

FAQ for Behavioral Health providers regarding audit process

1. What is the process providers should expect to follow in an audit?

For reviews scheduled on or after July 1, 2015, agencies will receive notification of the audit via certified mail. The notification will provide information on the process and how to provide delivery of the documents for audit via hard copy within two weeks of notification. Provision of the complete member records should include documentation for all billed dates of service (DOS) under review to include, but not limited to, all pertinent assessments, evaluation/management notes, service orders, treatment plan(s) associated with the service period under review, progress notes, medication records, rating scales, crisis/safety plans, discharge summary, etc. Providers are also required to provide a completed Employee Listing form inclusive of all staff rendering care during the record review period. Please note, in addition to submitting hard copy records, providers are now able to submit electronic copies by contacting the Behavioral Health Review Helpline at 1-888-507-0709 to request electronic uploading access and provide the following information:

- Provider name
- Contact name
- Email address
- Phone number

Upon receipt of member records, Alliant Georgia Medical Care Foundation (GMCF) will initiate desktop record review and issue a report of findings to Amerigroup Community Care.

Following receipt of the Audit Findings Report, depending on the outcome of the audit, Amerigroup staff will contact the agency to schedule a follow-up meeting to review findings. In the event that significant concerns of quality of care, or probable fraud, waste and abuse are identified, Amerigroup actions may include recoupment, immediate suspension or termination from the network and/or referral to Special Investigations Unit (SIU) and/or Medicaid Fraud Control Unit (MFCU).

2. What do providers need to have prepared ahead of a scheduled audit?

As noted above, a complete service record for all billed DOS for identified members via hard copy is required, along with a completed Employee Listing form.

Additionally, documentation of supervision for any supervisee/trainees rendering care for members during the period under review is required. Please note, documentation of supervision is described by O.C.G.A. 43-10A-3 as, "a contemporaneous record of the date, duration, type (individual, paired, or group), and a brief summary of the pertinent activity for each supervision session." Supervision must be completed monthly. Documentation of supervision for the previous month must be in the employee file by the tenth day of the following month. For example, January supervision must be recorded by February 10.

3. In addition to clinical records, what other documentation may be reviewed in an audit?

Please see above, regarding the Employee Listing form and supervision documentation.

4. What is the timeline to receive feedback on audit results and what method is used to deliver these results?

Amerigroup is targeting approximately 45 business days for provider follow-up meetings; however, this timeline is dependent upon review findings, provider availability and mutual scheduling needs. For audit reviews that do not require any additional processing, provider follow-up meetings may take place in person or teleconference.

5. Is there an audit tool or checklist that can be used by providers to prepare for audits?

There is not a formal audit tool for distribution. Our audit vendor leverages Section III, Documentation Requirements, of the Georgia Department of Behavioral Health and Developmental Disabilities manual, which can be found at <http://dbhdd.org/files/Provider-Manual-BH.pdf>, along with the Amerigroup Provider Manual Behavioral Health Addendum, the provider contract, and corporate and state policy guidelines to assess compliance or deficiencies.

The auditor completes a “Yes –Compliant/No – Deficiency Noted” review based on the standards outlined in the aforementioned resources. In instances of deficiency (example: IRP missing or deficient), additional drill down is provided in the Audit Report (example: the IRP with the start date September 9, 2013, is not signed by the individual/guardian), along with the policy citation(s) resulting in the noted deficiency.

6. What is the process of review/scoring and how are scores reported? Is there an exit interview or other feedback prior to final results being issued?

Amerigroup will not include an audit scorecard as part of our provider review process at this time. Post audit review meetings will generally include:

- A high level summary of audit findings
- Detailed claim level reporting findings
- Billing profile information
- A discussion of general clinical management findings

This information will be provided to develop a better understanding of agency practices and standards of operation, and to support Corrective Action Planning where indicated. As noted in question 1, paragraph 3, based on the outcome of the audit findings, next steps following audit may include discussion of review finding, provider education, corrective action planning, recoupment, referral to SIU/MFCU or immediate termination

7. What is the process for Corrective Action Planning?

Based on audit outcomes, a Corrective Action Plan (CAP) may be required for submission to Amerigroup within 14 calendar days following the Post Audit Follow-up meeting. The CAP should include any request for reconsideration of audit findings and the specific area that is being appealed along with the rationale for opposition of audit findings. No additional records will be accepted in appealing audit findings. Only findings for those records initially delivered to Alliant may be disputed.

8. Is there a specific time frame that will be reviewed in an audit?

At this time, we will review 12 months of claims with a three-month claims run-out period to ensure a comprehensive claim file is available. In addition to the member record review, a 24-month billing profile will become part of the provider review discussion for reviews completed after July 1, 2015.

9. What do I do if I disagree with the audit findings?

If you disagree with audit findings, you may request an administrative review. Your request for administrative review must be submitted in writing and received within 14 days following your Audit Findings Meeting with the Amerigroup team. The request must include all grounds for appeal and must be accompanied by any supporting documentation and explanation that the provider wishes to be considered. Additional clinical documentation beyond what was originally submitted will not be considered.

Failure to comply with the requirements of administrative review, including failure to submit all necessary documentation within 14 days following your Audit Findings Meeting shall constitute a waiver of any and all rights for further consideration concerning the matter in question.

All correspondence concerning administrative review should be sent to the following address:

Alliant GMCF
Attention: BH Review Team
P.O. Box 105337
Atlanta, GA 30348

10. What is the appeals process if I want to appeal the administrative review?

For recoupable deficiency findings, Amerigroup will forward a claims report to the Amerigroup Cost Containment Unit. Each provider has the right to submit a formal dispute.