

CLAIMS BILLING AUDITS

INTRODUCTION

ValueOptions®, the parent company of ValueOptions® of California, pays for mental health services for millions of members and makes payments to tens of thousands of mental health providers. As such, this provides ample potential for improper billing whether erroneous or fraudulent in nature. ValueOptions® has a department, the Special Investigations Unit (SIU) responsible for reviewing and monitoring claims and billings by providers to ensure payment has been properly requested and made. The SIU works with ValueOptions® of California to review and monitor provider claims and billings.

All of these are subject to scrutiny by the ValueOptions® SIU as well as regulatory authorities responsible for monitoring health insurance fraud and abuse activity. Provisions in both the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) make it very evident that federal lawmakers are intent on addressing issues of fraud and abuse. Within the industry the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services Offices of the Inspector General (HHS-OIG), the FBI, and the United States Attorney's Offices, have joined forces to administer a comprehensive anti-fraud program. In addition, state insurance laws and enforcement authorities have focused considerable effort on improper billing and fraud.

ValueOptions® and ValueOptions® of California therefore have both legal and fiduciary obligations to ensure that the funds it receives from clients, including federal and state government funding, is properly paid for services rendered by providers. The SIU of ValueOptions® is charged with this responsibility on behalf of ValueOptions® of California and its clients.

Billing and Audit Process

The SIU monitors and investigates potential cases of improper billing and fraud. The SIU identifies potential cases through a variety of means: (i) member inquiry or complaint; (ii) external referral from state, federal and other regulatory agencies (iii) internal staff inquiry, (iv) data analysis of certain statistical anomalies, and (v) whistleblowers. Not every case identified as potential improper billing results in actual findings of improper billing or fraud. The SIU and ValueOptions® of California investigate any potential case thoroughly before making any conclusions and taking any action.

The SIU and ValueOptions® of California conduct audits in two ways: (1) record review audit and (2) on-site audit. The Special Investigations Unit (SIU) conducts the majority of its audits through record review audits. This entails requesting a sample of records from the provider to compare against claims submission records. The initial sample size is based on the following: 5

records or 5%, whichever is greater, of the total number of ValueOptions® of California members served by the provider during the requested audit sample date span. If a conclusion can not be determined based on the initial sample provided, ValueOptions® of California reserves the right to request additional records, which may include all identified ValueOptions® of California members served by the provider, for the date span of the audit. (The provision of these files for audit purposes is a requirement of the provider contract.) Failure to supply requested documentation or cooperate with the SIU Investigation could result in disciplinary action for breach of the provider contract, including loss of participating status (i.e. termination or disenrollment from the ValueOptions® of California provider network and/or the recoupment of funds previously paid on claims associated with the audit period (i.e. 12 month span, 24 month span, etc). The scope of audit varies based on state and contractual requirements. Clinical files pertaining to members of ValueOptions® of California should be maintained for the time period detailed in your provider agreement.

Providers must supply copies of requested records to ValueOptions® of California within the time notated, which is typically ten (10) calendar days, however, the allotted time in which to return records can vary and is based on the number of records SIU requests. *The following records must be provided even if associated with Psychotherapy sessions: Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.* ValueOptions® of California will treat your records confidentially. At the conclusion of the audit, records will be retained for the time period specified and/or destroyed according to ValueOptions® of California's record retention policy. Records are reviewed by our Special Investigations Unit, and as necessary with consultation of appropriate members of our Clinical and Quality Teams. These records are compared against the claims submissions to verify the accuracy of the claims submissions. The SIU completes a review of the records and reports its findings to the provider in writing. If additional records are required based on the initial review, ValueOptions® of California will send notification requesting those additional records.

Notification of Findings

In the event that improper or fraudulent billings are identified the SIU and ValueOptions® of California send a detailed written report detailing findings including a required Action Plan with specific recommendations. These recommendations may include but are not limited to:

- **Provider Education** – Working with our Provider Relations team, the SIU department develops an educational program that will review the deficiencies identified, and provide tools to assist the provider in correcting these concerns and work towards full compliance with ValueOptions® of California requirements as well as state and federal regulations as applicable.

- Corrective Action Plan – The SIU may require that the provider submit a Corrective Action Plan (CAP) clearly identifying steps the provider will take to meet ValueOptions® of California standards and correct all identified deficiencies. Within this CAP, the provider will detail his/her understanding of our findings, willingness to carry out all recommendations by ValueOptions® of California, and a timeframe that all changes will be completed. Generally, a provider is allowed up to thirty (30) calendar days to complete this requirement.
- Repayment of Claims Funds – The SIU and ValueOptions® of California will specify a repayment requirement, if any, with the Action Plan. The repayment amount will be based on the actual deficiency determined in the sampling process. The provider will be responsible for paying the actual amount owed based on ValueOptions® of California findings. Once any Action Plan has been delivered, additional documentation will not be considered for the purpose of adjusting the original claims repayment amount. Required repayments must be made within (10) business days unless an installment payment plan is approved. A provider has the right to dispute the determination. The Provider Dispute guidelines are described in ValueOptions® of California’s policies and procedures. You can obtain a copy of these policies by contacting the Provider Relations Department or under the *Provider Dispute and Member Grievances* section of this same Handbook.
- Monitoring – ValueOptions® of California may require additional monitoring of claims submissions and treatment record standards for a period of six (6) to twelve (12) months.

Provider Non-Compliance

ValueOptions® of California respects its partnership with its network providers and will work with our providers in an effort to handle SIU cases. Failure to comply with SIU Action Plans may result in the following, as appropriate:

- Network Termination - When issues of abusive or inappropriate billings are not resolved by our network providers, ValueOptions® of California will recommend to the VOC Credentialing Committee immediate termination of said provider from our networks.
- State and/or Federal Referral - ValueOptions® of California will report any suspicion or knowledge of fraud and/or abuse that requires an external investigation to the appropriate authorities. ValueOptions® of California will cooperate fully in any investigation or subsequent legal action that may result from an investigation. ValueOptions® of California and its providers are required to make available to investigators any administrative, financial, and medical records such investigators may require.

Fighting fraud and abuse strengthens and preserves ValueOptions® of California services to providers and members and enhances the health care delivery system as a whole.

Abuse or Inappropriate Billing Examples

ValueOptions® of California defines abuse as any practice, direct or indirect, that is inconsistent with sound or established fiscal, business, insurance, or medical practices and results in an unnecessary cost to a behavioral health benefits program. It also consists of reimbursement for services performed that are not medically necessary or that fail to meet professionally recognized standards for health care. A provider may or may not have knowingly and/or intentionally misrepresented facts to obtain payment. Abuse also includes any practices by a member that results in unnecessary costs to a behavioral health program.

Abusive billing or practices involve payments for services or items when there is no legal entitlement to that payment even though the provider did not intentionally misrepresent facts to obtain payment. Under certain circumstances abuse may constitute or evolve into fraud. Some examples of abuse are as follows:

- Inappropriate balance billing;
- Inadequate resolution of overpayments;
- Lack of integrity in computer systems;
- Failure to maintain confidentiality of information/records;
- High utilization of procedures or tests not medically necessary;
- Providing services that are not medically necessary;
- Providing poor quality medical services;
- Unbundling/exploding charges (e.g., the unpacking and billing separately of services that would ordinarily be all-inclusive);
- Coding a service at a higher level than what was rendered (i.e. up-coding);
- Violation of provider agreement by provider;
- Breaches of provider agreement that result in members being billed for amounts not allowed by ValueOptions® of California;
- Failure to collect coinsurance and deductible amounts;
- Excessive charges for services;
- Inappropriate documentation of services rendered.

Fraud Examples

Some of the more common forms of fraud include:

- Submitting claims for services that were not provided. This includes billing for “no shows” or canceled appointments (i.e. billing ValueOptions® of California for services which were not actually rendered because the member failed to keep their appointments).
Note: If appropriate documentation is on file, the member may be billed directly for a “no show” or canceled appointment;
- Misrepresenting the diagnosis for the member in order to justify payment;

- Utilizing split billing schemes (i.e., billing procedures over a period of days when all treatment occurred during one visit);
- Altering a claim form to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (i.e., paying for a referral of members in exchange for ordering of diagnostic tests, other services, or supplies);
- Duplicate billing in an attempt to gain duplicate payment (e.g. this can involve billing multiple claims to ValueOptions® of California or billing a claim to both ValueOptions® of California and another insurer in an attempt to gain duplicate payments);
- Billing for a service not furnished as billed;
- Participating in schemes that involve collusion between a provider and a member;
- Billing for non-covered services as covered services (CPT codes);
- Billing based on “gang visits” (i.e., a provider visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to, or on behalf of, individual members);
- Knowing misuse of provider identification numbers that results in improper billing;
- False or fraudulent filings of claims;
- Members providing false information for potential gain;
- Misrepresenting the service rendered, place of service, date of service, etc.;
- The acceptance of, or failure to return, monies allowed or paid on claims known to be false or fraudulent;
- Intentionally failing to provide needed medical services;
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment;
- Billing for services by a provider for services actually rendered by an affiliated (i.e. employed or associated with same group, etc.) provider who is not a contracted or credentialed provider of ValueOptions® of California.

Responsible Parties

Those who might perform such acts may include, but are not be limited to, a provider, a hospital, an agency, an organization, or other institutional provider, an employee of a provider, a billing service, a member, or any person in a position to file a claim for behavioral health benefits.

Documentation Standards

Claims must be supported by adequate documentation of the treatment services rendered. ValueOptions® of California defines treatment record standards under the *Participating Provider Responsibilities* section of this same Handbook. Strict adherence to these guidelines is required. A member’s medical record must contain documentation to substantiate the billed services. The lack of documentation will result in denial of benefits, or, if payment has already been issued, recovery of payment.

Waiving Member Responsibilities

Co-payment	That portion of a charge for services that must be paid by a member and is not covered by the member's benefit program. Providers are not allowed to bill members for charges not covered by the member's benefit plan aside from any applicable co-payments and deductibles.
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Waiving a co-payment, coinsurance, or a deductible, if the member's benefit's requires one, changes the fee. If you file a claim listing your usual and customary fee of \$100.00, but you plan to waive the \$20.00 co-payment, your fee is really only \$80.00, in the view of the health plan. Accordingly, the provider has misstated the fee to the health plan, and that misrepresentation can constitute either fraud or a false statement within the meaning of the Portability Act.

Network providers must collect applicable deductibles, coinsurance and/or co-payments from the member at the time of services. ValueOptions[®] of California will reimburse the network provider the balance up to the fee schedule maximum or negotiated rate or the billed charge (whichever is less) for covered services upon receipt of a clean claim form in compliance with ValueOptions[®] of California policies and procedures.

Eliminating Fraud and Abuse

To eliminate fraud and abuse successfully, providers, facilities, and members must work together to prevent and identify inappropriate and potentially fraudulent billings. This can only occur by:

- Monitoring claims submitted for compliance with billing guidelines;
- Adherence by providers and facilities to Treatment Record Standards;
- Education of all staff members responsible for dealing with medical records (including documentation, storage, retrieval, or review) or who are involved with billing; and
- Referring cases of suspected fraud and abuse.

Reporting Fraud and Abuse

Reports of fraud and abuse, or suspicions thereof, can be made by sending written responses to:

ValueOptions[®] of California
Claims Liaison/SIU Coordinator
P.O. Box 6065
Cypress, CA 90630