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Announcing Leadership Awards

Awards

Distinguished Member

Distinguished Service

Educator

Rising Star

Motivator

The deadline for submitting nominations for the WHIMA Leadership awards is March 1, 2001

Nomination forms can be obtained from the Executive Office by calling 608-787-0168.

Your Department Compliance Plan—Seven Easy Steps

by Rose Dunn, RHIA, FACHE

We think that creating another plan will take days—days we do not have. Nevertheless, in fact, the first one I prepared was for a client and it took about 7 hours and that was with not knowing where to find certain documents. So, let's look at the components of the Health Information Management Department's Compliance Plan in seven (7) easy steps so that you only need to find 1 hour—7 times!

Where do all the regulations come from?

Compliance plans attempt to address all regulations that affect health information. The Plan must be dynamic since regulations are being modified/implemented daily. HIPAA will go through many stages before it is final and then, it will probably change again. The following are a few of the regulations to consider when developing the Plan:

1. JCAHO standards
2. Conditions of Participation
3. State regulations
4. Federal regulations on release of protected information
5. HIPAA
6. False Claims Act
7. PPS-Inpatient and Outpatient
8. EMTALA
9. Medicare claims processing guidelines (HIM-10)
10. Local Medical Review Policies

Models and Samples

There are a number of sources of compliance plan samples. The Office of the Inspector General's website (www.hhs.gov/progorg/oig) has many examples of model plans. The Columbia site (www.columbia-hca.com) is another popular site for plans and procedures. Furthermore, many healthcare organizations have now posted their compliance plans on their websites, so a simple search of "compliance plans" will yield enough examples to give you weeks of reading!! For sources of model plans and language specific to health information, one need look no further than AHIMA's publications and website (www.ahima.org) for compliance guidance. Two important sources that are already in your facility are the organization's compliance plan and the organization's/department's performance improvement plan. These will serve as models for or can be excerpted into your new Department Compliance Plan. Try to avoid redoing something that already exists, even in part. Your Plan can always reference these existing plans to fulfill one or more of the items listed on the insert.

Avoid Interruptions—Just Do It

The development of your compliance plan has been broken up into Seven Steps that should take no more than 1 hour each to complete. Establish each step as a designated appointment on your calendar, close your office door and do not answer the telephone. These actions will allow you to concentrate on the task(s) defined in each step. Last, remember you do not need to re-write the policies and procedures. Reference policies and procedures as attachments in your Plan and, as needed, elaborate or expand upon the policies and procedures in the written Plan itself. Don't throw out the baby with the bathwater.... you have many of the items I've listed below already in your procedure manuals. Do not repeat them...reference them in your Plan. Good luck!

Editor's Note: The author provided a 7-step outline (See insert). Rose Dunn,Vice President of ***First Class Solutions, Inc.***℠, a healthcare consulting firm based in St. Louis, MO that provides operational and coding guidance and assistance to healthcare facilities.

Compliance Plan
Seven Steps—Seven Hours

Step 1: Establish the basic premises

- the Department Mission, including:
  - ensuring it is consistent with your organization's mission;
  - addresses the HIM Department staff commitment to ethical and legal business practices as well as the organization's Compliance Plan;
  - a statement that HIM professionals value health information of the highest quality, evidenced by its integrity, accuracy, consistency, reliability, and validity; and
  - a statement that the HIM Department will attempt to avoid waste, fraud, and erroneous health information processing.

- the Code of Conduct, including:
  - agreement to strive to fully comply with all organization, local, State, and Federal rules and regulations governing the management of health information, medical documentation, and the coding of diagnoses and procedures, at this organization;
  - be guided by the AHIMA Code of Ethics;
  - respect the confidentiality of individually identifiable information;
  - shall not knowingly take any action that is in violation of any statute, rule, or regulation, nor shall we participate in any illegal or unethical act, nor conceal an illegal, incompetent, or unethical act of others;
  - shall be guided by the Coding Standards of this organization, AHIMA's Standards of Ethical Coding, and those recognized by Federal regulatory agencies; and
  - we will guide individuals in proper documentation practices.
  - acknowledgement of the discipline, including termination that will be forthcoming if the Code of Conduct is violated.
  - annual acknowledgement.

Step 2: Pulling together the Policies and Procedures to support the Mission—remember we are ensuring high quality health information processing (Part I):

- Coding
  - Policies/Procedures to validate coding:
    - describe types of records/conditions coded
    - including evaluating whether coding should be done before or after discharge summary completion
    - mechanism to communicate with physician about ambiguous and incomplete documentation
    - frequency of validation
    - sample size (look to JCAHO standards—30 or 5%)
    - what are required skills, education, experience for coders
    - what background reference checks are performed
    - how does organization assist coders to maintain skills
    - reference materials available
    - how are reference materials (LMRPs, carrier bulletins, fraud alerts, etc.) circulated
    - how/when is a coding consulting firm selected
  - Goals-quality and quantity levels for coding

Step 3: Pulling together the Policies and Procedures to support the Mission—remember we are ensuring high quality health information processing (Part II):

- Loose Materials
  - Policies/Procedures to avoid "waste"—every time a record is provided to a physician without all the documents may result in a test being duplicated, thus "waste" of insurer/Medicare funds.
    - describe sources/reasons for loose materials
    - frequency of filing
    - how loose materials are kept to a minimum or null
    - how we ensure that they are filed accurately
    - sample size
    - what are the required skills, education, experience for the loose materials clerk(s)
  - Goals-quality and quantity levels for loose material handling

- Release of Information
  - Policies and procedures that ensure:
    - valid authorizations (HIPAA/organization regs)
    - only information released as authorized (HIPAA/ organization regs)

- timeliness and cost effectiveness of release (State/ organization/Conditions of Participation)
- Goals-quality and quantity levels for release of information services

Step 4: Pulling together the Policies and Procedures to support the Mission—remember we are ensuring high quality health information processing (Part III):

- Master Patient Index (MPI)
  - Policies and procedures that ensure:
    - reduction/correction of duplicate/multiple patient numbers for the same patient (waste)
    - avoidance of duplicate/multiple patient number
  - Goals-quality and quantity levels for MPI management

- Analysis/Deficiency Assignment
  - Policies and procedures that ensure:
    - proper/complete documentation
    - timely completion (JCAHO/State/Federal/ Conditions of Participation)
  - Goals-quality expected for patient record documentation
    - clinical pertinence/open/closed record reviews

Step 5: Establish the Department Compliance Team

- Select Compliance Coordinator:
  - a HIM professional
  - recognized for integrity and honesty
  - preferably a strong coding background

- Select Compliance Assistants:
  - Coding
  - Release of Information
  - File Area
  - MPI
  - Chart Completion

- Create Compliance Procedures
  - Activities that will be reviewed, when
  - Sample size
  - Report results to whom?
  - How to monitor if corrective action is taken (look to your PI, TQM, QA plan)
  - When are results reported to Compliance Officer and/or organization's legal counsel

Step 6: Education Program

- Content of General Training, including:
  - Review of Code of Conduct
  - Discipline for failing to comply with the Code
  - Coding Standards
  - How to report suspected or known fraudulent, unethical acts
  - How to identify waste or abuse
  - The "hot line" number
  - Financial penalties
  - Where to find newsletters, carrier bulletins, fraud alerts, etc.
  - Number of hours required per year (by title or department)
  - How/the frequency of skills assessment
  - Options for skills improvement
  - Distribution of the Code of Ethics
  - Keep an attendance roster

- Content of Focused Training (and eventually monitoring) that could be offered by HIM:
  - Physicians: Proper documentation, documentation to support service levels billed
  - Registrars and Ancillary Staff: Medical Secondary Payer, ABNs, basic coding
  - Ancillary Staff: Untimely test reporting
  - Scheduling: "Inpatient" only procedures
  - Coders: Coding standards, updated rules, new procedures and conditions, new coding classifications, discharge disposition codes
  - Patient Accounts: Follow-through on denials due to coding, unbundling, or medical necessity; ensuring claims represent services that were reasonable and necessary for treatment and diagnosis
  - Financial and HIM Team: Chargemaster updating
  - ER: Documentation requirements to support EMTALA

Step 7: Revisit the program, annually, to validate that it is doing what you said it would do.

- Were all areas of the plan reviewed/assessed?
- Were the goals met?
- What was done with the findings?
- Was any policy/procedure revised based on the Plan's findings?
- Do position descriptions comply with skill requirements established?
- Did everyone receive training?
- Was the training effective?
- Were staff updated on fraud alerts, new regulations, etc.?
- Were offenses found during the year?
- Were they self-reported?
- What was done about the offenses?
- Were overpayments repaid?

About the Author

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