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Weekly News and Compliance Strategies on Federal Regulations, Enforcement Actions and Audits

Contents

3 CMS Transmittals and *Federal Register* Regulations, June 4-June 10, 2021

3 Leveraging ADT, HL7 Data May Help Hospitals Prevent Denials

4 Checklist: Kicking the Tires of Your Telehealth Compliance

8 News Briefs

In Rebooting Compliance Program, CO and PO Write Interactive Code, Build Partnerships

When the compliance program began 20 years ago at MultiCare, a health system in Washington state, Samantha Karpenko, who worked in revenue cycle there at the time, said it was perceived as "red tape." There was that sense of compliance as "intimidating," with more of a police aura.

"The team wasn't very approachable and didn't have much of an identity," according to Karpenko, who joined the compliance department in 2011 and ultimately became director of corporate compliance. Over the years the compliance program evolved and improved, culminating last year in a reboot under the direction of Karpenko and Monica Freedle, the director of privacy and civil rights. The difference between then and now is an object lesson in how far compliance has come and how important it is not to leave it in the past, especially with the Department of Justice expecting organizations to do far more than check the boxes.

"It was a 20-year-old program that really needed to be updated and made more relevant to current times," said Karpenko, who recently left MultiCare to become senior compliance manager at 98point6, a telehealth app.

Karpenko and Freedle described the metamorphosis of the compliance program April 21 at the Health Care Compliance Association's Compliance Institute.[1] When Karpenko joined compliance, it was combined with the internal audit program under a single vice president. "The compliance program was run very proscriptively," she said. "It was a heavy lift as we looked at how we needed to adjust and change

continued on 7

Radiation Therapy Provider Pays $3.6M in CMP Settlement; OIG: 25 CPT Codes 'Involved'

A Colorado radiation therapy provider has agreed to pay $3.569 million in a civil monetary penalty settlement with the HHS Office of Inspector General (OIG).

According to the settlement, OIG alleged that HealthONE Radiation Therapy at Red Rocks LLC, which at the time was part of the HealthONE network of hospitals and clinics in the metro Denver area, billed Medicare and Medicaid for services that were false or fraudulent. Between Jan. 1, 2013, and April 16, 2017, HealthONE allegedly submitted claims for some radiation and oncology services that (1) used incorrect CPT codes and dates of service, (2) were not provided, (3) didn't have documentation to support the necessity of the services, (4) "were unbundled" and (5) "had incomplete documentation."

The settlement, which was obtained through a Freedom of Information Act request, stemmed from HealthONE's self-disclosure to the OIG. A spokesperson for the HealthONE system said it "no longer owns and has no role in the operation of Red Rocks Oncology."

OIG alleged the improper claims "involved" 25 CPT codes, and "encompass" radiation therapy planning and simulation services and evaluation and management

continued

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services furnished to patients undergoing radiation therapy. The CPT codes are:

1. G6002: Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
2. 31575: Laryngoscopy, flexible; diagnostic
3. 77014: Computed tomography guidance for placement of radiation therapy fields
4. 77262: Therapeutic radiology treatment planning; intermediate
5. 77263: Therapeutic radiology treatment planning; complex
6. 77280: Therapeutic radiology simulation-aided field setting; simple
7. 77285: Therapeutic radiology simulation-aided field setting; intermediate
8. 77290: Therapeutic radiology simulation-aided field setting; complex
9. 77295: Three-dimensional radiotherapy plan, including dose-volume histograms
10. 77300: Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician
11. 77301: Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
12. 77307: Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
13. 77321: Special teletherapy port plan, particles, hemi-body, total body
14. 77331: Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician
15. 77333: Treatment devices, design and construction; simple (simple block, simple bolus); intermediate (multiple blocks, stents, bite blocks, special bolus)
16. 77334: Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
17. 77338: Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
18. 77370: Special medical radiation physics consultation
19. 77470: Special treatment procedure (e.g., total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
20. 99204: New patient evaluation and management (E/M) (level 4)
21. 99205: New patient E/M (level 5)
22. 99213: Established patient E/M (level 3)
23. 99214: Established patient E/M (level 4)
24. 99215: Established patient E/M (level 5)
25. 99245: Office consultation (level 5)

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OIG Found IMRT Billing Errors Nationally

HealthONE didn't admit liability in the settlement. In a statement, the company said: "During HealthONE's joint ownership of Red Rocks Oncology, incorrect bills for oncology services were submitted to the [Centers for Medicare & Medicaid Services] (CMS). Upon learning of the billing errors, we self-disclosed them and worked to rectify the billing errors with CMS. At no point has there been any concern about patient care or treatment." OIG accepted HealthONE into the Self-Disclosure Protocol in November 2019.

The Denver area provider was not alone in (allegedly) making mistakes in its IMRT billing. Billing for IMRT, an advanced radiation procedure for hard-

to-reach tumors, was called out by the OIG in a 2018 audit report.[1] Medicare pays a bundled payment to hospitals to cover IMRT planning services that may be performed to develop a treatment plan. OIG reviewed planning services billed using CPT code 77290, which represented a complex simulation billed by a hospital on a claim that included one or more services. A random sample of 100 line items on claims submitted by 91 hospitals was selected.

The findings: Payments for outpatient IMRT planning services were not compliant with Medicare billing requirements. The hospitals separately billed for complex simulations when they were performed as part of IMRT planning on all 100 line items for the audit period (2013-2015) and received overpayments of $21,390 as a result. The cause: unfamiliarity or misinterpretation of CMS guidance for billing IMRT planning services. "On the basis of our sample results, we estimated that Medicare overpaid hospitals nationwide as much as $21,543,154 for complex simulations billed during our audit period," OIG said. It identified an additional $4 million in potential overpayments for other IMRT planning services. ✧

Endnotes

1. Gloria L. Jarmon, *Medicare Improperly Paid Hospitals Millions of Dollars for Intensity-Modulated Radiation Therapy Planning Services*, A-09-16-02033, Office of Inspector General, U.S. Department of Health & Human Services, August 2018, https://bit.ly/2RI0a3X.

CMS Transmittals and *Federal Register* Regulations, June 4-June 10, 2021

Transmittals

Pub. 100-4, Medicare Claims Processing

- Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) -- Manual Instructions, Trans. 10839 (June 9, 2021)
- July 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 10836 (June 8, 2021)
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits, Trans. 10831 (June 2, 2021)

Pub. 100-20, One-Time Notification

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--July 2021, Transmittal 10832 (June 2, 2021)

Pub. 100-03, Medicare National Coverage Determinations

- National Coverage Determination (NCD) Removal, Trans. 10838 (June 8, 2021)

Leveraging ADT, HL7 Data May Help Hospitals Prevent Denials

A Medicare auditor downcoded a hospital's high-dollar MS-DRG claim for an implantable cardioverter defibrillator (ICD) because the cardiologist's documentation didn't square with Medicare's revised national coverage determination (NCD 20.4).[1] There was no evidence of formal shared decision-making between the physician and the patient before the procedure using an evidence-based decision tool, and the medical necessity boxes weren't checked, leaving the hospital to foot the bill for the device when the MS-DRG was changed to heart failure and shock.

"If you don't get this right in the clinic before the scalpel touches skin, you will get a denial later by audit, whether it's a private payer or CMS," said Kendall Smith, M.D., chief medical officer of Intersect Healthcare + AppealMasters in Towson, Maryland. "We can argue until we're blue in the face to administrative law judges. They're sympathetic to hospitals, but they're limited by what's in the medical record."

Hospitals are far better off preventing denials by getting payer-specific coverage requirements (e.g., NCDs, clinical policy bulletins)[2] into the hands of physicians and other clinicians before patients have procedures or are discharged from the hospital rather than appealing them, he said at a May 26 webinar[3] sponsored by the company. This is very challenging because hospitals treat patients covered by many different payers that change their payment and coverage policies on a regular basis. To do a better job of preventing denials, hospitals may move in the direction of payer documentation integrity (PDI), an "amalgamation" of utilization review and clinical documentation integrity (CDI) and "the future of CDI," Smith said. Hospitals would leverage their own data sets from admissions, discharges and transfers (ADT) and Health Level 7 International (HL7).

"The ground has shifted from capturing appropriately coded diagnoses to ensuring payer documentation compliance," Smith explained. For example, hospitals are seeing payer denials for sepsis even though CDI specialists clarified the diagnosis with the physician. The reason: payers who use Sepsis-3 criteria aren't finding a sequential organ failure assessment (SOFA) score in the medical record. A SOFA score isn't required for Sepsis-2, which is used by some payers, including Medicare. Unless that information is conveyed to the physicians before discharge, the medical record may not have the documentation necessary to survive an audit by payers using Sepsis-3.

Clinical policy bulletins vary by payer, and some are 50 to 80 pages long. "No human being involved

in clinical care wants to be responsible for an 80-page policy," Smith said. It's difficult to distill them to a template or automated process for physicians to act on in real time. "What we have realized in the past decade is we need an early warning system," Smith said. He suggested taking "actionable intelligence" out of the back end and putting it into the revenue cycle, creating triggers that alert case management and utilization review when the patient is in a hospital or clinic. "There are a lot of exclusions or special notes to procedures," he said. For example, a payer may not cover spinal stimulators for neuropathy when patients have comorbid illnesses like diabetes. "It's important to know the exceptions so the physician has informed discussions with the patient."

Leveraging ADT and HL7 Data Sets

Using their own data, hospitals can establish early warning systems about prior authorization and coverage requirements, said Tracey Tomak, area vice president of Intersect Healthcare + AppealMasters, at the webinar. ADT data, which is demographic information about patients (e.g., name, address, insurance and the patient's movement during the stay) and HL7 data, the common digital language behind all health information systems, can be used to create triggers to review patient activities in real time "and stop potential denials."

She suggested talking to the information technology department about creating "watch lists" that can lead to alerts. The data is out there, although it has to be directed to another system. For example, an alert would pop up if patient status were changed from inpatient to observation without the use of condition code 44 or from observation to inpatient without an inpatient order. The alerts should be payer specific and based on payer guidelines. "It's crucial to have payer content laying the foundation for a comprehensive, real-time denial avoidance process," Tomak said. Payer policies change often, so she suggested checking them annually or quarterly. "There's a global lack of awareness on the clinical side of payer-specific rules," Smith said.

With so much information available, he recommended focusing on the top 10 inpatient denials and top 10 inpatient and outpatient procedure denials by the top three to five payers in recent months. The goal is to avoid the grind of appeals. "The tide is turning against providers," Smith said. "It's getting harder to overturn denials." He estimated the overturn rate has dropped 10% to 15% in recent years. "You can write a knowledgeable appeal, and you won't prevail."

Contact Smith at ksmith@intersecthealthcare.com and Tomak at ttomack@intersecthealthcare.com. ✧

Endnotes

1. Centers for Medicare & Medicaid Services, "National Coverage Determination (NCD) for Implantable Automatic Defibrillators (20.4)," Trans. 211, Medicare National Coverage Determinations, Pub. 100-3, February 2018, https://go.cms.gov/3zgIWvn.
2. Nina Youngstrom, "Gaps in Clinical Policy Bulletins Put Commercial Claims at Risk," *Report on Medicare Compliance* 28, no. 10 (March 18, 2019), https://bit.ly/3gaWFg0.
3. Kendall Smith and Tracey A. Tomak, "Winning Upfront with Denial Prevention/Avoidance: Using Your ADT Data and Payer-Specific Rules to Stop the Denial Freight Train," webinar, Intersect Healthcare + AppealMasters, May 26, 2021, https://bit.ly/3xd5JGE.

Checklist: Kicking the Tires of Your Telehealth Compliance

This checklist was developed by attorney Joseph F. Zielinski, with Dinsmore & Shohl. He spoke with attorney Katea Ravega of Quarles & Brady about implementing telehealth effectively and legally April 21 at the Health Care Compliance Association's Compliance Institute.[1] Contact Zielinski at joseph.zielinski@dinsmore.com and Ravega at katea.ravega@quarles.com.

TELEHEALTH COMPLIANCE ASSESSMENT FORM

Organization:	
Person Completing Assessment:	
Title of Person Completing Assessment:	
Date Assessment Completed:	
Notes:	

Area 1: Written policies and procedures

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
1.1	Do you have a written policy(s) and procedure(s) that describe compliance expectations for telehealth?	☐	☐		

1.2	Have you implemented the operation of telehealth compliance program?	☐	☐		
1.3	Do you have a written policy and procedure that provides guidance to employees on dealing with potential telehealth compliance issues?	☐	☐		
1.4	Do you have a written policy and procedure that provides guidance on how to communicate telehealth compliance issues to appropriate compliance personnel?	☐	☐		
1.5	Do you have a written policy and procedure that provides guidance on how potential telehealth compliance problems are investigated and resolved?	☐	☐		

Area 2: Designate an employee vested with responsibility

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
2.1	Has a designated employee been vested with responsibility for the day-to-day operation of the telehealth compliance program?	☐	☐		
2.2	Are the designated employee's duties clearly defined?	☐	☐		
2.3	If the designated employee's telehealth compliance duties are combined with other duties, are the telehealth compliance responsibilities satisfactorily carried out?	☐	☐		
2.4	Is there a "subject matter expert" outside of the designated employee with oversight of telehealth compliance?	☐	☐		
2.5	Does the "subject matter expert" have qualifications satisfactory to be an "expert"?	☐	☐		
2.6	Does the designated employee periodically report directly to the governing body on the activities of the telehealth compliance program?	☐	☐		

Area 3: Training and education

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
3.1	Is training and education provided to all affected employees on telehealth compliance issues and the telehealth compliance program operation?	☐	☐		
3.2	Is telehealth compliance training offered periodically?	☐	☐		
3.3	Is telehealth compliance training part of orientation for affected new employees?	☐	☐		
3.4	Are education/training sessions evaluated for effectiveness?	☐	☐		

Area 4: Communication lines to the responsible telehealth compliance position

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
4.1	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to all employees to allow telehealth compliance issues to be reported?	☐	☐		
4.2	Are there lines of communication to the designated employee referred to in item 2.1 that are accessible to all governing body members to allow telehealth compliance issues to be reported?	☐	☐		
4.3	Is there a method in place for anonymous and/or confidential good faith reporting of potential telehealth compliance issues as they are identified?	☐	☐		

Area 5: Disciplinary polices to encourage good faith participation

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
5.1	Do disciplinary policies exist to encourage good faith participation in the telehealth compliance program by all affected individuals? *For purposes of Area 5, "affected individuals" shall mean those persons who are required to receive training and education under Element 3 above.*	☐	☐		

continued on p. 6

continued from p. 5

5.2	Are there policies in effect that articulate expectation for reporting compliance issues for all affected individuals?	☐	☐		
5.3	Are there policies in effect that articulate expectations for assisting in the resolution of telehealth compliance issues for all affected individuals?	☐	☐		
5.4	Is there a policy in effect that outlines sanctions for failing to report suspected problems for all affected individuals?	☐	☐		
5.5	Is there a policy in effect that outlines sanctions for participating in non-compliant behavior for all affected individuals?	☐	☐		
5.6	Is there a policy in effect that outlines sanctions for encouraging, directing, facilitating or permitting non-compliant behavior for all affected individuals?	☐	☐		
5.7	Is there a policy on non-intimidation and/or non-retaliation for good faith participation in the telehealth compliance program, including but not limited to reporting potential issues, investigation issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials?	☐	☐		
5.8	Are all telehealth compliance-related disciplinary policies fairly and firmly enforced?	☐	☐		

Area 6: A system for routine identification of telehealth compliance risk areas

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
6.1	Do you have a system in place for routine identification of telehealth compliance risk areas specific to your provider type?	☐	☐		
6.2	Do you have a telehealth compliance work plan and goals?	☐	☐		
6.3	Do you have a system in place for self-evaluation of the risk areas identified in 6.1, including internal audits and as appropriate external audits?	☐	☐		
6.4	Do you have a system in place for evaluation of potential or actual non-compliance as result of self-evaluations and audits identified in 6.3?	☐	☐		
6.5	Do you have a system in place to mitigate the telehealth compliance risks identified in 6.1?	☐	☐		
6.6	Do you have a designated individual assigned to oversee any necessary mitigation or corrective actions identified in 6.5?	☐	☐		

Area 7: A system for responding to telehealth compliance issues

#	Description	Yes	No	Evidence of Compliance or action required Include specific references to documents that support and "Yes" response	Additional Notes
7.1	Is there a system in place for responding to telehealth compliance issues as they are raised?	☐	☐		
7.2	Is there a system in place for investigating potential telehealth compliance problems?	☐	☐		
7.3	Is there a system in place for responding to telehealth compliance problems as identified in the course of self-evaluations and audits?	☐	☐		
7.4	Is there a system in place for correcting telehealth compliance problems (as referred to in 7.3) promptly and thoroughly?	☐	☐		
7.5	Is there a system in place for implementing procedures, policies and systems as necessary to reduce the potential for recurrence?	☐	☐		
7.6	Is there a system in place for identifying and reporting telehealth compliance issues to Federal agencies, if necessary?	☐	☐		
7.7	Is there a system in place for refunding Medicare/ Medicaid overpayments?	☐	☐		
7.8	Is there a process for notifying the governing body of any potential violations?	☐	☐		

Endnotes

1. Joseph F. Zielinski and Katea M. Ravega, "How to Effectively and Legally Implement Telehealth in Your Organization," Compliance Institute, Health Care Compliance Association, April 21, 2021, https://bit.ly/3zjUwG3.

Compliance Program Reboot: Write New Code

continued from page 1

the perception of our program and make ourselves into something new." In 2017, MultiCare made a significant acquisition in another geographic area and, a year later, began taking its first big steps with the compliance program. Internal audit was pulled out of compliance, and the hotline was moved from Karpenko's desk to an external company. MultiCare launched its first tracking system and branded the integrity line. "We also created the first regional position to deal with various operational hats. I started in mid-2018, and we could already see a huge shift," Freedle said.

The following year brought leadership changes. "While always awkward, it gave us a chance to experiment with things," Freedle said. "We had an external effectiveness review so they were able to point out things we already knew and other things we hadn't dived into." Oversight of the compliance program was moved from the CEO to another person, and Freedle and Karpenko were promoted and pulled out as a stand-alone team. They acted in a dyadic manner over the compliance program. "We had the same service-level expectations and documentation standards across our teams, and we collaborated to put together the compliance committee and board reports," Karpenko explained.

MultiCare also had its first maturity assessment, Freedle said. "It wasn't an effectiveness review, but it gave us insight into our effectiveness. It was eye-opening to see where we were on the benchmark maturity level. It called out areas where we were babies in the world and gave us something tangible to move forward to help us be more effective."

The 2020 mission was to rightsize the compliance program because MultiCare is not the same organization in the same geography as it was 20 years ago, and the world has changed enormously since then.

Reboot Had Five Goals

Karpenko and Freedle established five goals for the reboot. The first was to show the work of the program. Before 2019, MultiCare's work plan was limited, focused mostly on compliance and tied to a broad risk category (e.g., billing). In 2020 and 2021, the work plan was split into three:

1. The program (e.g., code of conduct, board reporting).
2. Compliance (e.g., Medicare requirements, Stark, conflicts of interest).
3. Privacy/civil rights.

The work plan includes audits, major projects, ongoing initiatives and education. That's a departure from five to eight audits on past work plans. Showing a fuller, truer picture of the compliance program's agenda, including rewriting the standards for business conduct, helps build support with the board and compliance steering committee.

The compliance team also started tracking metrics. "We have a commitment to try to respond within two days of [people] reporting to the hotline and started being transparent with how we were doing with that and putting in detailed updates on our activities. We broke it into the seven elements so everything we gave the board was tied to the work plan, charter and the other components of the program." By showing their work, Karpenko and Freedle could support the argument to rightsize the compliance programs.

New Code of Conduct Has Live Links

The second goal for the reboot was to create tangible resources. A big one is the standards for business conduct. "We hadn't fundamentally changed our code of conduct in 20 years except for one update," Karpenko said. Some basic questions were asked: Was it easy to read? Not really; the questions and answers were at the end, so people had to search all of them to find an answer to their specific query. Was it visually appealing? Sort of; MultiCare had done a graphic design update, but it didn't have the visual consistency that engages readers, she said. Was the content accurate? Mostly, but "we didn't have a decision-making guide, and that's a best practice for a code of conduct, and we didn't address leadership responsibility," Karpenko said. Also, some topics that have become more relevant, including diversity, were absent.

That's why "we did a complete rewrite from scratch" and rolled it out in the fourth quarter of 2020, she said. "It was meant to transform the usability of our document and ensure it would be able to be used as a tool for our readers across the organization." For the first time, the standards for business conduct are interactive, which makes it easier for the reader to use as a tool. Blue and orange boxes throughout reference policies or guidance documents and link directly to MultiCare's policy management system. Other boxes with a paper clip image hit on the key points. "It really gave our document life," Karpenko said.

The compliance and privacy teams also were intentional about the visual consistency of the code because it looks good and increases readability. A paper clip on yellow background always has the takeaway for that section. For example, a page on leadership expectations states, "Managers and leaders are role models, and their behavior must exemplify MultiCare's values. Workforce members rely on their managers for guidance in difficult situations. Because of this, managers must foster a trusting and compliant culture and encourage their teams to bring concerns forward" and then lists specific responsibilities. There are links in orange and blue boxes to five policies (e.g., nonretaliation, contracting, the integrity line) and a separate box tying it all together with the paper clip, saying,

"As a leader, it is your duty to ensure that your teams are aware of changes and updates to MultiCare policies and procedures. Regular communication is expected to happen about both system-level and local policies. As a leader, if you approve or participate in actions that violate the Standards, company policies and procedures, laws or regulations, or fail to cooperate in an investigation, you are subject to corrective actions."

The third goal of the reboot was to develop collaborative partnerships. Freedle said the compliance and privacy/civil rights teams worked hard to "build/mend/create relationships with high-touch partners," including human resources, information technology and operational leadership, "and shed the big-brother perception." It was also important to establish the scope of the compliance program. Who was responsible for what? "We had ongoing check-ins with leaders of all the organizational units and some of the C-suite," she said.

Getting their arms around the compliance committee was a big part of building relationships and defining the scope of authority. Before 2018, MultiCare had a single compliance committee, and from 2018 to 2019, each operational unit had an independent committee. All that would change in 2020, when the health system redesigned the structure. There's now a compliance steering committee with subcommittees and cross-business-unit functional committees that focus on more specific risk areas (e.g., pharmacy, imaging).

The fourth goal was to clearly define the program's authority. "Part of this aligns with the collaborative partnership conversation," she explained. "Is compliance leading investigations? Are we over joint ventures because we are asked questions about them?" Nailing this down took a lot of conversations, but it was cleared up with a new charter and with the support of the steering committee.

The original charter was "very rigid and focused on what the compliance program looked like when it was first built. It was both vague and detailed," Freedle said. "It had been shortened but not wholly revised in a long time." In 2020, MultiCare updated the charter, clarifying everyone's roles in the compliance program.

"We are not the only people doing compliance," she noted. "Every single member of the workforce does compliance, so we had to get that clarified and communicated." All the roles were broken out, including the board, which oversees and ensures adequate resources for the compliance program; employees, because their role is to follow policies and report concerns; the compliance and privacy team; and the leadership team.

The fifth goal was to be specific in setting standards. Part of that is being transparent in defining expectations at every level. Another part is having consistency in visuals used on documents, posters and other items. They aimed for a junior high reading level because it should be easy to understand but not condescending, Karpenko said.

After years of debate over an image for the compliance program, the compliance team decided on a red phone receiver. The image appears on guidance documents, compliance posters, swag (e.g., mugs, hand sanitizer), email signatures and integrity line education and marketing, which has the tagline "integrity line" under the red phone receiver, Karpenko said. "The idea is when someone saw the red phone sticker, they would think of the compliance and ethics program."

Contact Freedle at mrfreedle@multicare.org and Karpenko at samantha.karpenko@98point6.com. View MultiCare's standards for business conduct by scrolling to the bottom of the page at https://bit.ly/35ftYIc. ✧

Endnotes

1. Monica Freedle and Samantha Karpenko, "Effectiveness Reboot: Rebooting an Existing Program from Scratch," Compliance Institute, Health Care Compliance Association, April 21, 2021, https://bit.ly/2SlWCVq.

NEWS BRIEFS

◆ **CMS' supplemental medical review contractor (SMRC) is now doing postpayment reviews of Medicare claims for electrodiagnostic (EDX) testing axial muscles and spinal levels with 2019 dates of service, according to its website.**[1]

◆ **A Maryland physician pleaded guilty to conspiracy to violate the Anti-Kickback Statute in connection with a scheme to take payments from the drug manufacturer Insys Therapeutics Inc. in return for prescribing Subsys, a fentanyl spray it makes for breakthrough pain in cancer patients, for off-label purposes, the U.S. Attorney's Office for the District of Maryland said June 10.**[2] Howard Hoffberg, M.D., of Reisterstown, Maryland, was the associate medical director and part-owner of Rosen-Hoffberg Rehabilitation and Pain Management. "In order to conceal and disguise that kickbacks and bribes were being paid to Hoffberg to prescribe Subsys, Insys falsely designated the payments to Hoffberg as 'honoraria' for purportedly providing educational programs about Subsys (the 'Speakers Bureau Program')," said the U.S. Attorney's Office for the District of Maryland. "As part of the scheme, through January 2018 Hoffberg prescribed Subsys to patients of the Practice who were not suffering from cancer, some of whose insurance coverage was paid for, in whole or in part, by a federal healthcare program." The HHS Office of Inspector General recently warned about speaker programs in a special fraud alert.[3]

Endnotes

1. "01-047 Electrodiagnostic Testing Axial Muscles and Spinal Levels Notification of Medical Review," Noridian Healthcare Solutions, last updated June 10, 2021, https://bit.ly/2SowUzE.
2. U.S. Department of Justice, U.S. Attorney's Office for the District of Maryland, "Associate Medical Director of Baltimore County Pain Management Practice Pleads Guilty to Accepting Kick-Backs," news release, June 10, 2021, https://bit.ly/3whrFQP.
3. U.S. Department of Health & Human Services, Office of Inspector General, "Special Fraud Alert: Speaker Programs," November 16, 2020, https://go.usa.gov/x7m3B.