Affordable Care Act Focuses on Compliance Plans

By Joseph W. Gallagher, JD, LLM

COMPLIANCE PLANS FOR MEDICARE AND MEDICAID PROVIDERS NO LONGER A MATTER OF CHOICE

The era of the voluntary compliance plan for providers who treat Medicare or Medicaid patients is coming to an end. Although compliance plans have always been a good idea, they were not mandated for healthcare providers until enactment of healthcare reform legislation. The Patient Protection and Affordable Care Act (ACA), signed into law in 2010, mandates that healthcare providers enrolled in Medicare and Medicaid adopt a healthcare compliance plan. Section 6401 of the ACA specifically states that healthcare providers must establish a compliance program that contains certain “core elements” as a condition of enrollment in government programs.

Under Section 6401, the secretary of Health and Human Services (HHS), in consultation with the HHS Office of Inspector General (OIG), is required to define what “core elements” must be contained in the compliance plan. Under the law, “core elements” will vary according to the type of healthcare provider. As of the date of this article, the implementation date of the Section 6401 mandate is still to be determined, and HHS has not yet issued regulations defining “core elements.” But do not let these unknowns be an excuse to ignore what’s coming. Even though these regulations have not yet been written, it is highly likely that a previously issued guidance from OIG setting out seven fundamental elements of an effective compliance plan will form the basis of the mandated plans. This OIG guidance (described in detail below) was published in October 2000.

WHY YOUR PRACTICE NEEDS A COMPLIANCE PROGRAM

Even outside the context of the new ACA mandate, practices currently without a compliance plan should consider adopting such a program as a matter of smart management. Compliance plans help providers avoid or mitigate the significant penalties associated with violations of healthcare regulations. Enforcement initiatives against doctors, particularly with respect to Medicare fraud, are increasing. Further, the OIG has placed increased emphasis on compliance programs. In the OIG’s Fiscal Year 2012 Work Plan, the government identified compliance-related action areas such as claims accuracy, “reasonable and necessary” standards, and provider training. With enforcement likely to increase, the risks of non-compliance for oral and maxillofacial surgeons are significant. If you are found to be in violation of Medicare or Medicaid program requirements, criminal and civil liability can arise under a number of federal statutes and regulations, including the False Claims Act, the Medicare/Medicaid Civil Monetary Penalties Law and the Anti-Kickback Act.

The False Claims Act prohibits the “knowing and willful” submission of a false or fraudulent claim for payment to the federal government, the “knowing and willful” use of a false statement or misrepresentation to obtain payment, or a conspiracy to defraud the United States.

The Medicare/Medicaid Civil Monetary Penalties Law provides for civil monetary penalties plus fines equal to three times the amount of a fraudulent claim for services that the individual knows—or should know—were not provided as claimed.

The Anti-Kickback Act prohibits the knowing and willful solicitation, offer, or payment of any remuneration, whether direct or indirect, in cash or in kind, to induce or in return for (i) referring an individual, or (ii) purchasing or otherwise arranging for an item or service, for which payment may be made under federal or state health plans. The Anti-Kickback Act is violated whenever there is an exchange of “remuneration” (money, referrals, or anything else of value) for referrals of Medicare or Medicaid patients or business. This could be used, for instance, to target a space lease signed by an OMS practice with a key referrer that provided for the referrer/lessee to pay below-market rent. Potential penalties for violation of these statutes include: jail time, exclusion from Medicare/Medicaid participation, and large fines.

Thus, setting aside the fact that ACA now requires them, you should recognize that compliance plans make good sense from a risk management and business perspective. Defending against an accusation of a fraud and abuse violation can be as costly as paying the penalty for an actual violation. The
purpose of a compliance program is to identify areas of existing or potential noncompliance and correct them on an ongoing basis. Having fraud and abuse compliance safeguards in place will be considered a mitigating factor by the OIG in the event of an investigation and may help your practice avoid an investigation altogether.

**FRAMEWORK OF A COMPLIANCE PROGRAM**

An effective compliance program needs to be tailored specifically to the needs of your practice. To ensure that your compliance program is right for your situation, start with an internal audit of all practice areas potentially affected by the “fraud and abuse” laws (both federal and state).

Fraud allegations can be leveled against oral and maxillofacial surgeons in a variety of ways whether or not they treat Medicare or Medicaid patients. While the abundance of regulatory focus stems from abuse of the government programs, oral and maxillofacial surgeons must also be careful not to run afoul of commercial insurance requirements or the regulatory and ethical guidelines of state dental boards and/or professional societies. Examples of potential legal landmines include services by an unlicensed provider or clinician, billing a full fee when non-Medicaid patients are charged less for the same service, services provided by an excluded provider, payment for referrals, and the like. There are other obvious types of fraud, such as when the surgeon’s office: bills for services not performed; up-codes for services that were performed, generates patient charges in excess of the amount submitted to insurance; diagnoses and performs services of questionable “need”; improperly bills anesthesia to a Medicare or Medicaid patient; bills for services rendered on dates that the surgeon was not available to see patients in the office; or, bills under a different provider’s name.

The OIG recommends that practices perform one of two types of audits. The standards and procedures audit focuses on whether the practice’s standards and procedures are complete. The second type of audit is a claims submission audit that focuses on whether bills and medical/dental records are in compliance with coding, billing and documentation requirements. The OIG targets the following as specific risk areas for practices that are most in need of internal checks and balances to prevent Medicare/Medicaid payment errors and possible fraud:

- coding and billing protocols;
- reasonable and necessary services;
- timely, accurate and complete medical/dental record documentation with respect to diagnosis and treatment; and
- kick-backs, inducements and self-referrals that come about through relationships with providers, hospitals and other third parties.

**OUTSIDE HELP**

To protect yourself from legal risk, consider using an attorney to conduct your practice audit and assist with the development of your compliance plan. Using legal help will identify areas of concern, develop third-party credibility and give “objectivity” to the audit.

Also, if an attorney assists you, information and documentation generated as part of the audit may be protected from disclosure to investigators under the “attorney-client privilege.” Generally, investigators may not compel a client to disclose confidential communications with its lawyer if those communications are for the purpose of obtaining legal advice. Otherwise, documents generated by a practice as part of an internal compliance audit must generally be disclosed to investigators upon request.

**OIG’S SEVEN FUNDAMENTALS OF A COMPLIANCE PROGRAM**

The findings of your audit will set the framework for developing your compliance program. Your compliance program should be an organized, documented initiative, to be carried out through practice policies and procedures written in your personnel policy manual, shareholder or board minutes, or similar documents.

The OIG has identified seven key elements that must be addressed by an effective compliance plan. Your compliance plan should, at a minimum:

1. **Designate** a chief compliance officer. Give significance to this appointment by charging the individual with the power to educate other employees, update the doctors, call meetings and (if necessary) initiate corrective action in the event of a violation. Administrators, nurses, billing and office managers or other personnel with executive responsibilities are good choices, and they should be trained in healthcare compliance matters. The compliance officer’s duties should include: (a) overseeing and monitoring the implementation of the compliance program; (b) establishing methods to improve the practice’s efficiency and quality of services and to reduce the vulnerability to fraud and abuse; (c) periodically revising the compliance program to reflect changes in the needs of the practice, the law or standards and procedures of government and private payer health plans; (d) developing, coordinating and participating in a training program for compliance; (e) ensuring
that the practice’s providers and contractors are not excluded from federal programs; and (f) investigating allegations of improper business practices and monitoring corrective action.

2. **Implement** written compliance policies that are distributed to all employees (including the doctors) of the practice. According to the OIG, practices should consider creating a resource manual that contains their written standards and procedures as well as information such as OIG Fraud Alerts and Advisory Opinions and Health Care Financing Administration directives and carrier bulletins. Update clinical forms periodically to ensure the forms facilitate complete documentation of medical/dental care that is provided.

3. **Require** regular compliance education and training for all employees (including the doctors) of the practice. This includes compliance education for all new employees and annual refresher courses for all personnel. Maintain a written file of the educational meetings: when they were held and the content covered, as well as documentation of any outside seminars or training attended. Keep a statement on file signed by each employee by which he or she certifies to: (a) attendance; (b) receipt of compliance materials; and (c) understanding of the content.

4. **Establish** a user-friendly process for reporting compliance-related complaints anonymously and without fear of retribution.

5. **Create** a mechanism for responding to allegations of non-compliance and for enforcing disciplinary action against employees who violate practice policies; violators could be issued reprimands, put on probation, demoted, suspended and even terminated with referral to government authorities.

6. **Develop** a process for monitoring ongoing practice compliance (eg, regular audits. For example, make it a practice to review patient charts every six months to ensure that the documentation supports the services billed.

7. **Implement** mechanisms for investigating and correcting identified problem areas, and screening out potential problem employees during the hiring process.

**CONCLUSION**

The ACA’s expansion of practice compliance programs from voluntary to obligatory dramatically raises the stakes for every practice and provider treating patients covered under government payer programs. Using the OIG guidelines as the presumed template, the practice must ensure strict compliance with government regulations, policies, and interpretations. Even though the specifics of ACA compliance programs are not yet available, the OIG’s past guidance is a good indicator of what practices can expect. The failure to implement an effective, ongoing compliance program will result in increased exposure to liability for substantial penalties.

Give your practice the important protection of a compliance program. Take advantage of the OIG’s compliance program guidance. It gives good insight to the areas of a practice the OIG is most concerned with and believes poses the most risk for fraud and abuse. By taking a look at these areas in your particular practice, you can isolate existing or potential noncompliance. Use the OIG tools to develop and implement the internal controls and procedures necessary for your practice.

For additional information concerning fraud and abuse and compliance with federal regulations visit the AAOMS Web site at http://www.aaoms.org/docs/practice_mgmt/fraud_and_abuse.pdf to retrieve the article “A Review of Healthcare Fraud and Abuse in America” written by the AAOMS Committee on Healthcare and Advocacy. Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this article is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.

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