

Department of Behavioral Health
TRANSMITTAL LETTER

SUBJECT Claims Audit		
POLICY NUMBER DBH Policy No. 911.1	DATE OCT 03 2016	TL# 301

Purpose. The purpose of this policy is to establish procedures for auditing paid claims submitted by the Department of Behavioral Health providers and recouping claims that failed to comply with the conditions of payment.

This policy was converted from a Department of Mental Health (DMH) policy to a Department of Behavioral Health (DBH or Department) policy, generally updated, and expanded to include: (1) focused audits and (2) extrapolation, which will affect the calculation of the recoupment (see Section 6k of the policy).

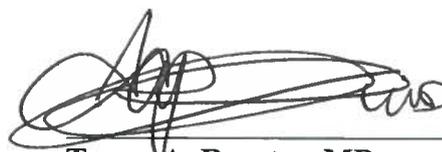
Applicability. Applies to all DBH-certified providers that have a contract or grant with the Department to provide behavioral health services and submit claims pursuant to a contract, including Human Care Agreement, or grant.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices and providers (see applicability above).

Effective Date. This policy is effective immediately.

Superseded Policy. This policy replaces DBH Policy 911.1C, Claims Audit, dated August 10, 2012.

Distribution. This policy will be posted on the DBH website at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure the affected staff is familiar with the contents of this policy.


Tanya A. Royster, MD Date 10/3/2016
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA  DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 911.1	Date OCT 03 2016	Page 1
	Supersedes DBH 911.1C, Claims Audits, dated August 10, 2012		
Subject: Claims Audits			

1. **Purpose.** The purpose of this policy is to establish procedures for auditing paid claims submitted by the Department of Behavioral Health providers and recouping claims that failed to comply with the conditions of payment.

This policy was converted from a Department of Mental Health (DMH) policy to a Department of Behavioral Health (DBH or Department) policy, generally updated, and expanded to include: (1) focused audits and (2) extrapolation, which will affect the calculation of the recoupment (see Section 6k of the policy).

2. **Applicability.** Applies to all DBH-certified providers that have a contract or grant with the Department to provide behavioral health services and submit claims pursuant to a contract, including Human Care Agreement, or grant.

3. **Authority.** 42 USCS § 1320a-7k; The Department of Behavioral Health Establishment Act of 2013, D.C. Official Code § 7-1241.01, *et seq.*; Title 22 DCMR Chapter A34 Mental Health Rehabilitation Services (MHRS) Provider Certification Standards, as amended; and Title 22 DCMR Chapter A63, Certification Standards for Substance Use Disorder (SUD) Treatment and Recovery Providers.

4. **Policy.** DBH shall perform claims audits of all DBH-certified providers that submit claims pursuant to a Human Care Agreement or grant. The audits shall be done at least annually and on an as-needed basis in accordance with the terms of this policy to ensure program integrity and compliance with Medicaid and District of Columbia conditions of payment.

5. **Definitions / Abbreviations.** For purposes of this policy:

5a. **DHCF:** refers to the D.C. Department of Health Care Finance (DHCF), the District agency responsible for administering the D.C. Medicaid Program.

5b. **Discovery:** means identification by DBH or DHCF of an overpayment, and the communication of that overpayment finding to the provider.

5c. **Focused Audit:** refers to audits conducted in response to specific programmatic, utilization review, business process, or investigatory concerns. Focused audits may be performed on random samples or samples of convenience.

5d. **Overpayment:** means the amount paid to a provider in excess of the amount allowable, or supported by documentation, for a service.

5e. Statistically Valid Sample: DBH uses the description of statistical sampling found in the Medicare Program Integrity Manual (Pub. 100-08 Medicare Program Integrity)

6. General Audit Procedures.

6a. DBH Audit Team. The DBH Office of Accountability (OA) is responsible for the claims audits. The audit team shall primarily consist of staff from OA. The team may be expanded to include any number of staff, experts, consultants, or designees of DBH as deemed appropriate.

6b. Audit Location / Other Details. DBH shall conduct audits on-site at the provider's location or at another location at DBH's discretion. Audits may also be conducted remotely through an electronic medical record (EMR). In all cases, DBH shall give the provider two (2) week notice, as well as sending the proposed sample, when scheduling annual claims audits with the provider and shall arrange a brief entrance meeting, by phone if necessary. Focused audit samples will be provided at least 48 hours in advance, along with the reason the audit is being conducted. This meeting shall include the purpose of audit, introduction of the DBH Audit Team, and a description of resources and documents to which the team will require access. OA audit staff will access only those areas of consumer and provider records necessary to conduct the nature of its work. OA shall coordinate with the audited provider to ensure that OA's access into a consumer's records, including an EMR or DBH electronic management systems, is logged for privacy accounting purposes in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and associated regulations promulgated at 45 CFR Parts 160, 162 and 164 as amended, and the DBH Privacy Manual

6c. Claims Audits. DBH conducts claims audits of each provider who has submitted claims to DBH during a specified time period. The audit is conducted to determine whether the claims meet Medicaid and District of Columbia conditions of payment. Annual claims audit results are subject to extrapolation according to this policy when the provider's audit failure rate is shown to be a sustained or high level of payment error by equaling or exceeding 20%.

6d. Focused Audits. DBH also conducts focused audits to investigate particular questions related to program integrity and provider compliance. These audits may, for example, focus on a particular time period or service, or a particular investigatory question. Focused audit results are not subject to extrapolation unless the sample size meets the audit methodology requirements for extrapolation in accordance with this policy and the audit error rate is 20% or higher.

6e. Audit Process. The audit process, as described below, consists of the following activities in the following order:

- (1) A sample is developed;
- (2) An audit is conducted on the sampled claims;

- (3) The provider is provided with preliminary results and asked to respond;
- (4) Claims where the DBH Audit Team and the provider disagree after the provider has responded to preliminary results are sent to the Claims Review Committee;
- (5) The audit results are finalized and the provider is notified;
- (6) The provider may ask for an Administrative Review from the Director of DBH;
- (7) After the results of the Administrative Review, the provider may choose to appeal the audit results to the Office of Administrative Hearings.

6f. Audit Methodology. Claims audits shall utilize statistical sampling methodology. OA shall select samples randomly using the RAT-STAT statistical software developed by the Department of Health and Human Services, Office of the Inspector General (OIG) Office of Audit Services, or other software recognized as appropriate for statistically valid sample generation. OA shall use the default error rate to calculate sample size. See Exhibit 1, DBH Claims Audit Valid Statistical Sampling Methodology, for a description of the RAT-STAT procedures. In the case of focused audits, DBH may opt to audit a sample of convenience or one chosen by other criteria such as service type. (see above) DBH will provide the sample universe and the relevant RAT-STAT print out when we send each provider their sample.

6g. Documentation. Claims must be supported by all documentation required by federal and D.C. law and regulations. Providers must present all documentation onsite, or have it present in the EMR at the time of the audit. DBH will inform providers of missing documentation as the audit progresses, to provide an opportunity for the provider to produce the documentation, but will not accept documentation from the provider after auditors have left the provider's site.

6h. Audit Tools. The audit tools incorporate elements that reflect the applicable certification standards and other requirements to ensure compliance with federal and District laws, regulations, and policies, and may also include elements of best-practice and quality controls standards. See Attachment A for an example of a DBH claims audit tool, as well as a description of specific reasons for audit failure.

6i. Provider Participation. Providers shall cooperate with OA during the audit process. The providers shall provide OA access to any requested documents and information necessary to validate claims for payment and any records necessary for evaluation of the economy, efficiency, and effectiveness of DBH certified programs. Failure to cooperate is a serious matter and may result in suspension of payment, referral to the Medicaid Fraud Control Unit and termination of a provider's contract or grant. Further, furnishing false information or concealing any type of information from OA or obstructing OA audits could constitute violation of law. Cooperation includes, but is not limited to, designating a contact person (i.e., Director of Quality Improvement [QI] or designee) who will:

- (1) Arrange to have any key staff/managers associated with the program(s) being audited present at the entrance meeting with DBH;

- (2) Assist DBH staff during audits;
 - (3) Provide any orientation on the organization of the records, respond to questions about the documents during the audit; and
 - (4) Provide the DBH Audit Team sufficient working space to review records and make all requested treatment records available to the audit team, including providing access to any EMRs used to house records associated with the audit.
- 6j. Passed/Failed Claims. Claims and parts of claims (units) pass an audit when they contain all elements determined by DBH to be required conditions of payment for the claim. This includes, but is not limited to, proper identification of those who provided the service, appropriate signatures, accurate detailing of time and location for the service, and timely completion of the documentation. In addition, documentation for paid claims must demonstrate that a service meeting DBH regulations took place, and the time claimed for the service must be justified by the note describing the service (*i.e.*, a claim for four units of service must have a note that demonstrates four units of time spent).
- 6k. Claims Review Committee (CRC).
- (1) The DBH Audit Team may refer one or more claims to the Claims Review Committee if the team has a substantial question whether the claim is valid. The committee shall meet on a regular basis to review any claims referred by the audit team.
 - (2) The CRC is comprised of either three or five voting members who have an independent clinical license and are familiar with the rules and regulations of the services being reviewed and the population being served. If the CRC is meeting with three members, one must be a provider representative, if meeting with five members, two must be provider representatives.
 - (3) The CRC reviews documentation collected by the auditors for any claim referred to the committee in order to determine if the documentation supports passing some portion (some number of units) of the claim. After examination of the documentation, based on the clinicians' experience and training, the CRC determines how many units of the claim pass the audit and how many fail.
- 6l. When audited, claims may pass or be determined to be a full or partial overpayment.
- 6m. The Department shall not calculate an overpayment based on extrapolation or attempt to recover such extrapolated overpayment when the provider presents credible evidence that the Department's action or inaction caused the overpayment.
- 6n. Audit Error Rate. The audit error rate is a percentage determined by using the following audit error rate formula: Value of Unallowable Units divided by the Sample Value.

For example:

- (1) Of a total universe of 30,000 claims, 70 claims totaling \$2,000 (sample value) were audited.
- (2) Of these audited claims, a total of \$500 (Value of Unallowed Units) worth of services failed.
- (3) The error rate equals $\$500/\$2,000 = .25$ or 25%.
- (4) If the error rate is less than 20% (using standard rounding), DBH will only recoup the actual failed claims.
- (5) If the error rate is 20% or greater (using standard rounding), DBH will recoup an extrapolated amount as described in section 6k below.

6o. Extrapolation. For any audit meeting the audit methodology criteria in paragraph 6f above, covering a date of service on or after October 1, 2016 with an audit error rate of 20% or higher, the recoupment amount shall be extrapolated. The extrapolation formula is Value of Unallowable Claims divided by the Sample Size multiplied by the Total Audit Universe. For Example:

- (1) The audit sample was 70 paid claims from a Total Audit Universe of 30,000 claims.
- (2) The audit found errors totaling \$500.
- (3) To calculate the recoupment amount, the Value of Unallowable Units (\$500) is divided by the Sample Size (70) to produce a mean error per claim of \$7.14.
- (4) The mean error per claim (\$7.14) is then multiplied by the Total Audit Universe (30,000) to produce a total overpayment point estimate of \$214,286.
- (5) The extrapolated recoupment amount is the lower bound of a 95% confidence interval applied to the point estimate. In other words, the point estimate will be reduced by 5% prior to recoupment to insure that the value is appropriately determined by the sample.

6p. Substance Abuse Services. Extrapolation for Substance Abuse claim audits will begin for dates of service on or after October 1, 2017, to provide the Substance Abuse provider network an opportunity to fully implement Chapter 63 and Medicaid billing procedures. Overpayments on claims for dates of service prior to October 1, 2017, shall be recouped on a dollar for dollar basis in the same manner as mental health audits with error rates less than 20%, as described above.

7. Audit Results.

7a. OA will send preliminary audit results to the provider for review and comments. These results will include all Claims Audit tools filled out used to calculate the results of the audit. The provider shall respond to the preliminary audit results within thirty (30) days, but may request an extension for good cause.

7b. The Provider will have the option of requesting an informational meeting with OA within thirty (30) days of receiving the preliminary results, prior to DBH issuing the Joint Demand Letter.

7c. After reviewing the preliminary audit response, OA will send any claims that are still under dispute to the CRC.

7d. OA will issue notice of final audit results to the provider after all disputed claims have been reviewed by the CRC.

7e. Joint Demand Letter. DBH shall coordinate with DHCF to issue a joint demand letter. The joint demand letter will include the reasons for the recoupment, the amount of the recoupment, and the procedures for requesting an Administrative Review. In addition, the letter will include an explanation of the sampling methodology, and a chart that identifies all of the audited claims in the sample with the following elements: sample number, service ID number, Healthcare Common Procedure Coding System (HCPCS) codes, service dates, amount reimbursed, and amount allowed.

7f. DBH shall notify providers by certified mail and provide results and specific claims that have been identified as failed. With the consent of the provider, DBH may notify the providers via encrypted electronic mail. DBH shall require written verification of receipt of the joint demand letter from the provider.

8. Administrative Review/Appeal.

8a. The providers shall have thirty (30) days from the date of the demand letter to submit a written request to the Director for Administrative Review of the proposed recoupment. If the provider fails to respond in writing within thirty (30) days, the provider waives any right to contest the findings contained in the joint demand letter and the amount identified shall become immediately due and owing, subject to repayment and recoupment in accord with paragraph 10 below.

8b. The written request to the DBH Director shall include: (a) a description of each claim to be reviewed, (b) the reason why the disputed claim should be approved, in whole or in part, (c) any and all documentation in support of the disputed claim, and (d) the particular relief requested.

8c. If the provider challenges the statistical sampling utilized to calculate the overpayment, the provider shall identify any alleged sampling errors with particularity. Failure to articulate specific errors shall waive any objections to the Department's sampling methodology.

8d. The Administrative Review will be conducted by a group of independently licensed clinicians who have not previously examined the claims under review. The DBH Director will then make a final determination regarding the claims under review.

8f. DBH shall mail a written determination relative to the Administrative Review not later than ten (10) days from the date of the written request for Administrative Review. The Administrative Review decision constitutes DBH's final decision. Any recoupment remaining after the Administrative Review will begin thirty (30) days following the date of the written determination.

9. Appeals.

9a. The provider may appeal the results of the Administrative Review by requesting a contested case hearing at the Office of Administrative Hearings (OAH) within fifteen (15) days of the written determination. The scope of the contested case hearing shall be limited to the particular matters raised in the written request for Administrative Review.

9b. Filing an appeal with OAH pursuant to this section shall not stay any action to recover any overpayment to the provider.

10. Repayment and Recoupment of Funds. All repayments by the provider will be made through off-sets (*i.e.*, "take backs") from future claims. In the alternative, the Department may enter into a repayment plan agreement with the provider to recoup the overpayment over a period not to exceed twelve (12) months. If off-set or repayment plan is not possible or practical, or direct payment is required by law, the provider will have to repay DHCF or DBH the full amount immediately. Collection actions shall be forwarded to the Office of the Attorney General.

11. Claims Analysis and Trends. DBH Office of Accountability shall trend claim failures by provider and by reason for failure on an annual basis, and provide reports to the Compliance Committee, the DBH Internal Quality Committee, and the Quality Council. Audit results are public records and will be made available on the Department's website.

12. Reporting Fraud, Waste and Abuse. In the event that an audit by DBH and DHCF identifies any fraud, waste and/or abuse of Medicaid or District funds by a provider, DBH will make all appropriate referrals for criminal, civil, and/or administrative prosecution under applicable District or federal laws, rules, regulations, policies, and/or agreements. Nothing in this policy affects a provider's independent legal obligation under federal law to self-identify overpayments and repay within sixty (60) days of discovery.

Approved By:

**Tanya A. Royster, MD
Director, DBH**



(Signature)

10/3/2016
(Date)

DBH Claims Audit Valid Statistical Sampling Methodology

The audit process begins by extracting a random sample of claims paid by the Department of Health Care Finance and/or Department of Behavioral Health to behavioral health providers. The sample size is based on 95% confidence level, 5% confidence interval, and error rate (Anticipated Rate of Occurrence - ARO), based on past claim audit performance of each agency.

Confidence Level is expressed as a percentage and represents how often the true percentage of the population lies within the confidence interval. A 95% confidence level means we can be 95% certain. The 95% is chosen because it is commonly used.

Confidence Interval is a measure of a specified degree of precision. This is determined using a desired width of confidence interval. In this case, 5% confidence interval will be used as part of the random extraction criterion.

Putting it together (confidence level and confidence interval). Suppose of all the sample claims that went through an audit process, 50% failed. One can be 95% sure that if the entire paid claim went through an audit process, between 45% and 55% of paid claims will fail the audit. Keep in mind there is still that 5% uncertainty.

Error Rate or Anticipated Rate of Occurrence (ARO) is based on prior knowledge or history of a result of an audit (failure rate). Basically, the higher the error rate, the larger the sample size.

- A statistical software, RAT-STATS, is used to determine sample size for each audit. The sample size formulates the basis for recoupment relative to the total of failed claims. Claims are audited for adherence to federal and District conditions of payment.
- RAT-STATS is owned by the *Department of Health and Human Services, Office of the Inspector General, Office of Audit Services* and is free to the public. One unique feature that RAT-STATS offers is the ability to take error rate into account when determining the sample size. As indicated above, the error rate significantly affects sample size.

Initial Audit Sampling Methodology. Determination of the ARO for the Audit Sampling Methodology for a specific fiscal period (e.g., fiscal year) is as follows:

- The sample size for providers will be ARO of .05

Office of Accountability (OA) Claims Audit Process Flow

