Issue 10, Summer 2015

This newsletter is prepared by the Office of Compliance and is intended to provide you with current information about healthcare compliance and HIPAA privacy issues. For additional information, to view past newsletters, or to provide comments about this or any future issues of this newsletter, please contact the Office of Compliance at (213) 740-8258 or at compliance@usc.edu.

New Policy on Fraud and Abuse

The USC Office of Compliance has posted a new policy on "Detecting and Preventing Fraud and Abuse in Federal Healthcare Programs."

The policy provides guidance on the types of incidents that can result in fraud and abuse, and explains procedures for reporting suspected violations. Employees are reminded that they are obligated to report concerns about documenting, coding and billing practices that may be non-compliant, and that any person who reports a concern in good faith is protected from retaliation by University policy and by state and federal laws.

This policy replaces the USC Care Medical Group Deficit Reduction Act policy and became effective on June 30, 2015. The policy applies to all of Keck Medicine of USC.

To review the new policy, go to:
http://ooc.usc.edu/sites/ooc.usc.edu/files/pdfs/CO-111-Detecting-and-Preventing-Fraud-and-Abuse-in-Federal-Health-Care-Programs.pdf

ICD-10 Compliance and What It Means

This time, it's for real. From clinical documentation to quality measures, from coding to claims, the October 1, 2015, compliance date for ICD-10 is less than a month away. The new code set includes updated and more specific medical terminology and classification of disease, and is more clinically accurate than the current ICD-9 system. With improved clinical documentation, the switch to ICD-10, is expected to result in enhanced quality measurement, a reduction in coding errors, improved analysis of disease patterns across populations, and better public health reporting.

For one year after the compliance date, Medicare will not deny claims based solely on specificity of the ICD-10 diagnosis code as long as the physician uses a code from the correct family of codes. Likewise, Medicare clinical quality data reviews will not subject physicians or other Eligible Professionals to penalties under the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) based on the specificity of the ICD-10 diagnosis code. Again, the physician or Eligible Professional must select a code from the correct family of codes. For more information, go to the CMS Provider Resources page:
https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

The USC Help & Hotline is a number that all faculty, staff, and students can use to report suspected violations of an applicable law, regulation, or university policy confidentially and without fear of retribution. The Help & Hotline can also be used to ask questions about applicable laws, regulations, and university policies that may impact your job duties.

The USC Help & Hotline is staffed 24 hours a day, 365 days a year: (213) 740-2500.

To help physicians provide enough specificity in their diagnoses to support coding, as well as list the correct diagnoses and problems, a new KeckCare tool called Diagnosis Assistant has been implemented. Diagnosis Assistant will provide a structured format to help the physician choose diagnoses by prompting for things such as site, laterality and other requirements for ICD-10 terminology. In addition, a new Electronic Professional Charge Capture Process (aka Patient Keeper) has been developed. The new electronic charge process is integrated with KeckCare Power Chart and allows providers to easily select the diagnosis that has already been documented in KeckCare. This new process will eliminate the need for paper charge tickets by interfacing directly with GECB.

Over the past year, the Compliance Office has worked closely with IT and the Office of Revenue Cycle and fully support the use of these new tools to help ease the transition to ICD-10.

CMS Cutting-Edge Technology Identifies & Prevents $820 Million in Improper Medicare Payments in First Three Years

After three years of operations, the Centers for Medicare & Medicaid Services (CMS) reported on July 14, 2015 that the agency's advanced analytics system, called the Fraud Prevention System, identified or prevented $820 million in inappropriate payments in the program's first three years. The Fraud Prevention System uses predictive analytics to identify troublesome billing patterns and outlier claims for action, similar to systems used by credit card companies. The Fraud Prevention System identified or prevented $454 million in Calendar Year 2014 alone, a 10-to-1 return on investment.

The Fraud Prevention System was created in 2010 by the Small Business Jobs Act, and CMS has extensively used its tools, along with other new authorities made possible by the Affordable Care Act, to help protect Medicare Trust Funds and prevent fraudulent payments. For instance, last month, Health & Human Services (HHS) and the Department of Justice announced the largest coordinated fraud takedown in history, resulting in charges against 243 individuals, including 46 doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $712 million in false billings.

You can read the full release here:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-14.html

OIG Releases Semiannual Report to Congress

The Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") recently released its Semiannual Report to Congress ("Report"), summarizing OIG's activities for the six-month period ending on March 31, 2015.

The Report highlights OIG's accomplishments over the first half of FY 2015, including:

- Expected recoveries of over $1.8 billion, comprised of approximately $544.7 million in audit receivables and $1.26 billion in investigative receivables.
- 486 criminal actions against individuals and entities that engaged in crimes against HHS programs

- 326 civil actions, including false claims cases, unjust-enrichment lawsuits, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters.
- Exclusions of 1,735 individuals and entities from participation in Federal health care programs.

In addition, the Report emphasizes the efforts and accomplishments of the Health Care Fraud Prevention and Enforcement Action Team ("HEAT"), a collaborative program between HHS and the Department of Justice launched in 2009. Moreover, the Report compiles and summarizes the various individual reports OIG published over the first half of FY 2015 regarding its efforts to reduce waste or inefficiency in the Federal health care programs.

For the full story, please visit http://www.natlawreview.com/article/oig-releases-semiannual-report-to-congress.

And the report can be found on the OIG's website: https://oig.hhs.gov/reports-and-publications/semiannual/index.asp

USC Office of Compliance | University Gardens Building | 3500 S. Figueroa Street | Suite 105 | Los Angeles | CA | 90089-8007