



Welcome to the Step by Step: Initiating and/or Enhancing Billable Services Module 3:
Corporate Compliance: Concepts for Policy and Procedure Development

RR Health Strategies

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Learning Objectives

- Describe the core elements of corporate compliance
- Discuss both internal and external audits including corrective action
- Examine the rules and regulations of non-physician practitioner services
- Describe other elements of corporate compliance (human resources, occupational safety, and laboratory testing)

Corporate Compliance

What is a Compliance Program?

A compliance program will help preserve an organization's commitment to being honest and accountable by identifying and averting illegal and unethical conduct; improving the quality and consistency of patient care; and developing procedures for rapid and systematic investigation of misconduct.



Compliance programs will vary based on size or organization and resources.

Why Does Our Practice/Clinic Need a Compliance Program?

- Increase in Office of Inspector General (OIG), & Office of Civil Rights (OCR) administration
- Health care fraud and abuse laws including associated penalties
- Patients are more knowledgeable
- Whistleblowers
- Criminal, civil and administrative penalties
- Reduce billing errors
- Outline expectations for employee behavior
- Federal Sentencing Guidelines offer relief for having an effective compliance program by reducing fines
- Patient safety



A compliance program will:

- Ensure employees understand the Federal Law regarding compliance and the consequences of violating it.
- Cultivate a culture of compliance within your practice/clinic.
- Educate your practitioners and office staff on what to do when a compliance issue arises.

Compliance Program Challenges

- The Patient Protection and Affordable Care Act (“ACA”) initiated the change from voluntary to mandatory compliance programs for health care providers who participate in federal health programs
- In addition to seven listed Elements of the OIG Compliance Program, ACA established element number eight



-The Affordable Care Act of 2010 mandates that all health care entities and providers participating in federal health care programs, including individual and small-group physician practices, implement effective compliance programs.

- A Compliance program is not simply having a manual. The program involves conducting audits, training employees, and enforcing disciplinary standards through policies and procedures.

Core Element #1

Written Policies, and Procedures and Standards of Conduct

Must have policies, procedures and standards of conduct that:

- Articulate commitment to comply with Federal and State standards
- Describe compliance expectations
- Implement operation of compliance program
- Provide guidance on dealing with compliance issues
- Identify how to communicate compliance issues
- Describe how compliance issues are investigated and resolved
- Include policy of non-intimidation and non-retaliation



- Generic, “off the shelf” manuals will not provide practice/clinic specific P&P’s.
- Generalized P&P’s can be more harmful than helpful to your organization.

Core Element #2

Compliance Program Oversight: Compliance Officer

- Reports directly to and is accountable to Chief Executive Officer (CEO) or other senior management
- Is vested with day-to-day operations of the compliance program
- Is an employee of the organization, its parent company or a corporate affiliate
- Periodically reports directly to the governing body on activities and status of compliance program, including issues investigated, identified and resolved by compliance program



- The CO must understand the importance of his/her role in the organization and take their job responsibilities seriously.
- The CO should be a certified compliance professional.

Core Element #3

Training and Education

- Establish, implement and provide effective training and education for employees, including senior administrators or managers
- Training and education must occur at least annually and be made a part of the orientation for new employees



- Some basic staff training may be performed by the CO.
- Other more specific training, such as coding and documentation requirements and HIPAA, may be best performed by an outside vendor.

Core Element #4

Lines of Communication

- Establish and implement effective lines of communication (e.g., memos, email, scheduled meetings)
- Accessible to all including governing bodies, administration and related entities
- Method for anonymity and confidentiality
 - Would your employees feel comfortable reporting suspected noncompliance?
 - Feedback during exit interviews?
 - Non-retaliation policy?



- Your staff should feel that they can anonymously report a compliance issue.
- The non-retaliation policy should be strictly enforced. This will allow staff to report issues without concerns about their position.

Core Element #5

Establish and Maintain Disciplinary Policies

- Identify noncompliant, unethical or illegal behavior, through examples of inappropriate conduct employees might encounter in their jobs
- Provide for timely, consistent and effective enforcement of standards
- Disciplinary action must be appropriate to seriousness of violation
- Employees must know what to expect should they violate standards of conduct or ethical requirements
- Disciplinary measures must be consistently enforced across the organization



- Disciplinary P&P's should be drafted and review with Legal before implementation.
- The CO must strictly enforce disciplinary policies.
- All members of Administration should reinforce and stand behind these P&Ps.

Core Element #6

Monitoring, Auditing and Risk Identification

- Internal monitoring and audits
 - **Monitoring:** Regular reviews performed as part of normal operations, to confirm ongoing compliance
 - **Auditing:** Formal reviews of compliance, with particular set of standards as base measures
- External audits
- Compliance with CMS requirements
- Effectiveness of Compliance Program



- Ongoing internal monitoring is an essential function to ensure appropriate coding and billing functions.
- A formal audit (preferably performed by an certified external auditor) will provide validation or identify potential risk areas.

Monitoring Versus Auditing

Monitoring

- The on-going, day-to-day process that ensure that things do get done on time and correctly

Auditing

- The process of going back and looking at some thing or some part of an ongoing process that is completed and checking to see whether it was done and, if it was done, was it done correctly



- The Practice Administrator and the Billing Manager should work together to identify the areas to be monitored on a quarterly basis.
- A formal audit will review provider documentation to validate if the services (E/M, CPT, ICD-10 and modifiers) are supported by the documentation.

Core Element #7

Responding to Compliance Issues/Corrective Action

- Step 1: Clearly state the problem or weakness, including the root cause
- Step 2: List the individuals who will be accountable for the results of the corrective action
- Step 3: Create simple, measurable solutions that address the root cause
- Step 4: Each solution should have a person that is accountable for it
- Step 5: Set achievable deadlines
- Step 6: Monitor the progress of the plan



- Likely the most difficult aspect of the compliance program requirements.
- Depending upon the issue identified, legal or a compliance consultant may need to be engaged for assistance and guidance.
- Once you are aware, you must act!

Core Element #8

Assess the Compliance Program and Activities

- U.S Sentencing Guidelines emphasize the importance of assessing compliance programs
- A compliance program must be well-designed, applied in good faith, and implemented across the organization
- The assessment focus is to confirm the program is structured properly to deter and detect actual or potential violations or law



- This added step is fairly new and organizations are responding differently based on their compliance program activities and resources.
- Even the most basic steps for assessment and validation should be instituted.

Program Audits

Internal Audits

- Health Insurance Portability and Accountability Act (HIPAA) Security Audits
- HIPAA Privacy Audits
- Billing Audits
- Coding Audits



- Various audits will be required based on the different potential risk areas.
- This will require various levels of knowledge and expertise.

HIPAA Security Audit

Management Process

- Review annual risk assessment
- Review system activity based on audit logs and access reports
- Consult with department managers, Information Technology (IT) and Human Resources regarding security violations and sanctions imposed on employees

Clearance and Authorization

- Review policies and procedures for the authorizing; provisioning and de-provisioning; and supervising of appropriate access of eProtected Health Information (PHI) to workforce



- The Security Officer, along with management, should designate a month in which all HIPAA tasks are performed (e.g., risk assessment, training, policy review).
- Appropriate access to electronic PHI does not only mean via a PC. Security incidents occur related to the use of laptops, other portable and/or mobile devices and external hardware that store, contain or are used to access electronic PHI.

HIPAA Security Audit

Workforce Security

- Test **SYSTEM** user list against termination list; review for former employees

Awareness and Training

- Review system requirements and capabilities to monitor log-in attempts and reported discrepancies
- Review procedures for creating, changing, and safeguarding passwords
- Review training program



- Develop a practice/clinic checklist for terminated employees which should be signed off by management. Include things such as building badge and/or key return and the deactivation of usernames and passwords.
- Many of the items that are required to be tracked for Security purposes can all be placed on one (1) spreadsheet with various tabs.

HIPAA Security Audit

Incident Procedures

- Survey employees regarding procedures on how to recognize and report suspected/known security incidents

Contingency Plan

- Review policies and procedures for continuation of critical business processes for protection of the security of ePHI while operating in emergency mode



- All security incidents must be documented with remediation.
- The Contingency plan is a policy that is required for HIPAA Security Compliance and the specific procedure must be written specifically for your practice/clinic.

HIPAA Security Audit

Business Associate Contracts

- Validate existence of current Business Associate Agreement (BAA)

Facility Access Controls

- Observe if employees wear identification (ID) badges

Workstation Security

- Evaluate workstation security and proper disposal of paper PHI

Access Controls

- Review application user ID list to ensure that ID's are not shared among the workforce



- The practice/vendor list should be reviewed yearly for new vendors and the corresponding BAAs.
- Various aspects of the HIPAA Audit are performed by simply walking through the practice/clinic.

HIPAA Privacy Audit

- Based on the organization's regulated HIPAA Program
- Sample audit monitors:
 - Confidential Conversations
 - Visible PHI (computers, desks)
 - Trash and Shred Bins
 - Notice of Privacy Practices (distributed, signed)
 - Training



A standardized Privacy Audit Monitor should be established for ease of tracking progress and deficiencies.

Billing and Coding Audits

- **Objective:** to determine compliance with the Centers for Medicare and Medicaid Services (CMS) rules and regulations for coding and billing
- Specific local and Department of Health (DOH) requirements must be considered
- **Scope:** Includes sample charts to claim and code review for a selected sample
- Selection of scope may be specific to a particular service



- Billing audits should include the claim and carrier EOBs.
- Coding audits focus on the provider documentation compared to the coding submitted.

Billing and Collection of Patient Co-Payments, Coinsurance and/or Deductibles

- Make a good faith effort to collect all applicable copayment, coinsurance and/or deductible amounts owed by patient
- A patient's copayment, coinsurance and/or deductible amounts may be waived, and/or free or discounted services may be offered as a professional courtesy (limited circumstances, policy and procedure is required)
- Notify patients of their potential financial responsibility (form outlining practice/clinic's financial policy should be reviewed, in detail with patient and signature must be obtained)
- Patients should not be notified that payment by their insurance carrier will be accepted as "payment in full" or that they will not be responsible for any applicable copayment, coinsurance and/or deductible amounts
- Limited circumstances for waiving or discounting patient copayment, coinsurance or deductible amounts. Financial hardship must be proven.



- The law does not allow routine write-offs of co-pays and deductibles without risk to for violating payer contracts or federal and state laws.
- A provider may waive a coinsurance or deductible amount in consideration of a particular patient's financial hardship.

Billing and Coding Audit Plan

The audit plan should answer the following questions:

- What is the audit focus? (e.g., medical necessity, copy and paste, high level evaluation/management (E/M) services)
- Will the selection be generated from paid or unpaid claims?
- Which claims or charts will be audited?
- What method will be used for tracking the data?
- What information should be included in the report?
- Who will the report be reviewed with?
- Who will be responsible for the Corrective Action Plan?



Billing Audit:

- When selecting the focus of the audit, target potential areas of risk (high level E/M services, new procedures, highly reimbursable procedures, etc)

Coding Audit:

- A random select is always best.
- The common number of encounters to be reviewed is 5 or 10 encounters per provider.

Sample Billing and Coding Audit Spreadsheet

Audit Steps:																				
Audit Name:																				
Purpose:																				
Assumptions:																				
Source(s):																				
Preparer:																				
Reviewer:																				
Date:																				
Tickmark Legend:																				
QUALITY ASSURANCE <small>(Additional audit steps may need to be added when regulatory requirements are tested to determine compliance)</small>																				
STANDARD CODING AND BILLING <small>(Additional audit steps may need to be added depending on audit plan)</small>																				
DEMOGRAPHICS																				
QUALITY ASSURANCE																				
STANDARD CODING AND BILLING																				
Audit Steps	MFN	HAR	DOB	Hospital Admit Date/ Hospital Discharge Date	Physician Order Written and Signed	Audit Step identified to determine compliance with specific CMS, CoP or TJC	Audit Step identified to determine compliance with specific CMS, CoP or TJC	Claim is available for review	Claim Type Correct	Revenue Codes Correct	Procedure Codes Correct	Facility ICM Code (Facility Audit, if applicable)	CPT/ HCPCS Code Correct	NDC# (Pharmacy Audit only) Correct	NDC ID# (Pharmacy Audit only) Correct	Units Billed (Pharmacy Audit only) Correct	Principal Diagnosis Correct	ICD-10 Codes Correct	Physician on Claim Correct	
CMS/TJC/ Additional Government Requirements	The Joint Commission			CMS Requirement	CMS, CoP, TJC Requirement	CMS, CoP, TJC Requirement														
Determining																				
Correct Data																				
Location in EMR																				



- Be sure to utilize a template or spreadsheet that allows the reviewer to capture consistent data for all encounters.

External Audits

- Medicare Administrative Contractors (MAC)
- Medicare Recovery Auditors (formerly “RAC”)
- Office of the Inspector General (OIG)
- Department of Justice (DOJ)
- Health Resources and Services Administration (HRSA)
- State Attorneys General
- Third-party Payors



- These audits are occurring routinely.
- The Federal payers have outsourced resources to assist in the high volume of audits being conducted.
- Be sure to respond to carrier requests timely and thoroughly.

Corrective Action for Audits

- Draft report summarizing issues identified
- Final report with recommendations
- Follow-up on status of implementation of recommendations/corrective actions
- Identify monitoring activities for long-term compliance
- Establish follow-up reporting timeframes
- Education and training



- Once an issue has been identified, the practice/clinic must develop a plan of action to correct the issue(s).
- This may not be correctable overnight but the organization must be committed to the plan to correct the issue.

Non-Physician Practitioner (NPP) Services: Understanding the Rules

Key Incident-To Elements

- An integral, although incidental part of the physician's professional service
- Services are of a type that are commonly furnished in a physician's office or clinics
- Allows the physician to be paid for services provided by an NPP
- It is "transparent" to the payors

Incident-to claims look just like a claim for a physician service

- CMS was the 1st payer to recognize NPPs as billing providers.
- The reimbursement is 85% of the physician fee schedule.
- Incident-to allows the NPP service to be billed under the MD name and NPI to collect the 100% reimbursement.

Medicare Requirements

Elements of the following four key criteria must be met in order to bill Medicare for an incident-to service:

1. Site of Service
2. Type of Personnel
3. Type of Service
4. Level of Physician Involvement

The Medicare I-2 guidelines are stringent and not easy to follow for all services.

Medicare Requirements

The NPP and the physician must be employed by the same entity or the services/supplies are furnished by an individual who qualifies as an employee of the physician

- W2, 1099 or leased employee

Initial Service:

- “There must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the NPP is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his/her continuing active participation in and management of the course of treatment”

- There must be a financial tie between the MD and NPP for I-2 to apply.
- A new patient visit can NEVER be billed as I-2.

Medicare Requirements

Established Plan of Care:

- The individual providing the incident-to service should:
- Document the “link” between their face-to-face encounter with the patient and the physician’s preceding service to which their service is incidental.
- Reference by date and location the precedent providers’ service that supports the active involvement of the physician
- Clearly note the supervising physician for the encounter

- The MD must establish the POC that will be followed explicitly by the NPP.
- The NPP should be “linking” to the MD’s POC in the follow-up visits.

Medicare Requirements

- Medical Doctor (MD) must be in office suite
- MD must maintain direct supervision
- MD does not have to see patient
- NPP can see only established patients (not new patient or new problem) for “incident to”

- The in office and direct supervision requirements mean that the MD must be immediately available and in the suite.
- It must also be an established patient with no change in the MD’s POC – e.g.; increasing or decreasing Rx by MD, ordering labs, providing Rx for Physical Therapy, etc.

What Qualifies as “Direct Supervision?”

- The physician whose name and National Provider Identifier (NPI) number will be used on the claim form for billing purposes ***must be physically present*** in the office suite and immediately available to provide assistance and direction as necessary
 - *Verify that you have proof that a supervising physician was actually onsite and available for the date of service*

Direct supervision mean “immediately” available.

Who is the Supervising Physician?

- If the physician is part of a group practice, any group member can supervise the incident-to service
- The physician who initiated the plan of care does not need to be present in the office during the incident-to service, provided that another group member physician is available in the office when the encounter occurs

- The supervising MD must be available in the office when the patient is being seen by the NPP.
- If the MD is on vacation or out of the office, another MD from the group (of the same specialty) can supervise.
- The service must be billed in the name and NPI # of the MD in the suite providing supervision.

Incident To” Link – Best Practices

Evidence of the link may include:

- A co-signature or name and credentials of both the practitioner who provided the service and the supervising physician on the patient's chart
- While co-signature of the supervising physician is not required, it is suggested as a means of verifying the physician's availability for oversight
- Some indication of the supervising physician's involvement with the patient's care. The indication could be satisfied by:
 - Notation of supervising physician's involvement within the text of the associated medical record entry
 - Documentation from other dates of service (e.g. initial visit) other than those requested, establishing the link between two providers

- The I-2 guidelines do not require the MD sign the NPP's note.
- This is a best practices recommendation.
- The 4th requirement for I-2 is that the MD stay actively involved in the care of the patient. Reviewing the medical record documentation by the NPP can be considered maintaining involvement.

Incident-To Guidelines	
Requirements	<ul style="list-style-type: none"> • Physician must personally perform the initial services. Follow-up visits can be performed by the NPP as “incident to” • Best practice and strongly recommended by National Government Services (NGS) that the NPP is participating in the Medicare program • Physician must remain actively involved during the treatment course • Physician must be immediately available in the office suite for direct supervision • Follow-up visits by the NPP must be within the physician’s Plan of Care (POC) (not a new problem/not a new patient)
Examples	<ul style="list-style-type: none"> • The physician initiates treatment for hypertension and the NPP conducts follow-up visits to monitor the treatment over weeks, months or years. The MD does not need to see the patient, but must be present in the same office suite and immediately available. • Physician initiates the POC and orders injections (documentation shows drug, dosage, route and frequency). The injection administered by NPP or ancillary personnel. Services are billed under the supervising MD. The MD does not need to see the patient, but must be present in the same office suite and immediately available. • RN removes uncomplicated sutures (previously placed by the physician). The MD does not need to see the patient, but must be present in the same office suite and immediately available.

The examples provided in this slide will serve as a resource for you/the organization.

Incident-To Guidelines	
Documentation	<ul style="list-style-type: none"> • Clearly state reason for the visit • Means of relating the visit to the initial service and/or ongoing service provided by the physician • Patient progress, response to POC • Signature of the person providing the service • Evidence that the physician is actively involved in the care of the patient and was present and available during the encounter (co-signature or proof of continued involvement) • Documentation must support Level of Service (LOS) billed
Applicable to	Only physician's office, Place of Service (POS) 11
Facts	<ul style="list-style-type: none"> • Does not apply to Article 28 Clinics – POS 22 • NPP should bill under their own NPI when: <ul style="list-style-type: none"> • seeing new patient • physician is not immediately available in the office to provide direct supervision • independently seeing established patients with new problems • independently formulating a new POC • Services for established patients with new problems or new POC that are shared between the physician and the NPP may be billed by the physician if there is a medically necessary face-to-face services documented

- Documentation is the key element for I-2 services.
- The MD must document and clear and concise POC for the NPP to follow.
- The NPP must be sure to follow the POC or bill service independently.

Human Resources and Occupational Safety and Health Administration

Human Resources

- Employment laws are ever-changing and vary state to state
- Fines for noncompliance: the average lawsuit settlement is \$165,000
- Minimum requirements for an effective Human Resources Department:
 - Organization model
 - Hiring Processes and Standards
 - Compensation and benefit rules
 - Employee relations and support
 - Safety, security, and Workers' Compensation
 - Accurate recordkeeping and documentation



- - Human resources oversees and implements the organization's policies and procedures
- A resourceful HR department provides guidance to employers and employees for standard and compliant practices under current employment laws

OSHA

With the Occupational Safety and Health Act of 1970, Congress created the Occupational Safety and Health Administration (OSHA) to assure safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education and assistance

- Provide OSHA training to all employees
- Keep a record of all safety and health trainings



- OSHA standards protect both the practice/clinic and the employee.
- OSHA standards identify possible causes of job-related injuries and require explanation for procedures and equipment that can pose to be a workplace hazard.

OSHA Guidelines

1. **Bloodborne Pathogens:** universal precautions, post-exposure medical exams, Hepatitis B vaccine, and use of color coding to indicate different types of regulated waste
2. **Ionizing Radiation:** x-ray equipment and all doors to rooms containing x-ray equipment to be labeled with signs reading “Caution: X-Ray Radiation”, monitor badges, and restricted access
3. **Hazard Communications:** list of hazardous chemicals and Material Safety Data Sheets
4. **Fire and Exits:** safe and accessible exits and prominent EXIT sign placement



- OSHA compliance for practices/clinics should focus on training and record keeping of all incidents.
- Annual training should include all OSHA updates within the past year.

Clinical Laboratory Improvement Amendments (CLIA)

CLIA

CLIA regulations define three categories of testing complexity:

- **Waived Tests** are simple laboratory examinations and procedures that have an insignificant risk of an erroneous result such as rapid streptococcus and Human Chronic Gonadotropin (HCG)/pregnancy testing. Waived tests include test systems cleared by the FDA for home use.
- **Moderately Complex Tests** are those that are available on automated clinical laboratory equipment such as electrolyte profiles, chemistry profiles and complete blood count.
- **Highly Complex Tests** include those that require clinical laboratory expertise beyond normal automation to perform. Examples include cytology, immunohistochemistry, peripheral smears, flow cytometry, gel electrophoresis, and most molecular diagnostic tests.



- CLIA categorization is determined after the FDA has cleared or approved a marketing submission.
- The FDA determines the test's complexity by reviewing the package insert test instructions.

CLIA: Benefits of Testing

Some of the benefits of performing waived testing include:

- Rapid availability of test results while the patient is available for immediate follow-up
- Simple tests have minimal need for training
- Portability of many waived tests allows for easier testing in nontraditional settings



Waived tests represent a compromise between access and quality of care.

CLIA: Issues to Consider

- Testing oversight: Staff member assigned responsibility for managing testing and decision-making to assure quality testing
- Regulatory requirements: Practice/clinic will need to follow applicable federal, state, and/or local requirements for testing, safety, confidentiality, and privacy
- Location for testing: Testing will need to be performed in a location with adequate space, an appropriate physical environment, and accommodations for proper disposal of biohazardous waste
- Selecting tests: Consider the test characteristics, sample requirements, and costs when selecting tests

Being able to maintain a consistent high level of quality and service should be part of the decision to offer testing.

CLIA: Issues to Consider

- Testing personnel: Personnel who perform testing will need to be trained and periodically assessed on their ability to perform quality testing
- Starting to test: Ensure understanding and follow the current manufacturer's instructions
- Quality assurance: Continually monitor, evaluate, and identify ways to improve the quality of testing

- The practice/clinic that decides to perform waived testing should identify one person responsible for overseeing testing and decision-making (e.g., provider or manager) who has the appropriate background to make decisions about laboratory testing.

CLIA: Certification Requirements

- Agree to abide by CLIA regulations that laboratory testing procedures will ensure timeliness, accuracy and dependability irrespective of the location of the tests. This includes maintaining complete policies and procedures, conducting staff training, and retaining accurate quality control documents
- Complete an application (Form CMS-116) available online at www.cms.hhs.gov/clia or from your local State Agency
- Forward a completed application to the address of the local State Agency for the State in which the laboratory is located. A list of State Agencies is available on the above site



- CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the CLIA.
- All clinical laboratories must be properly certified to receive Medicare or Medicaid payments.

Case Study

HIPAA Compliance

Challenge: A small family practice with three doctors and one physicians assistant whose been providing outstanding health care to their patients for the past three decades. They have been utilizing an EMR since 1994 and have never performed a HIPAA Security Risk Analysis to help them gauge their compliance and attest for meaningful use.

Solution: The practice sought assistance from a consulting firm that specialized in compliance after working with their EMR vendor and struggling with the complicated reports that would present. They performed a full HIPAA Security Risk Analysis helping to identify processes and procedures that needed to be put in place as soon as possible to ensure HIPAA compliance.

Result: Through this training and understanding requirements, the practice implemented processes and procedures to help them become HIPAA compliant.



Session Highlights

- Importance of a Corporate Compliance Program
- Conducting Audits: HIPAA, Billing and Coding
- Non-Physician Practitioner Guidelines
- Significance of Human Resource functions in the day-to-day operations of practice/clinic
- OSHA Guidelines for Medical Practices/Clinics
- CLIA considerations

Session 3 Mini-Assignments

- A Corporate Compliance Program begins with the formulation of policies and procedures. List the practice/clinics available written policies and procedures (e.g., front desk, finance, patient care policies)
- List the types of any internal audits currently conducted in your practice/clinic
- Formulate a list of any follow-up questions regarding Non-Physician Practitioners
- Assess your practice/clinic's Human Resource Department and its activities
- Obtain the date of your practice/clinic's most recent OSHA training
- Draft a list all laboratory testing currently performed in your practice