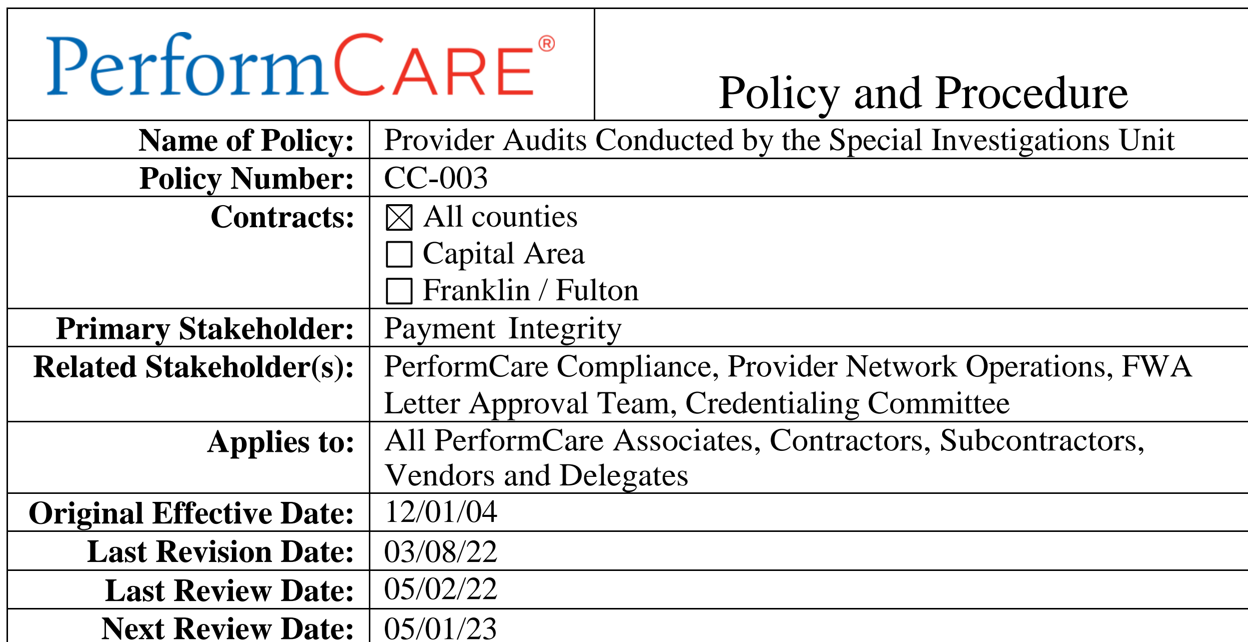


PerformCARE®	Policy and Procedure
Name of Policy:	Provider Audits Conducted by the Special Investigations Unit
Policy Number:	CC-003
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Payment Integrity
Related Stakeholder(s):	PerformCare Compliance, Provider Network Operations, FWA Letter Approval Team, Credentialing Committee
Applies to:	All PerformCare Associates, Contractors, Subcontractors, Vendors and Delegates
Original Effective Date:	12/01/04
Last Revision Date:	03/08/22
Last Review Date:	05/02/22
Next Review Date:	05/01/23

Policy: To describe the process whereby the PerformCare Special Investigations Unit (SIU) will monitor provider compliance with regulatory requirements for clinical care and fiscal responsibility. The SIU is responsible for the preventing, detecting, correcting, investigating and reporting abuse within the HealthChoices Behavioral Health program across the PerformCare provider network (e.g. provider fraud).

Purpose: To ensure PerformCare follows Appendix F of the HealthChoices Behavioral Health Program Standards and Requirements to conduct Provider Audits.

Definitions: **Abuse:** As defined in §42 CFR Part 455.2 as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. Abuse can be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

CMS: Centers for Medicare and Medicaid Services: Part of the U.S. Department of Health and Human Services which oversees federal health care programs, including those that involve health information technology, such as electronic medical records.

Data Mining: The analysis of large amounts of claims data to determine patterns for potential SIU investigations.

Fraud: As defined in §42 CFR Part 455.2 as an intentional deception or misrepresentation made by a person with the knowledge that the deception

could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. It may be an intentional deception, misrepresentation, or concealment of material facts by a provider or recipient with the knowledge that the deception could result in some unauthorized benefit, gain, or unjust advantage to him or herself or some other person.

HIPAA: The Health Insurance Portability and Accountability Act of 1996: National standards to protect individuals' medical records and other personal health information and requires appropriate mechanisms to be implemented to protect the privacy of personal health information and sets limits and conditions on the use and disclosure of such information.

SIU Manager/Fraud, Waste and Abuse (FWA) Coordinator: An employee position dedicated to preventing, detecting, investigating, and referring suspected Fraud, Waste and Abuse in the HealthChoices Behavioral Health program to Department of Human Services and drafting periodic and ad-hoc reports.

FWA Letter Approval Team: Reviews and approves all letters relating to SIU related functions. Letter review and approval is the responsibility of:

- PerformCare Compliance Officer
- PerformCare Executive Director
- SIU Manager, Clinical/FWA Coordinator

PerformCare Compliance Officer (CO): Responsible for internal fraud, waste, and abuse monitoring and training. The CO ensures systematically that contract obligations are monitored and met; works in conjunction with privacy officer to ensure corporate structure adheres to HIPAA; and spearheads the employee code of conduct implementation.

Special Investigations Unit (SIU): The AmeriHealth Caritas Family of Companies/PerformCare unit responsible for preventing, detecting, correcting, and reporting fraud, waste, and abuse across various categories of health care (e.g. provider fraud, Member fraud, or external fraud).

SIU Clinical Investigator: An employee position responsible for reviewing referrals, gathering information related to the allegations, conducting clinical reviews and claims audits and evaluation of findings to determine if evidence indicates billing errors, over-utilization, abusive activity, or a strong suspicion of fraud or abuse.

SIU Director: An employee position responsible for the management and overall direction of the unit to ensure its primary objectives – to prevent, detect, investigate, and correct fraud, waste, and abuse.

Statistically Valid Random Sample (SVRS): A subsection of the population that represents the population used to request a portion of the total records for audit.

Targeted Review: An audit or investigation of provider billing as a result of a complaint, Corporate Compliance monitoring activity, previous audit or other referral to see if the event meets the Bureau of Program Integrity (BPI) criteria for reporting as referenced in 55 P A Code Section 1101.

Waste: As defined by CMS for Medicare Part D, as overutilization of services or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather the misuse of resources. The thoughtless, careless or otherwise improper use of services by members, provision of and billing for such services by providers, or payment for the services by payors. Waste includes erroneous claims adjudication by PerformCare.

Acronyms:
BPI: Bureau of Program Integrity
DHS: Department of Human Services
MA: Medical Assistance or Medicaid
MFCU: Medicaid Fraud Control Unit, Pennsylvania Office of the Attorney General

Procedure: The Special Investigations Unit (SIU) for PerformCare will conduct all targeted reviews and provider audits in a professional manner and in accordance with *Appendix F* of the HealthChoices Program Standards and Requirements as outlined below. Audits include, but are not limited to the following types: provider self-reports, Member medical record review audits, site audits, data mining/claims audits, and interviews.

Provider Self-Reports:

1. As per the PerformCare Provider Manual and the Provider Agreement, all providers are obligated to designate a Compliance Officer and notify PerformCare of any suspected fraud, waste, or abuse, including overpayments, within 72 hours of discovery. The PerformCare Provider Manual includes a list of the information providers are to submit in a self-report to the SIU. Once all requested information is submitted, the self-report will be reviewed by the SIU and a self-report response letter will be sent to the provider, noting any identified overpayment. All Fraud, Waste, Abuse or quality referrals must be made within thirty (30) days of the identification of the problem/issue. The Behavioral Health – Managed Care Organization must send to BPI all relevant documentation collected to support the referral. Suspected fraud, waste and abuse may also be reported anonymously to the Bureau of Program Integrity (BPI) by the following methods:
    - Via the DHS website: http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/index.htm.
    - Emailed anonymously to omaptips@state.pa.us.
    - Via the DHS hotline 1-866-DPW-TIPS (1-866-379-8477).
    - Providers can report suspected fraud, waste and abuse to the Pennsylvania Office of the Attorney General's Medicaid Fraud Control Unit (MFCU), the Pennsylvania Office of the Inspector General, and the U.S. Justice Department.

Internal PerformCare Identification of Potential Fraud, Waste, or Abuse:

2. Any potential fraud, waste, or abuse noted during completion of tasks related to assignments of PerformCare associates should follow *CC-001 Reporting Suspected Provider Fraud, Waste and Abuse*.

Performing the Audit: Member Record Request Audits of Documentation:

3. The assigned SIU Clinical Investigator will develop a treatment record or documentation request letter to be sent to the provider, approved by the FWA Letter Approval Team. The SIU will determine whether to request the Member records identified in the referral or from a statistically valid random sample (SVRS) of Member records, depending on the referral issue and other provider/network factors. The provider will be notified in the record request letter of the due date for the information by the SIU and contact information to address any questions.
   3.1. Once the requested records are received from the provider, the assigned SIU Clinical Investigator completes a review of the submitted documentation, as well as PerformCare claims reporting.
   3.2. Upon completion of the review of records, the assigned SIU Clinical Investigator and SIU Manager/FWA Coordinator will develop the next steps in the case progression.

Performing the Audit: Site Audit/Obtaining Documentation at the Provider site:

4. The assigned SIU Clinical Investigator will develop a treatment record or documentation request letter to be delivered to the provider during the site audit. The SIU will determine whether to request the Member records identified in the referral or from a statistically valid random sample (SVRS) of Member records, depending on the referral issue and other provider/network factors. The provider will be notified in the record request letter of the due date for the information by the SIU and contact information to address any questions.
   4.1. The SIU Team at the site audit will review the treatment record or documentation request letter with the provider at the audit site. The SIU Team will also record the provider staff member name(s) which were present when the items were discussed.
   4.2. The SIU will obtain copies of the requested records and/or other pertinent information related to the referral to be maintained in a secure manner. If the provider refuses to provide the requested records to the SIU, the SIU will contact the Legal Department of AmeriHealth Caritas for next steps.
   4.3. The SIU will not conduct an exit interview with the provider, as the SIU is precluded from discussing any elements of the investigation.
   4.4. The SIU audit will proceed in the same manner as a record request sent to the provider, once the requested records are transported to the PerformCare office for review.
   4.5. Once the requested records are received from the provider, the assigned SIU Clinical Investigator completes a review of the submitted documentation, as well as PerformCare claims reporting.

4.6. Upon completion of the review of records, the assigned SIU Clinical Investigator and SIU Manager/FWA Coordinator will develop the next steps in the case progression.

Performing the Audit: Data Mining/Claims Audits:

5. Review of PerformCare claims either in the course of another audit or independent of an audit, in data mining actions, could reveal issues to be addressed regarding provider claim submission, such as duplicative billing and unbundling of codes to impact reimbursement to providers.
   - 5.1. The Clinical Investigator will develop a plan to proceed and potentially open an investigation following consultation with the SIU Manager/FWA Coordinator. Provider records could be requested via a record request letter, as in sections 3 and 4 above, if the clinical documentation requires review in relation to the claims review findings to support or dispute the concerns noted.
   - 5.2. If claims reporting reveals a potential violation of proper billing procedures for the identified level of care and an overpayment is identified without requiring a review of the corresponding clinical documentation, an overpayment letter with findings of the audit is drafted by the SIU, sent for review by the FWA Letter Approval Team and sent to the provider once approved.

Performing the Audit: Interviews:

6. During the review of the referral received by the SIU or in the course of an audit, it may be determined that it is necessary to contact former or current provider staff, adult Members, parents of Members, etc. and conduct interviews to validate the referral or the results of the audit.
   - 6.1. All discussions/interviews and written correspondence with individuals as part of the audit to investigate the referral are documented in the case database as evidence of the review.

Provider Correspondence of Audit Results:

7. Following conclusion of the review of case documentation, data mining activities, and/or interviews of staff or Members/families and others, the assigned SIU Clinical Investigator will compile the Case Summary, *Attachment 2 Case Summary Report*, which will be reviewed by the SIU Manager/FWA Coordinator or designee as needed for comment and direction of further case actions.
   - 7.1. If there are findings noted at the conclusion of the audit, the SIU will send a Recovery/Overpayment letter, see *Attachment 3 SIU Recovery Letter*, and if applicable, the details of any claim findings identified via the audit, see *Attachment 1 SIU Recovery Audit Spreadsheet*.

Provider Follow Up:

8. Written provider responses to audits or provider disputes will be reviewed upon receipt and the SIU will provide a response to the provider via a dispute response letter. The SIU dispute response letter to the provider will be reviewed with the FWA Letter Approval Team prior to sending to the provider. The process for provider appeal/dispute of the SIU findings is outlined in *CC-005 Provider Dispute Policy*.

8.1. The SIU Clinical Investigator will send a letter within 45 days of the audit completion confirming the final terms and requirements of the audit with a copy sent to the designated County HealthChoices contact and BPI, and/or the MFCU if appropriate.

8.2. The SIU Clinical Investigator will notify BPI, designated Regional Oversight, as well as the MFCU, Vice President of Network Development and the Credentialing Committee of the findings if appropriate.

Related Policies: *CC-001 Reporting Suspected Provider Fraud, Waste and Abuse*
CC-005 Provider Dispute Policy

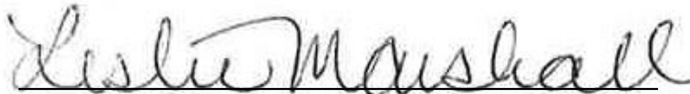
Related Reports: None

Source Documents and References: *Title 42 -Public Health §42 CFR Part 455.2*
55 PA Code Section 1101

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 SIU Recovery Audit Spreadsheet*
Attachment 2 Case Summary Report
Attachment 3 SIU Recovery Letter

Approved by:



Primary Stakeholder

PerformCARE

Provider:
Case #:
Total Recoupment:
Payor:

Claim Number:	MAID	Member Name	Provider ID:	Provider Name:	Service Date	Service Through Date:	Procedure Code:	Units Billed:	Paid Amount:	Overpayment amount:	COMMENTS

DATE

CCO Name, Corporate Compliance Officer
Provider Name
Address

CERTIFIED LETTER #:

Corporate Compliance Case (CCC) #:
Case Reference Number:
DHS Bureau of Program Integrity Referral #:
HealthChoices Region:

Re: Overpayment: Provider

Dear :

While conducting a recent claims audit, the Special Investigation Unit (SIU) for PerformCare identified potential overpayments to your organization that may have occurred as a result of:

- XXX (*citation to support finding/violation*)

Based on our calculations, the overpayments on the claims in question totaled $*XXXX*. We are obligated to recover all overpayments that are identified.

Enclosed you will find the claim payment detail for your review. If you have specific questions regarding the calculation of the overpayment amount, please contact *ASSIGNED* at *717-671-*.

In the event you do not agree with our findings, you must notify us in writing within 30 days from the date of this letter. Your letter should reference the CCC Number listed above and include appropriate supporting documentation. Send your correspondence to:

PerformCare SIU
AmeriHealth Caritas
8040 Carlson Road
Harrisburg, PA 17112
Attention:

If we do not receive written notification from you within 30 days from the date of this letter, we will determine you agree with our findings. We request that you send a check for the amount of $XXXX made payable to PerformCare. Upon receipt of this check, PerformCare will close this case. For reconciliation purposes, please ensure the SIU case tracking identifier CCC Number XXXX-XX is included with each payment, and mail to the address below:

PerformCare
8040 Carlson Road
Harrisburg, PA 17112
Attn: Finance Department

If a check is not received within 30 days from the date of this letter, these claims will be reprocessed and all overpayments will be recovered from future payments. Please be advised that other service lines on the affected claims could potentially be impacted when these overpayments are reprocessed.

Thank you for your continued participation in the PerformCare network.

Sincerely,

ASSIGNED
TITLE
Amerihealth Caritas Family of Companies/PerformCare

Cc: OVERSIGHT
Mary Ann Zimmerman, Bureau of Program Integrity
Amanda Flowers, Supervisory Special Agent, Office of Attorney General