Fraud, Waste & Abuse (FWA) Compliance & Program Integrity 2018 Policy Updates

May 17, 2018

HealthChoices Contracts:
Allegheny
Berks
Blair
Carbon/Monroe/Pike
Chester
Erie
Lycoming/Clinton
North Central
Northeast
York/Adams

Scope: This Provider Alert applies to all HealthChoices contracts.

Purpose: To alert providers of FWA policy revisions and additions.

Community Care’s Fraud, Waste & Abuse (FWA) Special Investigations Unit (SIU) is issuing this alert to keep providers informed, prepared, and up-to-date with existing, revised, and new policies to promote compliance with all Community Care, state, and federal fraud, waste & abuse laws, regulations, and requirements. The policies and procedures provide the framework for the Program Integrity - Fraud, Waste & Abuse program and also serve as a guide for providers to prepare for audits. The primary materials used to audit a provider’s medical record include:

- Community Care policy & procedures, Provider Alerts & Manuals
- Audit Exception Table (located in the Chart Documentation, Audit Exceptions and Corrective Action Plans Policy #FWA 015
- Rules and regulations (clinical, administrative, billing)
- HealthChoices Program Standards & Requirements and other guiding documents
- Provider program descriptions, policies and procedures

FWA Policy & Procedure Revision
Community Care’s website houses policies & procedures which describe how Community Care monitors the provider network for FWA issues as required by state and federal regulations. Please ensure that the individual(s) responsible for your compliance function carefully reviews the newly posted policies and procedures, educates agency staff and leadership, updates your Compliance Plan, as needed, and again reviews the materials prior to and during any FWA audit. The following listing of revised policies as well as a new policy (Prepayment Claims Hold Audit #FWA 018) has an effective date of April 15, 2018.
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Revised Fraud, Waste & Abuse (FWA) policies:
- Compliance Program (#FWA 001)
- Compliance Auditing (#FWA 003)
- Audit Appeal (#FWA 011)
- Chart Documentation, Audit Exceptions and Corrective Action Plans (#FWA 015)
- False Claims Act Policy (#FWA 010)
- NEW: Prepayment Claims Hold Audit (#FWA 018)

Note: For audits in progress, prior to this posting, the FWA Clinical Auditor will provide continued access to the applicable policies for the audit. The Auditor is also available to answer questions related to this policy transition.

Policy Updates and Highlights Include:
- Application of policies to all Community Care departments and to the Community Care HealthChoices provider networks
- Reinforcement of provider responsibility to submit complete and accurate documentation for an audit
- Applicability of a provider's corrective action plan (CAP) to all programs, levels of care and locations
- Response to ongoing deficiencies: CAP, re-audit, repayment, training, extrapolation of audit findings and/or FWA consultation with Network Provider Relations
- Scope and limitation of arbitration in FWA matters
- Collection of Precluded Provider Screening and Compliance Plans on audit
- Provider inclusion of an annual staff training schedule (on applicable FWA rules and regulations) within their Compliance Plan
- Precluded Provider Reporting and Credible Allegation of Fraud
- Exception Table revisions
- Medicaid Fraud Control Section reporting
- Changes to the Civil Monetary Penalty calculation
- Regulatory resources

NEW Policy: Prepayment Claims Hold Audit #FWA018
Like current FWA Retrospective Claims Audits, the Prepayment Claims Hold Audit (PCHA) will be conducted to determine if the utilization of billing codes is correct and if the medical record documentation supports the billing of these claims. Providers can expect direct communication and guidance from the FWA Clinical Auditor who will be conducting the review. This will include both verbal and written communication throughout the process.

In a Retrospective Claims Audit, providers submit documentation to support a group of previously paid claims identified by an auditor. The auditor makes the determination if the documentation supports the past payment for the claims/services. Typically, provider education and/or repayment is required when it is determined that the documentation does not support the paid claims.

Conversely, in a Prepayment Claims Hold Audit, claims are held at the point of submission (prepayment) and are audited to determine if they will be paid or denied. With guidance from the auditor, the provider will submit specific medical record documentation to the auditor. This will be done simultaneous to submitting each claim through the claims system, as usual (no medical record documentation is to be sent to the Provider Reimbursement Department as this may delay the process/claims payment). In conclusion, only those claims which are supported by the medical record documentation will be paid to the provider.

For example, if an audit was previously conducted and it was found that a provider had no encounter forms, the FWA SIU, Community Care leadership and the primary contract administrator may determine that a future PCHA will be conducted. When possible, the provider will be informed that an audit will be conducted and will be educated on expectations for the audit. This also allows time for the provider to carry out their CAP to obtain compliance. Upon audit, the auditor will contact the provider and request a copy of each encounter form be submitted directly to him/her, as the provider is submitting the claims to Provider Reimbursement, as usual. This audit would continue until the provider reaches substantial compliance with the encounter form requirements.
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Additional areas covered in the PCHA policy:
- Audit Selection
- Provider Notification
- Audit Process
- Claims Review
- Prepayment Claim Hold Audit Conclusion
- Removal from Prepayment Claims Hold

Please direct any questions to your regional FWA Clinical Auditor.