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Care1st HEALTH PLAN

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Compliance "Spotlight" for Board of Directors

Ingredients for Establishing Compliance Best Practices

The rare and elusive concept of "best practices"- in the health care industry, discuss in conferences, seen on print, we strive for, or maybe even claim it within our own organizational confines—but do we really know what it is? Does it even exist? Are there truly practices for a given set of procedures or particular functions that are the *best* way to accomplish those actions or achieve that result? The perceived elusiveness of best practice comes from the desire for an off-the-shelf set, a canned collection of tools and instruments that, when utilized, place our organization at the top of the class. Organizations vary though, and they vary so much that it would be foolish to assume that any such set of practices that might work for one organization would work with the same success in any other organization. Services, resources, finances, operations, technology—all of these components to organizations serve as unique ingredients in the larger recipe that represents what the organization is and does.

As a result, those elusive "best practices" must not be seen as clear and concise instructions on how an organization ought to operate, rather as the potential with which it can operate. Of course, we must make some assumptions, and for purposes of this article, we'll assume that best practices represent those methods or techniques we employ and evolve over time in an effort to achieve whatever our desired results may be (e.g. more efficient customer service, increased profits).

Critical Components

To achieve measurable and superior performance, a few critical components are required. First, inventory must be taken of the tools an organization has at its disposal. Achieving best practices is only possible using the resources an organization possesses. Only with an assessment of organizational inventory can an organization begin to understand what its capabilities are and, consequently, how it can position itself to best achieve its desired results.

Second, a framework is required. Even the best tools and resources are useless without a meaningful method of organizing them. With an organizational inventory and a framework that allows for the incorporation of key risks, the path to best practice is only in need of effectively using the two together.

Lastly, and perhaps most significantly, the utilization of those tools and resources within that framework must be not just efficient and thorough, but also up-to-date and in accordance with current regulatory and investigatory development.

Preventing Provider Medical Identity Theft

Physicians, other providers, and beneficiaries of Medicare and Medicaid are at risk for medical identity theft. The Centers for Medicare & Medicaid Services (CMS) is working to raise awareness among providers and help them protect their medical identities. Medical identity theft is "the appropriation or misuse of a patient's or [provider's] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services," according to *S. Agrawal* and *P. Budetti* in their article, *"Physician Medical Identity Theft,"* in the *"Journal of the American Medical Association." Volume 307, Number 5, pages 459-460 (February 1, 2012).*

A common provider medical identity theft scheme involves a fraudster billing services directly in a physician's or other provider's name even though the clinician never provided the service. Using physician and other provider medical identifiers to refer patients for additional services and supplies, such as home health services, diagnostic testing, and medical equipment and supplies, is another common scheme.

Providers can mitigate their vulnerability to theft. Strategies to use to protect themselves to theft include: (1) Actively managing enrollment information with payers by providing updates about material enrollment changes such as opening, closing, or moving practice; separating from an organization; or, changing banking information. (2) Monitoring billing and compliance processes by strengthening policies and procedures (P&Ps) to minimize risks and improve overall program integrity. P&Ps might include adopting sound billing practices (e.g., reviewing remittance notices); carefully reading documents before signing them; and, limiting and monitoring third party use of medical identifiers. (3) Controlling unique medical identifiers by taking steps, such as thoroughly training staff on all P&Ps; screening employees; securing all information technology; and, keeping track of all prescription pads. (4) Engaging patients in conversation about the risks of medical identity theft by explaining the impact it can have on the patients and the patients' medical records; looking for signs of potential identity theft; and, warning patients of the dangers of card sharing.

If you suspect compliance, ethics, or integrity violation, or have questions about specific practices, please use the following resources:

- Talk to your Supervisor or Manager
- Call the Care1st HOTLINE at 1-877-837-6057. Anonymous. Available 24/7. Trained Professionals. Toll-Free
- Contact the Compliance Department at ComplianceSIU@care1st.com or ComplianceDepartment@care1st.com
- Call the Corporate Compliance Officer, Brooks Jones, CHC, at extension 6202
- Call Ellen Smart, AVP, Human Resources at extension 6203