

CourseAvenue's eComply for Healthcare series provides healthcare compliance courses written by CCH, a part of Wolters Kluwer Law & Business, a leading provider of research products and software solutions in key specialty areas for legal and business professionals.

CourseAvenue is leading the simplification of creating and distributing eLearning compliance courseware. All courses are published in SCORM/AICC standards-compliant formats, integrating seamlessly into LMS systems used by healthcare organizations today.

The following courses are included in CourseAvenue's eComply Healthcare Series of eLearning courses. More information can be found at www.courseavenue.com/ecomply-healthcare.aspx.

Course Title	Course Description
Advance Notification of Medicare Noncoverage	This course will assist healthcare providers in understanding when it is appropriate to use either an ABN or an HINN. In addition, this lesson will illustrate the elements that ABNs and HINNs must contain in order to provide effective notice to beneficiaries that Medicare is unlikely to, or will not, reimburse for a healthcare product or service.
Advanced EMTALA	In your role as an emergency service provider, you deliver life-saving care. Your treatment decisions are complex and must be made quickly. The importance of emergency care is also recognized in the law. EMTALA requires that Medicare-participating hospitals with emergency departments respond to the medical needs of individuals with emergency medical conditions, including women in labor. Generally, such individuals must be given medical screening examinations and appropriate treatment to provide medical stabilization. However, complying with EMTALA is a complex undertaking with different requirements for various situations. The purpose of this lesson is to help emergency department personnel understand their responsibilities in complying with EMTALA requirements.
Alcohol and Drug Abuse Medical Records	This course covers the content of the Alcohol, Drug Abuse, and Mental Health Administration Act. The concept of "records" as defined by the Act will be discussed, as well as the restrictions placed on the disclosure of these drug and alcohol abuse records. An understanding of these concepts will help to prevent violations of the Act, which could subject violators to criminal fines.
Ambulatory Surgical Centers	This course will provide administrators, executives, and physician investors with a detailed discussion of the relevant factors involved in the development of an Ambulatory Surgical Center (ASC). The first half of the lesson will provide an overview of key federal and state licensure issues and also will discuss Medicare reimbursement principles, including the primary financial incentives and limitations that impact the operation of an ASC. The second half of the lesson is geared towards properly structuring transactions involving the development of an ASC and will discuss relevant anti-kickback safe harbors and exceptions to the STARK legislation.
Anti-Kickback Law and Ambulance Restocking	Sometimes a hospital restocks an ambulance with drugs and supplies used while transporting a patient to that hospital. If the restocking is done free of charge, it may violate the federal law prohibiting kickbacks. In this course you will be exposed to how to help hospital emergency room directors, pharmacy managers, and compliance officers understand what activities may constitute violations of the anti-kickback statute.
Basic EMTALA	This course provides an overview of the basic requirements of EMTALA including a hospitals duty to provide appropriate medical screening examinations and stabilizing medical treatment. the course also covers the circumstances under which an individual may be transferred from one emergency department to another in compliance with EMTALA.

Course Title	Course Description
Basic Hospital Patient Rights	The Centers for Medicare & Medicaid Services (CMS) mandates specific standards of patient rights in its Condition of Participation (CoP) for Hospitals: Patients Rights. Hospitals must follow these standards to participate in Medicare and other federally funded healthcare programs. This lesson focuses on what hospitals must do to comply with CMS requirements.
Billing for Services and Supplies Incident to Physician Services	This lesson defines the term "services and supplies incident to a physician's professional services" and identifies the non-physicians to whom this term applies for purposes of Medicare reimbursement. This lesson also discusses other issues related to the use of and billing for services provided by non-physicians.
Civil False Claims Act Training	On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law. Certain parts of the DRA are intended to reduce and control federal spending on Medicaid program benefits. Section 6032 of the DRA creates a new requirement that certain entities participating in the Medicaid program must establish policies to inform their employees, contractors, and agents about state and federal false claims laws, whistleblower protections, and the entity's own policies for detecting and preventing fraud and abuse. The purpose of this lesson is to introduce you to the new employee-education requirements and provide a basic understanding of the laws that must be described within the policy.
Compliance Basics for Physicians	The Office of Inspector General of the Department of Health and Human Services has published a range of Compliance Program Guidance documents, including one for Individual and Small Group Physician Practices. OIG indicated that these guidelines are not mandatory or all-inclusive, but can be helpful in developing a voluntary and active physician practice compliance program. This course examines four major areas where individual and small group physician practices are most at risk for violations, and suggests basic methods for avoiding compliance problems in each of them.
Compliance by Inpatient Psychiatric Hospitals	This course includes a description of the legal criteria for certification as a psychiatric hospital under the regulations, an explanation of the requirements for reimbursement of inpatient psychiatric services, how to determine whether the patient has exceeded the prescribed benefit period, what kinds of psychiatric services may be reimbursed, and the criteria under which a psychiatric patient may be placed in seclusion or restraint.
Compliance for Nurses	Like all other medical professionals, nurses must comply with a variety of state and federal laws and regulations. This course includes information on licensing laws, medical records requirements, quality of care standards, and laws designed to prevent fraud and abuse.
Compliance Issues for Academic Medical Centers	This course describes how to comply with the applicable requirements for Medicare reimbursement of costs associated with Academic Medical Centers while also complying with the requirements of the self-referral exception.
Compliance Process I	In healthcare, perhaps more than in any other American industry, the violation of a recently implemented law or an obscure regulation can result in severe and potentially devastating penalties. In self-defense, most hospitals take a systematic approach--generally known as compliance planning--to deter, detect, and correct violations of healthcare laws and regulations. This lesson, together with Compliance Process II: Anonymous Reporting Systems and Preventing Violations and Compliance Process III: Reporting, Investigating and Responding to Compliance Complaints, outlines the elements of a hospital compliance program that meets the minimum standards for such programs established by the OIG of the Department of Health and Human Services, specifically addressing: - The seven elements of an effective compliance program - Standards of conduct - Compliance officers and compliance committees - Compliance education and training

Course Title	Course Description
Compliance Process II	In healthcare, perhaps more than in any other American industry, the violation of a recently implemented law or an obscure regulation can result in severe and potentially devastating penalties. In self-defense, most hospitals take a systematic approach--generally known as compliance planning--to deter, detect, and correct violations of healthcare laws and regulations. This lesson, together with Compliance Process I: Elements of Effective Compliance, and Preventing Violations and Compliance Process III: Reporting, Investigating and Responding to Compliance Complaints, outlines the elements of a hospital compliance program that meets the minimum standards for such programs established by the OIG of the Department of Health and Human Services addressing: - Anonymous reporting systems - Screening of employees, other hospital personnel, and agents - Acknowledgments - Surveys - Exit interviews
Compliance Process III	This course, together with Compliance Process I: Elements of Effective Compliance Programs and Compliance Process II: Anonymous Reporting Systems and Preventing Violations, outlines the elements of a hospital compliance program that meets the minimum standards for such programs established by the Office of the Inspector General (OIG) of the Department of Health and Human Services. It addresses reporting protocols, complaint classifications, investigation protocols, and preventive and corrective action.
Compliance with Outpatient Technical Modifiers	Use of modifiers is mandated by the Centers for Medicare and Medicaid Services (CMS) concurrent with the implementation of the Hospital Outpatient Prospective Payment System (PPS). You must comply with specific requirements concerning modifiers to receive reimbursement for outpatient services. Failure to do so may result in overpayments and false claims violations. This course will show you how to use modifiers appropriately when submitting claims for hospital outpatient technical services to Medicare.
Cost Allocation - Home Office	As healthcare organizations become more complex, they often develop multilayered corporate structures that are controlled by a central organization. This central organization is called a "home office," and the multilayered corporate structure is called a "chain organization." A home office generally provides centralized services to its component organizations, or "chain components." Medicare has developed rules and regulations on the proper methods for allocating home office costs to chain components. A chain component can then report these costs as part of its allowable expenses in its Medicare cost report. This lesson will show chain organizations how to properly allocate their home office costs among their chain components.
Duties of the Hospital Board	Board members are faced with difficult decisions and complex situations. The law requires board members to act as conscientious trustees for the organizations they represent. This course will orient board members to their fiduciary duties under the law and will examine the two fundamental fiduciary duties of due care and loyalty. It will also explain how they affect job responsibilities and decision-making processes. Lastly, it will identify government resources relevant to the duties to members of the board of a healthcare organization.
E-Medical Records Compliance	Healthcare providers are increasingly moving from paper records and implementing electronic medical records (EMR) systems. The federal government has established a national goal of ensuring that most Americans have access to secure, interoperable EMRs by 2014. EMRs can help improve patient safety and reduce costs. Despite the benefits of EMRs, however, they also increase a provider's exposure to liability resulting from unauthorized access. This course will introduce you to the risks and benefits of using EMRs. You will learn about the benefits of, as well as the risks of, electronic medical records. The course also describes the application of the HIPAA Privacy and Security Rules, and the application of Stark and Anti-Kickback laws.

E&M Coding Part I	For billing purposes, federal regulations assign virtually every physician office and hospital service, except the performance of procedures, to a category known as evaluation and management (E&M) services. E&M services account for more than 40% (in dollars) of all claims submitted to Medicare and Medicaid. This course, E&M Coding Part I, acquaints you with the structure of the HCPCS codes used to characterize categories of E&M services according to key components.
E&M Coding Part II	For billing purposes, federal regulations assign virtually every physician office and hospital service, except the performance of procedures, to a category known as evaluation and management (E&M) services. E&M services account for more than 40% (in dollars) of all claims submitted to Medicare and Medicaid. This course, E&M Coding Part II, addresses CMS documentation requirements for different types of patient encounters where E&M coding is based on key components. Topics include the general purpose and principles of medical record documentation and the CMS documentation guidelines.
EMTALA and Managed Care	This course presents an overview of what EMTALA requires a Medicare-participating hospital to do when its dedicated emergency department provides treatment, how to monitor its practice and how to address unique requirements that apply to Medicare and Medicaid managed care plans.
Essentials of Compliance for Department Managers	This course provides lessons on the role of federal agencies that enforce healthcare compliance as well as understanding the responsibilities of the healthcare institution for personal and institutional compliance.
Fundamentals of Compliant Hospital Billing	The course is designed to help hospitals ensure that their billing operations comply with Medicare law.
Gainsharing	Gainsharing is a novel twist on an old business practice: profit sharing. In healthcare, the term "gainsharing" is usually applied to a program whereby a hospital (or other healthcare provider) contracts with physicians (or other licensed healthcare practitioners) to reduce costs associated with certain medical procedures or types of admissions. Hospitals use gainsharing as a mechanism to confront reduced reimbursement for services by government health care programs and insurers. In turn, physicians are paid a portion of the cost savings realized by the gainsharing arrangement. This course identifies gainsharing arrangements common in the healthcare field and highlights the inherent compliance risks.
General Marketing Guidelines	This course is used to educate employees and agents of Medicare Advantage (MA) plans, Medicare Advantage Prescription Drug (MA-PD) plans, and Prescription Drug plans (PDPs) regarding the new marketing regulations and marketing guidelines provided by the Centers for Medicare and Medicaid Services (CMS). These regulations and guidelines represent CMS current, official position on marketing policy and operational instructions for these types of plans.
Gifts and Gratuities	Historically, some companies have provided gifts and gratuities to physicians and other healthcare employees who are in a position to order or prescribe their products. The gifts have been made in a variety of forms. The Office of Inspector General (OIG), operating under the Department of Health and Human Services, scrutinizes healthcare providers to determine whether such gifts are accepted, which may result in such companies influencing the providers healthcare decisions for patients. This course informs hospital employees of federal laws applicable to the acceptance of gifts or gratuities from individuals, organizations and companies attempting to gain access to the healthcare industry.
Health Plan - Appeals and Grievances - State Regulation	Failure to meet regulatory standards for appeals and grievances can cause significant legal, regulatory, and reputational risks to a health insurer. This course will increase your knowledge of how states regulate appeals and grievances and teaches you to identify the specific state regulatory requirements that apply to your organization, understand the regulatory risks related to those requirements, and apply controls described in the course to reduce the risk of regulatory noncompliance.

Health Plan - Benefit and Coverage Determination Consistency	This course will help you understand some basic reasons benefit and coverage determinations may be inconsistent, and teaches how inconsistent determinations can harm your organization.
Health Plan - Consumer Disclosure Requirements	This course explains the consumer disclosure compliance requirements and risks for health plans. It describes specific compliance risks and suggests procedures for controlling those risks.
Health Plan - Health Plan Corporate Compliance Programs	This course helps you to identify factors for evaluating legal and regulatory risk in the health insurance market. You will also learn how to build a legal and regulatory risk model consisting of compliance controls and key performance indicators. The course covers building a compliance monitoring process and developing a compliance auditing and monitoring work plan.
Health Plan - Legal and Regulatory Risk Assessment	Legal and regulatory risk assessments are a snapshot of the organizations vulnerability to legal and regulatory noncompliance. In identifying the organizations legal and regulatory risks, the OIG recommends that health plans not only look to the activities of regulators but also conduct an internal risk assessment. This course will help you to (a) identify factors for evaluating legal and regulatory risk in the health insurance market; (b) build a legal and regulatory risk model consisting of compliance controls and key performance indicators; (c) conduct a legal and regulatory risk assessment; and (d) develop a compliance auditing and monitoring work plan.
Health Plan - Medicare Advantage Enrollment and Disenrollment Process	This course provides an understanding of the regulatory requirements applicable to the Medicare Advantage (MA) enrollment and disenrollment process. You will be introduced to basic regulatory concepts and requirements applicable to the MA enrollment process. You will gain an understanding of the regulatory requirements, the financial and regulatory risks inherent in the process, and the methods to manage and control these risks.
Health Plan Medicare Advantage Appeals and Grievances	In this course you will learn how to examine the appeal and grievance requirements for Medicare Advantage products. A better understanding of the requirements will help ensure that organizations are in compliance with Medicare regulatory requirements.
Health Plan: Claim Prompt Payment Standards	This course will teach you how to provide an understanding of prompt payment regulations. Upon completion of this lesson, you will gain an understanding of the regulatory requirements and the information systems, data, and production issues that may cause delays in payment. You will also learn how to monitor basic controls in your organization to ensure compliance with internal and regulatory prompt payment standards.
Health Plan: Introduction to Compliance for Health Plans	This course teaches the importance of compliance for professionals in the healthcare industry and their organizations. This course defines compliance, explains possible consequences of noncompliance to individuals and their employers, what should be done if a law or regulation is being broken, and keys to personal compliance to reduce the likelihood of a compliance violation.
HIPAA for Health Plans - Consents and Authorizations	This course will provide you with the ability to identify who is a plan sponsor within the meaning of the HIPAA Privacy Rule. You will learn to determine what amendments must be made to group health plans plan documents as they relate to the plan sponsors obligations as well as understand what the plan sponsor must obligate itself to do before the plan may disclose protected health information to the sponsor.
HIPAA - Patient Consents	In this course you will learn about HIPAA consent requirements, and how the requirements apply to providers and other covered entities.
HIPAA - Penalties of Noncompliance Issues	This course provides an overview of specific parts of the HIPAA privacy and security rules, including (a) the minimum necessary requirements; (b) de-identified information; (c) business associates; (d) individual rights; (e) the administrative requirements; (f) requirements for transition to compliance with the privacy requirement. It also provides an overview of penalties for an entity's failure to comply with any HIPAA rule.

HIPAA - The Use of Authorizations	The HIPAA privacy rule describes and limits the ability of a healthcare provider or other covered entity to use or disclose protected health information. One requirement under the HIPAA rule is that a healthcare provider or other covered entity must obtain an individuals permission to use or disclose information. This course covers the various situations where an authorization is mandatory, the requirements for a valid authorization, and the applicability of such requirements to healthcare providers and other covered entities.
HIPAA Administrative Simplification	This course introduces the user to the HIPAA Administration Simplification Rules and provides a basic understanding of the Rules requirements.
HIPAA Business Associate Liability	The HIPAA privacy rule requires that healthcare providers and other covered entities enter into business associate contracts before they disclose protected health information to their business associate. This course summarizes how to determine who is a business associate and what provisions need to be in the business associate agreement. It also describes the circumstances in which a healthcare provider or other covered entity can be held liable for prohibited disclosures of protected health information by its business associates. You will learn about when the healthcare provider or other covered entity can be held liable to individuals for unauthorized disclosures of protected health information under laws and rules other than the privacy rule, the requirements for de-identifying protected health information so that it no longer qualifies as protected health information under the privacy rule, and will be provided with an explanation of the procedure for aggregating protected health information.
HIPAA Contracting with Business Associates	The privacy rule generally requires that a covered entity and its business associates enter into a written contract before the covered entity may disclose protected health information. The contract establishes the permitted and required uses and disclosures of the protected health information by the business associate. This course provides an overview of who business associates are, when the privacy rule requires a business associate agreement and when one is unnecessary, and what must be contained in a business associate agreement.
HIPAA for Health Plans - Communication with Plan Sponsors	This course will teach you how to identify who is a plan sponsor within the meaning of the HIPAA Privacy Rule and determine what amendments must be made to group health plans plan documents as they relate to the plan sponsors obligations.
HIPAA for Health Plans - Health Plans and Oral Communications	In this course you will learn how to have an understanding of the dramatic effect that the Privacy Rule has on these routine operations of health plans.
HIPAA for Health Plans - Health Plans and Written Communications	The HIPAA Privacy Rule does not distinguish between oral and written communications or between different forms of written communications such as electronic or paper. However, it is important for employees of health plans to be aware of how the Privacy Rule affects the written communications of the health plan. This course provides an understanding of the dramatic effect that the Privacy Rule has on how these basic communications between health plans and their participants are carried out.
HIPAA for Health Plans - HIPAA - Fundamental Concepts	This course provides health plan professionals who already have a basic knowledge of the HIPAA regulations with a more detailed look at certain key areas of HIPAA compliance including Treatment, Payment, and Operations, business associates, consents and authorizations, and members' rights and responsibilities.
HIPAA for Health Plans - HIPAA and Workstation Security	This course will provide a general overview of the HIPAA security standards and how to identify your responsibilities for complying with the security standards contained in both the security rules and the privacy rules. You will also determine how HIPAA applies to basic security issues at your workstation.
HIPAA for Health Plans - HIPAA Privacy for Health Plans	This course introduces health plan professionals to the HIPAA Privacy Rule and provides a basic understanding of how the Rule affects the way health plans do business.

HIPAA for Health Plans - Marketing and Fundraising Issues	This course provides a basic understanding of what constitutes marketing and fundraising under the HIPAA Privacy Rule and how these activities are regulated under HIPAA.
HIPAA for Health Plans - Overview of HIPAA for Health Plans	The course outlines the basic structure of the patient privacy rules published under the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA.
HIPAA for Health Plans- Business Associate Contracts for Health Plans	Perhaps no aspect of compliance with the HIPAA Privacy Rule is more central to the business of health plans than the provisions dealing with business associates. This course identifies those situations in which a business associate contract is required; distinguishes business partners who are not considered business associates for HIPAA purposes from those that are; discusses the essential components of business associate contracts and what actions are required when the business associate breaches the contract; and explains the transition period provided by the Final Privacy Rule with respect to business associate contracts.
HIPAA Introduction to Privacy, Security and Code Sets	One of HIPAA's goals was to reduce healthcare costs by realizing savings through the simplification and standardization of administrative functions of the healthcare system. The privacy, transactions and code sets, security, and unique identifier rules are the administrative simplification rules of HIPAA. This course covers the HIPAA Administration Simplification Rules and provides a basic understanding of the rules fundamental requirements.
HIPAA Patients Rights to Notice and Additional Protections	This course familiarizes healthcare providers and other covered entities with the HIPAA privacy rules individual rights requirements. Specifically, this course addresses the individual's right to notice and to request restrictions on the use and disclosure of protected health information.
HIPAA Privacy and Security Risk Assessment	The HIPAA privacy rule details the privacy protection that covered entities must extend to the protected health information they maintain. The purpose of this course is to serve as a baseline from which a healthcare provider or other covered entities and their employees can assess the extent to which their organization is currently in compliance with the HIPAA privacy rule. This course sets forth the basic requirements organizations must adhere to in order to become compliant with the privacy and security rules.
HIPAA Privacy Rule - Overview	The Privacy Rule is a great step toward federal protection of patient privacy. Until the Privacy Rule was released, there were no federal rules protecting the privacy of patient health information or patient's rights to access their health information. Most states have laws to protect the privacy of patient health information, but some laws are weak and private information is often given out without the patient even knowing. This course provides an overview of the Privacy Rule created by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and discusses the purpose of the privacy rule, who the rule affects, and what the rule covers.
HIPAA Privacy Rule and Academic Medical Centers	This course will familiarize you with how the Privacy Rule affects the ways in which academic medical centers carry out their special and critically important educational and research functions.
HIPAA Protected Health Information Patient's Rights	This course will provide a lesson to familiarize you with the individual rights granted by the HIPAA privacy rule. This includes individual rights how they can access information and when their individual rights might be denied.
HIPAA Provider Staffing and Training Requirements	This lesson explains the staffing and training requirements of the HIPAA privacy and security rules. You will learn about the responsibility of privacy and security officials, the requirements for training employees and mitigation policies for unauthorized use and disclosures of protected health information.

Home Health - Plan of Care and Qualifying Services	This explores home health compliance issues identified by the OIG as key compliance concerns, including: when Medicare beneficiaries qualify as homebound; the elements which must comprise a beneficiary plan of care and the role of physicians in development of that plan; what constitutes a qualifying service for Medicare reimbursement; how the presence of other willing caregivers, or those obligated by contract, can make home health services unnecessary and, therefore, not reimbursable by Medicare.
Home Health Payment Issues	This course introduces important Medicare payment issues applicable to home health agencies (HHAs). Covered topics include: the Medicare Conditions of Participation for HHA employees and contractors; the requirements for HHA arrangements with other providers; and the defining characteristics of allowable HHA coordination activities.
Home Health PPS Compliance Issues	This course discusses important Medicare compliance issues applicable to home health agencies (HHA), and provides information on compliance risk areas for HHAs. Topics include: risk areas related to referrals for HHA services, allowable administrative costs for HHAs, services excluded from payment under Medicare benefits for HHAs, and consolidated billing practices.
Hospice - Eligibility Election and Referrals	The goal of hospice care is to provide palliative care that lessens the physical and mental effects of terminal illness rather than to provide treatment to cure the disease. This course assists hospice personnel in understanding three key compliance issues that may give rise to compliance violations: when Medicare beneficiaries are eligible for hospice care, how Medicare beneficiaries must elect hospice care, and what types of activities may violate the federal anti-kickback provisions.
Hospital Pharmacy Compliance	Institutional hospital pharmacies and their pharmacists must comply with laws controlling hospital pharmacy procedures and the proper submission of claims involving drugs and biologicals. Federal healthcare programs, such as Medicare, Medicaid, and CHAMPUS, require compliance in the claims process. These laws also provide penalties for the submission of improper claims. In this lesson, you will learn what a hospital pharmacy must do to comply with federal laws regarding drugs and biologicals, and what the penalties for noncompliance are.
Introduction to Ambulatory Payment Classifications (APCs)	This course introduces you to the Outpatient Prospective Payment System and the use of Ambulatory Payment Classifications. This course also reviews the steps to take to avoid submission of a false claim due to improper coding of hospital outpatient services subject to this payment methodology.
Introduction to Coding	This course introduces you to Medicare's coding system and helps you learn to avoid the common errors that lead to denials of payment and, in more serious circumstances, to sanctions and penalties.
Introduction to Compliance	Because you work in the healthcare industry, you must obey the laws and the regulations that affect your job. Obeying healthcare laws and regulations is called "compliance." Failure to follow those laws and regulations is called "noncompliance" or a "compliance violation." This course will teach you the importance of compliance, both to you and to the organization for which you work.
Introduction to Medicare Part D Prescription Drug Program	This course introduces the Medicare Part D prescription drug benefit as outlined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Topics covered include Medicare Part D overview, enrollment issues, eligibility, provider education, Medicare Part B vs. Part D, covered prescriptions, formularies, and HIPAA compliance.
Introduction to Therapy Billing	This course will provide you with methods for how to identify compliance issues common to all rehabilitation therapy settings. You will learn how to describe a therapist's role in documenting medical necessity and explain the importance of using properly licensed and certified individuals. The importance of therapy documentation as it relates to billing and reimbursement is also covered.

Laboratory	This course introduces the various components of general laboratory regulations including medical necessity, billing, unbundling, and the Stark self-referral law. Complying with the many regulations of each area is essential for Medicare coverage for laboratories. This course provides an overview of (a) the definition of medically necessary laboratory services, (b) an introduction to the Physician Ordering Rule, (c) laboratory notice to physicians regarding Medicare requirements, (d) proper billing for laboratory services, (e) Stark as it relates to laboratory services billing, and (f) the 3-Day Window Rule.
Laboratory Conditions of Participation	This course introduces the Medicare Conditions of Participation (COP) as they relate to laboratories. The COPs govern many aspects of laboratory operations including: testing, services, personnel, and patient notification. This course provides an overview of: the level of laboratory services considered to be adequate by CMS, notification protocol when potentially HIV infectious blood is transfused, the three levels of laboratory test complexity created by the Clinical Laboratory Improvement Amendments of 1988, and the general requirements of laboratory directors, technical consultants, clinical consultants, and testing personnel within a laboratory.
Marketing Agents	This course describes areas of improper MCO marketing including the use of physicians as marketing agents, so you can enroll beneficiaries to specific Managed Medicare products without violating the law.
Medical Clinic Business Process	The business process of physician offices, like all other Medicare and Medicaid providers, involves compliance with a myriad of federal regulations. This course addresses important compliance topics including: ensuring that Medicare deductibles and co-payments are properly collected; if waived, waived only under appropriate circumstances; giving Advance Beneficiary Notices (ABNs) to patients when called for; making sure that the ABN contains the proper information, and; using the correct place of service indicator on the clinic's bills to Medicare.
Medical Necessity Certification - Durable Medical Equipment	Medicare cannot legally reimburse a claim for Durable medical equipment (DME) unless a physician certifies that the DME meets the legal definition of "medically necessary." A physician or DME supplier who fails to adhere to the rules for proper certification may be subject to severe sanctions by the government. This course discusses the elements of a legally proper certification of medical necessity for DME.
Medical Necessity Certification - Home Health Services	Physicians must establish that home health services ordered for patients are medically necessary. Without proper physician certification, federally funded healthcare programs such as Medicare may refuse reimbursement or seek compensation for payments already made. Convinced that physicians and home health agencies (HHAs) frequently ignore or circumvent this rule, the government has singled out certification violations as a special target for compliance enforcement. This course describes a physician's role in avoiding compliance issues by providing medical necessity certifications that meet government mandates.
Medical Necessity Certification - Skilled Nursing Facilities	Everyone who works or volunteers in a skilled nursing facility/unit or nursing home has to follow state and federal laws designed to protect residents' legal rights and quality of care. This course familiarizes you with those laws and what is required of nursing facility employees and volunteers.
Medical Records	This course provides hospital administrators, physicians, nurses, and other clinical staff responsible for medical records documentation with an overview of federal laws and regulations that impose documentation requirements. Also covered is the need for hospitals to maintain a Medical Records department in order to participate in the Medicare program and the basic components required of such a department.
Medicare Allowable Bad Debt	When a Medicare beneficiary does not pay the Medicare deductible and coinsurance to the provider, those uncollectible amounts are considered Medicare allowable bad debt. Medicare reimburses the provider for this type of bad debt only. This course identifies the qualifications of Medicare allowable bad debt and discusses collection and documentation efforts necessary to claim non-collected amounts as Medicare allowable bad debt.

Medicare Allowable Costs	Medicare has identified costs that are considered to be reimbursable. It is a matter of accurate, consistent cost accounting to identify the allowable costs and report them appropriately. This course helps hospital accounting staff and those responsible for preparing the hospital cost report to know which costs Medicare allows and which it does not allow.
Medicare as Secondary Payer	Within the Medicare program, CMS has developed the "Secondary Payer Rule" to clearly spell out the instances in which Medicare will not have the primary responsibility of paying for a healthcare service. Under this rule, Medicare payment for items or services that may be covered under other health insurance plans or policies, such as workers compensation, liability insurance or employer health insurance, is strictly prohibited. This course provides a brief overview of a healthcare provider's rights and responsibilities under the Medicare Secondary Payer Rule.
Medicare Billing for Nurse Practitioner Services	This course covers the requirements for billing Medicare for nurse practitioner services. Such requirements address the qualifications that nurse practitioners must have for their services to be covered and the types of services that are covered by Medicare. In addition, this course will discuss the provision of services and supplies that are "incident to" the professional services of a nurse practitioner and the circumstances in which Medicare payment may be made directly to nurse practitioners.
Medicaid Fraud Enforcement	This course describes the Medicaid Integrity Program (MIP), which was created to detect and prevent Medicaid fraud and abuse, how it can affect providers, and what they can do to mitigate risks. CMS was required by the Deficit Reduction Act of 2005 to create the Medicaid Integrity Program, CMS's first national strategy to detect and prevent Medicaid fraud and abuse. The federal government has appropriated millions of dollars for CMS to implement the new MIP; with that increased funding, Medicaid providers should expect increased audits and enforcement activity. This course describes the new program, how it can affect providers, and what they can do to mitigate risks.
Myocardial Perfusion Imaging	This course discusses what measures physicians must take to ensure that myocardial perfusion imaging, with or without the use of pharmacological stress agents, is medically necessary, documented appropriately, and supervised adequately to justify payment by Medicare. The discussion of supervision applies only to tests conducted in physicians' offices and other non-hospital outpatient facilities, and not to the inpatient setting.
OIG Compliance Guidance for SNF Managers	This course acquaints Skilled Nursing Facility (SNF) upper management and board members with the appropriate structure of a compliance program that comports with Office of the Inspector General (OIG) compliance program guidance for SNFs. In addition, this course identifies and briefly discusses various areas of SNF activities that the OIG associates with frequent or severe compliance violations.
Partial Hospitalization Program	This course provides an introduction to Partial Hospitalization Programs (PHP). PHPs provide intensive psychiatric treatment on an outpatient basis to patients who would otherwise require inpatient psychiatric care. Course topics include: the Medicare standards for PHPs including what patients, treatments, and services are permissible and impermissible; the determination of reasonable and necessary services; the requirements for patient's treatment plans and progress notes; the requirements for physician supervision; and the exception to physician supervision with respect to nurse practitioners, clinical psychologists, physician assistants, and clinical nurse specialists.
Patient Rights - Privacy, Confidentiality, and Care Participation	This course introduces three areas of patient rights that are mandated by the Centers for Medicare and Medicaid Services: the right to confidentiality of and access to medical records, the right to actively participate in care decisions, and the right to privacy and safety in the hospital. It is a continuation to topics covered in the course titled, "Basic Hospital Patient Rights".
Patient Rights - Notification, Informed Consent, and Advance Directives	This course identifies the patients rights contained in the Medicare Conditions of Participation (CoP) and describes the elements of a grievance process. It also covers the duties of hospitals to ensure informed patient decision-making and defines hospitals duties with respect to CMSs regulations on advance directives under the CoP.

Patient Rights - Restraints and Seclusion	To encourage a patient care environment that is as free as possible of restraints, CMS has adopted a standard that requires hospitals to adopt and follow strict policies and procedures governing the use of restraints and seclusion in the narrowly defined circumstances where their use is acceptable. This course introduces the standards mandated by CMS to promote and protect the right of patients to be free of medically inappropriate use of restraints and seclusion.
Physician Billing at Teaching Hospitals	This course discusses Medicare rules that govern the circumstances under which teaching physicians may bill Medicare for patient services. These rules address billing by three categories of physicians at teaching hospitals: teaching and supervising physicians, assistants at surgery, and residents.
Physician Compliance - The Stark Law	This course is intended to define prohibited referral relationships under the Stark Law between physicians and healthcare entities and to identify and illustrate referral relationships that are legally acceptable because they meet the criteria for one of the statutory exceptions to the Stark law's general ban on physician self-referrals.
Physician False Claims and Anti-Kickback Law	The federal government has made eliminating fraud and abuse in the federal healthcare programs a top priority. Conduct receiving particularly close attention includes the making of false or fraudulent statements in connection with claims for reimbursement, and the giving or receiving of anything of value in exchange for federal healthcare program referrals. This course will help you to identify the conduct most likely to arouse the suspicion of Federal authorities and to acquaint you with the concept of safe harbors, which are narrowly defined exemptions contained in the Federal anti-kickback provisions that permit certain healthcare business relationships that would otherwise violate those provisions.
Physician Recruitment - Anti-Kickback and Stark Law	This course assists you in structuring physician recruitment arrangements to comply with federal anti-kickback and Stark law requirements. It also explains the potential penalties that may be levied if a recruitment arrangement is found to violate the law.
Physician Recruitment and Tax-Exempt Status	This course illustrates how senior hospital management and physicians acting on behalf of the hospital should structure physician recruitment arrangements to avoid risking the hospitals tax-exempt status or incurring financial sanctions.
PPS for Inpatient Rehabilitation - Payment Issues	This course will provide the basics of the Prospective Payment System for Inpatient Rehabilitation Facilities, including its payment and clinical components.
Prescriptions and False Claims	This course introduces the pharmacist and pharmacy staff to the laws governing false claims as they apply to situations in which customers do not receive medication that was billed to a government payer.
Prohibited Marketing Activities	This course delineates areas of improper managed care marketing, so your MCO can enroll beneficiaries to Managed Care Medicare products without violating regulations concerning the marketing of the Managed Care Medicare product.
Provider-Based Designation	Provider-based status is a Medicare designation that a particular site, service, or entity is part of a healthcare provider, and that it is not an independent or freestanding provider or supplier. This course, part one of a two-part series, addresses the basic criteria for provider-based determinations and designation of new subordinate facilities.
Provider-Based Designation II	Provider-based status is a Medicare designation that a particular site, service, or entity is part of a healthcare provider, and that it is not an independent or freestanding provider or supplier. This course, part two of a two-part series, addresses special cases and exceptions, emergency cases - obligations for provider-based facilities, incident to services and the assumption of physician supervision, and notice to beneficiaries obligations of provider-based facilities.

Quality Review Organizations	This course describes the methods by which Peer Review Organizations (PROs) (a) monitor the quality of care provided to Medicare patients, and (b) ensure Medicare program integrity by examining the system and providers for efficiency and adherence to Medicare rules. This course clarifies PRO objectives and procedures for the providers who must understand how those objectives and procedures will affect them directly.
Reimbursement for Observational Services	This course explains when observation services should be used by a hospital and how the hospital should seek Medicare reimbursement for observation services.
Related Party Transactions	In this course you will learn how to state the manner in which Medicare reimburses costs furnished by a related party and how to identify when a related party relationship exists due to common ownership. You will learn how to identify when a related party relationship exists due to common control and recognize when an exception to the related party principle applies.
Reserve Cost Reports	Hospital reporting of reserve costs has prompted multiple lawsuits and is intensely scrutinized by the Centers for Medicare and Medicaid Services and the Office of the Inspector General. This course explains how improper reserve cost reports may constitute submission of a false claim.
Skilled Nursing Facility Prospective Payment System	Among the trickiest issues facing skilled nursing facilities under the Prospective Payment System are how to bill therapy time and the Centers for Medicare and Medicaid Services requirements for proper supervision of therapy assistants and therapy aides. This course explains how to comply with the 3-day prior hospitalization rule, the proper methods for billing therapy minutes, therapy supervision requirements, and how discount agreements with suppliers may be legally structured.
The 3-Day Window Rule	This course discusses the scope, applicability, and technical requirements of the rules governing billing for pre-admission services. It also discusses the government's methods for identifying and punishing violators.
The Discharge - Transfer Rule	The discharge-transfer rule, also known as the post-acute transfer rule, is an important billing consideration for Medicare-participating hospitals that are paid according to the prospective payment system (PPS). Hospitals must ensure that they correctly distinguish between patient discharges and transfers when seeking Medicare reimbursement. The purpose of this lesson is to distinguish discharges from transfers for purposes of Medicare reimbursement and to illustrate the operation of the new discharge and transfer rule.
Therapy Billing in Post-Acute Care	While there are many compliance concerns that are common to rehabilitation therapy billing in all settings, this course addresses issues unique to each of three specific rehabilitation therapy settings including SNFs, CIR units/hospitals, and outpatient care. Compliance concerns in these post-acute care settings arise from variations in the government reimbursement schemes applicable to each. This course explains the variations in reimbursement schemes, along with compliance issues and trends for these three rehabilitation therapy settings, and will provide checklists for use in compliance program planning in these settings.
Upcoding - Basic Principles and Three High-Risk DRGs	This course illustrates examples of appropriate and inappropriate coding and describes how to avoid submission of potential false claims of upcoding. Availability of the ICD9-CM code book will be useful while viewing this course.

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