INTRODUCTION

The government, through its Medicare and Medicaid programs, is the Society's single largest payment source. In order for the government to achieve greater certainty that it is being accurately billed for services furnished to Medicare and Medicaid beneficiaries, and be assured that the services are of good quality, long-term care providers such as ours are expected to maintain what is called a "compliance program." A compliance program consists principally of policies and procedures that, if followed, will help us meet the government's standards.

Over the years, The Evangelical Lutheran Good Samaritan Society has demonstrated its commitment to upholding the high standards of conduct the government is seeking. Our policies and procedures have long addressed the same objectives. Thus, our compliance program relies chiefly on our existing policies and procedures. This "roadmap" provides a listing of government expectations and the corresponding Society policies and/or procedures that address each expectation.

Although the government modifies its expectations from time to time (as it discovers new problems or identifies new priorities), the following list captures its current areas of most pressing concern. If the government makes significant modifications to this list, we may need to develop new policies and/or procedures. If so, an updated version of this roadmap will be furnished.

Roadmap Table of Contents

Home Care Roadmap Table of Contents

ADMISSIONS

Government Expectations		Society Policy/Procedure(s)
Residents should be admitted to our facilities in accordance with government guidelines.		Nursing Services: Admission, II.A.5 (Po) Admission, II.A.5b (Pr) Social Services: Admission, II.A.5 (Po) Admission, II.A.5a (Pr)
Employees may offer gifts to organizations (such as hospitals) or individuals (such as physicians or discharge planners) who make or influence referrals to our facilities only in accordance with Society policy.		Employee Handbook: Pg. 40 Administration: Prohibition of Kickbacks and Inducements, VI.E(1)(a)(3)(a) (Po)
Employees may not offer gifts to potential residents as an incentive to their entering our facility.		Nursing Services: Admission, II.A.5 (Po) Social Services: Admission, II.A.5 (Po) Admission, II.A.5a (Pr) Administration: Prohibition of Kickbacks and Inducements, VI.E(2)(c)(6) (Po)
An admission should not be conditioned on our receiving a guarantee of payment for services covered by Medicare or Medicaid, or for amounts above what is paid by Medicare or Medicaid.		Nursing Services: Admission, II.A.5 (Po) Social Services: Admission, II.A.5 (Po) Admission, II.A.5a (Pr) Administration: Prohibition of Kickbacks and Inducements, VI.E(2)(c)(6) (Po)
The Society's receipt of a charitable donation from a potential resident (or a member of his/her family) should not influence our admitting decision.		Nursing Services: Admission, II.A.5 (Po) Social Services: Admission, II.A.5 (Po) Admission, II.A.5a (Pr) Administration: Prohibition of Kickbacks and Inducements, VI.E (Po)

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS

Government Expectations		Society Policy/Procedure(s)
Each resident's care needs should be thoroughly assessed, and an interdisciplinary care plan should be developed that is responsive to those needs.		Activity Services: Care Plan, V.H (Po) Care Plan, V.H.1 (Pr) Assessment, V.G (Po) Dietary Services: Dietary Documentation, VIII.A Care Plan, VIII.B (Po) Care Plan, VIII.B.1 (Pr) Nursing Services: Care Plan, II.C.3 (Po) Comprehensive Care Plan and Care Conferences, II.C.3a (Pr) Assessment, II.A.12 (Po) Assessment, II.A.12.a (Pr) Social Services: Care Plan, II.C.1 (Po) Comprehensive Care Plan and Care Conferences, II.C.1.a (Pr) (See Section 3, Interdisciplinary Care Team) Assessment, II.A.7 (Po) Assessment, A.7.a (Pr)

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
The care that is furnished to each resident should be consistent with his/her care plan and, within reason, neither more nor less than what is necessary to treat the resident.		Activity Services: Care Plan, V.G (Po) Care Plan, V.G.1 (Pr) Dietary Services: Dietary Documentation, VIII.A Care Plan, VIII.B (Po) Care Plan, VIII.B.1 (Pr) Nursing Services: Care Plan, II.C.3 (Po) Nursing Services Staff, II.N.10 (Po) Documentation, II.D.8 Social Services: Comprehensive Care Plan and Care Conference, II.C.1a (Pr) Documentation, II.D.4 (Po) Documentation, II.D.4a (Pr) Staff Development: Orientation Program, (See Section VI of Learning and Development Manual) General Orientation Manual

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Residents (or their representatives) should be encouraged to participate in the development of their care plan, and should be furnished the information they need (such as education about advance directives) to make informed choices.		Nursing Services: Care Plan, II.C.3 (Po) Comprehensive Care Plan and Care Conferences, II.C.3.a (Pr) Refusal of Treatment, II.R.3 (Po) Refusal of Treatment, II.R.3.a (Pr) Resident / Family Education, II.R.6 Resident Rights, II.R.8 Right to be Informed of Health Status, II.R.3 Right to Refuse Experimental Research, II.R.14 Restraints: Physical, II.R.12 Psychopharmacological Medications & Sedatives / Hypnotics, II.M.8.l (Po) Social Services: Care Plan, II.C.1 (Po) Comprehensive Care Plan and Care Conferences, II.C.1.a (Pr) (See 1c, 2b, 3b, 3c) Family Council/Group, II.F.1 (Po) Family Council/Group, II.F.1.a (Pr) Refusal of Treatment, II.R.1 (Po) Refusal of Treatment, II.R.1.a (Pr) Right to Refuse Experimental Research, II.R.3 (Po) Right to Refuse Experimental Research, II.R.3.a(Pr) Resident Council, II.R.4 (Po) Resident Council, II.R.4.a (Pr) Resident/Family Education, II.R.6(Po) Resident Rights, II.R.10 (Po) Resident Rights, II.R,10a (Pr) Restraints, Physical, II.R.13 (Po) Restraints, Physical, II.R.13a, 13b, 13c, 13d, (Pr) Right to be Informed of Health Status, II.R.14 (Po)
If needed, residents should receive assistance in performing activities of daily living.		Nursing Services: Activities of Daily Living, A.4(Po) Restorative / Therapy Services: Restorative Nursing Care, IV.A (Po)

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Activities programming should be adequate and address individual needs.		Activity Services: Activity Program, II.A (Po)
Care protocols should be in place and followed for the following problems common to nursing home residents: a) pressure ulcers		Clinical Resource Packet: Pressure Ulcers / Wound Care, STR2643 Dietary Services: Monitoring Residents with Impaired Nutrition and Nutritional Risk, VII.I (Po) Interventions for Nutritional Risk of Residents, VII.I.1 (Pr) Nutritional Risk Committee, VII.I.2 (Pr) Nursing Services: (Wound and Pressure Management) Pressure Ulcers, II.W.4.a (Po) Pressure Ulcers, , II.W.4.b, 4.c, 4.d, 4.e, 4.f, 4.g, 4.h, 4.i, 4.j, 4.k (Pr)
b) dehydration		Nursing Services: Hydration, II.H.8 (Pr) Nutrition, II.N.11 (Po) Nutritional Risk of Residents, II.N.11.a, 11.b (P&P) Dietary Services: Hydration, VII.H, VII.H.1, VII.H.2, VII.H.3

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
c) malnutrition		Nursing Services: Hydration, II.H.8 (Pr) Supplements, II.S.16 (Po) Nutrition, II.N.11 (Po) Nutritional Risk of Residents, II.N.11.a, 11.b (P&P) Dietary Services: Hydration, VII.H, VII.H.1, VII.H.2, VII.H.3 Monitoring Residents with Impaired Nutrition and Nutritional Risk, VII.I (Po) Interventions for Nutritional Risk of Residents, VII.I.1 (Pr)
d) incontinence		Nursing Services: Bowel and Bladder Assessment, II.B.11 (Po) Bladder and Bowel Retraining, II.B.11.a, 11.b, 11.c, 11.d, 11.e, 11.f, 11.g (Pr) Catheterization, II.C.5 (Po) Catheterization, II.C.5.a, 5.b, 5.c, 5.d, 5.e, 5.f, 5.g, 5.h, 5.i
Residents should be furnished therapy services appropriate to their needs.		Nursing Services: Activities of Daily Living, II.A.4 (Po) Restorative / Therapy Services: Benefits of Rehab / Restorative Program, II.A

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Residents should receive proper medications (including psychotropic and anti-depressant medications), appropriate to their needs.		Nursing Services: Medications, II.M.8 (Po) Administration of Medication, II.M.8.b (Pr) Controlled Substances, II.M.8.i (Pr) Documentation of Medications, II.M.8.d (Pr) Medication Errors, II.M.8.e (Po) Medication: Psychoactive, II.M.8.k (Pr) Medication System, II.M.8.a (Po) Crushing Medications, II.M.8.g (Pr) Restraints, II.R.12 (Po) Physical Restraints, II.R.12.a (Pr) Application of Physical Restraints, II.R.12.b (Pr) Reduction Committee, II.R.12.c (Pr) Social Services: Psychopharmacological Medications & Sedatives / Hypnotics, II.P.7 (Po), 7.a (Po)
Thorough and accurate records should be maintained for each resident.		Accounting, Vol. II: Resident Trust Account, IX Nursing Services: Assessment, II.A.12 (Po) Assessment, II.A.12.a (Pr) Documentation, II.D.8 (Po) Documentation, II.D.8.a, 8.b, 8.c (Pr) Physician's Orders, II.P.9 (Po) Physician's Orders, II.P.9.a (Pr) Medicare: Consolidated Billing – Section III.G Medicare Part A Admission to the Center – III.B.1 Skilled Therapy Coverage and Documentation – Section III.D Social Services: Documentation, II.D.4 (Po) Documentation, II.D.4.a (Pr) Health Information Management: Maintenance of Active Medical Records, V.C

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Residents should be afforded access to their records upon request.		Social Services: Resident Rights (See pg. 2), II.R.10
Records are private to each resident and should be treated in a confidential and respectful manner.		Nursing Services: Medical Record, II.M.4 (Po) Privacy and Security: Confidentiality of Protected Health Information, I.G Social Services: Confidentiality, II.C.3 (Po) Resident Rights (See pg. 2), II.R.10
Residents must be protected from verbal, mental or physical abuse.		Activity Services: Abuse and Neglect, IV.A (Po) Abuse and Neglect, IV.A.1 (Pr) Abuse Definitions, IV.A.2 Indicators of Abuse and Neglect, IV.A.3 Nursing Services: Abuse/Neglect of Residents, II.A.2 (Po) Abuse/Neglect II.A.2.a (Pr), II.A.2.b Social Services: Abuse and Neglect, II.A.1 (Po) Abuse and Neglect, II.A.1.a (Pr) Abuse Definitions, II.A.1.b Indicators of Abuse and Neglect, II.A.1.d Residents at Risk Abuse Others, II.A.1.e Predicting Abusive Behavior, II.A.1.c Access and Visitation to Residents, II.A.2 (Po) Employee Handbook: Pg. 23

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Any incidents of mistreatment, neglect or abuse must be reported.		Nursing Services: Abuse/Neglect of Residents, II.A.2 (Po) Social Services: Abuse and Neglect, II.A.1 (Po) Abuse and Neglect, II.A.1.a (Pr) Abuse Definitions, II.A.1.b Indicators of Abuse and Neglect, II.A.1.d Residents at Risk Abuse Others, II.A.1.e Predicting Abusive Behavior, II.A.1.c Activity Services: Abuse and Neglect, IV.A (Po) Abuse and Neglect, IV.A.1 (Pr) Abuse Definitions, IV.A.2 Employee Handbook: Pg. 23
Restraints or involuntary seclusion are to be used only in accordance with Society policies and procedures – not for staff convenience or resident discipline.		Nursing Services: Restraints, II.R.12 (Po) Physical Restraints, II.R.12.a (Pr) Application of Physical Restraints, II.R.12.b (Pr) Reduction Committee, II.R.12.c Medication: Psychoactive (Chemical Restraints), II.M.8.l (Pr) Social Services: Behavior Management Committee, II.B.2 Target Behaviors - Sample, II.B.2.d Behavior Causes and Interventions II.B.2.b Psychopharmacological Medications & Sedatives / Hypnotics, II.P.7 (Po) Restraints, Physical, II.R.13 (Po) Physical Restraints, II.R.13.a (Pr) Guidelines for Risks to a Resident when a Restraint is Used, II.R.13.c Restraints/Psychopharmacological Medications & Sedatives / Hypnotics Alternatives, II.R.13.d Reduction Committee, II.R.13.b Understanding Differences Between Describing Behavior Objectively and Labeling the Person, II.B.2.c

DEVELOPMENT AND OPERATIONS DELIVERY SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Each resident has a right to choose to manage his or her own financial affairs, or permit the Society to hold and manage those funds.		Accounting, Vol. II: Resident Trust Account, IX.A – IX.I Social Services: Resident Rights, Pg 3, II.R.10 Resident Funds, II.R.7 (Po) Resident Funds, II.R.7.a (Pr) Resident Mail, II.R.9 Legal Instruments, II.L.2
Residents should receive a full and proper accounting of their resident trust account funds held by the Society.		Accounting, Vol. II: Resident Trust Account, IX.A – IX.I Nursing Services: Abuse Definitions, II.A.2b Property and Valuables, II.P.13 (Po) Property, Missing Items, II.P.13.a (Po) Social Services: Misappropriation of Resident Property, II.A.1 (Po) Misappropriation of Resident Property, II.A.1a (Pr) Resident Funds, II.R.7 (Po) Resident Funds, II.R.7.a (Pr)
Resident funds should not be used to pay for items or services paid for by Medicare or Medicaid.		Accounting, Vol. II: Resident Trust Account, IX.A – IX.I Social Services: Resident Funds, II.R.7 (Po) Resident Funds, II.R.7.a (Pr)
Serious deficiencies noted in the survey process should be addressed promptly.		State Operations: (MAN 2030a) Section VII, Plan of Correction

PAYMENT SYSTEMS

Government Expectations		Society Policy/Procedure(s)
A resident's eligibility for coverage under Medicare Part A must be established and documented prior to submitting any claims for payment to Medicare. This determination of eligibility involves the Case Manager (or another staff member functioning as the case manager in your facility) determining: a) that the resident requires daily skilled nursing services or daily skilled rehabilitation services which must be performed by or under the supervision of licensed or certified personnel; b) that the resident requires these skilled nursing services seven days per week or skilled rehabilitation services five days per week; c) that, based on financial and efficiency reasons, the daily skilled services can be provided only on an inpatient basis; and d) that primary coverage from another payor source is not available.		Nursing Services: Medicare and Medicaid Benefits, II.M.5 (Po) Medicare: General Definitions for SNF Part A, II.A.7 Medicare Skilled Nursing Facility Part A Overview, III.A.1 Skilled Services Defined, III.A.2 Principles for Determining a Skilled Service, III.A.3 30-Day Transfer – Medical Predictability, III.A.9 Flow Chart for Determining Eligibility, III.A.11 Inpatient Services Provided as a Practical Matter, III.A.12 Medicare Part A Admissions to the Center, III.B.1 Skilled Care Coverage, III.C.1
The government should not be billed for individual items or services that are included in the Part A per diem rate.		Medicare: Medicare SNF Coverage Guidelines and Consolidated Billing Under PPS, III.A 6 Consolidated Billing – III.G (entire section) SNF Medicare Claims Filing: Ancillary Charges – Section IV

PAYMENT SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Claims should be submitted to Medicare, Medicaid and/or other payers only for those items or services which have been ordered, and for which there is documentation that the items or services have been furnished as ordered.		Nursing Services: Documentation, II.D.8 (Po) Medicare and Medicaid Benefits, II.M.5 (Po) Medicare: Consolidated Billing – Section III.G Medicare Part A Admission to the Center, III.B.1 Skilled Therapy Coverage and Documentation – Section III.D SNF Medicare Claims Filing: Ancillary Charges – Section IV No Payment Claims – Section III.E Code of Ethics, #9
Signatures must not be forged to create the appearance of timeliness or to support items or services that were never provided.		Nursing Manual: Documentation, II.D.8 (Po) Health Information Management: Legal Documentation Standards, X.A Medicare Manual MDS, RUG Levels and ARDs – Section III.E Physician Certifications and Recertifications, III.B.2 Code of Ethics, #9
Any items or services for which a claim is submitted to Medicare, Medicaid and/or other payors should be warranted by a resident's documented medical condition. A resident's medical condition must be based on true and accurate information.		Medicare: SNF Level of Care Overview, II.A.9 Skilled Services Defined, III.A.2 Medicare Part A Admission to the Center, III.B.1 Covered Therapy Services, III.D.1 Consolidated Billing, Section III.G Managing Contractors with "Under Arrangement" Agreement, V.B.1 Code of Ethics, #9

PAYMENT SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
The billing code(s) that is(are) selected should be the most accurate descriptor(s) of the service or condition.		Medicare: Overview of PPS Payment System, III.E.1 Managing Contractors with "Under Arrangement" Agreement, V.B.1 SNF Medicare Claims Filing: UB-04 Completion – Section III.A Code of Ethics, #9
Care should be taken that Medicare, Medicaid and/or other payors is not billed more than once for the same item or service—by the Society or by the Society and one of our vendors.		Medicare: Covered SNF Billable Services, II.A.12 Non-Billable Items, II.A.13 Consolidated Billing – Section III.G SNF Medicare Claims Filing: Medicare Secondary Payer Claims – Section III.F Ancillary Charges – Section IV
If it comes to the attention of billing staff that a resident received substandard care, Medicare should not be billed for that care.		Medicare: Denial of Payment – Section II.B
Credit balances (owed to the government, another payor or a resident) should be identified in a timely way, reported accurately and repaid promptly. Credit balances are addressed each year. Centers are required to send in an audit action plan to address the credit balances.		SNF Medicare Claims Filing Manual: Medicare Bad Debts – Section I.C

PAYMENT SYSTEMS (CONT.)

Government Expectations		Society Policy/Procedure(s)
Reports to Medicare and Medicaid of Society costs must be completed truthfully, accurately and in accordance with Society policies and procedures.		Medicare Cost Report Procedures: Medicaid Cost Report Procedures Online in Reimbursement and used in education to cost report preparers Code of Ethics, #9
Resident coinsurance or deductible amounts should not be waived without first making a good faith determination that the resident is in financial need.		Accounting, Vol. II Collections and Write-Off, VII.A – VII.G Administration: Prohibition of Kickbacks and Inducements, VI.E(2)(c)(6)(a)

WORKFORCE SYSTEMS

Government Expectations		Society Policy/Procedure(s)
Candidates for employment should be screened for: a) conviction (or pending charges) of a criminal offense related to healthcare; and b) debarment or exclusion (or proposed debarment or exclusion) from, or otherwise having become ineligible for, participation in any federal healthcare program		Administration: Screening Individuals and Organizations for Government Program Violations, VI.H Human Resources: Background Investigations, II.B.11.a (Po)
Each employee must maintain (in good standing) the professional licensure or certification required for his/her position.		Nursing Services: Nurse Practitioner, II.N.8 (Po) Nursing Services Staff, II.N.10 (Po) Human Resources: Registry, Licensure and Verification, II.B.9 Employee Handbook: Certification and Licensure, *Information and Guidelines*, pg. 24–25
Each employee should know and understand the government compliance-related concerns which apply to his or her job responsibilities.		Compliance Program Handbook General and Department Orientation Employee Handbook: *Employee Conduct*

WORKFORCE SYSTEMS (CONT.)

Each employee also should be made aware that failure to meet the government's standards can result in corrective action, including possible termination of employment.		Human Resources: Corrective Action, VI.A Employee Handbook: *Employee Performance and Conduct* General and Department Orientation (using CVTC forms)
Each employee should be trained sufficiently to perform his/her work responsibilities.		Human Resources: General and Department Orientation (using CVTC forms) Annual Performance Evaluation
No employee may accept personal gifts from residents (or their families). Employees also may not offer such gifts.		Human Resources: Accepting Gifts, V.X Employee Handbook: *Information and Guidelines,* Accepting Gifts General Orientation and Department Orientation

PURCHASING (CONTRACTING)

Government Expectations		Society Policy/Procedure(s)
When purchasing good or services, and in relationships with organizations or individuals who refer residents to our facilities, the following guidelines should be followed: 1) A facility may not give a vendor access to residents' medical records (and other information needed to bill Medicare) in exchange for the facility receiving items of value from that vendor. 2) A facility may not refer Medicare Part B business to a vendor in exchange for receiving a discount on Medicare Part A items from that vendor. 3) A facility (or an employee) may accept non-cash contributions (or gifts) from vendors only in accordance with Society policy. 4) Arrangements with organizations or individuals who refer residents to our facilities or certified plans of care (including Medical Directors) should not involve additional payments (or "perks") in exchange for referring residents to a facility or certifying plans of care. 5) Employees should avoid doing business with any individual or organization with whom the employee has a family relationship. If it appears it will be necessary to do business with a family member, the relationship should first be disclosed to the facility administrator.		Administration: Prohibition of Kickbacks and Inducements, VI.E

RESOURCE DEVELOPMENT

Government Expectations		Society Policy/Procedure(s)
Charitable Donations from Vendors: A facility may accept or solicit cash donations from businesses or business owners that serve or seek to serve as vendors to the facility only in accordance with Society policy.		Administration: Prohibition of Kickbacks and Inducements, VI.E(1)(a)(3)(a)
Charitable Donations from Residents, Potential Residents or Their Families: A facility may accept or solicit cash donations from residents, potential residents or their families with the following limitations: a) with respect to current residents or their families, the facility's receipt of a donation should not result in the resident being granted special privileges; and b) all donations must be reported according to the Society's resource development procedures.		Nursing Services: Admission, II.A.5 (Po) Admission, II.A.5.a (Pr) Social Services: Admission II.A.4 (Po) Re-Admission II.A.4.a (Pr)

HOME CARE ROADMAP

IMPLEMENTING WRITTEN POLICIES AND STANDARDS OF CONDUCT

Government Expectations		Society Policy/Procedure
• Development and distribution of written policies, standards, and practices that identify specific areas of risk and vulnerability to the home care agency.		• Policies and procedures address compliance with statutes, regulations and broad principles that guide employees in conducting business properly and professionally. **Home Care Skilled Manual** **Home Care Employee Handbook** **Administration Manual** **Home Care Corporate Compliance Plan**
Standards of Conduct • Development of standards of conduct that clearly delineate the home care agency's commitment to compliance. • The organization's mission, goals, and ethical requirements of compliance are clearly stated. • Distributed to all affected employees. • Standards are updated as applicable.		• Standards of conduct have been developed by the Society that explicitly state the organization's mission, goals and ethical requirements of compliance. • Standards of conduct are updated and distributed as appropriate as regulations and program requirements are modified. • New employees working for the home care agency are issued standards of conduct and sign a statement certifying that they have received, read and understood the information.
Risk Areas ✓ *False dating of amendments to nursing notes.* ✓ *Falsified plans of care.*		✓ *Once the entry has been electronically signed, the Allscripts application will track all alterations to documentation electronically.* ***(III.E Electronic Signatures)*** ✓ *All treatments and care must be ordered, dated, and signed by the physician consistent with appropriate state and federal regulations.* ***(IV.K Physicians Orders).***

Government Expectations		Society Policy/Procedure
✓ *Untimely and/or forged physician certifications on plans of care.* ✓ *Forged beneficiary signatures on visit slips/logs that verify services were performed.* ✓ *Knowing misuse of provider certification numbers which results in improper billing.*		✓ *Tracking via Allscripts should be utilized to ensure orders are signed and dated by the physician and returned to the client's clinical record within 30 days.* ***(IV.K Physician's Orders)*** ✓ *Policy and procedures address accepted professional standards. All visit notes will be verified and signed by the client or delegated caregiver. If a signature is not able to be obtained, documentation should be completed to state why this did not occur.* ***(III.B Documentation Standards)***

CLAIM DEVELOPMENT AND SUBMISSION PROCESS

Government Expectations		Society Policy/Procedure
• Provide for sufficient and timely documentation of all nursing and other home care services including subcontracted services prior to billing to ensure that only accurate and properly documented services are billed. ***Risk Areas*** ✓ *Billing for items or services not actually rendered.* ✓ *Inadequate management and oversight of subcontracted services which results in improper billing.* ✓ *Duplicate Billing*		• Services billed to Medicare will be supported by the medical record. All staff shall utilize the Allscripts Software program approved by the Society to ensure that the client's medical record contains documentation for the services, supplies, drugs and/or equipment for which a bill is being submitted: (a) have been furnished; and (b) have been certified by the client's attending physician. ✓ *See above.* ✓ *Included in the* ***Agreement for the Provision of Home Health Therapy Services and other Products*** *(GSS #3-HCBS) is the requirement for the establishment of procedures for submitting clinical and progress notes, scheduling of visits and periodic client evaluation. (****II.U Contractual Personnel)*** ✓ *Society home care agencies have procedures to prevent duplicate billing*

Government Expectations		Society Policy/Procedure
		*utilizing the Allscripts application, pre-scheduling visits a minimum of one week in advance, and utilizing clinician involvement to address complex situations. (**IX.H Non-Duplicate Billing**)*
• Claims should be submitted only when appropriate documentation supports the claim and only when documentation is maintained, appropriately organized in a legible form and available for audit and review.		• Services billed to Medicare will be supported by the medical record. All staff shall utilize the Allscripts Software program approved by the Society to ensure that the client's medical record contains documentation that the services, supplies, drugs and/or equipment for which a bill is being submitted have been furnished.
Risk Areas		
• Indicate that the diagnosis and procedure codes for home care reported on the reimbursement claim should be based on the client's medical record and other documentation as well as comply with all applicable official coding rules and guidelines.		• Diagnosis codes are expected to be accurate and supported by documentation. Updates in client's diagnosis, and any resulting change in codes are to be communicated to the billing office in a timely manner.
• Claims should be submitted for services that the home care agency has reason to believe are medically necessary and that were ordered by a physician.		• Home care providers must furnish only medically necessary services for clients receiving Medicare reimbursement. Case managers are responsible for ensuring the delivery of medically necessary care to clients and terminating home care services for a client only in accordance with the notice requirements required by law and regulation.
Risk Area		
✓ *Billing for medically unnecessary services.*		
• Medicare clients must meet homebound reimbursement requirements to receive home care services.		• A client's qualifications for Medicare covered home care services must be supported by the medical record. Home care staff are required to document a client's homebound status in the medical record and ensure that the condition qualifying the client for some care, and a plan of care, have been certified by the client's attending physician. Clients must be homebound to qualify for Medicare reimbursement. Professional field staff (nursing and therapy) are required to assess and document a client's homebound status no less than every sixty (60) days and take necessary steps to ensure that
Risk Area		
✓ *Billing for services provided to patients who are not confined to their residence (or homebound).*		

Government Expectations		Society Policy/Procedure
		clients who no longer meet Medicare "homebound" criteria are disqualified for the purpose of Medicare coverage.
• All reasonable steps to ensure that claims for home care services are ordered and authorized by a physician.		• Physician orders shall be in place consistent with client needs for the ongoing services being furnished by the agency. Nursing, paraprofessional and therapy staff shall render services in accordance with the physician's prescribed plan of care (and/or order), and shall document whether a client's condition is ongoing. Nursing staff shall assure that physician's orders include justification for the home care services. Physician orders must support ongoing supplies, drugs and/or equipment furnished. Staff are expected to ensure that supplies, drugs and/or equipment are furnished pursuant to a physician's order that includes justification for the supplies and/or equipment being ordered.
• Before the home care agency bills for services provided to the Medicare beneficiary, the plan of care must be established, dated and signed by a qualified physician who attests the services provided are medically necessary and meet the requirements for services to be covered under Medicare.		• A plan of care must be established, dated and signed by a qualified physician prior to the billing of services. The Allscripts order tracking process should be utilized. **(IV.J Physician Notification, IV.V Plan of Care)**
• The plan of care must be periodically reviewed by the physician in order for the beneficiary to continue to qualify for Medicare coverage of home health benefits.		• The plan of care is reviewed at least every 60 days by the attending physician and if a change in the Medicare beneficiary's status occurs. **(IV.J Physician Notification, IV.V Plan of Care)**
• Home care services are only billed if the agency is acting upon a physician's certification attesting that the services provided to a client are medically necessary and meet the requirements for home care to be covered by Medicare.		• All clinical services are implemented and billed only in accordance with a plan of care established and signed by a physician's written orders. **(IV.V Plan of Care)**
• The home care agency when consulted assists the physician in determining the medical necessity of home health		• Medical necessity is defined as services that are reasonable and necessary. If the physician contacts

Government Expectations		Society Policy/Procedure
services and formulation of an appropriate and certified plan of care.		the home care agency to clarify medical necessity the home care director or designee will assist with formulating an appropriate plan of care. **(IV.L Admissions – Certification Process)**
• The home care agency properly documents any assessment it has made of a beneficiary's home health needs which may be used by a physician in developing and authorizing a plan of care.		• A comprehensive assessment will be conducted on all clients requiring skilled Medicare services and other payers as required. The assessment will accurately reflect the client's health status and includes information to establish and maintain a plan of care. **(IV.L Admissions – Certification Process)**
• Lack of qualifying service. In addition to addressing the issues associated with other reimbursement coverage criteria, a home health agency's policies and procedures should ensure that all claims satisfy the requisite need of a qualifying service.		• A beneficiary must have the need for skilled nursing care on an intermittent basis, physical therapy, speech language pathology services or a continuing need for occupational therapy. **(IV.L Admissions – Certification Process)**

COST REPORTS

Government Expectations		Society Policy/Procedure
• Costs are not claimed unless they are reimbursable, reasonable and are based on appropriate and accurate documentation. • Allocations of costs to various cost centers are accurately made and supportable by verifiable and auditable data. • Unallowable costs are not claimed for reimbursement. • Accounts containing both allowable and unallowable costs are analyzed to determine the unallowable amount that should not be claimed for reimbursement. • Costs are properly classified. • Medicare fiscal intermediary prior audit readjustments are implemented		• The Society has developed reporting instructions: CMS 1728-94 for all home care agencies to complete cost reports. • Society agencies submit annual reports to Medicare reimbursement of administrative, overhead, and other general costs. Procedures are defined for the downloading of financial files and completion of the reporting worksheet. • All Society home care agencies must use the cost per visit by type of visit method of apportioning costs between Medicare and non-Medicare beneficiaries. Under this method, the total allowable cost of all visits for each type of service is divided by the total number of visits for that type of service. For each type of service, the number of Medicare covered visits is multiplied by the average cost per visit just

and are either not claimed for reimbursement or, if claimed for reimbursement, are clearly identified as protested amounts on the cost report. • All parties are identified on the cost report and all reported party charges are reduced to the cost of the related party. • Management fees are reasonable and necessary and do not include unallowable costs such as certain acquisition costs associated with the purchase of a home health agency. • Any return of overpayments including those resulting from an audit, are appropriately reflected in cost reports. • Procedures are in place and documented for notifying promptly the fiscal intermediary in writing of errors discovered after the submission of the cost report. ***<u>Risk Areas</u>*** ✓ *False cost reports* ✓ *Billing for unallowable costs associated with the acquisition and sale of home health agencies.*		computed. This represents the cost Medicare will recognize as the cost for that service, subject to the cost limits published by CMS.

ANTI-KICKBACK AND SELF-REFERRAL CONCERNS

Government Expectations		Society Policy/Procedure
• All of the home health agency's contracts and arrangements with actual or potential referral sources are reviewed by counsel and comply with all applicable statutes and regulations.		• Vendors will be chosen on the basis of cost, quality, availability and other legitimate service factors. Agreements to purchase goods are consistent with corporate contracts and agencies will utilize corporate contracts whenever possible to ensure quality, availability and reasonable costs.
• The home health agency does not submit or cause to be submitted to the federal healthcare programs for patent which were referred to the home health agency pursuant to contracts of financial arrangements that were designed to induce such referrals in violation of the anti-stark self-referral law, or similar federal or state statute or regulation.		• Charitable contributions from persons (or organizations) with whom the home care provider currently does business (or may do business) will be handled through resource development consistent with Society established policies, procedures and practices. Contributions shall be accepted from current or potential vendors only in the context of community-wide Society fundraising efforts through the resource development department. Contributions of an unusually large amount from vendors or potential vendors shall be referred to the Good Samaritan Foundation at National Campus for evaluation.
• Home health agencies will not offer incentives to actual or potential referral sources (e.g., physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other, similar federal or state statutes or regulations. • The home health agency does not offer or provide gifts, free services, or other incentives to patient's relatives, physicians, hospitals, contractors, assisted living facilities, or other potential referral sources for the purpose of inducing referrals in violation of anti-kickback statute		• Society home care agencies will not offer free services or gifts (of more than a nominal value) that could be construed as incentives for referrals to the agency to inpatient facilities or their employees. Society home care agency persons may assist with discharge planning of an individual from an inpatient facility to home care but may not act as the discharge planner for the referring inpatient facility.
Risk Areas		
✓ *Home health agency incentives to actual or potential referral sources.*		✓ *See Above*

Government Expectations		Society Policy/Procedure
✓ *Joint ventures between parties, one of whom can refer Medicare or Medicaid business to the other.*		✓ *Home care agencies are not permitted to offer or transfer "remunerations" to any Medicare or state health program beneficiary that the person knows is likely to influence the beneficiary to order or receive items or services from a particular provider, practitioner or supplier.* ***(Home Care Corporate Compliance Program)***
✓ *Stark physician self-referral law.*		✓ *A physician (or an immediate family member of a physician) who has a financial relationship with the home care agency may not make a referral to the home care agency for furnishing services that may be reimbursed under the federal health care programs.*
✓ *Improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services.*		✓ *Society home care agencies may not utilize prohibited or inappropriate conduct (e.g. offer free gifts or services to clients) to carry out their initiatives and activities to maximize business growth and client retentions.* ***(Home Care Agency Corporate Compliance Program)***
✓ *Compensation programs that offer incentives for number of visits performed and revenue generated.*		✓ *Society home care agencies do not offer incentives for productivity or the number of visits performed.* ***(Home Care Corporate Compliance Program)***
✓ *Discriminatory admission and discharge of patients.*		✓ *Admissions to the home care agency are based on the home care agency's ability to meet the client's needs. All home care agencies and inpatient facilities making referrals to the agency will offer clients a choice of home care providers consistent with applicable laws and regulations.* **(IV.L Admissions – Certification Process)** ✓ *It is the policy of Society home care agencies to admit and treat clients without regard to race, color, sex, national origin or age.* **(IV.L Admissions – Certification Process)**

Government Expectations		Society Policy/Procedure
✓ *Patient abandonment in violation of applicable statutes, regulations, and federal healthcare program requirements.*		✓ *Clients are discharged from the home care agency when certain defined conditions are met.* ***(IV.Q Discharge Process)*** ✓ *Home care agencies will terminate the client/provider relationship consistent with agency procedure. The following may constitute a desire by the client to terminate services: failure to be available for three consecutive visits; failure to agree to private payment arrangements in the absence of third-party payment; failure to make private payment; and presence of violent behavior by client/significant other. Written notification should be given to the client regarding termination of services.* ***(IV.G Termination of Client – Provider Relationship)***

RETENTION OF RECORDS

Government Expectations		Society Policy/Procedure
• Home health agency compliance programs should provide for the implementation of a records system. The system should establish policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents		• Policies and procedures are established regarding the creation, distribution, retention, storage, retrieval, and destruction of documents. **(Skilled Home Care Manual: Section III-Clinical Record Documentation and Maintenance)**

DESIGNATION OF A COMPLIANCE OFFICER AND COMMITTEE

Government Expectations		Society Policy/Procedure
• Designating a Compliance Officer and Compliance Committee • Responsibilities of the Compliance Officer • Overseeing and monitoring the implementation of the Compliance		• A Corporate Compliance Officer (CCO) position is in place at National Campus. Executive managers and administrators are responsible for coordinating and overseeing compliance activities at an agency level. **(Home Care Corporate Compliance Plan)** The CCO is responsible for assisting the Society to stay abreast of government expectations in the area of compliance and coordinate internal

Program • Reporting on a regular basis to the agency's governing board and compliance committee. • Periodically revising the program in light of changes in the organization's needs, and in the law and policies and procedures of government and private payer health plans. • Reviewing employee's certifications that they have received, read, and understood the standards of conduct. • Developing, coordinating and participating in a multifaceted educational and training program that focuses on the elements of the compliance program and seeks to ensure all relevant employees and management are knowledgeable of, and comply with, pertinent federal and state standards. • Ensuring that independent contractors who furnish home care services to clients of the agency are aware of the requirements of the agency's compliance program. • Coordinating personnel issues with human resources to ensure that the National Practitioner Data bank and Sanction Report have been checked for all employees. • Assisting with financial management in coordinating internal compliance reviews. • Independently investigating and acting on matters related to compliance. • Developing policies and programs that encourage employees and managers to report suspected fraud. • Continuing the momentum of the compliance program.		activities geared toward improved compliance. The CCO is a resource to staff that has questions or concerns about whether the Society is meeting its compliance obligations. He or she is accountable directly to the Society's Chief Legal Officer. A "Compliance Management Committee" comprised of vice presidents, directors of operations, directors, and consultants, provides input to the COO function. **(Home Care Corporate Compliance Plan)**

CONDUCTING EFFECTIVE TRAINING AND EDUCATION

Government Training		Society Policy/Procedure
Training should include topics such as: • Government and private payer reimbursement principles. • General and private payer reimbursement principles. • Improper alterations to clinical records. • Providing home health services with proper authorizations. • Proper documentation of services rendered including the correct application of official ICD and CPT coding rules and guidelines. • Compliance with Medicare conditions of participation. • Duty to report misconduct.		In employee orientation as well as annually, all employees are educated concerning home care eligibility, coverage and eligibility rules, proper documentation and payment rules. An overview of the Compliance Program is provided through the agency's general orientation program. Specific, compliance-related job expectations are listed in each employee's CVTC form. Also, compliance-related job expectations may be communicated through departmental orientation. Ongoing training occurs on an individual as well as a group level. On an individual level, supervisors are expected to utilize the Society's CVTC. **(Home Care Corporate Compliance Plan)**

DEVELOPING EFFECTIVE LINES OF COMMUNICATION

Government Expectations		Society Policy/Procedure
• Access to the Compliance Officer		• Any Society employee may report compliance-related concerns directly to the Corporate Compliance Officer. **(Home Care Corporate Compliance Plan)**
• Hotlines and Other Forms of Communication		• Compliance representatives are available Monday to Friday. An 800 hotline has been established.

ENFORCING GUIDELINES THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

Government Expectations		Society Policy/Procedure
• Discipline Policy and Actions		• Policies and procedures have been established to provide guidance regarding disciplinary action for managers and employees who have failed to comply with the home care agency's standards of conduct and policies and procedures. **(II.D Job Description / Performance Feedback)**
• New Employee Policy		• For all new employees, the home care agency conducts a reasonable and prudent background investigation, including a reference check as part of every employment application. Policies prohibit the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, excluded, or otherwise ineligible for participation in federal healthcare programs. **(II.B Hiring Practices)**

AUDITING AND MONITORING

Government Expectations		Society Policy/Procedure
• Ongoing evaluation process of reports of suspected non-compliance. At a minimum audits should be designed to address the home health agency's compliance with laws governing kickback arrangements, physician self-referral, claim development and submission, reimbursement, cost reporting and marketing. Audits should also inquire into the agency's compliance with the Conditions of Participation.		• Each agency monitors how well it is meeting government requirements by conducting audits on a regular basis. • Audit processes have been established in the Allscripts application for concurrent review of clinical documentation to ensure regulatory and Medicare requirements are being met.