Magellan Compliance Notebook

Magellan Behavioral Health of Pennsylvania, Inc. (Magellan) strives to be proactive and use education as a preventative tool to help ensure our members receive the highest quality of care through you, the provider. The Compliance Department at Magellan is committed to sending monthly e-mails to targeted providers regarding a Compliance-related subject.

This e-mail communication is specific to your HealthChoices (Pennsylvania Medicaid) Contract with Magellan.

This communication serves as our annual announcement regarding self-reports/ self-disclosures of Fraud, Waste or Abuse (FWA). **Please read through the below reminders thoroughly.**

Through Magellan's partnership with DHS, other PA HealthChoices Behavioral Health Managed Care Organizations and our provider network, we encourage the practice of **self-reporting** FWA with the common goal of protecting the financial integrity of the MA program. Magellan supports the notion that treatment providers have an ethical and legal duty to promptly return inappropriate payments that they have received from the MA Program.

Magellan supports the Centers for Medicare & Medicaid Services (CMS) Compliance Program Guidelines which includes a component on provider self-auditing. All providers should develop a Claims Auditing Policy which includes a procedure and mechanism for oversight in this area. Self-auditing is a good tool to measure internal compliance and ensures compliance with MA regulations. A comprehensive Claims Auditing Policy should include (at a minimum): the frequency audits are conducted; the number or percentage of records reviewed; how the sample is selected; whether audits are conducted prospectively (before claims are submitted) or retrospectively (after claims are submitted); the indicators that are measured; and the procedure/workflow regarding action steps to correct internal claims error findings. Magellan reviews Providers' Claims Auditing Policies during routine Compliance Audits and Integrated Audits.

The CMS Comprehensive Program Integrity Review of Pennsylvania in 2014 identified "Expanded Use of Provider Self-Audits" as one of four *Effective Practices*. There are two types of self-audits:

- **Provider-initiated self-audits**
  Providers identify potential violations through internal policy-standard monitoring protocols, perform audits of their own records, report their findings, submit corrective action plans, and return any inappropriate payments. "DHS announces, through this protocol, that it will accept reimbursement for inappropriate payments without penalty in the event that such inappropriate payments are disclosed voluntarily and in good faith, and that the acts that led to the inappropriate payments were not the result of fraudulent conduct on the part of the provider, its employees, or agents."

- **Targeted third-party initiated provider self-audits (e.g. Magellan or OMHSAS, BPI on behalf of Magellan)**
  Through various mechanisms such as data mining or on-site audits, program integrity personnel identify billing patterns appearing to be out of compliance with payment policies. The provider is notified of the issue and the performance of a self-audit is requested.

Due to lack of uniformity of provider audits submitted for purposes of self-disclosure, DHS established a protocol for self-audits in 2001. This protocol is for MA providers that participate in both the fee-for-service and managed care environments. The protocol provides guidance to providers on the preferred methodology to identify and return inappropriate payments. The DHS "Pennsylvania Medical Assistance Provider Self-Audit Protocol" is posted on their website:

http://www.dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/

The three types of provider self-audits include:

1. **Option 1 - 100 Percent Claim Review**
   A provider may identify actual inappropriate payments by performing a 100 percent review of claims. This option is recommended in instances where a case-by-case review of claims is administratively feasible and cost-effective.

2. **Option 2 - Provider-Developed Audit Work Plan**
   AUDIT WORK PLAN MUST BE SUBMITTED TO MAGELLAN FOR PRE-APPROVAL PRIOR TO CONDUCTING THE AUDIT

   When it is not administratively feasible or cost effective for the provider to conduct a 100 percent claim review, a provider may identify and project inappropriate payments pursuant to a detailed work plan submitted to the MCO for approval.

The proposed work plan should also include an overview of the issues identified, the proposed time period of the review, including the reason for the time period selected, and the corrective action taken to ensure that the errors do not reoccur in the future.

Once the proposed plan has been approved, the audit should be conducted and inappropriate payment(s) projected. Acceptance of payment by the MA Program does not constitute agreement as to the amount of loss suffered.

3. **Option 3- Statistically Valid Random Sample (SVRS)**
   AUDIT WORK PLAN MUST BE SUBMITTED TO MAGELLAN FOR PRE-APPROVAL PRIOR TO CONDUCTING THE AUDIT

   Extrapolation allows auditors the ability to statistically infer that overpayments found in a subset of data (a statistically representative random sample) is representative of the overpayments found in the larger population of claims. This method reduces the number of claims required to be reviewed.

   Extrapolation may only be applied to a SVRS. Magellan uses RAT-STATS, a CMS and HHS-OIG recognized software application, to determine SVRS. This application will be used to evaluate the provider's data when extrapolation is used in a provider self-audit to ensure that the extrapolation is in accordance with DHS requirements.

- Whether overpayments are identified via a Magellan initiated self-audit or a provider initiated self-audit, the Pennsylvania Medical Assistance Provider Self-Audit Protocol should be utilized.

Following completion of the self-audit in accordance with the DHS MA self-audit protocol (and Magellan pre-approval if indicated), the following information should be submitted:

- Provider Self-disclosure Claims Recovery Spreadsheet of all identified claims that could not be substantiated.
- Investigative Report (at a minimum, please include the following in your report):
  - ✓ Identification of the self-audit mechanism utilized
  - ✓ Description of the adverse finding(s)
  - ✓ How it was discovered
  - ✓ Who conducted the audit (internal staff, outside agency, or combination of both)
  - ✓ Parameters used in determining the audit sample
  - ✓ Criteria used in establishing those parameters

- ✓ Date range of the audit sample
- ✓ Services audited (include CPT and modifier codes)
- ✓ Scope of the audit (broad audit encompassing an entire program, site, or agency; or employee(s) specific). Include full name(s) and SS# of staff person(s) or contractor(s) under investigation if applicable.
- ✓ Verification methods used (member surveys/phone calls; staff interviews etc.). Include the number of members and/or staff contacted or interviewed.
- ✓ Corrective action taken by agency to reduce the likelihood of re-occurrence. (e.g. workflows, policies, or process changes).
- ✓ Any HR action(s) applied to any employee/contractor as a result of this self-audit. (e.g. termination of employment or contract etc.).

The Provider Self-disclosure Claims Recovery spreadsheet should only be utilized in those cases of potential Fraud, Waste or Abuse. Billing mistakes or errors should be corrected by following Magellan's Claims Resubmission process whereby a provider can submit a Corrected Claim (see Provider Handbook for details).

Please submit all PAHC Medicaid self-reports and accompanying documentation to the following address: PAHCSelfreport@magellanhealth.com

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At Magellan, we will continue to educate our providers with updated MA Bulletins, Regulations and other pertinent information in order to ensure Compliance.

Thank you for your ongoing hard work and dedication to our members!

Magellan of Pennsylvania's Compliance Team

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