OBJECTIVES:

1. To determine the propriety of claims reimbursed by the MO HealthNet (Medicaid) Program.

2. To determine compliance with applicable regulations:
   - 13 CSR 70-3.030
   - 13 CSR 70-91.010
   - 19 CSR 15-7.021
   - 19 CSR 30-82.060
   - RSMo 192.2495.2

3. To determine compliance with the MO HealthNet Division Provider Manuals for Homemaker, Personal Care, Consumer Directed Services, and Respite programs.

PROCEDURES:

PRELIMINARY:

1. Initiate the audit process by determining which provider will be reviewed. This may be based on complaints, referrals, exception reports, direction from supervisor, or geographical areas.

   - Review the Open Investigations report to be sure the investigations unit does not have any pending actions with the provider.

   - Check SURS to see when the last review was done. This screen should be printed and kept in the "Miscellaneous" folder of the provider file or a note can be done on the case narrative regarding whether a past review has been done and when. Check with Contracts Coordinator if in question about whether RAC, MIC or Medi Medi may be looking at this provider. Check provider in Case.net.

2. Once you have determined the case is not active with any other entity that may be in conflict with opening the case, initiate completing the pertinent sections of Tab 1 of the SURS 109A form. This information will populate to the Case Card. Forward the form to the Unit Supervisor for approval. Once the approval is returned via email, the email will need to be saved to the provider's electronic file in the "Miscellaneous" folder and note made to the SURS narrative that it was approved by the supervisor.

3. After approval and depending on the reason for opening the case, run the Truven (FADS) reports. The normal look back period is no more than 3 years from paid date due to the availability to view claims on the system. 5 years is the maximum look back period. The number of claims to review and the review period will depend on the reason for the review; how much time is needed to complete the review; or the number of claims in the review period. Be sure to include modifier 1 and 2 on the report to identify waiver participants. MMAC reports reviews of waiver participants to MHD to report to CMS. Be sure to review any AIDS WAIVER (U4) or MFAW (U5) participants that are found in the review period and notify your supervisor of your findings for the Waiver spreadsheet. Please reference the Aids Waiver and Medically Fragile Adult Waiver provider manuals.

4. The FADS report with the parameters will be saved in the "Miscellaneous" Folder. From this report the selected claims for review should be chosen. This will become your Claims Data report. This report will also need to be saved in your "Working Documents" folder as the case is being reviewed.

5. The SURS 109A should be forwarded to the appropriate clerical staff to assign a case number. Once a printed version of the case card is returned to the analyst, review for accuracy. A corrected case card must be printed if errors are found. Update the electronic version of the SURS with the case number that has been assigned. Updating the SURS Narrative should be a continuous process while doing a review.

6. Review the data to determine any obvious aberrant billing patterns. Analysts performing Home and Community Based reviews may select claims for review by using one of the following methods: (1) a one hundred percent (100%) review of all claims within a review group; (2) a random claim-by-claim selection, or (3) a 25% statistical sample.

   a) A report for all the participants in your review period should be run to identify all claims paid during the review period. This will allow you to review other services the participant is getting within your review period. You should review this report specifically for:
   b) Whether the consumer is receiving services through the state plan or another Waiver; the State plan services should be accessed and exhausted prior to the waiver being utilized. This information may be available by reviewing the claim history of each participant.
   c) Whether duplicate or overlap of services is being billed, i.e., inpatient hospital or adult day care while also billing Personal Care or state plan Personal Care and waiver Personal Care for the same dates of service. Total combined units may indicate more than 24 hours in a day. Look for improbable combinations of service.

7. Once the case is open, a decision needs to be made whether to perform an onsite or desk audit. The type of audit done is based on several factors. This should be discussed with the supervisor.

Below are instructions regarding all 3 types of audits:

INITIAL WORK for Onsite visit:

1. Determine the date of the on-site visit and which analyst(s) will be available for the review. Discuss dates and timing with supervisor. Prepare an itinerary.

2. Prep for onsite:
   a) Hotel reservations – the request should be sent to your supervisor who will forward to the Finance Unit.
   b) Car reservations – this can be done through the OA Car Reservation website
   c) Equipment reservations – laptop, scanner, state cell phone, etc. These can all be reserved through the Outlook Resources. A couple days before going onsite, log onto the laptop for proper security approval and check scanner settings.

3. Prepare the notification letter to be hand-delivered to the provider upon arrival at the audit site. Letter needs to be signed and a copy kept for the file. (See the end of this document for folder names and placement of items in each).

4. Prepare an alphabetical listing of participant files to be reviewed with participant name and Date of Birth. Attach a list of documents needed. See the Required Records Section, page 5 for documents that may need to be requested.

5. If providing a partial list of participants to the provider before arriving; make arrangements for how this will be done. This may be done via fax or email before you leave for the on-site review or have another employee email or fax when you have notified them that this can be done. It will be necessary to obtain the appropriate fax or email address from the provider. Inform the provider how many more records will be requested when you arrive.

6. Call the provider at least one day prior to your arrival. Inform the provider of your estimated arrival time and the time period being reviewed. Ask for a contact person for when you arrive and provide them information on how many reviewers will be on-site. Also, inquire about the necessary space for reviewers to work with scanners and laptops. Provide the partial list of participant records needed. Send the notification letter to the provider at this time.

7. Request a summary report from the Electronic Visit Verification (EVV) system. Request the key (code sheet) also be provided. Prepare the EVV Questionnaire for all audit of Personal Care, Homemaker Chore and Consumer Directed Service providers.

8. Prepare the Documentation Disclosure Statement.

9. Prepare the Billing Questions.

10. Prepare the Audit Summary Report. This may also be done on the 109A narrative.

11. Check the HCBS data base for satellite offices. Make sure the participants in the review are in the same area as the office where you are scanning records.

12. Check if the provider has a 27 number (reassessment number). If they are performing reassessments you need to ask the questions. See On-Site Visit.

13. Prepare the Exit Conference form.

ON-SITE VISIT:

1. Cordially introduce yourself and your team. Explain the review is routine and within the normal course of business. Present the audit notification letter and complete list of participants.

2. Document all questions/answers between the provider/staff and reviewer(s). Ask if they have a copy of the MO HealthNet manuals and bulletins and are aware of the Internet website. Document response and offer to follow up with assistance.

3. If noted during the preparation of audit that the provider's address has changed, inform the provider that it is their responsibility to get this updated with the Provider Enrollment Unit at MMAC. This can be done through the MMAC website.

4. Trace every service date on the Claims Data report to substantiating documentation and scan.

5. Compare the documentation and date of the service billed to the claim. If you are not sure of what a particular document looks like or signature, etc., be sure to ask. If a provider is using acronyms, ask them to explain what they mean or have them provide a key that explains them.

6. Do not assume that because you do not see it, that it is not there. Always ask if the document could be anywhere else, i.e., on the computer, in storage, another file, audiotape, etc. In addition, get their explanation of where records are or might be.

7. All MO HealthNet providers *must* retain for 5 years, from the date of service, fiscal and medical records that coincide with and fully document services billed to the MO HealthNet

Agency. These records *must be* furnished or made available for inspection or audit by the Department of Social Services or its representative upon request.

BEFORE LEAVING THE AUDIT SITE:

1. Complete the Billing Checklist by discussing billing procedures with the provider.

2. Establish that the provider has furnished all records/documents for review. Ask the provider to sign the Documentation Disclosure Statement.

3. If records are missing or the provider was unable to locate any records, make a note (on the disclosure form) regarding which records are missing. If the provider offers an explanation of why the records cannot be located, this information should also be noted on the form. If provider agrees to send any documents at a later date, this information should also be noted on the form. The provider should sign this document and a copy of it should be provided to the provider. Be sure to note the date the documents are to be received at MMAC.

4. Hold an exit conference if the provider desires and complete the Exit Conference Form. The discussion should only be general. Inform the provider the review is inconclusive at this stage. Do not try to put a dollar value on what the potential outcome may be. Review again the list of the missing documentation for the provider. Document the exit conference in detail **For audits after July 1, 2015, ask about EVV implementation efforts. How many participants are using EVV, problems implementing, problems with vendors, etc. Document the name of vendor.** Complete the EVV Questionnaire form. If EVV has not been fully implemented, ask why.

5. If the provider is billing for reassessments (27 number) you will need to ask the following during the exit conference. How many people in the office do reassessments? Get the person(s) name(s) that do reassessments. Ask who trained them. How long have they been doing reassessments? How many reassessments do they complete in a month? Get a copy of one assessment package they completed including the care plan. Record your conversation on the Exit Conference form.

6. Keep a detailed Audit Summary Report of events, circumstances, responses, and field findings.

RETURN TO THE OFFICE:

1. All documents received or scanned during onsite need to be saved to the appropriate provider file on the MMAC/ drive. This should be done within 3 business days upon return to the office.

2. Equipment used during on-site should be returned to the appropriate area. If there were any equipment issues, this needs to be reported to supervisor or appropriate personnel.

3. Complete any notes regarding on-site visit including a list of all MMAC personnel that went on the review, how long you spent on-site and any specific issues that were not noted in any other documents.

4. Scan the EVV questionnaire into the file and give the original to the supervisor within 1 business day of returning to the office. The supervisor will enter the information into the EVV spreadsheet.

DESK AUDIT:

1. Prepare the Request for Records letter to be mailed to the provider with the dates of service being reviewed and a deadline for receipt of records by MMAC. With the letter include:

a. List of participants being reviewed
b. Date of Birth
c. List of documentation required. See Required Records section, page 5.

2. Providers must make records available on a timely basis. MMAC requests that records be submitted within fifteen (15) business days from the date of the written request for records. If the provider fails to respond to the request, MMAC will make reasonable efforts to contact the provider by way of phone call, e-mail, fax, or by a second request for documents. The provider may be granted an extension of five (5) business days for good cause. A provider may have good cause in the following circumstances:
   a. The documents requested are difficult to access;
   b. MMAC is requesting a large number of records; or
   c. An MMAC supervisor determines that it would be in the best interest of the MO HealthNet program to allow more time.

3. If a provider fails to submit records as requested, MMAC may issue a recoupment of all claims that were reimbursed by MO HealthNet in the review period. This should be discussed with the supervisor before issuing a letter.

4. Depending on the preliminary findings of the desk audit, MMAC may initiate a full-scale on-site review. MMAC will notify the provider of the on-site visit.

5. An onsite visit must still be performed to assess EVV compliance before completion of the audit.

REVIEW OF SCANNED RECORDS:

The objective of the audit is to review the provider's documentation of services provided to ensure that claims for services were provided and documented as required.

1. Determine if paid claims are adequately documented in the provider's files.

2. Trace every service date, on the report of claims paid, to substantiating documentation and evaluate against program requirements.

3. As you are completing the review, note all violations found. The violations are found at 13 CSR 70-3.030. Once the review has been completed, these violations shall be reviewed for the appropriate sanction.

4. Once you have started the review and note there are documents missing which are required to complete the review, it may be appropriate to request the missing documents from the provider. Allow appropriate amount of time for them to furnish the information. You may need to discuss this with your supervisor.

5. The narrative on the SURS 109A should stay updated on the progress of your case and the amount of time needed for each step. Any contact with the provider should be recorded on the Report of Contact form and kept up to date in the provider's file.

ADEQUATE DOCUMENTATION:

All services provided must be adequately documented in the record. Refer to the Code of State Regulations, 13 CSR 13 70-3.030, Section (2) (A) for definitions of adequate documentation and adequate medical records.

REQUIRED RECORDS:

1. Care plan/webtool printout or LTACS for each participant that corresponds with the review period.

2. Any and all documents that support services billed to each participant for the dates of service in the review period. This may be timesheets, paper or EVV after dates of service July 1, 2015 or any other documents deemed necessary to complete the review.

3. Copies of the initial FCSR screening for each employee who provided services during the review period. This includes any good cause waiver requests and the outcome.

4. List of all employees who provided services during the review period to include:
   a. Complete name, current and former
   b. Home address
   c. Date of hire and date of first client contact and
   d. Termination date if applicable.

5. Documentation to support all Authorized RN visits.

6. May request one complete participant and one employee file while on-site.

For Quality Assurance Purposes:

a. Request documentation for 2 employees/attendants that verifies initial and ongoing training requirements were met. This includes classroom and on the job training. Request any waivers of training and the supporting documents.

b. Request verification of current liability insurance and a dishonesty bond. Record the information on the IHS-CDS QA log.

Personal Care, Homemaker, and Respite Services

1. Documentation for services delivered must include the following:
   - The participant's name;
   - The date of service delivery, including year;
   - The time spent providing the service. Time spent is defined as follows: the actual clock time the aide began the services for each visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time;
   - A description of the service (the specific activities or tasks performed); (not needed for respite) and
   - The name of the aide who provided the service.
   - The signature of the participant for each date of service. If the participant is unable to sign, the following substitutions are acceptable:
     - The mark of the participant witnessed by the full signature of at least one person (who may be the Personal Care Aide);
     - The full signature of another responsible person present in the participant's house at the time of the service; and/or

- The full signature of the Personal Care Aide, if the participant is unable to sign and there is no other responsible person present.

  (Note: The requirement for the signatures is waived if using EVV.

2. A full 15 minutes of direct service for each unit of service paid, including time spent completing work vouchers and obtaining the participant's signature must be documented. Time spent in the delivery of service of less than 15 minutes for any participant may be accrued to establish a full unit of service, but only through the last day of the month in which the services were rendered. Rounding is not allowed.

   (Reference 13 CSR 70-91.010(4)(A) and 19 CSR 15-7.021(24)(A)2; Section 13.7.D of the Personal Care Manual, and Section 13.6.D of the Aged and Disabled Waiver Manual.)

Advanced Personal Care (APC)

1. Advanced Personal Care tasks must be documented using the same criteria as is required for Personal Care tasks.
2. Determine the aide performing APC tasks is qualified to do so. An APC aide must:
   - Be a Licensed Practical Nurse (LPN); or
   - Be a Certified Nurse Assistant (CNA); or
   - Be a competency evaluated home health aide who has completed both written and demonstration portions of the test required by the Missouri Department of Health and Senior Services and 42 CFR 484.36; or
   - Has successfully worked for the provider for a minimum of three consecutive months while working at least 15 hours per week as an in-home aide that has received Personal Care training.
3. Determine the aide performing APC tasks received proper training. Examine the aide's personnel file for the following:
   - Documentation of 8 hours of classroom hours of APC training, including dates and topics, completed prior to the provisions of any APC tasks; OR
   - Documentation of any waiver of the 8 classroom hours of APC training. The 8 classroom hours may be waived.
   - If the proposed APC aide is a LPN or CNA currently licensed or registered in the state of Missouri.
   - If the proposed APC aide has previously completed APC training from a Medicaid or SSBG in-home provider agency, and the aide has been employed at least half-time by a MO HealthNet or SSBG provider as an APC aide within the previous six months; AND
   - Signed statement(s) by an RN certifying the aide has successfully completed on-the-job training for **each** APC task the aide is required to perform. (This requirement may be waived only if the APC aide is a LPN.)

   (Reference 13 CSR 70-91.010(5)E), Section 13.9 of the Personal Care Manual)

Authorized Nurse Visit

Documentation of the authorized nurse visit is the written notes and observations maintained in the participant's file. A unit of service is the visit. No minimum or maximum time is required to

constitute a visit. With the exception of performing on-the-job training and competency testing for APC aides, the authorized nurse visit may be provided by a LPN if under the direction of a RN.

(Reference 13 CSR 70-91.010(6)(E) and (6)(F), Section 13.8 of the Personal Care Manual)

Consumer Directed Services (CDS)

- The spouse may not provider CDS services.
- There are no authorized nurse visits in the CDS program.
- Aides may provide transportation to CDS clients. Transportation will be authorized In the care plan and should be documented on the timesheet/EVV.

For Quality Assurance Purposes**:**

a. Check for evidence that the consumer was trained by the Provider. Pull two files.
b. Check that the appropriate tax forms have been completed and turned into the employer. Pull two files.

(*Reference 19 CSR 15-8.100 to 19 CSR 15-8.400, 19 CSR 30-82.060 and RSMo 192.2495.2)*

UPON COMPLETION OF THE REVIEW:

1. Complete the Program Violation and Sanction Recommendation to determine the appropriate sanction to be imposed for any violations found. The final outcome may include one or more administrative actions: provider education, overpayment, other agency referral, suspension or termination.

2. If the final outcome includes overpayment, compute the overpayment and prepare the appropriate overpayment letter and attachments:
   a. Prepare the explanation of errors identified in the review; this will be sent to the provider as Attachment A. Identify each error with an alpha letter. This attachment may include only errors that result in overpayment, only education, or a combination of both.
   b. Assign the error code and the related overpayment to the correct claim on a clean copy of the Claims Data report. The final version of this report will be sent to the provider as Attachment B.
   c. If the overpayment has been computed by statistical sampling prepare Attachment C, Computation of provider overpayment using statistical sampling.
   d. Prepare the correct decision letter. Templates for all letters are saved in the Letters folder on the PI drive.

3. If the final outcome is no errors, proceed with the correct letter (no errors) and close case. Follow case closure procedures.

4. If the final outcome is education only, proceed with the correct letter.

5. If the final outcome results in an overpayment or suspicious activity was found, complete the Referral to Investigations Form.
   a. Submit the overpayment letter, Attachment A and B and the Referral to Investigations form to your supervisor electronically for review and approval.
   b. Once you have received the supervisor sign off on the investigations referral, the referral may be given to the investigations unit. Update the 109 with the date of referral to

investigations.

c. If Investigations accepts the case, a delay in sending the decision letter will occur. An update to the Case Narrative with investigative acceptance should be done. Hold further action on the case until investigations returns it. If the case is referred to MCFU and it is accepted, proceed with closure of the case.
d. If Investigations declines the case, the final, signed decision letter, Attachments A, B, and/or any other attachments need to be scanned and saved to the provider's file in the Final Decision Letter and Attachments folder. At this point, the original signed document and attachments can be given to clerical to be mailed out by certified mail. The ART number should be sent to clerical for the certified card along with the provider type.

6. Complete the Accounts Receivable Transmittal (ART). Forward this to Finance upon notification that the provider has received the final decision letter. SURS Only is reported when either staff or the provider voids the claims. Analysts should track their own ARTS within an ART log. No later than 30 days after the final decision letter has been mailed identifying an overpayment, the analyst should check the post office website to determine if delivery was made if they have not been contacted by the provider, have not received returned mail or the certified green card has not been received. The ART should be transmitted to Finance only after confirmation that the provider has received the notice. Provider Enrollment should be notified of any returned mail.

   - Every ART has a unique ART number and if you require new numbers, contact the MMAC Finance Unit for additional numbers.

7. Complete the SURS-109A documentation. Send the 109 to clerical to close the case. The case is considered closed once any determination letter has been sent. The date of the determination letter is the closed date.

8. After all forms are updated, scan all documents to the MMAC drive under the appropriate file. Be sure to have the signed copies of all documents scanned.

9. For in home providers, log training information on the training spreadsheet. Complete the EVV spreadsheet for any services verified by an EVV report.

10. Send electronic notification to the supervisor indicating case is ready to close and review. The supervisor will complete review of all electronic documents saved for the case, print the supervisor check off sheet, fill out appropriate information and sign. The completed check off sheet from the supervisor will indicate the case is approved for closure.

11. Retain the file for 30 days. If at the end of 30 days, the case has not been appealed, the case should be ready to be scanned into the MMAC drive. Give the check off sheet to clerical staff along with the location of the provider file. Any documents not already scanned should be given to clerical at this time to be scanned into the electronic file.

    - If the case is appealed, move the entire case to the "Cases under Appeal" folder. You will want to keep any hard copies of the file until completion of the case.

12. Once the staff has completed scanning your file and notified you this has been completed, review the scanned file to ensure everything was saved appropriately. Once completed, you may delete the file from your list of providers and shred any paper documents.

13. Follow-up on the ART to make sure recoupment/repayment takes place timely. Follow up on

plan of corrective action. All plans of corrective action require a written response to the provider.

14. The analyst needs to save the final copy in the provider's folder, "ART, Repayment Agreement, POC".

15. The analyst is responsible for following the recovery of the case. If the provider proposes a repayment plan, discuss this with your supervisor.

16. Be sure to add the provider name/number, case date opened/closed, and action to your individual case log.

DOCUMENTATION/FOLDER PLACEMENT:

All documentation should be filed in the MMAC drive under the analyst's name in the following folders. Not all folders may pertain to the case, so only use the folders needed to maintain the documentation retained for the case. Cases should remain on the MMAC drive until the 30 day appeal period has passed. If no appeal is filed, notify clerical the case is ready to be moved to the scanned case file and delete from the analyst's folder. If appealed, move the file to your appealed cases folder on the MMAC drive.

1. 109-A and Sanction Recommendation – This folder includes the entire 109-A document which includes the SURS page, SURS narrative, Provider or Special Project case card, Referral to Investigations form and Supervisor Closed Case Checklist, along with the Violation and Sanction recommendation.

2. ART, Repayment Plan and Plan of Corrective Action – This folder includes all versions of the ART, emails to and from Finance, signed Repayment Plan, Plan of Corrective Action, copy of checks and any ICN listings sent with ART.

3. Consultant (optional) – This folder includes a copy of everything sent to the consultant and everything returned.

4. Desk Review – (only for desk review) This folder includes medical record requests, list of consumer records requested, Request for Employee Information, and the Document Disclosure Statement.

5. Employee Information – This folder includes FCSR information and training documents.

6. Final Decision Letter and Attachments – This folder includes the PDF of signed letters and attachments, which includes rescission letters, revised letters and scan of green card(s) and anything else the provider received.

7. Investigative Reports – This folder includes the Referral returned from Investigations and Investigative Report if present.

8. Miscellaneous – This folder includes anything pertinent to the case that needs to be kept. Referrals to licensing, email for approval to open case, signed settlement agreement, completed supervisor check off list, Excel version of final Attachment B, parameters for running Truven (FADS) report, print off of SURS Analyst page to check prior cases, provider enrollment printout, provider payment summary, final case card from clerical, etc.

9. On-Site Documentation – (only for on-site review) This folder includes the Notice of Audit letter, Billing Interview Form, Audit Summary, if done, Exit Conference Form, Document

Disclosure Statement, Request for Employee information, etc.

10. Prepayment Review (optional) – This folder includes the 5-A memo, PPR letter to provider, PPR forms, education letters.

11. Report of Contact – This folder includes documentation of all phone calls to and from providers, copy of emails, faxes, returned mail and envelope. The actual emails and faxes shall be named by date. This is a running report to keep going until case is closed.

12. Reviewed records – This folder includes all the documentation used in the review, which includes records, timesheets, care plans, EVV reports, etc.

13. Working file – This folder includes all documents in progress before finalization of review, which includes spreadsheets, drafts/unsigned letters, notes, worksheets, etc.
    Please reference the Provider Review Procedure Manual for further instructions.