Policy Title:	Auditing, Detecting, and Preventing Fraud, Waste, and Abuse (CMP)
Category:	CMP - Compliance
Policy Number:	100-012
Initial Effective Date:	08/01/19
Review Date(s):	
Revised Date(s):	11/29/22, 03/20/24
Associated Forms & Policies:	100-007 Compliance Education and Training 100-005 Reporting Compliance Issues and Non-Retaliation
Regulation Reference *(if applicable)*:	NYS Social Services Law (SSL) §363-d and 18 NYCRR Part 521 Deficit Reduction Act of 2005, Section 6032 Health Insurance Portability and Accountability Act of 1996 (HIPAA) NYS OMIG Mandatory Provider Compliance Plan 8 NYCRR § 521 OMIG website is: https://omig.ny.gov/compliance/compliance
Key Words:	Auditing, Detect, Prevent, Fraud, Waste, Abuse

I. Policy

It is the policy of Crouse Medical Practice ("CMP") to adhere to all applicable state and federal laws and regulations concerning the delivery of patient care, billing and reimbursement for such care, and our business practices in general. CMP is committed to conducting its operations in an ethical and lawful manner and has therefore developed and implemented a Corporate Compliance Program.

II. Purpose

The Compliance Program is intended to prevent and detect health care fraud, waste and abuse, and to detect and correct violations of applicable law, regulations, third-party payer requirements, CMP's policies and procedures, the Code of Conduct, and other applicable standards. The policy ensures that affected individuals are familiar with CMP's efforts to detect and prevent health care fraud, waste and abuse as required by CMP's Code of Conduct, Corporate Compliance Program and the Deficit Reduction Act of 2005. The policy assists employees, staff, providers, vendors and other affected individuals in recognizing instances of potential fraud, waste and abuse, and encourages good faith reporting.

CMP's audit program should be based on criticality/risk. Risk factors such as the importance of the processes, changes to the organization, and the results of previous internal/external audits should be considered when developing the work plan.

Ongoing and periodic reviews of the Compliance Program's operations and systems will be audited. This process will be used to determine whether the elements of the Compliance Program are consistently being addressed and satisfied. Also, all departments/ offices will be audited at least annually for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and New York State laws pertaining to privacy and confidentiality.

III. Scope

This policy applies Practice-wide

IV. Procedure

The Practice is committed to ensuring that the Plan is properly implemented through periodic monitoring and establishment of an annual Work Plan that will list audit priorities based on risk areas. The Corporate Compliance Officer shall be responsible for conducting and/or ensuring the performance of ongoing and periodic reviews of all aspects of the Compliance Program to monitor its effectiveness and to take appropriate steps as necessary to assure adherence to the Compliance Program.

The Practice will conduct audits at regular intervals, not less than annually, to evaluate priorities identified in the Practice's Work Plan and to ensure ongoing claims processing accuracy and compliance with any new rule or regulation implemented since the previous audit. Significant variations will be investigated to determine their cause. In some instances, a legitimate explanation may exist and no systemic error is at fault. In such cases no corrective action may be required. If deviation is due to improper procedures, misunderstandings of rules, fraud or systemic problems, prompt corrective action will be taken.

1. The Compliance Officer ("CO") or their designee, shall ensure that employees and staff are provided information concerning CMP's efforts to detect and prevent health care fraud, waste or abuse, in accordance with CMP's Compliance Education and Training Policy (100-007). The Corporate Compliance Department and the Corporate Compliance Committee meet regularly to monitor and review developments in applicable laws influencing CMP's legal duties under the Compliance Program and to revise and update the Compliance Program as necessary.
2. The CO, or their designee, shall ensure that affected individuals who are covered under this policy are provided access to this policy and other information concerning CMP's efforts to prevent and detect health care fraud, waste or abuse. This includes access to CMP's Corporate Compliance Program Handbook, the Code of Conduct and compliance-related policies. Access to such information may be via the shared file or CMPs website https://crousemed.com/compliance/ .
3. CMP shall establish and implement and effective system for the routine monitoring and identification of compliance risks. The system should include internal monitoring/audits and as appropriate, external audits to evaluate CMP's compliance with Federal/State requirements and the overall effectiveness of the compliance program. The Compliance Department shall identify risk areas that require review on a periodic basis or in response to a specific issue raised. Risk areas include:
    a. Results of all internal and external audits, or audits conducted by the state or federal government;
    b. Billing
    c. Payments;
    d. Ordered Services;
    e. Medical Necessity;
    f. Quality of Care;
    g. Governance
    h. Mandatory Reporting;
    i. Credentialing;
    j. Contractor, subcontractor, agent or independent contractor oversight;
    k. Other risk areas identified by the practice.

Any risk areas identified will be included in updates to the compliance work plan.

4. The CO, or their designee, shall ensure that internal and/or external audits are conducted on a periodic, regular basis, to verify the accuracy of CMP's claims submission processes and reimbursement practices and for the purposes of preventing and detecting potential instances of fraud, abuse and waste. Such audits will be conducted in accordance with CMP's Corporate Compliance Program and the results shared with appropriate CMP departments and committees, including without limitation, the Corporate Compliance Committee. Prompt action shall be taken to correct any improper practices or deviation from the Compliance Program, Code of Conduct, other Crouse Medical Practice (CMP) policies and procedures, applicable laws and regulations and third-party payer requirements. Documentation shall be retained in accordance with CMP's record retention policies and procedures.
    a. In collaboration with any relevant CMP department, the Corporate Compliance Officer shall conduct and/or ensure audits are conducted, which may include, but is not limited to, the following:
        i. Periodic review of the coding and claims processing systems, including but not limited to audits of claims to be submitted to federal healthcare programs, including Medicare and Medicaid;
        ii. Review of documentation generated by providers and other personnel who have a direct impact on claim development and submission, including claims prepared by new employees to ensure proper training and knowledge of the claims processing system;
        iii. Follow up audits in response to complaints and/or concerns raised related to the claims processing and other Compliance Program processes;
        iv. Review of physician and allied health professional licensing and credentialing requirements;
        v. Review of government disqualified/excluded provider lists;
        vi. Review of adherence to CMP's Compliance Program/Code of Conduct; for example, assess compliance with education and training requirements for affected individuals;
        vii. Review of CMP's complaint and reporting logs to determine if complaints or reports were handled appropriately and whether there have been repeated inquiries regarding the same topic or issues of concern
        viii. Review of compliance with CMP's various mandatory reporting obligations;
        ix. Review of compliance with standards applicable to governance;
        x. Review of patient quality of care for services rendered to Medicare, Medicaid and other patients; and
        xi. Other reviews and risk areas identified by the Corporate Compliance Department, the Compliance Board Committee and/or individual departments.
    b. Reviews/audits shall be periodically updated to reflect changes in applicable laws, regulations, coding guidelines, and third-party payer requirements.
    c. Reviews/audits shall include both internal audits conducted by CMP and external audits conducted by an outside auditor engaged by CMP or through its legal counsel.
    d. CMP shall devote resources that are reasonably necessary to ensure audits are adequately staffed by persons with appropriate knowledge and experience.

5. While the Compliance Officer is responsible for coordinating formal audits, the audits themselves may be performed by internal or external auditors with expertise in federal and state health care statutes, regulations and policies. Audits of coders will be conducted periodically by Practice Resources, LLC ("PRL"). PRL will provide CMP with a written report of its audit findings, which provides data for the Practice to evaluate the Coder's accuracy and competence for the audit period.

6. The results of the audit process may be communicated to and discussed with legal counsel to determine whether any corrective action is required.

7. The Compliance Officer will report the results out to the appropriate management and, depending on the results, may request that a corrective action plan be completed. The corrective action plan is due back to the Compliance Officer within 14 calendar days from the date it was sent.

8. Employees, staff, providers and vendors covered by this policy should report questions, concerns, and/or suspected violations of CMP's policies and procedures and applicable law, and/or instances of potential fraud, waste and abuse to the Compliance Officer, use the reporting form on https://crousemed.com/compliance or go to the applicable department's supervisor or manager. In addition, they can report anonymously using the hotline (315-479-5070 ext. 66107). CMP has adopted a strict non-retaliation policy for good faith reporting of compliance issues or concerns. For further information, refer to CMP's Corporate Compliance policy: Reporting Compliance Issues and Non-Retaliation (100-05)

9. Department Monitoring of HIPAA
    a. The HIPAA Privacy and Compliance Officer and/or the HIPAA Security Officer will conduct an audit of each department at least annually to determine their compliance with privacy standards.
    b. A predetermined set of criteria, formatted on an audit tool, will be utilized for each audit.
    c. A summary and list of recommendations will be forwarded to the director/manager of that area. A copy will also be kept on file in Corporate Compliance.
    d. If any issues and/or recommendations are given, the manager will be asked to provide a response to each item on the audit tool with a due date of 14 calendar days from the date it was sent. A follow up

Definitions:

Fraud: Intentional deception or misrepresentation that a person knows to be false or does not believe to be true, when it is known that the deception could result in an unauthorized benefit to such person or another party. This could include payment under a governmental healthcare program such as Medicare and/or Medicaid or another third-party payer.

Waste: Acting in a manner that results in unnecessary costs or consumption of healthcare resources

Abuse: Improper or excessive incidents that are inconsistent with accepted medical or business practices

Affected Individuals: All persons who are affected by the providers risk areas including employees, chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors and governing and corporate offices.

The following are just a few examples of fraud, waste and abuse in a health care setting. This list is for purposes of illustration and is not intended to be a complete list of fraud, waste and abuse situations.

Examples include:

- Billing for services or items not provided;
- Billing for care already reimbursed by another payer;
- Assigning incorrect codes to secure higher reimbursement;
- Falsifying claim forms;
- Characterizing non-covered services or costs in a way that secures reimbursement;
- Offering or receiving kickbacks, bribes or illegal rebates;
- Using another person's Medicare or Medicaid number to obtain services or payment;
- Not seeking payment from beneficiaries who may have other primary payment sources;
- Excessive charges for services or supplies;
- Claims for services that are not medically necessary
- Breach of the Medicare and Medicaid participation or assignment agreements;
- Improper documentation and/or billing practices