Department of Mental Health

TRANSMITTAL LETTER

SUBJECT **Claims Audits**		
POLICY NUMBER **DMH Policy 911.1C**	**DATE** AUG 1 0 2012	**TL#** 176

Purpose. DMH initially began conducting audits using an Anticipated Rate of Occurrence (ARO) of .05 to determine the sample size for agency audits since there was no prior history of audit results. This policy is being reissued to revise Exhibits 1 and 2 to reflect that DMH will now use a tiered ARO depending on the audit history of each agency to determine the sample size of claims to be audited.

Applicability. Applies to all certified Mental Health Rehabilitation Services (MHRS) providers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Mental Health Authority offices.

Implementation Plans. A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work. *Implementation of all DMH policies shall begin as soon as possible.* ***The new sampling methodology outlined in Exhibit 1 of this policy will begin with the FY10 MHRS Claims Audits.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the DMH Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

ACTION

REMOVE AND DESTROY

DMH Policy 911.1B, same subject
dated November 9, 2010

INSERT

DMH Policy 911.1C

Stephen T. Baron
Director, DMH

8/10/12

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 911.1C	Date AUG 1 0 2012	Page 1
	Supersedes 911.1B, Claims Audits, dated November 9, 2010		

Subject: Claims Audits

1. **Purpose**. The purpose of this policy is:

   - To maintain compliance with the Deficit Reduction Act; the Federal False Claims Act; the D.C. False Claims Act, and other statutes;
   - To set forth procedures for auditing the documentation of certified providers to determine the presence of required information that supports the billing for mental health services and supports; and
   - To ensure that clinical and administrative record reviews are conducted to determine compliance with service requirements and to monitor the quality of the services provided.

2. **Applicability**. Applies to all certified Mental Health Rehabilitation Services (MHRS) providers.

3. **Authority**. MHRS Provider Certification Standards, as amended; the Department of Mental Health Establishment Amendment Act of 2001; Deficit Reduction Act of 2005; the Federal False Claims Act (2007); D.C. False Claims Act (2007); and the Second Amendment to the Memorandum of Understanding Between DMH and the D.C. Department of Health Medical Assistance Administration (now Department of Health Care Finance), effective 11/1/2007.

4. **Policy**. The Department of Mental Health (DMH) shall perform regularly scheduled audits of all certified providers by reviewing documentation to promote best documentation practices for treatment and financial validity purposes, to ensure compliance with MHRS standards and other applicable regulations, and to enhance the overall quality improvement efforts in the delivery of mental health services. The documentation must be consistent with the MHRS Provider Certification Standards and applicable District and federal regulations. DMH conducts these audits in collaboration and cooperation with the Department of Health Care Finance (DHCF).

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

   5a. CMS - Centers for Medicare and Medicaid Services.

   5b. DHCF - DC Department of Health Care Finance, formerly known as the Department of Health, Medical Assistance Administration (MAA), the state agency responsible for administering the D.C. Medicaid Program.

   5c. Mental Health Rehabilitation Services (MHRS) - mental health rehabilitative or palliative services provided by a DMH-certified community-based mental health provider to consumers in accordance with the District of Columbia State Medicaid Plan and Chapter 34, Title 22A, DCMR.

   5d. Discovery – when a Medicaid claim is determined by DHCF to have failed. Discovery occurs on the *date* that the DMH/DHCF joint demand letter is mailed to the provider and

marks the time from which DHCF has sixty (60) days to repay CMS for an identified over payment.

5e. DMH - DHCF MOU – A Memorandum of Understanding (MOU) between DMH and DHCF (previously known as MAA) effective May 6, 2008, that outlines the audit process by DMH of provider's paid claims, and the repayment and recoupment process of any resulting failed claims that involve Medicaid funds.

5f. Demand Letter – is a joint letter sent to any MHRS provider from DMH and DHCF for Medicaid claims, or from DMH alone for local dollar claims, demanding recovery of payments for failed claims.

5g. Recoupment of Payment – a process to recover funds paid to a provider to which the provider was not entitled.

6. **General Audit Procedures**.

6a. DMH Audit Team. The DMH Office of Accountability (OA) is responsible for the claims audits, and 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 DMH as deemed appropriate.

6b. Audit Location/Other Details. DMH shall conduct audits on-site at the provider's location or at another location at DMH's discretion. DMH shall give the provider reasonable notice when scheduling audits with the provider and shall arrange a brief entrance meeting. This meeting shall include purpose of visit, introduction of the DMH audit team, and a description of resources and documents to which the team will require access.

6c. Claims Audits. DMH conducts claims audits of each provider who has submitted claims during a specified time period. The audit is conducted to determine whether the provider has sufficient and correct documentation to support payment of specific claims for the provision of services.

6d. Audit Methodology. All claims audits are conducted based on RAT-STATS, a valid statistical sampling methodology that is fully described in Exhibit 1, and includes an explanation of how the sample size is determined. RAT-STATS is a package of statistical software tools initially developed by the Regional Advanced Techniques staff that is used to determine sample size and evaluate results, and is utilized by the U.S. Department of Health and Human Services. Also see the Claims Audit Process Flow in Exhibit 2.

6e. Documentation. Claims must be supported by all documentation required by federal and D.C. law and regulations.

6f. Audit Tools. The audit tools incorporate elements that reflect the MHRS Provider Certification Standards and other elements to ensure compliance with federal and District laws, regulations, and policies, and may also include elements of best-practice and quality controls standards.

6g. Provider Participation. Providers are required to designate a contact person (i.e., Director of Quality Improvement [QI] or designee) who will:

- Arrange to have any key staff/managers associated with the program(s) being audited present at the entrance meeting with DMH;
- Assist DMH staff on-site during audits;

- Provide any orientation on the organization of the records, respond to questions about the documents during the audit; and
- Provide the audit team sufficient working space to review records and make all requested treatment records available to the audit team.

6h. Claims Review Committee (CRC).

(1) The committee meets on a regular basis to review claims that the auditor was unable to either pass or fail in its entirety.

(2) The CRC is comprised of the following voting members: a clinical representative from the Child Youth Services Division and Adult Services Division, and a representative from Provider Relations and the Office of Accountability (non-auditor) who have a clinical background. Non-voting members include the QI Director, a representative from the Office of the General Counsel, and the lead auditor.

(3) The CRC reviews documentation collected by the auditors for any claim that is considered a partial pass or partial fail, and after examination of the documentation, based on the clinicians' experience and training determines what portion of the claim will be allowed and what portion of the claim will be disallowed.

(4) Pass Fail Rate for Partial Pass/Fail Claims.

(a) For claims that are partially failed, whether or not the claim is considered a failed claim for purposes of determining an agency's failure rate (see Section 8 below) depends on the percentage of the claim that actually failed. If 51% of the claim fails, the claim will be considered a failed claim as demonstrated in the following examples:

(i) If a claim is partially failed (e.g., a claim is submitted for 8 units, 6 pass and 2 fail).

- 2 units will be recouped; however, only claims that are failed on a partial basis of 51% or more will count as a "failed claim" for the purpose of establishing the failure rate for the agency submitting the claim.
- Thus, for the example above, only 25% of the claim failed (2/8), so it will not count in the failure rate for the provider agency.

(ii) If the claim is evenly split (e.g., 4 unit claim: 2 units pass, 2 units fail) the claim will not have failed as the "failure" is only 50%.

(iii) If there is a claim for 8 units and the CRC only passes 3 units, then the claim would have a 62% failure (5/8 units failed) and that "failed" claim would be considered for the overall failure rate of the provider agency.

(b) Contact the DMH Office of Accountability if you have questions regarding this process.

7. **Audit Results**.

7a. DMH shall:

- Notify providers by certified mail; and
- Provide results and specific claims that have been identified as "potential fails" (see Section 7c below).

7b. The Provider:

- Must respond to the DMH Office of Accountability in writing within ten (10) business days from the date of notification from DMH;
- Has the opportunity of correcting the audit finding of a claim that was earmarked as a potential fail during the audit process by presenting supporting documentation that existed at the time of the audit, but was missing or unavailable during the audit; and
- Can provide their response via mail, email, fax, or in person to DMH staff.

7c. **Potential failure of a claim** occurs when any mandatory supporting documentation for the claim cannot be provided to support the claim, or when the documentation presented does not substantiate the claim.

7d. **Actual failure of a claim** is determined after the provider has had an opportunity to respond to the notice of potential failed claims but did not present to DMH any documentation that was corrective, and

- for Medicaid claims, DMH has made a final determination that the claim has failed and has so notified DHCF.
- for non-Medicaid claims, DMH has made a final determination that the claim has failed.

7e. **Discovery** is when a Medicaid claim is determined by DHCF to have failed as stated in Section 5d above.

8. **Expanded Audits**.

8a. DMH shall conduct a second audit for the same time period of any provider who has a fifteen percent (15%) or greater potential failure rate after an initial claims audit. Procedures for notification to the provider of audit results and provider response to DMH shall be the same as in Section 7 above.

8b. DMH may conduct additional audits as deemed necessary or appropriate at the sole determination of DMH.

9. **Repayment and Recoupment of Medicaid Funds**.

9a. Upon completion of a claims audit of an MHRS provider, DMH will verify Medicaid payment of the claims failed or partially failed on audit. DMH and DHCF will issue a joint demand letter to the provider for repayment of funds for failed claims. For claims that were partial fail claims, only that portion of the claim that is failed will be submitted for repayment. This letter will include final audit results and notification of appeal rights.

9b. If possible, all repayments by the provider will be made through off-sets (i.e., "take backs") from future claims to DHCF. If off-set is not possible, the provider will have to repay DHCF the full amount.

9c. Pursuant to D.C. regulations, the provider will have thirty (30) days to submit documentary evidence and/or written argument against the proposed demand action to DMH and DHCF. An additional thirty (30) days may be requested from DHCF for good cause shown. If a statement or other documentary evidence is submitted within the authorized time period, then that information will be considered by DMH and DHCF to determine if the repayment amount should be modified. The joint demand letter sent by DMH and DHCF will include specific information to the provider on where to forward their response.

9d. If no statement is received from the provider within the authorized time period, repayment shall begin at the end of that period. If a statement is received, the provider will receive final written notice of the determination as to whether the repayment amount has been modified; repayment of the final amount will begin at least fifteen (15) days after this final notice.

9e. The provider has the right to request a hearing from the D.C. Office of Administrative Hearings (OAH) to appeal the repayment determination. If an appeal is filed, repayment will not occur until a final decision is made following a hearing on the appeal.

10. **Repayment and Recoupment of Local (D.C.) Funds**.

10a. After a claim that was paid for by local D.C. funds has been determined to have actually failed, DMH will issue a demand letter to the provider for recoupment of the funds. This letter will include final audit results and notification of appeal rights. For claims that were partial fail claims, only that portion of the claim that is failed will be submitted for repayment.

10b. If possible and when approved by DMH, recoupment of failed local claims will be made through off-sets (i.e., take-backs) from future claims to be paid by District funds. If off-set is not possible, the provider will have to repay the full amount within an agreed-upon time period.

10c. The provider will have thirty (30) days to submit documentary evidence and/or written argument against the proposed demand action to DMH Office of Accountability. An additional thirty (30) days may be requested from DMH for good cause shown. If a statement or other documentary evidence is submitted within the authorized time period, that information will be considered by DMH to determine if the repayment amount should be modified.

10d. If no statement is received from the provider within the authorized time period, repayment shall begin at the end of the period. If a statement is received, the provider will receive final written notice from DMH Office of Accountability of the determination as to whether the repayment amount has been modified; repayment of the final amount will begin at least fifteen (15) days after this final notice.

10e. The provider can submit a written appeal of the repayment determination for non-Medicaid claims to the DMH Director. An appeal should only be submitted if it is based on significant information regarding the claim(s) that would justify a reversal of the repayment determination and all other avenues for resolution within DMH have been exhausted. If an appeal is submitted, repayment will not occur until a final decision is made on the appeal. The DMH Director shall convene a group of subject matter experts to make a recommendation to him/her within fifteen (15) days after receipt of the appeal. The decision of the DMH Director is final.

11. **Providers' Internal Review Plans**. Each provider must also show DMH auditors evidence of their use of an internal review plan. This plan must incorporate their internal method(s) of reviewing their clinical, treatment, and financial records to ensure appropriate documentation of submitted charges.

12. **Claims Analysis and Trends**. DMH 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 DMH Internal Quality Committee, and the Quality Council.

13. **Reporting Fraud, Waste and Abuse**. In the event that an audit by DMH and DHCF identifies any fraud, waste and/or abuse of Medicaid or District funds by a provider, DMH will make all appropriate referrals for criminal, civil, and/or administrative prosecution under applicable District or federal laws, rules, regulations, policies, and/or agreements.

14. **Exhibits**.

Exhibit 1 – DMH Claims Audit Valid Statistical Sampling Methodology
Exhibit 2 – OA Claims Audit Process Flow

Approved By:

Stephen T. Baron
Director, DMH

8/10/12

(Signature) **(Date)**

DMH 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 Mental Health to mental 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 Initial Audit Sampling Methodology for a specific fiscal period (e.g., fiscal year) is as follows:

- The sample size for new providers without audit history will be determined using ARO of .05
- Agencies with a previous fiscal year Audit Failure Rate of 0% - 14.99% will be assigned an ARO of .05
- Agencies with a previous fiscal year Audit Failure Rate of 15% - 30.99% will be assigned an ARO of 2.0
- Agencies with previous fiscal year Audit Failure Rate of 31% or greater will be assigned an ARO of 4.0

2nd Audit Sampling Methodology. A larger second audit of claims during the same fiscal period will be conducted for agencies having an Initial Audit Failure Rate of 15% or greater. Determination of the ARO for the larger 2nd Audit Sampling Methodology will be assigned as follows:

- Agencies with an Initial Audit Failure Rate of 0% - 14.99% will not have a larger 2nd audit
- Agencies with an Initial Audit Failure Rate of 15% - 30.99% will be assigned an ARO of 5.0
- Agencies with an Initial Audit Failure Rate of 31% or greater will be assigned an ARO of 7.0

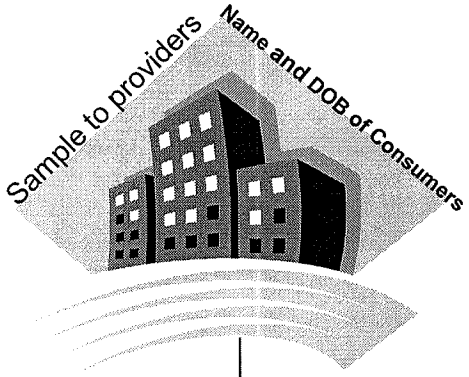
Office of Accountability (OA) Claims Audit Process Flow

e-Cura

Paid claim extraction
-By provider
-By fiscal year

RAT-STAT

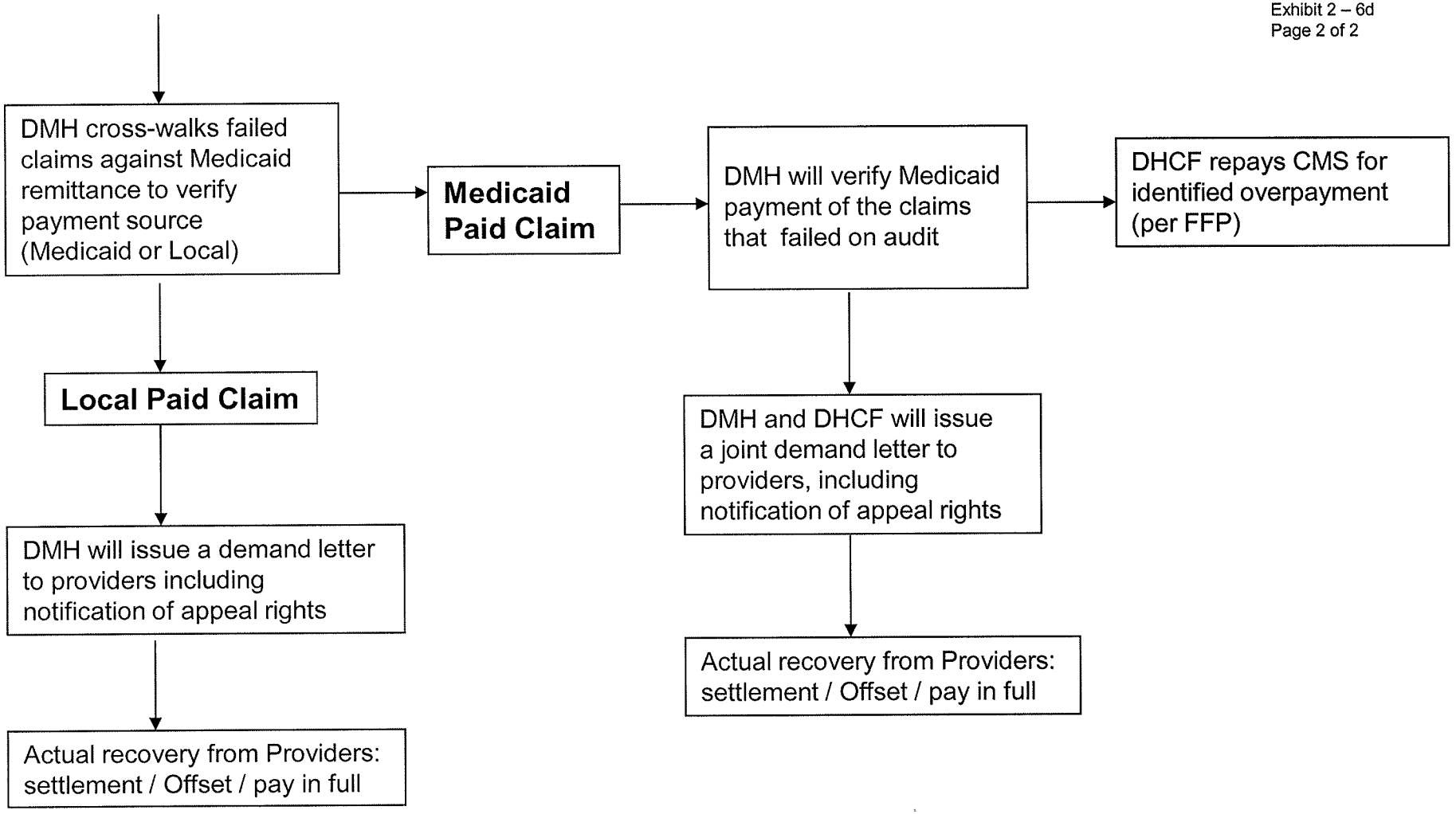
Valid statistical sample *
-CL = 95%*
-CI = 5%*
-ARO = rate based on audit history for each agency (see Exhibit 1 for determination of ARO)



- Preliminary audit results are tabulated
- Potential failed claims identified

- DMH sends certified letter to Providers identifying potential failed claims
- Providers respond within ten business days with any additional supporting documents
- DMH will identify actual claim failures after Providers have an opportunity to respond.

** CL= Confidence Level*
** CI = Confidence Interval*
** ARO = Anticipated error rate*
** RAT-STAT = OIG Statistical Application*


DMH cross-walks failed claims against Medicaid remittance to verify payment source (Medicaid or Local)
Medicaid Paid Claim
DMH will verify Medicaid payment of the claims that failed on audit
DHCF repays CMS for identified overpayment (per FFP)
Local Paid Claim
DMH and DHCF will issue a joint demand letter to providers, including notification of appeal rights
DMH will issue a demand letter to providers including notification of appeal rights
Actual recovery from Providers: settlement / Offset / pay in full
Actual recovery from Providers: settlement / Offset / pay in full