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 Community Care departments and to the Community Care HealthChoices Provider Network.

V. PROCEDURE

A. Audit Selection

All policies, procedures, standards, directives, rules or regulations contained in these materials and however denominated, developed, published, or promulgated by Community Care Behavioral Health are subject to change, revision, modification or withdrawal by Community Care Behavioral Health at any time without notice and subject only to any required governmental approvals or contractual obligations as to such changes or modifications.

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1. A collaborative FWA workplan 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.

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

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## Fraud, Waste and Abuse (FWA) Compliance Auditing

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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 service 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.

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 must assure that documents have been carefully reviewed for completeness, accuracy and a thorough reflection of compliance with regulatory requirements.
requirements prior to submission. Documents for submission include but are not limited to:

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 which includes regularly scheduled FWA training for staff

l. Precluded Provider Screening Policy and evidence of monthly screening

10. The Provider must 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. It is the provider’s responsibility to compile and submit all relevant documentation at the beginning of the audit (the opening of the onsite audit or the due date for record submission to a desk audit). Late or missing
documentation is an audit finding that may result in full repayment to Community Care for each involved claim. Upon receipt of the documentation, the SIU considers the documentation to be a full and complete record of the documentation that exists at the commencement of the audit.

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

13. The length of time to complete an audit is variable. For audits that span more than a few months, the auditor will periodically notify the Provider of any updates that may be available.

14. The auditor may engage in periodic peer reviews of the audit findings and obtains FWA management approval of the audit findings prior to audit completion.

15. 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.

16. 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).

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

**B. 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).

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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 (CAP), when indicated.

4. The CAP is to be submitted within 30 calendar days of the request by the Auditor. The provider is expected to address all deficiencies identified in the audit to obtain compliance across all of its programs under contract with Community Care.

### C. Re-Audit

1. When deficiencies are identified during a FWA audit which require a Corrective Action Plan (CAP), a re-audit of the Provider may be conducted, usually within 6 to 12 months after the provider’s CAP was to be implemented or 3 months after completion of the plan. The schedule will be determined by Community Care’s Special Investigations Unit and Regional Director in collaboration with the Primary Contract based on the scope and nature of required corrective actions.
   a. Please note: Per Fraud, Waste and Abuse (FWA) Chart Documentation, Audit Exceptions and Corrective Action Plans, the effectiveness of the CAP will be measured by the SIU via the following requirements: SIU re-audit, data review, prospective payment claims hold review, focused Provider self-audit or submission of training documents, or other activities or other methods as determined by the SIU. The Primary Contractor will be notified when the CAP reaches satisfactory resolution.
2. When a re-audit is conducted, if the identified deficiencies continue after the re-audit is completed, the provider is encouraged to participate in Community Care’s compliance training. The provider must also submit a second corrective action plan within 30 days of notification of the audit conclusion.

3. An additional provider re-audit may be conducted which may include a retrospective claims review, retrospective claims review with an extrapolation of the audit results across the body of the provider’s submitted claims or a pre-payment claims hold audit. The timeframe to conduct the audit will be based on the scope, type and nature of the correction required.

4. If upon conclusion of this audit cycle, significant compliance is not obtained, FWA will confer with Network Provider Relations and the Primary Contract regarding the provider’s status within the network.

5. Deficiencies identified in the preceding audit/re-audit activities will result in the requirement of repayment to Community Care, when indicated.

**Records Retention**

Community Care business units are responsible for verifying that records are retained according to established internal processes.
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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.