

Compliance Programs for Physician Practices

Audio Seminar/Webinar

November 15, 2007

Practical Tools for Seminar Learning

Disclaimer

The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

As a provider of continuing education, the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or services(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

Faculty

Dianne Wilkinson, RHIT

Ms. Wilkinson is the compliance officer and quality manager for MedSouth Healthcare, in Dyersburg, TN, where she consults on compliance activities for clients, particularly the auditing and education components. Ms. Wilkinson has worked in HIM for 36 years, including managing HIM departments in hospitals and physician office settings. She particularly enjoys E/M auditing, coding, teaching, and working with physicians.

Table of Contents

Disclaimer	i
Faculty	ii
Objectives	1
Compliance Plan	
Based on OIG Model	1
Poll Question #1	2
7 Core Elements of a Plan	2
Poll Question #2	3
Coding and Billing Risk Areas	3
Poll Question #3	5
Examples from Particularly Challenging Risk Areas	5
Poll Question #4	6
Great Model for a Compliance Plan	7
Poll Question #5	7
Sample Compliance Plan	8
Poll Question #6	8
Coding Compliance with Respect to Fraud and Abuse	9
Poll Question #7	9
Protection for the Coder	10
OIG Guidance for Specific Categories of Coders	11
Highlights of the 2008 OIG Work Plan	
Focus Areas	12
Skills for the Coder	14
Skills for the Biller	15
Resources	16
Audience Questions	
Appendix	20
Sample Compliance Plan	21
CE Certificate Instructions	29
Note: Appendix B (separate document)	
OIG Physician Compliance Program	
OIG 3 rd Party Biller	
OIG Advisory for Consultants	
1995 Documentation Guidelines for E/M Services	

Seminar Objectives

- ◆ **Discuss the requirements for an effective coding and billing compliance program**
- ◆ **Provide guidance on issues related to coding compliance with respect to fraud and abuse**
- ◆ **Highlight the OIG work plan for the physician office setting**

1

A written compliance plan based on the following:

- ◆ **OIG Model Compliance Guidance for Individual and Small Group Physician Practices, and/or**
- ◆ **OIG Compliance Program Guidance for Third Party Billing Companies**



2

Polling Question #1

Which of the following statements is the most accurate:

- *1** The compliance plan does not need a provision for self-reporting to Medicare when a criminal or civil violation is identified as long as the staff person is terminated.
- *2** It is better not to implement a compliance plan than to implement one and not follow it.
- *3** The amount of overpayment to Medicare, when coding errors have been identified, is negotiable between Medicare and the Practice.

3

Seven core elements of a compliance plan

per the OIG (Office of the Inspector General):

- Auditing and monitoring
- Policies and procedures/standards of conduct based on OIG-identified areas of risk
- Oversight (Compliance Officer)
- Training and education
- Responding to detected offenses (corrective action planning)
- Open lines of communication
- Enforcing disciplinary standards as necessary

4

Polling Question #2

The clinic administrator is not always the best choice to be the compliance officer.

- *1 True**
- *2 False**

5

Examples Coding and Billing Risk Areas OIG Compliance Guidance

- ♦ **Billing for items or services not rendered or provided as claimed**
- ♦ **Billing for items/equipment/supplies that are not medically necessary**
- ♦ **Upcoding**
- ♦ **Unbundling**
- ♦ **Billing for non-covered services as if covered**

6

***Examples Coding and Billing Risk Areas
OIG Compliance Guidance (continued)***

- ◆ Failure to use modifiers properly
- ◆ Clustering
- ◆ Misuse of provider identification numbers
- ◆ Duplicate billing in an attempt to gain duplicate payment
- ◆ Internal coding practices
- ◆ Coding without proper documentation

7

***Examples Coding and Billing Risk Areas
OIG Compliance Guidance (continued)***

- ◆ Inadequate resolution of overpayments
- ◆ Inappropriate arrangements between physicians and third party billing companies
- ◆ Professional courtesy/waiver of coinsurance

8

Polling Question #3

It is always wise to write off a legitimate charge for an angry Medicare patient...for the sake of good will?

- *1 True**
- *2 False**

9

Examples From Particularly Challenging Risk Areas

- ♦ **Evaluation and management coding in general**
- ♦ **Correct billing and documentation of 99211 services**
- ♦ **Wide variances in bell curve patterns**
- ♦ **Medicare rules for coding/documentation of consultation**
- ♦ **E&M service on the same day as a minor procedure**

10

Examples From Particularly Challenging Risk Areas (continued)

- ♦ Coding/billing/documentation of preventive visits to Medicare
- ♦ Keeping providers aware of local and national coverage decisions
- ♦ Obtaining a valid Advance Beneficiary Notice
- ♦ "Incident to" and other issues of billing for mid-level providers
- ♦ Keeping current CCI edits top-of-mind
- ♦ Inadequate documentation to support E&M levels and other services billed

11

Polling Question #4

It is permissible to bill a non-covered preventive visit ("annual physical") to Medicare as long as the note also reflects some chronic problems that are being managed?

- *1 True
- *2 False

12

Great model for a compliance plan:

- ◆ **Joint Commission’s Ten Step Model Quality Assurance Plan**
 - Contains all seven core elements of a compliance plan
 - Plus additional valuable elements



13

Polling Question #5

Which of the following describe the two most important elements of a compliance plan?

- *1 Policies and procedures and effective action-planning**
- *2 Oversight and training and education**
- *3 Auditing/monitoring and training and education**

14

Sample Compliance Plan

- ♦ **See sample compliance plan for a physician practice coding and billing department in the Appendix of the resource materials.**

SAMPLE COMPLIANCE PLAN:

Coding and Billing Department

MISSION STATEMENT/CODE OF ETHICS: Coding and Billing Staff of BestDoctors Medical Clinic, P.C. will adhere to the highest standards of professional coding and billing practices. Coders will observe the guidelines and conventions of ICD-9-CM and CPT/HCPCS coding and utilize their own skills and knowledge in selecting appropriate diagnosis and procedure codes. Codes to be billed are to be clearly and consistently supported by physician documentation in the health record. Coding and billing staff members should strive for optimal payment to which the Practice is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines. Coders and billers will not engage in fraudulent practices.

15

Polling Question #6

Which of the following statements are accurate:

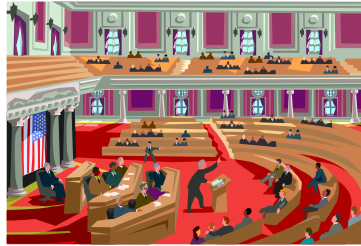
- *1 A variation from the norms in E&M coding always indicates a problem.**
- *2 Choosing one E&M code virtually all the time will never be a problem as long as it is a low-level code.**
- *3 Medical necessity based on severity of presenting problems is the primary driver of E&M code selection.**
- *4 All of the above.**

16

Coding Compliance With Respect to Fraud and Abuse

Laws outlining coding risks and their penalties

- **The False Claims Act**
- **The Social Security Act**
- **The Program Fraud Civil Remedies Act**
- **HIPAA**



17

Polling Question #7

There is no protection under the False Claims Act for a physician making innocent coding and billing errors if he never made an attempt to learn Medicare rules for claims submission or provided any educational opportunities for his staff.

- *1 True**
- *2 False**

18

Protection for the Coder

- ♦ **A Corporate Compliance Plan with “teeth”**
- ♦ **A Coding and Billing Compliance Plan**
- ♦ **Keep your skills sharp; consider certification**
- ♦ **Log all advice from Medicare carrier...who, what, when**
- ♦ **New codebooks every year**

19

Protection for the Coder

- ♦ **Go to reliable workshops, budget permitting**
- ♦ **Stay current with Medicare (and other payer) billing guidelines**
- ♦ **Keep copies of all correspondence, meetings, etc., providing coding information and education to providers and other staff**

20

Can an honest, ethical coder be prosecuted or fined when false claims are submitted?

21

OIG Guidance for Specific Categories of Coders

- ♦ **OIG Compliance Program Guidance for Third Party Billing Companies (link included with reference materials)**
- ♦ **OIG Special Advisory: Practices of Business Consultants (included with reference materials)**

22

Highlights of the 2008 OIG Work Plan

Physician Office Setting



23

Focus Areas

Medicare Physicians and Other Health Professionals



1. Place of service errors
2. E&M services during global surgery periods
3. Medicare payments for psychiatric services
4. Services performed by clinical social workers

24

Focus Areas

5. Medicare payments for selected physician services

- **Surgery**
- **Consultations**
- **Home/Office/Institutional calls**



25

Focus Areas

- 6. Medicare "Incident To" services**
- 7. Appropriateness of Medicare payments for polysomnography**
- 8. Long distance physicians claims for Home Health and skilled nursing facility services**
- 9. Assignment rules by Medicare providers**
- 10. Business relationships and use of MRI under Medicare Physician Fee Schedule**

26

Focus Areas

- 11. Medicare payments for interventional pain management procedures**
- 12. Geographic areas with high utilization of ultrasound services**
- 13. Geographic areas with a high density of independent diagnostic testing facilities**
- 14. Payments for high frequency chiropractic treatments**
- 15. Physician reassignment of benefits**

27

Skills For The Coder

- 1. Coding expertise and experience in ICD-9-CM and CPT/HCPCS**
- 2. Staying up to date on fraud and abuse laws**
- 3. Ability to abstract/interpret health record documentation and compare with what is being billed**
- 4. Knowledge of payer rules, including your Medicare carrier**



28

Skills For The Coder (continued)

- 5. Communication skills**
- 6. Human resources skills**
- 7. Management and skills**
- 8. Educating skills**
- 9. Medical terminology**
- 10. Consider certification!**



29

Skills for the Biller:

- 1. Organization skills...strong attention to detail**
- 2. Good oral and written communications skills**
- 3. Ability to deal with others with professionalism, courtesy, and effectiveness**
- 4. Knowledge of HIPAA and other laws relevant to claims submission**
- 5. Medical terminology**

30

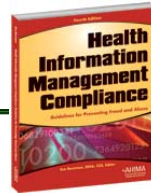
Skills for the Biller (continued)

6. Data entry skills with keying speed and accuracy
7. Knowledge of ICD-9-CM and CPT/HCPCS coding
8. Knowledge of billing and reimbursement cycle and claims processing
9. Staying current with billing rules of Medicare and other payers



31

Resources



Health Information Management Compliance: Guidelines for Preventing Fraud and Abuse, Fourth Edition

Sue Bowman, RHIA, CCS AHIMA (2007)

To order: <https://imis.ahima.org//orders/productNew.cfm>

Product Number: AB102107

ISBN/ISSN: 1-58426-168-4

32

AHIMA Online Distance Education Course Discount

Participants in today's audio seminar can receive a **20% discount** on registration in the following AHIMA distance education program:

**Healthcare Information Management:
Physician Practice EHR Solutions Program**

For program details and to receive discount, visit

<http://campus.ahima.org/promotion/himppehr>

Coupon code: 25704

Offer ends December 15, 2007

33

Audience Questions



Audio Seminar Discussion



***Following today's live seminar
Available to AHIMA members at
www.AHIMA.org***

*Click on Communities of Practice (CoP) – icon on top right
or sign on to MyAHIMA*

AHIMA Member ID number and password required – for members only

Join the **Coding for the Physician Practice Community** from your Personal Page then under Community Discussions you will be able to:

- Discuss seminar topics
- Network with other AHIMA members
- Enhance your learning experience

AHIMA Audio Seminars/Webinars

Visit our Web site

<http://campus.AHIMA.org>

for information on the seminar schedule.

While online, you can also register for seminars or order CDs and pre-recorded Webcasts of past seminars.



2008 Seminar/Webinar schedule now posted

Upcoming Seminars/Webinars

- ◆ ***Coding Urology (Male) Procedures***

Faculty: Jean Jurek, MS, RHIA, CPC and
Jerome Ndayishimiye, MS, RHIA, CIC

November 29, 2007



- ◆ ***CPT Update***

Faculty: Margi Brown, RHIA, CCS, CCS-P, CPC and
Karen Scott, MEd, RHIA, CCS-P, CPC

December 6, 2007 (rebroadcast December 7)

Thank you for joining us today!

**Remember – sign on to the
AHIMA Audio Seminars Web site
to complete your evaluation form
and receive your CE Certificate online at:**

<http://campus.ahima.org/audio/2007seminars.html>

**Each person seeking CE credit must complete the
sign-in form and evaluation in order to view and
print their CE certificate**

**Certificates will be awarded for
AHIMA and ANCC
Continuing Education Credit**



Appendix

Sample Compliance Plan	21
CE Certificate Instructions	29

Appendix

SAMPLE COMPLIANCE PLAN:

Coding and Billing Department

MISSION STATEMENT/CODE OF ETHICS: Coding and Billing Staff of BestDoctors Medical Clinic, P.C. will adhere to the highest standards of professional coding and billing practices. Coders will observe the guidelines and conventions of ICD-9-CM and CPT/HCPCS coding and utilize their own skills and knowledge in selecting appropriate diagnosis and procedure codes. Codes to be billed are to be clearly and consistently supported by physician documentation in the health record. Coding and billing staff members should strive for optimal payment to which the Practice is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines. Coders and billers will not engage in fraudulent practices.

RESPONSIBILITY/OVERVIEW:

The Compliance Plan for the Coding and Billing Department is reflected as Appendix C in the Corporate Compliance Plan for BestDoctors Medical Clinic, P.C. The Board of Governors has the overall responsibility for all compliance activities in the Practice. The Corporate Compliance Committee members are the Medical Director, one physician-at-large, the Compliance Officer, and the departmental supervisors. The Committee meets on an ad hoc basis. The Corporate Compliance Officer is the Practice Manager who has delegated the responsibility for oversight of the Coding and Billing Department's compliance activities to the Supervisor of the Coding and Billing Department, who will perform data collection and initial data analysis for all auditing and monitoring activities.

SCOPE OF ACTIVITIES:

The Coding and Billing Compliance Plan will include all specialties, providers, and ancillary departments in BestDoctors Medical Clinic, P.C. and all locations where services are performed and billed. While Medicare will be a primary focus for auditing and monitoring activities, Medicaid, commercial insurance, and all other categories of payment sources will also be included over time.

Scope of Coding and Billing Functions at BestDoctors Medical Clinic, P.C.:

1. CPT/HCPCS coding (procedural coding, modifiers, global packaging, all appropriate coding conventions)
2. ICD.9 diagnosis coding using appropriate coding conventions
3. Data edit/entry for claims generation
4. Submission of electronic data to clearinghouse with receipt of appropriate reports for further action as needed
5. Posting payments and working denials
6. Sending out statements
7. Collections

Appendix

Coding and Billing Policies and Procedures:

1. Assignment of E&M levels/Changes on superbills
2. Computer security safeguards
3. Changes/added information to documentation when working denials
4. Orientation/training and education for staff
5. Auditing and monitoring
6. Updates and adherence to Medicare LCDs/NCDs pertinent to Practice
7. Interactions with vendor/clearinghouse
8. Frequency policy for sending out statements
9. Write-offs/collections
10. Working denials/appeals process
11. Billing of services of nurse practitioners
12. Professional courtesy/waiver of coinsurance

IMPORTANT ASPECTS OF CODING AND BILLING:

1. Accuracy of E&M coding with supporting documentation (high volume, high risk, problem prone)
Medicare rules for correct billing of consultation (high volume, high risk)

E&M service on same day as minor procedure (high risk, problem prone)

Billing of annual exams, with or without problem visit (high risk, problem prone)

Level 5 visits (high risk)

E&M services in the nursing facility setting (high volume, problem prone)

CPT code 99211 billings (high risk, problem prone)

Visits billed on the basis of time (counseling and/or coordination of care, problem prone)
2. CCI edits/bundling issues (high volume, problem prone)
3. Accurate CPT/HCPCS coding (high volume)
 - a. Use of modifiers (problem prone, high risk)
 - b. Global surgery rules (Medicare and CPT [different]) (high volume, problem prone)
4. Accurate ICD.9 diagnosis coding (high volume)
5. Medicare coverage restrictions (NCDs/LCDs) (high risk, problem prone)

Appendix

- LCD for benign skin lesion removal (high risk, problem prone)
- LCD for bone density measurement (Dexascan) (high volume, high risk, problem prone)
- 6. Presence/Absence of ABNs when required (high risk, problem prone)
Use of -GA, -GZ, -GY (high risk, problem prone)
- 7. Billing of services of non-physician practitioners (high volume) Incident to"
(high risk, problem prone)
Shared Visits (high risk)
- 8. Professional courtesy/waiver of coinsurance (high risk)
- 9. Effective working of denials (high risk, problem prone)
- 10. Accuracy of information in every box of the claim form (high volume)
- 11. Submission/receipt of information from the clearinghouse (high volume)
- 12. Effective collections process (high risk, problem prone)

AUDITING AND MONITORING/QUALITY INDICATORS:

It is impossible for any department to audit and monitor every aspect of work they perform, all the time. It is prudent, therefore, to choose from the Important Aspects of Coding and Billing on a rotating basis the most important areas in need of auditing and monitoring (based on areas of highest risk, highest volume, and or those most problem-prone). A yearly calendar showing a schedule of what is to be audited/monitored is permissible and effective. For this sample compliance plan, we will include some sample audit criteria/indicators which in no way would be conclusive over time, but which would give an idea of how to choose criteria/indicators.

1. E&M coding and documentation audits (Source: E&M Coding and Documentation Guidelines, 1995 Version, CPT, and CMS/Carrier Instructions as Appropriate)
 - a. Baseline for new providers, 20 office encounters, 10 hospital encounters, 10 nursing home encounters
 - b. Quarterly audits for all providers, 10 office encounters, 5 hospital encounters, 5 nursing home encounters
2. Pro time visits including the billing of a 99211 will contain all of Medicare's criteria for medical necessity of the 99211 in the nurse's documentation.

Appendix

3. Benign skin lesion removals for Medicare patients with claims reflecting use of the –KX modifier will have chart documentation of at least one of the approved signs/symptoms.
4. Benign skin lesion removals for Medicare patients who were billed as cosmetic, with use of the –GY modifier will have a valid ABN on file in the patient record.
5. Medicare well-woman exams including screening pelvic/breast exam, Pap, and a problem visit component will be coded and billed and documented in accordance with CMS guidelines (criteria on file in Billing Department.)
6. Coinsurance will only be waived for Medicare patients for hardship reasons as outlined in the Medicare Manual.
7. Accuracy of procedural coding for hospital surgeries (multiple procedures.)
8. Accuracy of diagnosis coding for diagnoses not printed on the superbill.
9. Review of all Medicare denials for medical necessity.
10. Review of all Dexascan denials from Medicare for frequency edits.

THRESHOLDS FOR EVALUATION (A few examples):

1. E&M Coding and Documentation Auditing
 - a. Random sample, as described in quality indicator
 - b. Threshold on overall process audit criteria: 90%
 - c. Threshold of level five visits not meeting medical necessity by severity of complaint(s): 0%
 - d. Threshold of notes over-coded by two or more levels: 0%
2. Pro Time Visits Including Billing of 99211

Random sample, 10 per quarter per provider

Threshold on notes not meeting all of Medicare's documentation requirements: 0%
3. Accuracy of Diagnosis Coding (for Diagnoses Not Printed on Superbill)
 - a. Random sample: Coding Supervisor re-codes 20 office encounters for each coder per month (may go to smaller sample once accuracy is established).
 - b. Threshold for diagnosis coding errors: 2%

Appendix

4. Medicare Denials for Frequency Edits for Dexascan
Review sample: 100%
Threshold for frequency denials: 0%

DATA COLLECTION:

For each indicator or monitoring activity currently in use, consider the following and build into your plan:

1. Is sampling reasonable, or is the indicator one of such high risk that the sample should be 100%?
2. If sampling is reasonable, decide how many encounters would be adequate. If any providers, location, or patient population should be exempt, etc.
3. What is the frequency of data collection?
4. Will data be collected prospectively or retrospectively? Pre-claim or post-claim?
5. Who is responsible for collecting the data (performing the audit; e.g., is this also the person who will be doing the initial data analysis on the findings?)
6. As data are collected and tabulated, compare each indicator with its threshold to see if further evaluation is necessary.

ANALYSIS OF DATA/AUDIT FINDINGS (Includes Data Display):

1. For each auditing and monitoring activity, for each period of data collection, analyze the findings for whether threshold is exceeded, and particularly if there are patterns or trends when compared to previous audit findings. We will use E&M coding and documentation auditing as an example for this section.
2. For the quarterly review (10 office encounters, 5 hospital and nursing home encounters respectively, per provider), prepare a trend sheet for each series of E&M codes that shows the providers, with three consecutive quarters of results on display.
3. Review the trend sheet for compliance to process criteria/thresholds, for percentage of over-coded encounters, under-coded encounters, etc., and compare to previous quarters (again, looking for trends/patterns).
4. Determine whether there are problem areas...by specialty, by provider, by type of E&M service (e.g., most of the over-coded encounters are level 4 consultations and new office patients).

Appendix

5. Prepare a summary report of findings and forward with trend sheets (confidential correspondence) through appropriate channels as outlined in your Corporate Compliance Plan (which should outline responsibility for taking action as appropriate, in-service as needed, etc.).

EFFECTIVE ACTION-TAKING:

Data analysis will indicate whether further action is needed on any of the auditing and monitoring activities. Let's discuss a few examples:

1. There are eight coders in the Practice. The Supervisor re-codes 20 office encounters per month on all eight coders, for diagnoses not printed on the superbill. She trends her findings over time. She might find:
 - a. That six of the eight coders' coding errors are consistently within the 2% threshold (this would mean that no further action is needed in this case).
 - b. One of the coders has been consistently within threshold for several monitoring periods, but her error rate for the past three months is 5%, 6%, 4%. Further investigation is necessary, and action would be necessary.
 - c. The eighth coder has shown erratic results for the past year and has only been within the 2% error threshold once during that time; discussions with her have not corrected the problem. Further corrective action is necessary!
2. One physician in the Practice has shown a consistent variance in bell curve statistics on E&M coding and documentation review since he joined the Practice a year ago (he consistently bills approximately 60% level 4 consults and 20% level 5 consults). His documentation is thorough, but medical necessity of the higher levels is sometimes questionable. Discussions with him by the Medical Director have resulted in no change. Further action is necessary (suggestion: 100% pre-claim review of notes with E&M level selected based on documentation).
3. Corrective action must be appropriate to the problems' cause, which usually falls into one of three common areas:
 - Insufficient knowledge
 - Defects in systems
 - Deficient behavior or performance

The problem may self-correct with additional in-service or attendance at a reliable workshop. Systems defects can be evaluated and corrected. Deficient behavior or

Appendix

performance is usually more difficult...at some point disciplinary action will probably be necessary.

ENFORCEMENT OF DISCIPLINARY STANDARDS:

Things to consider:

1. The objective should be to correct the problem with the least invasive disciplinary action possible; if the gentler methods do not work, then progressive disciplinary action would be required.
2. For purposes of this compliance plan model, we will address the coding and billing staff only. Some examples of disciplinary action could include, as appropriate:
 - Oral and written warnings
 - Suspension
 - Termination
3. Disciplinary action should be consistently enforced on a fair and equitable basis.
4. The Practice's Corporate Compliance Plan should address disciplinary action involving illegal acts or those, which would represent civil or criminal violations of State or Federal law.

FOLLOW-UP ON PROBLEM AREAS/ACTION PLANS:

If this area of monitoring and evaluation is not performed effectively, the compliance program and plan will be of no effect. The person or persons with responsibility over auditing and monitoring in the Coding and Billing Department must have a consistent system to:

- a. Follow up on all identified problems, trends and patterns during the auditing and monitoring process for all areas under review.
- b. Follow up on all corrective action plans, with progress reports to appropriate medical and administrative staff, insuring that time lines are followed, and that the action plan is resulting in improvement. If plan "A" is not working, proceed to plan "B".
- c. Keep accurate records, audit materials, minutes of meetings, in-service attendance sheets, etc., that reflect all corrective action plans and disciplinary actions.
- d. Keep the objective top-of-mind: If it's important enough to audit and monitor, the action plan must progress to the point of solving the problem.

Appendix

COMMUNICATION:

1. The compliance plan for the Coding and Billing Department must have a mechanism for an employee to report a suspected billing/coding violation or error. This is ideally done face to face, but the compliance plan should also contain a process for the employee to report the violation or error anonymously. The importance of reporting violations and errors that could put the Practice at risk should be stressed at new hire orientation.
2. Auditing and monitoring activities should result in sharing valuable information back to providers and/or staff, e.g. a physician's performance on quarterly E&M coding and documentation auditing. Share great information as well...the coders with consistently low coding error rates, the dramatic decrease in medical necessity denials due to lack of an ABN, etc. Again, the responsible person should keep records of all such correspondence.
3. Coders and billers should consistently receive information from Medicare bulletins and workshops, coding and billing requirements of Medicaid and commercial payers, pertinent "hot topics" from other publications and sources. Specialty-specific coding journal subscriptions are highly recommended, to be circulated as a reading file, with sign-off from all appropriate staff.
4. The Practice should have a consistent system for providing information from coding and billing activities to physicians, mid-levels, nurses, and ancillary staff...anyone with the need to know. This can be accomplished through memos (ideally they would all come from the same person), reports at Board or committee meetings, or one-on-one as appropriate. If medical necessity denials continue because a Family Practice physician doesn't know about Medicare's LCD on benign skin lesion removal, the only way he will know is from effective communication from the coding and billing department.

SUMMARY:

This model plan is based on Joint Commission's Ten Step Quality Assurance Plan Model from the late 1980s and early 1990s, which happens to contain the seven elements required of a compliance plan. It is the best model, in my opinion. It is only a model, and should be tailored to YOUR Practice and your policies and procedures.



To receive your

CE Certificate

Please go to the Web site

<http://campus.ahima.org/audio/2007seminars.html>

click on

"Complete Online Evaluation"

You will be automatically linked to the CE certificate for this seminar after completing the evaluation.

Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.