HEALTH LAW
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ALERT

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OMIG Issues New Provider Compliance Regulations

Gregory J. Naclerio

On January 14, 2009, the Office of the Medicaid Inspector General (OMIG) published new regulations concerning provider compliance (See provider compliance at www.omig.state.ny.us).

The regulations apply to:

1. All Public Health Law 28 and 36 entities.
2. All mental hygiene entities governed by Article 16 and 31.
3. All Medicaid providers who orders receive or submit claims in the amount of $500,000 in a consecutive 12-month period.

Should the OMIG or the Commissioner of Health determine a required provider does not "have a satisfactory program," the provider may be subject to "…any sanctions and penalties permitted by federal or state law and regulations including revocation" of a provider's Medicaid status.

The OMIG's demand for provider compliance agreements is based upon Section 363-d of the social services law that was passed in 2006. That statute gave the OMIG the authority to promulgate rules pursuant to the new statute that became effective in January 2007. Now, two years later, those regulations have been made public.

THE PROGRAM

Initially, each required provider should have a compliance program that addresses:

- Billing
- Governance
- Payments
- Credentialing
- Medical Necessity/Quality of Care
- Mandatory Reporting
- Other risk areas identified by the provider

Moreover, a required provider's compliance program MUST include the following elements:

1. Written policies and procedures which include:
   a. A "Code of Conduct"
   b. The operation of the compliance program
   c. Guidance in dealing with compliance issues
   d. Communication of compliance issues
   e. How potential compliance problems are investigated and resolved
2. Designation of a Compliance Officer.
3. Training of employees, executives and governing body members.
   a. This training should occur "periodically" – once a year should be sufficient – for all new hires and governing body members.
4. A method by which to report compliance issues, including anonymous reporting and confidential good-faith reporting.
5. Disciplinary policies to encourage participation in the program.
   a. Articulate expectations for reporting.
   b. Provide disciplinary action for:
      i) Failing to report a suspected problem
      ii) Participating in non-compliant behavior
      iii) Encouraging others – actively or passively – to engage in non-compliant behavior
6. A system for identification of compliance risk areas specific to the provider's industry.
7. A system for investigating and correcting compliance issues.
8. A policy of non-retaliation for good faith participation in the compliance program.

THE PENALTY

If a required provider does not have an "effective and appropriate" compliance program, the provider can be subject to state and federal sanctions including revocation of the right to participate in Medicaid.

THE BOTTOM LINE

Many providers have – at best – given only lip service to §363-d. When it first became law there was a flurry of activity as providers scrambled to implement compliance programs. These compliance programs have generally been "paper programs" gathering dust along with the corporate kit. Providers generally don't want complaints made to the compliance officer. How many complaints has your "hot line" gotten in the two years since §363-d became law? What action have you taken to identify areas of compliance concern? When was your staff last trained in the compliance program?

Those who have dealt with OMIG auditors know how diligent they are on billing audits. I suspect we will see the same when compliance audits commence. OMIG is big on compliance and self-disclosure issues. Don't be one of the required providers who fails the test.

RMF
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