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A message to *Business Office Managers*

Memo No. 05-08

TO: All AmeriHealth participating hospitals in Delaware

FROM: Edward Litchko
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DATE: July 9, 2008

SUBJECT: CFID FACILITY AUDIT BULLETIN

AmeriHealth is sending this bulletin to increase awareness of the Corporate and Financial Investigations Department (CFID) and to alert you to some recently identified trends in questionable billing practices.

THE ROLE OF CFID

The CFID at AmeriHealth identifies, investigates, and seeks prosecution for internal and external fraud. The department partners with state and federal law enforcement, regulatory agencies, and other insurance companies in the fight against these crimes. CFID not only protects groups and members, but it also helps hospitals to resolve their outstanding credit balances.

In addition to CFID's role in combating fraudulent practices against AmeriHealth, the department is also responsible for conducting audits of facility and professional providers, ancillary service providers, and pharmaceutical-related entities.

CFID utilizes sophisticated data-mining software tools to analyze all claims submitted by medical providers, facilities, and pharmacies and compares them against member enrollment data and overall provider information. Any trends, patterns, or aberrant billing practices are targeted for an in-depth audit or investigation.

UPCOMING AUDITS TO INVESTIGATE TRENDS IN QUESTIONABLE BILLING

Health care fraud is a violation of state and/or federal law. Under federal law, it is a felony offense (18 USC 1347), punishable by a fine of up to $250,000 and/or up to 10 years imprisonment. If the violation results in serious bodily injury, a prison term of up to 20 years is possible.

Several questionable billing trends have been identified recently that will result in an in-depth review. The Facility Provider Audit Team, a group under CFID that consists of registered nurses, medical coders, and claims experts, will be focusing on these upcoming audits:

- **DRG validation audits —** to assure that submitted claims are coded properly and remitting appropriately;

- **Outpatient fee schedule coding audits —** to assure that CPT®/HCPCS codes are properly submitted to reflect the services rendered and that remittance is consistent with policy/contracts;
- **Outpatient observation audits —** to assure that services rendered accurately match services billed;
- **Outpatient critical-care audits —** to assure accurate coding of outpatient critical-care ER visits.

Although CFID's ongoing efforts to ensure health care insurance costs are appropriate, we need your help. There is no substitute for our health care providers' own vigilance. An easy-to-use process exists for reporting suspected fraud, waste, and abuse. This reporting process can lead to prevention, as providers may become aware of suspicious practices of other providers, subscribers/patients, or billing companies. If you are suspicious of any health care related activity, please call our toll-free Corporate Compliance and Fraud Hotline at 1-866-282-2707, or visit www.amerihealth.com/anti-fraud. These tips can lead to audits, fraud investigations, and money recoveries, all of which help keep health care costs down.

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