General Information

Policy Name:	Detecting and Preventing Fraud, Waste and Abuse
Category:	Risk Management – Corporate Compliance
Applies To:	All Crouse Hospital employees, staff and contractors, subcontractors and agents who, on behalf of Crouse Hospital, furnish or authorize the furnishing of, Medicare/Medicaid health care items or services, perform billing or coding functions, or are involved in the monitoring of health care provided by Crouse Hospital
Key Words:	Health Care Fraud, Non-Retaliation, Compliance Reporting, Regulations
Associated Forms & Policies:	Compliance Education and Training (P0163) Corporate Compliance Handbook (Doc #8537) Internal Quality Audit Program: Compliance Risk & HIPAA Monitoring (P0169) Non-Intimidation & Non-Retaliation (P0170) Whistleblower: Compliance Reporting (P0174)
Original Effective Date:	07/01/10
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This Version's Effective Date:	03/10/23

Policy

It is the policy of Crouse Hospital 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. Crouse Hospital is committed to conducting its operations in an ethical and lawful manner and has therefore developed and implemented a Corporate Compliance Program.

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, Crouse Hospital's policies and procedures, the Code of Conduct, and other applicable standards. This policy ensures that affected individuals are familiar with Crouse Hospital's efforts to detect and prevent health care fraud, waste and abuse as required by Crouse Hospital's Code of Conduct, Corporate Compliance Program and the Deficit Reduction Act of 2005. The policy assists employees, staff, providers and vendors in recognizing instances of potential fraud, waste and abuse, and encourages good faith reporting.

Procedure

1. The Compliance Officer ("CO") or his/her designee, shall ensure that affected individuals are provided information concerning Crouse Hospital's efforts to detect and prevent health care fraud, waste or abuse, in accordance with Crouse Hospital's Compliance Education and Training Policy (P0163).

2. The CO, or his/her designee, shall ensure that affected individuals who are covered under this policy are provided access to this policy and other information concerning Crouse Hospital's efforts to prevent and detect health care fraud, waste or abuse. This includes access to Crouse Hospital's Corporate Compliance Program Handbook, the Code of Conduct and compliance-related policies. Access to such information may be via the Intranet or on Crouse's website (Crouse.org).

3. The CO, or his/her designee, shall ensure that internal and/or external audits are conducted on a periodic, regular basis, to verify the accuracy of Crouse Hospital'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 Crouse Hospital's Corporate Compliance Program and the results shared with appropriate Crouse Hospital departments and committees, including without limitation, the Compliance Committee. Refer to Crouse Hospital's Corporate Compliance policy: Internal Quality Audit Program: Compliance Risk & HIPAA Monitoring (P0169).

4. Affected individuals covered by this policy should report questions, concerns, and/or suspected violations of Crouse Hospital's policies and procedures and applicable law, and/or instances of potential fraud, waste and abuse to the CO, the Compliance Department, or to the applicable department's supervisor or manager. They can report anonymously using the hotline ((315)470-7770) or the reporting form on Crouse Insider. Crouse Hospital has adopted a strict non-retaliation policy for good faith reporting of compliance issues or concerns. For further information, refer to Crouse Hospital's Corporate Compliance policies: Whistleblower: Compliance Reporting (P0174) and Non-Intimidation & Non-Retaliation (P0170).

References

Centers for Medicare and Medicaid Services, Fraud Overview: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

Crouse Hospital Code of Conduct and Corporate Compliance Handbook, including Appendix A: Description of Fraud and Abuse/Non-Retaliation Laws. Corporate Compliance Handbook (Doc #8537)

Department of Health and Human Services, Office of Inspector General's Fraud and Abuse Prevention Website: https://oig.hhs.gov/fraud/.

Deficit Reduction Act of 2005, Section 6032. https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf

NYS OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521. OMIG's website is: https://omig.ny.gov/compliance/compliance

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 provider's risk areas including employees, chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors and governing and corporate offices

Addendums, Diagrams & Illustrations

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