MEDICAID PROVIDER BULLETIN
July 2017

Alliant Health Solutions collaboration

Summary: Effective July 1, 2017, Anthem Blue Cross and Blue Shield Medicaid has contracted with Alliant Health Solutions to assist in validating provider compliance with applicable health care policies and identify instances of incorrect billing and/or medically unnecessary or inappropriate services. Through the use of proprietary software, Alliant Health Solutions includes roster review, desktop audits, claims patterns and trend analysis, statistical summaries, and comparative data reporting to support provider education and prevent/reduce risk of inappropriate utilization and/or billing practices. Utilizing systematic sampling methodology and a broad range of algorithms, the audits will be customized to support specific policies and expectations as outlined in the Anthem Blue Cross and Blue Shield Medicaid provider manual, *Clinical Practice Guidelines*, medical necessity criteria, and the general requirements of the state licensing agencies.

Providers will be notified 14 business days in advance of record retrieval requests. Records can be submitted by mail, electronic media or by submitting electronic copies via an upload.

Provider cooperation with our behavioral health quality management program is essential to ensure compliance with state and federal requirements to prevent fraudulent or abusive health care billing practices.

Please see the attached *Frequently Asked Questions* document for more detailed information on this audit process.

Provider action

Please share this information with your office staff.

Questions

If you have questions about this communication, please contact your Provider Relations representative or the Provider Services department at **1-855-661-2028**.

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Behavioral health audit process FAQ

What is the process I should expect to follow in an audit?

You will receive notification of the audit via certified mail. The notification will have information on the audit process and how to deliver the requested documents via hard copy or electronic upload. Documents should be delivered within 14 business days of notification.

Complete patient records should include documentation for all billed dates of service (DOS) under review to include, but not be limited to:

- All pertinent assessments
- Evaluation and 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

You are also required to complete and submit an *Employee Listing* form inclusive of all staff rendering care during the record review period. You may request access to upload and submit electronic copies by contacting the Behavioral Health Review Helpline at **1-888-507-0709**. The following information will be required:

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

Upon receipt of patient records, our vendor partner Alliant ASO will initiate a desktop record review and issue a report of findings to us. Following our receipt of the *Audit Findings* report, our staff will contact your office to schedule a follow-up meeting and review findings. If significant concerns of quality of care or probable fraud, waste and abuse are identified, our actions may include recoupment, immediate suspension, termination from the network and/or referral to the Special Investigations Unit (SIU) and/or the Medicaid Fraud Control Unit (MFCU). In these cases, a follow-up meeting may not occur.

What do I 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 or electronic upload is required, along with a completed *Employee Listing* form. Please note that any assessments, treatment plans, orders for service, diagnosis verification, etc., completed for the patient before the audited DOS should also be included in the medical record submission.

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Additionally, documentation of supervision for any supervisee/trainees rendering care for members during the period under review is required. 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 2017 supervision must be recorded by February 10, 2017).

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

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.

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.

What is the timeline to receive feedback on audit results? What method is used to deliver these results?

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

Is there an audit tool or checklist that I can use to prepare for audits?

There is no audit tool or checklist available. Our audit vendor leverages the provider contract and corporate and state policy guidelines to assess for compliance or deficiencies.

The auditor completes a "yes, compliant/no, deficiency noted" review based on the standards outlined in the resources above. In instances of deficiency (for example, the integrated rating plan [IRP] is missing or deficient), additional drill-down is provided in the audit report (for example, "The IRP with the start date of September 9, 2013, is not signed by the individual/guardian"). Policy citation(s) resulting in the noted deficiency are also included.

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?

At this time, we will not include an audit scorecard as part of our provider review process. 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 practices and standards of operation and to support corrective action planning where indicated. Based on the outcome of the audit findings (as noted in the first question, paragraph four), next steps may include discussion

of review findings, provider education, corrective action planning, recoupment, referral to the SIU/MFCU or immediate termination.

What is the process for corrective action planning?

Based on audit outcomes, a corrective action plan (CAP) may be required for submission to us within 14 calendar days of the post-audit follow-up meeting. The CAP should include any request for reconsideration of audit findings, the specific area that is being appealed and 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.

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 calendar days of your audit findings meeting. The request must include all grounds for appeal as well as any supporting documentation and explanation(s) to be considered.

Note: 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 of 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 mailed to:

Alliant ASO
Attn: Behavioral Health Review Team
P.O. Box 105337
Atlanta, GA 30348

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

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

For more information about the appeals process, please refer to your provider manual, which is posted on the provider website.