

CATHOLIC HEALTH INITIATIVES CORPORATE RESPONSIBILITY PROGRAM FY 2007 MBO RISK ASSESSMENT MATRIX -- *NON CRITICAL ACCESS VERSION*

The purpose of the assessment is to determine the primary legal standards with which Catholic Health Initiatives (CHI) Market Based Organizations (MBOs) must comply, assess policies and systems currently in place that address these areas, and, if appropriate, incorporate them into the proposed Corporate Responsibility Program. This form of assessment is for non-critical access MBOs (a separate form exists for critical access MBOs).

MBO Name:

	<i>ISSUE</i>	Yes	In Process	No	N/A	<i>SPECIFY POLICIES OR DOCUMENTED PRACTICES TO ENSURE COMPLIANCE*</i>
A.	<i>GENERAL ISSUES APPLICABLE TO ALL MBO ENTITIES</i>					
	Anti-Kickback and Self-Referral Laws					
1.	Has the MBO implemented the Corporate Responsibility Program (CRP) Plan document? (1)					
1.a.	Are all applicable employees periodically trained with regard to the CRP? (1.a)					
1.b.	Are employees appropriately disciplined for any failure to comply with the CRP? (1.b)					
2.	Have all management personnel responsible for overseeing physician contracting been educated on CHI's physician transaction review policies/guidelines? (2)					
2.a.	Has each MBO assigned an appropriately trained and qualified individual to oversee physician contracting? (new)					
3.	Do all contracts and other financial arrangements with actual and potential referring physicians comply with CHI's physician transaction review policies/guidelines? (3)					
4.	Does the MBO have policies/guidelines and procedures that: (4)					
4.a.	Ensure all financial relationships with physicians are documented in a written agreement, signed by the applicable physician as well as the designated MBO representative? (4.e)					

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4.b.	Ensure all physician agreements are reviewed periodically to ensure the agreement is still in effect or, if it is expired or about to expire, that a renewal or new agreement is put in place immediately? (new)					
4.c.	If there are separate written agreements that relate to multiple financial relationships between a physician/group and an MBO (or other provider), does each agreement cross-reference the other, or is a written master list maintained that references each agreement? (new)					
4.d.	Address soliciting, accepting, or receiving any gift or gratuity of more than nominal value from physicians, potential referral sources, vendors and others with which the MBO has a business relationship (see CHI Policy Governing Requesting or Accepting Gifts from Business Sources)? (4.a)					
4.e.	Has the CHI vendor site visit frequently asked questions document (10-18-06 CRO Update) been communicated to applicable individuals within the MBO? (new)					
4.f.	Ensure all contracts and other financial arrangements provide for compensation or other benefits that are consistent with fair market value, not taking into account any referrals or potential referrals (except upon approval by legal counsel, such as in physician recruitment arrangements)? (4.b)					
4.g.	Identify and avoid contracts that require or are based on referrals between the parties, or that restrict the other party from establishing medical staff privileges, referring to, or doing business with non-CHI entities (unless approved by legal counsel)? (4.c)					
4.h.	Ensure that: (i) all medical director or physician consulting agreements require the physician to keep detailed time records documenting his/her services, and (ii) time records are regularly reviewed to ensure compliance with the physician's contractual obligations? (4.d)					

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4.i.	Ensure all physician agreements are reviewed periodically to ensure the physician is complying with the terms, that compensation remains consistent with fair market value, and that the agreement has not expired? (4.f)					
5.	With regard to courtesy discounts:					
5.a.	Are courtesy discounts made available to medical staff members (or affiliated physicians), their immediate family members or their employees? List any courtesy discounts provided. (5.a)					
5.b.	Are employees offered patient/resident discounts for items/services received at the MBO? (5.b)					
5.c.	Does the MBO offer or provide patients/residents discounted or free services and items that fall outside the CHI Uninsured/Underinsured Patient Discounts (Charity Care) policy or the MBO's official write-off policies? If so, please list. (5.c)					
6.	Are rebates and discounts received from suppliers and vendors: (6)					
6.a.	In compliance with the anti-kickback statute discount safe harbor? If not, please define. (6.a)					
6.b.	Reflected on the MBO's cost report(s) (if the MBO files a cost report)? (6.b)					
7.	Is there a comprehensive list of all financial relationships with potential referral sources? This list should include: (7)					
7.a.	Payments to physicians for services (e.g., medical directorships, coverage, income guarantees)? (7.a)					
7.b.	Consulting services and physician recruitment? (7.b)					
7.c.	Leases of office space and/or equipment to or from referral sources? (7.c)					
7.d.	Loans to physicians? Do all loans charge a commercially reasonable rate of interest and provide for adequate security (unless in a valid physician recruitment arrangement)? (7.d)					

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7.e.	Provision of free or discounted goods and services, including the provision of free staff, space and/or supplies? (7.e)					
7.f.	Is the appropriateness of providing any free or discounted services documented? (7.f)					
7.g.	Cross-referral arrangements with other healthcare providers? Have all cross-referral arrangements been approved by legal counsel? (7.g)					
7.h.	Arrangements with marketing representatives? Do marketing arrangements avoid commission-based compensation, unless the marketer is a W-2 employee? (7.h)					
7.i.	Routine waiver of deductibles and coinsurance without an individualized determination of financial need or otherwise meeting a "safe harbor?" (7.i)					
7.j.	Other (please specify)? (7.j)					
8.	Have the financial relationships defined above been reviewed for compliance with the federal anti-kickback statute and physician self-referral statute (Stark law) as well as corresponding state laws? (8)					
9.	Does the MBO ensure that compensation for billing department personnel and billing consultants does not provide any financial incentive to increase reimbursement? (9)					
	Gainsharing (<i>Applicable to hospitals and physician practices</i>)					
10.	Has the hospital or any MBO-owned physician group(s) entered into any "gainsharing" programs? (10)					
	Ethics at Work					
11.	Are the <i>Ethics at Work</i> Acknowledgement and Receipt cards retained on file by the MBO, and available for review by the MBO CRO? (11)					

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12.	Was the November 2006 EAW Addendum circulated to all employees, volunteers, medical staff members, and board and board committee members before January 1, 2007 in support of the compliance provisions of the 2005 Deficit Reduction Act? (new)					
12.a.	Has a process been developed to ensure new employees and volunteers, newly credentialed medical staff members, and newly appointed board and board committee members receive the EAW and the Addendum within 30 days? (new)					
Compliance Reporting						
13.	Do MBO employees know who the designated CRO is and how to contact that person? Specify how the MBO communicates this information to employees. (12)					
14.	Does the MBO regularly provide information to employees regarding the CRP Ethics at Work Line (including the phone number) and the CHI Reporting Process for reporting CRP concerns? Specify how the MBO communicates this information and how often. (13)					
Excluded Providers						
15.	Does the MBO have an established process to screen and periodically recheck the following in the OIG and GSA excluded provider databases in accordance with CHI's Excluded Provider Policy: (14)					
15.a.	Employees? (14.a)					
15.b.	Temporary employee agencies? (14.b)					
15.c.	Vendors? (14.c)					
15.d.	Contracted individuals and entities? (14.d)					
15.e.	Practitioners (credentialed and non-credentialed) who order procedures or tests? (14.e)					

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16.	Do the MBO's policies prohibit the continued employment or engagement of individuals who have been convicted of a criminal offense related to health care or who are excluded, debarred, or otherwise become ineligible for participation in federal health care programs? (15)					
16.a.	Do the MBO's policies and written contracts permit it to terminate the individual/contractor in such event? (15.a)					
17.	Does the MBO's employment application and written contracts specifically require the applicant/contracting party to disclose any criminal conviction or exclusion from participation in the federal health care programs? (16)					
18.	Does the MBO conduct a reasonable and prudent background investigation and reference check before hiring employees who have access to patients/residents or their possessions, or who have discretionary authority to make decisions that may involve compliance with the law? (17)					
	Coding					
19.	Does the MBO have a written coding compliance manual? (18)					
20.	Does the MBO provide coding staff with regular training on coding updates and when coding errors are identified? (19)					
21.	Does the MBO perform regular coding accuracy audits/reviews? If so, detail the frequency of such audits/reviews and the sampling techniques used. (20)					
22.	Does the MBO have established policies and procedures to ensure that coding errors are rebilled within 60 days of identification? (21)					
23.	Are all patient/resident billing errors identified during internal audits/reviews (performed by CHAN and/or the CRP Department) or external audits/reviews timely corrected and rebilled as appropriate? (22)					

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	Preparation and Submission of Claims					
24.	Do the MBO's written policies and procedures address the following areas: (23)					
24.a.	Proper and timely documentation of all physician and professional services to ensure that only accurate and properly documented services are billed? (23.a)					
24.b.	Provide that claims are submitted only when appropriate documentation supports the claim and is maintained and available for audit and review? (23.b)					
24.c.	Documentation records the time spent for the service (for those services where timing is required) and the identity of the individual providing the service? (23.c)					
24.d.	Require that any standing orders: (i) have the ordering physician's signature, and (ii) are reviewed periodically? (23.d)					
24.e.	Medical records and documentation is appropriately organized in a legible form for audit and review purposes? (23.e)					
24.f.	Identify individuals with authority to make entries in the medical record and the circumstances when late entries may be made in a record? (23.f)					
25.	Has the MBO implemented a Chargemaster maintenance policy, setting forth responsibility and timelines for maintaining, reviewing and revising the Chargemaster? (24)					
26.	Is the MBO's Chargemaster accurate when compared to the current version of the CPT-4 code book? (25)					
27.	Is the MBO's Chargemaster accurate when compared to the current version of the HCPCS code book? (26)					
28.	Does the MBO review and implement CMS guidance, including manual changes and updates, transmittals, and other guidance in a timely manner? (27)					

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29.	Does the MBO review and update billing edits quarterly or as needed? (28)					
30.	Does the MBO have established processes or edits to prevent duplicate billing? (29)					
30.a.	Does the MBO have established processes or edits to prevent duplicate billing for prescription drugs, under Part B and Part D? (OIG)					
31.	Does the MBO have established processes or edits to prevent upcoding (of DRGs, APCs, RUGs, etc)? (30)					
32.	Does the MBO have established processes or edits to prevent “unbundling” of services that are required to be billed on a consolidated basis? (31)					
33.	Does the MBO have policies or procedures addressing Medicare Secondary Payer requirements? (32)					
34.	Does the MBO have an established process to ensure that credentialed and non-credentialed provider UPINs are collected prior to submission of any associated claim? (33)					
35.	Has the MBO engaged an outside resource for the purpose of implementing a clinical documentation and coding improvement effort (e.g., HP3, J.A. Thomas, etc.)? (new)					
35.a.	If so, specify the vendor and implementation phases/timing of the engagement. (new)					
35.b.	If not, are there plans to engage an outside resource; and what is the associated timing of the engagement? (new)					
35.c.	Does or will the engagement include clinical documentation and coding improvement of both inpatient and outpatient services? (new)					
	Medical Necessity and Documentation					
36.	Does the MBO have written policies and procedures to ensure: (34)					

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36.a.	Claims are submitted only for services which are ordered by a physician or other appropriately licensed practitioner and are medically necessary? (34.a)					
36.b.	Compliance with National and Local Coverage Determinations? (34.b)					
36.c.	Non-physicians do not sign forms for physicians, without the physician's express approval. (34.c)					
36.d.	Medical record documentation is not altered or retroactively created (except as appropriate). (34.d)					
37.	Is the MBO prepared to provide patients'/residents' medical records and physician orders to support medical necessity? (35)					
	Cost Reports (n/a physician practices)					
38.	Does the MBO have a reimbursement compliance manual (see the CHI Financial Standards and Guidelines Manual)? (36)					
39.	Do reimbursement personnel receive regular education and training on cost reports and related issues? Does the MBO document this education and training? (37)					
40.	Does the MBO have written policies and procedures that ensure: (38)					
40.a.	Costs are claimed based on appropriate and accurate documentation? (38.a)					
40.b.	Costs are properly classified? (38.b)					
40.c.	Fiscal intermediary prior year adjustments are timely implemented and not claimed for reimbursement? If not implemented, adjustments are clearly identified as a protested item on the cost report (see Section 4 – Cost Report – Protested Items/Issues in the CHI Financial Standards and Guidelines Manual)? (38.c)					

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40.d.	All related parties are identified on Form CMS-339 and all related party charges are reduced to cost? (38.d)					
40.e.	Allocations from CHI's home office cost statement to individual cost reports are properly documented and supported by verifiable data? (38.e)					
40.f.	The MBO has established procedures to promptly notify the fiscal intermediary (or other appropriate payor) of errors discovered after cost report submission and, where applicable, after the submission of CHI's home office cost statement? (See Section 1 - Cost Report Compliance in the CHI Financial Standards and Guidelines Manual.) (38.f)					
	Credit Balances					
41.	Does the MBO have procedures for timely and accurate reporting of Medicare and other governmental healthcare program credit balances? (39)					
42.	Does the MBO's information system have the capability to print out individual patient/resident accounts that reflect a credit balance? (40)					
43.	Has the MBO designated an individual who is responsible for tracking, recording, and reporting credit balances? (41)					
	Bad Debt (n/a physician practices)					
44.	Has the MBO developed a mechanism to review, at least annually, whether it is properly reporting bad debt for unpaid Medicare deductibles and coinsurance? (42)					
45.	Does the MBO review, at least annually, whether Medicare bad debt is being claimed in compliance with all applicable Medicare requirements? (43)					
46.	Does the MBO ensure that uncollected deductibles and coinsurance are not claimed as bad debt when reasonable collection efforts have not been made? (44)					

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47.	Does the MBO have an established process to ensure that bad debt is not claimed for non-covered services? (45)					
Advance Beneficiary Notices and Notices of Exclusion from Medicare Benefits						
48.	Are Advance Beneficiary Notices (ABNs) appropriately issued to patients for Medicare Part B services and items where payment may be denied on medical necessity grounds? (46)					
49.	Are Notices of Exclusion from Medicare Benefits (NEMBs) appropriately issued to patients for services and items that are not covered by Medicare? (47)					
Credentialing and Licensing						
50.	Does the MBO have policies and procedures that ensure all practitioners are credentialed, recertified and/or licensed as required by state law? Do these policies and procedure include a requirement that practitioners who order procedures or tests are licensed to do so in accordance with state law? (48)					
51.	Does the MBO ensure that the National Practitioner Data Bank has been checked with respect to all physicians whom are being credentialed or with whom the MBO is contracting? (49)					
HIPAA Privacy, Security and Electronic Transactions Rules						
52.	Has the MBO implemented, and is it monitoring compliance with CHI's HIPAA Privacy Policies and Procedures and all applicable "more stringent" state laws? (50)					
53.	Does the MBO have procedures to identify each contract with a HIPAA "business associate" and ensure it includes the required business associate provisions? (51)					
54.	Has the MBO implemented CHI's HIPAA Security Standards? (52)					

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55.	Is the MBO in compliance with the HIPAA Standards for Electronic Transactions? (53)					
	Record Retention					
56.	Do contracts for Medicare goods and services provide for access to books and records by HHS Secretary or Comptroller General in accordance with the Medicare statute and regulations (<i>n/a to physician office practices</i>)? (54)					
57.	Have policies and procedures been implemented addressing creating, distributing, retaining, storing, retrieving, and destroying all records and documentation (e.g., clinical and medical records, billing and claims documentation) pursuant to federal or state government standards? (55)					
58.	Do the policies and procedures address records, documentation, and audit data that support and explain cost reports and other financial activity, including any internal or external compliance monitoring activities? (56)					
59.	Does the MBO document and retain a log containing records of requests for advice from government agencies or intermediaries/carriers, as well as the responses? (57)					
	Charity Care/Third Party Collection					
60.	Does the MBO adhere to CHI Charity Care guidelines? (new)					
61.	Does the MBO adhere to CHI Third Party Collection guidelines? (new)					
	Transport of Hazardous Materials Through Interstate Commerce					
62.	Has the MBO implemented policies and procedures regarding shipping and transferring hazardous materials including biohazardous and radioactive materials? (new)					

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B.	<i>ISSUES APPLICABLE TO HOSPITALS</i>					
	Medical Necessity and Documentation					
1.	The OIG has targeted the following areas for medical necessity and documentation: (1)					
1.a.	Inpatient Psychiatric Stays (1.a)					
1.b.	Inpatient Rehabilitation Facilities Payments, and timeliness of patient assessments (1.b)					
1.c.	Diagnostic Testing Performed in Emergency Rooms (1.c)					
1.d.	Inpatient Prospective Payment System Wage Indices (1.d)					
1.e.	Consecutive Inpatient Stays (1.e)					
1.f.	Coronary Artery Stents (1.f)					
1.g.	Outpatient Cardiac Rehabilitation Services (1.g)					
1.h.	Ambulance Services (1.h)					
1.i.	Payments for Non-ESRD Epoetin Alfa (1.i)					
1.j.	Allergy Treatments (1.j)					
1.k.	Independent Diagnostic Testing Facilities (1.k)					
1.l.	Physical Therapy Services (1.l)					
1.m.	Speech Language Pathology Services (1.m)					
1.n.	Occupational Therapy Services (1.n)					
1.o.	Outpatient Alcoholism Services (1.o)					
1.p.	Outpatient department generally, including multiple and repeat procedures, global surgeries. (1.p)					

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2.	Has the hospital disseminated to appropriate staff a summary of applicable medical necessity rules? (2)					
3.	Does the hospital obtain all required physician certifications and recertifications of medical necessity? (new)					
Coding and Documentation						
4.	Do coding policies and procedures address the following: (3)					
4.a.	Updating diagnosis related group (DRG) codes? (3.a)					
4.b.	OIG and CMS coding review initiatives (e.g., pneumonia, sepsis, post-acute care transfers, DRG pairs, cerebral vascular accidents, pathological fractures and diabetes) (3.b)					
5.	Does the hospital conduct periodic reviews of DRG and APC patterns to identify improper coding practices? (4)					
6.	Does the hospital have policies and procedures to follow the National Correct Coding Initiative? (5)					
7.	Does the hospital ensure observation services are recorded and billed in accordance with the Medicare rules? (7)					
8.	Does the hospital have established processes to review: (8)					
8.a.	Same-day discharges and readmissions? (8.a)					
8.b.	Outlier and other charge-related issues? (8.b)					
8.c.	One-day inpatient hospital stays? (8.c)					
8.d.	Outpatient hospital psychiatric claims? (8.d)					
8.e.	Skilled nursing facility coverage after unnecessary hospital stays? (8.e)					

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	Outpatient Services Rendered in Connection with an Inpatient Stay (72 Hour Rule)					
9.	Does the hospital have software that identifies diagnostic outpatient services furnished within 72 hours of an inpatient visit so that these services are not billed separately from the inpatient stay? (9)					
10.	Does the hospital do periodic post-submission auditing to ensure that outpatient claims do not contain services that should have been billed as part of an inpatient stay? (10)					
	Laboratory Services					
11.	Does the hospital have written policies addressing: (11)					
11.a.	Tests are only billed after they are performed? (11.a)					
11.b.	If charges are generated at the time of order, does the hospital have an automatic credit process for tests not reported or performed? (11.b)					
11.c.	The hospital bills for services only when supported by a valid physician/practitioner order? (11.c)					
11.d.	Any verbal orders or add-on requests are subsequently authorized by a written order? (11.d)					
11.e.	Repeat and follow-up testing protocols? (11.e)					
11.f.	Staff submits diagnostic information (ICD-9 CM codes) obtained only from qualified ordering personnel; staff contact ordering personnel to obtain correct diagnostic information in the event it was not provided? (11.f)					
11.g.	For outsourced tests, the hospital has an established process ensuring the 72-hour guidelines are met? (11.g)					

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11.h.	The lab test requisition form meets OIG Compliance Program Guidance for Laboratories and includes: (11.h) <ul style="list-style-type: none"> • Physician choice, • Diagnosis code, • A statement that Medicare does not generally cover routine tests, • Only standard CMS approved panels are offered, • Offers individual 22 automated multi-channel chemistry tests? 					
12.	The hospital requires department physician heads to approve the lab custom profile notices at least annually? (12)					
13.	The hospital distributes annual notice to those who order tests in accordance with the OIG Compliance Program Guidelines? (13)					
13.a.	Where the hospital outsources tests, it coordinates and reviews the letter sent by the outsourced company? (13.a)					
14.	Does the notice include a complete description of all panels/ reflex options and state that tests included in panels and reflex options may be ordered individually? (14)					
15.	Does the hospital have policies ensuring venipunctures are billed no more than once per day, per patient? (15)					
16.	Does the hospital track and report reference laboratory services as unrelated business income for tax purposes? (16)					
	Physician and Other Health Professional Documentation and Billing (applicable to MBOs providing billing services for providers)					
17.	Are claims for physician consultations adequately documented and appropriately billed? (17)					

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18.	Does the hospital periodically review coding of evaluation and management services for accuracy and unusual patterns? (18)					
18.a.	Does the hospital ensure such coding follows published CMS guidelines? (18.a)					
18.b.	Does the hospital perform periodic reviews to ensure modifier - 25 is used appropriately; e.g., if evaluation and management services are provided on the same day and are unrelated to the procedure code? (19)					
18.c.	Does the hospital perform periodic reviews to ensure that evaluation and management codes are not separately billed during a global surgery period? (OIG)					
19.	Does the hospital ensure physician and other professional services meet medical necessity criteria? Specific attention should be focused on the following: (20)					
19.a.	Care Plan Oversight? (20.a)					
19.b.	Diagnostic Testing? (20.b)					
19.c.	Radiation Therapy Services? (20.c)					
19.d.	Cardiology and Echocardiography Services? (20.d)					
19.e.	Wound Care Services? (20.e)					
19.f.	“Long distance” Physician Claims? (20.f)					
19.g.	Psychiatric Services for Inpatients (OIG)					
19.h.	Polysomnography Services (OIG)					
20.	Consistent with the National Correct Coding Initiative, does the hospital submit claims with modifiers to allow payment for multiple services within a code pair? (21)					
20.a.	Does the hospital assign appropriate modifiers based on the medical record documentation? (21.a)					
21.	Does your facility employ allied health professionals? (22)					

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21.a.	If so, does the hospital have policies and procedures to ensure that costs allocated to Medicare regarding educational programs for nurses and allied health professionals are appropriate? (22.a)					
Physicians at Teaching Hospitals (PATH)						
22.	Does the hospital have written policies related to the OIG Physicians at Teaching Hospitals (PATH) initiative for physician services furnished in a teaching setting? (23)					
22.a.	The teaching physician is identified when submitting claims and the HCPCS GC ¹ modifier is entered into block/field 24d of the Form CMS-1500 denoting that the service was performed, in part, by a resident under the direction of a teaching physician? (23.a)					
22.b.	Teaching physicians assure that medical records include appropriate documentation of key components of the E/M service provided or supervised (e.g., patient history, physician examination, and medical decision making) and the documentation adequately reflects the procedure or portion of the service performed by the physician? (23.b)					
22.c.	Teaching physicians document their physical presence during key portions of a resident's services, and participate in patient management? (23.c)					
22.d.	Patient medical records actually contain the above documentation? (23.d)					
End-Stage Renal Dialysis Services						
23.	Does the hospital have policies and procedures that address the following areas related to end-stage renal dialysis (ESRD) services: (24)					
23.a.	Method II billing? (24.a)					
23.b.	Questionable ESRD claims? (24.b)					
23.c.	Separately billable services? (24.c)					

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23.d.	Hepatitis tests frequency for ESRD patients is reasonable and necessary for diagnosis? (24.d)					
23.e.	Billing for inpatient rather than observation services (OIG)					
	Reimbursement					
24.	Does the hospital have review and control processes to monitor the following areas: (25)					
24.a.	Changes in the Medicare case-mix index? (25.a)					
24.b.	DRG payment limits? (25.b)					
24.c.	Payments for capital items? (25.c)					
24.d.	Payments for related hospital and skilled nursing stays? (25.d)					
24.e.	Unbundling of hospital outpatient services (25.e)					
24.f.	Inpatient only services furnished in outpatient setting (25.f)					
25.	Does the hospital ensure that graduate medical education (GME) and indirect medical education (IME) payments for dental and podiatry programs, and for educational programs at non-hospital sites are appropriate? (26)					
25.a.	If the hospital claims GME/IME payments for residents receiving training at a non-hospital site, does the MBO ensure that it bears all costs for supervisory physicians, pursuant to a written agreement? (new)					
26.	Does the hospital ensure expenses not related to organ acquisition, such as transplant and post-transplant activities and costs from other cost centers, are not included in the organ acquisition costs? (27)					
	Long-Term Hospital Payments					
27.	If the hospital has long-term care hospital patients, does the average length of stay for such patients exceed 25 days? (28)					

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28.	Is the hospital aware of applicable Medicare rules regarding early discharges to home, interrupted stays, outlier payments, and payments for services under arrangements? (29)					
29.	For a long-term care hospital operating as a “hospital-within-hospital,” does the hospital have policies and procedures that address: (30)					
29.a.	To the extent the percentage of referrals from the host hospital exceed 25%, payment for patients who exceed that limit will be made at the acute care hospital PPS rate, rather than the LTCH rate. (30.a)					
29.b.	To the extent the LTCH discharges patients to the host hospital and subsequently readmits more than 5% of them, the LTCH will not receive a separate, second DRG payment for patients in excess of the 5% limit. (30.b)					
	Cost Reports					
30.	Does the hospital ensure non-allowable costs are not claimed for reimbursement? Specific unallowable costs include: (31)					
30.a.	Advertising and marketing? (31.a)					
30.b.	Entertainment, including alcoholic beverages? (31.b)					
30.c.	Cafeteria or meal costs? (31.c)					
30.d.	Organization costs? (31.d)					
30.e.	Gifts or donations? (31.e)					
30.f.	Drugs sold to non-patients? (31.f)					
30.g.	Operation of hospital gift shop? (31.g)					
30.h.	Luxury items or services? (31.h)					
30.i.	Private-duty personnel? (31.i)					
30.j.	Vocational and scholastic training expense? (31.j)					

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30.k.	Personal comfort items (e.g., telephones, TVs and radios)? (31.k)					
30.l.	Political and lobbying activities? (31.l)					
30.m.	Fundraising? (31.m)					
30.n.	Fines or penalties? (31.n)					
30.o.	Taxes? (31.o)					
30.p.	Goodwill amortization for purchase of a facility or for a non-compete agreement? (31.p)					
31.	Costs are properly classified? (32)					
32.	Requests for exceptions to TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) limits and the routine cost limits are properly documented and supported by verifiable and auditable data (only applicable to PPS-exempt hospitals)? (33)					
	Clinical Research					
33.	Are there established institutional review board policies and procedures for clinical trials and other research? (34)					
34.	Does the hospital have policies and procedures to ensure that services related to clinical trials are billed appropriately? (35)					
35.	Does the hospital have policies and procedures addressing the proper allocation of and accounting for research grants? (36)					
	Emergency Medical Treatment and Active Labor Act (EMTALA)					
36.	Does the hospital provide the following staff with regular training on the most current CHI EMTALA policy: (37)					
36.a.	Emergency department? (37.a)					
36.b.	Labor and delivery? (37.b)					

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36.c.	Areas where psychiatric patients may seek emergency treatment? (37.c)					
36.d.	Any other department where patients may present themselves in an emergent situation? (37.d)					
37.	Has the hospital provided general EMTALA training to all patient care personnel? If so, document date of training. (38)					
38.	Does the hospital conduct periodic reviews to determine whether the facility satisfies its EMTALA obligations? (39)					
	Miscellaneous					
39.	Does the hospital ensure that all off-campus outpatient units or departments that are billed under the name/provider number of the hospital meet CMS's provider-based requirements? (new)					
40.	Does the hospital have policies and procedures to ensure all patient deaths that may have been caused by the use of restraints or seclusion are appropriately reported to Medicare and state survey agencies? (40)					
41.	Does the hospital have policies and procedures for disposing of unclaimed property in accordance with state law? (41)					

C.	<i>ISSUES APPLICABLE TO LONG-TERM CARE FACILITIES</i>					
	Quality Assurance					
1.	Are resources directed to verify that the facility has corrected any deficiencies cited in surveys? (1)					
2.	Are the corrective actions incorporated into the facility's policies and procedures, as well as reflected in its training and educational programs? (2)					

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3.	Does the long-term care facility have a quality assessment and assurance committee? (3)					
4.	Does the committee consist of interdisciplinary facility staff members, including the director of nursing services and at least 3 other members of the facility's staff? (4)					
5.	Does the committee meet a minimum of quarterly? (5)					
6.	Does the facility have a written transfer agreement with an acute care hospital? (6)					
7.	Has the facility implemented a system to improve resident outcomes and correct quality deficiencies? (7)					
Quality of Care						
8.	Is there a comprehensive and standardized assessment of each resident's functional capacity and a comprehensive care plan with measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs? Does the assessment include the following requirements: (8)					
8.a.	The assessment is done within 14 days of admission? (8.a)					
8.b.	The care plan is completed within 7 days of the assessment? (8.b)					
8.c.	An RN signs and certifies that the assessment is completed? (8.c)					
8.d.	The care plan is prepared by an interdisciplinary team? (8.d)					
9.	Does the facility address residents' clinical conditions, including the following: (9)					
9.a.	Pressure ulcers? (9.a)					
9.b.	Dehydration? (9.b)					
9.c.	Malnutrition? (9.c)					
9.d.	Incontinence? (9.d)					

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9.e.	Mental or psychosocial problems? (9.e)					
10.	Do policies and procedures exist to support: (10)					
10.a.	Compliance with Federal dietary service requirements and the adequacy of these services (ensuring nutrition and hydration needs are met)? (10.a)					
10.b.	Accommodating individual needs and preferences, except when health or safety would be endangered? (10.b)					
10.c.	Properly administering and monitoring drugs? (10.c)					
10.d.	Assisting patients in selecting and enrolling in Medicare prescription drug plans? (OIG)					
10.e.	Considering resident acuity and medical needs in determining staffing levels/sufficiently supervised staff to provide medical, nursing, and related services? (10.d)					
10.f.	Provision of /arrangement for rehabilitation services listed in the plan of care? (10.e)					
10.g.	Appropriate services to assist residents with activities of daily living (e.g., feeding, dressing, bathing)? (10.f)					
10.h.	Activities program in accordance with comprehensive assessment, the interests and the physical, mental and psychosocial well-being of residents? (10.g)					
10.i.	Timely notice to resident's physician and legal representative/family member as to accidents, significant changes in physical, mental, or psychosocial status; need to alter treatment significantly; transfer or discharge of resident, or change in room or roommate assignment? (10.h)					
11.	Physician visits: (11)					
11.a.	At least every 30 days for first 90 days after admission? (11.a)					
11.b.	At least every 60 days thereafter? (11.b)					

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11.c.	Either done personally or alternates MD with PA, NP or clinical nurse specialist? (11.c)					
11.d.	Physician reviews and signs plan of care and prepares, signs and dates progress notes at each visit? (11.d)					
11.e.	Are policies, procedures and templates regularly reviewed to reflect changes in the law? (11.e)					
	Residents' Rights					
12.	Do policies and procedures address the following risk areas to protect resident rights: (12)					
12.a.	Freedom from improper denial of access to care? (Primarily governed by state law.) (12.a)					
12.b.	Freedom from verbal, sexual, mental, or physical abuse, corporal punishment, and involuntary seclusion? (12.b)					
12.c.	Freedom from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms? (12.c)					
12.d.	Ensuring residents have personal privacy and access to their personal and health records? (12.d)					
12.e.	Ensuring residents' right to participate in care and treatment decisions? (12.e)					
12.f.	Protecting resident funds? (12.f)					
12.g.	Is there a mechanism in place for reporting violations to the facility administrator immediately following any incident involving mistreatment, neglect or abuse, or misappropriation of resident property? Does the facility act to prevent further potential abuse, and is the alleged violation reported as required by state law? (12.g)					

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12.h.	Does the facility follow all federal law requirements related to transfer and discharge, including documentation, notice, orientation, and bed hold/readmission policies? (12.h)					
12.i.	Notice (in language resident understands) of rights, including right to access records, refuse treatment, legal rights (funds, Medicaid, advocacy groups, file complaints/grievances, examine survey results, mail, visitation, telephone, personal property). (12.i)					
Billing and Cost Reporting						
13.	Compliance with consolidated billing under the prospective payment system? (13)					
14.	Billing Medicare where no 3-day inpatient stay/not admitted within 30 days of hospital discharge? (14)					
15.	Billing Medicare where missing physician certification or recertifications or where they are untimely? (15)					
16.	Conditioning admission/continued stay on third-party guarantee of payment or soliciting payment for Medicaid-covered services beyond what facility is permitted to charge under state Medicaid law? (16)					
17.	Arrangements with a hospital under which long-term care facility will accept a Medicare/Medicaid beneficiary only if hospital supplements payment? (17)					
18.	Documentation of medical necessity for rehabilitation and infusion therapy services? (18)					
19.	Documentation of medical necessity for imaging and laboratory services? (19)					
20.	Documentation of medical necessity for psychotherapy services? (OIG)					
21.	Documentation that care provided to patients with consecutive hospital inpatient stays is medically necessary? (20)					

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22.	Implementation of Medicare prohibition on billing for day of discharge? (21)					
23.	Submission of “no-pay bills” as required, to track beneficiaries’ benefit periods? (OIG)					
Creation and Retention of Records						
24.	Do the facility’s policies and procedures provide for documentation of the following: (22)					
24.a.	All nursing and therapy services, as well as MDS information? (22.a)					
24.b.	Resident assessment instrument, comprehensive plan of care, and all corrective actions in response to surveys? (22.b)					
24.c.	Incorporation of appropriate portions of hospital inpatient record (including documentation used to complete MDS assessment)? (22.c)					
Auditing and Monitoring						
25.	Treatment plans established by physician and reflect timely physician signature? (23)					
26.	Appropriate calculation of therapy minutes? (24)					
27.	Accuracy of MDS assessment? (25)					
28.	Appropriate assignment of HIPPS (health insurance prospective payment system) modifier? (26)					
29.	Does the review process include any or all of the following techniques: (27)					
29.a.	Unannounced mock surveys, audits, and investigations? (27.a)					
29.b.	Reevaluation of deficiencies cited in past surveys for state law and Medicare requirements? (27.b)					

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D.	<i>ISSUES APPLICABLE TO PHYSICIAN PRACTICES</i>					
	Stark Law; Kickback Issues					
1.	Does practice meet Stark’s “group practice” definition? (1)					
2.	Does practice have off-site locations that provide “designated health services” (e.g., imaging, lab, therapy)? (2)					
3.	Does practice compensate physicians based on orders of ancillary “designated health services?” (3)					
4.	Have space or equipment rentals to referring persons/entities been analyzed to assure fair market value and commercial reasonableness? (4)					
5.	Are all financial relationships between physicians/groups and MBOs (or other health care providers) reflected by a signed written agreement? (new)					
6.	If there are separate written agreements that relate to multiple financial relationships between a physician/group and an MBO (or other provider), does each agreement cross-reference the other, or is a written master list maintained that references each agreement? (new)					
	Practice Standards and Procedures					
7.	If the practice has incorporated compliance standards of other entities (e.g., physician practice management company, independent practice association, physician-hospital organization, or third-party billing company), has the practice tailored those standards/procedures to its environment (to the extent permitted or practical)? (5)					

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	Coding and Billing					
8.	Do the standards and procedures address the following: (6)					
8.a.	Knowing misuse of provider identification numbers? (6.a)					
8.b.	Appropriate use of billing by reassignment, proper filing of 855-R? (6.b)					
8.c.	Services furnished "incident to" physician services? (6.c)					
8.d.	Purchased diagnostic tests? (6.d)					
8.e.	Billing for reference laboratory tests? (6.e)					
8.f.	Pathology services? (6.f)					
8.g.	Independent diagnostic testing facility (IDTF) certification needed for referred diagnostic imaging test? (6.g)					
8.h.	Cardiology and echocardiography services? (6.h)					
8.i.	Physical and occupational therapy services? (6.i)					
8.j.	Initial preventive physical exams? (6.j)					
8.k.	Mental health services? (6.k)					
8.l.	Wound care services? (6.l)					
8.m.	Eye surgeries? (OIG)					
8.n.	E/M Services during Global Surgery? (OIG)					
8.o.	Long-distance physician services? (6.m)					
8.p.	Psychiatric services to inpatients? (OIG)					
8.q.	Polysomnography? (OIG)					
8.r.	Advanced imaging services? (OIG)					
8.s.	Limiting charges? (6.n)					
8.t.	Clustering? (6.o)					

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8.u.	Site of service designation? (6.p)					
8.v.	Diagnosis code linked with the reason for the visit or service? (6.q)					
8.w.	Appropriate use of modifiers? (6.r)					
	Medical Record Documentation					
9.	Does the documentation of each patient encounter include the following: (7)					
9.a.	Reason for the encounter? (7.a)					
9.b.	Any relevant history? (7.b)					
9.c.	Physician examination findings? (7.c)					
9.d.	Prior diagnostic test results? (7.d)					
9.e.	Assessment? (7.e)					
9.f.	Clinical impression or diagnosis? (7.f)					
9.g.	Plan of care? (7.g)					
9.h.	Date? (7.h)					
10.	If not documented, is the rationale for ordering diagnostic and other ancillary services easily inferred by an independent reviewer of third party who has appropriate medical training? (8)					
11.	Are CPT and ICD-9-CM codes used for claims submission supported by documentation and the medical record? (9)					
	Additional Risk Areas					
12.	To the extent the following risk areas are applicable, the practice should consider whether to incorporate them into its written standards and procedures manual, and its training program. (10)					

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12.a.	Physician liability for certification in the provision of services (including medical equipment and supplies and home health services). (10.a)					
12.b.	The physician's role in EMTALA. (10.b)					
12.c.	Teaching physicians. (10.c)					
12.d.	Third-party billing services. (10.d)					
12.e.	Billing practices by non-participating physicians, including Medicare opt out and private contracts with beneficiaries. (10.e)					
12.f.	Prescribing OxyContin and other drugs of potential abuse (OIG)					

E.	<i>ISSUES APPLICABLE TO DME SUPPLIERS</i>					
	Billing					
1.	Are there systems in place to ensure the supplier does not bill for: (1)					
1.a.	Rental items after they are no longer medically necessary? (1.a)					
1.b.	Excessive amounts of items? (1.b)					
1.c.	Items that do not meet the definition/requirements of the item ordered? (1.c)					
1.d.	Items subject to the "capped rental" rule? (1.d)					
1.e.	Rental items when the beneficiary is residing in an institution? (1.e)					
1.f.	Items <i>prior</i> to receiving physician order and/or appropriate Certificate of Medical Necessity (CMN)? (1.f)					

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2.	Are there systems in place to ensure the supplier bills for power mobility devices only in accordance with law, including the prerequisites of (i) a face-to-face examination of the beneficiary by the prescribing practitioner, (ii) a written prescription from the prescriber within 30 days following such examination, and (iii) sufficient supporting documentation? (2)					
	Coding					
3.	Are there systems in place to ensure the appropriate use of place of service codes? (3)					
4.	Are billing personnel aware of the SADMERC (Statistical Analysis Durable Medical Equipment Carrier) help line, when coding questions arise? (4)					
5.	Are claims containing ZX, KX and KS modifiers being appropriately coded, and does the supplier have appropriate documentation on file? (OIG)					
	Medical Necessity					
6.	Are there systems in place to ensure that initial claims for oxygen therapy include the written results of an arterial blood gas study or oximetry test? (5)					
7.	Are all applicable personnel aware of the prohibition on a DME supplier performing the blood gas/oximetry tests so as to qualify patients for oxygen? (6)					
7.a.	Does the supplier provide free oximetry or oxygen to patients?					
8.	Are there systems in place to ensure that the supplier keeps the signed CMN on file, and is able to provide sufficient documentation to the DMERC upon request? (7)					
9.	Are there systems in place to ensure that the supplier documents medical necessity for DME furnished to patients who are also receiving home health services? (8)					

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10.	Are there systems in place to ensure that the supplier documents medical necessity for therapeutic footwear? (9)					
11.	Are there systems in place to ensure that the supplier documents medical necessity for wound care equipment and supplies and glucose test strips? (10)					
Mail Order DME						
12.	If the supplier provides mail order items, are systems in place to ensure that supplies are delivered in accordance with the applicable physician's order? (11)					
13.	Does the supplier use a tracking system to determine whether patients have actually received the items? (12)					
Fraud and Abuse						
14.	Are there systems in place to ensure that cover letters to physicians do not encourage the ordering of medically unnecessary items? (13)					
15.	Are there systems in place to ensure that all co-location agreements with physicians (e.g., consignment closets) and other referral sources reviewed have fair market value, commercially reasonable terms? (14)					
Supplier Standards and Licensing						
16.	Do written policies provide that the DME supplier will not submit bills for drugs unless the supplier is licensed to dispense the drug? (15)					
17.	Are there systems in place to ensure that all Medicare supplier standards are and continue to be met? The standards include that the supplier: (16)					
17.a.	Honors all warranties under state law. (16.a)					
17.b.	Maintains a physical facility on an appropriate site. (16.b)					

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17.c.	Furnishes information to beneficiaries on how the beneficiary can contact the supplier by telephone. (16.c)					
17.d.	Does not contact beneficiaries by telephone unless an exception applies. (16.d)					
17.e.	Accepts returns from beneficiaries of substandard items. (16.e)					
17.f.	Maintains a complaint resolution protocol. (16.f)					
F.	<i>ISSUES APPLICABLE TO HOME HEALTH AGENCIES</i>					
	Billing					
1.	Are there systems in place to ensure that the agency does not bill for services provided to patients who are not homebound? (1)					
2.	Are there systems in place to ensure that the agency does not bill for services when willing and able family members or other persons could provide adequate services instead? (2)					
3.	Are there systems in place to ensure that the “therapy threshold” is properly met, when so indicated on claims to Medicare? (3)					
4.	Are there systems in place to ensure that the agency does not separately bill for items that are bundled into the home health PPS rate? (4)					
5.	Are there systems in place to ensure that the agency accurately codes information in the Outcome and Assessment Information Set that is used to determine the applicable HHRG? (OIG)					
6.	Are there systems in place to ensure that the agency correctly reports all cost information related to potential outlier cases? (5)					

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	Medical Necessity					
7.	Are there systems in place to ensure that the patient's plan of care is periodically reviewed by a physician? (6)					
8.	Are there systems in place to ensure that all claims satisfy the "qualifying service" requirement? (7)					
9.	Are there systems in place to ensure that services provided to patients residing in assisted living facilities are reasonable and necessary? (8)					
	Supplier Standards					
10.	Are there systems in place to ensure the agency meets and continues to meet the applicable Medicare conditions of participation? The standards include that the agency: (9)					
10.a.	Fully informs and gives beneficiaries the right to participate in their care and treatment and in any changes to care/treatment that might affect the individual's well-being? (9.a)					
10.b.	Ensures that beneficiaries' property is treated with respect? (9.b)					
10.c.	Gives beneficiaries the right to voice grievances and investigates complaints? (9.c)					
10.d.	Advises patients of the availability of the toll-free home health agency hotline in the applicable state? (9.d)					
10.e.	Does not use as a home health aide any individual who does not meet applicable requirements? (9.e)					
10.f.	Performs an assessment of each patient accurately reflecting the patient's health status and needs for care? (9.f)					

**CATHOLIC HEALTH INITIATIVES CORPORATE RESPONSIBILITY PROGRAM
FY 2007 MBO RISK ASSESSMENT MATRIX -- NON CRITICAL ACCESS VERSION**

	<i>ISSUE</i>	Yes	In Process	No	N/A	<i>SPECIFY POLICIES OR DOCUMENTED PRACTICES TO ENSURE COMPLIANCE*</i>
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G.	<i>ISSUES APPLICABLE TO HOSPICES</i>					
	Patient Consent					
1.	Are there systems in place to ensure that the hospice obtains informed consents from beneficiaries to elect the Medicare hospice benefit? (1)					
2.	Are there systems in place to ensure that patients who remain eligible are not pressured to revoke the hospice benefit, merely because care has become too expensive? (2)					
	Inappropriate Billing/Substandard Care					
3.	Are there systems in place to ensure that patients are not admitted to hospice care unless they are terminally ill? (3)					
4.	Are there systems in place that attempt to ensure that another provider is not submitting claims for care that is covered by Medicare's hospice benefit? (4)					
5.	Are there controls in place to help prevent duplicate drug payments under Part A and the newly implemented Part D? (OIG)					
6.	Are there systems in place to ensure that an appropriate amount of care/utilization of services is furnished? (5)					
7.	Are there systems in place to ensure the hospice makes all covered services available and does not inappropriately discharge patients in nursing homes because of the cost of inpatient care? (6)					
8.	Are there systems in place to ensure that "core services" and management responsibilities are not inappropriately relinquished to nursing homes and others? (7)					
9.	Are there systems in place to ensure that substantially all core services are routinely provided directly by hospice employees? (8)					

**CATHOLIC HEALTH INITIATIVES CORPORATE RESPONSIBILITY PROGRAM
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	<i>ISSUE</i>	Yes	In Process	No	N/A	<i>SPECIFY POLICIES OR DOCUMENTED PRACTICES TO ENSURE COMPLIANCE*</i>
	Medical Necessity					
10.	Are there systems in place to ensure that the level of hospice care provided is reasonable and necessary? (9)					
	Plan of Care					
11.	Are there systems in place to ensure that a written plan of care is established and that care is provided in accordance with the plan? (10)					
12.	Are there systems in place to ensure that the plan of care is reviewed and updated, at intervals specified in the plan? (11)					
	Fraud and Abuse					
13.	Are there systems in place to ensure that all arrangements with nursing homes are appropriate? In particular, do policies ensure that the hospice does not: (12)					
13.a.	Offer free or below fair market value goods to induce a nursing home to refer patients? (12.a)					
13.b.	Make “room and board” payments in excess of what the nursing facility would have received directly from Medicaid had the patient not been enrolled in hospice? (12.b)					
13.c.	Pay above fair market value for non-core services that Medicaid does not consider to be included in its “room and board” payments to the nursing facility? (12.c)					
	Supplier Standards					
14.	Are there systems in place to ensure that the hospice meets and continues to meet all other applicable Medicare conditions of participation? (13)					

* Column “Specify Policies or Documented Practices to Ensure Compliance” must be completed for each Issue. Examples may include, but are not limited to: 1) specific policies and procedures, 2) current documented practices, 3) specific education or materials developed and provided to applicable staff, 4) sample forms or documents, 5) etc., that satisfy compliance with the issue/question. If a mandated CHI policy exists, the MBO must adopt the policy. At a minimum, the MBO must document practices supporting its compliance efforts.

Note: Any shaded rows do not require a response.