Sentara®

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| **Policy:** | **Program Integrity Audit, Reconsideration and Appeals** | | |
| **Manual:** | None | **Original Date:** | 3/1/2018 |
| **Section:** | None | **Revision Date:** | 8/31/2023 |
| **LOB:** | Medicaid | **Approved By:** | Program Integrity Unit |
| | | **Process Owner:** | Program Integrity Unit |

**Revision Description (Most Recent):** Reviewed with no Changes

**Policy Statement:**
Sentara Health Plans (SHP) follows all state and federal regulations (Deficit Reduction Act) which support the detection, prevention and reporting of fraud, waste, or abuse of health care funds. Audits are utilized to validate data from medical records as related to appropriate coding and billing practices, appropriate medical necessity and in accordance with SHP's policies and procedures.

To establish guidelines to meet State and Federal contract requirements related to Fraud, Waste and Abuse (FWA) efforts. To ensure the prevention, identification, and reporting of suspected fraud, waste and abuse by members, providers, subcontractors, and employees of SHP in accordance with all state and federal laws and regulations. This policy outlines SHP's Program Integrity Department guidelines for audits.

**Exceptions:**
None

**Procedure:**

SHP's Program Integrity Unit conducts claim reviews and/or audits either on a prepayment or post payment basis. Claim reviews/audits are conducted to confirm that healthcare services and supplies were delivered in compliance with the member's plan of treatment and/or to confirm that charges were accurately reported in compliance with SHP's policies and procedures as well as general industry standard guidelines and State and Federal regulations.

To conduct reviews and audits, SHP's Program Integrity Department and its designees will request documentation, mostly in the form of patient medical records. SHP's Program Integrity Department will accept other documentation in addition to the medical record from the provider or facility that substantiates the treatment or service. The documentation may be the provider's or facility's established internal policies, professional licensure standards that reference standards of care, or business practices justifying the service. The provider or facility must review, approve, and document all such internal policies and procedures as required by applicable accreditation bodies.

Upon request from SHP's Program Integrity Department or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits
6. Claims for services found to possibly conflict with medical necessity
7. Claims being reviewed for potential fraud, waste and abuse or demonstrated patterns of billing/coding inconsistencies
8. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
9. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

SHP's Program Integrity Department or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment review/audit:

1. Upon confirmation of the provider's or facility's address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of the date of the final request (45 days total):

a. SHP's Program Integrity Department or its designee will initiate claims denials for claims identified as pre-payment review claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment denials. Or

b. SHP's Program Integrity Department or its designee will initiate claim retractions for claims identified as post payment audit claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment retractions.

SHP's Program Integrity Department or its designee will not be liable for interest or penalties when payment is denied or recouped when provider or facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit.

All healthcare entities and providers are required to keep medical records. These records are a legal document, which serves both clinical needs and substantiates the services and items billed on the claim submitted.

Incomplete or illegible records can result in denial of reimbursement for services billed. Claim payment decisions that result from a medical review of records are not a reflection on the provider's competence as a health care professional or the quality of care provided to the patient/member. Specifically, the results are based on review of the documentation that was received.

1. SHP's Program Integrity Department or its designee will request in writing final and complete itemized bills and/or complete medical records for all claims under review. The requested documentation will be in the format requested by SHP's Program Integrity Department or its designee within the time frame outlined above.

2. SHP's Program Integrity Department or its designee determines whether the audit will be a desk audit or an on-site audit.

3. SHP's Program Integrity Department or its designee retains the right to conduct an on-site visit which may be invoked at any time. There may be instances when SHP's Program Integrity Department or its designee must respond quickly to requests by regulators or its clients.
4. Federal and State contracts require SHP's Program Integrity Department to conduct on-site visits. SHP's Program Integrity Department will conduct on-site visits to randomly selected provider's or facilities to collect information as part of an audit. The unannounced on-site visit must take place during regular work and office hours.

5. SHP's Program Integrity Department or its designee may conduct audits from its offices (desk audit) or on-site at the provider's or facility's location at SHP's Program Integrity Department discretion. If SHP's Program Integrity Department or its designee conducts an audit at a provider's or facility's location (on-site audit), the provider or facility will make available suitable workspace for SHP's Program Integrity Department or its designee's on-site audit activities. During the audit, SHP's Program Integrity Department or its designee will have complete access to the applicable medical records including invoice and accounting details without producing a signed member's authorization. When conducting credit balance reviews, the provider or facility will provide SHP's Program Integrity Department or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. Additionally, SHP's Program Integrity Department or its designee will have access to the provider's or facility's patient accounting system to review payment history, notes, explanation of benefits and insurance information to determine validity of credit balances. If the provider or facility does not allow SHP's Program Integrity Department or its designee access to the items requested to complete the audit, SHP's Program Integrity Department or its designee will complete the audit based on the information provided. Per your

contract with SHP, all audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any provider or facility policy to the contrary.

6. Upon completion of the audit, SHP's Program Integrity Department or its designee will provide a findings letter to the provider or facility. The findings letter will be provided when the audit is completed in its entirety. The findings letter will list items such as charges unsupported by adequate documentation, under-billed items, late billed items, and charges requiring additional supporting documentation. If the provider or facility agrees with the audit findings, the provider or facility has thirty (30) business days to reimburse SHP the amount indicated in the findings letter. Should the provider or facility disagree with the findings, the provider or facility may request a reconsideration of the findings in writing within thirty (30) business days of the date of receipt of the audit findings.

7. If the provider or facility does not request a reconsideration of the findings within the thirty (30) business day timeframe, the initial determination will stand and SHP will offset and recover the overpayment against future payments.

8. A reconsideration of the audit findings must be in writing and received by SHP's Program Integrity Department or its designee within thirty (30) business days of the date of receipt of the audit findings unless State Statute expressly indicates otherwise. The request for reconsideration must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's reconsideration. All findings disputed by the provider or facility in the reconsideration must be accompanied by relevant supporting documentation.

9. Upon receipt of a timely reconsideration along with complete supporting documentation as required under this policy, SHP's Program Integrity Department or its designee shall issue a reconsideration response to the provider or facility. SHP's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's reconsideration. SHP's Program Integrity Department or its designee's reconsideration response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the findings letter. The reconsideration response will be sent via certified mail to the provider or facility within sixty (60) business days of the date SHP's Program Integrity Department or its designee received the provider's or facility's reconsideration request. Revisions to the audit findings will be included in the mailing.

10. If the provider or facility agrees with the reconsideration findings, the provider or facility has thirty (30) business days to reimburse SHP the amount indicated in the findings letter. Should the provider or facility disagree with the findings, then the provider or facility may request an appeal of the reconsideration findings in writing within thirty (30) business days of the date of receipt of the reconsideration findings.

11. If the provider or facility does not request a final appeal of the reconsideration within the thirty (30) business day timeframe, the reconsideration determination will stand and SHP will offset and recover the overpayment against future payments.

12. A final appeal of the reconsideration findings must be in writing and received by SHP's Program Integrity Department or its designee within thirty (30) business days of the date of the audit findings unless State Statute expressly indicates otherwise. The request for a final appeal must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's final appeal. All findings disputed by the provider or facility in the final appeal must be accompanied by relevant supporting documentation.

13. Upon receipt of a timely final appeal along with complete supporting documentation as required under this policy, SHP's Program Integrity Department or its designee shall issue a final appeal response to the provider or facility. SHP's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's final appeal. SHP's Program Integrity Department or its designee's final appeal response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the findings letter. The final appeal response will be sent via certified mail to the provider or facility within sixty (60) business days of the date SHP's Program Integrity Department or its designee received the provider's or facility's final appeal request. Revisions to the final audit findings will be included in the mailing.

14. The provider or facility will have thirty (30) business days from the date of the final appeal response to send a check to SHP. If a check is not received within the thirty (30) business day timeframe, SHP will recoup the overpayment indicated in the final appeal response by offsetting from future remits.

15. If the provider or facility still disagrees with SHP's Program Integrity Department or its designee's final appeal audit findings, the provider or facility may then appeal to the appropriate governmental agency if applicable.

16. The provider's or facilities written request for an extension to submit an appeal or payment will be reviewed by SHP's Program Integrity Department on a case-by-case basis. If the provider or facility chooses to request an appeal extension, the request should be submitted in writing no later than fifteen (15) business days from receipt of the audit findings letter. One appeal extension may be granted during the appeal process at SHP's Program Integrity Department discretion, for up to fifteen (15) business days from the date the appeal would otherwise have been due. Any extension of the appeal timeframes contained in this policy will be expressly conditioned upon the provider's or facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in a contract which limits the timeframe by which a recoupment must be completed.

## Program Integrity's Medical Record Requirements & Audit Standards

### Medical Records Standards

The purpose of a medical record is to ensure the member is receiving high-quality, safe medical care. It is important that providers maintain accurate, clinically useful, timely and consistent medical records for each patient that is provided care. Documentation should be handwritten, typed, or dictated and must be legible. Dictation must be transcribed, reviewed, and signed within 14 days.
Providers are required to maintain a member's medical records with sound professional medical practice and health management. The provider is required to maintain a member's permanent medical record on site. Medical records must be kept according to the State and Federal regulations. Medical records must also be kept in accordance with the following Optima Health standards.

Per Optima Health's contracts and policies, all practitioners must maintain a patient record for a minimum of 10 years following the last patient encounter with the following exceptions:

1. Records of a minor child, including immunizations, must be maintained until the child reaches the age of 18 or becomes emancipated, with a minimum time for record retention of 6 years from the last patient encounter regardless of the age of the child (Age of 18 plus statute of limitations)

2. Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative

3. Records that are required by contractual obligation or federal law are to be maintained for a longer period of time.

### Medical Record

The medical record should reflect all aspects of patient care. At a minimum, the medical record should meet:

- Cultural and linguistic needs are being met by including documentation of interpretation service provided.

- Legibility — Each record must be legible to someone other than the writer.

- Patient identification — Each page in the record must contain the patient's name and/or patient ID number.
- Patient biographical information — The record must include the patient's age, sex, address, employer, home and work telephone numbers, and marital status.
- Allergies — Prominent notation of medication allergies and adverse reactions are required on the record. In the absence of allergies, notation of no known allergies is required.
- Provider identification — All entries must have a signature and identify the author.
- Entry date — All entries must be dated.
- Current problems — Illnesses, medical and behavioral health conditions, and health maintenance concerns must be identified in the medical record. Including any conditions that may affect the patient from performing both activities of daily living and instrumental activities of daily living.
- Medication information — Current medications must be clearly identified in each patient's record. The dosage and date initially prescribed and any refills for each medication must be identified.
- Past medical history — Past medical history must be identified. For children, include past medical history related to prenatal period.
- Smoking, alcohol, and substance abuse — Tobacco products, alcohol use and substance abuse must be stated if present in patients 12 years old and older. Referrals to a Behavioral Health Specialist should be documented as appropriate.
- History and physical examination — The medical record must have the history and physical exam. Appropriate subjective and objective information is obtained for the chief complaints. The physical exam must consist of more than one body system.
- Records should indicate that preventive screening services are offered in accordance with Optima Health's Preventive Health Guidelines. This should be documented in the progress notes for adults 21 years and older.
- All requested consults must have return reports from the requested consultant or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed or altered treatment plans should be noted in progress notes. Consultations filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically need to show representation of PCP review.
- Continuity and coordination of care among all Providers involved in an episode of care, including PCP and Specialty Physicians, Hospitals, Home Health, Skilled Nursing Facilities, and Free-Standing Surgical Centers, etc. must be documented when applicable.

- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.

- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.

Per the Department of Medical Assistance Services Chapter II of the Physician-Practitioner Provider Manual "concerning the timeliness of provider signatures for purposes of medical record documentation of covered services have been modified to allow 14 calendar days to complete the required signatures for paper charts, as well as Electronic Health Records for providers of general physician services in medical inpatient and outpatient settings".

### Behavioral Health Medical Record

Psychotherapy notes are not included in the medical and billing records. The psychotherapy notes should be kept separately from the medical and billing record and not accessible. The behavioral health medical record should reflect all aspects of patient care.

The treatment record must contain the following member information:

- Name or unique identification number on **each page**
- Address
- Employer or school
- Home and alternative phone numbers
- At least one emergency contact, including address and phone number
- Guardianship information, if applicable
- Marital/legal status
- Each clinical entry must clearly indicate:
- Date of entry
- Type of contact
- Practitioner's signature
- Practitioner's degree/credential

### Member Rights and Confidentiality

The following information requires **member or legal guardian** signature and must be in the treatment record:

- Informed consent for evaluation, treatment, and communication

- Patient Bill of Rights
- Authorization to use and disclose information to other behavioral health care practitioners and the member's Primary Care Physician (PCP)
- Informed consent for medication, if applicable
- Advance psychiatric directive, if applicable
- Documentation of refusal to sign any consent or authorization, if applicable

**Initial Evaluation**
The initial evaluation must cover the following information and include documentation of findings in the treatment record:

- Member's presenting problem(s), along with relevant psychological and social conditions affecting the member's medical and psychiatric status
- Psychiatric history including the following:
  - Previous providers and treatment dates, if applicable
  - Previous treatment interventions and response to treatment, if applicable
  - Sources of clinical data
  - Relevant family information
  - Results of lab tests and consultation reports, if applicable
- Psychosocial information that includes:
  - Support systems
  - Legal history
  - Educational history
- Relevant medical conditions
- Current providers caring for the member
- Current medications, prescribed dosages, dates of initial prescription or refills and use of over-the-counter medications
- For members aged 12 and over, a substance abuse evaluation covering nicotine, caffeine, as well as illicit misuse of prescribed and over-the-counter drugs
- For children and adolescents, documentation of prenatal and perinatal events and a complete developmental history (physical, psychological, social, intellectual, and academic)

- Allergies and adverse reactions, or no known allergies (NKA) or sensitivities, to foods, drugs, and other substances
- Mental status that documents member's:

  - Affect
  - Mood
  - Judgment
  - Attention/Concentration
  - Impulse Control
  - Speech
  - Thought content
  - Insight
  - Memory

- Risk factors and special status situations noted, documented, and revised in compliance with written protocols, including:
  - Non-compliance with treatment
  - Against Medical Advice (AMA)/elopement potential
  - Prior behavioral health inpatient admissions
  - History of multiple behavioral diagnosis
  - Suicidal/homicidal ideation
  - Imminent risk of harm

- DSM diagnosis consistent with the presenting problem(s), history, mental status exam and/or other assessment data
- Follow-up appointment scheduled following initial evaluation
- Ambulatory follow-up, including referral source for member to current behavioral health provider
- Indication whether member is referred to practitioner as a result of discharge from a partial, intensive outpatient, or inpatient hospitalization; residential treatment center, or other facility within the previous 14 days

### Coordination of Care

The treatment record must include documentation of communication, or attempted communication, with the member's Primary Care Physician (PCP), other behavioral health providers and/or Managed Care Coordinator:

- Documentation of the member's authorization for provider to communicate with PCP, other providers and/or Care Coordinator
- Documentation of member's refusal to authorize PCP communication, if applicable
- Documentation of PCP communication after initial evaluation
- Evidence of at least one PCP communication at significant points in treatment (e.g., safety issues, medication changes, treatment plan changes, hospitalization, discharge)
- Documentation of communication with member's Care Coordinator
- Documentation of provider's participation in the member's Integrated Care Team (ICT) meeting that includes the Care Coordinator
- Evidence of at least one Care Coordinator communication at significant points in treatment (e.g., safety issues, medication changes, treatment plan changes, hospitalization, discharge)

### Treatment Plan

The treatment record must include an individualized treatment plan consistent with the member's diagnosis and must include:

- Objective, measurable goals that include the member's preferences and prioritized goals
- Estimated time frames for goal attainment or problem resolution
- Treatment interventions consistent with treatment plan goals
- Evidence of member's understanding of the treatment plan
- Documentation of identification of barriers to meeting the member's goals and preferences or implementing the plan, if applicable

### Progress Noted in Treatment

Progress notes describe the member's strengths and limitations in achieving treatment plan goals, including environmental factors that support change or may serve as obstacles to progress. The treatment record must include:

- Date of next appointment
- Preliminary discharge plan, if applicable
- Documentation that the member is referred for and receiving medication evaluation for psychotropic medication, if applicable
- Discharge note completed within 60 days of last visit, and documentation of goal achievement or needed referrals

### Medication

Opioids should be prescribed in accordance with both the CDC and the Virginia Board of Medicine guidelines (18VAC85-21-10 through 18VAC85-21-170).

Completion of medication flow sheet and progress notes must include:

- Current psychotropic medication, dosages, and date(s) of dosage changes
- Member education regarding reason for medication and possible side effects
- Member education to women of child-bearing age on risks during pregnancy while taking psychotropic medication, and to notify psychiatrist immediately upon becoming pregnant
- Acknowledgment by member of their understanding of medication education
- Avoidance of Drug Enforcement Agency (DEA) scheduled drugs in treatment of members with a history of substance abuse/dependency

### Referral/Outreach

The treatment record must document the utilization of preventative services, as appropriate, including:

- Relapse prevention strategies
- Lifestyle changes
- Stress management
- Wellness programs
- Referrals to community resources

Members who become homicidal, suicidal, or unable to conduct activities of daily living must be promptly referred to the appropriate level of care.

### Medical Record Policies

Participating Providers must treat all communications and records pertaining to the Member's healthcare as confidential and no records may be released without the written consent of the Member or as otherwise permitted by state or federal law. In the case of an unemancipated minor, the release of information requires the authorization of the legal guardian. Healthcare Providers are required to accept a photocopy, facsimile, or other copy of the original document signed by the patient providing authority for the requester to obtain the records, as if the copy were an original document. Participating Providers must obtain a separate Release of Information, or waiver, from those Members with certain conditions, such as sexually transmitted diseases.

### Charging for Copies of Records

Providers may not charge the Plan for copies of medical records or for the completion of forms when being audited by the SIU on behalf of government programs.

### Retention of Medical Records

- Providers must maintain records as required by applicable state or federal law.

- If a Provider practice or facility is sold, the medical records go with the sale, but the selling Provider must notify its patients in writing that it is selling its facility or practice and must state where the records will be located. Providers must also ask patients if they wish to receive their records.
- If the practice or facility is being closed, medical records must be maintained in accordance with the applicable state statute.
- Providers are advised to contact their malpractice insurance carrier to see if they have any additional stipulations regarding medical record retention.

### Amending Medical Records

Optima Health is aware that amendments, corrections, and late entries occur in a medical record. Whether a documentation submission derives from a paper record, or an electronic record, amendments, corrections, or late entries must:

- Clearly and permanently identify the amendment, correction, or late entry as such
- Indicate the date and author of the amendment, correction, or late entry
- Not delete, white out, mark through etc. the original documentation

If Optima Health has initiated an audit on the documentation, amendments, corrections, late entries will not be accepted. Medicare states that if the service was not documented then the services were not performed.

Providers are expected to complete the documentation of services during or as soon as practicable after the service was provided.

### Audit Standards

Optima Health continually monitors provider-billing practices and conducts investigations for purposes of detecting inappropriate, inaccurate, or abusive billing patterns, medical necessity, as well as patient safety and quality of care. Data on provider services for specified time periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Optima Health will pull 3 years of data for Medicaid, Medicare and FEHBP claims to audit. 12 months of claims data will be pulled for the Commercial product. Providers will be selected based on their utilization and billing patterns, relative to their peers.

Providers who are an outlier may be subject to further analysis, including desk or on-site investigations. Investigations will include a review of the provider's medical records that pertain to the billed services and may employ offset of overpayments or extrapolation methods.

A statistically valid random sample of records for the questioned services is requested. Typically, qualified nursing staff and/or Certified Professional Coders (CPC) perform the investigation. In performing the investigation (whether pre- or post-payment of claims), the investigator will use applicable criteria to assess adequacy of documentation for the services billed.

Optima Health will use audit standards appropriate for the services billed. Not limited to but including the following:

- Applicable service guidelines published by the American Medical Association (AMA)
- 1995 or 1997 Documentation Guidelines published by CMS
- Social Security Act (SSA) §1833(e) for supporting documentation
- Social Security Act (SSA) §1862(A)(1)(a) for reasonable and necessary
- National Correct Coding Initiative (NCCI) edits
- CPT coding guidelines and code definitions (HCPCS coding when applicable)
- American Hospital Association (AHA) guidelines
- CMS/HHS guidelines
- Department of Medical Assistant Services (DMAS) guidelines and Manuals
- Internal clinical policies

Additionally, we utilize provider contracts, LCDs, NCDs, and any other applicable guidelines and policy requirements.

**Monitoring:**
Outcomes Monitoring and Document Management: The PI Unit shall be responsible for developing, communicating, and maintaining this policy and related procedures and job aids necessary for the implementation and continuance of the policy. This policy shall be reviewed at least every year for repeal or amendment as appropriate.

**Related Documents:**

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| *Policy* | None |
| *Job Aids* | None |
| *Regulatory References* | Deficit Reduction Act of 2005<br>Social Security Act Section 1936<br>18VAC85-21-10 - 18VAC85-21-170<br>Optima Health Provider Manuals |