

**Maryland Public Mental Health System
Mental Hygiene Administration
Office of Managed Care Compliance**

**Policy and Procedures for Provider Audit
With in the
Public Mental Health System (PMHS)**

01. Purpose

The purpose of this policy is to outline the roles, lines of communication and collaboration among agencies and procedures for the on-site audit of providers of services within the Public Mental Health System (PMHS). The audit process is designed to identify a provider's compliance with applicable State or federal rules and regulations governing the healthcare program and payment to the provider (including but not limited to documentation and staffing) and to identify quality of care issues. The audit is used as a tool to educate providers about regulatory compliance and to identify fraud and abuse. The audit process will use DHMH approved audit tools across all agencies performing auditing activities and ensure that audits by different agencies will be coordinated as much as practical to reduce the burden on the provider. The audit process will also allow MHA to assess current provider practices in the provision of services and to determine trends and best practices. As a result, MHA will develop strategies to address identified deficiencies in a provider's compliance to rules and regulations, quality of care issues, and issues relating to the overall performance of the Public Mental Health System.

02. Scope

This procedure applies to all providers within the Public Mental Health System.

03. Definitions

- A. Public Mental Health System- a coordinated system for the delivery of mental health services to eligible individuals. A key component of this system of care is to ensure consumers have access to mental health services that are high-quality and cost effective.
- B. Audit- an examination of the quality and appropriateness of medically necessary services delivered to consumers within the PMHS to determine whether the services were billed accurately and supported through documentation in the medical record.
- C. Auditor(s) or Audit Team are individuals approved by the Mental Hygiene Administration to conduct audits pursuant to this policy.
- D. Audit Agency – the agency serving as the lead on an audit activity. Generally this will be the ASO, MHA or CSA.

- E. Mental Hygiene Administration (MHA) is the mental health authority for the state with overall responsibility for implementing and maintaining this policy.
- F. Office of Compliance is a unit within the MHA responsible for identifying fraud and abuse, educating providers about compliance issues, and ensuring consistency with state and federal regulations.
- G. Core Service Agency (CSA) is the county, multi-county authority or private non-profit entity, designated under Md. Ann Code, Health General §10-1201 et. seq., responsible for planning, managing and monitoring publicly funded mental health programs.
- H. Administrative Service Organization (ASO) is a contracted organization, selected and approved by the Department of Health and Mental Hygiene, to provide administrative services as determined by MHA, including but not limited to, auditing providers within the PMHS and quality designated activities. The ASO maintains administrative databases that are useful in identifying trends in service provision in the PMHS.
- I. Office of Health Care Quality (OHCQ), Mental Health Survey Office, is an administration separate from MHA responsible for approval of mental health programs for the PMHS.

04. Selection of Providers for Review

- A. An audit committee, chaired by the MHA and composed of representatives of the CSA (2 representatives), the ASO (2 representatives), and MHA (2 representatives), OHCQ (1 representative) will determine which providers shall be audited utilizing one or more of the following criteria (list not all-inclusive):
 - 1) High Volume Services: selected by program type, service category, average length of treatment, CPT code, or other as indicated; High Cost Services: selected after review of claims by program type, service category, CPT code, other; Exceptional Cases: these are problem prone services or specific issues that may be selected after review of administrative data such as duplicate billing, claims exhibiting a high number of errors, quality of care; complaints, repeated submission of treatment plans lacking clear goals & interventions or other documentation, and specific issues identified as a result of other activities (such as OHCQ visit or routine monitoring visit by a CSA).
 - 2) New providers
 - 3) Random selection
- B. The committee will develop coordination and communication among all parties involved in audit activities to limit duplicative audit activities.
- C. The audit committee will be apprised of the audit schedules of each party on a quarterly basis as well as being advised of the rationale behind the audits.

- D. The committee will review the monthly schedule, discuss and review significant issues from prior audits and disseminate information to all relevant parties.

05. Procedures for Conducting an Audit

- A. Each auditor or audit team will use the following procedures to conduct an audit activity.

- (1) Review the provider's latest OHCQ survey result, and check the current OHCQ visit schedule. If appropriate, the review schedule shall be coordinated with OHCQ.
- (2) Notify the provider (verbally and by letter) no more than one week prior to the date of the audit, of the date, time and place of the audit.
 - (a) Determine whether the provider operates more than one program location under the same Medical Assistance number, and whether the consumer records are at the location listed in the audit notice. If the provider has more than one site, the audit team/agency and provider will agree on the designated site.

Note: The names of consumer records to be reviewed shall be provided to the program one business day before the audit.

- (3) Request the provider designate an individual to act as a contact person for the audit. The contact person will be responsible for providing files and answering questions.
- (4) Review the provider's paid claims data and, if necessary, additional information from the Administrative Services Organization (ASO).
- (5) Select consumer names that will undergo a comprehensive medical record review.
 - (a) Consumers shall be identified through random selection, or based upon an identified methodology.
 - (b) An audit shall consist of a minimum of 20 medical records or 100% of records, if the provider has less than 20 current and recently discharged records. The auditor maintains the discretion to audit additional records.
- (6) On arrival at the audit location:
 - (a) Review Staffing records to determine there is sufficient qualified staff, including staffing requirements set forth in regulations.
 - (b) Review the selected medical records using an audit tool approved by Mental Hygiene Administration. The most current audit tools can be found in the "For Providers" section of the ASO website. Data found in the medical records will be recorded on an audit tool worksheet or electronic auditing tool.

(7) If at anytime during the audit, the audit team has reason to believe criminal action or intentional fraudulent activities may have occurred, or that there are quality of care issues that present an immediate risk of harm to consumers, a member of the audit team shall immediately notify the MHA Office of Compliance. If criminal action or fraudulent activities are suspected, the audit may be suspended and MHA may refer the matter to the Office of the Attorney General - Medicaid Fraud Unit. If MHA decides to further investigate suspected fraudulent activities, MHA reserves the right not to disclose the details of the investigation until the matter has been resolved.

(8) If find problems with licensed professional a report will be filed with the appropriate licensing Board

(9) Conduct an exit interview with the provider to:

(a) Present findings and preliminary conclusions.

(b) Allow the provider to present documentation located in the medical record that was not previously identified;

Note: Documentation that are late entries will not be deemed to support the provided service.

(c) Provide a copy of the audit tool worksheet which will also be included in the final audit report;

(d) Explain that a written report of the audit findings will be provided to the MHA Office of Compliance and the CSA.

(e) Explain to the provider that deficiencies identified in the audit report will need to be addressed through a plan for improvement submitted to the audit team within one month of the receipt of the final audit report.

(f) Explain that the plan for improvement may be forwarded to the OHCQ, MHA, ASO, and the CSA for the county/region is located within;

(g) Request the signature of the individual representing the program certifying that the initial audit findings have been reviewed, and that they have been given an opportunity to locate additional documentation in the medical record;

(h) Advise provider that no more than 24 hours will be allowed to locate the missing documentation;

Note: Explain that additional analysis/investigation may be needed to determine final conclusions after collating all audit data. This may result in additions or refinements to the audit report.

(10) The auditing agency will:

(a) Within 45 calendar days after completion of the audit, submit a written report to the provider. Reports may be submitted sooner than 45 days if completed. The provider will have thirty calendar days after receipt of the audit report from the auditing agency to review and provide comments to the written report and develop a plan for improvement as needed.

(b) The auditing agency will require, if appropriate, the provider to submit a Plan for Improvement to address quality of care issues raised in the audit. At a minimum,

plans for improvement shall include notation of each audit deficiency; action specific to that deficiency that the agency will undertake to address the deficiency; person(s) responsible for the action; and timeline for completion. Acceptance of a Plan of Improvement does not prevent additional investigation or action against a provider.

- (11) Within two weeks of receipt of an Improvement Plan from the provider, the auditing agency will forward the Audit Report and the provider's Improvement Plan to MHA, the CSA and the ASO. MHA and the CSA will be notified of all providers who do not submit a Plan of Improvement within 30 calendar days.

.06 Post Audit Procedures

A. Audit findings will result in one of three possible outcomes:

No or minimal action required
Action Required
Action and Sanctions Required

- (1) No or minimal action required audits require no Plan for Improvement, but may require minor corrective actions. Upon receipt of the report from the auditing agency, MHA Office of Compliance will issue a final letter of determination within 45 days.
- (2) Action Required audits that need either a quality of care or financial Plan for Improvement: The Audit and Plan for Improvement will be forwarded to the MHA Office of Compliance. Plans for Improvement developed by the provider and auditing agency may be distributed to the OHCQ, MHA Office of Compliance, CSA in which the program is located, and the ASO. MHA will issue a final letter of determination within 45 days.
- (3) Audits and Sanctions that include findings of significant quality of care issues and/or improper billing: The MHA Office of Compliance will receive audit reports that recommend an action by MHA because of significant quality of care issues or improper claims.

B. The MHA Office of Compliance will issue a letter of determination within 45 days *after receipt of audit report* that includes the following:

- (a) Audit findings and recommendations;
- (b) Date of undocumented service or services or services not supported due to insufficient/improper documentation or not medically necessary.
- (c) Regulatory or statutory citations/deficiencies;
- (d) The CPT/procedure code of undocumented service; and
- (e) The amount of funds paid by the ASO for undocumented services.

C. The MHA Office of Compliance will notify the provider of retraction of funds paid by the ASO if the audit report finds that:

- (a) Claims were paid which have not been appropriately documented; or
 - (b) services were not provided, or
 - (c) services were not provided by appropriate staff.
- D. The MHA Office of Compliance will, if appropriate, require and monitor a Program Integrity Agreement;
- E. The Core Service Agencies (CSAs) will monitor the implementation by the provider of the Plans for Improvement. As the final letter of determination is written by the MHA, CSAs will advise MHA regarding whether or not the provider's improvement plan will require onsite monitoring. As appropriate, CSAs will schedule follow-up audits 90 days after the last scheduled implementation date of improvements outlined in the improvement plan submitted by the provider and approved by the MHA. Depending on the plan and the improvements needed, CSAs have flexibility to schedule follow-up audits earlier or later.
- F. Timelines for the audit and MHA reviews may be extended if issues require additional investigation.
- G. The MHA Office of Compliance will copy the ASO and CSA on all correspondence regarding the audit: the determination letter, retraction report, and Program Integrity Agreement. However, MHA reserves the right not to provide correspondence if an investigation of the provider has commenced. MHA will inform the agency(s) performing an audit of the results of the investigation.

07. Appeals

- A. A provider may submit an appeal by sending written notice of appeal to MHA within 30 days of the date on the notice of the letter of determination.
- B. The MHA Office of Compliance will advise the provider of the right to appeal the findings to the Office of Administrative Hearings.
- C. If the provider does not file an appeal within 30 days of receipt of the MHA findings, the Office of Compliance shall forward a copy of the final report to the ASO with instructions to retract from the provider the amount of funds identified in the report.
- D. Timelines for MHA and the audit team are discretionary, and not mandatory, and may not be used by the provider to nullify findings or penalties.