

## **Making Your Corporate Compliance Plan Work – 10 Issues to Review Right Now**

### **I. ASSESS PLAN TO DETERMINE IF IT ACCOMPLISHES ITS PURPOSES**

- A. Prevents future problems
- B. Sets the standards for the Facility
  - 1. Does the plan incorporate the mission statement?
  - 2. Does the plan reflect the Code of Conduct?
  - 3. Does the plan clearly delineate expectations?
- C. Policies help the employees to carry out their duties to meet the standards
  - 1. Do the policies address how to meet the standards?
  - 2. Do the policies address layers of regulatory compliance?
- D. Acts as an insurance policy should the Facility be investigated
  - 1. Does the policy meet Federal Sentencing Guidelines:
    - (a) Ensures that the Facility's Code of Conduct contains an ethics component, providing employees with guidance not only on how to follow the applicable rules, but why to follow them.
    - (b) Ensures and increases the Board of Directors' involvement and oversight in the operation of the Compliance Plan. This is consistent with recent guidance issued to Boards by the Office of the Inspector General (OIG) and will require that Board Members have a working understanding of the health care regulatory system and the potential risks facing the Facility.
    - (c) Ensures that the Facility develops and documents a "culture of compliance," spearheaded by management, that guides all aspects of the organization's business.
    - (d) Establish compliance standards and procedures reasonably capable of reducing the prospect of criminal or wrongful conduct.
    - (e) Address oversight responsibilities - assign compliance officers.
    - (f) No delegation of substantial discretionary authority to individual

that knows/should know had propensity to engage in illegal activities.

- (g) Communicate standards and procedures to employees; develop training programs.
- (h) Develop monitoring, auditing and reporting system to achieve compliance.
- (i) Enact enforcement and disciplinary system for offense and failing to detect offense.
- (j) Take reasonable steps to respond to detected offense and prevent in future.

E. Protects reputation of Facility

- 1. Have there been any investigations?
- 2. Have there been any bad public relations?

F. Promotes consistency of Facility's operations

G. Improves quality of patient care

- 1. Mock Surveys
- 2. QI/QA Committee
- 3. Has the Facility conducted a "before/after" audit to determine if operations, care, and reimbursement have improved?

H. Amendable to meet the needs of the Facility and changes in controlling laws and regulations

- 1. How long has the plan been in place?
- 2. Has the plan ever been revised or amended?

## **II. VEST CORPORATE COMPLIANCE OFFICER POSITION WITH AUTHORITY AND DELINEATE RESPONSIBILITIES AND DUTIES**

A. Is the corporate compliance officer position vested with authority:

- 1. Is there a named corporate compliance officer?

2. What qualifications does the corporate compliance officer have?
  3. Is the corporate compliance officer respected?
  4. Does the corporate compliance officer have the backing of the Commissioners and CEO/Administrator?
  5. Do the employees know who the corporate compliance officer is?
- B. Is the corporate compliance officer position vested with the following responsibilities and duties:
1. Providing Facility leadership for compliance efforts,
  2. Implementing Facility-wide policies, programs, and procedures to ensure compliance with applicable federal and state laws,
  3. Staying informed of legal requirements and changes,
  4. Developing and writing or delegating policies and procedures that set up standards for compliance, giving specific guidance to management, staff and individuals where appropriate, and update periodically,
  5. Developing materials to train staff on the Facility's compliance program,
  6. Communicating governmental compliance priorities and consequences for non-compliance,
  7. Facilitating ad-hoc functional area audits,
  8. Facilitating investigation and follow-up of reports of suspected non-compliance,
  9. Investigating directly suspected instances of fraud and abuse,
  10. Monitoring and directing follow-up activities for identified instances of health program exclusions among Facility staff, vendors and affiliated healthcare providers,
  11. Developing policies and programs that encourage managers and employees to report suspected fraud and abuse without fear of retaliation,
  12. Directing activities for Facility-wide audits established to investigate and monitor compliance,

13. Regularly reports to chief legal officer or Facility's President/CEO and Commissioners on the progress of implementation and in establishing methods to improve the Facility's efficiency and quality of services and to reduce Facility vulnerability to fraud, abuse and waste,
14. Investigating and acts on matters related to compliance, including the design and coordination of internal investigations and any resulting corrective action,
15. Working and communicating with designated Facility representative responsible for compliance issues,
16. Advising on methodologies to provide awareness to independent contractors and agents who furnish services to the Facility of the Facility's compliance program,
17. Assisting Facility's finance functions in coordinating internal compliance review and monitoring efforts,
18. Reviewing complaints, concerns, or questions relative to compliance issues, and
19. Acting as a resource for staff regarding compliance requirements.

### **III. COMPLIANCE COMMITTEE COMMITMENT**

- A. Is a compliance committee established?
  1. Who are the members?
  2. What are their qualifications?
- B. Does the compliance committee:
  1. Hold regular meetings,
  2. Analyze industry environment, the legal requirements with which it must comply, and the specific risk areas,
  3. Assess existing policies and procedures that address those risk areas for possible incorporation into the compliance plan,
  4. Work with appropriate Facility departments to develop standards of conduct and policies and procedures to promote compliance within the Facility,

5. Recommend and monitor, in conjunction with the relevant departments, the development of internal systems and controls to carry out Facility's standards, policies and procedures as part of its daily operations,
6. Determine the appropriate strategy/approach to detect of any potential violations,
7. Develop a system to, evaluate and respond to complaints and problems, and
8. Monitor internal and external audits and investigations for the purpose of identifying deficiencies and implementing corrective action.

#### **IV. ASSESS STAFF COMPLIANCE**

##### **A.     OIG Focus - Criminal Background Checks**

1.       Must have criminal background checks on all agents and employees who have direct contact with residents or who have unsupervised access to resident personal living quarters.
2.       Make sure to obtain pre-hire applicant's current name, Social Security number, and aliases (e.g., maiden names) to avoid an instance where an individual uses middle name or maiden name to go undetected.

##### **B.     OIG Exclusion Checks**

1.       OIG website publishes monthly a list of excluded individuals (<http://exclusions.oig.hhs.gov>).
2.       Periodically check website to ensure that employees and contractors are not barred from Medicare/Medicaid programs.

##### **C.     Licensure**

1.       Review to ensure that staff licenses are up-to-date as expired licenses could create issues related to Medicare reimbursement.

##### **D.     Staffing Levels**

1.       Know and comply with state law regarding staffing ratios.
2.       Staff based on acuity of care to ensure sufficient staff. Consider:
  - (a)     Staff skills,

- (b) Resident case mix,
- (c) Staff-to-resident ratios,
- (d) Staff turnover,
- (e) Staffing schedules,
- (f) Disciplinary records,
- (g) Payroll,
- (h) Timesheets,
- (i) Adverse event reports,
- (j) Interviews, and
- (k) Resident and family feedback.

3. Maintain meticulous staffing records and retain those records.

## V. **ASSESS CONTRACTS**

### A. Government Review of Contracts

- 1. Reviews during cost reporting process.
- 2. Reviewers can assess contracts for compliance and are instructed to report issues.

### B. Fraud and Abuse Issues

- 1. Review vendor contracts to ensure payment is FMV for services rendered.
- 2. Review contract to ensure provisions satisfy a Safe Harbor or Stark exception as applicable:
  - (a) Personal services
    - (i) The agency agreement is set out in writing and signed by the parties.
    - (ii) The agency agreement specifies the services to be provided by the agent.

- (iii) If the agency agreement is intended to provide for the services of the agent on a periodic, sporadic or part-time basis, rather than on a full-time basis for the term of the agreement, the agreement specifies exactly the schedule of such intervals, their precise length, and the exact charge for such intervals.
  - (iv) The term of the agreement is for not less than one year.
  - (v) The aggregate compensation paid to the agent over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or a State health care program.
  - (vi) The services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.
- (b) Leasing of equipment and space
- (i) The lease agreement is set out in writing and signed by the parties.
  - (ii) The lease specifies the equipment/space covered by the lease.
  - (iii) If the lease is intended to provide the lessee with use of the equipment for periodic intervals of time, rather than on a full-time basis for the term of the lease, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such interval.
  - (iv) The term of the lease is for not less than one year.
  - (v) The aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals for business otherwise generated between the parties for which payment may be made in whole or in part under Medicare or State health care program.

(c) Discounts

(i) Safe Harbor requirements:

- a. the discount must be earned based on purchases of that same good or service bought within a single fiscal year of the buyer;
- b. the buyer must claim the benefit of the discount in the fiscal year in which the discount is earned or in the following year;
- c. the buyer must fully and accurately report the discount in the applicable cost report; and
- d. the buyer must provide information to HHS required to be provided by the seller (i.e., the amount of the discount provided to the buyer).

(ii) The term “discount” for purposes of the Safe Harbor means a reduction in the amount a Seller charges a buyer (who buys either directly or through a wholesaler or a group purchasing organization) for a good or service based on arms-length transaction. The term “discount” does not include:

- a. cash payment;
- b. supplying one good or service without charge or at a reduced charge to induce the purchase of a different good or service, unless the goods and services are reimbursed by the same Federal health care program using the same methodology and the reduced charge is fully disclosed to the Federal health care program and accurately reflected where appropriate, and as appropriate, to the reimbursement methodology;
- c. a reduction in price applicable to one payor, but not to Medicare or a State health care program;
- d. a routine reduction or waiver of any coinsurance or deductible amount owed by a program beneficiary;
- e. warranties; or

f. services provided in accordance with a personal or management services contract.

(iii) Rebates are allowed as a “discount” so long as the terms of the rebate are fixed and disclosed in writing to the buyer at the time of the initial purchase to which the discount applies, but which is not given at the time of sale.

(iv) It is important to remember that discounts are not discouraged by the Medicare Program, and in fact, are encouraged.

C. Renewal

1. Review all contracts annually as they come up for renewal.
2. Develop tickler file to assist in timely content review.

D. Contract Audit Checklist

1. In writing and executed by all parties,
2. Identification of parties to the contract (full legal names, addresses, contact information, etc.),
3. Responsibilities/duties of both parties clearly outlined,
4. Term of agreement for at least one year,
5. Termination provisions
  - (a) Clear statements of how contract can be terminated,
  - (b) Refrain from agreeing to terms such as “automatic renewal unless notice given 30, 60, 90 days or more prior to end of term”, and
  - (c) For cause termination clearly stated, including ability to cure the cause, and
  - (d) Without cause termination clearly stated.
6. HIPAA/Confidentiality language,
7. Indemnification language,
8. Non-solicitation clause (if applicable),

9. Required disclosures,
10. Insurance requirements (including certificates),
11. Agreement to comply with federal and state laws,
12. Licensing and certification requirements, and
13. Remedies for nonperformance.

**VI. ASSESS CARE AND DOCUMENTATION ISSUES**

**A. Medication Management**

1. Must have processes that advance safety, minimize adverse drug interactions, and ensure drug regimen irregularities are promptly discovered and reported.
2. Policies and procedures for maintaining accurate drug records and tracking medications.
3. Need effective consultant pharmacist.

**B. Psychotropic Medications**

1. Policies provide for an audit of resident records to ensure that physician documentation includes reason why resident continues to need psychotropic medications.
2. Policies provide for documenting any attempts to wean a resident from medication or reason why weaning is not appropriate.
3. Policies provide for tailored documentation.

**C. Define the Role of Doctor/Medical Director in Policies and Procedures**

- 1, Physician Services – 42 CFR § 483.40
  - a) Physician must personally approve in writing a recommendation that an individual be admitted to the Facility.
  - b) Medical care of each resident must be supervised by a physician.
  - c) Physician must review the resident's total plan of program care including treatments and medications at each visit.

- d) Physician must see the resident at least once every 30 days for the first 90 days after admission and at least every 60 days thereafter.
  - (i) In skilled nursing facilities after the initial visit at the option of the physician required visits may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist except when the regulations state the physician must perform a task personally or delegation is prohibited under the State law or by the Facility's own policies
- e) Facility must provide or arrange for the provision of physician services 24 hours a day for emergencies.

2. Medical Director – 42 CFR § 483.75(i)

- a) Facility must designate a Medical Director.
- b) Medical Director responsible for
  - (i) Implementation of resident care policies;
  - (ii) Coordination of medical care in Facility.
- c) OIG expects Medical Directors to assist Facility in meeting Requirements of Participation, and also to deliver quality care and control, oversee attendings.

D. Comprehensive Resident Care Plans

- 1. Clinical assessments are completed prior to care-plan meeting.
- 2. Effective communication between direct-care providers and care-plan providers and care-plan team.
- 3. Involvement of residents' families, legal representatives and attending physicians.
- 4. Plans of care match assessments.

E. Maintain Adequate Documentation/Retention Policies to Substantiate Action in the Event of Breach

- 1. Most compliance issues are due to:
  - (a) Failure to document;

(b) Failure to maintain the “smoking gun” document, and

(c) Failure to accurately complete documents.

2. Make sure to review the statutory/regulatory timeframes for maintaining documentation.

F. Matters that Can Lead to False Claim Act Case

1. Billing for items or services not actually rendered,

2. Providing medically unnecessary services,

3. Upcoding,

4. Waiver of Coinsurance and Deductibles,

5. Medicare Secondary Payor issues,

6. Unbundling,

7. Filing False Cost Reports,

8. Payments to Induce Reduction or Limitation of Services, and

9. Quality of Care Issues.

G. OIG Focus – Quality of Care

1. Develop plans of care based on assessment of beneficiaries,

2. Provide services to beneficiaries in accordance with plans of care, and

3. Plan for beneficiaries’ discharge.

H. OIG Focus – Emergency Preparedness and Evacuations During Natural Disasters

1. Develop emergency plans and procedures to meet all potential emergencies, and

2. Train all employees in the Facility’s emergency procedures.

VII. Topics to Train and Educate the Commissioners

A. Working Knowledge of the Facility's Regulatory Environment

1. Fraud and Abuse Basics

- (a) Anti-Kickback Statute establishes criminal penalties for any person who knowingly and willfully (i.e., with specific intent) offers, pays, solicits, or receives any remuneration (i.e., anything of value) to induce or in return for:
  - (i) Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service payable in whole or in part under the Medicare or Medicaid programs; or
  - (ii) Purchasing, leasing, or ordering, or arranging for or recommending purchasing, leasing, or ordering, any good, Facility, service, or item payable under the Medicare or Medicaid programs.
- (b) False Claims Act prohibits the knowing filing of a false or fraudulent claim for payment to the United States, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim paid by the conspiracy to defraud the United States by getting a false or fraudulent claim allowed or paid. Unlike the criminal provisions, a person may be held liable for a “knowing” violation of the law. “Knowing” requires at least a deliberate ignorance or reckless disregard of the truth or falsity of the information; no proof of specific intent to defraud is required. In addition, a corporation may be liable for the fraud of its agent who had acted with “apparent” authority.
- (c) Stark Law prohibits referrals by physicians to entities providing certain “designated health services” in which entity the physician or a member of his/her family has an ownership or compensation interest. Stark also prohibits the entity from presenting a claim for such services, and sets forth numerous exceptions to these broad provisions.

2. Licensure and Certification Basics

- (a) How is the Facility licensed? What are the requirements to maintain those licenses?
- (b) How is the Facility paid by the various payor sources, and what are the requirements to obtain payment?

3. Awareness of “risks” to Facility operating in healthcare regulatory environment
- B. Working Knowledge of the Facility’s Corporate Compliance Plan
1. Code of Conduct
    - (a) What is expected of the Facility’s employees and Commissioners?
    - (b) Does the Code of Conduct reflect the Commissioners’ vision for the Facility?
    - (c) Are the Commissioners ensuring that all members of the Facility follow the Code of Conduct?
  2. Education and Training
    - (a) The Compliance Plan requires significant commitment and investment from the Facility. Is the program adequately supported?
    - (b) Are the Commissioners briefed on the nature of the educational training and the results/rewards of such training?
    - (c) Are the Commissioners advised on significant regulatory and industry developments?
  3. Reporting and Oversight Responsibilities
    - (a) Have the Commissioners received periodic and annual compliance reports from the Compliance Officer?
    - (b) What actions have the Commissioners taken in response to compliance reports? Remedial measures?
    - (c) Does the Facility’s Compliance Officer have direct access to the Commissioners? Does the Compliance Officer have enough authority and autonomy to fulfill the functions of the position?
    - (d) What is the Commissioners’ involvement in the Facility’s reports to federal and state government agencies?
  4. “Big Picture Issues”
    - (a) Does the Plan reflect the Commissioners’ goals for the

Facility? What are the Commissioners' expectations?

- (b) Will the Commissioners periodically review the Plan to determine the need for updates and modifications?
- (c) Have the Commissioners provided adequate support for the Plan, both financially and in terms of involvement and effort?
  - (i) annual budgetary commitment
  - (ii) human resources allocation

C. **OIG's Expects Commissioners in the role of a Board to Ask**

1. What are the goals of the quality program and benchmarks used? Is management accountable?
2. How is quality measured and by whom?
3. How is quality integrated into policies and operations, and how are they enforced? What controls are in place?
4. Is there an education program on quality for the Commissioners, and do any Commissioners have quality expertise?
5. What is the essential information on quality, and how frequently is it received?
6. How do quality and compliance coordinate, and how are they addressed in the risk assessment and other plans?
7. What are the processes for reporting quality issues and preventing retaliation? What are the guidelines for Commissioners reporting?
8. Are human and other resources adequate to support quality? Are systems in place to account for different patient needs?
9. Do competencies, training, credentialing and peer review adequately focus on quality?
10. How are adverse events identified, analyzed, and reported and incorporated into performance improvement?

**VIII. ASSESS REPORTING MECHANISMS AND FOLLOW-UP**

- A. What kind of reports are being received?

1. Do reports relate to compliance matters?
  2. Do reports relate to employment matters?
- B. Has the Facility publicized its reporting mechanisms?
1. Compliance Hotline,
  2. Directly to Compliance Officer, and/or
  3. Report, in writing/oral, to immediate supervisor.
- C. Educate Employees and Commissioners on affirmative duty to report
- D. Method of reporting and follow-up
1. Compliance Officer will review all reports received and investigate all instances of claimed misconduct or noncompliance by:
    - (a) interviews with complainant and others who may have knowledge of problem; and
    - (b) identification/review of suspect bills or claims.
  2. Investigation will result in a report from the Compliance Officer to the Facility's Compliance Committee (and, in some cases, directly to the Commissioners).
  3. After results are in, if Compliance Officer determines that noncompliant conduct occurred because of:
    - (a) negligence, then the matter will be referred to Human Resources Department for disciplinary action, and
    - (b) knowing or willful conduct, or gross negligence, then the matter will be referred to the Corporate Compliance Committee for disciplinary action and to determine reporting requirements to government.

**IX. SCHEDULE, SCHEDULE, SCHEDULE**

- A. Establish Schedules for:
1. Periodic audits,

2. Annual audits,
3. Due dates for Departmental Reports,
4. Due dates for completion of Departmental Policies,
5. Training sessions,
6. Monitoring of Hotline Reports,
7. Compliance Committee Meetings,
8. Mock Surveys,
9. Contractual Review,
10. New Employee Audits, and
11. Training Sessions.

- B. Maintain a “Compliance Calendar”  
(A model Compliance Calendar is attached.)

**X. DAY-TO-DAY IMPLEMENTATION**

- A. Regular Communications

1. Notes/Letters from Commissioners,
2. CEO/Administrator Promotion,
3. Facility Newsletter,
4. Brochures,
5. Compliance bulletins and updates, and
6. Compliance “program awards”.

- B. Documenting Effectiveness of Plan

1. Maintain minutes of all compliance committee meetings,
2. Maintain, organize and file all documents that support compliance plan:
  - (a) Policies,

- (b) Records demonstrating training session, and
  - (c) Memoranda, etc. of conversations with government, fiscal intermediaries, and consultants.
3. Maintain Logbook of Reporting Mechanisms (hotline calls).

C. Monitoring Techniques

- 1. Sample protocols to identify and review variations from the baseline, or “snapshot” of operations determined during the benchmarking analysis conducted in conjunction with the implementation and adoption of the Plan,
- 2. On-site visits,
- 3. Interviews with key personnel,
- 4. Questionnaires testing billing and claims reimbursements staff on its knowledge of applicable program requirements and claims/billing criteria,
- 5. Review of backup records on a random basis to assess reliability of billings,
- 6. Periodic review of claims department and submission process, beginning with a patient’s admission and ending with the submission of the claim to the government payor or third party payor,
- 7. Contract with independent organizations, as needed, to review the billing process, policies and practices to ensure governmental third party payors are billed accurately,
- 8. Unannounced mock surveys,
- 9. Examine logs and investigative files,
- 10. Legal assessment of contractual relationships with ancillary, providers and potential referral sources,
- 11. Re-evaluation of deficiencies cited in past surveys and checking for patterns of deficiencies,
- 12. Analyze past survey reports to determine if the proposed corrective plan of action identified and corrected the underlying problem,

13. Check personnel records to determine if disciplined employees are now conforming to Facility's policies, and
14. Validate physician and staff qualifications, including verification of license renewals.

## **COMPLIANCE CALENDAR**

### **I. SCHEDULED MEETINGS**

- A. Quarterly Compliance Committee Meetings
  - 1. February \_\_\_\_, 20\_\_ (1<sup>st</sup> Quarter)
  - 2. May \_\_\_\_, 20\_\_ (2<sup>nd</sup> Quarter)
  - 3. August \_\_\_\_, 20\_\_ (3<sup>rd</sup> Quarter)
  - 4. November \_\_\_\_, 20\_\_ (4<sup>th</sup> Quarter)
  
- B. Quarterly Meetings With Compliance Counsel
  - 1. January \_\_\_\_, 20\_\_ (1<sup>st</sup> Quarter)
  - 2. April \_\_\_\_, 20\_\_ (2<sup>nd</sup> Quarter)
  - 3. July \_\_\_\_, 20\_\_ (3<sup>rd</sup> Quarter)
  - 4. October \_\_\_\_, 20\_\_ (4<sup>th</sup> Quarter)
  
- C. Confirm that Facility Compliance Coordinator hold Facility-specific compliance meetings.

### **II. REPORT DEADLINES**

- A. Quarterly Compliance Reports From Facility
  - 1. March \_\_\_\_, 20\_\_ (1<sup>st</sup> Quarter)
  - 2. June \_\_\_\_, 20\_\_ (2<sup>nd</sup> Quarter)
  - 3. September \_\_\_\_, 20\_\_ (3<sup>rd</sup> Quarter)
  - 4. December \_\_\_\_, 20\_\_ (4<sup>th</sup> Quarter)
  
- B. Annual Compliance Report
  - 1. January 30, 20\_\_ (for 20\_\_ Calendar Year)

### **III. AUDIT SCHEDULE**

- A. Billing/Certification Audit for 20\_\_
  - 1. Facility to be audited on \_\_\_\_\_, 20\_\_
  - 2. Completion of report by \_\_\_\_\_, 20\_\_
- B. Survey/Clinical Audit for 20\_\_
  - 1. Facility to be surveyed on \_\_\_\_\_, 20\_\_
  - 2. Completion of report by \_\_\_\_\_, 20\_\_
- C. New Employee Audits
  - 1. To be done within 90 days of hire
  - 2. Confirm that such audits are being done at the Facility level
  - 3. Send notices/reminders to Facility Compliance Coordinators
    - a) March \_\_, 20\_\_ (1<sup>st</sup> Quarter)
    - b) June \_\_, 20\_\_ (2<sup>nd</sup> Quarter)
    - c) September \_\_, 20\_\_ (3<sup>rd</sup> Quarter)
    - d) December \_\_, 20\_\_ (4<sup>th</sup> Quarter)

### **IV. CORPORATE EDUCATION AND TRAINING SCHEDULE**

- A. Annual Training Session on Plan Requirements
  - 1. DATE  
Audience
- B. Periodic Training Sessions
  - 1. DATE  
Audience  
Topic

2. DATE  
Audience  
Topic

3. DATE  
Audience  
Topic

**V. ONGOING CORPORATE COMPLIANCE OFFICER DUTIES**

A. Policy Development

1. Human Resources (1<sup>st</sup> Quarter)
2. Billing/Coding/Cost Reporting (2<sup>nd</sup> Quarter)
3. Quality/Clinical Care (3<sup>rd</sup> Quarter)
4. Documentation retention (4<sup>th</sup> Quarter)

B. Hotline

1. Maintain Log of Calls

C. Periodic Check of OIG Exclusions Database

1. April 20\_\_ – Check database for new vendors contracted between January – March 20\_\_
2. August 20\_\_ - Check database for new vendors contracted between April – June 20\_\_
3. October 20\_\_ – Check database for new vendors contracted between July – September 20\_\_.
4. January 20\_\_ – Check database for new vendors contracted between October – December 20\_\_.

D. Review and Revision of Plan

1. As necessary, depending on input and experience

E. Periodic Checks of Web Sites for Updates

1. OIG
2. CMS
3. DOH
4. DPW
5. Trade Associations

# **MAKING YOUR CORPORATE COMPLIANCE PLAN WORK – 10 ISSUES TO REVIEW RIGHT NOW**



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The information herein reflects the views of the authors. The information should be construed as general guidelines and not interpreted as legal advice. The materials should serve as a general reference to facilitate more thorough research and analysis with the assistance of a competent professional who would have an opportunity to consider the facts of any particular situation.