VISITING NURSE SERVICE OF ROCHESTER, NEW YORK	Strong Home Care Group, Inc.	Corporate Compliance
	POLICY: Definitions	Policy #101A
	SECTION: 100A	
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Policy: Strong Home Care Group has defined the following terms for use in the Corporate Compliance program.

Description:

Abuse

This constitutes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Although abuse may appear similar to fraud, abusive acts are not committed knowingly, willfully or intentionally. Center for Medicare & Medicaid Services (CMS) uses three standards when judging if abusive acts in billing were committed. They are:

- Medical necessity.
- Conformity to professionally recognized standards.
- Fair price.

Examples of abuse include, but are not limited to:

- Charging excessive amounts for services.
- Providing medically unnecessary services.
- Providing services that do not meet professionally recognized standards.
- Billing Medicare based on a higher fee schedule than for non-Medicare patients.
- Submitting bills to Medicare that are the responsibility of other insurers.
- Violating the provider participation agreements.

Conditions of Participation

The Medicare Conditions of Participation (COP) are rules that agencies must comply with to participate in the Medicare program. The COP delineate the clinical, administrative and operational requirements for the agency. State surveyors determine whether the agency is following these COP requirements through periodic surveys. Surveys will occur more frequently if complaints or deficiencies are found throughout the year.

The general categories included in the Conditions of Participation are:

- Patient Rights. This section includes our obligation to respect patients' rights, and to inform them of their rights in writing.

- < Compliance with federal, state and local laws. This section describes compliance with federal, state and local laws, disclosure and ownership information, and accepted professional standards and principles.
- < Organization, services and administration. This section includes a description of lines of authority, governing body, institutional planning and personnel policies.
- < Group of professional personnel. This section describes the professional advisory committee (also known as corporate compliance and quality improvement committee**)** that is responsible for the evaluation of the agency.
- < Acceptance of patients, plan of care and medical supervision. This section describes accepted standards, what comprises a plan of care, how often it should be reviewed and the importance/requirement of physician**'**s orders.
- < Skilled nursing services, therapy services, medical social services and home health aide services. This section describes the duties involved in the provision of these clinical services. Home health aide training requirements are detailed.
- < Clinical records. This section describes the clinical record, its components, retention and protection requirements.
- < Agency evaluation. This section describes how, why and by whom the agency is evaluated. The requirements of the quarterly clinical record review are included.

Corporate Compliance Program

The Corporate Compliance Program uses education, training and oversight to ensure compliance with the laws and regulations applicable to the ongoing operation of VNS. Compliance is everyone's business and this program involves the active participation of all levels of employees, as well as the Board of Directors.

Cost Report

The cost report is a detailed accounting of administrative, overhead, direct service expenses and other expenses, which is sent to Medicare so that VNS can be reimbursed for these expenses. These expenses must be reasonable and necessary for maintenance of VNS as well as related to patient care.

Fraud

Fraud is defined as intentionally, knowingly or willfully making false statements or representations of material facts to obtain benefit or payment that one would not otherwise be entitled to receive. Examples of fraud include, but are not limited to:

- < Billing for services not provided.
- < Altering claims or records to receive higher payments.
- < Duplicate billings.
- < Offering, paying, soliciting or receiving bribes, kickbacks or rebates.
- < Misrepresenting the services provided, (i.e., describing non-covered services in a way that allows Medicare to cover the services**)**.
- < Over utilization (evidence of services billed which do not meet the homebound/medical

necessity requirements.)

- < Falsification or alteration of records.
- < Non-allowable costs on the cost report.
- < Falsification of time sheets.

Homebound

Homebound standards relate to the ability or inability of the patient to be able to leave the home for medical services (*See* Criteria 1) and /or the availability of certain medical services that are not able to be performed in the home (*See* Criteria 2.)

Criteria 1: The patient's medical condition restricts his ability to leave the home: (a) without the assistance of another individual, (b) without the assistance of a supportive device, or (c) because absences from the home are medically contraindicated.

Criteria 2: The patient leaves the home: (a) only to receive medical treatment which cannot be provided in the patient's home, (i.e., dialysis, chemotherapy, radiation or other treatments that require equipment which cannot be made available in the patient's home) or (b) infrequently and for short periods of time for non-medical purposes, and these absences do not indicate the patient has the capacity to obtain health care provided outside, rather than inside, the home.

Kickback

This is an illegal activity where one knowingly or willfully solicits, receives, offers or pays anything of value to induce referrals.

Examples of kickbacks include:

- < Direct payment to physicians for each plan of care.
- < Disguising referral fees as salaries for services not rendered.
- < Free services to beneficiaries if they agree to switch providers.
- < Providing hospitals with services in exchange for referrals.
- < Free services to physicians' offices or personal care homes in exchange for referrals.

Anti-kickback statutes prohibit knowingly and willfully giving or receiving anything of value to encourage referrals. VNS prohibits any business arrangements wherein physician practices refer business to or order services and items from an outside entity on terms that do not represent fair market value. In addition, all business arrangements must be reviewed and approved by in-house legal counsel. By way of example, counsel should review any arrangements involving facility leases, equipment rentals, personal services and management contracts, sales of practices, referral services, discounts, and rebates.

Knowing or Knowingly

This means that a person: (a) has actual knowledge of the information, or (b) acts in deliberate ignorance of the truth or falsifies the information, or (c) acts in reckless disregard of the truth or falsifies the information.

Medical Necessity

Medical necessity is addressed to some extent below. Additional information is available through your Group Leader or the Quality Management Department.

Covered Skilled Nursing Services are reimbursable by Medicare if they are:

- Ordered by a physician.
- Provided by a registered nurse, or a licensed practical nurse or vocational nurse under the supervision of a registered nurse.
- Reasonable and necessary to the treatment of the beneficiary's illness or injury, and
- Required on an intermittent basis (*as discussed in* Section 205.1 of the Medicare Home Health Manual - HIM-11.)

Covered Skilled Therapy Services are reimbursable under Medicare if the services are:

- Ordered by a physician.
- Provided by a skilled physical, speech, or occupational therapist, or under the general supervision of a skilled therapist, and
- Reasonable and necessary to the treatment of the patient's illness or injury, or to the restoration or maintenance of a function affected by the illness or injury.

Non-Covered Therapy Services are:

- Exercises to promote overall fitness or flexibility.
- Exercises to promote diversion.
- Exercises to promote general motivation.
- Visits to the patient's home to teach other agency personnel a therapy routine. (This is an administrative cost to the agency.)

OIG (Office of the Inspector General)

The OIG was established at the Department of Health and Human Services (HHS) by Congress in 1976. Its purpose is to identify fraud, abuse and waste in Health and Human Services programs, including Medicare. The OIG performs nationwide audits, investigations and inspections.