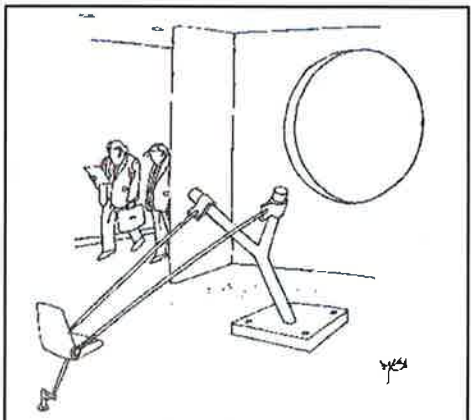
SAINT LOUIS UNIVERSITY

Compliance News

Compliance Department Newsletter
Spring 2004, Issue 3

(877) 525-KNOW
Saint Louis University Compliance Department



"Do you have any mechanism in place for handling coding fraud and abuse?"

COMPLIANCE FAQ

Question: It is becoming increasingly common to receive advertisements that promote HIPAA, OSHA, Medicare or Sarbanes-Oxley compliant software. Do these still need approval from the Compliance Department, Security or Privacy Officers?

Answer: Software programs themselves do not guarantee compliance. The procedures used to implement the programs ensure that the University is complying with all regulatory requirements. It is important to consult with the appropriate University official or department when purchasing software and when implementing new procedures.

RESOURCES

- Compliance Department 977-5545
- Compliance HELPLINE **(877) 525-KNOW**
- SLU Compliance website www.slu.edu/services/compliance
- SLU HIPAA website www.slu.edu/hipaa/
- Center for Medicare & Medicaid Services http://cms.hhs.gov/
- Missouri Medicare Services www.momedicare.com

Any comments or questions regarding the Compliance Newsletter should be directed to the Compliance Department at monahanl@slu.edu.

COMMISSION TIGHTENS RULES FOR COMPLIANCE PROGRAMS

(Adapted from The U.S. Sentencing Commission News Release, 5/3/04)

On April 20, 2004 the United States Sentencing Commission sent to Congress significant changes to the federal sentencing guidelines. The amendment strengthens the criteria an organization must follow in order to create an effective compliance program. The amendment takes effect November 1, 2004, unless Congress disapproves it during a 180-day review period.

An effective compliance program has been a fundamental component of the organizational sentencing guidelines since the Commission first promulgated them in 1991. Under the guidelines, an organization's punishment is adjusted according to several factors, one of which is whether the organization has in place an effective program to prevent and detect violations of law. For such a program to be considered effective, the Commission articulated seven minimum requirements that are the benchmark against which organizational compliance programs are measured. The proposed amendments enhance the rigor and detail of these requirements. Basically, organizations must promote a culture that encourages ethical conduct and a commitment to compliance with the law. The amendment requires boards of directors and executives to assume responsibility for the oversight and management of compliance programs. Effective oversight and management presumes active leadership in defining the content and operation of the program. Minimally, the amendment explicitly requires organizations to identify areas of risk where criminal violations may occur, train high-level officials as well as employees in relevant legal standards and obligations, and give their compliance officers sufficient authority and resources to carry out their responsibilities.

The U.S. Sentencing Commission, a federal agency in the judicial branch, was organized in 1985 to develop a national sentencing policy for the federal courts.

RESPONDING TO REQUESTS FOR MEDICAL INFORMATION

What steps does your department take when an agency or payor requests additional medical information before paying a claim?

Earlier this year, the SLU Billing and Compliance Meeting featured presentations by Education Specialist Sally Frese, and Compliance Coordinator Lynn Monahan. Sally discussed the *"R's" of Responding to a Request for Information.* Lynn reviewed an example of an actual case where a durable medical equipment company requested a SLU physician signature and Medical Necessity certification for equipment the physician never ordered.

There are many valid reasons for the release of medical information, but in today's environment of HIPAA regulations and heightened attention to health care fraud and abuse, diligent review is required whenever patient information is released. It is important to take the time to evaluate every request carefully. Before submitting medical information to an outside agency, the Compliance Department suggests that you take the time to address Sally Frese's *"R's of Responding to a Request":*

- REASON FOR THE REQUEST – *Why do they need the info?*
- READ BETWEEN THE LINES – *Is this a valid request?*
- REVIEW THE INFORMATION – *Is the info gathered complete?*
- RESTRICT THE INFO SENT – *Am I sending only what is needed and no more?*
- REQUEST ASSISTANCE – *Do I have any questions? Which resource can answer them?*
- RESPOND – *Am I sending the info to the correct person and address?*
- RECORD AND TRACK – *Have I logged the request and info released?*

CELEBRITY SPOTLIGHT

The Compliance Newsletter spotlight this month focuses on Saint Louis University certified coders. These individuals have committed themselves to a high standard of professionalism by meeting rigorous exam criteria to earn national certification in their field. They maintain their certification by earning continuing education credits on a yearly basis. The two organizations that provide certification in the coding field are the American Academy of Professional Coders (AAPC) and the American Health Information Management Association (AHIMA).

The American Academy of Professional Coders (AAPC) provides education and certification for professional coders by focusing on physician practice (CPC) and hospital outpatient facility (CPC-H) coding. The AAPC offers continuing education through local chapters, workshops, monthly publications and annual conferences. Initial certification is earned by passing the national exam which is offered at different locations throughout the country. The physician practice or the hospital outpatient facility-coding exam is a five-hour monitored multiple-choice test which encompasses several different areas of coding. More information may be obtained through the AAPC website, http://aapc.com/.

The American Health Information Management Association (AHIMA) is the professional association that represents more than 46,000 specially educated health information management professionals who work throughout the healthcare industry. Health information management professionals serve the healthcare industry and the public by managing, analyzing, and utilizing data vital for patient care. AHIMA issues credentials in health information management through a combination of education and experience, and performance on national certification exams. Certified Coding Specialist (CCS) and Certified Coding Specialist –Physician-based (CCS-P) are but two of the eight areas provided for exam and credentialing. AHIMA members must maintain their credentials through rigorous continuing education requirements. Additional information regarding AHIMA may be obtained through their website, http://ahima.org/.

Correct reimbursement for health care professional services is crucial in today's environment of increased financial pressures and government scrutiny. While code selection will always be the physician's ultimate responsibility, certified coder involvement benefits an organization by ensuring a greater level of accuracy and quality in selecting the correct codes for provider services.

HEALTH CARE FRAUD AND ABUSE HEADLINES

U. of Washington Affiliates Pay $35-Million to Settle Medicare Overbilling Case

(from The Chronicle of Higher Education and Seattle Post-Intelligencer)

Several entities affiliated with the University of Washington have agreed to pay the federal government a total of $35 million in fines and restitution for alleged overbilling of the Medicaid and Medicare programs.

The settlement was reached at the end of April after lengthy negotiations to conclude a whistle-blower lawsuit that was filed in 1999 by Mark Erickson, a former compliance officer for two university-affiliated physicians' groups. Mr. Erickson alleged that the physicians' groups had falsely reported that certain medical procedures were performed by physicians when in fact they were performed by medical residents. Erickson also alleged that the university-hospital system had destroyed documents in order to conceal the practice.

In a statement released on April 30, the Washington, D.C.-based law firm of Phillips & Cohen, which represented Erickson, said that this is believed to be the largest settlement in a case of this kind. The previous record was a $30-million settlement in 1995 that involved the University of Pennsylvania's medical school.

The University of Washington has not conceded that its employees or affiliates committed any fraud. In a statement released on April 30, Dr. Paul Ramsey, vice president for medical affairs and dean of the medical school, said that the dispute concerned "billing errors" and that "most of these errors were the result of innocent mistakes." During the criminal phase of the investigation, Dr. H. Richard Winn, the former head of neurosurgery, pleaded guilty to obstruction of justice, and Dr. William Couser, the former nephrology chief, admitted to committing fraud. The doctors were ordered to pay $600,000 in restitution, which is included in the $35 million settlement.

The university also signed a compliance agreement that will require extensive audits for the next five years. Dr. Ramsey said the University has added staff members, provided more training to improve billing practices and now spends nearly $4 million per year on compliance.

Under the provisions of the federal whistle-blower law, Mr. Erickson will receive a $7.25-million portion of the settlement.

SLU COMPLIANCE AUDIT METHODOLOGY

As a result of ongoing quality improvement efforts the Compliance Department has proposed two modifications to the method used for monitoring provider billing compliance. In the past, all errors noted were attributed to the provider. The department has initiated a review process that distinguishes provider errors (i.e., inadequate documentation, incorrect coding) from operational errors (i.e., charge entry mistakes). Both the providers and the clinical departments benefit from this determination. Providers are not penalized for compliance problems they do not directly control. Department administrators benefit when operational issues are brought directly to their attention.

The other modification regards the number of provider records reviewed in the annual baseline audit. Previously, five provider records were reviewed to determine whether the provider passed or failed the audit. Currently, the Compliance Department is piloting an audit process where five records are reviewed initially. If a provider fails this audit, a second set of five records is reviewed to determine the provider score. It is anticipated that this methodology will further refine the accuracy of the audit results and provide a more comprehensive review of the provider's documentation and billing practices. The UMG Legal and Compliance Committee reviewed and approved these modifications and will monitor the outcomes.