

JOB DESCRIPTION

Job Title: Quality & Compliance Officer

Date Effective:

Job Grade: Nonexempt

Reports To: Management

Job Summary: Responsible for creation, implementation, and maintenance of CHEC's Quality & Assurance Compliance Program. Check accuracy of diagnosis/procedure codes and works closely with staff to eliminate/solve issues.

Duties:

1. Accountable for meeting behavioral expectations: professionalism, supporting management, the dignity of all persons, and responsible stewardship of resources.
2. Responsible for creation, implementation, and maintenance of Quality & Assurance Compliance Program (see compliance program to follow).
3. Oversees an effective, ongoing training and/or educational program for all professional and support personnel on a yearly basis. (E.g., courses, videos, conferences, AAO or other ophthalmic specific coding/billing courses, OSHA, personnel laws. See list of library material to follow.) Routine staff training meetings held with minutes maintained. (Example of form to follow.)
 - a. Covering periodically new rules concerning record keeping/documentation of E&M codes.
 - b. Discuss appropriate use of ICD-9 and accident codes for identification of a patient medical problem and CPT-4 codes for coding a physician's services in response to medical problems.
 - c. Discuss carrier coverage guidelines.
 - d. Discuss medically unnecessary form and guidelines.
 - e. Identify and provide examples of misbilling and/or improper billing and legal ramifications.
 - f. Meeting minutes to reflect issues discussed and measure to resolve or minutes to reflect there were no issues to address.
 - g. Coordinate and log educational training for staff in coordination with CME coordinator.
 - h. Federal and State anti-kickback statutes, anti-trust, stark ban on self-referrals acts, Hippa's anti-beneficiary inducement provisions and their effect on transportation services, advertising and marketing prohibitions.
 - i. OSHA compliance - review and reinforce the importance of OSHA compliance. (Kip Crowell and Dr. Scott C. Richards oversee the OSHA training.)
 - j. FDA compliance.
 - k. Controlled Substance Act requirements.

- l. Labor laws.
 - m. Informed consent issues.
 - n. Ensures all employees and Physicians read “Part B Answer Book,” and sign completion roster, which is updated monthly. (Book is found in the Billing Department and example of log to follow.)
 - o. Ensures an independent coding/billing audit/review will be conducted every other year by a non-affiliated agency (E.g., Utah Ophthalmological Society).
 - p. A staff satisfaction survey may take place to help access and improve staff satisfaction and cohesiveness with employee/employer relationship(s).
4. Conduct random audits: There are two types of coding/billing reviews/audits. Pre-payment reviews done prior to a claim being submitted to the insurance company and post-payment review, which is completed after the claim has been submitted to the insurance company. Monitoring processes to assure accuracy in medical record entries, billing, and other systems believed to be in place are effective using designated audit forms (bases solely on what was written) will take place monthly (see audit forms to follow).
- a. Findings and recommendations will be in written form and results will be conveyed to staff and physicians with their role in the correction plan and a follow-up plan in place, identifying steps to be taken.
 - b. Monitoring appropriate documentation versus requirements is the key component of the compliance program.
 - c. Confirmations that the proper E&M codes are used, based on current HCFA guidelines (e.g., no up-coding or under-coding).
 - d. A minimum of five charts per physician per month.
 - e. Batching the audit process by ancillary service type ensuring all specific aspects of services are reviewed (e.g., hospitals, inpatient and outpatient, LASIK, Optical).
 - f. Monitor each sheet in the patient’s medical record for the patient’s name appearing on both sides of all double-sided forms and verify insurance information on billing form.
 - g. Monitor medical history and every progress notes or exam for signature by the physician. Audit comparing chart, fee ticket, EOBs, with the system looking for missing and/or incorrect charges, incorrect coding, or sequencing of codes, duplicate billings, claims/EOBs over and under reimbursed. Bundling or unbundling.
 - h. Confirmations that diagnosis codes on encounter forms match the conditions evaluated/treated and reflected in the medical record.
 - i. Confirmation that the physician’s signature is on each medical record.
 - j. Accuracy of date of service billed compared to the date in the medical record.
 - k. Medical necessity of procedures billed as covered services
 - l. Guidelines and process for medically unnecessary explanation and form for patient to sign.
 - m. Accuracy of “bundling” and “unbundling” of services billed according to CPT 99 or HCFA policies.
 - n. Accuracy of billing for “incident to” services.
 - o. Random copying of EOBs and/or use of the computer score program to evaluate fair and proper reimbursement patterns.
 - p. Review of fee ticket and computer system charge master or changes in codes and/or charges.

- q. Ensure HIV/chemical dependant patients sign a special authorization to release medical records. Monitor that protocol is followed for HIV/chemical dependant authorizations to release medical records. (See HIV/chemical dependant protocol - medical record policy to follow.)
 - r. Periodic review of CHEC laser log. (Book found by the Argon Laser.)
 - s. Review denials and troubleshoot resolutions to decrease occurrences. Ensure that denied claims and problem claims are appropriately corrected and expedited.
 - t. Federal and State anti-kickback statutes, anti-trust, stark ban on self-referrals acts, Hippa's anti-beneficiary inducement provisions and their effect on transportation services, advertising and marketing prohibitions.
 - u. OSHA compliance.
 - v. FDA compliance.
 - w. Controlled Substance Act requirements.
 - x. Labor laws.
 - y. Informed consent issues.
 - z. Ensures all employees and Physicians read "Part B Answer Book," and sign completion roster, which is updated monthly. (Book is found in the Billing Department and example of log to follow.)
 - aa. Ensures an independent coding/billing audit/review will be conducted every other year by a non-affiliated agency (e.g., Utah Ophthalmological Society).
 - bb. A staff satisfaction survey may take place to help access and improve staff satisfaction and cohesiveness with employee/employer relationship(s).
5. Mistakes or misconduct in billing will not be tolerated by CHEC or the State or Federal organizations. An intentional false claim is grounds for immediate termination.
- a. Honest mistakes are discussed, documented, and educational processes encouraged ensuring future accuracy and compliance. The issue(s) is documented and personnel given a chance to correct the error and improve.
 - b. IF error persists, the issue is then discussed again and documented. A third occurrence results in termination. Document each occurrence and measure follow-up on results to determine group success.
6. Physician's to audit each other's charts at least yearly. If you wrote it you know what you meant, it may not be obvious to the reader.
7. CHEC will conduct a coding/billing audit every other year by and independent agency. (E.g., UOS, UOA.)
8. Monitor, log, and resolve messages left on the 24-hour compliance voice mail hotline (ext.#530). This line is intended for personnel to leave anonymous messages regarding any concerns pertaining to State and Federal compliance, which an employee feels CHEC may not be compliant with. Issues and measures to resolve and results discussed at staff meetings with general thank you for participation and ongoing invitation for all to participate.

9. Personnel process of responding to identified offenses is as follows:
 - a. Personnel must communicate in writing, in person, or by phone mail to the compliance office (ext.#530) and/or Management immediately. The compliance officer will report to Management. Corrective action initiatives will be applied.
10. Monitors logged results of patient satisfaction questionnaire and reports results to staff and Management.
11. Check accuracy of diagnosis and procedure codes regarding services rendered and cross reference to insurance coverage. Re-bills insurance when necessary.
12. Return to the Physicians any claims or documentation issues requiring additional information from Physician.
13. Confirmation that procedures are in place to notify employees of changes in billing rules.
14. Processes and submits all electronic claims daily.
15. Close out “day” and reconcile all batches by begin of business each day. Working provider report to ensure all charges are entered and billed on correct provider prior to electronic claims submissions.
16. Completes and ensures accuracy and timeliness of month-end close.
17. Update, and responsible for proper training on computer system to ensure vital deletion of data does not occur, the patient insurance and demographic information as necessary and/or applicable.
18. Manage workload to meet Accounts Receivable Days and Bad Debt goals.
19. Responsible for charge entry and monitoring of coding accuracy of all surgical procedures and follow-up of fair, proper, and timely payment.
20. Oversees quality and productivity of Check-In and Check-Out to include ongoing training.
21. Ensures applicable regulatory requirements are complied with and follows guidelines that maintain safety for oneself, patients, visitors, and co-workers.
22. Balances Account Receivables system process on computer (out of balance steps) through utilities.
23. Confers with personnel and Management on patient account/billing issues.
24. Coordinates running of month end process and procedures.
25. Establish and maintain operational environment that responds to the needs of the accounts.

26. Prepares required reports when/as necessary within the requested time frame.
27. Achieved proficiency of computer systems.
28. Performs secretarial and clerical duties for physician, as requested.
29. Participates in continuing education and other appropriate experiences to maintain and enhance professional competence.
30. Maintains patient confidentiality 100% of the time; demonstrates complete discretion when discussing patient information.
31. Always appears well groomed and presents a positive and professional manner to the patients, other professionals, and staff.
32. Maintains established office policies and procedures, follows OSHA guidelines.
33. Consistently is on time and ready to begin work at the start of the workday. Does not abuse or take advantage of sick time or personal days.
34. Maintains an organized and clean office or work area.
35. Must be flexible and committed to being a team player.
36. Other duties as assigned by the Physician and/or Management.

EMPLOYEE	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Melanie	Run Analysis Of Service Report For Prior Week To Select Charts To Audit. Meet With Susanne To Present Audit Findings.	Audit Two Physician's Charts For Proper Documentation.	Audit Two Physician's Charts For Proper Documentation. Audit Pods' Tracking Logs.	Audit One Physician's Charts For Proper Documentation.	OFF
Patti	Analyze, Log, Chart, And Input All Material From The Audit For Presentation. Meet With Susanne To Present Audit Findings.	Run Analysis Of Service Reports And Perform Follow-Up Audits.	OFF	Audit A Couple Of Physician's Charts For Proper Documentation.	Audit A Couple Of Physician's Charts For Proper Documentation.
	MONTHLY PROJECTS				
Melanie	Audit Physicians' Charts, Fee Tickets, Billing, and EOB for Reimbursement Issues. Audit also for Sequencing of CPT Codes with Proper Diagnosis. Attend Monthly Staff Meetings.				
Patti	Audit Physicians' Charts, Fee Tickets, Billing, and EOB for Reimbursement Issues. Audit also for Sequencing of CPT Codes with Proper Diagnosis. Assemble Medicare Packets and Distribute to All Employees. Attend Billing and Clinical Staff Meeting, Prepare Subject Matter That I Will Present. Browse Through Waiting Areas and Talk to Patients to Gather Patient Data. Input Patient Satisfaction Surveys.				

Qualifications:

- ?? High school graduate or equivalent with 2-3 years related work experience in a medical business office or clinical setting required.
- ?? Procedural Coder, certification preferred.
- ?? Must demonstrate knowledge of CPT and ICD-9 coding.
- ?? Extensive experience with medical terminology required.
- ?? Proficient knowledge with insurance companies and their various requirements.
- ?? Ability to successfully interface with patients, insurance companies, clinic, and CHEC staff.
- ?? Dependable. Ability to manage multiple priorities. Detail oriented.
- ?? Excellent written and verbal communication skills.
- ?? Computer literate: Windows, MS Word, MS Excel, PerfectPracticeMD (formerly POM). Ability to learn computer programs quickly and effectively.
- ?? Typing 40 wpm preferred.
- ?? 10-key calculator skills.
- ?? Required machine skills:
 - ☞☞Phone
 - ☞☞Adding machine/calculator
 - ☞☞Computer
 - ☞☞Photocopier
 - ☞☞Fax