Background

The Pennsylvania **Medicaid Provider Self-Review Protocol** advises providers participating in the State's Medicaid program of two methods for conducting self-audits in order to return identified overpayments and improper payments of Medicaid funds:

- Option 1: 100 Percent Claim Review
- Option 2: Provider-Developed Review Work Plan (CBH pre-approval required)
  - A work plan proposing the use of a statistically valid random sample (SVRS) is classified under Option 2

Instructions

There are two CBH documents required by the CBH Program Integrity 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: The 100 Percent Claim Review does not require pre-approval and you must complete and submit the Provider Self-Auditing Form once the self-audit is completed. For Option 2 (including SVRS), providers must first complete pages 1-5 in the Provider Self-Auditing Form and receive written approval from the CBH Program Integrity Department before initiating a self-audit. A timeframe for the completion of the self-audit will be included in the written approval.

2. **Overpayment Spreadsheet**

   The **Overpayment Spreadsheet** must be completed for any compliance-related overpayments or improper payments that are to be returned to CBH.

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

The CBH Program Integrity Department can assist with the secure submission of self-audit documents. Email **CBH.ComplianceContact@phila.gov** with the subject line "Self-Audit" to notify that a self-audit is being initiated, when ready to facilitate the secure submission of self-audit documents, and with any questions about the self-audit process.

Submission Date	

Provider Contact Information

Provider Name		Provider MA ID #	
Address Line 1		Address Line 2	
City/ST/ZIP		Phone	
Contact 1 Name		Contact 1 Title	
Contact 1 Phone		Contact 1 Email	
Contact 2 Name		Contact 2 Title	
Contact 2 Phone		Contact 2 Email	

Discovery

1. Date the concern was identified:

2. 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. Provide information about specific staff or contractors identified (include full names and license information).

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

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

☐ Option 1: 100 Percent Claim Review

The Pennsylvania MA Provider Self-Review 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 Review Protocol states, "when it is 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." A work plan proposing the use of a statistically valid random sample (SVRS) is classified under Option 2. Option 2 requires CBH pre-approval.

If choosing Option 1, continue to page 6, question #18.

If choosing Option 2, continue to the next page and follow instructions to obtain CBH pre-approval.

Proposed Audit and Sample Details

7. Date range of service impacted by concern:

8. Proposed date range of service for the self-audit:

9. Number of members impacted by concern:

10. Proposed number of members 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 the 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 any software tools used to select samples.

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

16. Identify any 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:

For CBH pre-approval of Option 2, securely submit pages 1-5 to CBH Program Integrity Department.

Following the completion of the self-audit, securely submit remaining pages 6-7 to CBH Program Integrity Department along with the Overpayment Spreadsheet.

Self-Audit Results

18. List a summary of findings (3-7 sentences). If applicable, include the overpayment dollar amount to be returned to CBH as a result of the self-audit.

19. Describe how the sample size was determined. Include dates of services reviewed (date range).
For providers that submitted an audit work plan to CBH for pre-approval, identify any changes from the original proposal.

20. List any service verification methods used (e.g., member surveys, phone calls, staff interviews). Include the number of members and/or staff contacted or interviewed.

21. Identify any corrective action taken to reduce the likelihood of reoccurrence (e.g., changes to internal policies and procedures, staffing, training, internal compliance plan). Include HR actions 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 to CBH for pre-approval, identify any changes from the original proposal.

22. Additional Information:

Attestation

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 CBH Provider Agreement and may result in partial or full termination of my in-network status with CBH. I also understand that the statements made in the Provider Self-Auditing Form are subject to the penalties of 18 Pa. C.S.A. § 4904 relating to unsworn falsification to authorities.

Authorized Signature: _____ Date: _____

Print Name and Title: _____

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

Following the completion of the self-audit, securely submit this form to the CBH Program Integrity Department along with the Overpayment Spreadsheet for any overpayments or improper payments that are to be paid back to CBH. Relevant supporting documentation may also be securely submitted (e.g., screenshots, documentation, encounter forms).