PerformCARE®	Policy and Procedure
Name of Policy:	Provider Dispute Policy
Policy Number:	CC-005
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Payment Integrity
Related Stakeholder(s):	Credentialing Committee, FWA Letter Approval Team
Applies to:	All PerformCare Associates, Providers, Contractors, Consultants, Subcontractors, Vendors and Delegates
Original Effective Date:	10/25/11
Last Revision Date:	11/04/24
Last Review Date:	11/04/24
OMHSAS Approval Date:	N/A
Next Review Date:	11/01/25

Policy: PerformCare will ensure that concerns raised by providers during the Special Investigations Unit (SIU) audit process are presented, reviewed, and processed in a manner that ensures that audit findings are correct and provider issues are addressed in a professional and non-discriminatory manner.

Purpose: To describe the process whereby a provider can dispute a recovery resulting from an audit. The Special Investigations Unit (SIU) is responsible for the preventing, detecting, correcting, investigating and reporting abuse and potential fraud within the HealthChoices Behavioral Health program across the PerformCare provider network.

Definitions: **Abuse:** Any actions that may, directly or indirectly, result in: unnecessary costs to the Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. 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. Abuse is 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.

Arbitration: The settling of disputes between two parties by an impartial third party.
Audit Narrative: A summary of the audit issues, including the corresponding citations of each individual finding, in the Overpayment Letter from the Special Investigations Unit (*Attachment 1 SIU Overpayment Letter)*.
Audit Spreadsheet: A spreadsheet of claims paid to the provider detailing which claims had audit findings and the overpayment associated with these findings (*Attachment 3 SIU Audit Spreadsheet)* which accompanies the SIU Overpayment Letter.
First Level Dispute: The level of dispute which can be filed within 30 days of the receipt of the SIU Overpayment Letter *(Attachment 1 SIU Overpayment Letter)*, if a provider does not agree with the findings of the SIU audit. Information about the filing of a First Level Dispute is located in the SIU Overpayment Letter. The First Level Dispute consists of a letter listing the identified violations the provider is disputing and any additional documentation to support the dispute to overturn the findings.
Fraud: Any deliberate action which results in illegally obtaining payment or something of value for services, or illegally obtaining medical services. 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. Fraud is 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.
FWA Letter Approval Team: Reviews and approves all letters relating to SIU related functions. Letter review and approval is the responsibility of:

- PerformCare Compliance Director
- PerformCare Executive Director
- SIU Manager, Clinical
- SIU Team Lead, FWA Coordinator

Overpayment Letter: Letter sent to the provider when there are findings identified during the audit process. A spreadsheet of the corresponding claims and reasons for the recovery accompanies the Overpayment Letter. The letter details the audit findings, regulation citations that were violated and total recovery amount for the associated claim(s) and notifies the provider of their right to dispute the audit findings within 30 days of the date of receipt of the Overpayment Letter. The letter also includes the name and contact information for the person in the SIU assigned to the audit for questions or to file a dispute of the SIU findings. The Overpayment Letter is also sent to all cc'd individuals, including the Primary Contractor's designated FWA person.
Provider: A provider of behavioral healthcare services funded by PerformCare, entered into contracts to provide State plan in lieu of and in addition to services to HealthChoices members.

Second Level Dispute: The level of dispute which can be filed within 30 days of the receipt of the First Level Dispute Response Letter *(Attachment 2 SIU First Level Dispute Response Letter)* from the SIU if the provider does not agree with the findings from the First Level Dispute. The Second Level Dispute consists of a letter listing the identified violations the provider is disputing and any additional documentation to support the dispute to overturn the findings.

Senior Manager, SIU: 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.

SIU Clinical Investigator: Reviews referrals, gathers information related to the allegations, evaluates findings through provider documentation and claims audits to determine if evidence indicates billing errors, over-utilization, abusive activity, or a strong suspicion of fraud, waste, 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.

Special Investigation Unit (SIU): PerformCare unit responsible for preventing, detecting, correcting, and reporting fraud, waste, and abuse across various categories of health care involving providers or PerformCare Members.

Waste: 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 payers. Waste includes erroneous claims adjudication by the company. Waste, as defined by CMS for Medicare Part D, means 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.

Acronyms: **CMS:** Center for Medicare and Medicaid
DHS: Department of Human Services

Procedure:

1. **First Level Dispute** (filed within 30 days of receipt of the Overpayment Letter)
   - 1.1. In the Overpayment Letter, the provider is notified of the right to file a First Level Dispute. The provider notifies the SIU in writing of their desire to dispute the audit findings.
     - 1.1.1. The dispute also needs to include a description of the audit findings with which they disagree and additional documentation to support their dispute.

1.1.2. All information must be received by the SIU within 30 days of the receipt of the Overpayment Letter, *Attachment 1 SIU Overpayment Letter*.

1.1.3. Providers can contact the SIU during the 30-day time frame with any questions regarding the findings.

1.2. The First Level Dispute is to include additional written information that directly supports the reasons for the provider dispute.

1.3. The review of the provider First Level Dispute and audit of the additional information submitted to support the dispute is conducted by a Clinical Investigator not previously involved in the clinical review to determine whether the initial audit findings should be revised.

1.4. Based on the review of the provider's First Level Dispute, the SIU will draft a letter to the provider and submit it to the FWA Coordinator, or designee, and the FWA Letter Approval Team for review and final approval.

1.5. The assigned SIU Clinical Investigator will send the First Level Dispute Response Letter to the provider (*Attachment 2 SIU First Level Dispute Response Letter)*. The letter is also sent to all cc'ed individuals, including the Primary Contractor's designated FWA person. The First Level Dispute Response Letter will include any revisions to the audit narrative and an audit spreadsheet with any revisions from the review to the provider, see *Attachment 3 SIU Audit Spreadsheet*. The dispute response from the SIU will be sent to the provider within 60 days of the SIU receipt of the provider dispute and additional supporting documentation. The dispute is solely on the items that are cited in the initial SIU findings and are not extended to additional findings as part of the dispute.

1.5.1. If the provider is satisfied with the response to their First Level Dispute, the overpayment is finalized and will be received from the provider via check or recouped from future claims within 30 days of the receipt of the First Level Dispute Response Letter.

1.5.2. If the provider is not in agreement, a Second Level Dispute may be requested by the provider within 30 days of the receipt of the First Level Dispute Response Letter.

2. **Second Level Dispute** (filed within 30 days of the date of the receipt of the First Level Dispute Response Letter from the SIU)

2.1. In the Second Level Dispute, the provider submits a letter to the SIU identifying the findings with which the provider continues to disagree. The Second Level Dispute is to include additional written documentation that directly supports the reasons for the provider dispute for audit by a Clinical Investigator not previously involved in the prior clinical reviews.

2.2. All information must be received by the SIU within 30 days of receipt of the First Level Dispute Response Letter and audit spreadsheet *(Attachment 3 SIU Audit Spreadsheet)*.

2.3. At any time, the provider or SIU can request a meeting either via teleconference or face to face in the Harrisburg PerformCare Office to discuss the findings and outcome of the review. The provider may invite additional individuals, as deemed appropriate, to attend the meeting in order to facilitate the audit discussion. PerformCare participants may include the Senior Manager, SIU, SIU Manager, Clinical, Program Integrity Legal Department, FWA Coordinator, or designee, Clinical Investigator, the PerformCare Compliance Director and Executive Director, and any other individuals pertinent to the audit.

2.4. The purpose of the meeting will be to review the provider's issues with the audit, provide related regulations and contractual citations for ongoing educational purposes in a discussion format and address any issues related to the audit findings. The meeting could result in any or all of the following:

- Ongoing education to the provider regarding the issues found in the SIU audit
- Discussion of a payment plan to be agreed upon by all parties in terms of the identified overpayment
- A compromise/negotiation in the resolution to the overpayment finding
- Involvement of the Health Choices contractors or oversight entities
- A referral to PerformCare Credentialing Committee
- Involvement of DHS's Bureau of Program Integrity (BPI) and/or the Office of the Attorney General (OAG)

2.5. The SIU Clinical Investigator will draft a written response to the Second Level Dispute (*Attachment 4 Second Level Dispute Response Letter)* and submit it to the FWA Coordinator or designee and the FWA Letter Approval Team for review and final approval. If the dispute meeting occurs after the provider has filed two levels of dispute, a letter is sent to the provider with any revised/negotiated overpayment and any revised audit findings as a result of the dispute meeting. The dispute is solely on the items that are cited in the initial SIU findings and cannot be extended as part of the dispute.

2.5.1. The Second Level Dispute response from the SIU will be sent to the provider within 60 days of the SIU receipt of the Second Level Provider Dispute.

2.5.2. The Second Level Dispute Response Letter will be sent to the provider and include any required revisions to the audit narrative and audit spreadsheet (*Attachment 3 SIU Audit Spreadsheet).* If a dispute meeting is requested, the letter will include the resolution from the meeting, in terms of the violations and overpayment. The letter is also sent to all cc'ed

individuals, including the Primary Contractor's designated FWA person.

2.6. The overpayment finalized as part of the Second Level Dispute will be received from the provider via check or recouped from future claims. The case will be closed upon receipt of the overpayment.

2.7. Arbitration can be filed by the provider within 30 days of the date of the Second Level Dispute Response Letter.

Related Policies: *CC-001 Reporting Suspected Provider Fraud, Waste and Abuse*
PR-020 Non-Routine Site Visits
FI-027 Appeals of Administrative Denials

Related Reports: None

Source Documents and References: *Title 42- Public Health §42 CFR Part 455.2*

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 SIU Overpayment Letter*
Attachment 2 SIU First Level Dispute Response Letter
Attachment 3 SIU Audit Spreadsheet
Attachment 4 SIU Second Level Dispute Response Letter

Approved by:

Primary Stakeholder

PerformCARE | 8040 Carlson Road
Harrisburg, PA 17112

DATE

XXX, Corporate Compliance Officer
Provider Name
Address

CERTIFIED LETTER #:

Corporate Compliance Case (CCC) #:
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*)

Based on our calculations, the overpayments on the claims in question totaled $«RECOVERY_AMT». 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 (enter name of auditor) at 717-xxx-xxxx.

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 Reference Number listed above and include appropriate supporting documentation. Send your correspondence to:

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

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 amount of $XXXXX 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 Reference Number XXX 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.

We value you as a provider and apologize for any inconvenience that this may cause.

Sincerely,

INVESTIGATOR'S NAME/CREDENTIALS
SIU/TITLE
Amerihealth Caritas Family of Companies/PerformCare

cc: OVERSIGHT
Pamela Hunter, Bureau of Program Integrity
Amanda Flowers, Supervisory Special Agent, Office of Attorney General (*if referring to the OAG*)

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

DATE

NAME, TITLE
PROVIDER
ADDRESS

CERTIFIED LETTER #:

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

Dear :

In a letter dated *DATE*, we informed you that we had identified overpayments paid to your organization that may have occurred as a result of:

-
-

ADD IF APPLICABLE In addition, the following was noted with no overpayment identified:

-

Based on our calculations at that time, the overpayments on the claims in question totaled $XXX. We had enclosed this information along with the claim payment detail in a letter to you dated, *DATE*. You were provided time to dispute our findings, which you did in the form of a letter, dated *DATE*. Additional information was received with the letter and was reviewed by the Special Investigations Unit (SIU).

After review of the additional documentation submitted and our review of your dispute letter, we continue to uphold/overturn the original findings listed below:

- *List violations and citations from above (if disputed)*
    - *Support for the continued findings based on the review of the dispute documentation submitted.*

AND/OR

- *List violation and citation from above (if no dispute of the finding, no need to provide support for the continued findings)*

From review of your dispute and support documentation, the total overpayment continues to be $xxx/has been revised to $xxx.

Enclosed you will find the claim detail and information pertaining to the first level dispute for your review. Please contact *NAME OF ASSIGNED* at 717-xxx-xxxx with any questions concerning the calculation of the overpayment amount.

In the event you do not agree with our revised findings, you must notify us in writing within thirty (30) days from the date of this letter. Your letter should reference the Corporate Compliance Case Number listed above and include appropriate supporting documentation.

To facilitate your response most efficiently, please send correspondence to the following address:

AmeriHealth Caritas -PerformCare
8040 Carlson Road
Harrisburg, PA 17112
Attention: *NAME OF ASSIGNED*

If we do not receive written notice 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 $XXX made payable to PerformCare. Upon receipt of this check, PerformCare will close this case. For reconciliation purposes, please ensure the Corporate Compliance Case Number above 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 cooperation.

Sincerely,

NAME OF ASSIGNED, Credentials
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 *(if applicable)*

PerformCARE

Provider:
Case #:
Total Recoupment:
Payor:

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

PerformCARE®
8040 Carlson Road
Harrisburg, PA 17112

DATE

NAME, TITLE
PROVIDER
ADDRESS

CERTIFIED LETTER #:

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

Dear :

In a letter dated *DATE*, we informed you that we had identified overpayments paid to your organization that may have occurred as a result of:

-
-

ADD IF APPLICABLE In addition, the following was noted with no overpayment identified:

-

Based on our calculations at that time, the overpayments on the claims in question totaled $XXX. We had enclosed this information along with the claim payment detail in a letter to you dated, *DATE*. You were provided time to dispute our findings, which you did in the form of a letter, dated *DATE*. Additional information was received with the letter and was reviewed by the Special Investigations Unit (SIU).

After review of the additional documentation submitted and our review of your dispute letter, we continue to uphold the original findings listed below:

- *List violations and citations from above (if disputed)*
    - *Support for the continued findings based on the review of the dispute documentation submitted.*

AND/OR

- *List violation and citation from above (if no dispute of the finding, no need to provide support for the continued findings)*

From a review of your First Level Dispute and supportive documentation, the total overpayment was $xxx/had been revised to $xxx. We had enclosed this information along with the claim payment detail in a letter to you dated, *DATE*. You were provided time to file a Second Level Dispute of our findings, which you did in the form of a letter, dated *DATE*. Additional information was received with the letter and was reviewed by the Special Investigations Unit (SIU).

After review of the additional documentation submitted and our review of your Second Level Dispute letter, and meeting held on *DATE,* we continue to uphold/have overturned the original findings listed below:

- *List violations and citations from above (if disputed)*
    - *Support for the continued findings based on the review of the dispute documentation submitted.*

AND/OR

- *List violation and citation from above (if no dispute of the finding, no need to provide support for the continued findings)*

From review of your Second Level Dispute and supportive documentation, the total overpayment continues to be $xxx/has been revised to $xxx.

Enclosed you will find the claim detail and information pertaining to the first level dispute for your review. Please contact *NAME OF ASSIGNED* at 717-xxx-xxxx with any questions concerning the calculation of the overpayment amount.

In the event you do not agree with our revised findings, you must notify us in writing within thirty (30) days from the date of this letter. Your letter should reference the Corporate Compliance Case Number listed above and include appropriate supporting documentation.

To facilitate your response most efficiently, please send correspondence to the following address:

AmeriHealth Caritas -PerformCare
8040 Carlson Road
Harrisburg, PA 17112
Attention: *NAME OF ASSIGNED*

If we do not receive written notice 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 $XXX made payable to PerformCare. Upon receipt of this check, PerformCare will close this case. For reconciliation purposes, please ensure the Corporate Compliance Case Number above 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 cooperation.

Sincerely,

NAME OF ASSIGNED, Credentials
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 *(if applicable)*