standards through well publicized guidelines
7. Responding to detected offenses and developing corrective action plans

After reading the program guide, look very closely at the risk areas. There are 47 of them. These risk areas are there because they represent years of DME audits and investigations conducted by the federal government. There are many areas, so where do you begin? I’ve broken down the risk areas into two groups. The first group consists of high risk areas and should be addressed as soon as possible through:
1. The creation of written policies and procedures.
2. Training employees on policies and procedures.
3. Setting up a system of auditing and monitoring to ensure that goals are reached and maintained.

The second group may not be as problematic and can be addressed in the same manner in the near future. While I’ve placed certain risk areas in the high risk group based on my 26 years in the DME industry, each risk area should be evaluated based on the needs of the organization. My comments are italicized and in the high-risk group. “Location:” is a tip on where to generally find the information for auditing purposes. The footnotes match the references in the Office of the Inspector General DME Compliance Program Guidance.

First tier risk group
1. Billing for items or services not provided (30) Often there is no proof of delivery available in the patient chart.
   Proof of delivery can be in the form of a patient/caregiver signature or a tracking number generated by a delivery service such as UPS or FedEx. If it is not in the chart, it didn’t happen; therefore, did you just send in a false claim? Location: Patient chart
2. Billing for items or services not ordered (34) This happens most often when a prescription is not on file; therefore, there is no proof the physician ever ordered the products. Another cause can be incorrectly entered products in the billing system. Location: Patient chart
3. Upcoding (36) Audit a random sample

Continued on page 24
The Health Care Compliance Association presents

Medicare Prescription Drug Part D Compliance Conference

The Health Care Compliance Association (HCCA) will be holding a Medicare Prescription Drug Part D Compliance Conference in Baltimore, MD, September 10–12, 2006. Topics to include:

- Part D Drug Coverage
- Fraud and Abuse Under Part D
- Long-Term Care Issues
- Pharmacy
- Appeals & Grievance
- Auditing & Monitoring
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of at least 30 products in the DME billing software (if applicable) to ensure products have been assigned the correct HCPC (Healthcare Common procedure Code). The entire product list should be verified annually for accuracy. Location: Within the system software look at the assigned HCPC and compare the HCPC description with the product description to ensure a match. I would also suggest looking at your top 30 products and do the same.

4. Unbundling items or supplies (37)
This is a problem most often found when providing urological supplies giving the supplier higher reimbursement that is not due. Location: Sample 30 patient charts receiving urological supplies. Be aware there are other areas of “bundling” such as wheelchair parts.

5. Continuing to bill for rental items after they are no longer medically necessary (39) Conduct monthly follow-ups to determine if the patient is still using the rental equipment. Medicare takes the position that it is the responsibility of the supplier to determine if medical necessity continues to be valid. Location: Contact 30 patients with equipment rental of more than six months and ask if they are still using the equipment. This is a great opportunity to talk with patients and ask them about their experience with the organization.

6. Capped rentals (46) The correct modifiers must be included during a specific month of rental. While Medicare’s claims processing system can track capped rentals (that’s how violators are caught), it is the supplier’s responsibility to track capped rental equipment, which includes sending out a capped rental option letter to the patient in the tenth month. Location: Audit 30 charts where the patient is renting equipment in the capped rental category. Choose varying months of rental and check to ensure the correct modifier was used. If the patient has more than 10 months of rental, there should be proof that the 10-month capped rental letter was sent to the patient. Refer to section II.A.3.k in the OIG’s DME program guide for more detailed information to assist in auditing.

KH - initial claim, purchase or first month rental
KI - second and third month rental
KJ - fourth through fifteenth month
MS - maintenance and servicing

7. Failure to monitor medical necessity on an on-going basis (47) This is similar to the above issue of continuing to bill for rental items after they are no longer medically necessary. If a physician writes a prescription for 12 months, but the patient is no longer using the equipment after 4 months, Medicare has no obligation to pay for equipment if it is not being used by the patient. Location: Look at the prescription in the patient chart to see if the prescription matches the length of time the patient needed the equipment.

8. Delivering or billing for certain items or supplies prior to receiving a physician’s order and/or appropriate CMN (Certificate of Medical Necessity) (48) Items include, but are not limited to TENS units, multiple types of pressure pads and cushions, various wheelchairs and accessories, scooters and power wheelchairs, and powered seat-lift mechanisms. The complete list of items can be found at: http://www.cignagovernmentservices.com/dmerc/dmsm/C03/sm0302.html#prior Location: Check the written prescription found in the patient chart and match the date to the date of delivery. The prescription date must precede or be equal to the date of delivery.

9. Falsifying information on the claim form, CMN, and or accompanying documentation (49) Changing information that falsifies patient information or alters medical necessity should be considered a serious offense. There have been times when field representatives look for ways to obtain a qualifying prescription without “bothering” the physician. Location: Look at the prescription for corrected information such as crossed out/corrected data that lacks dates or initials.

10. Completing portions of the CMN reserved for completion only by the treating physician or other authorized person (50) Only the physician or the physician’s staff can fill out section B and only the physician can sign the CMN (signature stamps are acceptable under controlled circumstances within the physician’s office). Location: Sections A and C of a CMN are to be filled out by the supplier prior to the physician receiving the CMN. Look for the same handwriting in section B as in A and C. This may indicate that an employee from the supplier illegally filled out section B. Specific instructions are on the back of the CMN, or can be found in section 100.2.1 at: http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf

11. Manipulating the patient’s diagnosis in an attempt to receive improper payment (52) During the billing process, the DME supplier must enter a diagnosis into the billing system; in doing so, the person entering the diagnosis must match the diagnosis on the prescription with one in the billing software. Accuracy in making the translation is important; therefore, the person making these choices must be trained well in using ICD-9 codes. Location: Look at the written pre-
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Starting a compliance program  ...continued from page 24

scription and compare it to the claim sent to Medicare.

12. Failing to maintain medical necessity documentation (53) If it’s not documented, it didn’t happen. Audit charts to complete information that will support the claim. Location: At a minimum, the patient’s file should contain a prescription, proof of delivery, assignment of benefits, and a copy of the ABN.

13. Routine waiver of deductibles and coinsurance (57) The key word is “routine”; therefore, if the supplier occasionally writes off coinsurance and deductibles, a routine pattern cannot be established. If patterns of write-offs for a particular doctor’s patients are apparent, or if write-off’s have become standard practice in the organization, these practices can be viewed as providing something of value in exchange for more referrals. Location: Look at 30 charts to determine if the coinsurance was properly processed.

14. Failing to refund overpayments to a federally funded health care program (72) A refund policy should be written and employees trained about it annually. This policy should state that refunds to federally funded health care programs will be promptly refunded within a reasonable time. I would suggest refunding within 30 days of discovery. Location: Obtain a list from Accounts Payable or Finance of the 30 most recent refunds to Medicare or Medicaid. Pull the patient chart and system notes to determine when the refund was discovered and how long it took for the refund to be processed.

15. Failing to refund overpayments to patients (73) A policy should specifically state that refunds to patients are to be refunded in a timely manner. The time frame should be no different than any refunds going back to the government. Location: Same as 14.

All 15 elements in the high risk group should be examined individually and ranked according to the risk of the company. Each of the risk areas should include a policy/procedure, training and an auditing/monitoring process with the results to be reported to management. Quality improvement processes should be applied to place downward pressure on the risk. Establish an error rate of 5% or less as a goal and celebrate the progress. Once the initial goal is achieved, the next step in a mature program is to establish a goal of 3% or less. Anything under 3%, while admirable, may not provide an acceptable return. Upon obtaining a consistent error rate of less than 5%, focus your compliance assets to address the remaining 32 risk areas.

The key is to demonstrate progression with your compliance program. Use Quality Improvement Processes to keep up the momentum and build compliance credibility with the employees and management.

Second tier risk group

16. Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other (60) This is a high profile area with the OIG and should be addressed via a written policy. The following link provides information from the OIG on joint ventures by DME companies:

http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

17. Billing for services that the DME-POS (Durable Medical Equipment Prosthetic, Orthotics & Supplies) supplier believes may be denied

(31)This is not a risk area. Suppliers are required by law to submit a claim on the beneficiary’s behalf.

18. Billing patients for denied charges without a signed written notice (32) Correct use of an ABN (Advanced Beneficiary Notice) is critical in getting paid properly.

19. Duplicate billing (33) This is inevitable and happens occasionally, but what the OIG is looking for are patterns of claim dumping or large resubmissions of claims that have already been processed.

20. Using a billing agent whose reassignment arrangement violates the reassignment rule (35) This is applicable only if the supplier uses a third-party billing company instead of its own in-house billing department. If this is the case, this opens a new compliance process which includes auditing and monitoring of the billing company. See more information at:

http://oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf

21. Billing for new equipment and providing used equipment (38) Most suppliers sell only new equipment, but if used equipment is sold, a special modifier, UE, must be attached to the HCPC.

22. Resubmission of denied claims with different information in an attempt to be improperly reimbursed (40) The key words are “improperly reimbursed.” Medicare denies the claim due to insufficient documentation, meaning the supplier must provide different information to justify medical necessity, but the information must accurately reflect the patient’s medical necessity.

23. Refusing to submit a claim to Medicare for which payment is

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made on a reasonable charge or fee schedule basis (41) Unless a beneficiary indicates they do NOT want a supplier to send in a claim on the patient, the supplier is bound by Medicare rules to do so. The beneficiary has the right to change his/her mind and request a claim be submitted on his/her behalf at a later date.

24. Inadequate management and oversight of contracted services, which results in improper billing (42) This is applicable if the supplier has contractors working on the supplier’s behalf.

25. Charge limitations (43) Never bill Medicare more than your usual and customary amounts. Price gouging is not tolerated by Medicare and comes into effect when items not found on the fee schedule such as E1399 items are submitted for inflated amounts. As a rule, do not charge below Medicare’s fee schedule rate unless there is a contractual arrangement with the payor. Medicare has the authority to change a supplier’s reimbursement, if they find an established pattern of reimbursement below the current fee schedule.

26. Providing and/or billing for substantially excessive amounts of DMEPOS items or supplies (44) With most items, Medicare has established monthly limits and will not pay for an excessive number of products delivered on a month to month basis.

27. Providing and/or billing for an item or service that does not meet the quality and standard of the DMEPOS item claimed (45) Equipment must meet the description of Durable Medical Equipment and what would be considered “reasonably accepted quality standards.”

28. Altering medical records (51) The altering of a patient’s medical record for the purpose of receiving reimbursement not due the supplier would be the submission of a false claim. Having a policy and procedure written and trained on how to properly make corrections to a medical record is strongly suggested providing the procedure follows legal guidelines.

29. Inappropriate use of place of service codes (54) The place of service code must accurately reflect where the patient received the services. Most often, the code is a 12, but at times it can be 31 or 33. The correct code must be placed in box 24B on the 1290 (1500) claim form.

30. Cover letters that encourage physicians to order medically unnecessary items or services (55) Cover letters that encourage or coach physicians to prescribe more equipment than is medically necessary can be a concern. Cover letters should be in a standardized format and employees should be trained about the use of cover letters.

31. Improper use of the ZX modifier (56) The ZX modifier is a promise to Medicare that the supplier is in possession of documentation proving medical necessity. Medicare is not capable of processing all documentation proving medical necessity and relies on suppliers to provide the documentation on demand.

32. Providing incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, skilled nursing facilities, home health agencies or others) that may violate the anti-kickback statute or other similar federal or state statute or regulation (58) Establish a policy limiting the amount spent on lunches, gifts, etc. Following a rule where gifts are of “nominal” value will keep the DME supplier out of trouble.

33. Compensation programs that offer incentives for items or services ordered and revenue generated (59) Incentives could induce the ordering of more equipment and/or supplies that are beyond medical necessity.

34. Billing for items or services furnished pursuant to a prohibited referral under the Stark physician self-referral law (61) This risk area can be a special concern with hospital health systems having their own DME company. Patients should have documented in their file that they were given a choice of DME suppliers.

35. Improper telemarketing activities and high-pressure marketing of non-covered or unnecessary services (65) Any marketing information offered by the DMEPOS supplier should be clear, correct, non-deceptive, and fully informative.

36. Improper patient solicitation of DMEPOS items and supplies with the referral source (64) Although such arrangements are not prohibited per se, the OIG believes that such arrangements may potentially raise anti-kickback and self-referral issues, particularly when the DMEPOS supplier pays the physician an amount above fair market value to rent the space.

37. Co-location of DMEPOS items and supplies with the referral source (64) Although such arrangements are not prohibited per se, the OIG believes that such arrangements may potentially raise anti-kickback and self-referral issues, particularly when the DMEPOS supplier pays the physician an amount above fair market value to rent the space.

38. Noncompliance with the federal, state, and private payor supplier standards (65) The supplier is responsible for the training of billing employees not only on government payor rules and regulations, but also on private payor rules and regulations.

39. Providing false information on the Medicare DMEPOS supplier enrollment form (66) The application forms must be correct and any changes to the suppliers information should be submitted
within 30 days. If errors are found, immediately submit the changes. This is Form 855S and can be found at the National Supplier Clearing House Web site at: http://www.pgba.com/palmetto/providers.nsf/12a24b80b4b368c385256ecb00760037/85256d580043e75485256b5a00599c13?OpenDocument

40. Not notifying the National Supplier Clearinghouse in a timely manner of changes to the information previously provided on the DMEPOS supplier enrollment form (67) See 39.

41. Misrepresenting a person’s status as an agent or representative of Medicare (68) An employee from the supplier cannot act or lead the patient to believe that the employee is representing Medicare.

42. Knowing misuse of a supplier number, which results in improper billing (69) Only a third-party billing service can use a supplier's number, provided that a fully executed contract is in place between both parties.

43. Failing to meet individual payor requirements (70) This is the same as “noncompliance with the federal, state, and private payor supplier standards.”

44. Performing tests on a beneficiary to establish medical necessity (71) Specifically addressing a supplier cannot qualify a patient for home oxygen. The testing must be completed by someone or an organization having no financial incentive to see the patient qualify.

45. Improper billing resulting from a lack of communication between the DMEPOS supplier, the physician, and the patient (74) This puts the responsibility of correct documentation and reimbursement in the hands of the supplier, not the physician.

46. Improper billing resulting from a lack of communication between different departments within the DMEPOS supplier (75) In other words, departments should be communicating with each other. Feedback of the audits and errors found should be communicated to those involved. Along with having an effective compliance committee, quality improvement processes are the key to success.

47. Employing persons excluded from participation in federal health care programs (76) A policy should be written so that the supplier will check each new employee against the government’s exclusion list. This same process should occur at least annually for all employees, vendors and independent contractors. The OIG provides a free service for this purpose: http://oig.hhs.gov/fraud/exclusions.html

Additional Tips

Exit interviews or questionnaires should ask a question such as: “Do you know of, or suspect any inappropriate or illegal activity in the organization?” This statement can help defend the DME Company if it is eventually involved in a whistle-blower case. Cost: Low

Train everyone concerning the difference between assignment and non-assignment. All DME suppliers should be non-participating providers with Medicare. While this statement may sound strange, non-participating allows a supplier to choose whether or not to accept assignment on any claim. A good explanation of this can be found at: http://www.umd.nycpic.com/ParvNPar.html Cost: Low

Training should emphasize ethical and moral behavior at all times. Teaching employees to trust their own judgment and values, yet ask for help when they are not comfortable about a situation is critical. Cost: Low

Compliance training and subsequent performance should be an element of each employee’s annual review. Compliance performance can be tied to a bonus structure if one exists. Cost to set this up: Medium. Once established: Low

Establish a policy/procedure on how to deal with a government auditor or investigator if one were to walk in the front door. Train key people such as the receptionist, management, and legal counsel on the DME company’s rights and responsibilities. When compliance training is approached as if the government will be walking in the door tomorrow, everyone will convey the right attitude, if the event becomes a reality. Cost: Low

Create a policy and procedure on how to conduct formal DME investigations. This policy will outline who has responsibility, how an investigation is conducted, who receives the information, how the investigation is documented and how the results are dealt with. Be prepared to conduct an investigation before the need presents itself. Cost: Low

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Implementing the basics of “The Seven Elements of an Effective Compliance Program” – Part I

By Jonathan Wilkenfeld

Editor’s note: Jonathan Wilkenfeld is President, Potomac River Partners, a specialized management consulting firm focusing on health care compliance solutions. Mr. Wilkenfeld has been consulting on health care compliance issues since 2002. He may be reached by telephone at 800/656-4595 or by e-mail at jwilkenfeld@potomacriverpartners.com

A respected marketing professor once described certain product characteristics as “hygiene features,” meaning features that products are required to have but are not “differentiators,” or those that are strategically advantageous. As the professor described it, good personal hygiene is required at a cocktail party, but you will not get any extra credit for having it. An example of a hygiene feature in the product world might be seat belts—no one will buy a car without them—but they won’t lead one to purchase a specific automobile in the same way as greater horsepower, better handling, longer gas mileage, or plushy leather seats.

In terms of compliance, is a compliance program a “hygiene feature” or a “differentiator?” Is it merely sufficient to show the OIG (or other federal or state government officials) that you meet the required elements or is it possible to demonstrate superior compliance? Does your organization need to just meet the minimum standards or are there benefits to exceeding the minimum requirements?

A compliance program can fall under both categories. When the OIG recommends that institutions implement the “Seven Elements of an Effective compliance program,” there are clearly some aspects that are hygiene features. But, at the same time, there are ways to implement best practice approaches that can differentiate your compliance program.

This two-part article will examine both of these aspects of the Seven Elements. Part one will focus on the basics of compliance, the hygiene feature portion. Part two will highlight industry best practices to help create a differentiated program.

Scope: Do I need to have a compliance program?

At the minimum, the following entities should have a compliance program based on direct guidance from the OIG. The date of publication of the guidelines is listed in parentheses:

- Hospitals (Feb 1998)
- Home health agencies (Aug 1998)
- Clinical laboratories (Aug 1998)
- Third party medical billing agencies (Dec 1998)
- Durable medical equipment, prosthetics, orthotics and supply industry (July 1999)
- Hospices (Oct 1999)
- Medicare+Choice organizations (Nov 1999)
- Nursing facilities (Mar 2000)
- Individual and small group physician practices (Oct 2000)
- Ambulance suppliers (Mar 2003)
- Pharmaceutical manufacturers (Apr 2003)
- Recipients of PHS Awards (Draft: Nov 2005)

The OIG has suggested that these organizations implement the “seven elements” of a compliance program. While it is widely known that OIG guidelines are voluntary, it is important to note that the federal government has recovered more than ten times the amount of dollars than it has put into enforcement. Thus, prudent organizations have compliance programs. And as South Beach Community Hospital learned this past March, failure to implement a compliance program can result in exclusion from participating in federal health care programs. If you fall under one of the above categories and have not implemented such a program, you will want to read closely.

The seven elements

The seven elements as defined by the OIG:

1. Implementing written policies and procedures
2. Designating a compliance officer and a compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected problems and undertaking corrective action

Additionally, in its newest Guidance, the OIG added an eighth element:

8. Roles and responsibilities and assigning oversight responsibility

As the OIG sees it, these are the basic building blocks for a compliance program. Complete failure to address one of these topics would be akin to seriously poor hygiene, like not brushing your teeth!

1. Implementing written policies and procedures. Compliance Officers should make sure that clear documentation exists of the organization’s general ethical standards as well as organization-specific risk areas, as outlined by the OIG. These policies and pro-

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SAVE THE DATE!
Looking ahead at EHR developments from a compliance perspective

By Kathy Kenyon, J.D., CHC

Policy analysts verge on wildly enthusiastic about the promise of electronic health records (EHR), and they know that the key to success is getting EHR into the offices of physicians, hospitals, and other providers. Despite that, health care organizations should not expect direct financial help for EHR adoption from the federal government any time soon. Instead, expect verbal encouragement, while the federal government’s efforts are directed at creating a legal and regulatory framework, including standardization and certification, that should make it easier to evaluate and eventually connect EHR systems.

This article looks at foreseeable regulatory and legal challenges likely to affect EHR development, as well as at changes in public and payor expectations and in payment methodologies. Finally, despite foreseeable challenges, risks, and uncertainties, this article encourages moving ahead with EHR adoption and makes a few recommendations for managing the risks associated with doing so in the areas of information technology contracting, privacy and security compliance, and fraud and abuse compliance.

Plan for these developments

Interoperability. Sooner or later the federal government is going to issue interoperability standards; they have been promised for 2006. The high priority given to interoperability standards within the Department of Health and Human Services (DHHS) is clearly evidenced by the formation of the “American Health Information Community” in September 2005, led by DHHS Secretary Mike Leavitt, to “provide input and recommendations to HHS on how to make health records digital and interoperable, and assure that the privacy and security of those records are protected, in a smooth, market-led way.” The DHHS Office of the National Coordinator for Health Information Technology also issued a contract to the American National Standards Institute to do “standards harmonization” required for interoperability. In the private sector, EHR vendors got the message a couple of years ago that interoperability is coming, and formed an EHR Vendor’s Association under the auspices of the Healthcare Information and Management Systems Society. In February 2006, it issued an “Interoperability Roadmap” that is likely to shape this issue for vendors and may influence government standards. Information technology staff within health care organizations should follow developments in this area.

In the meantime, every health care organization considering the purchase of an EHR system should build an interoperability warranty into its EHR contracts. If your organization already has EHR, then you should be talking to your EHR vendor about upgrades to meet interoperability standards.

CCHIT certification. In October 2005, DHHS awarded a contract to the Certification Commission for Health Information Technology (CCHIT) (http://www.cchit.org/) “to develop criteria and evaluation processes for certifying EHRs and the infrastructure or network components through which they interoperate.” In May 2006, CCHIT began certifying EHR systems for physicians’ offices, and it is scheduled to identify certified systems in July. Inpatient hospital EHR certification standards are scheduled for finalization in 2007. At this point, the consequences of not being certified are unclear, but, assuming payors and governments start requiring certification, CCHIT is likely to be the certifying organization. Once the CCHIT certification system is fully in place, providers should require that the EHR systems they purchase are certified or become certified.

RHIOs and HIEs. Regional Health Information Organizations (RHIOs) or Health Information Exchanges are strengthening and spreading with private and government encouragement. Because of its broad based public-private support, clear statement of policies, and technical detail, the most important recent development in this area is Connecting for Health Common Framework, a report published in April 2006 with sponsorship of the Robert Wood Johnson Foundation and the Markle Foundation.

Well before the Connecting for Health Common Framework was issued, the federal government had taken steps toward consideration of some form of Nationwide Health Information Network (NHIN), based on RHIOs. The Office of the National Coordinator has announced that in June 2006 it will hold the “first nationwide health information network forum” to develop “functional requirements” that will focus on...
“the critical technical components of architectures to support a Nationwide Health Information Network.”

The building blocks of any nationwide network are likely to be RHIOs or Health Information Exchanges (HIE). HIE appears to have become the preferred term by the most active private organizations supporting HIE development, including the eHealth Initiative, which is responsible for managing the Connecting for Health program. The eHealth Initiative works with many fledgling HIE or RHIO projects, and this year produced a very useful “Toolkit” for developing HIEs. The Agency for Healthcare Research and Quality (AHRQ) is supporting demonstration HIE programs in six states. Some states have made significant progress toward creating RHIOs. Just one example, CalRHIO in April 2006 issued a document on “data standards” that is likely to impact vendors and, therefore, providers. So far, the lack of reliable financial support has been a significant problem, but, as the utility of HIEs becomes clear, viable economic models are emerging, often with help from eHealth Initiative.

Providers should get involved in these efforts, if for no other reason than HIE decisions on issues like the functions performed by the HIE, information privacy and security policies, methods of patient identification, types of information shared, physician access, and other technical details will eventually impact provider operations and how health care is practiced.

Privacy and security developments. As most privacy officers will tell you, one consequence of the April 2003 HIPAA privacy rule has been the realization that privacy breaches happen far too often. They will probably also tell you that, while the April 2005 HIPAA security rule is a burden to implement and maintain, it is significantly improving privacy and security in ways long past due in health care. What makes the press, however, are security breaches that result in health information for hundreds of people potentially entering the public domain or becoming the basis for identify theft. The Connecting for Health Common Framework adopted nine principles for improved privacy and security because, without them, the public is very skeptical of interconnected EHR systems. The DHHS’s Office of the National Coordinator of Health Information Technology and the AHRQ are currently implementing grants involving 40 states to identify best practices and address privacy and security issues related to HIEs. The results from this research may well result in further guidance under HIPAA on privacy and security protections. Health care providers need to be prepared for constantly increasing privacy and security expectations from both the public and regulators.

Outcomes measures. EHR systems should be self-consciously designed from the beginning to enable health care organizations to readily measure outcomes, especially in areas where the federal government and private payors are already asking for outcomes measurement. For example, the Centers for Medicare and Medicaid Services (CMS) has initiated reporting of quality measures for hospitals and nursing homes. Recently, CMS initiated the “Doctor’s Office Quality Project” and a Physician Voluntary Reporting Program, which include 36 measurements that physician organizations need to have in mind when purchasing or upgrading their EHR systems. CMS keeps suggesting that EHR will facilitate outcomes measurement, but that will only happen if health care organizations insist on such functions and vendors respond. One hopes that certification of EHR systems will eventually support outcomes reporting functions.

Pay for performance. Pay for performance (or “results-based” payments or “value purchasing”) is still fairly uncommon (although where it exists, it can be important). But as performance measures become more widely accepted and reliable, pay for performance will spread. The underlying premise is compelling—the current dysfunctional payment system rewards volume and is neutral on quality; if payors want quality and efficiency, they need to reward it. Since payors believe EHR can improve quality and efficiency, we should expect some of the pay for performance incentives to encourage EHR adoption. This is already happening in some areas. At this point, the best source of information on private pay for performance is the Bridges to Excellence program. Pay for performance financial incentives by Medicare are expected to indirectly reward those with the foresight to have adopted EHR, but these incentives are only a promise at some unspecified time in the future.

Health care organizations should engage with payors in developing pay for performance models that create financial incentives for the right results, including for EHR adoption; otherwise the danger is that health plans will use quality or cost measures that physicians and health care organizations do not trust and that their EHR systems have trouble measuring.

Personal health records (PHR). Patient responsibility for health is being encouraged by policy analysts, health plans and employers, in part by encouraging the development of claims-based “personal health records.” The basic idea is to give patients the ability to track their health care history over time as they move between physicians and health care providers. In most models, patients would control access and be able to

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HCCA Presents its Fall 2006 Conference Calendar

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HCCA has a number of National Specialty, Academies, and Local Area Conferences planned for this Fall. Please check this listing below. Local Area Conferences are offered by HCCA to provide inexpensive compliance education and local networking opportunities for compliance officers and their staff. You will find conference details on the HCCA Web site, or you may call HCCA at 888/580-8373 with questions.

National Specialty Conferences and Compliance Academies

**Medicare Part D Compliance Conference**
September 10-12, 2006
Renaissance Harborplace Hotel
Baltimore, MD

**Research Compliance Conference**
September 17-19, 2006
Caesars Palace
Las Vegas, NV

**Audit & Compliance Committee Academy**
September 20-22, 2006
Orlando World Center Marriott Resort
Orlando, FL

**AHLA/HCCA Fraud & Compliance Forum**
September 25-27, 2006
Renaissance Harborplace Hotel
Baltimore, MD

**Physician Group Practice Compliance Conference**
October 1-3, 2006
Renaissance Parc 55 Hotel
San Francisco, CA

**Compliance Academy**
October 6-9
Portofino Bay Hotel
Orlando, FL

**Advanced Compliance Academy**
October 23-26, 2006
Harrah’s Las Vegas
Las Vegas, NV

Local Area Conferences

**New England Area Compliance Conference**
September 8, 2006
Boston, MA

**Upper Midwest Area Compliance Conference**
September 15, 2006
Minneapolis, MN

**Mid Atlantic Area Compliance Conference**
September 29, 2006
Pittsburgh, PA

**North Central Area Compliance Conference**
October 6, 2006
Chicago, IL

**Hawaii Area Compliance Conference**
October 19 - 20, 2006
Honolulu, HI

**Tri-State Area Compliance Conference**
November 3, 2006
Louisville, KY

**South Central Area Compliance Conference**
November 10, 2006
Nashville, TN
add information to their PHR. The question of physician access to the PHR as part of treatment, without explicit patient authorization, is still open to discussion. Some health plans see the personal health records they are developing as a potentially valuable tool for helping physicians identify other health care providers their patients have seen, as well as diagnoses, medications, lab tests, and imaging tests. Such information may be useful even if the claims-based nature of the data in the PHR do not include results or details, and, therefore, is not nearly as clinically useful as the EHR systems maintained by most health care providers.

Some companies are marketing a PHR as an option for health care organizations to offer to patients. This development deserves watching. If health care organizations consider adding a PHR option for their patients, they need to ask a great many questions about access control, portability for the patient, costs, privacy and security, the relationship to a local HIE (when they develop), the source of information that flows into the PHR, and the reliability of the vendor among other things.

Looking ahead: Managing the risks
At the risk of oversimplifying, most health care organizations could prudently manage most of the legal risks and some of the business risks associated with EHR adoption and implementation by concentrating on three areas: IT contracting, privacy and security compliance, and fraud and abuse compliance. (A fourth area would be risk management related to electronic discovery in malpractice cases, but that issue will go unaddressed in this article).

Information technology (IT) contracting. The topic of IT contracting deserves more detailed attention than this article can give. Contracts are often the best way, sometimes the only way, of managing the business risks (the risks of failure, delay, nonperformance) associated with EHR, and those risks are potentially huge. Health care organizations need to commit staff to the integrity and long term management of the IT contracting process. They need to hire a lawyer with expertise in health IT contracting and work with that lawyer on developing an entire IT contracting process. The IT contracting process starts during vendor selection with the Request for Proposal and continues into implementation, contract interpretation, and dispute resolution. Any health care organization that does not have disputes with its EHR vendor is probably not paying attention. While it is always better to resolve disputes amicably as allies in a long-term relationship, the contract is the backdrop for that relationship and can dramatically affect how amiable the relationship remains when the dispute involves real money and is not easily resolved.

Privacy and security compliance. Every group needs a HIPAA compliance plan, including all seven elements of an “effective” plan—a compliance/privacy/security officer and committee, policies and procedures, open lines of communication, training and education, monitoring and auditing, prompt response to detected deficiencies, and discipline. However, of overarching importance is leadership commitment to creating a culture in which the compliance staff, the IT staff, and the users of the EHR system agree on the importance of privacy and security protections for the success of the EHR system.

Many privacy officers, lawyers, and IT staff believe a “privacy backlash” is coming that will require privacy and security practices well above the minimum required by current HIPAA rules. Some of the developments discussed above reflect that concern.

Nonetheless, too often not nearly enough attention is paid to privacy and security, especially during the early phases of EHR development in an organization. Often health care organizations are primarily worried about making the EHR work for clinical reasons, so physicians and other providers have easy and quick access to all of the information needed for patient care. Beyond that, physicians and other providers are concerned about liability if information is in the EHR, but they cannot see it. While these concerns are important, they should not supplant attention to privacy and security protections that need to be carefully built into EHR systems from the beginning, including the ability to hide certain information behind higher security barriers at the request of patients.

As a vital first step, make certain the organization purchases adequate EHR auditing software to allow the privacy officer to determine if a “user” has looked at a particular patient’s record. A tamper-resistant “immutable audit log” is highly recommended by the Markle Foundation in a February 2006 report. One
The Seven Elements of an Effective Compliance

...continued from page 30

2. Designating a compliance officer and procedures should be centrally available and regularly updated.

The general ethical standards are typically outlined in a Code of Conduct or Employee Handbook and provide general guidance for employee behavior. Most Codes of Conduct not only provide guidance on health care compliance topics but may also cover broader ethical and legal topics such as harassment, insider trading, and antitrust issues. Codes of Conduct should be relatively brief and focus more on ethical principles than specific policies or processes.

Next, an organization needs policies and procedures that address the specific areas mentioned by the OIG for its industry. This is generally the most thorough aspect of any entity’s compliance program and will be tailored based on the type of organization. For instance, hospitals should have extensive coding procedures, ambulance suppliers need to describe their definition of “medically necessary,” and research institutions should develop a process for reporting time and effort. As you develop these policies and procedures, it will be helpful to record the date of all policy versions, particularly for updating purposes.

These policies and procedures should be centrally available. A good rule of thumb to consider is, if the OIG knocked on your door and asked for all of the compliance policies on a certain topic, would you be able to respond? Many organizations have begun posting all of their compliance policies and processes on either corporate intranets or directly on the Internet (either through a secured or public site). This approach has the added benefit of enhancing the communication of policies, as all employees and agents will know where to retrieve the policy.

3. Conducting effective training and education A key role of the Compliance Officer is to suggest topics to internal training departments. Training needs to include education on general principles as well as targeted topics. The Compliance Officer should recommend that training occurs whenever new policies are created.

Additionally, Compliance Officers should suggest training topics based on issues identified during auditing activities and those arising from their communications with others in the organization, including the Compliance Committee.

If the organization does not have a separate training department, the Compliance Officer should take the lead in developing the content and delivering the message internally or partner with an external training provider.

It is important to roll out training to three key audiences:
- Employees (e.g., new subject material)
- New hires
- Agents and contractors

Additionally, it is not sufficient to simply train one time and presume all employees will never forget what they have learned. Just as physicians and attorneys need to complete continuing education efforts, the Compliance Officer needs to ensure that his or her organization conducts refresher training. This is not only for employees, but for all covered persons.

Lastly, documentation is essential. Maintain copies of all training materials and handouts. Whenever you conduct compliance education, make sure to have a sign-in sheet or other mechanism for recording attendance and the date of the event. Failure to attend required training events should trigger disciplinary action. Many organizations require a minimum number of hours of required training. Tracking attendance at training events will also help identify when refreshers are needed.

4. Developing effective lines of communication Communication serves as the basis for creating an organization’s culture. Organizational cultures evolve based on the way that people interact and communicate with each other. To be effective at establishing a compliant culture, remember that communication is a two-way street. Sometimes you need to listen and sometimes you need to talk. Therefore, all compliance programs should have mechanisms to receive incoming
Openness around compliance is essential. Compliance Officers need to be seen internally as a “go to” resource on all compliance matters. This means being accessible and available to answer questions or respond to concerns. Compliance Officers must let the organization know that their office door is always open.

Furthermore, there needs to be a mechanism for receiving anonymous information, such as a hotline. As part of the program, Compliance Officers should install whistle-blower protection policies to help encourage reporting and corresponding non-retaliation policies. Conversely, there should also be consequences for failure to identify noncompliant behavior, especially for supervisors and management.

Additionally, the Compliance Officer needs to confirm that new guidance and regulations are communicated throughout the organization. This should be done through multiple channels. For instance, the hotline number could be listed on a department Web site, described in the Code of Conduct, and mentioned during training sessions, and depicted on signage in common areas, such as the cafeteria. Other avenues for communication include e-mail, newsletters, and posters.

And, of course, Compliance Officers should document everything. Keep a record of all feedback received and all communications sent to the organization.

5. Conducting internal monitoring and auditing
Auditing and monitoring is critical to validate that procedures have been implemented, effectively communicated, and followed. One approach is to have Operations groups develop self-monitoring procedures. For instance, coding supervisors can double check that billings are being charged appropriately to Medicare or Medicaid and hospital contract managers can review contract agreements with physicians to ensure that there is no violation of the Physician Self-Referral Law (i.e., Stark Law).

However, the OIG believes it is also important to implement regular independent audits. Under the Single Audit Act of 1984, “institutions that expend $500,000 or more in Federal assistance are required to have a single audit of the non-Federal entity.” Therefore, for most organizations, it is not sufficient to rely on...
The Seven Elements of an Effective Compliance

Once an issue has been identified and investigated, there needs to be consistent disciplinary action. With the backing of management, it will be much easier to enforce disciplinary action across the organization.

7. Responding promptly to detected problems and undertaking corrective action
The Compliance Officer needs to develop a protocol to determine how the organization will investigate potential compliance problems. Each case should be reviewed individually and promptly after the initial identification of the concern.

For instance, there needs to be a clear process for handling potential concerns identified via the hotline. While it is crucial to conduct a thorough inquiry, there also needs to be consideration for the reputation and risk of those being evaluated. You should consider gathering input from internal or external counsel when developing the investigation protocol.

If a problem is discovered following the completion of an investigation, the Compliance Officer needs to recommend corrective action. Many issues can be corrected through training and communication. Also, it may be helpful to revise either the existing policies or procedures to clarify roles and responsibilities. Lastly, enact consistent disciplinary action.

Additionally, there are certain situations when you need to report directly to the federal government. For instance, overpayments from Medicare or Medicaid need to be returned to the government, adjustments to “best price” for pharmaceutical products need to be reported, and you need to inform the government about suspected instances of scientific misconduct in clinical research. In April 2006, the OIG announced a protocol for self-reporting, which should be taken into account when developing internal resorting processes.

8. Defining roles and responsibilities and assigning oversight responsibility
In its most recent draft guidance, the OIG added a new eighth element to its compliance program Guidance for Recipients of Public Health Service Research Awards, the OIG wrote, “Roles and responsibilities for each position should be clearly communicated and accessible. Including roles and responsibilities in the institution’s written policies and procedures and in its formal training and education program could accomplish this objective.”

While this standard has not been specifically mentioned in other OIG Guidance, it is a very logical approach to building an effective compliance program and one the OIG will likely be looking for in the future. All organizations should review their policies and determine whether they have clearly defined not only what is required, but who is expected to perform the activity.

Stay Tuned
This article, part one of two, looked to address the “hygiene features” of an effective compliance program. Part two will look to identify ways to ensure that your compliance program goes beyond what is simply required by identifying ways to enhance your existing program.

1 The text and order of these elements comes from the most recent OIG Guidance for Recipients of PHS Awards from November 2005. Some of the earlier CPGs phrase these elements slightly differently or in a different order.
Looking ahead at EHR developments

The Stark law makes it illegal for an entity to submit claims for “designated health services” ordered by a physician if the physician (or a family member) has a “financial relationship,” defined broadly as involving “remuneration,” with the entity, unless the relationship meets every technical element of an exception. The anti-kickback statute criminalizes “remuneration” paid to knowingly induce referrals billed to a federal program. The anti-kickback statute has “safe harbors,” but they are not legally mandatory; close is generally sufficient, absent bad intent.

Anything of value extended directly or indirectly to outside referral sources can be “remuneration” under either the Stark or anti-kickback laws. Examples of potentially illegal remuneration would include a below fair market value sale of EHR technology to an outside physician practice, free technical support to evaluate purchase of EHR, donation of an old computer to the local homeless clinic, and free access to an e-library given to referral physicians. While the penalties under the Stark or anti-kickback laws are substantial, if the government piggybacks the Stark or anti-kickback violation on the False Claims Act, then the penalties are treble the amount of the claims, plus up to $11,000 per claim. In addition, violation of these laws risks potential exclusion from Medicare.

Fraud and abuse compliance. The penalties for failure to pay sufficient attention to fraud and abuse issues in an organization’s EHR business strategy are potentially devastating. The fraud and abuse problems arise most often under the Stark self-referral law, the anti-kickback statute, and the False Claims Act when nonemployed physicians or other providers are given EHR technology or technical support services for free or at prices below fair market value by an entity that bills Medicare or Medicaid. This is a situation in which no good deed extended to a referral source goes unpunished or, at least, goes without substantial legal risk. The fraud and abuse enforcement agencies often see the opportunity for fraud and abuse as the result of EHR donations, while many EHR proponents see the opportunity to improve quality, reduce errors, and measure outcomes by giving a partner in health care a helping hand. CMS and the Office of Inspector General (OIG) are expected this fall to issue exceptions and safe harbors to allow limited donations of EHR. Congress has also considered legislation that will eliminate some regulatory barriers to EHR donations, but legislation is not likely in the short run.

Because of the huge potential penalties, health care organizations need to subject their IT strategy to a fraud and abuse compliance plan. Such plans are especially crucial for organizations that are contemplating the sale or donation of EHR technology or technical support to nonemployed physicians or other providers in a position to refer. While donations are very problematic legally until the government changes the regulations, valid exceptions and safe harbors currently exist for fair market value sales under the Stark law and anti-kickback statute; however, staying within them requires careful attention to detail and documentation. The people responsible for the organization’s IT business strategy must develop a good working relationship with compliance staff trained in this area and with fraud and abuse lawyers, and they must willingly submit their plans for review before they implement those plans.

Conclusion

Given rapid changes in EHR technology and in the regulatory and payment environment, potential purchasers can be forgiven for having qualms about EHR. EHR roll-out strategies can be a legal minefield, and ensuring security is an ongoing challenge. But rapid change and legal minefields are not unusual in health care. The potential advantages of EHR, especially for the quality of patient care, are enormous. With proper planning, strong leadership, and teamwork between the IT and compliance staffs, health care organizations can reasonably manage EHR risks and should move ahead undaunted by the risks and uncertainty.

1 Sections of this article will also be published in the July/August 2006 Group Practice Journal.
3 The Web site is http://www.himssehrva.org/ASP/index.asp.
6 See http://www.cms.hhs.gov/PhysicianFocusedQualInit.
7 See its website at http://www.bridgestoexcellence.org/bte/
8 See America’s Health Insurance Plan’s (AHIP’s) November 2005 publication “Innovations in Health Information Technology” Chapter 5 for a description of this emerging, ill-defined phenomenon for health plans. The Connecting for Health project and the Commission on Systemic Interoperability also highlighted the potential of a “person-centered” record over a lifetime as good policy. See http://www.connectingforhealth.org/workinggroups/personal-healthw.html.
9 Lawyers worry because some of the Internet-based firms marketing PHRs are not “covered entities” under HIPAA, and therefore, the legal framework surrounding the privacy and security of these systems is open to question.
10 See Mackle Foundation, “Implementing a Trusted Information Sharing Environment: Using Immmutable Audit Logs to Increase Security, Trust, and Accountability,” February 2006. This topic is also discussed in Policy Guide 7 of the Connecting for Health Common Framework Inserted space
The following responses were provided by F. Lisa Murtha

**Q:** What are the hot topics being covered at this year’s Research Compliance Conference?

**A:** Clinical trial billing, effort reporting, compliance with GCP standards, auditing and monitoring issues, and much more.

**Q:** Are many of the conference speakers actively working in research compliance?

**A:** All of the conference speakers actively work in research compliance.

**Q:** Along with compliance officers working in research, who else within the research function would benefit from this program?

**A:** Principal investigators, research coordinators, hospital administrators, attorneys, consultants, billing professionals, etc.

**Q:** Who has been invited to address the conferences as the Keynote Speaker and Government Representatives?

**A:** Jo An Leonce, Chief Counsel to the NIH Office for Research Integrity and James Sheehan, Esq., AUSA, Eastern District of Pennsylvania

**Q:** If I have just been appointed to manage research compliance will this conference provide me with what I need to know?

**A:** It will provide the best foundation for how to develop a research compliance program, how to train investigators and coordinators, and how to audit and monitor ongoing compliance.

**Q:** What CEUs are being offered at the Research Conference?

**A:** AAPC, NASBA-CPE, HCCB, AHIMA, ACHE

**Q:** Will there be opportunities to network?

**A:** There will be a cocktail party/reception and lunches that will provide much opportunity to network.

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The following responses were provided by Debbie Troklus and Jennifer O’Brien

**Q:** What are the Hot Topics to be addressed by the Fraud & Compliance Forum this year?

**A:** There are several Hot Topics from which conference-goers may choose. For example: Gaining insight and knowledge in preparing for the Deficit Reduction Act (DRA). Another one is on ethical leadership and governance, as well as case studies on Health Care Fraud and False Claims Act cases with perspectives from the industry and the government, fraud and abuse concerns in an electronic record environment.

**Q:** If I attended the Compliance Institute in April, why would I also attend the Fraud & Compliance Forum?

**A:** The sessions at the Fraud and Compliance Forum addresses legal issues as well as compliance issues. At the Institute you get the hands-on technical compliance training with some legal, while at the Forum conference-goers get the legal aspects of compliance. I always enjoy the F&C Forum, as it offers workshops on the legal aspects of compliance which is a true benefit to non-legal compliance officers since knowing and understanding the law is an important part of our
**Q:** What are the unique features of the Fraud & Compliance Forum – is this conference one that I should attend with my organization’s General Counsel, and if so, why?

**A:** This is “the” conference to attend with your general counsel. It is always a great idea to have the legal counsel and compliance officer attend and hear the same information. Since this is normally a close working relationship attending together could only benefit the team.

**Q:** What CEUs will be offered?

**A:** CLE, CPE, ACHE, AHIMA, AAPC & HCCB

**Q:** Will this conference help to prepare for compliance certification?

**A:** Since the certification is based on the seven elements of an effective compliance program, many of these areas will be covered during this conference. Both the Fraud and Abuse Primer and Compliance 101 sessions would be very helpful to prepare and study for the exam. Also embedded in the conference are classes that would be helpful. Anyone interested in sitting for the CHC exam should review the content outline which can be found in the CHC Candidate Handbook (on the HCCA Web site) and then look for workshops which address these areas.

**Q:** Will the compliance certification exam be offered at the end of the conference?

**A:** Oh yes the CHC exam will be offered.

**Q:** If I am a newly appointed compliance officer, how will I benefit from the Fraud & Compliance Forum?

**A:** The Fraud and Compliance Forum offers insight into health care compliance regulations for both new and experienced compliance officers. As I mentioned earlier, this conference offers a Fraud and Abuse Primer and also Compliance 101, which are ideal for new compliance officers.

**Medicare Prescription Drug Part D COMPLIANCE CONFERENCE**

**September 10-12, 2006**

**Renaissance Baltimore Harborplace Hotel**

**Baltimore, MD**

The following responses were provided by Conference Chair Mona T. Peterson Rosow with the law firm of Halleland Lewis Nilan & Johnson PA:

**Q:** This is the 2nd Medicare Part D Compliance Conference planned – what is the need that prompted this 2nd conference?

**A:** Since the January 1, 2006 implementation date, Medicare Part D has raised many compliance issues, some of which were predicted last year, but many of which are new. In addition, CMS has released its final Fraud Waste and Abuse guidance and is starting to talk about issues its MEDIC (its integrity contractor) has identified in enrollment and marketing activities.

**Q:** The Medicare Part D Conference is planned with HCCA and the Centers for Medicare and Medicaid Services – will there be panel discussions or other interactive sessions where questions will be addressed?

**A:** Most of the speakers will allow for questions. While panel discussions will be limited, the sessions are designed to identify issues in Medicare Part D and allow for people to share their concerns and experiences.

**Q:** Will the speakers have experience in developing compliance programs addressing Medicare Part D?

**A:** There will be some speakers with direct experience in the development of compliance programs, but all speakers will have familiarity in the requirements.

**Q:** Along with CMS, what other government speakers will be addressing this conference?

**A:** Jim Sheehan, Associate U.S. Attorney, Eastern District of PA

*Continued on page 38*
Q: Recently compliance guidance was published for Medicare Part D – are there sessions planned to review this guidance?
A: Absolutely, yes.

Q: What other Hot Topics will be addressed at this conference?
A: Long term care issues, pharmacy issues, issues for pharmaceutical manufacturers, areas of risk for insurers

Q: Who is the intended audience for this conference?
A: Insurers, pharmacies, long term care facilities, pharmaceutical benefit managers

Q: Will there be opportunities to network?
A: Yes, there will be a variety of opportunities for networking including a reception on Monday night.

The following responses were provided by Debbie Troklus

Q: What are the Hot Topics that are going to be addressed at the Physician Group Practice Compliance Conference this year?
A: I'd say the following sessions:
Advice to Physicians from a Physician-Compliance Officer: Lessons Learned about Medicare and the Practice of Medicine
Ethics in Physicians Practice
Health Care Fraud Investigations
Compliance Effectiveness in the Physician's Office

Q: If I attended last year's conference, why should I attend it again this year?
A: With the many regulatory changes that affect the compliance professional, this conference provides up-to-date “new” information each year that is geared especially for those that work in or with physician practices.

Q: Will there be speakers from the government to address enforcement issues?
A: Yes! We will have government speakers that will address current regulatory information. Kim Brandt, Director of Program Integrity, CMS will address Compliance Effectiveness in the Physician’s Office and we have invited Sean McKenna, Assistant United States Attorney, U.S. Attorney’s Office Northern District of Texas to speak on Heath Care Fraud Investigations. Also, Arthur Di Dio, Senior Counsel, Administrative and Civil Remedies Branch, Office of the Inspector General, Department of Health and Human Services will speak on Fraud and Abuse for Physicians.

Q: While it is clear who the intended audience is for this conference - physicians and practice managers - who else would benefit from attending this conference?
A: This conference will benefit physicians, other health care providers, compliance professionals, coders/billers, auditors, educators, academic health centers and any others who work in or for physician practices.

Q: What CEUs are being offered?
A: ACHE, AHIMA, CME, HCCB, NASBA/CPE and Continuing Education for Nursing for CA.

Q: If someone has just been appointed as the compliance officer for a physician group practice would this conference provide him/her with the basic information they need to know?
A: We will offer Compliance 101, which is dedicated especially to new compliance officers. Many seasoned compliance professionals take Compliance 101 as a refresher and also as a tool to study for the CHC exam.

Q: Will there be opportunities to network?
A: There will be multiple opportunities for networking. We will have an opening reception on Monday Night, which allows an excellent opportunity to network.
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**Standard Error**: Measurement of the variation of the point estimate of the total with respect to all possible totals for this universe and these sample sizes.

**Confidence Level**: A percentage associated with the ability of the corresponding interval to contain the true mean (or universe total).

**Precision Percent**: A measurement of the closeness of the sample estimate of the universe total and the corresponding unknown universe value divided by the point estimate stated as a percentage.

RAT-STATS allows the user the option of having the program read a probe sample file to obtain an estimate of the universe mean and standard deviation. It is advisable to use the Random Number module of RAT-STATS to select the items for your probe sample to insure that your probe sample is a fair representation of your data universe. The probe sample file data can be contained in a text file, an Excel spreadsheet or a table within an Access database, (please consult the RAT-STATS user guide for the required file format). Another option is to manually input the universe mean and standard deviation directly without reading a probe sample file.

In the example, you indicated that a probe file of 30 claims yielded a 20% error rate from a data universe of 50,000 claims, however since you have not provided an example probe file, I will provide assistance in entering these two estimates manually. The most efficient way to obtain these two estimates is to utilize Microsoft Excel to calculate them. From within an Excel spreadsheet, create a consecutive range of numbers by data filling the cells down in column “A” equal to the number of items contained in your universe. Select the “AVERAGE” formula and highlight the range of numbers as an input criterion for the formula, (do the same for the STDEV formula). Record the results of each formula so it can be entered into RAT-STATS when prompted to enter the universe mean and standard deviation.

The Variable Sample Size Determination program allows you to estimate a quantitative characteristic or set of characteristics for specified confidence levels and specified precision percentages. The Variable Stratified module will determine optimum sample sizes for situations where the total sample size is either predetermined or unknown. The Attribute Sample Size Determination program allows the user to estimate the rate of occurrence of a given condition. For your example we will use the Variable Sample Size Determination since we want to calculate the quantity of records needed for a specified Confidence Level and Precision Percentage.

From within RAT-STATS select “Sample Size Determination” then select “Variable Sample Size Determination” and finally select “Unrestricted” from the main menu. On the next pop-up window click on “No Probe Sample Used” then click “OK” when prompted about entering the mean and standard deviation estimates. If you were utilizing a probe sample file, you would select the file format and direct RAT-STATS to the file location. On the next input screen enter 50,000 as the universe size; click on “90%” under Confidence Level; click on the “Other” box under Precision to allow you to enter a manual number. Enter “25” in the Specify Precision Percentage window and finally click on “OK”, (a Confidence Level of 90% and Precision Level of 25% are standard parameters utilized by the Office of Inspector General). When you return to the “Variable Sample Size Determination” window, click on “OK” one more time. Another input window will pop-up prompting you to enter the universe mean that you previously calculated in Excel, (in our example the universe mean is 25000.5). Click on “OK” after entering the value. A second pop-up window will appear prompting you to enter the standard deviation you previously calculated in Excel, (in our example the universe standard deviation is 14433.9). Click on “OK” after entering the value. Finally, a window will pop-up that displays a matrix that identifies the number of items required at the specified Confidence Level and Precision Level.

The answer to your question is as follows: for a universe of 50,000 claims, you would need to have a sample size of 14 fourteen items in order to project a point estimate with a confidence level of 90% and a precision level of 25%. Note that this sample size is based upon calculated values for the mean and standard deviation, which may not fairly represent the universe, it is advisable to obtain these values from a probe sample. Please note that RAT-STATS qualifies its calculated sample size when it is less than thirty. You may elect to increase the sample size that RAT-STATS calculates in order to meet organizational objectives.
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.

The following individuals joined HCCA between May and October 2005:

**Texas**
- Natalie Nichols Banks, JD, RHIA, Texas Children’s Hospital
- Pamela Bennett, RN, UT Southwestern
- Shelly Boehler, Broadlane
- Terri Caffey, The SCOOTER Store
- Jason B. Cagle, United Surgical Partners International, Inc
- Diane Tripp Carter, Brown McCarroll
- Sheryl Tator Dacso, JD, Dr, Dacso Law Firm
- Bonny Dalrymple, Good Shepherd Medical Ctr
- Charlotte Dokes, Texas Health and Human Svcs Commission
- Frances M. Feltovich, RN, MBA, CIC, CPHQ, The Methodist Hospital
- Cartherine Gibson, Thomason Hospital
- Stephanie Grubenhoff, Broadlane
- Diana Holub, RN, Medical City Dallas
- Jerry Hopgood, Baylor Health Care System
- Lowell A. Keig, Youth & Family Centered Svcs, Inc.
- Martha Kennemer, Houston NW Medical Ctr
- Pamela Kutner
- Amy LaBarge, MBA, CPA, CIA, Parkland Health & Hospital System
- Gail Madison, RN, JD, UNTHSC
- Scott McKenna, DO,MPH, FIRSTCARE
- Lacy E. Newberry, Our Angel Home Health
- Pedram Pahlavan, PharmD, BS/CPHQ, RPh, Chartwell Diversified Svcs Inc
- Jessica Pena, KCI
- Mike Phifer, Texas Health Resources
- Allie Ray, Electronic Data Systems
- Edward Russell, PhD, APRN-BC, CNS, Uvalde Memorial Hosp
- Christy L. Scheel, RHIA, Warm Springs Rehabilitation Syste
- Belinda Simpson, Clear Lake Rehabilitation Hospital
- Nancy Smith
- Victoria Soto, Rosenthal & Watson PC
- Cynthia Marcotte Stamer, Glast, Phillips & Murray, PC
- John Stephain, Stebbins Five Companies
- Sharron L. Swann, Brown McCarroll, LLP
- Debbie Telford, Colom & Carney Clinic
- Tamara K. White, Fertility Ctr of San Antonio
- Robin L. Williams, PHNS Inc
- Lance Youts, PricewaterhouseCoopers

**Utah**
- LeVoy Haight, Sorenson Medical, Inc
- Karen Wilson, Univ Medical Billing

**Vermont**
- Hania McAuliffe, Berry, Dunn, McNeil & Parker

**Virgin Islands**
- Julia V. Beresford, Gov Juan F Luis Hosp & Med Ctr
- Pamela Tepper, Juan F Luis Hospital

**Virginia**
- Frank Beatty, CPA, Navigant Consulting, Inc
- D Gregory Burkhart, Sentara Healthcare
- Paul Cramblet, Booz Allen Hamilton
- Brenda Grant, Piedmont Community Hlth Plan
- Peter M. Mellette, Mellette PC
- Patricia Mullins, Culpeper Regional Hospital
- Annette Norton, Univ of VA Health Sys

**Washington**
- Rebekah Stewart, JD, MBA, VA Commonwealth Univ Hlth System
- Ruth Tucci-Kaufhold, BS-Bus DP, Unisys Corporation
- Connie Agenbroad, Othello Community Hospital
- Patrick Anunsen, CPA, Group Health Cooperative
- Sandra L. Bateman, RN, Life Care Centers of America
- Joleen Bond, Group Health Cooperative
- Phuong Dao, Seattle Cancer Care Alliance
- James J. Fredman, III, Foster Pepper & Shefelman PLLC
- Denise Gandy, PeaceHealth
- Jeanne Gorder, Pacific Medical Centers
- Mary Grady, Swedish Medical Ctr
- Carmen Hand, Olympic Health Mgt
- Susan Harvey, DaVita, Inc.
- Marilyn Heger-Guy, Grays Harbor Community Hosp
- Michael G. Hynpe, Mary Bridge Children’s Health Allianc
- Douglas B. Jaquez, Stevens Healthcare
- Deborah Martin, Esq., Valley General Hospital
- Amy Milam, RN, JD, Skagit Valley Hospital
- Patti Newsted, MS, PeaceHealth
- Susan Pellicano, Coopersmith Health Law Group
- Barbara Smith, MBCHA
- Mary Ellen Swatta, Multicare Health System
- Judy Vezzie, Valley Medical Ctr
- Franklin West, Pacific Vascular Inc
- Tricia West, MBA, CCP, CBCS, RVS, Sound Consultative Svcs
- Roger Wiese, Valley Medical Center
- Amy Woodfin, PeaceHealth St Joseph Hospital

Continued on page 46
Welcome to new HCCA members and organizations which joined HCCA between November 2005 and May 2006:

**Alabama**
- Brian T. Bates, BS, CPA, CH, Baptist Health Systems

**Wisconsin**
- Sandra J. Badtke, Green Bay HeartCare
- Brent Bauman, Community Health Partnership Inc
- Marcia M Carlson, Schenck Health Service Solutions
- Beth DeLair, RN, JD, Univ of WI Hosp & Clinics
- Kay E. Fitzgerald, St Paul Elder Svcs, Inc
- David Harrison Adams, Prohealth Care Inc
- Katherine M. Juranitch, CPC, CCS-P, Medical Coll of WI
- Michelle M. Littel, Wisconsin Physicians Service Insurance Corp
- Cheryl Lutz, Wisconsin Physicians Service Insurance Corp
- Karen M. Navarro, BS, Prevea Clinic
- Roberta Navarro, Froedtert Hospital
- Susan L. Rehberger, Community Health Partnership
- Joyce Schaefer, Amery Regional Medical Ctr
- Holly J. Schlenvogt, Medical Asso Health Ctr

**West Virginia**
- Sarah E. Johnson, Jefferson Memorial Hosp
- Karen Robinson, CAMC Health System
- Judith Wise, MedMetrics Mgmt Svcs
- Judy Zieglar, West Virginia Univ Hospitals
- Heidi Beckham, RN, Mostellar Medical Center
- Sharon Cameron, Baptist Health System
- James Crandall, Cardiovascular Association, PC
- Donna M. Hankins, CPC, CHCO, Birmingham Radiological Group, PC
- Tereasa Jackson, Baptist Health System
- Micki R. Jernigan, JD, MPH, HealthSouth
- Kaye Keel, Baptist Health System
- Kimberly Manassa, Department of Veterans Affairs
- Sonia E. McKoy, Univ South Alabama
- Sylvia Renda, HealthSouth Corporation
- Debbie Rubio, DCH Regional Health Sys
- Stephen W. Stair, MD, Univ of AL Health Svcs Foundation
- Doran Stamps, Baptist Health System
- Sarah B. Wheeler

Compliance 101: The Second Edition is Here—Revised and Updated!

The second edition is now available of Compliance 101, the essential guide to health care compliance. The new edition has been revamped with a completely new design and a new chapter dedicated to the Health Insurance Portability and Accountability Act (HIPAA). In addition, Debbie Troklus has revised the book so that it reflects current developments in compliance.

The second edition incorporates material from the Federal Sentencing Guideline Revision and recent information from HCCA surveys. Moreover, the new edition includes an expanded glossary and appendix with more sample documents from compliance programs. All the changes and additions mean the second edition is a larger book. The first edition was 76 pages, but the second edition is over 130 pages. Anyone involved in compliance can benefit from this book. “I really think Compliance 101 is a good reference book,” says Debbie Troklus. “It’s a good refresher for any compliance officer. You can read the book in two days. I think it’s a good book to have all your staff read.”
On one side, it's a technology solution. On the other, a service solution. SMART2.o is more than a software tool, it's a technology solution designed to help you continuously assess coding accuracy and data quality as an important part of your hospital's compliance program.

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