General Information

Policy Name:	Internal Quality Audit Program: Compliance Risk & HIPAA Monitoring
Category:	Risk Management – Corporate Compliance
Applies To:	Applies throughout Crouse Hospital
Key Words:	OMIG, Auditing, DNV, ISO, Audits, Annual Compliance Review, Monitoring
Associated Forms & Policies:	Corrective Action Document (Doc #740)
Original Effective Date:	10/01/11
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This Version's Effective Date:	02/26/25

Policy

Crouse Hospital's audit program should be based on criticality/risk. Risk factors such as the importance of the processes, changes to the organization and the results of previous internal/external audits should be considered when developing the audit program. Adjustments to the audit plan and frequency may be made if approved by the Corporate Compliance Department (e.g. due to extenuating circumstances, changes affecting the organization). In addition to ISO 9001:2015 auditing, the Compliance Department, in collaboration with the Compliance Committee and relevant Hospital departments, will conduct ongoing and periodic reviews of the Compliance Program's operations and systems.

This process will be used to determine whether the elements of the Compliance Program are consistently being addressed and satisfied. In conjunction with the above mentioned auditing and monitoring processes, all departments will be audited at least annually for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and New York State laws pertaining to privacy and confidentiality.

Procedure

1. Quality System ISO 9001:2015

a) The Corporate Compliance Department will develop and communicate a schedule. Audits should be scheduled based on the status and importance of the activities being audited. For example: previous audit non-conformances, department volume, department complexity or newly implemented systems. Audits may be adjusted, but must be communicated to and approved by the Corporate Compliance Department.

b) Individuals conducting the ISO 9001:2015 audits will be pre-approved and trained as internal auditors. An auditor may not conduct an audit in their respective department and therefore, must be independent of the department they are auditing.

c) The Corporate Compliance Department will report the results of the audit. It is the responsibility of the department manager to follow up on all non-conformities identified for their respective area. Management needs to take the appropriate correction or corrective action without undue delay for the

deficiencies discovered during the course of the audit. Management is to complete all fields of the Corrective Action Document (Doc #740) under "Section to be completed by Department Management" and return the Corrective Action Document to the Corporate Compliance Department within 10 days from when the Corrective Action Document was sent. If approved by Corporate Compliance, the Corrective Action Plan due date may be extended in limited situations due to extenuating circumstances. The Corporate Compliance Department is responsible for ensuring follow-up audits to non-conformities identified by the DNV internal auditing teams are completed. Follow-up audits may require additional corrective measures be taken by department management. The Corporate Compliance Department will retain documentation of further actions that management plans to take.

d) The Corporate Compliance Department will retain internal audit records for review.

2. **Identification of Compliance Risk Areas**

a) Crouse Hospital shall establish and implement an effective system for the routine monitoring and identification of compliance risks. The system should include internal monitoring/audits and as appropriate, external audits, to evaluate the hospital's compliance with the requirements of the MA program and the overall effectiveness of the compliance program.

b) The Corporate Compliance Department shall identify risk areas that require review on a periodic basis or in response to a specific issue raised. Risk areas include:

1. Results of all internal and external audits, or audits conducted by the state or federal government;
2. Billing;
3. Payments;
4. Ordered services;
5. Medical necessity;
6. Quality of care;
7. Governance;
8. Mandatory reporting;
9. Credentialing;
10. Contractor, subcontractor, agent or independent contractor oversight;
11. Other risk areas identified by the hospital.

Any risk areas identified will be included in updates to the compliance work plan.

c) The Corporate Compliance Department shall be responsible for conducting and/or ensuring the performance of ongoing and periodic reviews of all aspects of the Compliance Program to monitor its effectiveness and to take appropriate steps as necessary to assure adherence to the Compliance Program.

d) The design, implementation and results of any internal or external audits will be documented and reported to the Compliance Committee and the relevant managers, other corporate officers and the governing body. Prompt action shall be taken to correct any improper practices or deviation from the Compliance Program, Code of Conduct, other hospital policies and procedures, applicable laws and regulations and third-party payer requirements. Documentation shall be retained in accordance with the Hospital's record retention policies and procedures.

e) The Corporate Compliance Department and the Compliance Committee meet regularly to monitor and review developments in applicable laws influencing the hospital's legal duties under the Compliance Program and to revise and update the Compliance Program as necessary.

f) In collaboration with any relevant hospital department, the Corporate Compliance Department shall conduct and/or ensure the performance of reviews and audits, which may include, but is not limited to, the following:

1. Periodic review of the coding and claims processing systems, including, but not limited to, audits of claims to be submitted to federal healthcare programs, including Medicare and Medicaid;
2. Review of documentation generated by providers and other personnel who have a direct impact on claim development and submission, including claims prepared by new employees to ensure proper training and knowledge of the claims processing system;
3. Follow up audits in response to complaints and/or concerns raised related to the claims processing and other Compliance Program processes;
4. Review of physician and allied health professional licensing and credentialing requirements;
5. Review of government disqualified/excluded provider lists;
6. Review of adherence to the hospital's Compliance Program/Code of Conduct; for example, assess compliance with education and training requirements for affected individuals;
7. Review of the hospital's complaint and reporting logs to determine if complaints or reports were handled appropriately and whether there have been repeated inquiries regarding the same topic or issues of concern;
8. Review of compliance with the hospital's various mandatory reporting obligations;
9. Review of compliance with standards applicable to governance;
10. Review of patient quality of care for services rendered to Medicare, Medicaid and other patients; and
11. Other reviews and risk areas identified by the Corporate Compliance Department, the Compliance Committee and/or individual departments.

g) Reviews/audits shall be periodically updated to reflect changes in applicable laws, regulations, coding guidelines and third-party payer requirements.

h) Reviews/audits shall include both internal audits conducted by the hospital and external audits conducted by an outside auditor engaged by the hospital or through its legal counsel.

i) The Hospital shall devote resources that are reasonably necessary to ensure audits are adequately staffed by persons with appropriate knowledge and experience.

3. **Annual Compliance Program Review**

a) Crouse Hospital shall develop and undertake a process for reviewing, at least annually, whether the requirements of the New York State OMIG Mandatory Provider Compliance Plan, 18 NYCRR § 521 have been met. The purpose of the review is to determine the effectiveness of the compliance program and whether any revision or corrective action is required.

b) Reviews will be carried out by staff or external auditors that have necessary knowledge and expertise to evaluate the effectiveness of the components of the compliance program and are independent from the functions being reviewed.

c) Reviews may include on-site visits, interviews with affected individuals, review of records, surveys or any other comparable method deemed appropriate, provided that such method does not compromise the independence or integrity of the review.

d) The hospital shall document the design, implementation and results of its effectiveness review and any corrective action implemented.

e) Results of the annual compliance program review shall be shared with the chief executive, senior management, the Compliance Committee and the governing body.

4. Department Monitoring of HIPAA

a) The Compliance Department will conduct monthly audits of each department/unit to determine their compliance with HIPAA privacy standards.

b) A predetermined set of criteria, formatted on an audit tool will be utilized for each audit.

c) Once the department/unit has been evaluated, a summary spreadsheet and list of recommendations will be forwarded to the director/manager of that area. A copy will also be kept on file in Corporate Compliance.

d) If any recommendations are given, a follow up visit will be performed within the next month of receiving the information. The follow up ensures that the recommendations have been implemented.

e) All audits and follow up visits will be scheduled utilizing Microsoft Outlook Calendar.

References

DNV Interpretive Guidelines to ISO 9001:2015

National Integrated Accreditation for Healthcare Organizations (NIAHO) Accreditation Requirements, Interpretive Guidelines and Surveyor Guidance for Hospitals Revision 20-1. Effective September 21, 2020.

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

Definitions

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

MA: Medical assistance for needy persons provided under Title 11 of Article 5 of the Social Services Law

Addendums, Diagrams & Illustrations

Not Applicable