HOW AND WHEN TO CONDUCT A COMPLIANCE INTERNAL AUDIT

HCCA Annual Compliance Institute
Sunday, April 19
9:00AM – 12:00PM

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MultiCare Health System, Tacoma, WA

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Principal, Health Care Industry Group
Moss Adams LLP

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TODAY’S OBJECTIVE

- Different types of compliance audits
- Risk assessment process
- Overview of audit process
- Process for showing the value add of these audits
- What do you want to get out of today?
INTRODUCTIONS

- Us
- You!

INTRODUCTION TO MHS

- Not for Profit Health System located in Tacoma, Washington
  - 5 hospitals
  - 100+ Outpatient/Professional services
  - 10,000+ employees
- Corporate Compliance & Internal Audit Dept
  - 5 auditors (2 Internal Auditors, 1 Senior Auditor, 1 Senior Nurse Auditor, 1 IT Auditor)

INTRODUCTION TO MOSS ADAMS

- Moss Adams LLP provides accounting, tax, and consulting services to public and private middle-market enterprises in many different industries.
- Founded in 1913 and headquartered in Seattle, Moss Adams has 24 locations in Washington, Oregon, California, Arizona, New Mexico, Kansas, and Texas.
- Moss Adams is one of the 15 largest accounting and consulting firms in the United States.
BACKGROUND

ONE OF THE SEVEN ELEMENTS

"An ongoing evaluation process is critical to a successful compliance program. The OIG believes that an effective program should incorporate thorough monitoring of its implementation and regular reporting to senior hospital or corporate officers. Compliance reports created by this ongoing monitoring, including reports of suspected noncompliance, should be maintained by the compliance officer and shared with the hospital’s senior management and the compliance committee."

http://oig.hhs.gov/authorities/docs/cpghosp.pdf


HHS/DOJ HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM’S (“HEAT”)

Internal Auditing
- Perform proactive reviews in coding, contracts & quality of care.
- Create an audit plan and re-evaluate it regularly.
- Identify your organization’s risk areas. Use your networking and compliance resources to get ideas and see what others are doing.
- Don’t only focus on the money – also evaluate what caused the problem.
- Create corrective action plans to fix the problem.
- Refer to sampling techniques in OIG’s Self Disclosure Protocol and in CIAs to get ideas.

HHS/DOJ Health Care Fraud Prevention and Enforcement Action Team's ("HEAT")

Enforcement of Policies and Procedures and Prompt Response to Compliance Issues

- Delegate/empower teams closest to the issues to perform reviews, but be careful of possible conflicts or personal relationships that may interfere with getting an objective review.
- Act promptly, and take appropriate corrective action.
- Create a system or process to track resolution of complaints.
- Enforce your policies consistently through appropriate disciplinary action.

RISK ASSESSMENTS

Risk Assessment Process Flow

Broad focus on all types of risks
AHLA & OIG COMPLIANCE GUIDANCE FOR BOARDS

- Does the compliance program address the significant risks of the organization? How were those risks determined and how are new compliance risks identified and incorporated into the program?
- How is the Board kept apprised of significant regulatory and industry developments affecting the organization's risk? How is the compliance program structured to address such risks?

DEFINE RISK ASSESSMENT GOALS

**Depth**
Are your risks and controls commonly named across your organization in order to integrate results?

**Reach**
Are you involving a smaller team or many people across the organization? Also, are your participants at one level (e.g., management) or across many levels?

**Integration**
How quickly are you able to execute the assessment from launch to reports?

**Accuracy**
Do you have responses from the most informed people? Do you have responses from enough people to have an accurate view?

**Speed**
Do your risks and controls commonly named across your organization in order to integrate results?

RISK ASSESSMENT APPROACH

- Determine the scope and preliminary list of compliance risks to be assessed
- Identify key compliance risk-related data
- Finalize set of risks to be assessed
- Evaluate control activities and level of risk mitigation
- Calculate risk concern level and rank risk areas
- Confirm risk evaluation results
- Create Action Plan
MHS RISK ASSESSMENT

Process Overview
- Each Department and their key functions are risk assessed based on annual revenue (more revenue generated higher risk)
- Management Interviews and surveys of risk (this is done as part of our Enterprise Risk Assessment Process)
  - Interviews conducted with Senior Level Management, Legal, Compliance Department Staff and others on an as needed basis.
  - Surveys sent to Director level and above and select staff level personnel

SAMPLE RISK RANKING ON $

<table>
<thead>
<tr>
<th>Enterprise Risks</th>
<th>Survey Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you see as emerging enterprise-level risks (i.e., competitive environment, internal changes) that will prevent MultiCare from achieving our strategic objectives? Do you feel that adequate controls or processes are in place to address these risks?</td>
<td></td>
</tr>
<tr>
<td>What significant changes in the external environment (i.e., rapid technology change, exchanges/ACOs, increased consumerism) may pose potential risk to MultiCare? Do you feel that the organization properly positioned to adequately address these risks?</td>
<td></td>
</tr>
</tbody>
</table>

Operational Risks
- What are your key areas of concern and/or what are the key business processes that clearly need improvement within your department(s) or within the organization as a whole?
- Are there risks that result from interdependencies with other parts of MultiCare that you feel have significant impact to your department(s)?

General
- What areas within the organization do you believe may have significant risk of fraud, waste or abuse?
- What keeps you up at night?
- Are there key internal control concerns or risks you would like to have C2A evaluate?
INTERVIEW QUESTIONS

- Are the top enterprise-level risks (per the MHS 2013/2014 Risk Dashboard below) still representative of the top strategic, operational and technology risk areas for MultiCare? How do you feel our current infrastructure, processes, people and technology are positioned to address these risks?

<table>
<thead>
<tr>
<th>Key Risks</th>
<th>Strategic Framework</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Delivery Transformation</td>
<td>Strategic</td>
<td>CEO</td>
</tr>
<tr>
<td>Clinical Innovation</td>
<td>Strategic</td>
<td>Clinical Leadership</td>
</tr>
<tr>
<td>Patient Privacy and Security</td>
<td>Strategic</td>
<td>Legal/Compliance</td>
</tr>
<tr>
<td>Staffing</td>
<td>Strategic</td>
<td>Recruiting</td>
</tr>
<tr>
<td>Information Security</td>
<td>Strategic</td>
<td>IT</td>
</tr>
<tr>
<td>Patient Privacy, Security, Clinical Innovation</td>
<td>Strategic</td>
<td>Legal/Compliance</td>
</tr>
<tr>
<td>Other</td>
<td>Strategic</td>
<td>Other</td>
</tr>
</tbody>
</table>

Legend

(1) Noted as a Top 5 Risk per Management Survey
(2) Noted as a Top 5 Risk per Staff Survey
(3) Noted as a Top 5 Risk in both the Management and Staff Surveys

INTERVIEW QUESTIONS

- Which of the below topics do you believe is a top risk concern/opportunity that can impact MultiCare’s ability to achieve our strategic objectives? Does our current infrastructure, processes, people and technologies positioned us adequately to properly address these risks?

- Are there other emerging enterprise-level risks that you feel may prevent MultiCare from achieving our strategic objectives? Do you feel that adequate controls or processes are in place to address those risks?

- What are the significant changes in our external or internal environment (people, processes and technology) that could affect our risk profile?

- What impacts to risk management may result from the recent organizational restructuring? As these changes introduce decentralization in some management practices, how will CEO Council establish a clear view of risk across MultiCare?

- How would you describe how responsibilities for the management of organizational risk are assigned within MultiCare? Do you believe that management is provided the tools and education necessary to execute those responsibilities?

- Are areas within the organization do you believe may have significant risk of fraud, waste or abuse?

- What keeps you up at night?
## Risk Assessment Tool

### Work Plan Development

**Risk Ranking Scale**

**Scale of 1 (Low) to 5 (High)**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>High Priority (Scores of 4 or 5) Must Do Items</td>
</tr>
<tr>
<td>Level II</td>
<td>Medium Priority (Score of 3) Should Do Items</td>
</tr>
<tr>
<td>Level III</td>
<td>Low Priority (Scores of 1 or 2) If Time Permits Items</td>
</tr>
</tbody>
</table>

## Risk Concern Levels

- **Likelihood**: Inherent probability of a risk occurring, without considering existing controls.
- **Impact**: The potential significance of a risk, without considering existing controls.
- **Risk Factor**: The estimated percentage of unmitigated risk.
**Calculation of Risk Concern Level**

(Likelihood) X (Impact) X (Risk Factor) X Confidence Level = Risk Concern Level

**Magnitude of Impact**

<table>
<thead>
<tr>
<th></th>
<th>Reputation (20%)</th>
<th>Legal/Regulatory (40%)</th>
<th>Financial (40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High</strong></td>
<td>Systemic loss of public confidence, resulting in loss of customers – headline news</td>
<td>Major infraction, resulting in criminal or civil prosecution – significant potential interruption of business</td>
<td>Significant financial impact</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Loss of confidence among large number of customers and a segment of the general public – media coverage</td>
<td>Infraction resulting in civil enforcement</td>
<td>Considerable financial impact</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Loss of confidence among limited number of customers</td>
<td>Minor infraction that is readily remediated with no loss in ability to operate</td>
<td>Minimal financial impact</td>
</tr>
</tbody>
</table>

**Risk Assessments – Other Organizations**

<table>
<thead>
<tr>
<th>No.</th>
<th>Process/Bond/Risks</th>
<th>Description/Risks</th>
<th>Likelihood of Error or Misstatement</th>
<th>Magnitude of Error or Misstatement</th>
<th>Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Construction/Bond</td>
<td>Risks include: compromised scope, budget or schedule including money spent but building not complete, payments not in compliance with contract terms and conditions, overpayments, changes made without approval, over pricing of change orders, fraud, waste, equipment damages, inadequate commissioning, inadequate payment to subcontractors, delays due to inspections, delays due to equipment arrival, delays due to long lead items, inadequate project documentation, inadequate facility documentation.</td>
<td>5</td>
<td>2</td>
<td>5</td>
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</tbody>
</table>
QUESTIONS

- How many in the room use an electronic tool for conducting risk assessments? What is it?
- Who is involved in conducting the risk assessment?
- Who do you interview during the risk assessment?

AUDIT PLANS

AUDIT PLAN DEVELOPMENT

- Based on risk assessment, interviews, industry knowledge, organization risks, etc.
- Taken to Compliance Steering Committee and Audit Committee for final approval.
- Annual audit plan finalized and quarterly plans developed.
AUDIT PLAN

Corporate Compliance Work Plan - Resource Hours Estimation (Subject to Change)

2014 Corporate Compliance Audit Work Plan (italicized items are prior year carryovers)

Type | Q1 | Hours | Q2 | Hours | Q3 | Hours | Q4 | Hours
--- | --- | --- | --- | --- | --- | --- | --- | ---
Privacy | At least 5 walkthroughs | At least 5 walkthroughs | At least 5 walkthroughs
Security | McKesson PACS 60 | Aria 60 | Acuity Plus 60 | QS 60
Facility (Rotation) | Laboratories 160 | MB Clinics 160 | Surgical Services - Supplies 160
Compliance Audits | Replacement Medical Devices 160 | Credentialing/Privileging Services 200 | DME 200
Monitoring (OIG Work Plan) | Anesthesia Services - Payments for Personally Performed Services 80 | Sleep Disorder Clinics - High Utilization of Sleep Testing Procedures 80 | Inpatient Claims for Mechanical Ventilation 80 | Review of Cardiac Catheterization and Heart Biopsies 80
Medication Management | Drug Diversion - Surveillance and Reporting Processes 240 | Risk Assessment Update 120 | Smart Pumps - Billing and Coding 160
ICD-10 Implementation | Q3 Readiness Assessment (90/60/30) 180
Follow-up: CC audits with "A" rated issues addressed in 2012/13

TOTALS 360 940 960 600

QUESTIONS?

- How do you ensure management buy in and support of compliance audits?
  - Board Level
  - Executive Level
  - Department Level
  - Clinical Level
- Who in your organization reviews and signs off on the audit plan?
AUDITING VERSUS MONITORING

- **Auditing**
  - The process of going back and looking at something 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.

- **Monitoring**
  - It is the on-going, day-to-day process that ensure that things do get done on time and correctly.

AUDITING & MONITORING - HOW?

- Use a RISK BASED APPROACH to determine what to audit and monitor.
- Develop and implement POLICIES AND PROCEDURES for periodic auditing and monitoring.
- Establish MONITORING SYSTEMS focused on prevention, early detection and resolution.
- Rotate through specific areas on periodic basis.
- Operating departments should be doing on-going monitoring of key processes and accounts.

MULTICARE'S AUDIT PROCESS

- Audits are based on:
  - An annual risk assessment
  - Current issues
  - Management requests
  - Regular rotations
  - Industry Guidance
  - Other
MULTICARE’S AUDIT PROCESS

Preliminary Discussion

Audit Outline / Scope

Testing, Interviews & Analysis

Observations & Dimensions

Engagement Letter

Entrance Conference

Exit Conference

Final Report

Death Report

Follow up

Direct Management Involvement

MULTICARE’S APPROACH

Plan and Confirm

Receive Desk Materials

Interview and Observe

Test to Validate

Identify Gaps

Opportunities

Quality Assurance

Confirm and Verify Findings

Deliver Report

MULTICARE’S QUESTIONS

o What process do you use to conduct audits?

o How are audits compared and trended?
AUDIT PROGRAM DESIGN

What should I plan for?

1. Define the need
2. Establish your compliance goal / accuracy rate
3. Obtain policies and procedures for area of focus
4. Choose an appropriate sample size
5. Choose who should perform review
6. Request data
7. Prepare the audit report with findings and recommendations
8. Corrective Action Plan (CAP)
9. Ongoing monitoring

DEFINE THE NEED

- Based identified concerns on reported activity
- Identified from monitoring
- Random or focused
- Document the audit objectives
- Define the reporting process of results
- How often will the audit be performed?
COMPLIANCE GOAL

- A policy to define expectations
- Define accuracy rate
- Determine what will be measured
- Define disciplinary or education

WHO PERFORMS?

- According the Office of Inspector General’s (OIG) auditing standards, evidence gathered by auditors and compliance officers should be sufficient, competent, and relevant.
  - Sufficiency
  - Competency
  - Relevancy

REPORTING AND FOLLOW-UP

- Draft report with stakeholders
- Rebuttals
- 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
DISCUSSION

- How do others track open audit issues?
- Do you have a standard process for determining issue remediation deadlines?

QUESTIONS

- How do you engage management into the audit?
- How many have standard audit programs? How are these documented and tracked?
- Is there a standard error rate?

WHAT SHOULD WE AUDIT?
MULTICARE STANDARD AUDITS

- HIPAA Security Audits
- HIPAA Privacy Audits
- Facility/Billing Compliance Audits
- Monitoring Audits

MULTICARE SECURITY AUDITS

- HIPAA Security Focused
  - Based on and I.S. risk assessment completed annually.
  - Ensures that technology systems used are meeting HIPAA Security Standards
- Objective: to assess the compliance of (system) with the 2005 HIPAA Security Rule, HITECH Act and internal policies and procedures
- Scope: Focused on the administrative, technical, and physical safeguards as referenced in the HIPAA Security Rule, HITECH Act and internal policies

<table>
<thead>
<tr>
<th>Test Category</th>
<th>Validation Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>Reviewed formal risk assessment performed by IS Security management for systems with electronic Protected Health Information (ePHI).</td>
</tr>
<tr>
<td></td>
<td>Reviewed system activity based on audit logs and access reports.</td>
</tr>
<tr>
<td></td>
<td>Consulted with department manager, Information Security, and Human Resources regarding security violations and sanctions occurring in the past 12 months to assess employee compliance with IS security guidelines.</td>
</tr>
<tr>
<td>Clearance and Authorization</td>
<td>Reviewed policies and procedures for the authorizing, provisioning and deprovisioning, and supervising of appropriate access of ePHI to workforce.</td>
</tr>
<tr>
<td>Workforce Security</td>
<td>Tested (SYSTEM) user list against Lawson termination list; reviewed for former employees.</td>
</tr>
<tr>
<td>Awareness and Training</td>
<td>Reviewed system requirements and capabilities to monitor login attempts and reported discrepancies.</td>
</tr>
<tr>
<td></td>
<td>Reviewed procedures for creating, changing, and safeguarding passwords.</td>
</tr>
<tr>
<td></td>
<td>Reviewed application training.</td>
</tr>
<tr>
<td>Incident Procedures</td>
<td>Surveyed employees and manager regarding procedures for education on how to recognize and report suspected or known security incidents.</td>
</tr>
<tr>
<td>Contingency Plan</td>
<td>Reviewed policies and procedures for continuation of critical business processes for protection of the security of ePHI while operating in emergency mode.</td>
</tr>
<tr>
<td>Business Associate Contracts</td>
<td>Validated existence of current Business Associate Agreement.</td>
</tr>
<tr>
<td>Facility Access Controls</td>
<td>Observed if employees wore ID badges in the facility.</td>
</tr>
<tr>
<td>Workstation Security</td>
<td>Evaluated the workstation security and proper disposal of paper PHI.</td>
</tr>
<tr>
<td>Access Controls</td>
<td>Reviewed policies and procedures for combination of critical business processes for protection of the security of ePHI while operating in emergency mode.</td>
</tr>
</tbody>
</table>

HIPAA Security Audit Steps
### MultiCare Privacy Audits

**HIPAA Privacy Focused**
- To ensure clinical locations are compliant with HIPAA Privacy requirements:
  - Conversations kept confidential
  - No paper with PHI visible
  - Patient Boards have limited Identifying Information
  - No sign-in sheets
  - How to clinic call patients back from waiting room (first and last or only one)
  - Shred bins (location and appropriate use)
  - Leak in the trash (any PHI?)
  - Notice of Privacy Practices (distributed, signed)
  - Are computers secured or visible to public
  - Do people log off when stepping away
  - Fax coversheets are used
  - Printers and fax machines are appropriate locations

### Example Facility/Billing Audit Spreadsheet

**Focus on coding and billing compliance**
- Does not include medical necessity
- **Objective**: To determine compliance with the Centers for Medicare and Medicaid Services (CMS) rules and regulations for coding and billing.
  - Also look at specific FI, JC, DOH requirements
- **Scope**: Includes a sample chart to claim review for a selected sample
  - Selection of scope is specific to service we are reviewing.

### Facility/Billing Audit Spreadsheet

![Spreadsheet Image]
**MONITORING AUDITS**

- Conduct Quarterly Monitoring Audits
  - Generally based on audits on the OIG work plan
  - Review consists primarily of data analysis
  - These audits are designed to “scratch the surface” to determine if a deep review is necessary.
  - Example: Place of Service Codes
    - Pull billing for last 6 months and compare POS codes on claims with actual place of service. Are all Hospital/Provider Based locations being billed with the correct POS code.
  - Sleep Disorder Clinics – high utilization of sleep testing procedures
  - Inpatient claims for mechanical Ventilation over 96 hours

**OTHER AUDIT OPPORTUNITIES**

- Based on
  - Management requests
  - Additional data mining
  - Other audits
  - OIG audits
  - PEPPER Reports
  - Current Events
    - HCCA magazine
    - Report on Medicare Compliance newsletters
    - Professional connections
    - Etc...

**QUESTIONS?**

- What has been the focus of your organization? How was the audit found or focused?
- How many people do audits of EHR changes?
  - How are you doing it?
CORRECTIVE ACTION PLANS

AHLA & OIG COMPLIANCE
GUIDANCE FOR BOARDS

- What processes are in place to ensure that appropriate remedial measures are taken in response to identified weaknesses?

REPORTING AND FOLLOW-UP

- Draft report for review with stakeholders
- 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
CORRECTIVE ACTION PLANS

- Based on root cause of issue
- Collaboration with management to develop appropriate corrective action
  - Specific
  - Actionable
  - Measureable
  - Has a timeline

<table>
<thead>
<tr>
<th>Issue Description</th>
<th>Management Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is involved?</td>
<td>Management Response</td>
</tr>
<tr>
<td>What is happening?</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>What is the issue’s impact?</td>
<td>Implementation Date</td>
</tr>
</tbody>
</table>

AUDIT ISSUE RANKING

<table>
<thead>
<tr>
<th>Issue Priority</th>
<th>Assigned To</th>
<th>General Considerations</th>
<th>Conditions for Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (High)</td>
<td>SVP Level (or above)</td>
<td>Immediate management attention is required to address the issue.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significantly lower risk to financial or reputational damage.</td>
<td></td>
</tr>
<tr>
<td>B (Moderate)</td>
<td>VP Level (or above)</td>
<td>Management should initiate timely action to address the issue.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significantly lower risk to financial or reputational damage.</td>
<td></td>
</tr>
<tr>
<td>C (Low)</td>
<td>Administrator/ Director Level (or above)</td>
<td>Management should initiate reasonable action to incorporate a plan to address the issue in the normal course of business.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significantly lower risk to financial or reputational damage.</td>
<td></td>
</tr>
</tbody>
</table>
AUDIT ISSUE MANAGEMENT

- All audit issues are tracked in our audit management software
  - Tracked by rating and deadline
  - 30 days prior to issue due date auditor sends reminder email to responsible party
  - Auditor works with responsible party to close issue prior to due date
  - If unable to close, institute issue extension process

REPORTING OF RESULTS
Corrective action plans and who to report to

ERROR CALCULATION

- Count of met and not met for:
  - Claims
  - Lines (services billed)
- Net reimbursement
- Weighted points to the total lines
  - By line
  - By type of CPT code
  - Diagnosis errors
  - Modifiers
  - Teaching physician count
<table>
<thead>
<tr>
<th>Date</th>
<th>Site Name</th>
<th>Category</th>
<th>X</th>
<th>Y</th>
<th>Z</th>
<th>X+Y+Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/17/2015</td>
<td>Site A</td>
<td>Category A</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>03/18/2015</td>
<td>Site B</td>
<td>Category B</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>15</td>
</tr>
</tbody>
</table>

**Summary of Data**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>Site B</td>
</tr>
<tr>
<td>Category A</td>
<td>Category B</td>
</tr>
</tbody>
</table>

**Graphical Representation**

![Graphical Chart](image-url)
**QUESTIONS?**

- How does your organization track corrective action plans?
- What is the interval for follow up? 60 days? 90 days?
- How do you maintain independence during presentation of audit results?

**HOW CAN WE BE PROACTIVE?**

**NATIONAL FRAUD PREVENTION PROGRAM**

**TWO CONCURRENT APPROACHES**

- Take quick administrative action to prevent improper payments.
- Take quick action to remove bad actors from Medicare.
- Identify bad actors and prevent them from enrolling in Medicare.
- Take quick action to remove bad actors from Medicare.
NATIONAL FRAUD PREVENTION PROGRAM
TWO CONCURRENT APPROACHES

Take quick administrative action to prevent improper payments.
Take quick action to remove bad actors from Medicare.

Predictive Analytics (Claims)
Provider Screening (Enrollment)

Identify bad actors and prevent them from enrolling in Medicare.
Take quick action to remove bad actors from Medicare.

Includes:
Submitted claims
Paid investigations
Complaints
Stolen IDs
Enrollment Alert Management System Zone PI Contractors

NATIONAL FRAUD PREVENTION PROGRAM CLAIMS PAYMENT

Integrates predictive modeling as part of an end-to-end solution that triggers effective, timely CMS administrative actions.

Assures that analytics are effective (minimize false positives), efficient (return on investment), and risk-based.

Meets the requirements of Section 4241 of the Small Business Jobs Act of 2010

ADVANCED TECHNOLOGY RISK SCORES BASED ON COMPREHENSIVE SET OF MODELS

Rules
Rules to filter fraudulent claims and behaviors

Anomaly Detection
Detect individual and aggregated abnormal patterns vs. peer group

Predictive Models
Predictive assessment against known fraud cases

Social Network Analysis
Knowledge discovery through associative link analysis
**OTHER KEY FACTS**

- **Increased Data Sources**
  - APS leverages thousands of government, public, and private resources to verify and supplement data submitted by providers.

- **Monitoring Alerts**
  - APS monitors critical eligibility requirements (e.g., sanctions, death, convictions) and immediately alert CMS to any changes.
  - APS also regularly re-screens all information on a provider enrollment application for continued accuracy.

- **Unified Screening Process**
  - APS will provide a unified screening process for all MACs to ensure that all Medicare providers are screened with the same degree of rigor.

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**COMPREHENSIVE STRATEGY**

**Program Integrity**

- Detect suspicious claims prior to payment
- Prevent fraudulent providers from enrolling
- Revoke bad actors from Medicare and Medicaid
- Focus on risk and reduce burden on legitimate providers
- Keep bad actors from re-enrolling
- Share information with States, law enforcement and private plans to target and track fraudsters

---

**SHOWING VALUE ADD**
QUARTERLY REPORTING

VALUE ADD REPORTING

OTHER VALUE ADD ACTIVITIES

- Data Analysis (missed revenue)
  - Missed Deliveries
  - Missed Facility Fee
  - Missed Workers Compensation Visit Charges
  - Non-matching CPT Codes
- System Go-live Readiness Assessments
  - New billing systems
  - New timecard systems
  - Electronic medical record implementations
  - ICD-10
- Validation reviews
  - Meaningful use
  - Quality data reporting (Leapfrog, PQRS)
QUESTIONS?

- What do others do to show the value of their work?
- Has anyone been successful at showing cost avoidance for incorrect claim submissions?

EXAMPLES

<table>
<thead>
<tr>
<th>Purpose</th>
<th>The purpose of this audit is to verify the use of high level E/M codes by one provider using time to assign E/M level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>Unless decided otherwise after initial research has been done, the audit will examine services billed for the provider in 2011. The charts will be examined solely for the purpose stated above.</td>
</tr>
<tr>
<td>Other</td>
<td>Place project under attorney client privilege.</td>
</tr>
</tbody>
</table>

SAMPLE AUDIT PLAN FOR HIGH LEVEL E/M
SAMPLE AUDIT PLAN

<table>
<thead>
<tr>
<th>Paid or not paid</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>What claims to audit?</td>
<td></td>
</tr>
<tr>
<td>Medical Necessity</td>
<td></td>
</tr>
<tr>
<td>Analyze and track?</td>
<td></td>
</tr>
<tr>
<td>Sample of?</td>
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<tr>
<td>Audit tool focus</td>
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<td>Inquiries</td>
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<td>What is to be in the report?</td>
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<tr>
<td>Review report with?</td>
<td></td>
</tr>
<tr>
<td>Corrective Action Plan</td>
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</table>

FRAUD CASE – NEW YORK

A Manhattan man charged with more than $30 million in health-care fraud saw his Lamborghini seized and made bail only after his parents put up their home as collateral in Brooklyn federal court yesterday.

The manager took over a Queens radiology office where he worked and billed Medicaid and Medicare for services credited to a doctor who no longer worked at the office, federal authorities charged.

"X is not a doctor," said Assistant US Attorney Williams Campos. "The defendant is accused of billing the government for radiological services for Dr. John Doe [whose name the feds are protecting], who didn't work there."

The feds say the manager billed Medicare about $20 million and Medicaid about $12 million for work supposedly done between May 2010 and March 2012. But that doctor told an FBI agent that he did no work during that period.

Read more: http://www.nypost.com/p/news/local/fraud_bye_bye_borghini_VMtACnvfnsqNKU4INmqLHI

FORMER OWNER OF DAYTONA BEACH CLINIC PLEADS GUILTY TO FRAUD, CONSPIRACY, AND MONEY LAUNDERING

- Submitted inflated bills to public and private health care beneficiary programs, including Medicare.
- Charged those programs at the higher rates for services rendered by medical doctors, instead of the rates appropriate for chiropractors.
- Systematically submitted claims for reimbursement for services not rendered.
- Submitted fraudulent billings in the names of medical doctors.
- Provided customers with prescriptions for prescription drugs, often in return for cash payments.
**2 - SAMPLE AUDIT PLAN FOR THIS TYPE OF CASE**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>The purpose of this audit is to review claims for services provided. Reported concern of manager.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>Identify scope by completing an utilization analyses which is reviewed by one or two physicians</td>
</tr>
<tr>
<td>Other</td>
<td>Place project under attorney client privilege.</td>
</tr>
</tbody>
</table>

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**SAMPLE AUDIT PLAN**

<table>
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**LOS ANGELES CASE**

- A doctor already serving a lengthy prison sentence in a narcotics case has been convicted of health care fraud for submitting approximately $1 million in fraudulent bills to Medicare in just seven months.
- The evidence presented at trial showed that the provider repeatedly lied to Medicare about services he claimed to have provided at clinic locations from which he had been evicted.
- The jury also heard expert testimony from a neurologist about the provider’s patient files, which contained so many internal inconsistencies and impossibly identical results that they appeared to have been a "copy-and-paste job."

VASCULAR SURGEON SENTENCED

- A Chicago area vascular and thoracic surgeon was sentenced today to 10 months in federal custody
- Made false statements in post-operation reports
  - Falsified post-operation reports
  - Included extensive details about aneurysm repairs that he never performed
  - Reported surgeries he did perform as being more complex and elaborate than they actually were

3 - SAMPLE AUDIT PLAN FOR THIS TYPE OF CASE

<table>
<thead>
<tr>
<th>Purpose</th>
<th>The purpose of this audit is to review claims for Copy and Paste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>Identify scope by completing an utilization analyses</td>
</tr>
<tr>
<td></td>
<td>Identify services by diagnosis type</td>
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<tr>
<td>Other</td>
<td>Place project under attorney client privilege.</td>
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SAMPLE AUDIT PLAN

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MOSS ADAMS...