



PROVIDER ALERT



Alert # 5 06-16-2011 HCAL, HCBK, HCCH, HCCMP, HCER, HCNC, HCNE, HCYA

FRAUD, WASTE AND ABUSE DEPARTMENT UPDATE

In response to the increased focus on fraud, waste and abuse prevention at the Federal and State levels, Community Care Behavioral Health Organization has strengthened its existing policies, and has developed new polices as well, in order to provide additional clarity regarding our auditing and appeal processes. ****PLEASE NOTE THAT THESE POLICIES BECOME EFFECTIVE FOR ALL SERVICES RENDERED ON OR AFTER AUGUST 1, 2011.** Fraud, Waste, and Abuse (FWA) policies are also posted on Community Care’s website at:

<http://www.ccbh.com/providers/phealthchoices/fraudabuse/index.php>

We at Community Care believe that the first step in fraud and abuse prevention is education. Web-based training sessions are available for services commonly provided within the HealthChoices program. Training modules are posted on the Community Care website to allow providers convenient, easy access to fraud, waste, and abuse educational information.

Policy information which includes procedures for monitoring the Provider Network for Fraud, Waste, or Abuse, as well as specific instructions regarding the Provider audit appeal process are also explained in Appendix A1: Fraud, Waste, and Abuse Compliance and Auditing Policies and Procedures in the PROVIDER MANUAL. Though review of all policies is strongly encouraged, Providers are urged to review Policy #015, Chart Audit Exceptions and Corrective Actions. This policy outlines audit exceptions identified during reviews, actions that will be taken for specific deficiencies, and documentation requirements for provider reimbursement.

Below is the audit exception grid along with the explanation key that is included in the Chart Audit Exceptions and Corrective Actions policy:

A. Whenever audit exceptions are discovered during a FWA audit, the following actions, designated in the grid below, will be taken:

1. Repayment or retraction is expected as a result of the deficiency
2. Provider education for the first audit, second audit will result in provider repayment or retraction for the same deficiency
3. Provider is made aware of the deficiency, no retraction to be taken

Determination of repayment or retraction amounts, in cases that involve billing the incorrect code or modifier for example, will be made after details of the audit are examined. In addition, Providers are required to submit a Corrective Action Plan in order to ensure that significant audit exceptions identified are addressed. Serious violations may result in more serious sanctions and are reported to the appropriate county, state, and federal entities as outlined in Policy FWA #001.

The table below outlines specific audit exceptions with examples and the action that will be taken by the FWA Department upon discovery of the deficiencies. The examples listed below reflect an incomplete list and the exceptions are not limited to the instances outlined below.

| Audit Exceptions and Examples | Action |
|---|---------------------------------|
| <p>1. Missing Documentation Notes not submitted with desk review info, or notes missing at site reviews. Missing notes include either paper or electronic documentation. (Provider is notified of missing documentation and must submit the documentation by the end of the same business day to the requesting auditor)</p> | #1 |
| <p>2. Billing for services not rendered Provider billing for “no shows”</p> | #1 |
| <p>3. Documentation supports fewer units than billed units Billed for 3 hours of service in a partial program---member only present for 2 hours.</p> | #1 |
| <p>4. Billed the incorrect code/modifier—resulting in reimbursement difference Billed for an extensive med check---documentation indicates routine med check performed</p> | #1 |
| <p>5. Overlapping services Billed a therapy session from 1-2 PM, billed a med check from 1:15-1:30 PM</p> | #1 |
| <p>6. Rounding- up of units Documentation for a 5 minute phone call, provider billed 15 min. or 1 unit. Three five minute phone calls may not be bundled together to make one 15 minute unit.</p> | #1 |
| <p>7. Billing for non-billable services BHRS BSC billing for supervision of staff, completing paper work/administrative duties</p> | #1 |
| <p>8. No breaks in time from one venue or member to another Member #1 seen from 1-2 PM, member #2 seen from 2-4 PM in BHRS services in different locations. **It is the responsibility of the Provider to clearly document treatment time, travel time, and location of service in order to substantiate claims</p> | #1 |
| <p>9. Services not performed by the billing provider A contracted and credentialed independent licensed practitioner has another licensed practitioner perform the service and bills</p> | #1 |
| <p>10. No treatment plans present in the records</p> | #1 |
| <p>11. Bundle billed when member did not receive the required 4 days a week of service Bundled methadone service must have documentation of 4 days a week of compensable service.</p> | #1 |
| <p>12. Billing for travel time when prohibited</p> | #1 |
| <p>13. Signature stamp used on progress notes</p> | #1 |
| <p>14. No consent for treatment forms in member’s record</p> | #2 initial audit, subsequent #1 |
| <p>15. Treatment plans not signed by the member or reviewed by the provider</p> | #2 initial audit, subsequent #1 |

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| <p>16. Identical/nearly identical treatment plans</p> | <p>#2 initial audit, subsequent audits #1</p> |
| <p>17. Identical or nearly identical BHRS evaluations or progress notes Evaluations or progress notes containing only a few sentence changes, or a few words changed in progress notes</p> | <p>#2 initial audit, subsequent audits #1</p> |
| <p>18. Greater than ten members participating in a group session</p> | <p>#2 initial audit, subsequent audits #1</p> |
| <p>19. Documentation does not support the submitted claims Progress notes lack treatment or interventions/minimal interventions documented for amount of units submitted for payment. **Please see section B of this policy for documentation requirements for reimbursement</p> | <p>#2 initial audit, subsequent audits #1</p> |
| <p>20. Billed the incorrect code/modifier—with no reimbursement difference</p> | <p>#3</p> |
| <p>21. No AM or PM noted with times in progress notes</p> | <p>#3</p> |