Medical Practice Compliance ALERT

News, tools and best practices to assess risk and protect physicians

August 8, 2011 | Vol. 23, Issue 15

IN THIS ISSUE

Power wheelchairs: OIG eyes doctors' role in abusive & fraudulent claims

A clear set of guidelines exist for prescribing a power wheelchair or other types of DME to patients, but instances of fraud and abuse with Medicare payments for DME are still prevalent.

A report released in July by the HHS Office of Inspector General (OIG) found Medicare spent $95 million during the first half of 2007 on claims for power wheelchairs that were either medically unnecessary or didn't have the required documentation to prove the medical necessity of the wheelchair. That amount totaled 61% of Medicare claims for power wheelchairs during that time period, according to the report.

TIP: Keep an eye out for not only a lack of necessary documentation with a prescription for DME, but also documentation that is

*(see **DME**, pg. 4)*

Compliance with e-prescribing for controlled substances still out of reach for practices

For many practices, it's hard enough to meet CMS' e-prescribing requirements to avoid the penalties that would reduce your payments starting in 2012. But it's even more difficult to comply with the e-prescribing quotas if you prescribe controlled substances. The rule that governs how to e-prescribe controlled substances isn't even final yet and software vendors have not made the upgrades that would allow their systems to comply with the interim rule currently in effect.

The e-prescribing program, which began in 2008, allowed CMS to pay you incentives for using e-prescribing systems to prescribe for Medicare patients. The incentives began at 2% of allowed charges in 2009 and 2010, are reduced to 1% in 2011 and 2012 and will be cut to 0.5% in 2013.

However, physicians are also penalized if they don't e-prescribe. Under CMS' proposed rule on e-prescribing, physicians had until June 30 to e-prescribe at least 10 times and report **G8553** to show CMS that they successfully e-prescribed. Currently, CMS only allows two

*(see **e-Rx**, pg. 5)*

Take care when you share patient information with debt collectors

HIPAA and state privacy laws don't stop you from sending a delinquent patient's accounts to debt collection agencies. But you – and your debt collector – don't have carte blanche. If you don't take certain precautions, you'll end up in trouble yourself.

Example: The California Supreme Court ruled June 16 that a patient, Robert Brown, could sue for the illegal disclosure of confidential patient medical information to third parties by a debt collector acting on behalf of a dentist. The dentist, Rolf Reinholds, had billed Brown $600 for a crown that Brown claimed he never received. When Brown refused to pay, Reinholds sent the bill to debt collector Stewart Mortensen. So far, so good.

However: The dentist didn't just send the claim or medical record pertaining to the crown to Mortensen. Reinholds gave the debt collector Brown's entire dental file and those of his children. The files included dental history, names, birth dates, social security numbers, addresses, and other confidential information. Mortensen in turn disclosed all of this information on several different occasions to the three national consumer reporting agencies to verify the debt, even though it had not been verified, no one claimed that the children owed any debt and the patient had not authorized such disclosures. Reinholds also sent some of this information personally to one of the consumer reporting agencies.

After Brown made several attempts to get Reinholds and Mortensen to clear his and his children's names, Brown sued both of them, according to Brown, who spoke directly with *Medical Practice Compliance Alert*. Reinholds settled out of court; Mortensen claimed that Brown couldn't sue him and asked the court to throw the case out. The court disagreed. The lawsuit is continuing.

The rule: HIPAA allows providers and business associates acting on their behalf to disclose patient protected health information (PHI) without patient authorization to obtain payment. However, HIPAA's privacy rule requires the provider and business associates, including debt collectors, to reasonably limit the amount of information disclosed for such purposes to the minimum necessary for the business associate to do his job, according to attorney Brad Rostolsky, with Reed Smith in Philadelphia. Here, the dentist gave too much information to the debt collector, and the debt collector gave too much information to the credit agencies.

To compound matters, California law, which is more stringent than HIPAA and thus not preempted by it, requires the patient to consent in writing to the disclosure, says Brown. Brown did not agree to the disclosure of his or his children's entire dental records.

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Medical Practice Compliance Alert **is published 24 times per year by:**

DecisionHealth® (a UCG company)
Two Washingtonian Center
9737 Washingtonian Blvd., Suite 100
Gaithersburg, MD 20878-7364

ISSN: 1047-1863
Price: $547 per year
DecisionHealth®, LLC

"[The dentist and debt collector] threw the information at the credit bureaus regardless whether there was a valid debt owed," points out Washington, D.C. privacy expert Bob Gellman. — *M. Durben Hirsch*

Test your compliance plan against New York's new guidelines

To see how your practice's compliance policy stacks up against government expectations, take a look at the New York Office of Medicaid Inspector General's (OMIG's) documentation review checklist for Medicaid providers (see the Compliance Toolbox, pg. 8). It can help you prepare for the day the HHS Office of Inspector (OIG) issues a mandatory compliance plan for physician practices.

The state's Office of the Medicaid Inspector General recently issued a compliance alert and documentation review checklist "to identify for Medicaid providers documentation that OMIG may request at the time of an effectiveness review," OMIG officials said in the alert.

The documentation review checklist includes documents like employee records, educational training documents, compliance logs and investigations and employee disciplinary records, according to the alert.

Follow these 8 strategies when you use a collection agency

HIPAA allows you to send patient information to a debt collector to try to get your bills paid, but your rights are not absolute (see story, pg. 2). To use collection agencies without running afoul of federal and state privacy laws, take these steps:

1. **Make sure that you have a valid signed business associate agreement with the debt collector,** according to attorney Adam Greene, with Davis Wright Tremaine in Washington, D.C. and former Senior Health Information Technology and Privacy Specialist, Office for Civil Rights, U.S. Department of Health and Human Services. That way you can educate or remind the debt collector that he is a business associate subject to HIPAA and provide guidance on not disclosing more information than the minimum necessary to collect the debt. "It may have helped [in the Mortensen case] if that was clarified," Greene points out.
2. **Try to get the collection agency to agree to indemnify you** for losses or costs you incur if the agency fails to comply with HIPAA or state privacy laws, suggests attorney Brad Rostolsky, with Reed Smith in Philadelphia. "It's a fairly reasonable argument that if a breach happens on the business associate's watch, the business associate should cover losses from the breach," he explains.
3. **Engage an experienced collection agency, and only after checking references**. If you use a reputable collection service these kinds of errors won't occur, says Rostolsky.
4. **Include in your notice of privacy practices** that patient information will or may be turned over to a collection agency if a patient fails to pay his bills. This way the patient is put on notice that you may have to disclose his protected health information (PHI) for payment purposes.
5. **Follow HIPAA when sharing PHI with a collection agency**. Only give the debt collector the minimum amount of PHI needed for the agency to do its job. Don't turn over information beyond the nature of the debt, even if it's easier to fax the whole file to the collector than go through it to pull only the relevant information, says Washington, D.C. privacy expert Bob Gellman. HIPAA's privacy rule also requires the covered entity to abide by any reasonable request from the patient for confidential communications and any agreed to restrictions on the use or disclosure of the confidential information. So if the patient has made such a request, and you've agreed to it, don't go back on your word.
6. **Use common sense when sending claims to a debt collector**. The Mortensen case stems from an alleged $600 crown that the patient states he never received. The dentist's office could have billed the wrong patient, or identity theft could have been involved; even if there had been a valid debt, the patient's children's credit should not have been compromised. "[This situation] seems almost vindictive," says Rostolsky.
7. **Also look at state law**. As in the Mortensen case, there may be more stringent requirements to follow to protect patient privacy, notes Greene.
8. **Keep an eye out for the final privacy and security rules** implementing the HITECH Act, since this may affect your liability regarding business associates (*MCPA 6/13/11*). HIPAA currently does not hold covered entities liable for the actions of their business associates. However, the proposed rule implementing HITECH would hold you liable for a business associate acting as your agent, which could be a debt collector. If the final rule adopts that proposal, you can be in compliance trouble if your collection agency violates HIPAA, even if you haven't, warns Greene. — *M. Durben Hirsch*

Providers such as hospitals have to have a protocol for collecting those types of documents in case of an audit, says Kenneth N. Rashbaum, a principal at Rashbaum Associates LLC in New York.

"It's a good checklist," Rashbaum says of the OMIG alert. "This is really a roadmap for what they will need."

The New York alert is a great tool for physician practices and it should be used to make sure all of its employees are following the latest compliance guidelines for Medicaid, according to Kristen Johnson, director of the health care compliance and investigations practice at Huron Consulting Group in New York.

Make sure your employees can answer questions like "Are we documenting?" as well as "Are we organizing?" and "How are we assessing what our risks are?" Johnson says. "What are some areas with a potential risk for fraud, waste and abuse?" she adds.

It's equally important for both small and large physician practices to continually improve their compliance programs using guides like the New York compliance alert, Johnson says. "Take a hard look and ask, 'how are we doing?'"

Your practice also needs to have good practices for governing and managing information for HIPAA, Medicare and Medicaid, Rashbaum says, including taking an inventory of your different types of protected health information (PHI), where it is and how it is used.

TIP: Compare your PHI policy with HIPAA's security requirements for compliance, including physical, technical and administrative policy and procedure safeguards, Rashbaum says. When you share PHI with a patient by email, make sure that email is sent over a secure, encrypted network, he adds. — *C. Huntemann*

On the Internet:

- New York OMIG compliance alert: *www.omig.ny.gov/data/images/stories/compliance_alerts/compliance_alert_2011-06.pdf*

DME

(continued from pg. 1)

missing dates or signatures, says Robert W. Liles, a managing member at Liles Parker PLLC in Washington, D.C., in an email to *Medical Practice Compliance Alert.*

TIP: Also be aware of a lack of documentation or inadequate documentation, such as missing dates or signatures, needed by the supplier to qualify for coverage and payment, Liles says in the email.

Compliance nightmares: Transferring claims to a different provider number

The following is another of an occasional series of actual compliance mistakes encountered by your peers, and how the nightmare could have been avoided (*MPCA 4/4/11*).

The warning: Transferring claims to a different provider billing number won't help you avoid an audit. A durable medical equipment (DME) company with two National Provider Information (NPI) numbers received an audit notification from its Zone Program Integrity Contractor (ZPIC). The ZPIC intended to audit claims filed under one of the provider numbers.

The company knew that ZPICs often impose a 100% prepayment review on providers during the audit. In an attempt to avoid the audit and the potential loss of revenue, the DME company did not respond to the notice and transferred all of its billing from the targeted provider number to its second NPI. The company believed this would prevent the ZPIC from reviewing and possibly denying its claims. It's unknown if the DME company was trying to be cagey or was simply incredibly naïve.

What happened: The DME company got caught when it failed to respond to the audit, according to consultant Wayne van Halem, president, the van Halem Group, Atlanta, Ga. The ZPIC suspected the DME company was trying to deliberately avoid an audit and reviewed claims under both provider numbers, put claims filed under both numbers on 100% prepayment review and proceeded to deny claims.

Remember: "Once an oversight entity gets it in its head that the provider has something to hide, there's higher scrutiny," van Halem explains.

The ZPIC has not yet accused the company of fraud. The company has learned its lesson and corrected its billing, says van Halem, who the DME company hired to appeal the denied claims. However, the DME company has already paid substantial fines due to the audits and is still on prepayment review for both provider billing numbers, which significantly affects the company's payment rate and cash flow.

What it should have done: The DME company should not have tried to avoid the audit. "You can't just transfer billing. You must respond," says van Halem. Once a payer or contracted auditor begins an audit of your company, you have to go through the process, van Halem adds.

Note: While this particular nightmare happened to a DME company, a physician practice that has more than one NPI for billing Medicare could find itself in the same situation. — *M. Durben Hirsch*

Make sure all practice employees – including physicians – and all supplier staff are educated on their obligations as it relates to DME, Liles adds. "Everyone should be carefully trained to guard against improper relationships or business conduct between providers and suppliers or suppliers and beneficiaries," he says in the email.

TIP: Clearly document the details for why your practice is prescribing DME for a patient, says Roberta Domos, owner and president of Domos HME Consulting Group in Redmond, Wash., which provides consulting services to DME providers.

Domos reviews claims daily and finds that DME like power wheelchairs and oxygen tanks are necessary for about 90% of patients, "but doctors aren't properly documenting the details," she says.

Note: CMS has posted a guide on its website for physicians who are considering prescribing DME such as wheelchairs or scooters for patients, a CMS spokesperson says in an email to *Medical Practice Compliance Alert*.

Example: If the patient's mobility is so limited that it significantly impairs his ability to participate in one or more mobility-related activities of daily living in their home, they may be eligible for a DME prescription, according to the CMS guide.

"Physicians have an obligation under the Medicare law to furnish and to prescribe only those items and services that are reasonable and medically necessary for the diagnosis and treatment of a medical condition," the spokesperson says in the email.

Make sure other steps are taken before prescribing DME to your patients, including having an inspection done on their homes to determine if there is adequate access for that equipment, including features like wide doorways, says Anna Grizzle, a partner at Bass, Berry & Sims in Nashville, Tenn.

TIP: Watch out for a DME supplier that is adamant you prescribe only the most expensive piece of equipment or offers to pay you a referral fee or some other kind of incentive, Grizzle says. She adds that you need to collaborate with the DME supplier to make sure your patient receives the most appropriate piece of DME.

Example: Inducements and other incentives can range from something obvious like cash to offerings like free meals or tickets to a sporting event, says Alan Gilchrist, a partner at The Health Law Partners in Southfield, Mich.

"Don't take anything of value from DME companies," Gilchrist says. If a DME vendor offers to pay any kind of consulting fee, bring it to the attention of your practice's legal counsel, he adds.

Also, if your patient is demanding a certain type of DME, "have a full conversation with them and determine what is needed and what is not needed," Grizzle says. "Explain to the patient what they need and make sure they understand that you're trying to remain in compliance with Medicare."

Television commercials can lead patients to think they need a certain piece of DME, "but you have to divorce yourself from your desire to please a patient when it interferes with your professional judgment," Gilchrist says.

TIP: If any of your physicians receive a Certificate of Medical Necessity (CMN) filled out by the DME vendor that only requires the physician's signature, "run away," Gilchrist adds. "The CMN must be filled out and signed by the doctor." — *C. Huntemann*

On the Internet:

More information on DME eligibility:

- OIG report on power wheel chairs: *http://oig.hhs.gov/newsroom/news-releases/2011/wheelchair-medicare.asp*
- CMS power wheelchair guidelines: *www.cms.gov/CoverageGenInfo/Downloads/MAEAlgorithm.pdf*

e-Rx

(continued from pg. 1)

hardship exceptions: (1) The physician or practice is in a rural area with limited Internet access; and/or (2) is in an area with limited available e-Rx compatible pharmacies.

The penalty for not meeting the e-prescribing requirements is 1% in 2012, 1.5% in 2012 and 2% in 2014. **Note:** If you e-prescribe at least 25 times by Dec. 31, you'll earn the bonus and offset the penalty.

If you prescribe controlled substances, meeting these goals is considerably harder. E-prescriptions of controlled substances count towards your e-prescribing goals, and the Drug Enforcement Administration (DEA) issued an interim rule effective June 1, 2010, allowing e-prescribing for controlled substances for the first time.

Fully 90% of prescribers write prescriptions for controlled substances, and 11% of all prescriptions are for

controlled substances, according to Tony Schueth, CEO and managing partner of Point-of-Care Partners, a health information technology (HIT), strategy and management consulting firm in Coral Springs, Fla.

Multiple hurdles thwart e-Rx compliance

Physicians are not e-prescribing controlled substances yet, more than a year later. Here's why:

The DEA's interim rule is too onerous, according to Robert Tennant, senior policy advisor for the Medical Group Practice Association (MGMA), in Washington, D.C. Under the interim rule, which the DEA calls an "interim final rule," prescribers must:

1) use an e-prescribing application that has been certified to manage these prescriptions electronically;

2) complete an ID proofing process conducted by a credential service provider or certification authority approved by the federal government;

3) use two-factor authentication every time they issue a prescription for a controlled substance (*MCPA 7/11/11*); and

4) meet other requirements, such as notifying DEA within one business day if a prescriber discovers that an e-prescription was issued fraudulently using his credentials.

Prescribers also must meet the general requirements of prescribing controlled substances, such as having a DEA number. "[This rule is] a detriment to e-prescribing. The physicians I know have no interest in this at all," says Tennant.

A survey of your peers supports this statement. According to a Surescripts report issued May 12, 2011, 74% of prescribers surveyed have a high degree of interest in the e-prescribing of controlled substances. However, this interest dropped 20% when the prescribers were presented with details regarding the DEA's ID-proofing requirements in the interim rule.

"A lot of people are waiting for the final final rule [in the hope that it will be less burdensome]," Tennant points out. The DEA received more than 150 comments on the rule. The agency has not announced when it will finalize it.

Many states prohibit e-prescribing for controlled substances. Only 33 states currently allow it, according to Schueth. However, CMS proposed in May to increase the number of hardship exceptions that prescribers can use to avoid the penalty if they don't meet the e-prescribing requirements; one of the new proposed hardship exceptions would exempt prescribers if federal, state or local laws prohibited them from e-prescribing. So if this hardship exception is adopted and you prescribe a lot of narcotics, this may help you avoid the penalty.

The technology to e-prescribe is still in development. "Some of the technology [needed] is phenomenally complicated," notes Ann Davis, Senior Director of State Advocacy and Outreach, American Academy of Physician Assistants, Alexandria, Va. Vendors and pharmacies are working on reprogramming their e-prescribing systems to accommodate the DEA's rule in the hope that the final rule won't be much different from the interim one, according to Kevin Nicholson, Vice President and Pharmacy Advisor, Governmental Affairs and Foreign Policy for the National Association of Chain Drug Stores, also in Alexandria.

One software vendor has conducted a pilot test in Massachusetts that went fairly well, says Tennant; the Surescripts network will also be conducting a limited release test in certain states in the near future. The DEA may be waiting to see how the pilot programs work before issuing the final rule, notes Schueth.

"Even if a physician wanted to get on board today and had a vendor [who was compliant], you need a state that allowed it and a pharmacy that has the ability to comply," points out Schueth.

3 steps to take while you wait for guidance

E-prescribing for controlled substances is voluntary. The burdens of going forward may be offset by the general benefits of e-prescribing, such as access to formulary information, ease of prescribing refills, and reduced liability, points out Tennant. If this is something you might want to take advantage of, you should:

1. Assess your operations and your state law and see if e-prescribing for controlled substances is a viable option for you, says Tennant.
2. Check with your vendor to see if/when your e-prescribing software is compliant with the DEA's current rule, says Schueth.
3. Keep an eye on developments, such as guidance on how to become certified and issuance of the final rule, says Tennant. — *M. Durben Hirsch*

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From the
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Case Files

Case 64: The case of the broken physical therapy documentation

The client: A mid-sized orthopedic group on the West Coast.

The audit: Review of documentation for physical therapy services to ensure that the services provided were justified by the medical record.

The audit result: Some services were missing adequate documentation during the therapy evaluation to justify the need for the level of services provided throughout the patient's therapy regiment. This called into question whether any or all of the therapy procedures provided to the patient would be payable.

Remember: The purpose of the evaluation for therapy is to clearly establish the therapy goals for the patient as well as the patient's tolerance for therapy services. It is billed with **97001.** Re-evaluations, billed with **97002,** measure progress toward the current therapy goals and the need to modify the goals or therapy treatment being given to the patient. You may only bill an evaluation for the same therapy problem by the same provider once every three years – other visits are billed as re-evaluations.

Lessons learned: All patients must be clearly evaluated, with the goals and tolerance for therapy clearly outlined in the patient's record. Medicare doesn't pay for maintenance therapy and private payers may not as well. Regardless, the patient's condition and need for therapy to achieve measurable goals must be outlined prior to the start of therapy care.

In addition, the practice may not bill for timed therapy encounters, such as **97110, 97112** or **97140** if the total length of the encounter is less than 8 minutes.

Recommendations: We recommended the practice ensure that no therapy encounters take place unless the patient's treatment record reflect that the practice has billed and documented the 97001 therapy encounter or the 97002 therapy re-encounter when there has been a gap in therapy care.

In addition, we created goals and therapy objectives sections for the documentation to require that the goals for the patient's therapy are clearly stated.

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PAS 2011

From the Compliance Toolbox

Model Compliance Policy Checklist

The following checklist is based on a recent compliance alert from the New York Office of Medicaid Inspector General *(see story, pg. 3)*. Use it to locate possible gaps in your practice's compliance policy. **Note:** Your attorney should review it to make sure it complies with state and local law.

1. Employee records

___ Copy of employee records that confirm employees have received the following:

[ ] Code of conduct for the practice
[ ] Initial compliance training
[ ] Annual compliance training

Comments: _____

2. Educational training

___ Copies of the following:

[ ] Education training material utilized for compliance training when the employee is hired and for their annual compliance training
[ ] Additional compliance-related training that has occurred outside of the training provided by the practice when the employee is hired and annually
[ ] Participant's sign-in sheet
[ ] Pre-test and post-test results

Comments: _____

3. Compliance logs and investigations

___ Copy of compliance hotline calls/logs that include, but are not limited to, how the complaint was:

[ ] Received
[ ] Recorded
[ ] Investigated
[ ] Resolved
[ ] If any further action was taken

Comments: _____

4. Employee disciplinary records

___ Copy of employee's disciplinary or termination records that include, but are not limited to:

[ ] Date of the incident
[ ] Nature of the allegation
[ ] Steps taken to address the incident
[ ] Information revealed during the investigation
[ ] Findings
[ ] Outcome and resolution
[ ] Corrective action plan (if warranted)

Comments: _____

5. Compliance risk areas/internal audits

___ Copy of internal audits documentation to include, but not limited to:

[ ] Who initiated the audit (organization or outside agency, etc.)
[ ] Scope and method of the audit (continued in next column...)

5. Compliance risk areas/internal audits (continued)

[ ] Findings from the audit
[ ] Recommendations
[ ] Corrective action plan
[ ] Continued follow-up plan (if warranted)
[ ] If the issue involved an overpayment (and was it reported, explained and repaid)

Comments: _____

6. External audits

___ Copy of external audits documentation to include, but not limited to:

[ ] Who initiated the audit (organization or outside agency, etc.)
[ ] Scope and method of the audit
[ ] Findings from the audit
[ ] Recommendations
[ ] Corrective action plan
[ ] Continued follow-up plan (if warranted)
[ ] If the issue involved an overpayment (and was it reported, explained and repaid)

Comments: _____

7. Reports of intimidation and retaliation

___ Copy of reports of intimidation and retaliation to include, but not be limited to:

[ ] Date of the incident
[ ] Nature of the allegation
[ ] Steps taken to address the incident
[ ] Information revealed during investigation
[ ] Findings from the investigation
[ ] Outcome and resolution

Comments: _____

8. Quality of care complaints/mandatory reporting

___ Copy of quality of care investigations/reports to include, but not be limited to:

[ ] Date of the incident
[ ] Nature of the allegation
[ ] Steps taken to address the incident
[ ] Information revealed during investigation
[ ] Findings from the investigation
[ ] Outcome and resolution
[ ] If the issue involved an overpayment (and was it reported, explained and repaid)

Comments: _____

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