TALLAHASSEE MEMORIAL HEALTHCARE

Corporate Compliance Orientation
TMH School Affiliation Education

• This information will be covered:
  ➢ Compliance Program
  ➢ HIPAA Privacy
  ➢ HIPAA Security
  ➢ Questions and Answers
Doing the Right Things...

The

Right

Way
Compliance Program Purpose

- The Compliance Program represents a means for health care organizations to demonstrate that they are making those “reasonable efforts to avoid and detect any misbehavior.”

- The Compliance Program is a comprehensive strategy to ensure that organizations and individuals comply with all applicable laws, rules, and regulations related to TMH business activities.

- For TMH, it is based upon the values, ethics, and moral standards under which TMH chooses to operate as documented in the TMH Code of Conduct.
## Compliance With Who and What

- Medicare
- Medicaid
- IRS
- Labor laws
- Health, Safety & Environmental regulations
- Licensing & Credentialing
- Patient Rights
- Americans with Disabilities Act
- EMTALA
- Federal Family Medical Leave Act
- ERISA
- Federal Regulations
- State Regulations
- EEOC
- Stark Anti-Referral Law
- Federal Anti-Kickback Statute
- OSHA
- EPA
- HIPAA
- TJC (Deemed Status)
- Patient Confidentiality
- Federal False Claims Act
- Conflict of Interest
- Record Retention
- FDA
- Antitrust
- Radiation Control Bureau
- ACHA
- American Recovery and Reinvestment Act of 2009 (ARRA)
- HITECH Act
- Patient Protection and Affordable Care Act (ACA)
- HIPAA Omnibus Final Rule
Autonomy? Authority?

Oversight of the Health Care Industry

CMS

- Congress
- Supreme Court
- Federal Circuit Courts
- Departments Appeals
- State Level: Survey and Certification, Courts, Attorneys General, Medicaid, Health Boards, Medical Boards, Local Governments, Licensure, Oversight, Departments
- DEA
- FAA
- OPOs
- SEC
- GSA
- IRS
- EPA
- FTC
- FEMA
- FCC
- ERISA
- CLIA
- OCR
- HHS/HRSA
- HHS/NIOSH
- FDA
- DOT
- OSHA
- DOJ
- Treasury
- FBI
- DOL
- NRC
- Other accreditation agencies
Reporting

When to Report

• If you have a compliance or privacy concern, you should talk to your preceptor or contact:
  • The Compliance Department at ext. 2667
  -OR-
  • For anonymous reporting call the Compliance Helpline at 877-772-6723
  -OR-
  • Enter a Safety Event in the Risk Management Portal
Reporting

Whistleblower Protection

- The False Claims Act and many state acts contain a section designed to prevent retaliation against whistleblowers by their employers as a result of their reporting fraud.
Reporting

Responsibility to Report

• Employees that report their concerns in good faith are protected from any retribution or retaliation by peers or leaders.
Inpatient Patient Care Responsibilities

Your Commitment:

• This is done by: “Doing the right thing, the right way each and every time.”
  
  • **The Right Thing**: Following clinical policy and procedure. Know the procedures for your role and follow them.
  
  • **The Right Way**: ...with COMPASSION. Treat our patients and your teammates with respect.
  
  • **Every Time**: Consistency brings positive outcomes. ERRORS may happen and can be handled. But...FAILURE happens when we are consistently not doing the right things.
  
• Lack of compassion and poor quality are symptoms when we fail our patients.
Inpatient Patient Care Responsibilities

Licensure

The FIRST STEP to providing quality care is KNOWING which services you are eligible to provide. Know those rules that affect your position:

- Hospital Policy & Procedure
- Medicare Regulations
- Commercial Insurer Regulations
- State Practice Act

These requirements support QUALITY because we have the right PEOPLE providing the right CARE
Inpatient Patient Care Responsibilities

Issues

• What if quality standards are not being followed at your location?

• Going along with questionable, unethical, or illegal practices impacts the quality of care. It also places your license and livelihood in jeopardy.

• When you are aware of patient care issues, your preceptor or manager should be your first point of contact. If your preceptor or manager is your concern, or they do not address your concerns, contact your Divisional Leadership or the Compliance Department.
Inpatient Patient Care Responsibilities

Expectations

• Often, our patients and their families do not know what to expect when they come to us.

• Communication is key to establishing realistic and attainable expectations.

• Explain: Take the time to explain the care provided.

• Listen: When we listen to patients and their families it helps to avoid misunderstandings in their care.
Inpatient Documentation Responsibilities

Once Upon a Medical Record tells a story:
It is your story about the patient’s time in our care. Your story has four audiences:
1. The other medical professionals caring for our patient.
2. Billers/coders submitting claims for payment.
3. Surveyors or lawyers determining if your care was appropriate.
4. Regulatory auditors determining the level of medical necessity and accuracy of codes.

The story you write, whether it is correct or incomplete, is the final account of what happened with that patient.

REMEMBER! “If it wasn’t documented in the medical record, it didn’t happen.”
Inpatient Documentation Responsibilities

• The same story must all be told in the same place. Make sure all pertinent information is in the medical record. Keeping information in a place other than the medical record makes it hard for the medical staff to communicate effectively and make informed decisions.

• Each audience is looking at the record for different reasons, but they are looking for the same information. Is it accurate? Is it complete? Is it timely?
Inpatient Documentation Responsibilities

If your record is incomplete or inaccurate, there are consequences for each of the four audiences:

1. For Medical professionals, the patient’s care suffers.
2. For Surveyors or lawyers, this indicates that a lawsuit or investigation may be warranted.
3. For Billers, the claim is rejected or pays at a reduced rate.
4. For Regulatory auditors, requests for monies paid to the hospital may have to be returned to payer.
Inpatient Documentation Responsibilities

The Medical Record Contains

• Sufficient information to identify the patient.
  • Support for the diagnosis.
  • Justification of the treatment.
  • The course and results of treatment.
  • Continuity of care among health care providers.
  • Support for the charges for services rendered.
Inpatient Documentation
Responsibilities

Who Can Tell the Story

- Only authorized individuals may enter information into the medical record and sign each entry. Those are:
  - Licensed/certified clinicians.
  - Individuals authorized in accordance with TMH policies and procedure.
  - Other personnel as determined by the applicable State Practice Act.
  - Medical Staff Rules and Regulations.

- The documentation must be timely (to ensure accuracy). This generally means at the point of service or within the same day.
Inpatient Documentation
Responsibilities

Alterations

• Remember, the medical record is the only real proof of the care and treatment provided to our patients. If any of the information is altered, it calls the whole document into question. The following are alterations that are not allowed in any system:
  • Do not use white-out.
  • Do not use erasers, erasable ink or pencils.
  • Do not cut and paste portions of reports if entries are made in the wrong record.
  • Do not obliterate or make the original entry illegible.
  • Do not destroy any portion of a medical record and/or substitute a new entry as if it was the original entry.
  • Do not enter a date and time of service other than the actual date and time.
  • Do not make a medical record entry for someone else and then sign it as if you were that person.
  • Do not rewrite any portion of the medical record
Inpatient Documentation Responsibilities

Legibility

- Poor handwriting results in a higher risk of medical error and potential for liability. Do whatever is necessary to ensure your medical record entries are legible. If your co-workers and peers can’t read it, the quality of care will suffer. Electronic medical records suffers from its own form of illegibility. Prior to ending an entry verify these items:
  - Check your spelling!
  - Case of Letters - Make sure you use initial upper case and followed by lower case.
  - “Correct” punctuation; . !
  - Avoid copying and pasting
Inpatient Documentation
Responsibilities

Errors and Corrections

• There are occasions when an entry in a medical record may need to be corrected.

• A single line should be drawn through the error followed by the date and time the correction is made, the individual’s signature or initials to correct the entry.

• If you discover someone else has made an error:
  • Inform the person of the error so that he/she can make the correction. If the error is substantive (i.e., is more than just a spelling error), attempt to notify all persons who may have relied upon the erroneous information.
  • If that person is unable to make the correction, the qualified clinician responsible for the record may correct the information following the correction policy and procedure.
  • There are times when there won’t be enough space to correct the error that was made in the medical record. The correction can be made by entering the information in a subsequent entry, or on addendum or amendment to the record, which is then referenced to the original entry.
Inpatient Documentation Responsibilities

Errors and Corrections

• Correction of electronic records = same principles
  • Current date, time, reason for making the change, and signature of person making change (done electronically in Powerchart)
  • For corrections in Powerchart documents may be modified or removed (unchart option in Powerchart)
    • Note when these options are selected, they do not remove the initial entry. If a document is modified, (Modified will appear after the entry).
    • When a document is removed/uncharted, the original entry will appear with a single line crossed through. Powerchart will require the documenter to enter a reason for removing the entry.
Inpatient Documentation
Responsibilities

Late Entries

• A late entry can be added to the medical record to supplement the existing notes to provide pertinent information needed to complete the medical record. The following are TMH’s policies regarding late entries:

  • Late entries usually include information previously omitted from the evaluation or notes. Never backdate a documentation entry in the clinical record.

  • Write “late entry” and note the date to which documentation is referring.

  • Sign your name and enter the date and time as it relates to a paper record on which the late entry was made.

  • All information in the late entry must be accurate. Do not guess or make up information.

  • Making a late entry for the purpose of increasing reimbursement or “fixing” a medical record that is being reviewed is strictly prohibited.

  • If there is not room on the original note for a late entry, and the documentation is added on a separate note or piece of paper, it should also state “out of treatment order” or “late entry for (date).”
Inpatient Documentation
Responsibilities

Abbreviations

• Communication among clinicians is key to assuring safe delivery of patient care.

• Hospitals strive to ensure that written communication in the patient’s medical record is understandable. Standard terminology, definitions, abbreviations, acronyms, symbols and dose designations are available.

• Taber’s Medical Dictionary is available on all TMH computers. Look for the icon below:
Inpatient Documentation
Responsibilities

Patient’s Story

• The documentation must tell the story of the patient’s stay. It is essential to document the patient’s status on a daily basis so that there is a logical progression from their admission to their current status.

• Quality concerns are raised when physician orders and our actions don’t match with the documentation in the patient’s record.

• It is important to complete physician orders and document the care. If the patient status changes and physician orders are revised it is essential to document the changes and the reason for the changes.
Inpatient Documentation
Responsibilities

Remember

An accurate, timely, and well documented record is the best tool to ensure:

- Safe, high quality patient care.
- Reduced liability for practitioners and the facility.
- Appropriate reimbursement
YOU MUST
Maintain the Privacy and Confidentiality of all Patient Information (PHI).

• Clinical (health care services / medical records)

  AND

• Demographic (payment activities / patient accounts)
  • Social Security Number
  • Date of Birth
  • Phone Number, etc.

(Electronic, Written, & Oral)
There must be a NEED TO KNOW:

To share patient information with another person or entity

OR

To access patient information yourself

(TPO – Treatment/Payment/Operations)
You may NOT access your own patient information or your family member’s.

Contact Medical Records or Patient Financial Services.
SCENARIO 1

You work in Patient Financial Services and are responsible for following up on patient accounts. As part of your job you may access 15–20 accounts each day to determine the status of collections. One day while walking through the Radiology Department you notice a patient on a stretcher who looks like your next door neighbor. When you get back to your office, you enter your neighbor’s name into the patient accounts system and determine that in fact he was admitted last night.
SCENARIO 1
Is this a violation of HIPAA?

1. Yes
2. No
3. Not if I don’t look at any medical information

100%
0% 0%
True False
It depends on what I report
You are an avid football fan. You attended the game on Saturday and saw the quarterback get injured and taken off the field by ambulance. When you get to work Sunday morning, you are curious and access the Cerner electronic medical record system to find out if the quarterback was admitted and how serious his injuries are.
SCENARIO 2
Is this a violation of HIPAA?

1. Yes
2. No
3. Not if his medical condition was already reported in the Tallahassee Democrat

100% True
0% False
0% It depends on what I report
SCENARIO 3

I have a doctor appointment tomorrow and need to know the result of some lab work that was done when I came to the emergency room last month. Since these are my own records, I look at them in our Cerner computer system and write down the results.
**SCENARIO 3**

Is this OK?

1. Yes
2. No
3. Ok if I write down the results and do not print them

It depends on what I report

- True: 0%
- False: 0%
- 100%
Information Security Policy Statement Recertification

What is the Information Security Policy Statement?

• The Information Security Policy outlines your responsibilities while using TMH computers and systems. It is a requirement of all workforce members, vendors, and students to read and acknowledge that you understand and will adhere to the established TMH policies.
Information Security

Social Schemes

- There have been incidents in the past in which healthcare workers were tricked into providing seemingly harmless information that should not have been provided.

  - If you receive an email or phone call, please make sure you can identify who is making the request.

  - If you receive a call or email from a person claiming to be a member of the IT service desk, they should only ask for your colleague ID# in response to a help desk ticket that you initiated. Thus, you should have the help desk person give you the ticket number for verification.
Information Security

Login and Password Security

- It is essential that your login and password be secure and not shared with anyone else. This includes your supervisor or manager.
- You are responsible for all activity occurring under your login.
- Do not post your username and password on a sticky note or other visible location.
Information Security

Information Security Company Use and Ownership

• TMH will hold users accountable for their individual behavior associated with the Tallahassee Memorial name and all their activity conducted with Tallahassee Memorial Corporate information assets.

• Electronic communications reside on corporate resources. Therefore, this information is the property of TMH and is to be used for valid business reasons only. Information is a critical corporate asset and as such must be protected from misuse, improper access, and delays in processing.

• By completing this training, you agree to follow the Information Access Security and Patient Confidentiality Agreement and the Internet Usage Policy, and abide by the rules and regulations in this training.
Information Security
Policy Statement Recertification

Protect Our Patients

- Identity theft is one of the nation’s fastest growing crimes. Too often, this crime is made possible by companies providing thieves easy access to documents that were not properly discarded.

- Take the necessary steps to protect our patients by following all policies and procedures associated with obtaining, using, and destroying personally identifiable information. This includes both financial and medical information.

- Students are not to remove ANY patient information from the Building.
Standards of Conduct

Expectations of Work Place Behaviors

• Provide Quality Care and Services.
• Promote Fair Employee Treatment.
• Comply with the Law in All Business Practices.
• Respect and Protect Confidential Information.
• Code, Bill, and Collect in Accordance with Applicable Guidelines.
• Avoid Conflicts of Interest.
• Safeguard Assets, Property, and Information.
• Maintain a Safe Environment.
Code of Conduct Certification

- Every workforce member is required to read, understand and certify their intention to follow the TMH Code of Conduct.

- By completing this training, you acknowledge you have received a copy of the TMH Code of Conduct and agree to conduct your business in accordance with the Standards of Conduct outlined within the TMH Code of Conduct.

- Signing this is important – and should have been in your orientation paperwork!

- The TMH Code of Conduct is listed on the TMH Intranet page under Compliance.

- You can view the TMH Code of Conduct here: https://www.tmh.org/about-us/corporate-compliance
Terms to know

**Abusive/Abuse** – Inappropriate, consistent or incorrect practices that directly or indirectly lead to incorrect payment for services; abusive acts may be committed without certainty of knowledge, willfulness or intention.

**Billing for Services and Items Not Rendered** – Submitting a claim which represents that the provider performed a service all or part of which was not performed.

**Colleagues** – All TMH Employees, Medical Staff members, temporary per diem personnel, volunteers, students and others rendering paid or unpaid services to TMH, and all TMH Agents.

**Compliance Program** – A process designed to promote ethical and honest practices in our day to day operations, detect and prevent illegal activities by employees, physicians, vendors and all others providing services and/or doing business within TMH.

**Conflicts of Interest** – Any situation in which the personal interest of any individual may conflict with the interest of the TMH System.

**Copyright Laws** – Laws granting the legal right for exclusive publications, products, sale or distribution of material to the author or designated individual. Material cannot be reproduced without written permission of the copyright holder.

**Credentialed/Credentialing** – The process of assessing qualifications and granting privileges to licensed health care professionals to treat patients.
Terms to know

**Upcoding** – The practice of using billing codes that provide a higher payment rate than the billing code that actually reflects the service furnished to the patient.

**Duplicate Billing** – Submission of more than one claim for the same service of the bill is submitted to more than one primary payer at the same time.

**Fraudulent/Fraud** – False statements, representation or concealment of material facts to obtain a benefit or payment for which no entitlement exists; acts that are committed knowingly, willfully and intentionally.

**Good Faith Reporting** – Reporting an act of known or suspected noncompliance based upon facts or observations that the individual making the report considers to be true to the best of their knowledge and belief.

**Harassment** – An inappropriate or unwelcome act or series of acts that significantly impacts the ability of another individual to perform his/her duties.

**Informed Consent** – Informed consent is a process which involves exchange of information between the patient and practitioner as well as permission, approval or assent. Informed consent is consent given by the patient based on knowledge of the nature of the procedure to be performed and its risks, benefits and alternatives, including neuroleptic drugs.

**TMH Agents** – Includes all persons and entities that have contracted with TMH to provide health care related services, equipment or other goods or services.
Referenced: 3/2019

COMPLIANCE TRAINING

COLLEAGUES | VOLUNTEERS | VENDORS