Christiana Care's Corporate Compliance Training

THE CHRISTIANA CARE WAY
We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.
Corporate Compliance Background

Mission
Christian Care Health System (Christian Care) is dedicated to maintaining excellence and integrity in all aspects of its operations and its professional business conduct. The goal of the Corporate Compliance Program is to maintain Christiana Care’s adherence to federal, state, and other regulatory agencies' laws, rules, and requirements. The strategic plan of the Corporate Compliance Program is to not only protect the integrity of Christiana Care, but also its employees, healthcare providers and ultimately the population we care for and serve.

Vision
To promote Christiana Care’s services to the highest ethical standards and provide accountability to the community it serves.

Corporate Compliance Background

The Compliance Program describes its commitment to the highest standards of corporate conduct and ethics. The purpose of the Program is to establish and maintain a system that encourages and promotes ethical business conduct throughout Christiana Care and prevents and detects violations of law and Christiana Care policy.

Christian Care has determined that it is best to organize, centralize, and formalize and implement procedures and enhancements, as directed by the U.S. Department of Health and Human Services, Office of Inspector General (OIG), and the Medicare Shared Savings Program Guidance (42 CFR 425 et seq.).

As part of this Program, we are charged with providing training and education that further supports our commitment to the highest standards of corporate conduct and ethics.
Topics Covered

- Patient's Freedom of Choice
- Conflicts of Interest
- Improper Claims
- Unbundling
- Upcoding
- Return of Overpayments
- Medical Necessity
- Documentation in EHRs
- Physician Self-Referrals
- Anti-Kickback
- EMTALA
- Confidentiality
- Information Security
- Reporting Violations

Patient's Freedom of Choice

The Medicare and Medicaid Programs require that all patients have the right to choose the providers who render care to them after they leave the hospital. By limiting a patient's choice, we run the risk of violating both Medicare and Medicaid rules, as well as Anti-Trust laws.
Patient’s Freedom of Choice
(Cont’d)

The Balanced Budget Act of 1997 and Conditions of Participation of the Medicare Program require hospitals only to develop a list of home health agencies that:

- Are Medicare certified
- Provide services in the geographic area in which patients’ reside
- Ask to be on the list

In addition, if hospitals have a financial interest in a home health agency that is included on the list, the hospital’s financial interest must be disclosed on the list. This list must be presented to patients discharged from hospitals who receive home health services.

The Social Security Act seeks to ensure that free choice is guaranteed to all patients. This gives patients the freedom to choose who they want as their post-hospital service provider.

Patient’s Freedom of Choice
(Cont’d)

The act of allowing patients to choose who provides their care after discharge applies to ALL providers, not just physicians. Case Managers/Social Workers are key to the protection of this legal and ethical requirement. They are required to make a neutral presentation of post-acute providers, and may offer patients publicly available references, so that patients can make an informed decision.

The provider may offer their professional opinion to the patient, but must close the statement by letting the patient know that ultimately, it is the patient’s choice. The Case Manager, Social Worker, and Provider are also required to honor patient choices without efforts to persuade them to change their choice.

Antitrust laws, also known as competition laws, are legal rules to promote fair competition in the marketplace. These laws can apply to both businesses and individuals. These laws help level the playing field for businesses and help protect the consumer.

By making it unlawful for competitors to fix prices and for dominant companies to abuse their position to stifle health competition, the laws benefit us all. When businesses play fairly, consumers see better products and services, lower prices, and product innovation.
Conflicts of Interest

A Conflict of Interest refers to a situation in which an individual’s financial, professional, or other personal considerations may directly or indirectly affect, or have the appearance of affecting, an individual’s professional judgement in exercising any Christiana Care duty or responsibility.

Typically, a Conflict of Interest may arise when an individual has the opportunity or appears to have the opportunity to influence Christiana Care business, administrative, academic, patient care, research, or other decisions in ways that could lead to financial, professional, or personal gain or advantage of any kind.

A Conflict of Interest refers to a situation where an individual engages in external activities, either paid or unpaid, that interferes with his/her primary obligation and commitment to Christiana Care.

Conflicts of Interest (Cont’d)

A Conflict of Interest may exist even if an individual perceives that there is no potential conflict or believes the relationship with the Interested Third Party will not affect their decision making ability.

A Conflict of Interest is evaluated according to a set of factual circumstances involving risk and not on the character of the individual. The existence of a potential Conflict of Interest does not imply that an individual is improperly motivated.
Conflicts of Interest (Cont’d)

Some Possible Conflict of Interest Areas Include:

- Influence on purchasing of equipment, instruments, materials or services for Christiana Care from a Third Party in which the medical staff member, or an immediate family member, has a financial interest.
- Influence upon the negotiation of contracts between Christiana Care and private organizations with which the medical staff member, or immediate family member, has consulting or other significant relationships, or will receive favorable treatment as a result of such influence.
- Giving, offering, or promising anything of value, as a representative of Christiana Care, to any government official to enhance relations with that official or the government.
- Improper use of institutional resources for personal gain.
- Acceptance of compensation or free services from a vendor, services provider, or contractor of Christiana Care, when medical staff member is in a position to influence Christiana Care’s purchase from those persons.
- Unauthorized disclosures of patient or Christiana Care’s information for personal gain.
- Transmission to a Third Party or other use for personal gain of Christiana Care supported work, products, results, materials, record, or information that are not made generally available.

Improper Claims

Individual practitioners are held accountable for the accuracy of all information on the claims submitted on their behalf, and are often held personally responsible for improper claims development or submission practices.

When a provider submits a claim for services to an insurance provider, they are filing a bill certifying that they earned the payment requested and complied with the billing requirements.

Under Federal Law, providers have an independent responsibility to prepare and maintain adequate documentation to support their claims for services.
Improper Claims (Cont’d)

The government continually reviews claims for reasonable documentation that services were performed and/or were medically necessary and consistent with the coverage provided. They may request information to validate:

- The medical necessity and appropriateness of the diagnostic or therapeutic services provided;
- That the services provided have been accurately reported;
- The site of the services.

Improper Claims (Cont’d)

It is important to recognize that physician documentation in the health record, especially documentation to support the medical necessity of every procedure or treatment, not only supports professional claims submitted on behalf of the physician, but is critical to driving the legitimacy of facility claims.

Examples of improper claims include billing for services that:

- Use an improper place of service code
- Were not actually rendered
- Were not medically necessary
- Were performed by an improperly supervised or unqualified employee
- Were performed by an employee excluded from participation in Federal Health Care programs
- Are unbundled
- Of such low quality that they are virtually worthless
- Are already included in a global fee, like billing for an evaluation and management service the day after surgery
Unbundling

Government health care programs like Medicare and Medicaid, as well as other insurance companies, have special reimbursement rates for groups of procedures that are typically performed together, such as laboratory tests or procedures.

One common type of fraud has been to “unbundle” these procedures or tests and bill each one separately, which results in greater reimbursement than the bundled reimbursement rate.

Unbundling (Cont’d)

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional when providers manipulate codes in order to maximize payment.

When an unintentional incident of unbundling is identified, a billing adjustment is required and the overpayment must be reimbursed to the carrier.

Ignorance is not an excuse! When the act of unbundling was to defraud the Federal Health Care Program, individuals who “knowingly” or “should have known” will be subject to prosecution under the False Claims Act.
Upcoding

Upcoding is also known as "upcharging" or "DRG draft." Upcoding refers to the practice of assigning a code that commands more money that the less expensive correct code would pay.

Say the doctor sees you for a 15 minute face-to-face counseling session. The code for that might mean he/she would get paid $50. If he/she uses the 30 minute counseling session code to bill, he/she would be paid $100.

Upcoding is illegal. It's a fraudulent practice used by providers who are trying to cheat the system so they will be paid more money than they have negotiated with payors.

Upcoding (Cont'd)

Anyone can commit health care fraud. Fraud schemes range from solo ventures to broad-based operations by an institution or group. Even organized crime has infiltrated the Medicare Program and masqueraded as Medicare providers and suppliers. Examples of Medicare fraud include:

- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items or billing Medicare for appointments that the patient failed to keep.
- Knowingly billing for services at a level of complexity higher than the services actually provided or documented in the file.

Defrauding the Federal government and its programs is illegal. Committing Medicare fraud exposes individuals or entities to potential criminal and civil consequences, including imprisonment, fines, and penalties.
Claims Coding and Billing Notice

For Improper Claims, Unbundling, and Upcoding:

Civil sanction may be imposed where a physician (or office staff) "knowingly" submits a claim that he/she knows -- or should know -- will fall into a prohibited category. Liabilities and consequences for violation of the False Claims Act can include damages of up to 3 times the amount of the total payment received on the false claims submitted, and penalties ranging from $500 to $15,024 for each false claim submitted.

The Patient Protection and Affordable Care Act of 2010 has enhanced the power of the False Claims Act by authorizing penalties of $50,000 for each submission of false statements or records that are material to a false claim.

Violations of the False Claims Act can also lead to exclusion from the Medicare or Medicaid Programs.

Return of Overpayments

Retention of a known overpayment may be a violation of the False Claims Act. Once a provider suspects they owe the government a refund on any claims submitted, they must, with all due speed, investigation to determine if a refund is actually due, calculate the refund, and return the overpayment.

There is a 60 day statutory deadline to return Medicare and Medicaid overpayments (the 60 day rule).
Return of Overpayments (Cont’d)

Medicare overpayments commonly occur due to:

- Duplicate submission of the same service or claim
- Furnishing and billing excessive or non-covered services
- Payment for excluded or medically-unnecessary services
- Payment to the incorrect payee

Return of Overpayments (Cont’d)

The provider may not always have actual knowledge that Medicare paid an erroneous claim. Once an error has been discovered, CMS says that the provider must investigate with "all deliberate speed" to determine whether the provider actually sent a mistaken claim to Medicare, and whether Medicare paid such a claim.

If a provider has evidence of a potential problem, but fails to investigate promptly, the provider risks a later finding that the provider acted in reckless disregard or deliberate ignorance, which may result in civil monetary penalties.
Medical Necessity

"Medical Necessity" means that the services provided, in the independent and objective judgement of the provider, are necessary for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate with regard to type, frequency, extent, site and duration, and are considered effective;
- Not more costly than an alternative service as likely to produce equivalent therapeutic or diagnostic results;
- Consistent with the requirements of national coverage determination (NCD’s) or local coverage determinations (LCD’s) developed by Medicare, which are statements of medical necessity for certain treatments/procedures through the use of evidence based clinical standards.

Documentation in the medical record must support the medical necessity of every service provided that it is billed to a government or commercial payer.

Medical Necessity (Cont’d)

Medical Necessity is contingent upon supporting documentation in the medical record. Unfortunately, oftentimes this documentation is sparse, clinically nonspecific, and with sufficient detail to meet Medicare’s medical necessity documentation requirements. The end result is medical necessity denials for both the hospital and the physician.

As a general rule, Medicare and Medicaid will only pay for services and items that are deemed “medically reasonable and necessary” for the diagnosis or treatment of an illness or injury.

National Coverage Determinations (NDCs) and Local Coverage Determinations (LCDs) identify which tests and procedures require additional medical necessity documentation before they will be approved for reimbursement.
Medical Necessity (Cont’d)

When claims for reimbursement are submitted for tests, procedures or services that are knowingly deemed “not medically necessary,” then the claims are considered to be “false claims” under the False Claims Act.

Common types of false claims involving no medical necessity include:

• Misrepresenting the diagnosis and symptoms on a patient’s records;
• Billing invoices to obtain payment for unnecessary lab tests;
• Performing inappropriate or unnecessary procedures; or
• Prescribing drugs, durable medical equipment, or treatment that are not medically necessary.

Documenting in the EHR

Electronic Health Records (EHR) replace paper medical records. EHRs allow clinicians access to the entire medical record, share data among colleagues, and eliminate poor handwriting that has historically been the cause of errors in patient care.

Each entry in an EHR must reflect the care provided at the time of the visit. EHRs contain powerful tools that assist with documentation, and it's important that they be used appropriately.

EHS's can also make it easier to unintentionally commit fraud. Sometimes it's difficult to tell whether information was copied in, pre-populated from a prior visit, or newly added at the time of the encounter.
Documenting in the EHR (Cont'd)

Areas of Concern

Authorship Integrity

- Borrowing record entries from another source of author and representing past as current documentation and (in some instances) misrepresenting the nature and intensity of the services provided.

- Order authenticity

Documentation Integrity

- Auto-population or automated insertion of clinical data and visit documentation using templates or similar tools with predetermined documentation components with uncontrolled and uncertain clinical relevance.

Documenting in the EHR (Cont'd)

On July 12, 2011, Lew Morris, Chief Counsel to the Office of Inspector General, testified before a governmental affairs committee on using technology to cut waste and curb fraud in federal health care programs.

"For example, electronic health records (EHR) may not only facilitate more accurate billing and increased quality of care, but also fraudulent billing. The very aspects of EHRs that make a physician’s job easier – cut and paste and templates – can also be used to fabricate information that results in improper payments and leaves inaccurate, and therefore potentially dangerous, information in the patient record. And because evidence of such improper behavior may be in entirely electronic form, law enforcement will have to develop new investigation techniques to supplement the traditional methods used to examine the authenticity and accuracy of paper records."
Physician Self-Referral

The Physician Self-Referral Law, commonly referred to as the Stark Law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

Financial relationships include both ownership/investment interests and compensation arrangements.

Physician Self-Referral (Cont’d)

For example, if you invest in an imaging center, the Stark Law requires that resulting financial relationship to fit within an exception or you may not refer patients to the facility and the entity may not bill for the referred imaging services. "Designated health services" are:

- Clinical laboratory services
- Physical therapy, occupational therapy, and outpatient speech language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- DME and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services
Anti-Kickback

The Anti-Kickback Statute is a criminal law that prohibits the knowing and willful payment of "remuneration" to include or reward patient referrals or the generation of business involving any item or services payable by the Federal Health Care Programs (e.g., drugs, supplies, or health care services for Medicare and Medicaid patients).

Remuneration includes anything of value and can take many forms, including cash, free office space, expensive hotel stays and meals, and excessive compensation for medical directorships or consulting engagements.

In some industries, it is acceptable to reward those who refer business to you. However, in the Federal Health Care Programs, paying for referrals is a crime.

Anti-Kickback (Cont’d)

The CCHS Compliance Program prohibits:

- Offering or accepting anything in return for the referral of patients or other healthcare business
- Paying physicians/physician groups more or less than fair market value for services provided or paying for services that are not medically necessary.
- Paying physicians more or less than fair market value for the leasing of space or equipment.
- Establishing a financial arrangement with a provider without a written contract.
- Accepting payment or other kickbacks for vendors meant to encourage purchasing of their products by the hospital.
- Accepting excessive payments or payments for unnecessary consulting or research services from drug or medical device companies.
- Accepting money for attending industry sponsored seminars if no legitimate services are performed.
Anti-Kickback (Cont’d)

The kickback prohibition applies to all sources of referrals, even patients. For example, where the Medicare and Medicaid Programs require patients to pay copays for services, you are generally required to collect that money from the patients.

Routinely waiving co-payments or deductibles may influence Medicare patients to use that provider, which could implicate the Anti-Kickback Statute.

Kickbacks in health care can lead to:

- Overutilization
- Increased program costs
- Corruption of medical decision making
- Inappropriate patient steering
- Unfair competition

EMTALA

The Federal Emergency Medical Treatment and Active Labor Law (EMTALA) applies to all Medicare-participating hospitals that have a "Dedicated Emergency Department", and requires that:

- Hospitals provide a medical screening examination to every individual presenting at its emergency department (ED) who requests care for a medical condition.

- If an emergency medical condition (EMC) is found to exist, the hospital must provide stabilizing treatment within its capabilities.

- If the patient requires stabilization capabilities not available at the hospital, the hospital must transfer the patient to another hospital with such capabilities.

- Hospitals must accept appropriate transfers of patients with EMC’s from other hospitals, when it has stabilization capabilities to accommodate the patient.
EMTALA (Cont’d)

The EMTALA statute was created to stop "patient dumping," that is, the refusal to treat uninsured and indigent patients that present to an emergency department (ED). It requires that a medical screening examination be conducted for all patients who present to the ED requesting to be evaluated.

If an emergency medical condition (EMC) does exist based on the medical screening examination, the patient will receive stabilization services, or may be transferred to other facilities better equipped to handle the patient’s care.

EMTALA (Cont’d)

When a physician is assigned to be "on-call" to the hospital’s Emergency Department (ED) on behalf of his/her specialty, he/she must:

- Respond immediately, or within a designated timeframe, by telephone to a call from the Emergency Physician
- Appear personally in the ED to further stabilize a patient, if requested to do so by an Emergency Physician
- As an alternative to personal appearance in the ED, move the patient to another hospital department where the patient will have more expedient access to personal services of the on-call physician or with other superior capabilities to stabilize the patient.
- Place the ED on notice and follow the backup plan set for his/her specialty, if the physician anticipates unavailability due to circumstances beyond his/her control.
Confidentiality

All members of Christiana Care's workforce (including physicians, other providers, employees, students and volunteers), as well as its business associates are required to maintain the confidentiality of patient protected health information (PHI).

All personnel are responsible for maintaining confidentiality of Christiana Care's business information.

Confidentiality (Cont’d)

Even if the information does not contain common identifiers, such as patient name, it is PHI if there is sufficient information to permit someone to identify the patient.

Patients generally have the right to control their health information. However, the patient's consent is not required to use or disclose PHI for purposes of treatment, payment, or healthcare operations or for certain other disclosures (such as for mandatory reporting, in judicial proceedings, to health oversight agencies).

Even when verbal disclosures of PHI are permitted (such as for purposes of treatment), it is important that care be taken to keep the information confidential. For example, providers should be careful in discussing patient information in public spaces.
Confidentiality (Cont’d)

If a patient’s information is disclosed to an unauthorized individual even by accident, the patient’s privacy is violated. The Privacy Office should be notified so it can investigate the violation and, if necessary, notify the patient and report to the government.

PHI includes all past, present and future individually identifiable health information including:

• An individual’s physical or mental health condition
• Health care services provided
• Payment for health care services
• Demographic information that identifies the individual.

Confidentiality (Cont’d)

Patients have the many rights regarding their PHI, including:

• Right to control PHI
• Right to obtain access to PHI
• Right to request an accounting of disclosures of PHI
• Right to request an amendment of inaccurate or incomplete information
• Right to Confidential status
• Right to designate a confidential mode of communication
• Right to request a restriction of disclosures
• Right to be notified if PHI is breached
Confidentiality (Cont’d)

The Privacy Office investigates potential breaches of patient information, notifies patients if their information is breached, and reports to governmental agencies. In addition to investigating reported concerns, the Privacy Office also proactively monitors access to patient medical records to look for access without a business purpose.

All workforce members are responsible for protecting patient privacy. They should only access or disclose the minimum necessary for the business purpose. They must be careful to transmit it securely and only to authorized individuals. And, when a paper document or CD is no longer needed, it should be shredded (usually by discarding it in a blue bin).

If you have a privacy concern, contact the Privacy Office at (302) 623-4468.

Information Security

Each year cyber attacks result in large losses of personal and financial data. The following guidelines will help you to protect yourself and Christiana Care from an attempted attack/data breach:

- Create strong passwords that cannot be easily guessed. Use a mix of numbers, letters and symbols (%$#).

- Do not respond to unsolicited E-mails that ask you for personal information, such as your account or user information. Avoid clicking on links or opening attachments from unknown senders.

- Log out or lock you workstations when not in use.

- Report security issues, such as suspicious E-mails or unattended workstations, to the IT Customer Service Center.
Information Security (Cont’d)

Protect yourself & CCHS from information security exposure by:

Creating Strong Passwords
• A strong password is a basic protection mechanism. While it is tempting to create an easy or generic password that is easy to remember, it’s not very secure.

Looking out for Phishing /Malicious Software
• If you receive an E-mail that looks suspicious, do not click on the links or open attachments provided in the E-mail. Do not provide personal information or financial data. Call (302) 327-EMER and let them know.

Log Off/Lock your device if you are walking away.

Information Security (Cont’d)

Information Security is the protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction. It is achieved by implementing technical and operational measures designated to protect information. There are three elements to protecting information:

• **Confidentiality** – Protecting information from unauthorized disclosure to people or processes.

• **Availability** – Defending information systems and resources from malicious, unauthorized users to ensure accessibility by authorized users.

• **Integrity** – Assuring the reliability and accuracy of information and IT Resources
Reporting Violations

In order to be able to recognize behaviors or activities that violate the Code of Organizational Ethics, you must read and be familiar with its principles. You are expected to report any actual or suspected activities that are inconsistent with Christiana Care policy or legal/regulatory requirements in any area of operation. As a general matter, concerns may be presented initially to managers or supervisors.

You may also contact the Compliance Officer directly at (302) 623-4693. In addition, the Compliance Hotline (877-REPORT-0) permits compliance issues to be reported on a confidential and anonymous basis 24 hours/day, 7 days/week. There can be NO retaliation against you for reporting suspected noncompliance in good faith.

Reporting Violations (Cont’d)

Examples of situations that must be reported include, but are not limited to, any known or suspected:

- Creation, development or submission of fictitious, unsubstantiated or medically unnecessary claims for items or services to government or commercial payors.
- Inclusion of false or misleading information in the organization’s financial statements or accounting records.
- Inclusion of false or misleading information in records or other documents supporting claims to government or commercial payors.
- Offering gifts or other financial incentives to referral sources or patients for the ordering or request of items/services or other business.
- Mislabling or altering of drugs or other items used for patients, or unauthorized altering of patient or employee/contractor records.
- Theft of organizational property (e.g., information, physical property).

Compliance policy establishes procedures for investigating known or suspected compliance violations.
Reporting Violations (Cont'd)

Compliance policy establishes procedures for investigating known or suspected compliance violations.

Corrective action, remediation, and/or disciplinary measures for improper conduct will be imposed uniformly for all levels of staff without regard to position or influence. The organization does not tolerate retaliation against any individual for reporting, in good faith, an actual or suspected violation even if the allegation is never substantiated.

However, the Compliance Officer will investigate situations in which there is reason to suspect that the motive for making a compliance report is other than honorable and in good faith.