Fraud, Waste, and Abuse (FWA) Updates

Scope: This Provider Alert applies to all HealthChoices contracts.

Purpose: To alert providers of FWA policy revisions, availability of updated FWA training and resources, share audit exception (deficiency) trends encountered during FWA audits over the past year and to share basic documentation tips with providers.

Policy Updates (2019)
Community Care’s 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, agreement & 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 Revisions
Community Care’s website houses policies & procedures that describe how Community Care monitors the Provider Network for FWA issues as required by state and federal regulations. Please assure that the individual(s) responsible for your compliance function carefully reviews the newly revised and 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 has an effective date of March 18, 2019:

- 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)
- Prepayment Claims Hold Audit (#FWA 018)
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Note: For audits in progress, prior to this posting date, 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:

- Additional FWA e-mail hotline address: CommunityCareFWAHotline@ccbh.com
- The primary contract, Office of Mental Health and Substance Abuse Services (OMHSAS), and Bureau of Program Integrity (BPI) approve FWA policies & procedures, annually, prior to implementation
- Audit Exceptions Table revision to focus on the FWA landscape and current audit trends
- Notice to providers that Compliance Plan must include regularly scheduled (at least annual) FWA training for every agency staff, or, for self for independent practitioners
- Reinforced reporting requirements from Community Care to the BPI & Medicaid Fraud Control Section (MFCS)
- Prepayment Claims Hold Audit indication includes lack of provider response to a request for a Corrective Action Plan, post audit
- While self-reporting is a voluntary process, providers are not permitted to retain overpayments and/or payment for claims that are not supported by required documentation.
- Appeals must be postmarked (or submitted via the cloud-based system) within twenty (20) business days of the postmark date of the Audit Results Letter.
- PA Department of Human Services (DHS), BPI telephone hotline: 1.844.DHS.TIPS (1.844.347.8477)
- Inclusion of statement that technology (claims system, external databases, compliance audit case management database and associated reporting mechanisms, etc.) is used to identify priorities and monitor for potential FWA
- FWA references and educational material have been updated on the Community Care website
Training and Resources

Community Care is hosting/has hosted a Program Integrity - Fraud, Waste and Abuse training presented by the Attorney General’s Medicaid Fraud Control Section (MFCS) for the provider community. Providers are afforded an opportunity to hear from special agents from the MFCS regarding their role as a criminal justice agency having investigative and prosecutorial power relative to behavioral health Medicaid fraud. Existing regulations, referrals, and prosecutions are reviewed in order for providers to enhance their knowledge base and proactively fortify their Compliance Plans. Providers also gain a more thorough understanding of the function of the MFCS and how to recognize and report FWA.

Updates have been made to Community Care website FWA reference and educational materials as well as regulatory resources, including:

- FWA Acronyms Glossary of Terms
- Fraud, Waste, and Abuse Program Integrity: A Manual for Providers
- Provider Alert: Peer Support - A Non-Compensable Service During Travel
- Provider Alert: Provider Screening of Employees and Contractors for Exclusion from Participation in Medicaid
- Fraud, Waste & Abuse Program Integrity: Outpatient Mental Health Documentation WebEx
- Fraud, Waste & Abuse Program Integrity: Targeted Case Management WebEx
- Fraud, Waste & Abuse Program Integrity: Peer Support WebEx

Please visit the [Community Care website](http://communitycare.com) and review FWA Policy Compliance Program (#FWA 001) for a comprehensive list of updated resources.

Audit Exception (Deficiency) Trends & Compliance Tips

As part of the mission of the SIU, we are invested in providing information and education for providers on various FWA topics to foster compliance. This information may serve as an additional compliance tool to assist providers in enhancing their Compliance Plans, as they plan to conduct internal audits.

To this end, the SIU periodically shares a summary of the most common exceptions (documentation deficiencies) noted on audit. This is followed by a listing of basic documentation “Do’s” and “Don'ts”.

### HealthChoices Contracts:

- Allegheny
- Berks
- Blair
- Carbon/Monroe/Pike
- Chester
- Erie
- Lycoming/Clinton
- North Central
- Northeast
- York/Adams
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Top Exceptions Ranked by Recovery Amount & Prevalence on Audit
- Treatment/service/other plans not signed, as required
- Missing, incomplete, or insufficient encounter form
- Missing, incomplete, or insufficient progress note
- Missing, incomplete, or insufficient treatment plans
- Billing for non-billable services
- Missing, incomplete, or insufficient consent for treatment
- Billing for services not rendered
- Member not seen by physician
- Potential falsified claims, encounters
- Identical or nearly identical progress notes
- Overlapping services
- Documentation supports fewer units than billed
- Missing, incomplete, or insufficient documentation (other)
- No breaks in time from one venue or member to another
- Services not performed by the billing provider
- Incorrect code or modifier resulting in reimbursement difference
- Group therapy session > 10 or < 2 members
- Bundled/unbundled billing when not permissible
- Rounding-up of units
- Billing for travel time when prohibited
- Identical or nearly identical treatment plans

The following is intended as a review of basic and frequently encountered documentation issues. Agency compliance staff, administrators and supervisors are encouraged to incorporate this information into their internal record monitoring process to enhance documentation compliance.

DO:
- Identify the member by name on each page
- Document the service date and assure it matches the date on the note, claim, and encounter form
- Indicate both the service start and stop time in the medical record
- Include the name(s)/title(s)/role(s) of the individual(s) who rendered the service
- Assure each signature in the record is dated, including the physician’s
- Identify the specific location where the services were rendered (e.g. name of child’s school)
- Identify the specific service rendered (e.g., individual/group/family therapy, medication management)
- Clearly describe the relationship of the service to the goals on the treatment plan
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May 15, 2019

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- Describe the member’s progress, change in diagnosis, change in treatment, response to treatment, and plan for follow-up
- State the type of intervention used and how it was used
- Ensure that all progress notes substantiate the amount of time billed for the service
- Write legibly
- Ensure that the responsible providers sign, legibly, identify any credentials, and date the entry in the medical record
- Review documentation for spelling and grammar accuracy (i.e. review voice-to-text, dictation)
- Draw a single line through any text that requires alteration in the member’s medical record, sign full name, and date correction made
- Include a key as part of the medical record if your agency utilizes unique abbreviations or codes to identify places, people, or activities, etc.
- Ensure that consent for treatment has an identified level of care
- Ensure that all documentation is complete if you are printing from an electronic health record, including signature pages
- Assure that all required elements are included on each encounter form

DO NOT:
- Use the word “community,” alone to describe a service location
- Only list action words (e.g., “discussed,” “encouraged,” “actively listened”) to describe a therapy intervention in a progress note
- Rely solely on check boxes to describe interventions, member’s progress, response to treatment and/or plan for follow-up with no other supporting narrative, in progress notes
- Document a progress note consisting only of what the therapist observed/member reported
- Utilize copy and paste or autofill features without carefully reviewing and comparing individualization from note to note and plan to plan
- Scribble over, black out, or white out text in the member’s medical record
- Leave blank spaces or incomplete sentences in the member’s medical record
- Duplicate a clinician, member, or other person’s signature (e.g., stamp, copy and paste, photocopy)
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Documentation References


Please direct any questions to your regional FWA Clinical Auditor.