Oneida Health

Oneida Health Hospital and Medical Practice Network

Corporate Compliance Program*

"DOING THE RIGHT THING"

Renee Olmsted, RHIA - Corporate Compliance and Privacy Officer, Director, Risk Management

Revised: April, 2025

*applies to OHH, ECF, Article 28 Health Centers, Oncology, Wound Care, Cardiology, OMP, OMS, GPP

Purpose of our Compliance Program?

To provide guidelines designed to reflect Oneida Health Hospital's commitment to promoting prevention, detection and correction of health care fraud, waste and abuse, and resolution of instances of potential misconduct within day-to-day operations, including non-compliance with Medicaid and Medicare requirements.

OHH's Board of Trustees is ultimately responsible for our program.

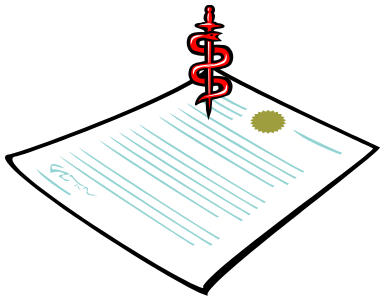
Affected Persons

- The Corporate Compliance Program applies to all persons affected by Oneida Health's risk areas throughout the organization*, including:
  - **employees,**
  - **the chief executive officer and other senior administrators, and managers,**
  - **contractors, agents, subcontractors and independent contractors, and**
  - **governing body and corporate officers**

*includes all individuals at the hospital and all of its departments and health centers, the Extended Care Facility, and Oneida Health's affiliated physician practices (Oneida Medical Services, PLLC, Oneida Medical Practice, P.C. and Genesee Physician Practice, PLLC)

CORPORATE COMPLIANCE POLICIES AND PROCEDURES

- Oneida Health's Corporate Compliance Program and Policies describe Oneida Health Hospital's mandatory Corporate Compliance Program and compliance obligations for all Affected Persons.
- All policies and procedures can be found on workgroups (S drive) under "Policy Index."
- Our CC plans, reporting policy & procedure, and Compliance concern reporting form are all available on our external web site.
  https://www.oneidahealth.org/our-organization/corporate-compliance-privacy/
- Copies are also available by contacting CCO.



OHH Code of Conduct – a Guide to Ethical Behavior

- Policy CC 16-45, Compliance Code of Conduct, serves as the foundation for the Compliance Program and describes OHH's commitment to conduct its business in an ethical manner, including the following values:
  - Respect
  - Communication
  - Collaborative work environment
  - Honesty and integrity
  - No discrimination
  - Vision, mission, and values drive practice and patient experience
  - Patient dignity, autonomy, positive self regard, civil rights, involvement in their own care
  - **Commitment to Patient Centered Care and to Co-workers to establish a culture of patient safety and teamwork.**

Our Collective Responsibilities:

- Obligated to Report:
  - possible violations;
  - suspected illegal or improper conduct.
- Refuse to participate in unethical or illegal conduct
- Safeguard OHH Resources
- Accurately maintain, authenticate, retain, & dispose of documents & records
- Maintain Confidentiality
- Avoid conflicts of interest
- Contribute and maintain the integrity of billing and payer relationships
- Avoid inappropriate acceptance of gifts
- Understand that non-compliant acts may result in progressive discipline or some course of action

Elements of an Effective Compliance Program

1. **Written standards of conduct, policies and procedures;**
2. **Designating a Compliance Officer and a Compliance Committee;**
3. **Training and education;**
4. **Lines of communication;**
5. **Responding to compliance issues;**
6. **Auditing and monitoring; and**
7. **Disciplinary standards.**

OMIG Risk Areas

(1) billings;

(2) payments;

(3) ordered services;

(4) medical necessity;

(5) quality of care;

(6) governance;

(7) mandatory reporting;

(8) credentialing;

(9) contractor, subcontractor, agent or independent contract oversight;

(10) other risk areas that are or should reasonably be identified by the provider through its organizational experience

Organizational Experience

The compliance program is designed and implemented to prevent, detect, and correct non-compliance with Medicaid program requirements, including fraud, waste, and abuse most likely to occur based on our risk areas and organizational experience.

- "**Organizational experience**" means:
  - knowledge, skill, practice and understanding in operating our compliance program;
  - identification of any issues or risk areas in the course of our internal monitoring and auditing activities;
  - experience, knowledge, skill, practice and understanding of our participation in the Medicaid program and the results of any audits, investigations, or reviews we have been the subject of; or
  - awareness of any issues it should have reasonably become aware of for its category or categories of service.

Corporate Compliance Officer

Renee Olmsted, RHIA

Corporate Compliance, Risk Mgt, Privacy

315-361-2117 phone

315-361-2317 fax

315-361-2116 (hotline)

rolmsted@oneidahealth.org

Compliance Program Structure

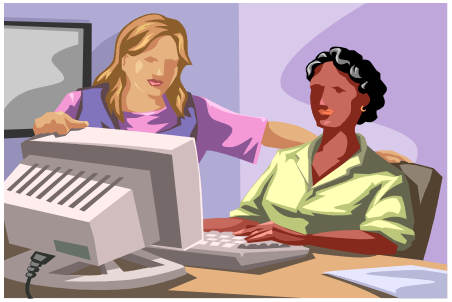
- *Policy: Governance for the Corporate Compliance Program, CC 16-27*
  - **CCO** is responsible for the day-to-day oversight of the Program, is accountable to the CEO but also has a line to report to the Board.
  - **Liaisons**: MPN Practice Managers and MPN Quality Director oversee the day-to-day activities of the Corporate Compliance Plan for OHH affiliated entities and the Article 28 Health Centers, with oversight from the Corporate Compliance Officer.
  - **Corporate Compliance Committee**: Includes senior leadership, dept directors and practices liaisons, meets monthly to discuss compliance issues across our continuum of care and serves as an oversight body for the Corporate Compliance Program.

Board Responsibilities

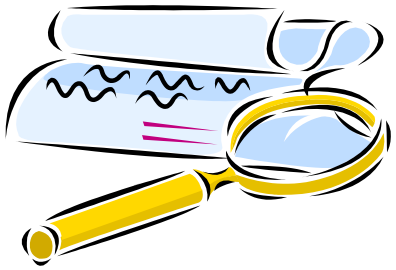
- Promote a culture of ethical behavior and commitment to compliance with the law
- Support the organization's expectations to raise awareness and to educate
- Help to maintain an environment of non-retaliation and encourage safe mechanisms for reporting
- Make inquiries to determine the adequacy and effectiveness of our program
- Review the CC work plan annually
- Review the "Practical Guidance for Health Care Governing Boards on Compliance Oversight"
- Ensure self compliance with solicitation and review of Conflict of Interest (COI) disclosures annually and when circumstances change
- Exhibit ethical behavior and attentiveness to good business judgement in a transparent manner.
- Support the System Wide Corporate Compliance Programs

CC Training and Education

- Policy CC 16-7, Compliance Training and Education
  - Attend General New Hire Orientation
  - Complete post test and score at least 80%
  - Annual training conducted via “Inservice Solutions”
  - Individualized or department specific training as necessary
  - External coding, billing, documentation, compliance related outservices
  - Provider Orientation and Semi-Annual Med Staff Mtg
  - Board Member Orientation and Education



Methods Available to Ask Questions & Report a Potential Concern



- Policies CC 16-1, Compliance Reporting System and CC 16-4, Compliance Hotline Operation
- Discuss with direct supervisor, Compliance Liaisons or members of the Compliance Committee.
- Call the CCO directly at extension 2117 or phone 315-361-2117.
- Call the CC Hotline at extension 2116 or phone 315-361-2116 (anonymous and confidential).
- Complete the report form and submit to CC Office.
- Email the CC Officer at rolmsted@oneidahealth.org

Response to Compliance Concerns

- **Policy CC 16-2**
- Corporate Compliance Officer (CCO) will promptly investigate and respond to all compliance issues as they are raised or identified in the course of audits and self-evaluations
- CCO will correct identified compliance problems promptly and thoroughly.
- This includes implementation of procedures, policies and systems, as necessary, to reduce the potential for reoccurrence and ensure ongoing compliance with federal health care program requirements, including Medicare and Medicaid.
- Evaluation of compliance training and education needs; recommending appropriate corrective action to be taken with respect to persons involved in non-compliant activity; and identifying and reporting compliance issues, as applicable, to appropriate federal and state agencies, and refunding of any identified overpayments.
- Implement corrective action plans
- Determine if there is a need for discipline.

Other Components of a Compliance Program

- Auditing/Monitoring - both internal and external
- Billing and Coding – accurately coding and billing for services, best practice
- Claim development and Submission - process
- Documentation – ensure documentation in the medical record supports the billed services
- Medical Necessity – ensuring that ordered tests/procedures are appropriate for diagnosis
- Illegal Activity – theft, contraband, or assault; fraud and abuse
- Conflicts of Interest – associations with other entities
- Program Certification – OMIG certification that our program is EFFECTIVE

Disciplinary Standards

- Policies CC 16-30 and HR-11. Particular attention to standards related to compliance with OHH's Compliance Program and prevention of fraud, waste and abuse.
- Any incident of noncompliance could be met with invoking this policy. For example:
  - Failure to report, disclose, and/or assist in an investigation of suspected non-compliance;
  - Participation in non-compliant behavior
- Intentional or reckless actions will be subject to more severe sanctions
- Discipline policy is enforced firmly and fairly and applies equally to all Affected Persons

Who are the OIG and OMIG?

- **OIG**: Office of Inspector General – Administering the Integrity of the Federal (Medicare) Program

- **OMIG**: Office of Medicaid Inspector General – State (Medicaid) Program Oversight

What is Fraud, Waste and Abuse?
Corp Compliance Policies 16-10, 16-33
Summary of Fraud and Abuse and Whistleblower Protection

Fraud – is an intentional act of deception, misrepresentation or concealment in order to gain something of value. It is willfully falsifying, altering, or padding information to make undeserved money on a claim.

- Billing for services that were never rendered
- Billing for services at a higher rate than is actually justified
- Deliberately misrepresenting services, resulting in unnecessary costs to the Medicare program, improper payments to providers or overpayments

Fraud, Waste and Abuse, cont'd:

- Waste – over-utilization of services (not caused by criminally negligent actions) and the misuse of resources.
- Abuse – excessive or improper use of services or actions that are inconsistent with acceptable business or medical practice. Refers to incidents that, although not fraudulent, may directly or indirectly cause financial loss.
  - Charging in excess for services or supplies
  - Providing medically unnecessary services
  - Billing for items or services that should not be paid for by Medicare

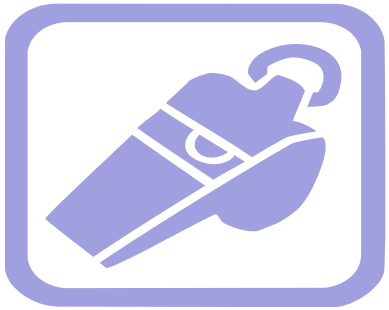
Federal and NYS False Claims

Allows a civil action to be brought against a health care provider who:

- Knowingly presents, or causes to be presented, a false or fraudulent claim for payment to any employee;
- Knowingly makes, uses or causes to be made or used a false record or statement to get a false or fraudulent claim paid; or
- Conspires to defraud the government by getting a false or fraudulent claim allowed or paid;
- A person can also be found liable under the false claims act who acts in reckless disregard of the truth or falsity of information;
- There no longer needs to be an “intent” of getting a false claim paid. The false claim cases going to court are now based on whether the false record or statement was “material” to getting the claim paid;
- A provider who receives monies to which they are not entitled, and retains those monies, known as an overpayment

False Claims Act

- False Claims Act- The Federal and NYS governments use the False Claims Act and other related laws to deter fraud, waste and abuse in their reimbursement systems- Medicare and Medicaid.
- It applies to any person or entity who tries to get paid by Medicare or Medicaid for a false claim.
  - A False claim means billing for services:
    - That are not provided
    - That are provided by an improper person
    - That are billed in a manner other than actually provided
    - That are of very poor quality
  - *Qui tam* (whistleblower) provision – OHH does have whistleblower protection language in our policies.



OTHER Important Regulations

- Stark Law- Provider self-referral is the practice of a Provider referring a patient to a medical facility in which the Provider has a financial interest, be it ownership, investment, or a structured compensation arrangement. -Exceptions have been carved out for specific transactions. Ex: we can not supply a Provider's office with a computer just to entice him to refer his patients to our lab.
- Anti-Kickback Law- Compensation in exchange for referral or use of a service, good, facility or item that may be reimbursed by a federal health care program (Medicare, Medicaid, Tricare)
  - Safe harbors – exceptions for specific transactions

Whistleblower Protections

- Policy 16-33
  - OHH has a policy of non-intimidation and non-retaliation for good faith participation in the Corporate Compliance Program.
  - No Affected Person shall suffer intimidation, harassment, discrimination or other retaliation for reporting in good faith actions they reasonably believe are illegal, fraudulent or in violation of any Laws or adopted policy of OHH or which pose a substantial danger to the public health and safety.

OIG AND OMIG Exclusion List

- Policy CC 16-47
- The OIG and the OMIG have the authority to exclude individuals and entities from participating in Medicare, Medicaid, and other federal health care programs.
- Exclusion means that no program payments will be made for items or services furnished, ordered, or prescribed by the excluded individual entity.
- We can not bill for services ordered or provided by an excluded individual.
- Perform monthly screening of all providers, employees and vendors/contractors via K-checks (software).

No concern you may have regarding compliance is too small or too unimportant…..

- Compliance Officer, Renee Olmsted, 315-361-2117
- Hotline: 315-361-2116 or extension 2116
- rolmsted@oneidahealth.org
- Report forms can be found outside Human Resources, in approved documents, and the internet

Questions?