Provider Self-Auditing Form

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Background: The Pennsylvania Medical Assistance (MA) Provider Self-Audit Protocol* advises providers participating in Pennsylvania's MA program of three methods for conducting self-audits in order to return identified overpayments and improper payments of MA funds:

Option 1 - 100 Percent Claim Review
Option 2 - Provider-Developed Audit Work Plan (**CBH Pre-Approval Required**)
Option 3 - Statistically Valid Random Sample (SVRS) (**CBH Pre-Approval Required**)

*Pennsylvania MA Provider Self-Audit Protocol:
http://dhs.pa.gov/learnaboutdhs/fraudandabuse/medicalassistanceproviderselfauditprotocol/index.htm

Instructions: There are two CBH documents required by the CBH Compliance Department for providers completing self-audits:

1. **Provider Self-Auditing Form**

   The **Provider Self-Auditing Form** contains details of the self-audit and must be completed by CBH providers.

   CBH Pre-Approval Process
   Providers conducting self-audits using Option 1 do not require pre-approval and must complete and submit the **Provider Self-Auditing Form** once the self-audit is completed. For Options 2 and 3, Providers must complete items 1-17 in the **Provider Self-Auditing Form** and receive written approval from the CBH Compliance Department before initiating a self-audit. A time frame for the completion of the self-audit will be included in the written approval.

2. **Claims Overpayment Spreadsheet**

   The **Claims Overpayment Spreadsheet** must be completed for any identified overpayments or improper payments that are to be returned to CBH. A time frame for the completion of the self-audit will be included in the written approval. A separate attestation must be completed for the Claims Overpayment Spreadsheet.

   Providers may also send supplemental documentation to the CBH Compliance Department in addition to (but not in replacement of) the Provider Self-Auditing Form and the Claims Overpayment Spreadsheet.

Submit documents via secure email to CBH.ComplianceContact@phila.gov with the subject line "Self-Audit." If unable to send secure emails, please contact SIU Supervisor Lauren Green at lauren.green@phila.gov or 267-602-2208. Documents may also be submitted to the following mailing address:

Attn: Lauren Green, Compliance Department
Community Behavioral Health (CBH)
801 Market Street, 7th Floor
Philadelphia, PA 19107

Provider Self-Auditing Form

PROVIDER CONTACT INFORMATION

Begin by clicking once on the first field (e. g. Pick a Date). Tab to the next field. There is a character limit to each field. If additional space is needed, add content at the end of this document in Question #22.

Date this Form was Submitted to CBH:	
Provider Name:	
Provider Medical Assistance Identification Number (MA ID, 13-digit number): *Additional Space Provided if Necessary*	
Provider Address (Address Line 1, Address Line 2, City, State, Zip):	Address Line 1 Address Line 2 City State Zip
Provider Telephone Number:	
Name and Title of Designated Contact Person:	
Contact Information for Designated Contact Person (Telephone 1, Telephone 2, Email Address):	**ext.** Telephone 1 Telephone 2 Email Address
Secondary Contact Person (Name, Telephone, Email Address): *Provide if Necessary*	Secondary Contact Person Name **ext.** Telephone 1 Email Address

DISCOVERY

- **Date the concern was identified:**

- **Describe the events that prompted the decision to self-audit. Include how the concern was discovered (e. g. routine record review, employee tip, referral from an outside organization):**

3. **Type(s) of service involved:**

4. **Identify if the concern involves specific staff (or contractors), a group of staff persons, a program, a provider site, or if the concern is agency-wide if applicable. Provide Information about specific staff or contractors identified (include full name(s) and license information):**

5. **Specify if this matter is currently under inquiry by a government agency, another BH-MCO, or in active litigation:**

DISCOVERY (CONTINUED)

6. Method for conducting the self-audit (check one option):

○ **OPTION 1 - 100 Percent Claim Review –** The Pennsylvania MA Provider Self-Audit Protocol states, "[a] provider may identify actual inappropriate payments by performing a 100 percent review of claims…recommended in cases where a case-by-case review of claims is administratively feasible and cost-effective."

○ **OPTION 2 - Provider-Developed Audit Work Plan** – The Pennsylvania MA Provider Self-Audit Protocol states, "[w]hen not administratively feasible or cost-effective for the provider to conduct a 100 percent claim review, a provider may identify and project inappropriate payments pursuant to a detailed work plan." **This option requires CBH pre-approval**.

◉ **OPTION 3 - Statistically Valid Random Sample (SVRS) –** The Pennsylvania MA Provider Self-Audit Protocol states, "[a] provider may identify and project inappropriate payment amounts by conducting a self-audit in accordance with DHS pre-approved methodology." **This option requires CBH pre-approval.**

IF CHOOSING OPTION 1 - 100 PERCENT CLAIM REVIEW, CONTINUE TO QUESTION #18 ON PAGE 7.

IF CHOOSING OPTION 2 - PROVIDER-DEVELOPED AUDIT WORK PLAN

OR

IF CHOOSING OPTION 3 - STATISTICALLY VALID RANDOM SAMPLE (SVRS) PLEASE CONTINUE WITH QUESTION #7 ON THE NEXT PAGE 5 AND FOLLOW INSTRUCTIONS TO OBTAIN CBH PRE-APPROVAL.

PROPOSED AUDIT AND SAMPLE DETAILS

7. Dates of service impacted by concern (date range):	**8. Proposed dates of service for the self-audit (date range):**
9. Number of clients impacted by concern:	**10. Proposed number of clients in sample:**
11. Number of claim lines impacted by concern (sampling frame):	**12. Proposed number of claim lines in sample:**

13. Provide a description and rationale of proposed self-audit plan (explain why the sampling frame, dates of service, sample size, and audit tool(s) were selected; identify staff involved):

14. Name software tool(s) to select sample (if applicable):

PROPOSED AUDIT AND SAMPLE DETAILS (CONTINUED)

15. **CBH may assist the provider in identifying payments that have been made by CBH, developing SVRS, and implementing the self-audit. Identify the type of assistance if needed:**

16. **Identify immediate action taken to reduce the likelihood of reoccurrence (e. g. changes to internal policies and procedures, staffing, training, internal compliance plan):**

17. **Anticipated completion date of self-audit:**

*SUBMIT PAGES 1-6 TO CBH COMPLIANCE FOR **PRE-APPROVAL** FOR OPTION 2 - PROVIDER-DEVELOPED AUDIT WORK PLAN OR OPTION 3 - STATISTICALLY VALID RANDOM SAMPLE (SVRS).*

FOLLOWING THE COMPLETION OF THE PROVIDER SELF-AUDIT, SUBMIT REMAINING PAGES 7-9 TO CBH COMPLIANCE ALONG WITH THE CLAIMS OVERPAYMENT SPREADSHEET.

SELF-AUDIT RESULTS

18. **List summary of findings (3-7 sentences). Include the overpayment dollar amount to be returned to CBH as a result of the self-audit (if applicable):**

19. **Describe how the sample size was determined. Include dates of service reviewed (date range).** *For providers that submitted an AUDIT WORK PLAN or STATISTICALLY-VALID RANDOM SAMPLE to CBH for pre-approval, identify any changes from the original proposal:*

20. **List service verification methods used (e. g. client surveys, phone calls, staff interviews). Include the number of clients and / or staff contacted or interviewed:**

SELF-AUDIT RESULTS (CONTINUED)

21. **Identify corrective action taken to reduce the likelihood of reoccurrence (e. g. changes to internal policies and procedures, staffing, training, internal compliance plan). Include HR action applied to any staff or contractor as a result of the self-audit (e. g. termination of employment or contract, notifying staffing agency.** *For providers that submitted an AUDIT WORK PLAN or STATISTICALLY-VALID RANDOM SAMPLE to CBH for pre-approval, identify any changes from the original proposal:*

22. **Additional information:**

ATTESTATION

TO BE COMPLETED BY AN AUTHORIZED AGENT OF PROVIDER ORGANIZATION

I hereby state and verify that the facts and information set forth in the foregoing Provider Self-Auditing Form are true and correct to the best of my knowledge, information and belief. I understand that any misleading statements or material omissions will result in an Event of Default under my Community Behavioral Health Provider Agreement and may result in partial or full termination of my in-network status with Community Behavioral Health. I also understand that the statements made in Provider Self-Auditing Form are subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities.

Typed Name/Title/Date: _____

Signature/Title/Date: _____

Acceptance of payment by CBH does not constitute agreement as to the amount of loss suffered, or agreement regarding compliance with federal and state laws, regulations, and policies relating to the MA program.

FOLLOWING THE COMPLETION OF THE SELF-AUDIT, SUBMIT THIS FORM TO THE CBH COMPLIANCE DEPARTMENT ALONG WITH THE CLAIMS OVERPAYMENT SPREADSHEET FOR ANY OVERPAYMENTS OR IMPROPER PAYMENTS THAT ARE TO BE PAID BACK TO CBH. RELEVANT SUPPORTING DOCUMENTATION MAY ALSO BE SUBMITTED (E. G. SCREEN SHOTS, DOCUMENTATION, ENCOUNTER FORMS).