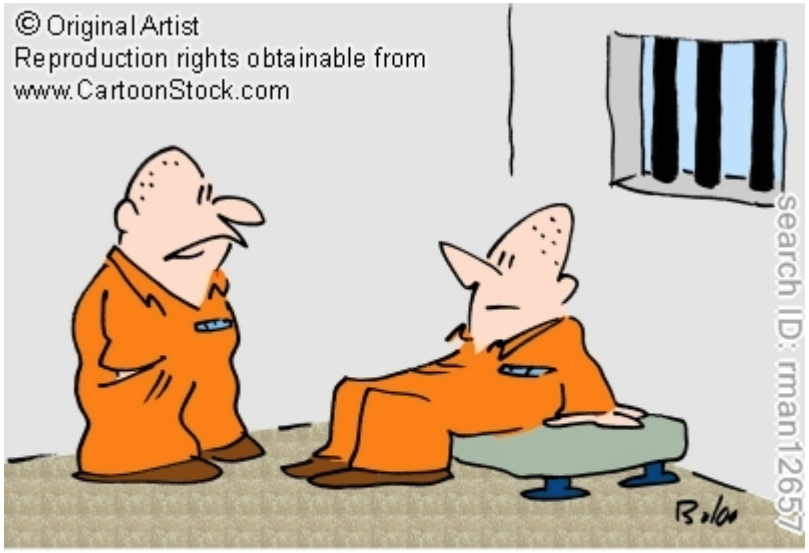
SHIAWASSEE
Health & Wellness

Corporate Compliance, Ethics and Deficit Reduction Act

A Relias Course revised for Shiawassee Health & Wellness

Why we have a Corporate Compliance Plan!



What Does "Corporate Compliance" Mean?

Background Information

In 1997, the Office of the Inspector General of the Department of Health and Human Services initiated a program to promote the identification and investigation of health care fraud and abuse.

As a result of this government requirement, health care organizations have developed Corporate Compliance Programs.

Corporate Compliance Defined

“Corporate Compliance” is a program of effective internal controls that promote adherence to applicable federal and state law and the program requirements of federal, state, and private health plans.

Benefits of Corporate Compliance Programs

Effective corporate compliance programs benefit organizations by:

Demonstrating a strong commitment to be an ethical, honest and responsible provider with appropriate corporate conduct.

Identifying and preventing criminal and unethical conduct.

Developing a methodology that encourages employees to report potential problems.

Developing procedures that result in prompt, thorough investigation of alleged misconduct and provide for corrective actions.

Minimizing risk.

Seven Components to a Corporate Compliance Program

1. Written policies and procedures
2. Compliance officer and committee
3. Effective education
4. Effective lines of communication
5. Auditing and monitoring
6. Enforcement
7. Response to detected offenses, development of corrective action initiatives, and reports to government authorities

Written Policies and Procedures

Establish written standards of conduct to be followed by all employees. These include written compliance policies and procedures and are to be distributed to all employees.

At Shiawassee Health & Wellness, the Corporate Compliance Policies and Procedures (as with all policies and procedures) are available on SharePoint.

Compliance Officer and Committee

Establish responsibility by designating a Compliance Officer (CCO) and a Compliance Committee from high- level personnel.

Effective Education

Provide education and training through a formal training program for all employees, officers, managers, supervisors, Board members, long-term temporary employees, and possibly contractors. Informal on-going training must also be provided.

Effective Lines of Communication

Develop an internal system for reporting suspected non- compliance.

This is often accomplished by establishing a Corporate Compliance “hot-line" and providing "drop-boxes".

An "open-door" policy for employee access to the CCO is also recommended.

Auditing and Monitoring

Develop an internal audit and monitoring system to ensure compliance. The monitoring system should determine whether recommendations and corrective action plans have been implemented.

Audits can be initiated through a random selection of records, because of emerging trends, as a follow-up to training or prompted by a pattern of errors by employees

Enforcement

Disciplinary policies should include sanctions for actual non-compliance, for failure to detect non-compliance, and for failure to report actual or suspected non-compliance. The organization must also use care to avoid delegating substantial discretionary authority to individuals whom the organization knows, or should have known, have a propensity to engage in illegal activities.

Response to Detected Offenses, Development of Corrective Action Initiatives, and Reports to Government Authorities

The organization should have policies and procedures that cover investigations, corrective action, and reporting protocol. **Evaluation and modification of these policies and procedures is an integral part of any compliance program.**

Ethics

"Ethics" is defined as moral principles or practices. It is the discipline of dealing with right and wrong and moral duty.

The difference between compliance and ethics might be viewed in this way:

Compliance = "Let's get out there and not break the law today!"

Ethics = "Let's aim for fairness, forthrightness, integrity and feat accomplished."

In other words, the ethical question to be asked is "Should I do this?" rather than "Can I do this?"

Ethical business practices include accurate billing procedures, accurate filing of claims, and reporting abuses of the system.

What is Fraud and Abuse?

Definitions and Examples of Fraud and Abuse:

- Health care **FRAUD** is the knowing and willful execution, or attempt to execute a scheme to defraud a health care benefit program to obtain, by means of false or fraudulent representation or promise, any money or other property owned by a health care benefit program.

- **ABUSE** generally encompasses incidents or practices that are inconsistent with sound fiscal, business or medical practices, that may result directly or indirectly in unnecessary program costs, improper payment, or payment for services that fail to meet professional standards of care or that are medically unnecessary .

High Risk Activities

Activities that are at high risk for violations according to the Federal government include:

False claims (up-coding or down-coding the billing code to obtain higher payment.)

Fraudulent billing (billing for services not provided or not medically necessary. All services must be listed in the Person Centered Plan and they must support medical necessity.)

Taking bribes or kickbacks, or giving excessive discounts (receiving gifts from other interests that could indicate an incentive to do business with them.)

Payment to other parties to induce referrals.

Providing service without a valid license.

Submitting a claim with inadequate documentation to support the amount billed. Clinical documentation must be timely and support the services outlined in the Person Centered Plan.

False documentation to support and bill for a service never rendered.

Investigations and Penalties

Healthcare fraud and abuse is prosecuted under the Federal False Claims Act. This Act prohibits a person or entity from knowingly presenting, or causing to be presented, claims or false records or statements to the Federal government in order to get payment for a false or fraudulent claim. Civil penalties can range from $5,500 to $11,000 per claim plus three times the amount of damages sustained by the Federal government. In addition to monetary fines, organizations can be excluded from Medicare and Medicaid programs, and CEOs and Boards can be subject to criminal penalties.

Federal Sentencing Guidelines

An effective corporate compliance program that demonstrates and encourages ethical behavior and compliance with legal and regulatory requirements provides a defense or protection for an organization.

In order to receive “credit” for good corporate behavior, the Federal Sentencing Guidelines require that organizational defendants exercise due diligence in the design and implementation of a compliance program intended to detect and deter fraud, waste and abuse.

However, the existence of a corporate compliance program is not protection from investigation or fines.

Reporting

Each employee is responsible for reporting any violation or suspected violation of corporate compliance policy.

Most organizations provide a corporate compliance “hot line” for verbal reporting. Others have corporate compliance incident forms which can be completed and forwarded to the Corporate Compliance Officer.

Employee Rights

An employee reporting an illegal activity is protected under Federal and State law.

The reporting person, or whistleblower, cannot be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms of conditions of employment by his employer because of lawful acts done by the employee.

If any of these should occur, the employee, an action under the Federal False Claims Act, shall be entitled to all relief necessary to make the employee "whole".

Things to Remember

“Corporate Compliance” is a program of effective internal controls that promote adherence to applicable federal and state law and the program requirements of federal, state, and private health plans.

The purpose of corporate compliance programs is to prevent and detect fraud, abuse and waste by creating systems that enable organizations to operate in a compliant manner within Federal and State legal and regulatory environments.

The seven basic elements of a compliance program are: written policies and procedures including standards of conduct; a compliance officer; effective education and training; effective lines of communication for a reporting system; auditing and monitoring; enforcement; evaluation and modification of the program.

“Ethics” is defined as moral principles or practices.

Health care fraud is the knowing and willful execution, or attempt to execute a scheme to defraud a health care benefit program to obtain, by means of false or fraudulent representation or promise, any money or other property owned by a health care benefit program.

Things to Remember

Abuse encompasses practices that are inconsistent with sound fiscal, business or medical practices, that may result in unnecessary program costs, improper payment, or payment for services that fail to meet professional standards of care or that are medically unnecessary or that are not listed on the Person Centered Plan.

Fraudulent high risk activities include up-coding, billing for services not provided, taking bribes or kickbacks, payment to other parties to induce referrals, providing service without a valid license, submitting claim with inadequate documentation, false documentation to support and bill for a service never rendered.

The existence of a corporate compliance program is not protection from investigation or fines.

Significantly increased resources are now available for Federal investigations.

Federal and State laws protect employees from retaliation from reporting corporate compliance violations.

The Deficit Reduction Act and The Medicaid Integrity Program

To offset healthcare fraud and abuse the Deficit Reduction Act (DRA) was passed and from this, the Medicaid Integrity Program (MIP) was developed. There is now more Federal scrutiny of healthcare providers, more audits and investigations, and more paybacks.

This increased oversight has resulted in many changes. What was a billing error in 1989 may now be considered **FRAUD** and investigations can result in fines that can go back to practices 10 years prior. The standard for guilt in an investigation is, “If you knew or should have known”, the fraudulent activity was taking place.

The new Deficit Reduction Act (DRA) took effect on January 2007.

The Five Areas I Need to Know About

The DRA requires entities that make or receive at least $5 million in annual Medicaid payments to establish written policies and procedures designed to educate their employees, contractors, and agents in **5 areas**:

1. The Federal False Claims Act

2. Administrative remedies for false claims and statements

3. Any state false claim laws

4. The rights of employees to be protected as whistleblowers

5. The role of the employer's policies and procedures for detecting and preventing fraud, waste and abuse

What Does the DRA do?

By 2030, spending for Medicare and Medicaid and Social Security will be almost 60% of the entire federal budget.

The DRA restraints spending for retirement programs while ensuring care for those who rely on these programs.

It is intended to:

Decrease growth of Medicaid spending

Bring mandatory Medicaid spending under control

Save the American people money

What Else Does the DRA do?

The DRA dramatically shifts the federal enforcement to Medicaid and provides funding for the Federal Medicaid enforcement fraud unit.

The DRA requirement is part of Federal law, but states are responsible for developing oversight and enforcement mechanisms.

How Does the DRA Impact Corporate Compliance?

Corporate Compliance

Corporate Compliance is a system of effective internal controls that promote adherence to federal and state law; program requirements of federal, state, and private health plans; and ethical behavior.

Education on DRA is part of your organization's overall Corporate Compliance system. Failure to comply with DRA requirements may result in an entity losing Medicaid funding.

Discovery of Fraud

Fraud is an intentional deceptive act done for unfair or unlawful gain.

Deliberate overcharging.

Unnecessary home health visits to obtain reimbursement.

Unnecessary procedures done for financial gain.

Giving False information for gain is also fraud.

Duplicate billing.

False codes on healthcare visits or procedures to obtain a higher reimbursement.

Claims for reimbursement of home health visits that were not made, and False reports.

What if I Make an Honest Mistake?

Fraud does not include acts that are honest, random mistakes. However, habitual re-occurring "mistakes" could be interpreted as fraud.

Mistakes can occur in billing and there can be reimbursement discrepancies but neither is fraud.

However, Federal law does not require proof of a specific intent to defraud the United States government.

What If I Suspect Fraud?

All employees have a duty to report cases of fraud. It is also important that you alert your organization to cases that could look like fraud.

After being alerted, the organization can solve the problems, and avoid legal accusations of fraud.

To be able to report fraud, you should know that:

Your organization has a policy and procedure for reporting suspected fraud.

You may need to contact a specific person, and/or dial a hotline number.

You cannot be penalized by your organization for reporting suspected fraud.

How Can I Prevent Fraud?

Mistakes such as simple billing errors and reimbursement discrepancies occur and, although not fraud, must be investigated to prevent future errors and to ensure that fraud is not intended.

Prevent all errors that could possibly appear as fraud or raise the suspicion of fraud. If your job involves billing, charging, or coding, please:

Learn the policies and procedures and then follow them

Document your work accurately and in a timely manner

Seek training if you do not understand how to do tasks

Take advantage of training opportunities

Be thorough and ask for help if needed

Treat all customers and clients courteously

Always give customers and clients accurate information

Cooperate in internal audits

Remember! If your job involves, billing, charging, or coding, learn the policies and procedures and document your work accurately.

What is the False Claims Act?

The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program (including Medicare and Medicaid). The FCA does NOT cover tax fraud.

The FCA is commonly known as the “Lincoln Law” because it was first enacted to counter fraudulent activities involving military procurement during the Civil War.

Under the False Claims Act, those who knowingly make a false claim are liable for civil penalty of not less than $5,000.00 and not more than $10,000, plus 3 times the amount of the damages which the government sustains because of the act of that person.

Activities That Are Covered

What Specific Activities Are Covered Under the False Claims Act?

Knowingly presenting (or causing to be presented) to the Federal government a false or fraudulent claim for payment

Knowingly using (or causing to be used) a record or statement to get a claim paid by the Federal government

Conspiring with others to get a false or fraudulent claim paid by the Federal government

Knowingly using (or causing to be used) a record or statement to conceal, avoid or decrease an obligation to pay money or transmit property to the Federal government

In general, the FCA covers fraud involving federally funded contract or program, with the exception of tax fraud.

What Does "Knowing" and "Knowingly" Mean?

The terms ***knowing*** and ***knowingly*** mean that a person, with respect to information:

Has actual knowledge of the information

Acts in deliberate ignorance of the truth

Acts in reckless disregard of the truth

Whistleblower Protection and Employee Responsibility

The False Claims Act contains Qui Tam and whistleblower provisions.

Qui Tam is a unique mechanism in the law that allows citizens with evidence of fraud against government contractors and programs to sue, on behalf of the government, in order to recover the stolen funds.

The Whistleblower Protection Act can provide confidentiality and protection from retaliation to employees, or former employees who report allegations of fraud and abuse. The act prohibits retaliation by employers on employees "who blow the whistle" by exposing fraud and abuse.

What Is My Responsibility as an Employee?

You, as an employee, may not be discharged, demoted, suspended, threatened, harassed or discriminated against by your employer.

You are entitled to relief including reinstatement, double back pay and compensation for any special damages including litigation costs and reasonable attorneys' fees.

As an employee it is important that you:

Know and follow your organization's policies and procedures relating to false claims.

Know and follow your organization's policies and procedures for detecting fraud, abuse, and waste.

Be aware of your rights to be protected as a Whistleblower.

Health Care Reform

Patient Protection and the Affordable Care Act

"…the ACA contains some of the strongest anti-fraud healthcare provisions in American history. So under this new law, we're going to attack fraud at every single stage of the process."

Secretary Sebelius

Patient Protection and the ACA

Coordinates and consolidates fraud fighting efforts across Medicare and Medicaid

Expands partnerships within the private sector investigators to help stamp out waste and fraud, and protect consumers

The “HEAT ” is on

Health Care Fraud Prevention and Enforcement Action Team

Patient Protection and the Affordable Care Act

- Strengthens law enforcement capabilities
- Shifts from old pay and chase to new prevention and program integrity efforts
- Targets resources to areas where fraud and abuse are greatest

Your Government at Work

Mitigate the Risk

Questions we must be prepared to answer

Did the services provided meet medical necessity?

Are medically necessary services written into the Person Centered Plan?

Do the employees code appropriately and accurately?

Is the medical record appropriately documented?

Are we providing training and education to the workforce?

Has SCCMHA conducted internal audits, and do I have monitors?

Are my organizations policies and procedures up to date?

Has my organization reviewed the newest OIG Work Plan?

Has my organization conducted a risk assessment?

Comments or Questions?

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Congratulations!

You have finished reviewing the course content.
Remember, this course is **NOT complete** until you pass the course last exam.