Compliance Program Education – Provider Edition

Corporate Compliance Operations Committee

Passion for excellence. Compassion for people.

ASPIRUS® HEALTH

Learning Objectives

- Understand commitment to ethical behavior.
- Understand how a Compliance Program operates.
- Learn how compliance concerns should be reported.

Why Do I Need Compliance Education?

Compliance is everyone's responsibility.

- What do you need to do?
  - Be effective, efficient, and ethical in your work
  - Follow the Code of Conduct
  - Report any concerns you have about compliance, quality, or safety

Compliance Program

- Established to support our culture of ethical behavior and
  - Prevent noncompliance
  - Detect noncompliance
  - Correct noncompliance
- Ensure compliance with ethical and legal standards including:
  - Code of Conduct
  - Policies and Procedures
  - Federal, state, and local laws and regulations
  - Government healthcare program requirements
- Code of Conduct is the foundation of our Compliance Program

Seven Core Compliance Program Requirements

Required by CMS

1. Written policies, procedures, and standards of conduct
   - Policies and Procedures are available on the Intranet
2. Compliance Officer and Compliance Committee
   - Eric Anderson is the Interim Compliance & Privacy Officer
   - Aspirus has a compliance committee
   - The Aspirus Board of Directors has oversight for the Compliance Program
3. Effective Training and Education
   - Staff are required to be trained at hire and annually thereafter
4. Effective Lines of Communication
   - Compliance has an open-door policy, anonymous hotline as well as an option to report compliance concerns on the Intranet

Seven Core Compliance Program Requirements (Continued)

Required by CMS

5. Well publicized disciplinary standards - Disciplinary policies are included in the policies on the Intranet	7. Procedures and System for Prompt Response to Compliance Issues - Reports of non-compliance are investigated and addressed promptly
6. Effective System for Routine Monitoring, Auditing and Identifying Compliance Risks - The Compliance Department routinely assesses and audits risk throughout the organization	

What is an Effective Compliance Program?

- An effective compliance program fosters a culture of compliance with an organization and at a minimum:
  - Prevents, detects, and corrects non-compliance
  - Is fully implemented and is tailored to an organization's unique operations and circumstances
  - Has adequate resources
  - Promotes the organization's Code of Conduct
  - Establishes clear lines of communication for reporting non-compliance

Know the Consequences of Non-Compliance

- Failure to follow Medicare Program requirements and the Centers for Medicare & Medicaid Services (CMS) guidance can lead to serious consequences including:
  - Contract termination
  - Criminal penalties
  - Exclusion from participation in all Federal healthcare programs
  - Civil monetary penalties
- Additionally, the organization must have disciplinary standards for non-compliant behavior. Those who engage in non-compliant behavior may be subject to any of the following:
  - Mandatory training or re-training
  - Disciplinary action
  - Termination

Non-Compliance Affects Everybody

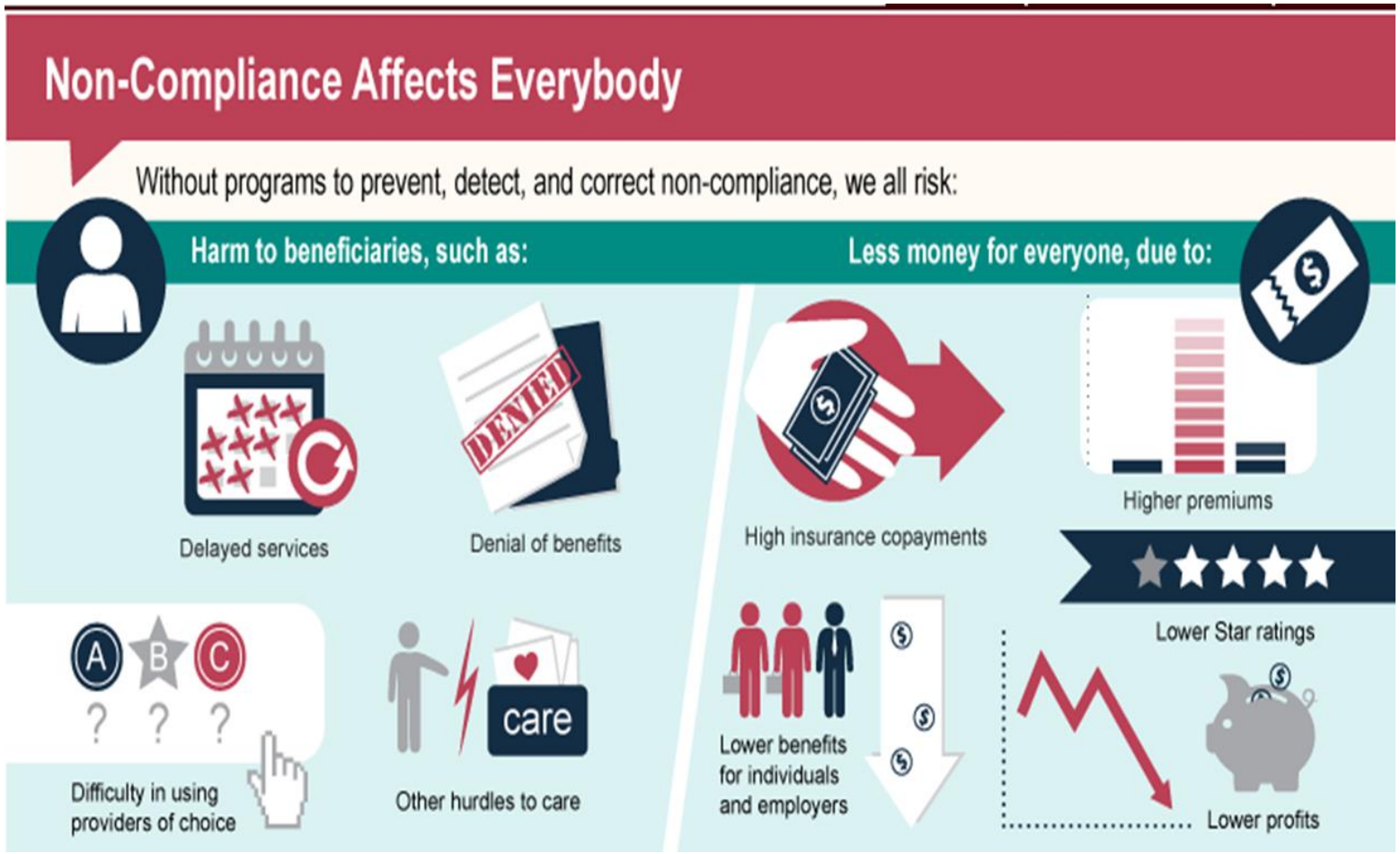


Image from Medicare Parts C and D General Compliance Training Content File 2020

Ethics—Do the Right Thing!

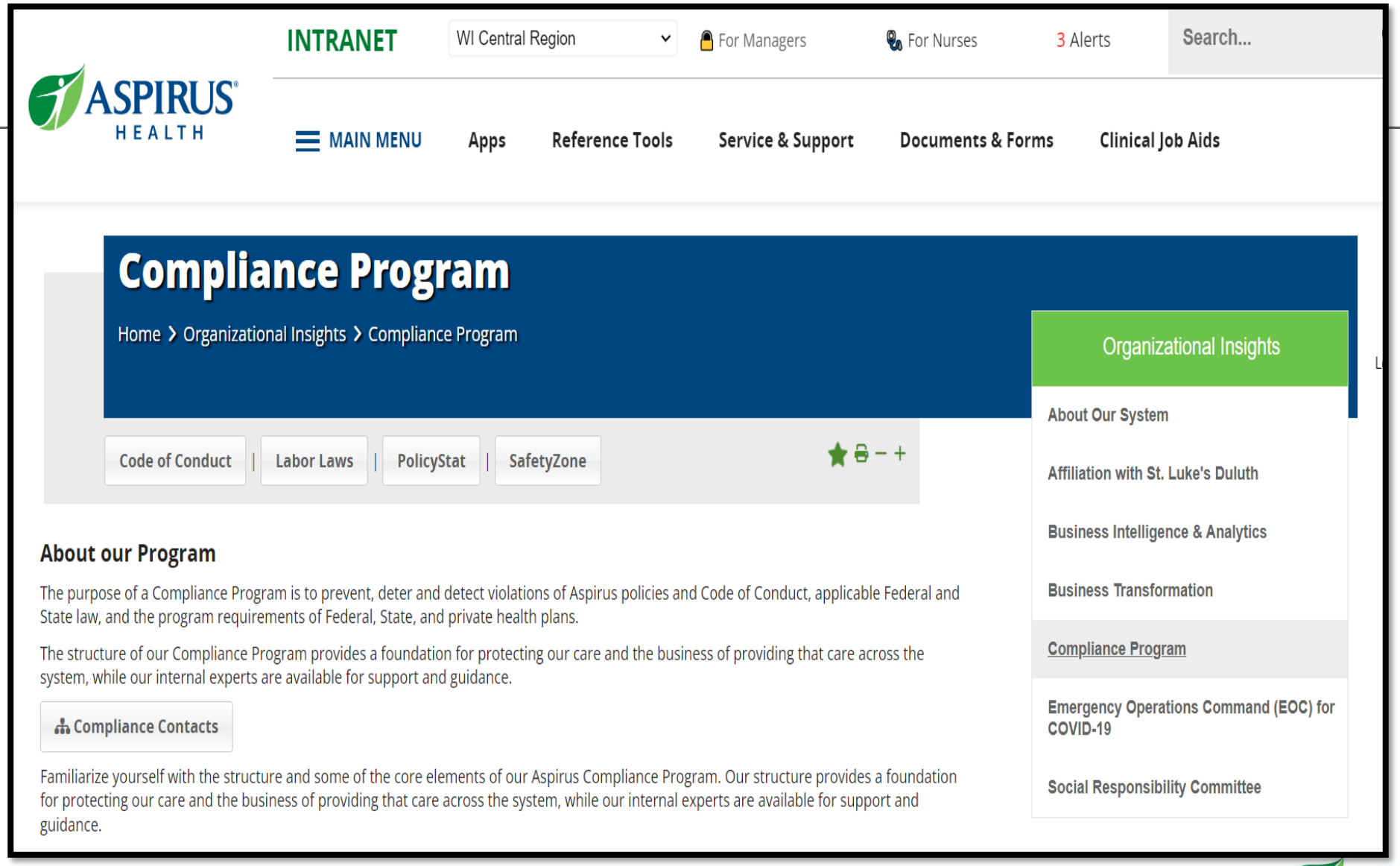
- As Aspirus employees, you must conduct yourself in an ethical and legal manner. It's about doing the right thing!
  - Act fairly and honestly
  - Adhere to high ethical standards in all you do
  - Comply with all applicable laws, regulations, and CMS requirements
  - Report suspected violations

Personal Responsibility—Reporting Compliance Concerns

- Employees are encouraged to report any concerns regarding compliance
- Retaliation against employees who make reports in good faith is prohibited
- If requested, your confidentiality will be honored as much as possible in light of obligation to investigate the concern
- Employees may report compliance concerns in the following ways:
  - Compliance Hotline: 715-847-2166
  - Email: compliance@aspirus.org
  - Report through Compliance Safety Zone portal on the Intranet

- Examples of compliance issues that should be reported:
  - Anti-Kickback
  - Billing/Charging/Reimbursement
  - Caregiver Misconduct
  - Civil Rights
  - Coding/Documentation
  - Conflict of Interest
  - Drug Diversion/Prescription Fraud
  - EMTALA
  - Excluded Individuals/Entities
  - Fiscal Services, Government Audits
  - HR/Fair Employment Practices
  - ID Theft/IT Security, Licensing/Credentialing/Enrollment
  - Physician Relations/Stark
  - Privacy/Confidentiality
  - Provider Scope of Practice

Reporting a Compliance Concern – Intranet



What Happens After Non-Compliance is Detected?

- After non-compliance is detected, it must be investigated immediately and corrected promptly
- However, internal monitoring should continue to ensure:
  - No recurrence of the same non-compliance
  - Ongoing compliance with CMS requirements
  - Efficient and effective internal controls
  - Enrollees are protected

What are Internal Monitoring and Audits

- Internal monitoring activities are regular reviews that confirm ongoing compliance and ensure that corrective actions are undertaken and effective
- Internal auditing is a formal review of compliance with a particular set of standards (for example, policies and procedures, laws, and regulations) used as base measures

Additional Laws and Policies You Should Know

Licensure

- Maintain your active licenses.
  - It is the provider's responsibility to complete any and all requirements to maintain their license to practice.
- Telehealth and outreach services have presented new aspects of licensing to consider before providing care for a patient. Practicing location matters.
  - Providers must hold a license in the state they are practicing.
    - Example: Patient is seen for a virtual encounter from their home in Wisconsin. Provider must hold a Wisconsin license in order to conduct this visit.
    - Example 2: Provider from Cardiology (Duluth, Minnesota) wants to do outreach appointments at Chequamegon (Ashland, Wisconsin). This provider must obtain a license in Wisconsin in order to see these patients.
    - Example 3: Provider is working from home in Wisconsin and wants to conduct virtual visits. This provider must have a Wisconsin license in order to practice from home.

EMTALA

- Every hospital must provide a medical screening examination (MSE) and stabilizing treatment to any individual who comes to the hospital requesting care, without discrimination and regardless of the individual's ability to pay. The hospital will not engage in any action to discourage individuals from seeking emergency medical care.
  - Screening and hospital care are provided to everyone, even if they do not have insurance or cannot pay for their care.
  - Screening and care is not delayed to get insurance information, but we can register the patient if it will not delay their care.
- The expectation of providers in regard to EMTALA is that pages are returned as soon as possible when on-call.
- Assist individuals that you may come across on campus that are looking for the emergency department.

Privacy

- Protecting your patient's privacy
  - Do not use text messages as a method of communication to send patient information or details of care unless through a secure software system approved through the IT Department
  - Emails related to work at Aspirus should only be sent and received through Aspirus email
  - Communications regarding patient care should be done through the EMR
  - Be mindful of where conversations regarding patients take place
    - Is the line in the café the best place to discuss with a colleague?
    - Is the elevator the best place to discuss with a colleague?

Privacy (Continued)

Treatment of Self or Family Members

- At Aspirus we strongly discourage providers to treat themselves or their family members. This is to avoid potential risks related to conflict of interest, lost objectivity, and privacy concerns. Providers should not perform E&M Visits, order diagnostic tests, enter referrals or order medications for themselves or family members. When the patient is a family member, the provider's personal feelings may unduly influence his or her professional medical judgment. Providers may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training. Insurance payers have also clearly stated in their policies that they will not reimburse services that are provided to a patient by a family member.
- Employees, including providers, may not access protected health information from their own or from relatives' records at any time without a written authorization given to Medical Records or the respective clinic. This includes billing or medical record information about dependent children, spouses, parents, siblings, adult children, or other relatives. Even with an authorization on file, access to health information will be limited to paper copies.
- **EMR access to relatives' health information is not permitted at any time.**

Documentation

- Timely Completion
  - CMS has clearly stated that documentation is to be completed in a reasonable timeframe. Reasonable meaning 24-48 hours from the time of service. CMS believes that it is unreasonable to expect a provider to recall specifics of a service that was rendered in the distant past.
  - A signed note indicates that the information within the document is accurate and complete.
- Code Selection
  - Codes for services and diagnoses are the responsibility of the provider to assign.
  - Remember to code diagnoses to the highest level of specificity.
- Professionalism
  - Notes can be viewed by patients and other members of the patients care team. Patients can now more easily view their records as they are available through the patient portal.
  - If the information is not pertinent to the patient's care, it is best not to include it in the record.

Documentation (Continued)

- Documentation should always be clear, concise, and to the highest level of specificity to provide the most clinically accurate picture of the patient's health status.
- General principles of medical record documentation apply to all types of medical and surgical services in all settings. While E&M services vary in several ways, such as the nature and amount of physician work required, these general principles help ensure that medical record documentation for all E&M services is appropriate.
- The medical record should be complete and legible.

Documentation (Continued)

- The documentation of each patient encounter should include:
  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results
  - Assessment, clinical impression, or diagnosis
  - Medical plan of care
  - Date and legible identity of the observer
  - If the rationale for ordering diagnostic and other ancillary services is not documented, it 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
  - The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
  - The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by documentation in the medical record
  - To maintain an accurate medical record, services should be documented during the encounter or as soon as practicable after the encounter

Medical Necessity

- Medicare defines “medical necessity” as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- CMS has the power under the Social Security Act to determine, on a case-by-case basis, if the method of treating a patient is reasonable and necessary.
- For all payors and insurance plans, even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national coverage policy, a local medical policy, or a clinically accepted standard of practice.

Coding

- **Upcoding** – coding at a higher level than supported by documentation or medical necessity.
- **Downcoding** – coding a level lower than that which is supported by documentation or medical necessity. This includes reporting diagnosis codes that do not capture the complete picture of the patient's condition (i.e., reporting E11.9 Type 2 DM, uncomplicated, when the provider has documented that the patient's diabetes is uncontrolled or has a comorbid complication).

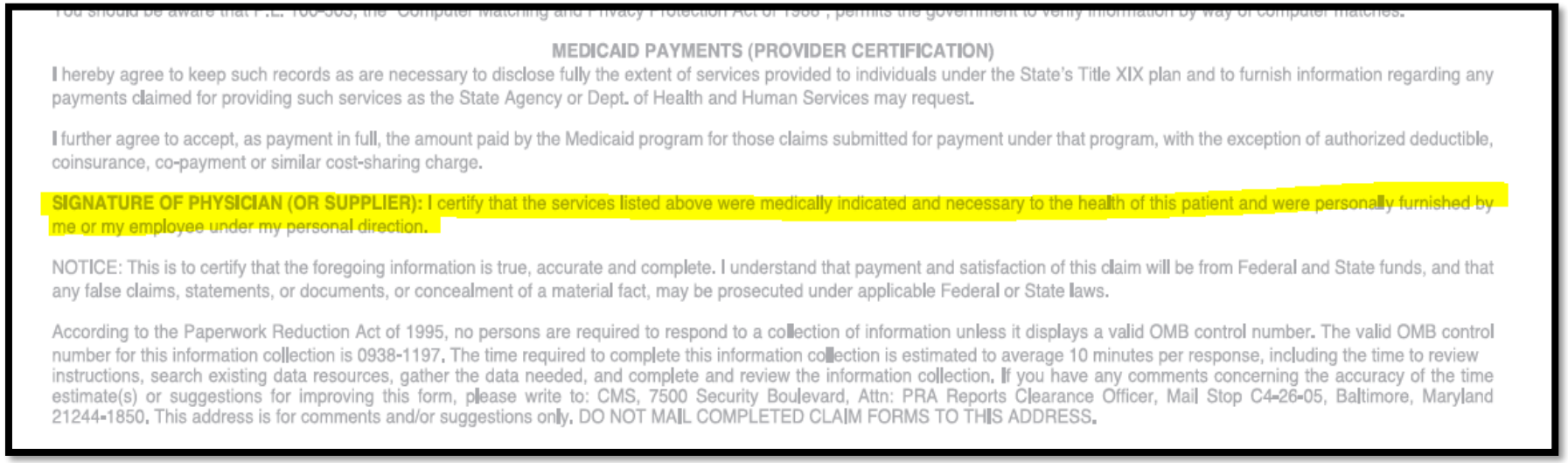
Both are serious compliance risks that may lead to payer audits, reimbursement takebacks, and allegations of fraud and abuse.

It is inappropriate to change or incorrectly report a diagnosis to get a service paid for when documentation does not support that diagnosis. This is considered fraud.

Report services exactly to the level of service that is documented.

Coding

The back of the CMS 1500 form specifically states that by signing the form the provider is attesting to the accuracy of the codes submitted. The fact that the claim is submitted electronically does not change that attestation. That is, whether the medical practitioner or a coder selects the code, **the practitioner is responsible for the codes submitted on a claim form.**



MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

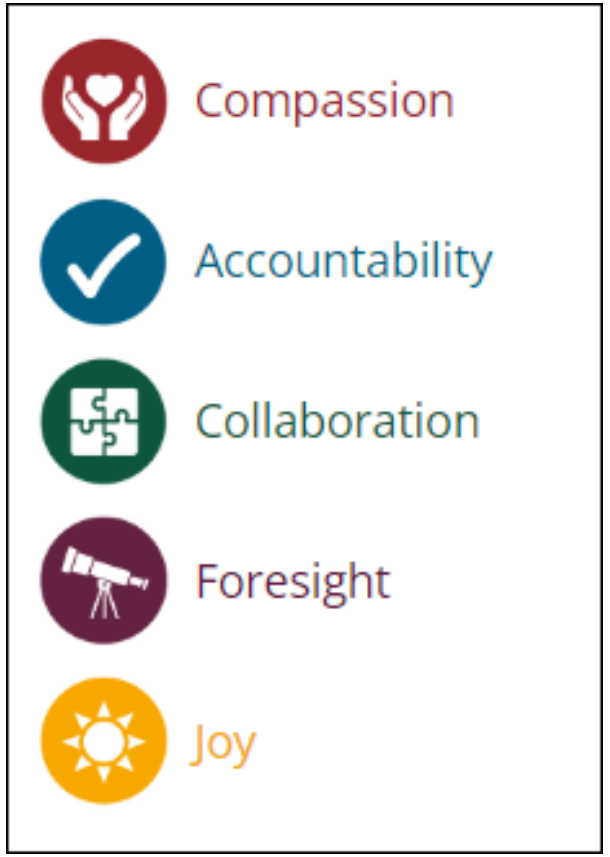
SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Role Model

- You are the face of Aspirus
- As a leader of the care team, it is important to live the Aspirus Core Values
  - Everyone is responsible for compliance
  - Be a “champion” for compliance
  - If you see something, say something
  - Employees are encouraged to report compliance concerns



Medical Directorship

Providers are responsible to notify Aspirus of outside obligations and need to obtain permission prior to making agreements.

Policies

- All policies are available via the Intranet
- Policies should be followed consistently throughout the organization
- If you cannot locate a policy or need help with understanding, ask for help

Sunshine Act/Open Payments

- The Physician Payments Sunshine Act is designated to increase transparency around the financial relationships between physicians, teaching hospitals, and manufacturers of drugs, medical devices, and biologics. CMS fulfills the law's mandate via the Open Payments Program.
- Manufacturers now must submit annual data on payment and transfers of value made to covered recipients.
- Physicians have 45 days to review their open payments data and dispute errors before public release.
- Aspirus cannot review this data until after it is made public, therefore, it is the responsibility of the provider to review prior to publication.

Conflict of Interest

A Conflict of Interest is a situation where an employee uses or appears to use his or her influence at Aspirus to get something for themselves, a family member, or a friend.

How does Aspirus handle this?

- People with the authority to make such decisions are required to tell their supervisor of any potential conflict of interest.
- They agree to avoid using their job position to benefit themselves or their family or friends.