Montefiore

MONTEFIORE HEALTH SYSTEM
ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT:	DETECTION AND PREVENTION OF FRAUD, WASTE, AND ABUSE	NUMBER: JC30.1
OWNER:	DEPARTMENT OF COMPLIANCE	
EFFECTIVE: 11/13	REVIEW/REVISED: 03/15	SUPERSEDES: 05/14, 11/13

REFERENCE: S. 1932, Deficit Reduction Act of 2005

CROSS-REFERENCE: Administrative Policy and Procedures, JF11.1, Provider Billing Compliance, JF03.1 Billing by Teaching Physicians, JE16.1, Ethical Conduct, Legal Compliance, Fraud and Misconduct, Montefiore Code of Conduct

Administrative Policy and Procedure JC30.1 for Montefiore Health System replaces Montefiore Medical Center Administrative Policy and Procedure JC30.1 that was effective 02/07 and all subsequent versions.

Policy:

It is the policy of Montefiore Health System and its affiliates and subsidiaries ("Montefiore") that all board members, associates, including employed physicians, and voluntary physicians; and vendors, consultants and agents who provide health care services or who perform billing or coding functions shall comply with all pertinent Federal and New York State false claims laws and regulations. Montefiore has developed systems to detect, correct and prevent fraud, waste and abuse especially in the areas that have been identified by the Office of the Inspector General of the Department of the Department of Health and Human Services to be "high risk" for fraud and abuse.

Scope:

This policy applies to all associates of Montefiore, whether assigned to perform duties in a division or unit of Montefiore or a corporate affiliate of the Montefiore, or at another institution under a contract between Montefiore and such institution, and to all Montefiore clinical chairpersons regardless of whether Montefiore is their employer. It is also applicable to all vendors, consultants and agents who perform health care services or billing and coding functions under contracts with Montefiore, with respect to their activities while performing those services or otherwise on behalf or purportedly on behalf of Montefiore.

This policy applies to all Montefiore locations except to the extent an entity has its own specific procedures that are based on its own systems, processes and departments.

Definitions:

Fraud — Fraud is the intentional deception or misrepresentation that an individual (1) knows to be false or does not believe to be true and (2) makes knowing the deception could result in some unauthorized benefit to himself/herself or some other person.

Waste – Waste is any healthcare spending or practice that can be eliminated without reducing the quality of care and includes incurring unnecessary costs because of inefficient or ineffective practices, systems or controls.

Abuse — Abuse involves incidents or practices that are inconsistent with accepted sound medical, business, or fiscal practices. These actions may result in unnecessary program costs and improper payment for services not meeting professionally recognized standards of care or medical necessity.

Application:

Montefiore has adopted an extensive set of programs for detecting and preventing fraud, waste and abuse. The Department of Compliance oversees these programs and depending on the nature of the allegations works collaboratively with other departments to conduct investigations in these areas.

As part of the commitment to ethical and legal conduct, associates are required to bring immediately to the attention of their immediate supervisor, department supervisor, or the Compliance Officer, information regarding suspected improper conduct. Associates, board members, vendors, consultants and agents may also contact the Compliance Hotline by telephone at 1-800-662-8595 or online at www.montefiore.alertline.com to report concerns about possible violations of the law or institutional policy, and may do so anonymously if they wish. Montefiore is committed to investigating any such allegation of fraud, waste, or abuse swiftly and thoroughly and will do so through its internal compliance programs and processes. To ensure that the allegations are fully and fairly investigated, Montefiore requires that all associates fully cooperate in the investigation. Failure to report or to assist in an investigation of fraud, waste and abuse is a breach of the associate's obligation to Montefiore and will result in disciplinary action, up to and including termination of employment.

Any associate of Montefiore who reports such information will be protected against retaliation for coming forward both under Montefiore's internal compliance policies and procedures and federal and state law. However, Montefiore retains the right to take appropriate action against anyone who has participated in a violation of federal or state laws, regulations, requirements of regulatory, licensing or accrediting agencies or hospital policy.

Procedures:

Work Plans — Each year, the Department of Compliance prepares work plans for the following year for each of the following areas: Corporate Compliance, HIPAA Privacy and Security, and Billing Compliance. The work plans set forth the auditing and monitoring activities that will be undertaken in the calendar year. All work plans are approved by the Executive Compliance Committee and presented to the Compliance Committee of the Board of Trustees.

Auditing and Monitoring — The Department of Compliance performs routine and periodic reviews of claims submitted to Medicare, Medicaid and other health care plans. Reviews of the claims development and submission process are also conducted, and may include reviewing the work of coders, billers, admitting and registration clerks, physicians and ancillary departments. Reviews may also be scheduled as a result of a complaint made directly to the Department of Compliance.

For HIPAA compliance, routine reviews of the clinical information system designed to identify unauthorized and/or inappropriate access to medical information are performed.

Risk Assessment — Certain laws and regulations require that a health care provider perform a periodic risk assessment. Risk assessment activities may be accomplished via the

administration of questionnaires, departmental reviews, or using computer-based tools.

Education and Training — Annual compliance training is mandatory for all board members and associates. In addition, depending upon the results of the reviews and other ongoing monitoring activities, the Department of Compliance will design department-specific training sessions to address the issues of potential non-compliance. In addition, some training sessions are mandatory for specific groups, such as the teaching physician guidelines training session, HIPAA privacy and security training, and training involving billing for research-related services.

Corrective Action/Re-Review — In accordance with policy JF11.1, Provider Billing Compliance, departments or any and all other providers that are performing below the threshold for error will be put on a corrective action plan that may include 100% audit of claims, and may be subject to disciplinary action. Violations of HIPAA privacy and security will result in written disciplinary action, and in some cases, termination.

Responsibility:

Department of Compliance

Regulatory Reference(s):

Deficit Reduction Act of 2005, S.1932 Sect. 6032 and Social Security Act, 42 U.S.C. 1396a(a)(68); Federal False Claims Act 31 U.S.C. 3729-3733; and New York State False Claims Provisions, Social Services Law Article 5 Title 1 §145-b; OIG Model Compliance Program Guidance for Hospitals, 63 FR 8987-8988 (2/23/98); OIG Supplemental Compliance Program Guidance for Hospitals, 70 FR 4858-4875 (01/31/05),