Contra Costa Health Services

Compliance	Preventing Fraud, Waste and Abuse: Audits and Risk Assessment	**Policy #** 706-C
		Original Date: 01/2007
		Revised: 03/2008
		Supercedes:

PURPOSE

One way to demonstrate an effective Compliance Program is to have a strong auditing and monitoring process. Audits and risk assessments are essential to ensure compliance with government and private payer rules and regulations. The purpose of this policy is to summarize the results of internal risk assessments used to identify the processes, systems, and/or procedures implemented by Contra Costa Health Services to detect and prevent fraud, waste, and abuse.

POLICY

Contra Costa Health Services (CCHS) is committed to ethical and legal conduct that is compliant with all relevant laws and regulations. This policy documents the protective measures implemented by Contra Costa Health Services to prevent fraud, waste, and abuse, and discusses some of the monitoring processes utilized by CCHS to detect potential problems.

REFERENCES

Deficit Reduction Act of 2005 (S.1932)
1998 Office of Inspector General Compliance Program Guidance for Hospitals
2005 Supplemental Compliance Program Guidance for Hospitals

PROCEDURE

The Contra Costa Health Services Compliance Program was developed to detect and prevent violations of any law or regulation, whether criminal or non-criminal, for which the organization is, or would be, liable. The basic principals of our Compliance Program are found in the Contra Costa Health Services Code of Conduct and the Compliance Program Manual. Together, these documents provide employees with standards to carry out their daily work activities, establish guidelines for determining prohibited activity and conduct, and provide detailed information to employees for reporting possible compliance violations.

To supplement the standards established by the Code of Conduct and the Compliance Program Manual, CCHS has implemented a variety of protective measures designed to address issues that the Office of Inspector General has determined are most vulnerable to fraud and abuse.

Preventing Fraud, Waste, and Abuse

There are several different types of allegations the government can make when pursuing a case against a provider. Most noteworthy are

cases involving inaccurate or unsupported claims. There are six types of inaccurate billing patterns or "traps" providers can fall into:

1) No documentation.
2) Insufficient documentation.
3) Double or duplicate billing.
4) Billing for medically unnecessary services.
5) Billing for unbundled services.
6) Billing for inaccurate/incorrect providers.

Depending upon the scope of these billing patterns, the OIG may allege fraud against the provider, particularly if investigations reveal an ongoing pattern or reveal knowledge of a problem without taking any corrective action. A pattern of billing for services that were never provided is a solid basis for fraud. Some of the preventative measures implemented by Contra Costa Health Services to ensure that correct claims are submitted to payers include:

1. Policies and Procedures

Contra Costa Health Services has developed a number of Policies and Procedures to provide employees with guidance on how to carry out their daily work activities in a way that is consistent with applicable federal and state laws and regulations.

In addition to Health Services Department Policies, each Division has established specific policies to provide guidance to employees working in high-risk areas so that they may conduct their day-to-day activities in a compliant manner. Many of these policies were developed to provide guidance on specific issues that were identified by internal reviews and investigations as being potentially vulnerable to fraud and abuse. For instance, policies have been developed to address Psychiatric Emergency Medicare Billing, Inpatient Psych Medicare Secondary Payer Billing, and Inpatient Psych Commercial Secondary Payer Billing. These policies are available to the affected employees, and most are available for review on the CCHS I-Site intranet.

Specific guidance is also available to address the following issues identified by the Office of Inspector General as areas that are vulnerable to fraud and abuse:

- Screening Individuals for Federal Sanctions

  Procedures are in place to ensure no payment is made for items or services provided by an individual excluded from participation in a Federal Health Care Program.

- Medicare 72-Hour Rule

  Procedures have been developed to ensure Medicare is not billed for outpatient services occurring within 72 hours of an inpatient admission.

- Medicare Post Acute Care DRG Transfers

  CCHS has implemented procedures to properly identify transfer situations when they occur so that the correct patient status code is assigned during the abstracting process to ensure proper reimbursement is claimed from the Medicare fiscal intermediary. CMS established this policy to prevent hospitals from discharging patients early to maximize profits.

- One-Day Stays

  Utilization Review evaluates all inpatient Medicare one-day stays to determine whether the patient actually received observation services and therefore should have been registered and billed as an outpatient.

- Physicians at Teaching Hospitals (PATH) Guidance

  Family Practice Residency Billing Guidance was developed to ensure compliance with the Physicians at Teaching Hospitals guidelines. Although the Medicare and Medi-Cal programs allow Family Practice residency billing with proper teaching physician oversight, Contra Costa Health Services has established stricter guidelines and has elected not to bill any payer for any services associated with the residency program until the resident has received his or her license number and has obtained a Medicare UPIN and a Medi-Cal provider number.

- Criteria for Determining Facility Charges

  Under the Outpatient Prospective Payment System (OPPS), the Centers for Medicare and Medicaid Services (CMS) will assume that a facility is in compliance with the

reporting requirements as they relate to the facility code reported on the bill as long as the services furnished are documented and medically necessary, and the facility is following its own system which reasonably relates the intensity of facility resources to the different levels of CPT codes for patient care. CCHS has established a system for mapping the services provided to every patient seen in the Clinics, Emergency Department, or Psychiatric Emergency Department to the different levels of effort represented by the CPT codes that define these respective visits.

- Medicare Secondary Payer (MSP)

  A policy has been developed to ensure the Registration staff screens all Medicare patients to determine if Medicare is the secondary payer to any other health coverage or program.

- Advance Beneficiary Notice

  A procedure has been developed to assure that Medicare patients are properly instructed regarding their liability should Medicare deny payment due to lack of medical necessity.

- Laboratory Compliance
  Lab policies have been developed to address numerous high-risk areas including:
  - Standing Orders and Reflux Testing,
  - Unbundling, Panel Billing and Automated Multi-Channel tests,
  - Outside lab referrals, and
  - Customized Panel Billing.

2. Electronic Edits on Billing Data

   A. Contra Costa Health Services utilizes the Keane billing system to process and generate claims data for services provided at the Contra Costa Regional Medical Center and Health Centers. Keane contains a number of billing edits that are utilized to review the aggregate claims data. Claims data from Keane is passed through additional billing edits in DSG (Data Systems Group) prior to generating a final bill. The table below summarizes some of the edits used to review data in order to minimize the risk of false claims.

Edit	Function of Edit
Code Accuracy	Ensure all codes are valid to the extent they are up-to-date and have the correct number of digits.
Bundling	CPT codes are run through the National Correct Coding Initiative unbundling edits to ensure services are not over-billed due to unbundled codes.
Duplicate Codes	Eliminates duplicate codes, unless the procedure is performed more than once and the procedure can be billed more than once.
Medical Necessity	CPT and ICD-9-CM data are run through the medical necessity edits of the Fiscal Intermediary (United Government Services) and the CMS National Coverage Determinations.
Gender Accuracy	Sex-specific codes agree with the sex field in the patient's record (e.g. a gynecology procedure or diagnosis must be on a female record).
Volume Controls	Establish norms for CPT and ICD-9-CM codes, based on federal, state, or local data.
Administrative	Edit for completion of all administrative fields, such as provider number, dates of service, patient status, condition codes, etc.

B. The Contra Costa County Mental Health Plan utilizes the PSP/InSyst billing system to process and generate mental health claims data. PSP/InSyst primarily generates Medi-Cal claims as the inpatient Medicare services are billed by the Keane system. PSP/InSyst contains a number of billing edits that are utilized to review the claim file before submission to the Department of Mental Health for reimbursement. The table below summarizes some of the edits used by PSP/InSyst to minimize the risk of false claims.

Edit	Function of Edit
Code Accuracy	Ensure all codes are valid to the extent they are up-to-date and have the correct number of digits.
Duplicate Codes	Eliminates duplicate codes for same-day service based on provider, type of service, and service length
Medical Necessity	Medical necessity as determined by mental health diagnosis is validated through the PSP/InSyst diagnosis master table to ensure elimination of non-mental health diagnoses
Administrative	Edit for completion of all administrative fields, such as provider number, dates of service, patient status, condition codes, etc.

3. Chargemaster Review Software

To manage the integrity of our chargemaster, CCHS utilizes Craneware Active Chargemaster, an automated tool that facilitates accurate coding and reimbursement.

4. Audits and Aggregate Data Analysis

Abstracting reviews and internal audits are utilized to determine whether claims are supported by appropriate documentation in the patient's medical record. In addition, Medicare billing information compiled by Lumetra, the local Medicare Quality Improvement Organization, is reviewed to determine whether CCHS Medicare billing data exceeds national or regional norms. These types of reviews are crucial for identifying and preventing potential billing errors, including CPT and DRG upcoding.

5. Mechanisms to Detect Fraud, Waste, and Abuse

CCHS has also implemented a number of monitoring techniques to detect potential fraud and abuse. These include:

A. Implementation of the CCHS 24-Hour Compliance Hotline for employees to report potential compliance violations.

B. Review of existing Policies and Procedures, CMS directives, OIG Fraud Alerts, and other guidance.

C. Professional meetings, seminars, and publications.

D. Prepayment audits.

E. Notifications from the Medicare Fiscal Intermediary (United Government Services) or the Medicare Carrier (National Heritage Insurance Company).

F. Exit interviews conducted with departing employees.

G. Interviews with personnel to determine whether policies and procedures either do not exist, or have not been updated in years.

RESPONSIBLE Compliance Officer
Division Directors

Departmental Review	Signature	Date
Health Services Director		
Compliance Officer		