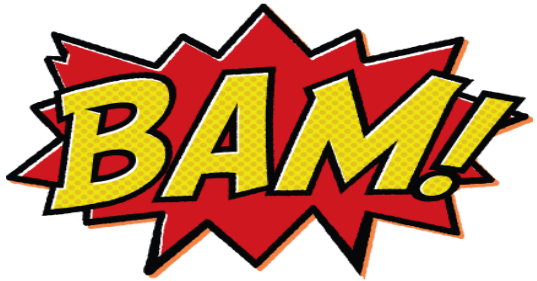

Compliance In Action

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Disclosures

Linda Gates

Nothing to disclose

7 Fundamental Elements of an Effective Compliance Program

1. Conduct internal monitoring and auditing
2. Implement compliance and practice standards through development of written policies and procedures
3. Designate a compliance officer or contact to monitor and enforce standards
4. Conduct appropriate training and education
5. Respond appropriately to detected violations and implement corrective actions
6. Develop open lines of communication
7. Enforce disciplinary standards

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Compliance In Action

- What would your internal reviews, corrective actions, education logs, audit results etc. show?
- Do you have the documentation necessary to show you have an active and effective compliance program?
- A compliance program isn't something that should just sit in a binder on a shelf

- Have you performed a risk assessment and developed a plan to review high risk areas?
- Are you promoting a culture of compliance?
- Would discussion on compliance concerns be

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Medical Directors – OIG Special Fraud Alert – June 9, 2015

- Focuses on compensation arrangements with medical directors
- Have you reviewed and documented:
  - How they are chosen?
  - How the compensation is determined?
  - Are you tracking duties and performance?
- Administrative approval for all arrangements
  - Fair market value
  - Appropriate business justification
  - Meets all legal requirements
  - Does it need to be updated?
  - Keep detailed duty tracking records
  - Stay on top of all space, & equipment leases

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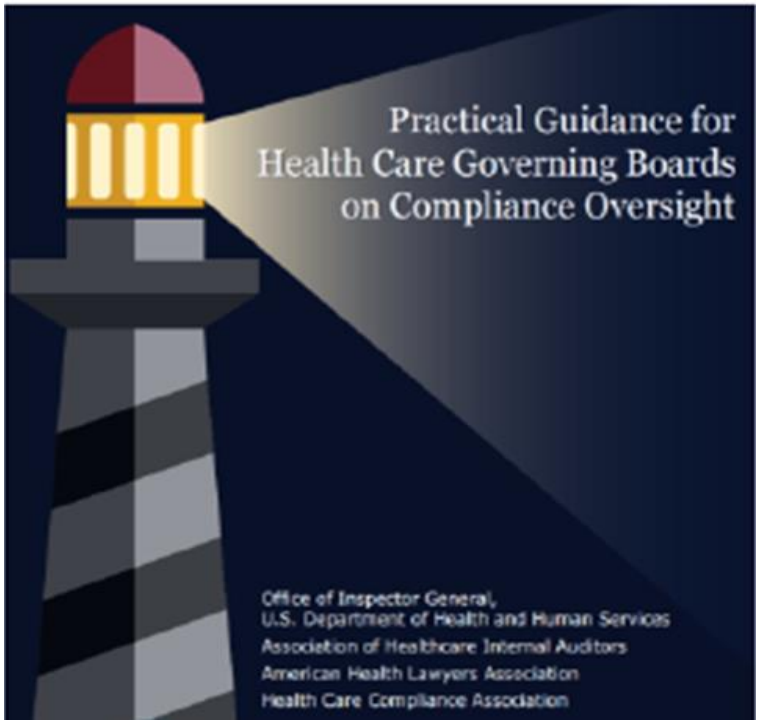
OIG Guidance For Boards



- Document the board's compliance oversight responsibilities
  - Includes the board asking the right questions
- Document education/discussion of high risk areas
- Document open communication and assessment of compliance program

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60-Day Overpayment Rule

- We must “report and return” an overpayment within 60 days of identification
- Failure to repay can lead to a false claim liability
  - “knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government”.

- A Final rule is expected in the first half of 2016
- We often think about audit results and the need to refund, – but how often are you working and monitoring your credit balances?

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PBB – On Campus/Off Campus

- Comparison of provider-based and freestanding clinics
- We will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on Medicare of hospitals' claiming provider-based status for such facilities. Provider-based facilities often receive higher payments for some services than do freestanding clinics. The requirements to be met for a facility to be treated as provider based are at 42 CFR § 413.65(d). (OAS; W-00-14-35724; W-00-15-35724; expected issue date: FY 2016)

- **REVISED** Medicare oversight of provider-based status
- We will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. We will also determine the extent to which provider-based facilities meet requirements described in 42 CFR Sec. 413.65 and CMS Transmittal A-03-030, and whether there were any challenges associated with the provider-based attestation review process. Provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments. Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries' coinsurance liabilities. The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; expected issue date: FY 2016)

"72 Hr Rule" - **NEW** Medicare payments during MS-DRG payment window

- We will review Medicare payments to acute care hospitals to determine whether certain outpatient claims billed to Medicare Part B for services provided during inpatient stays were allowable and in accordance with the inpatient prospective payment system. Certain items, supplies, and services furnished to inpatients are covered under Part A and should not be billed separately to Part B. (42 CFR § § 409.10 and 410.3). Prior OIG audits, investigations, and inspections have identified this area

Physicians–Referring/ordering Medicare services and supplies

- We will review select Medicare services, supplies and durable medical equipment (DME) referred/ordered by physicians and non-physician practitioners to determine whether the payments were made in accordance with Medicare requirements. Pursuant to ACA Sec. 6405, CMS requires that physicians and non-physician practitioners who order certain services, supplies and/or DME are required to be Medicare-enrolled physicians or nonphysician practitioners and legally eligible to refer/order services, supplies and DME. If the referring/ordering physician or non-physician practitioner is not eligible to order or refer, then Medicare claims should not be paid. (OAS; W-00-15-35748; expected issue date: FY 2016, ACA)

Working With NPPs

- NPPs have become an essential member of our care delivery system
- This is an area where processes just seem to “break”
- Keep a review of “incident to” in the office and “split/shared” services in the hospital on your compliance project list
- Every three to 4 months do some “preventative compliance” and ensure all processes are still functioning as you intended

- “Incident to” requires:
  - The MLP must be an employee of the physician
  - The MLP is following the physician’s care plan – so no new pts, and no established pts with a new condition
  - The supervising/billing physician must be physically present in the office at the time
  - There must be evidence of the physician’s review of services
- CAUTION: Overview only

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CMS Cardiology Benchmarks – How Do You Compare?

Benchmark_Medicare National Allowed %	
	CARDIOLOGY
New Patients: 99201-99205	
99201	0%
99202	2%
99203	17%
99204	57%
99205	25%
Established Patients: 99211-99215	
99211	11%
99212	3%
99213	32%
99214	48%
99215	6%

Hospital New Patients: 99221-99223	CARDIOLOGY
99221	8%
99222	38%
99223	54%
Subsequent Hospital Care: 99231-99233	
99231	11%
99232	64%
99233	25%

Top Billing Errors – From This Auditor's Perspective

E/M Coding

- Comprehensive ROS – 10 systems
- PFSH – Missing a family or social Hx
- Detailed exam on level 3 hospital F/U
- Consultation codes still accepted by most commercial payors

Intervention

- Understand AMI code
- Make distinction between CTO and 100% occlusion
- Use the bypass code if you go through a graft to a native artery
- Use two primary procedure codes for two different arteries

Electrophysiology

- LA catheter is billable with SVT ablation
- Understand use of the secondary arrhythmia codes in ablations
- Watch for errors with ambulatory monitoring, 24 hr, 72 hr, 7 day, MCOT

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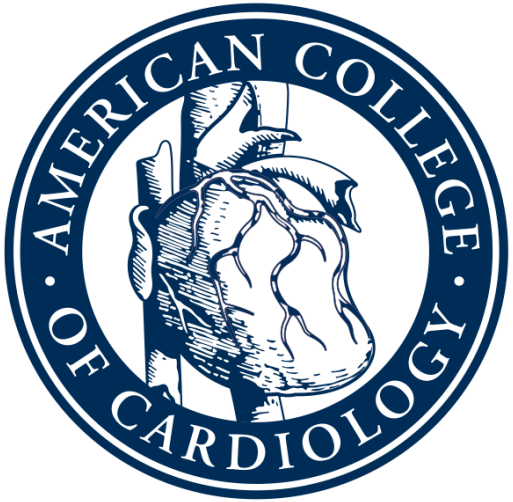

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