

**RISK ASSESSMENT PLAN FOR
CREIGHTON UNIVERSITY'S
BILLING COMPLIANCE PROGRAM**

November 2005

I. INTRODUCTION

Changes in the United States sentencing guidelines give emphasis to implementing an ongoing Risk Assessment as part of an effective compliance plan. Creighton's Risk Assessment Plan allows for systematic identification of processes or areas that are at risk for non-compliance, and the impact of any non-compliance on clinical and business operations.

Creighton University's Risk Assessment Plan:

- Contains methods for identifying specific processes, areas, and/or services that are at risk for non-compliance
- Provides a means of ranking identified risks
- Contains processes for actual determination of compliance or non-compliance within the risks identified
- Contains a reporting mechanism that leads to correction of any non-compliance
- Provides feedback for shoring up of activities vulnerable to non-compliance
- Provides feedback for recognition of successful compliance activities

II. IDENTIFICATION AND RANKING OF RISKS

Creighton Medical Associates (CMA) is a multi-specialty practice composed of teaching physicians employed by Creighton University. CMA provides physician services and also operates a reference laboratory. These services are billed to insurance carriers using CPT and ICD-9 codes. Although not all areas of risk are represented by CPT codes, many areas of risk can be examined via billed codes.

Step 1 Base Report Data Mining

The Compliance Auditor will request a report from CMA Patient Services for six months of billing data to be used in ranking risk by frequency and financial impact.

Step 2 OIG Work Plan

The OIG Work Plan becomes available in October. The Compliance Director will review the plan. Pertinent issues will be translated into CPT code usage by the Compliance Auditor. Data mining of the billing software will be done to determine code utilization and financial impact.

Step 3 OIG Advisory Opinions and Audit Reports

Advisory Opinions and Audit reports are released throughout the year. The current year's information will be reviewed by the Compliance Director. Pertinent issues will be translated into CPT code usage by the Compliance

Auditor. Data mining of the billing software will be done to determine code utilization and financial impact.

Step 4 CERT Results

CERT claims which have been reprocessed will be reviewed for the past twelve months. A summary of reprocessed claims will be reviewed by the Compliance Director. Pertinent issues will be translated into CPT code usage by the Compliance Auditor. Data mining of the billing software will be done to determine code utilization and financial impact.

Step 5 NCD's and LCD's

NCD, LCD's, Carrier Bulletins, and CMS Announcements will be reviewed annually by the Compliance Director. Pertinent issues will be translated into CPT code usage by the Compliance Auditor. Data mining of the billing software will be done to determine code utilization and financial impact.

Step 6 Hotline and Helpline

Hotline and Helpline information will be reviewed by the Compliance Director. Calls to the Hotline may have already resulted in audits. The Compliance Director will determine if an issue needs to be reviewed again as part of the coming year's Risk Assessment Plan. Multiple calls to the Helpline for the same billing issue may indicate areas of complicated billing which may be at higher risk for billing compliance difficulties. The Compliance Director will determine if an issue needs to be reviewed as part of the coming year's Risk Assessment Plan.

Step 7 Results of Internal Audits

Results of department audits, new provider audits, and reports from the Internal Audit Department will be reviewed by the Compliance Director and the Compliance Auditor for potential billing compliance risks.

Step 8 Claim Denials

Claim denials are processed by CMA Patient Services (CMAPS). Claim denials can provide information about codes, billers, and providers who may not understand the requirements for billing a certain code. This would include the code itself, modifiers, diagnosis, etc. CMAPS is broken down into units based on payer type. The unit supervisors will be queried on a six month basis to see if there are codes, billers, or physicians who have a pattern of billing denials. Communication lines with the unit supervisors will be maintained so that the supervisors can request review sooner than twice per year. The surveys and other communication with the CMAPS staff will be reviewed by the Compliance Director to determine if an issue needs to be reviewed as part of the coming year's Risk Assessment Plan.

Step 9 As Needed Reviews

At any time, the Compliance Director will request a review of a billing issue, if current information from any source, including all of the above, indicates necessity for doing so.

Step 10 Risk Assessment Ranking

The information contained in Steps 1 through 9 will be entered into the Risk Assessment Ranking grid.

Step 11 Creation of the Audit Plan

The Compliance Director will review the information obtained from the Risk Ranking tool and develop an audit plan for the coming year with the audits to be conducted by the Compliance Auditor.

Step 12 Approval by the Billing Compliance Committee

The Risk Assessment Audit Plan will be presented to the Billing Compliance Committee for approval. Needed changes will be made and the plan will be implemented upon approval by the Committee.

III. ONGOING RISK ASSESSMENT ACTIVITY

The Compliance Auditor will engage in ongoing review throughout the year, to include CERT activity, Hotline issues, claim denials and any other area identified by the Billing Compliance Committee or the Compliance Director.

If needed, an issue will be brought to the Billing Compliance Committee and the Compliance Director who will then decide if it is added to the Risk Assessment Plan.

RISK ASSESSMENT PLAN TIMELINE

AUGUST

Basic Data Mining

These reports will be used to rank frequency and financial impact when determining the level of risk for a billed service.

1. On the third Monday in August, the Compliance Auditor will submit a request to Creighton Medical Associates Patient Services (CMAPS) to generate a report for February 1st through July 31st of the current year to include the following information:
 - a. Total number of CPT codes billed
 - b. Total dollars billed
2. On the third Monday in August, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st of the current year which lists all CPT codes billed, the number of times each was billed, and the total dollar amount for each code.

CERT Results for CMA

1. The Compliance Auditor will review the previous twelve months of CERT requests made to CMA to determine the types of services which were reviewed and also the types of services which were reprocessed.
2. The Compliance Auditor will provide a summary to the Compliance Director.
3. The Compliance Auditor will determine the CPT codes used to bill the services.
4. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
5. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
6. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

OCTOBER

OIG Work Plan

1. The Compliance Director will review and digest the OIG Work Plan.

2. The Compliance Auditor will review to see if any services on the Plan are provided by CMA.
3. The Compliance Auditor will determine the CPT codes used to bill the services.
4. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
5. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
6. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

NOVEMBER

OIG Opinions and Audit Reports

1. The Compliance Director will review the OIG Advisory Opinions and Audit Reports for the most recent twelve months to determine if any of the issues pertain to services provided by CMA.
2. The Compliance Auditor will determine the CPT codes used to bill the services.
3. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
4. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
5. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

NCD's and LCD's

1. The Compliance Director will review NCD's and LCD's for the most recent twelve months giving special attention to new services and new coverage.
2. The Compliance Auditor will determine the CPT codes used to bill the services.
3. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.

4. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
5. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

Claim Denials

1. The Compliance Director and the Compliance Auditor will create a survey to be completed by team leaders and billing managers at CMAPS. The survey will query to see if there have been any frequent denials or “problem” codes.
2. The surveys will be sent on the second Monday in November.
3. The completed survey deadline will be the third Monday in November.
4. The Compliance Auditor will contact pertinent staff for any surveys not returned as of the deadline.
5. The surveys will be summarized for review by the Compliance Director.
6. The Compliance Auditor will determine the CPT codes used to bill the services.
7. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
8. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
9. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

CERT Results for Carrier

1. Cert results will be obtained at the CMS website for CERT:
<http://www.cms.hhs.gov/cert/>
2. The list for over-utilized codes for the Nebraska carrier will be obtained and summarized for review by the Compliance Director.

3. The carrier error rates by service type and service provider will be obtained and summarized for review by the Compliance Director to determine which services and/or provider types have high error rates.
4. The Compliance Auditor will determine the CPT codes used to bill the services.
5. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
6. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
7. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

DECEMBER

Hotline and Helpline

1. The Compliance Director will review the Hotline and Helpline sections of the minutes from the Billing Compliance Committee Meeting for the most recent twelve months.
2. The Compliance Auditor will determine the CPT codes used to bill the services.
3. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.
4. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
5. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

Results of Internal Audits

1. The Compliance Director will review the department audits, new provider audits and the reports from the Internal Audit Department for the most recent four quarters.
2. The Compliance Auditor will determine the CPT codes used to bill the services.
3. The Compliance Auditor will review the basic data reports for the CPT codes and summarize the results for review by the Compliance Director.

4. If only certain uses of a CPT code (ex. POS, Dept, Insurer) need to be examined, the Compliance Auditor will submit a request to CMAPS to generate a report for February 1st through July 31st which includes any needed code utilization subsets.
5. The Compliance Auditor will summarize this additional data against the basic data reports for review by the Compliance Director.

JANUARY

1. The Compliance Auditor will create a master list of all CPT codes identified in the above timeline as being at risk.
2. Using the Basic Data report, the codes will be listed in order of frequency of use, with the most infrequently billed codes at the beginning of the list, and therefore having a lower number for point correlation on the Risk Assessment Tool.
3. Using the Basic Data report, a second list of the codes in order of the total amount billed will be created, with the lowest amounts at the beginning of the list, and therefore having a lower number for point correlation on the Risk Assessment Tool.
4. The information will be transferred to the Risk Assessment Ranking Tool.
5. The Compliance Auditor will create a report for the Compliance Director with the results of the Risk Assessment Tool.
6. The Compliance Director and the Compliance Auditor will create an Audit Plan which will be presented at the Billing Compliance Committee Meeting for approval.
7. After approval is received from the Billing Compliance Committee, the Audit Plan will be implemented.

ONGOING RISK ASSESSMENT ACTIVITY

The Compliance Auditor will engage in ongoing review throughout the year, to include CERT activity, Hotline issues, claim denials and any other area identified by the Billing Compliance Committee or the Compliance Director.

If needed, an issue will be brought to the Billing Compliance Committee and Compliance Director who will then decide if it is added to the Risk Assessment Plan.

	Item		
Issue		Y = 1 pt	Y = 1 pt
Point Generation:		Y = 1 pt	Y = 1 pt
1. Is the item on the OIG Work Plan?			
2. Has an Advisory Opinion or Audit been released on this service?			
3. Does the item have a high Cert Error Rate for the Medicare Carrier for Nebraska?			
4. Does the item have a high reprocessing rate for CMA's Cert requests?			
5. Has the item been the subject of a new or recently updated NCD or LCD?			
6. Has the item been the subject of a Hotline call?			
7. Has the item been the subject of Helpline calls?			
8. Has the item been identified with a high error rate in an internal department audit?			
9. Has the item been identified through claims denial surveys?			
10. Service code frequency percentage (if applicable)			
11. Service code percentage of overall business (if applicable)			
12. Is this item/service new? (i.e. new code; new coverage by Medicare)			
13. Other:			
14. Other:			
15. Other:			
Total Number of Points			
Adverse Impact: High, Medium, or Low (H, M, L)			

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