Covered Persons Corporate Compliance Training

Compliance Training Objectives

- Identify the purpose of a Compliance Program, Code of Conduct and the Scope of AAMC's Program
- Identify Employee Roles and Responsibilities in our Compliance Program
- Identify Methods of reporting suspected fraud and abuse
- Understand the obligations of AAMC's Corporate Integrity Agreement
- Define what constitutes Medicare and Medicaid Fraud and Abuse
- Identify AAMC's Strategies for Prevention of Fraud and Abuse
- Overview of the Federal Fraud and Abuse laws and penalties
- Defining Conflict of Interests
- Overview of Billing, Coding and Documentation

Why have a Compliance Program?

AAMC is committed to providing the highest quality healthcare while operating in a lawful and ethical manner. The Program sets forth the expectation that everyone is accountable in preventing, detecting and correcting any conduct inconsistent with the principles of honesty, integrity, forthrightness and completeness.

Compliance Program Scope

- The Compliance Program is intended to reach all levels of AAMC including the Board of Trustees, the Corporate Compliance Officer, the Corporate Compliance Committee which consists of senior leadership, all employees, Medical Staff, volunteers and business holders.
- Through collaboration, the program creates accountability in order to prevent fraud, waste and abuse.

Healthcare Compliance

- Required by law
- Regulates billing and coding
- Prevents improper treatment and billing
- Protects the organization by following laws and regulations

Medicare and Medicaid Fraud

Obtaining a federal or state health care payment through misrepresentation or concealment of facts…..

Examples of Fraud

- Billing for services that were not provided
- Altering medical records or claims to receive a higher payment

Medicare and Medicaid Abuse

Abuse results in unnecessary costs to governmental programs and is inconsistent with the goals of providing patients with services that are medically necessary.

Examples of Abuse

- Billing for unnecessary services
- Billing inaccurate diagnosis and procedure codes on claims to ensure payment

Fraud and Abuse Laws

False Claims Act

Knowingly submitting a false or fraudulent claim to the government:

- Acting in deliberate ignorance of the truth
- Reckless disregard of the truth

Examples:

- Improperly admitting patients to the hospital for services that should have been provided in an outpatient setting
- Billing for tests that were not medically necessary

Anti-Kickback Statute

Prohibits knowingly and willfully offering, paying, soliciting or receiving any reward to induce referrals of service reimbursable by a federal health care program.

Anti-Kickback Statute examples:

- Cash for referrals
- Free staff in exchange for referrals
- Free rent or below market value rent for referrals

Stark Law

Prohibits physicians from referring Medicare beneficiaries for certain designated health services to an entity in which the physician or their immediate family member has an ownership/investment interest.

Stark Law Example:

- A physician refers a patient to a laboratory that he owns.

Deficit Reduction Act (DRC)

- DRA, **Public Law No. 109-171 ,** requires compliance for continued participation in the Medicare and Medicaid programs.
- The law requires:
  - the development of policies and education relating to false claims,
  - whistleblower protections and
  - procedures for detecting and preventing fraud, waste, and abuse.

EMTALA

It requires hospital Emergency Departments that accept payments from Medicare to provide an appropriate medical screening examination to individuals seeking treatment for a medical condition, regardless of citizenship, legal status or ability to pay.

Participating hospitals may not transfer or discharge patients needing emergency treatment except:

- With the patient's informed consent, or
- Stabilization of the patient, or
- When their condition requires transfer to a hospital better equipped to administer the treatment.

Exclusion Statute

The Office of Inspector General (OIG) is required by law **42 U.S.C. § 1320a-7**, to exclude from participation in all Federal health care programs individuals and entities convicted of the following types of criminal offenses:

- Medicare or Medicaid fraud
- Patient Abuse or Neglect
- Felony convictions

Excluded providers may not bill directly for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice.

Civil Monetary Penalties (CMP)

OIG may seek CMP and sometimes exclusion based on the type of violation. Penalties range from $10,000-$50,00 per violation. Some examples include:

- Presenting a claim for services not provided
- Violating Anti-kickback Statute
- Making false statements in documentation
- Violating physician Medicare agreements

Billing, Coding and Documentation

Billing is based on:

- A Procedure code (CPT),
- A Diagnosis code (ICD-10), and
- A Modifier (if applicable, helps further describe a procedure code without changing the definition)

Billing is based on services actually rendered

CPT and ICD-10 Code Selection:

- Code and modifier selection is based on the service rendered and documented in the medical record
- Code and modifier selection should never be based on whether they guarantee payment

Billing, Coding and Documentation

Documentation:

Medicare's rules for billing: "If its not documented, it didn't happen".

- Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

- The medical record should be complete and legible.
- All tests should have an order and support the medical necessity for performing the test.

Billing, Coding and Documentation

The documentation of each patient encounter should include:

- The reason for encounter and relevant history, physical examination findings, and prior diagnostic test results
- An assessment, clinical impression, or diagnosis
- Plan for care
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to the treating and/or consulting physician
- Appropriate health risk factors should be identified

Medical Record Documentation

Cloned Documentation Could Result in Medicare Denials for Payment

Medicare has noted an increase in frequency of medical records that contain identical documentation across services.

Cloning has been defined by Medicare as:

- Each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries, or
- When medical documentation is exactly the same from beneficiary to beneficiary.
- It can also occur when the documentation is exactly the same from patient to patient.
- Cloned documentation will be considered misrepresentation of the medical necessity requirement for coverage of services due to the lack of specific individual information for each unique patient.

Evaluation and Management Services (E/M)

Evaluation and Management Services are categorized by:

- Place of service- e.g. Inpatient or Office
- Type of Service- New Patient Visit, Initial Hospital Visit

Evaluation and Management Services (E/M)

The descriptors for the levels of E/M services recognize three key components which are used in defining the levels of E/M services. These components are:

- History
- Physical Examination
- Medical decision making

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. The volume of documentation should not be the primary influence upon which a specific level of evaluation and management service is billed.

Evaluation and Management Services

- The level of service is determined by the elements documented in the medical record.
- Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g.,. examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.
- In the case of visits which consist predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M service.
  - Time spent counseling must be greater than 50% of the encounter.

1995 Guidelines:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
1997 Guidelines
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

Penalties

In 2018, the Department of Health and Human Services (OIG) recently reported results of health care investigations that included the following:

- Over $2.3 billion in fraud judgments, settlements, and administrative actions were implemented;
- Criminal fraud charges were filed in 572 cases involving 872 defendants;
- 497 defendants convicted of healthcare fraud-related crimes;
- The DOJ opened 918 new civil health care fraud cases;
- OIG cases resulted in 679 criminal and 795 civil actions; and
- There were 1,267 OIG exclusions for criminal convictions, 201 exclusions for patient abuse/neglect, and 996 exclusions that included licensure revocations.

How Does AAMC Combat Fraud, Waste, & Abuse

- AAMC identifies potential fraud through:
  - Claims reviews
  - OIG/AAHS Work Plan
  - Inquiries from Staff, Vendors and/or Provider
  - Revenue Cycle Audits
  - Hotline Calls
  - Compliance E-mails

Fraud and Abuse Prevention

- Follow the Compliance Program Code of Conduct
- Maintain accurate and complete medical records and documentation
- Avoid submitting claims for unnecessary services
- Submit accurate coding and billing
- Avoid illegal conduct
- If you are not sure of the appropriateness of an action, call the Compliance Officer

Whistleblower Protection

- Whistleblowers may not be discharged, demoted, suspended, threatened, harassed or in any manner discriminated against as a result of reporting fraud or abuse.

Conflict of Interest

AAMC's policy prohibit situations that can create a Conflict of Interest.

Conflicts of Interest arise when a person's judgment and discretion is or may be influenced by personal considerations, or the interests of AAMC.

Examples:

1. Accepting gifts from vendors
2. Misuse of hospital assets
3. Being involved in a decision to hire a company in which your or a family member has ownership of the company

What is a Corporate Integrity Agreement (CIA)

- A negotiation between the Office of the Inspector General (OIG) and healthcare providers as part of a settlement of investigations arising under civil false claims statutes
- The healthcare provider consents to rigorous standards set forth by the OIG
- The OIG then agrees not to exclude the healthcare provider from participation in Medicare, Medicaid and other Federal Health Care Programs

Our CIA Obligations

- Compliance Officer & Compliance Committee
- Board Compliance Obligations
- Management Certification of Compliance
- Written Standards
- Training & Education
- Risk Assessment and Internal Review Process
- Independent Review Organization Claim Review
- Disclosure Program
- Additional CIA Requirements

CIA Requirements

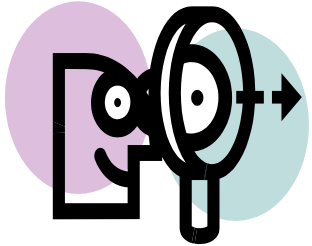
- The CIA will remain in effect for 5 years.
- During that time we will report to the OIG, who will monitor our compliance requirements through documentation and on-site visits.
- This is the usual length of time assigned for Corporate Integrity Agreements.

What is your Role in Compliance

- Identify
  - Know what your ethical role is for doing your job
  - Report is someone asks you to do something that does not feel right
  - Report if you witness someone doing something that doesn't feel right
  - Report if you believe if someone is violating and law, rule, regulation, or hospital policy.
- Summarize
  - Be able to summarize the who, what, where, when and how of the issue
- Report
  - Report to your one up and the Corporate Compliance Department

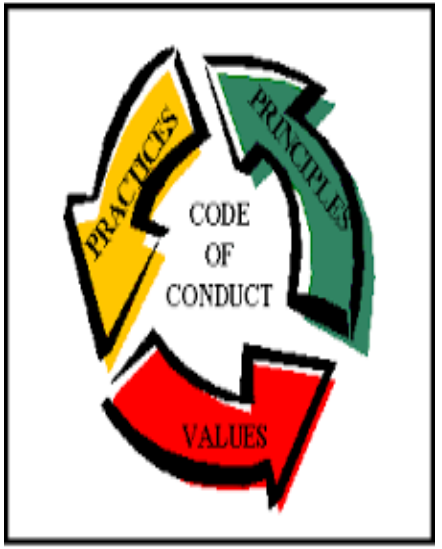
AAMC Employee Responsibilities

- It is essential that AAMC's employees understand what fraud and abuse is, how to detect it and how to assist members, providers, and other customers who may be reporting suspicious activities.
- AAMC has measures in place to prevent, detect and investigate all forms of fraud, including fraud involving employees or agents.
- Employees of AAMC are all responsible for the detection and prevention of fraud, waste, and abuse.



What is the Code of Conduct?

- The Code of Conduct provides guidance to ensure that our work is conducted in an ethical and legal manner.
- It emphasizes our culture of integrity and our responsibility to operate within ethical standards as we care for our patients, our community and each other.
- It sets the expectation of our commitment to our Core Values of Compassion, Trust, Dedication, Quality, Innovation, Diversity and Collaboration.



Compliance Reporting

- *Report directly to Corporate Compliance Team*

  Reports can be made anonymously!

Compliance and Ethics Hotline
443-481-1338; compliance@aahs.org

Chief Compliance Officer – Shirley Knelly
443-481-1328; sknelly@aahs.org

Senior Director Compliance – Michelle Hellstern
443-481-3731; mhellstern@aahs.org

Compliance Specialist – Sarah Harney
443-481-1661; sharney@aahs.org

http://www.aahs.org/corporatecompliance/