COMPLIANCE	ASPIRE HEALTH PLAN	Effective Date: 01/01/2022	
		Policy #: AHP-CO040	
	Special Investigation Unit (Provider Requirements)	**Review Date:** 12/20/2023	**Applicable to:** ☑ Medicare Advantage ☐ Commercial ☐ Anthem HMO ☐ Blue Shield Trio
	Approver's Name & Title	Anthony Serrano – Compliance Officer	

1.0 PURPOSE

1.1 The purpose of this policy is to inform our providers of the functions of the Special Investigations Unit (SIU) at Aspire Health Plan (AHP). AHP values the relationship with our providers and wishes to provide transparency into the process we follow if we audit claims submitted by your practice to fulfill our obligations to actively detect and investigate improper payments related to potential fraud, waste, and abuse (FWA). This policy is applicable to all contracted and non-contracted providers.

2.0 POLICY

2.1 AHP delegates the SIU function to a third-party services vendor, Integrity Advantage. This vendor functions as the SIU on behalf of AHP to support detection, investigations, and medical review. It is the Plan's policy to always comply with applicable Centers for Medicare and Medicaid (CMS), Federal, State, and Local laws, all rules and regulations established by regulatory agencies, AHPs Corporate Code of Ethics and Business Conduct, and other written policies.

2.2 In all matters related to FWA, AHP follows applicable guidelines set forth by CMS. The specifics of these guidelines, as pertaining to lookback periods, appeals, and recovery, are further detailed in their appropriate sections below.

2.3 Investigations are conducted in a fair and impartial manner and may include interviews and/or internal document review on both the provider(s)/practice(s) and member(s) involved with the allegation.

3.0 PROCEDURE

3.1 LOOKBACK PERIOD

3.1.1 AHP follows CMS guidelines regarding the SIU review lookback period.

3.1.2 An overpayment must be reported and returned in accordance with this section if a person identifies the overpayment, as defined in paragraph (a)(2) of this section, within 6 years of the date the overpayment was

received.

3.1.2.1 https://www.federalregister.gov/documents/2016/02/12/2016-02789/medicare-program-reporting-and-returning-of-overpayments

3.2 IDENTIFICATION

3.2.1 The SIU investigates allegations of FWA and cooperates with investigations conducted by federal, state, and local authorities. The SIU proactively identifies potential FWA through data mining by comparing claim information and other related data to identify potential errors and/or potential fraud by procedure/prescription claim submitted.

3.3 MEDICAL RECORD REVIEW

3.3.1 If further investigation indicates that medical records must be requested, a statistically valid random sample (SVRS) of paid claims may be utilized for record selection. An SVRS is a sample which allows us to project the results of the sample to the claims population and estimate an overpayment. AHP uses the industry standard for sampling and extrapolation guidelines which is outlined by the Center for Medicare & Medicaid Services (CMS) and uses the U.S. Department of Health and Human Services statistical software, RAT-STATS, to determine appropriate sample sizes, randomly select sample units, and estimate inappropriate payments[1].

3.3.2 Once a sample of claims is selected for review, a letter will be sent to the provider requesting the associated medical records and other documentation related to the claims. The provider will have 30 days to submit the associated records for review. Extensions may be considered on a case-by-case basis with appropriate communication. If records are not received within the 30 days, claims will be considered not supported as billed and AHP may pursue recovery of the overpayments.

3.3.3 When records are submitted, medical record reviews are conducted by Registered Nurses (RNs), Licensed Professional Nurses (LPNs) and/or Certified Professional Coders (CPCs). Medical records are reviewed to determine if the services billed are supported, and whether they are billed in compliance with all applicable evidence of coverage, coding, and payment policies such as LCD/NCD, CPT/HCPCS/ICD-10 coding conventions, definitions, and rules. Reviews will also consider professional association recommendations from entities such as the American Medical Association, the American College of Surgeons, and more.

3.4 FINDINGS

3.4.1 If the findings indicate the services billed are not supported, an overpayment may be pursued. The SIU may pursue overpayments via one

[1] https://oig.hhs.gov/compliance/rat-stats/

or more of the following options:

3.4.1.1 Send an education letter to the provider
3.4.1.2 Pursue a refund of the overpayment identified
3.4.1.3 Offset future claim submissions until the amount owed is satisfied
3.4.1.4 Prepayment monitoring of future claims

3.5 OVERPAYMENT RECOVERY

3.5.1 SIU recoveries are sent to the following address:
Aspire Health Plan
10 Ragsdale Drive, Suite 101
Monterey, CA 93940
Attn: SIU

3.5.2 Should a provider not agree with the findings, appeal rights are outlined below in the Appeal section.

3.5.3 If a recovery is not received within 30 calendar days, a second reminder letter may be sent. Deviations from this process can be approved by AHP on a case-by-case basis. If we have not received any communication from a provider after 60 days from the date the first overpayment letter was received by the provider, AHP may impose a manual offset or adjustment.

3.5.4 AHP may offset if a provider (contracted or not contracted) agrees and would like to have the overpayment balance recouped in this manner. If so, an Offset Acknowledgement letter will be sent to the provider for signature. In the event AHP does not receive communication from a contracted provider, AHP may initiate an offset without the provider's agreement. AHP may determine that legal action should be initiated in cases where the provider has chosen not to repay an identified overpayment.

3.5.5 If AHP and the provider agree to settle on a lesser amount than was originally identified for recovery, SIU will prepare a Settlement Agreement that will be sent to the provider for signature.

3.6 APPEAL

3.6.1 For contracted providers, AHP will consider a one-time appeal of the initial findings.

3.6.2 An appeal must be received within 30 days of the initial findings letter.

3.6.3 The appeal must be in writing and outline which specific claims the provider would like to have reconsidered.

3.6.4 If an appeal is not received within 30 days, AHP will consider this as an acknowledgement of the findings and pursue any overpayments as noted above.

4.0 REGULATORY REQUIREMENTS AND REFERENCES

4.1 Medicare Managed Care Manual

Managed Care Chapter 21 and Chapter 9 Compliance Program Guidelines | Guidance Portal (hhs.gov)

4.2 Medicare Program Integrity Manual

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033