Table of contents

Corporate and Financial Investigations Department

The Corporate and Financial Investigations Department (CFID) is responsible for the prevention, detection, and investigation of all potential areas of fraud, waste, and abuse against AmeriHealth. The CFID accomplishes this through the auditing and investigation of Providers and pharmaceutical-related services. When appropriate, the CFID seeks financial recoveries of overpaid claims and submits these claims for correct adjudication. The CFID is comprised of the following:

- CFID Support
- Financial Investigations
- Professional Provider Audits
- Facility Provider Audits
- Ancillary Provider Audits
- Pharmacy Audits

CFID Support

CFID Support uses data-mining software to proactively identify aberrant claims, billing patterns, and trends across all AmeriHealth lines of business. CFID Support gathers and evaluates information from a variety of sources to support CFID:

- Sophisticated software data-mining tools analyze all categories of claims received, Provider demographics, and Member benefits to identify potential outliers that may warrant a further review by audit or investigation.
- Members and Providers can confidentially report concerns through the toll-free hotline, 1-866-282-2707, and our website, *www.amerihealth.com/antifraud*.
- Leads are received from internal business areas, as well as external law enforcement agencies, regulatory authorities, and industry specialists.

Financial Investigations

Financial Investigations evaluates all allegations of fraud, waste, and abuse involving Providers, Members, vendors, associates, and others. They use a wide array of investigative tools to:

- identify and investigate potentially fraudulent and abusive activities;
- make Referrals to federal, State, and local law enforcement for criminal and/or civil prosecution;
- make Referrals to regulatory authorities for violations of professional licensure;
- recover losses related to fraud and abuse;
- employ prevention techniques to decrease and eliminate future losses;
- make recommendations to terminate Providers for cause from in the AmeriHealth network.

Payment Integrity and Audit Overview

The Agreement between you and AmeriHealth includes language that allows AmeriHealth the right to audit medical and financial records related to Covered Services provided to our Members and the records related to the billing and payment for services rendered. Ancillary and

Professional Provider audits are conducted by AmeriHealth staff, which consists of registered nurses, medical coders, and claims experts, or by an independent audit firm engaged by AmeriHealth.

Payment Integrity and Audit reviews Professional and ancillary service provider billings to determine the presence of unsupported charges and to identify under-utilization and over-utilization of medical services, billing inaccuracies, unbundling of charges, inappropriate coding and any claims processing errors.

Medical record audits compare information from a provider's claim with the provider's medical and clinical documentation. Billing audits compare information from a provider's claim with Medical coding sources, such as Current Procedural Terminology (CPT) and Claims Payment Policy. Medical/billing audits will determine whether all medical/clinical items or services billed and paid to the provider are supported by provider's medical/clinical documentation and/or Medical coding sources through routine and ad-hoc audits, Payment Integrity and Audit can also help identify patterns of potential fraud, waste and abuse with support of the Financial Investigations team.

Payment Integrity and Audits may include and are not limited to:

- Excessive billed charges or incorrect coding for services
- Medical record review in support of services billed
- Unbundling, Items not separately payable or included in another charge
- Non-covered services per provider contracts or policies
- Systematic payment errors
- Payment for services that do not meet professionally recognized standards/levels of care
- Unit errors, duplicate charges and redundant charges
- Services non-covered or were not provided based on documentation
- Peer claim submission comparisons

Process

To conduct an audit, AmeriHealth takes these steps:

1. Reviews prepayment and post-payment claims.
2. Reviews billing and/or medical records, if necessary, for audit process.
3. Notifies Provider in advance of an onsite audit.
4. Communicates the audit results to the Provider through letter or statement of remittance.
5. Conducts Provider credit balance audits, such as access to current credit balance reports, and aged accounts receivable trial balances, for any account where AmeriHealth made payment as primary, secondary, or tertiary Payor.
6. Requires the Provider to repay any overpaid claims.
7. Allow Providers to dispute audit findings through a two-level review process*; this must be requested in writing.

For questions or concerns regarding specific audit communications, Providers should contact the CFID auditor listed on the audit communication.

To check the status of a claim or submit a claim review request, please use the Claim Search transaction within Practice Management on the Provider Engagement, Analytics & Reporting (PEAR) portal. If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

**This two-level review process is limited to reviews of the AmeriHealth initial audit findings and is separate from the Provider claim appeal or Member appeal process.*

Production of records and examination under oath

When requested by AmeriHealth or designated representatives of federal, State, or local law enforcement and/or regulatory agencies, Providers shall produce copies of all medical/financial records requested within 30 days. Providers will permit access to the original medical/financial records for comparison purposes within the requested time frames and, if requested, shall submit to examination under oath regarding the same.

If a Provider fails or refuses to produce copies and/or permit access to the original medical records within 30 days as requested, in addition to other remedies, AmeriHealth reserves the right to retract payment for these claims until medical records are furnished.

Documentation requirements for durable medical equipment services

The AmeriHealth durable medical equipment (DME) documentation requirements are consistent with the Centers for Medicare & Medicaid Services documentation requirements, which underscore the importance of securing and retaining documentation. If required documentation is not available on file to support a claim at the time of an audit or record request, AmeriHealth may seek repayment from the DME supplier for claims not properly documented.

Documentation requirements for DME include the following:

- Before submitting a claim to AmeriHealth, the DME supplier must have on file a timely, appropriate, and complete order for each billed prescription order item that is signed and dated by the Member's servicing Provider.
- Proof of delivery is required in the medical record and must include a contemporaneously prepared delivery confirmation or Member's receipt of supplies and equipment. If delivered by a commercial carrier, the medical record documentation must include a copy of delivery confirmation. If delivered by the DME supplier/Provider, the medical record documentation must include a copy of delivery confirmation that is signed by the Member or caregiver. All documentation must be prepared at the same time as delivery and be available to AmeriHealth upon request.
- The DME supplier must monitor the quantity of accessories and consumable supplies that a Member is actually using and contact the Member regarding replenishment of supplies no sooner than approximately seven days prior to the delivery/shipping date. Dated documentation of this Member contact is required in his or her medical record. Delivery of the supplies should be done no sooner than approximately five days before the Member would exhaust his or her on-hand supply.

Report fraud, waste, and abuse

If you suspect health care fraud, waste, or abuse against AmeriHealth, we urge you to report it. All reports are confidential. You are not required to provide your name, address, or other identifying information. You have three options for submitting your report:

1. **Submit** the *Online Fraud & Abuse Tip Referral Form* electronically at *www.amerihealth.com/antifraud*.
2. **Call** the confidential anti-fraud and corporate compliance toll-free hotline at 1-866-282-2707.
3. **Write** a description of your complaint, enclose copies of supporting documentation, and mail it to:

   AmeriHealth
   Corporate and Financial Investigations Department
   1901 Market Street, 42nd Floor
   Philadelphia, PA 19103