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:	Program 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:	03/18/24
Last Review Date:	11/04/24
OMHSAS Approval Date:	N/A
Next Review Date:	11/01/25

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 substantial 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.

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
- SIU Team Lead, 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.

Probe Sample: A randomly selected sample utilized to assess risk and evaluate whether a full statistically valid sample is required.

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 Manager, Clinical: An employee position responsible for the direct oversight and management of the unit to ensure its primary objectives – to prevent, detect, investigate, and correct fraud, waste, and abuse.

SIU Team Lead, 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, drafting periodic and ad-hoc reports, and conducting provider audits as needed.

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 MA Provider Compliance Hotline Response Form: https://forms.dhs.pa.gov/dhs-ma-provider-compliance/
    - Via the DHS Hotline 1-844-DHS-TIPS (1-844-347-8477).
    - Via Mail: Department of Human Services
      Bureau of Program Integrity
      Commonwealth Tower, Floor 4
      P.O. Box 2675

Harrisburg, PA 17105-2675

- 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, from a randomly selected probe sample, 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 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, the SIU Team Lead, FWA Coordinator and/or the SIU Manager, Clinical 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, from a randomly selected probe sample, 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 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, the SIU Team Lead, FWA Coordinator and/or the SIU Manager, Clinical 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 Team Lead, FWA Coordinator and/or the SIU Manager, Clinical. /. Provider records could be requested via a 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 Member/families and others, the assigned SIU Clinical Investigator will draft a Recovery/Overpayment letter, *see Attachment 2 SIU Recovery Letter*, if there are findings noted at the conclusion of the audit. The SIU Recovery Letter will be reviewed by the SIU Team Lead, FWA Coordinator and/or the SIU Manager, Clinical for comment and direction of further case actions. The SIU will send the Recovery/Overpayment letter, and if applicable, the details of any claim findings identified via the audit, see *Attachment 1 SIU Recovery Audit Spreadsheet*, after review by the FWA Letter Approval Team.

7.1. Following conclusion of the review of case documentation, data mining activities, and/or interviews of staff or Member/families and others, the assigned SIU Clinical Investigator will draft a Closure letter, see *Attachment 3 SIU Closure Letter*, if there are no findings associated with an overpayment noted at the conclusion of the audit. The SIU Closure Letter will be reviewed by the SIU Team Lead, FWA Coordinator and/or the SIU Manager, Clinical for comment and director of further case actions. The SIU will send the Closure Letter after review by the FWA Letter Approval Team.

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 60 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, PerformCare Executive Management and the Credentialing Committee of the findings if appropriate.

Related Policies:
CC-001 Reporting Suspected Provider Fraud, Waste and Abuse
CC-002 FWA Program
CC-004 Reporting Suspected Recipient 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 SIU Recovery Letter
Attachment 3 SIU Closure Letter

Approved by:

Primary Stakeholder

PerformCARE

Provider: **Provider ID:**
Total Overpayment: **CCC#:**
Payor:

Claim Number:	Claim Line:	MAID Number:	Member Name	Service Date:	Place of Service:	Procedure Code:	Modifier:	Units Billed:	Paid Amount:	Overpayment Amount:	Comments:

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

DATE TBD

COMPLIANCE OFFICER
PROVIDER
ADDRESS 1
ADDRESS 2

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

Dear XXXXX,

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:

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

During the medical record and claims audit conducted by the SIU, the following issues were not included in the calculation of the overpayment. but serve as education regarding the documentation requirements for service provision. Please note, the documentation violations listed below may be identified with an overpayment in future audits conducted by the SIU.

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

Based on our calculations, the overpayments on the claims in question totaled $XXXX. We are obligated to recover all identified overpayments. 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 INVESTIGATOR at 717-XXX-XXXX or E-MAIL. Please note that Protected Health Information [PHI] should not be transmitted through a non-secure e-mail system.

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 to file a dispute of the SIU findings. Please indicate each violation from the Overpayment Letter that you are disputing and the corresponding Member name and date of service from the attached audit spreadsheet. Your letter should reference the CCC Number listed above and include supporting documentation for each violation/claim for your dispute. Documentation is to be sent in a secured manner that allows you to track and document the receipt of requested documents. Please do not staple documents together. Please send the requested documentation via secure e-mail, fax, encrypted CD/flash drive or other password protected, secure electronic method.

If submitting the requested records via secure e-mail, please send to INVESTIGATOR NAME and E-MAIL or via fax (844-688-2969). If mailing the requested records, the address is:

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

If we do not hear 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 overpayment 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 may 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.

In addition to the above, you will need to draft a Quality Improvement Plan (QIP) for SIU review and approval as a means to ensure there are mechanisms in place to prevent future occurrences of the issues identified in our review. Information regarding documentation standards and compliance requirements is located on PerformCare's website, http://pa.performcare.org, or can be provided by your assigned Account Executive. Please submit the QIP within 30 days to the below address:

Amerihealth Caritas – PerformCare
8040 Carlson Road
Harrisburg, PA 17112
Attn: INVESTIGATOR

Thank you for your continued participation in the PerformCare network.

Sincerely,

NAME, CREDENTIALS
TITLE, Special Investigations Unit
Amerihealth Caritas Family of Companies/PerformCare

Cc: OVERSIGHT
Elizabeth Foley, Bureau of Program Integrity

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

DATE TBD

COMPLIANCE OFFICER
PROVIDER
ADDRESS 1
ADDRESS 2

RE: SIU Closure Letter
Corporate Compliance Case (CCC) #:
Case Reference Number:
HealthChoices Region:

Dear XXXX,

The Special Investigation Unit (SIU) for PerformCare conducted an audit of claims and medical record documentation submitted to the SIU by your agency as requested for the abovementioned case. There were no regulatory violations found during the audit, therefore there is no identified overpayment for this case. The SIU asks that your agency continue to follow all applicable local, state and federal guidelines while providing services to PerformCare Members.

OR

During the medical record and claims audit conducted by the SIU, the following issues were not included in the calculation of an overpayment. But rather serve as education regarding documentation requirements for service provision. Please note, the documentation violations listed below could be identified with an overpayment in future audits conducted by the SIU.

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

Please note that both your agency's documentation of services rendered as well as billing practices must remain in compliance with local, state and federal requirements. Enclosed you will find the corresponding audit spreadsheet for your review, with the issues above listed by claim line with no identified overpayment.

If you have any general questions related to the contents of this letter, please submit them to [INVESTIGATOR] at [PHONE] or [E-MAIL]. Please note that Protected Health Information [PHI] should not be transmitted through a non-secure e-mail system.

Thank you for continued participation in the PerformCare Provider network.

Sincerely,

NAME, CREDENTIALS

TITLE, Special Investigations Unit
AmeriHealth Caritas Family of Companies/PerformCare

Cc: OVERSIGHT
Elizabeth Foley, Bureau of Program Integrity