Oneida Health

Oneida Health Hospital and Oneida Health Practice Management Corporate Compliance Program*
"DOING THE RIGHT THING"

Renee Olmsted, RHIA - Director

Corporate Compliance, Risk Management, Privacy Officer

Dr. Thomas Chmelicek

VP, Medical Affairs and Chief Medical Officer – Corporate Compliance Officer

Revised: December, 2021

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

What is a Compliance Program?

Compliance efforts are designed to establish an environment or culture that promotes prevention, detection and resolution of Medicaid non-compliance and health care fraud problems.

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

OHH Code of Conduct – a Guide to Ethical Behavior

- 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.**

Responsibilities:

- Report possible violations
- 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

8 Elements of an Effective Compliance Program

1. Designation of a Compliance Officer
2. Written policies and procedures
3. Training and education
4. Effective lines of communication
5. Well publicized disciplinary standards
6. System for routine monitoring and identification of compliance risks
7. System for promptly responding to compliance issues
8. Non-intimidation and non-retaliation

CORPORATE COMPLIANCE OFFICER (CCO)

Thomas Chmelicek, MD

VP, Medical Affairs and Chief Medical Officer – Corporate Compliance Officer

315-361-2409 or ext. 1190

tchmelicek@oneidahealth.org

Corporate Compliance Director (CCD)

Renee Olmsted, RHIA

Director, Corporate Compliance, Risk Mgt, Privacy

315-361-2117 phone

315-361-2317 fax

315-361-2116 (hotline)

rolmsted@oneidahealth.org

Compliance Program Structure

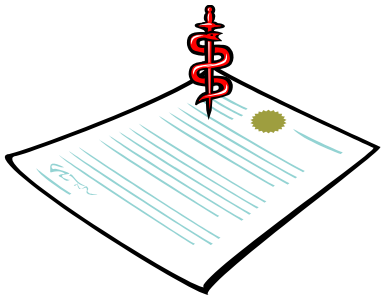
- *Governance for the Corporate Compliance Program, CC 16-27*
- CCD is responsible for the day-to-day operation of the Program and reports to the Board
- CCO reports and is directly accountable to CEO
- Corporate Compliance Committee, including individuals from Management and Practices, meet monthly to discuss compliance issues

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 Conflict of Interest (COI) annually and when circumstances change
- Exhibit ethical behavior and attentiveness to good business judgement in a transparent manner.

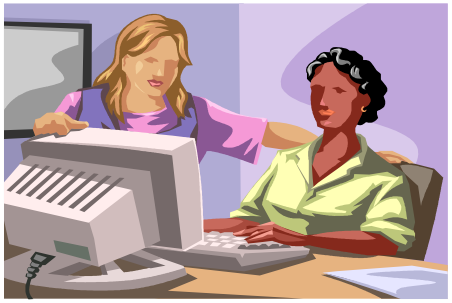
CORPORATE COMPLIANCE POLICIES AND PROCEDURES

- All policies and procedures can be found on the hospital intranet
- Our CC plans and our reporting policy and procedure and report form are all available on our external web site.
- www.oneidahealth.org
- The Plan contains a section, “What does Compliance mean to me?”, that further explains department specific examples.

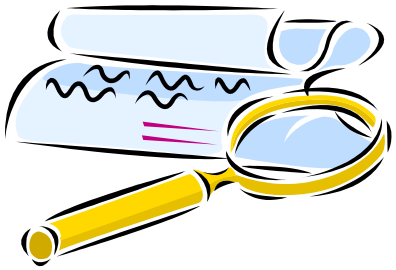


CC Training and Education

- Attend 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
- Board Member Orientation



Methods Available to Report a Potential Concern



- Discuss with direct supervisor.
- Call the CC Director 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 Director at rolmsted@oneidahealth.org

Other Components of a Compliance Program

- Auditing/Monitoring - both internal and external
- Billing and Coding – accurately coding and billing for services
- 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
- Non-retaliation - OHH has policy against retaliating or intimidating staff who bring matters to our attention (whistleblower protection). Policy CC 16-33
- Conflicts of Interest – associations with other entities
- Program Certification – OMIG certification that our program is EFFECTIVE

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

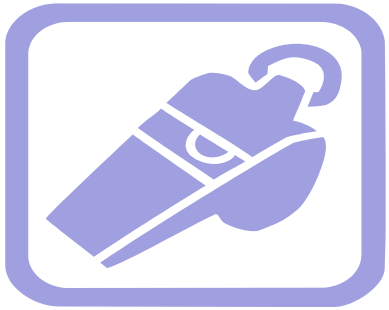
Federal and NYS False Claims

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;
- As of May 2009, 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.



Response to Compliance Issues

- OHH Policies on *Internal Investigations and Response CC 16-2* and *Monitoring and Auditing CC 16-8* describe:
  - how potential compliance problems are investigated and resolved
  - response to compliance issues identified in the course of audits and self-evaluations
  - implementing procedures, policies, and systems as necessary to reduce the potential for recurrence
  - corrective actions, including identifying and reporting compliance issues to DOH or OMIG and refunding overpayments

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

OIG AND OMIG Exclusion List

- 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, Dr. Chmelicek
- Compliance Director, Renee Olmsted
- 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?