I. **POLICY**

It is the policy of Community Care that its Fraud, Waste and Abuse (FWA) compliance program is designed to promote the detection, deterrence and prevention of instances of Provider and member intentional or unintentional misuse of Medical Assistance funds in behavioral healthcare (See: FWA Compliance Program Policy (FWA001)).

II. **DEFINITIONS**

N/A

III. **PURPOSE**

The purpose of this policy is to describe the important control within the FWA Special Investigations Unit (SIU) to conduct audits of claims submitted by Providers within the Community Care network.

IV. **SCOPE**

This policy applies to all departments that comprise Community Care and Provider Network.

V. **PROCEDURE**

A. **Audit Selection**

1. A collaborative FWA Work Plan is developed annually with each Primary Contract Administration based on mutually identified needs and in accordance with regulatory guidance of the Bureau of Program Integrity (BPI) of the Department of Human Services (DHS) and the SIU’s internal risk assessment and data mining analysis. This process includes a plan for auditing specific levels of care and Providers.

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2. The SIU, in collaboration with the Contracts, select programs to audit generated by the following sources: Contract Administrator priorities, routine audit plan, re-audit schedule, referrals from Community Care staff and Departments, Provider self-reports, members, hotline reports and regulatory and law enforcement.

3. Indicators for possible inclusion of a Provider on the audit schedule:
   a. No prior audits
   b. Greater than two (2) years since last audit
   c. Outlying patterns of claims submissions compared to similar peers
   d. High Dollar spends for a specific level of care or service in a quarter
   e. Highest number of paid claims for a specific level of care or service in a quarter
   f. Data-mining results
   g. Re-audit of previous findings
   h. Self-report
   i. Referral
   j. A provider who is determined to be high risk for FWA

4. An audit sample size is variable and consistent with parameters recommended by the DHS relative to the audit type, level of service and audit time frame. In general, a valid sample size for a routine audit includes a minimum of twenty-five (25) member charts. The sample size may be increased or decreased and selection methodology changed based on the number, seriousness and/or pattern of identified audit exceptions (deficiencies) or other factors.

5. The auditor may conduct member verification of services during the audit.

6. Focused or unannounced audits may be conducted based on issues identified in a complaint, referral, or data mining reports or other sources. These audits may have variable scope and may not follow the same steps outlined in the routine audit process.
B. Steps in the Routine Audit Process

1. The auditor sends an Audit Notification Letter to the Provider and follows with a telephone call informing the Provider of the audit.

2. For on-site audits, the Provider will be given the date and start time of the audit.

3. For desk audits, the Provider will be given the date by which records must be received by the auditor. Records may be mailed hard copy or submitted electronically through the FWA secure cloud based system. This system allows 24 hour access to the documents by the provider until the submission deadline and includes a tracking feature. Electronic health records can usually be exported in a PDF format for submission through the UPMC system. The benefits and use of the cloud-based system is explained during the audit notification process.

4. Contract representatives may participate in the audit.

5. The Audit Notification Letter and initial phone call explain the basic auditing process and allows time for the Provider to ask questions or seek clarification pertaining to the audit.

6. The member names/charts and dates of service requests will be mailed via letter to the Provider once the details of the audit have been arranged. Relative to confidentiality, Member ID numbers only will be sent via email or fax, when requested by the Provider.

7. For on-site audits, the Provider will have five (5) business days from the date on the Audit Confirmation Letter to assemble the member charts and submit all documentation at the commencement of the audit. For desk audits, the Provider will have ten (10) business days to mail/deliver hard copies of member records or submit them electronically via the FWA cloud-based system.
8. Providers are to assemble all relevant clinical, service and billing documentation required to support the billing of each claim to be audited. (For example: Submit any treatment or other required plan that supports each audited claim regardless of whether the plan was authored prior to the date range of the audit.)

9. Providers should assure that documents have been carefully reviewed for completeness, accuracy and a thorough reflection of compliance with regulatory requirements prior to submission. Documents for submission generally include the following core documents as well as others:
   a. Treatment/Service/Other Plans/Reviews/Updates
   b. Evaluations, Assessments, Screenings, Intakes
   c. All Progress Notes and related documentation
   d. Encounter Forms
   e. Consents for Treatment
   f. Behavior Plan(s)
   g. Plans of Care
   h. Medication check documentation
   i. Applicable Waivers
   j. Demographic Sheet
   k. Compliance Plan

10. The Provider should submit documentation related to each member claim for the audited level of care, regardless of location. (For example, a member may receive individual outpatient therapy at one of the agency’s programs and outpatient group therapy at another. Both services rendered to the member under the same contracted agency are subject to audit.)

11. Documentation will not be accepted after the opening of an onsite audit or after the due date issued for a desk audit.

12. Additional member charts may be requested during the audit for review.

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13. The auditor obtains FWA management approval of the audit findings.

14. A preliminary exit interview (verbal discussion) of audit findings is conducted by the auditor with the Provider immediately following the conclusion of an onsite FWA audit. The Provider may include various agency representatives (management, clinical, operations, fiscal and/or compliance). Information shared by the auditor includes a general description of exceptions/deficiencies, resources and education and subsequent steps in the process, including appeal. Financial implications of audit findings are not shared during this preliminary discussion.

15. A formal telephone exit interview with the Provider will be scheduled and conducted by the Auditor for all audits. The Provider may include various agency representatives (management, clinical, operations, fiscal and/or compliance). The auditor will review, as applicable:
   a. Audit exceptions (deficiencies)
   b. Required repayment amount to Community Care
   c. Mechanism of repayment to Community Care (retraction from current or future claims or consideration for direct repayment).
   d. Corrective Action Plan requirement
   e. Education and resources
   f. Potential re-audit, which may include a prospective payment audit
   g. The steps in the appeal submission process
   h. Notification that the Provider will be sent an Audit Results Letter within ten (10) business days from the date of this exit interview.
   i. Notification that the Audit Results Letter will be accompanied by a claims itemization (if exceptions were identified through the audit).

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See: FWA Chart Documentation, Audit Exceptions and Corrective Action Plans (FWA015).

C. Audit Conclusion

1. A summary of the audit findings, an Audit Results Letter, will be sent to the Provider within ten (10) business days of the audit closure/formal exit interview.

2. If the Provider is in disagreement with the audit findings, they have the option to file a written appeal of the audit. See: FWA Audit Appeal (FWA011).

3. If an appeal is not submitted, it is assumed that the Provider agrees with the findings of the audit and will comply with the repayment plan and complete a corrective action plan, when requested.

Records Retention

Community Care business units are responsible for verifying that records are retained according to established internal processes. Unless otherwise mandated by Federal or State law, or unless required to be maintained for litigation purposes, any documents, regardless of medium, recorded pursuant to this Policy are maintained for a minimum of ten (10) years from the date of recording.