Listed below are the items required for your Pre-contractual Audit

All Desktop documents are due by the date specified in the Notice of Pre-Contractual Audit Letter.

| **DESKTOP** | **ON-SITE** | **DELEGATION OVERSIGHT** |
| --- | --- | --- |
| 🗸 |  | * Biographical Information |
| 🗸 |  | * Sub-Contracted Service by Facility/Agency |
| 🗸 |  | Prepare for the audit by having the following information available: |
| 🗸 |  | **All sections** of the DOA tool documented with **road mapping** instructions for each element |
| 🗸 |  | Organizational chart(s) |
| 🗸 |  | Current job descriptions as relevant to audit |
| 🗸 |  | Delegation agreements with any sub-delegated provider |
| 🗸 |  | Ownership and Control Documentation |

The following is a list of items needed to prepare for the Offsite and Onsite audit.

| **DESKTOP** | **ON-SITE** | **Quality Management** |
| --- | --- | --- |
| 🗸 |  | Program, Plan and Description **(Desk Review)\*** |
| 🗸 |  | Committee meeting minutes from last 12 months to include agenda, sign-in sheet (attendance) and signed confidentiality statement: **(Desk Review or On-site Review)\* :** |
| 🗸 |  | * Recommendation of policy decisions |
| 🗸 |  | * Review and evaluation of QI activities |
|  |  | * Practitioner participation in the QI program through planning, design, implementation or review |
|  |  | * Identification and follow up of needed actions |
| 🗸 |  | Annual Work Plan **(Desk Review)\*** |
| 🗸 |  | Annual QM Program Evaluation **(Desk Review)\*** |
| 🗸 |  | Semi-Annual Reports for Health Plan **(Desk Review)\*** |
| 🗸 |  | Standards of Medical Care Access Policy and Procedure **(Desk Review)\*** |
| 🗸 |  | Notification of Termination policy and evidence that members were notified of practitioner termination |
| 🗸 |  | Continued Access to Practitioners policy and evidence that the delegate followed policy requirements |
| 🗸 |  | Sample supportive documentation or materials such as studies, audits, and surveys completed during the reporting period |

| **DESKTOP** | **ON-SITE** | **UTILIZATION MANAGEMENT** |
| --- | --- | --- |
| 🗸 |  | Program, Plan and Description **(Desk Review)\*** |
| 🗸 |  | Sample Annual Work Plan |
| 🗸 |  | Sample Annual Program Evaluation |
| 🗸 |  | Policies and procedures **(Desk Review)\*** |
| 🗸 |  | Committee minutes from last 12 months:  **(Desk Review)\*** |
| 🗸 |  | 1. Board of Directors |
| 🗸 |  | 1. Utilization Management Committee |
| 🗸 |  | 1. Subcommittee Meeting Minutes |
|  |  | Annual Inter-Rater Reliability Audit |
| 🗸 |  | Two examples that demonstrate the use of Board Certified consultants to assist with determinations  **(** |
|  |  |  |
| 🗸 |  | Criteria for Length of Stay and Medical Necessity used during the past 2 years  **)\*** |
| 🗸 |  | Fifteen (15) redacted referral files to include Denials, Modifications, Cancellations and Approvals; |
| 🗸 |  | Utilization Management statistics from the last twelve (12) months |
| 🗸 |  | Evidence that the Affirmative Statement has been distributed to providers and employees who make UM decisions |
| 🗸 |  | Evidence, other than via a denial letter, that the providers have been notified that they may contact a physician reviewer to discuss denial decisions |
| 🗸 |  | Sample Provider communications from last 12 months |
| 🗸 |  | Semi-Annual Reports for last 12 months |
| 🗸 |  | Evidence of current license for Providers (Doctor of Medicine (MD)/ Doctor of Osteopathic Medicine (DO)) and Employees (Registered Nurse (RN), Licensed Vocational Nurse (LVN)) who make UM Decisions |
| 🗸 |  | Copies of most recent mailroom policies |

## Utilization Management

| **DESKTOP** | **ON-SITE** | **CARE MANAGEMENT** |
| --- | --- | --- |
| 🗸 |  | Program Plan and Description |
| 🗸 |  | Care Management Policies and Procedures |
| 🗸 |  | Five (5) Redacted CM files with all required attachments |
| 🗸 |  | Five (5) sample cases of Carve Out/Waiver Programs |
|  |  |  |
| 🗸 |  | Five (5) sample cases with documentation of coordination of care with county mental health clinics for Members receiving specialty mental health services in accordance with California-specific measure CA1.7 on Care Coordination |

## Care Management

| **DESKTOP** | **ON-SITE** | **CREDENTIALING (Look back period of)** |
| --- | --- | --- |
|  |  | NCQA Certification, if applicable |
|  |  | Policies and procedures |
| 🗸 |  | Sample Credentialing meeting minutes including date and voting attendees from the look back period, which may include, but not limited to, references from: **(DesktopReview) (Virtual Review)** |
| 🗸 |  | 1. Quality Management Committee minutes |
| 🗸 |  | 1. Credentialing Committee minutes |
| 🗸 |  | 1. Peer Review Committee minutes |
| 🗸 |  | 40 Credentialing Files selected by Delegate |
| 🗸 |  | 40 Recredentialing files selected by Delegate |
| 🗸 |  | Evidence of Ongoing Monitoring of Sanctions |
| 🗸 |  | Practitioner files of those terminated for quality issues |
| 🗸 |  | Practitioner files that have appealed a decision |
| 🗸 |  | **Sample Delegation Agreements with any sub-delegated provider** |
| 🗸 |  | HIV/AIDS Annual Survey |
|  |  | Policy and File review will include, but not limited to, review for the following items: (Visual Review)(Desktop Review)   * Performance Monitoring; * Medicare Opt-Out Review; * Medicare Exclusions/Sanctions; * Medi-Cal Suspended & Ineligibility; * Reporting to Authorities; * Fair Hearing Panel Composition; * Assessment of Organizational Providers; * Delegation Agreements for all Sub-Delegation Arrangements; * Human Immunodeficiency Virus (HIV/AIDS) Identification Process; * Drug Enforcement Administration (DEA) Verifications within one hundred and eighty (180) calendar days; * Work History verification within one hundred and eighty (180) calendar days; and * Hospital Admitting Privileges. |
|  |  | Delegate must submit a spreadsheet of all organizational providers. IEHP will select credentialing and recredentialing files and the delegate may provide their spreadsheet tracking mechanism or file for the file audit |
|  |  | Credentialing delegation data, if applicable |
|  |  | Health Delivery Organization Tracking Mechanism for A |

| **DESKTOP** | **ON-SITE** | **CLAIMS** |
| --- | --- | --- |
| 🗸 |  | Policies and Procedures |
| 🗸 |  | Contracts Boilerplate(s) for: |
| 🗸 |  | 1. PCP’s, Specialists, Ancillary Providers, Hospitals |
| 🗸 |  | Blinded Claims Sample: |
| 🗸 |  | 1. 15 Paid (See Claims Sample Detail Below) |
| 🗸 |  | 1. 5 Denied (See Claims Sample Detail Below) |
| 🗸 |  | 1. 5 Provider Payment Disputes (See Claims Sample Detail Below) |
| 🗸 |  | Sample Reports and Logs: |
| 🗸 |  | 1. Paid Claims (See Claims Sample Detail Below) |
| 🗸 |  | 1. Denied Claims (See Claims Sample Detail Below) |
| 🗸 |  | 1. Provider Payment Disputes (See Claims Sample Details below) |
| 🗸 |  | 1. Pended Claims (See Claims Sample Details below) Open |
| 🗸 |  | 1. Claims/Inventory (See Claims Sample Details |
| 🗸 |  | 1. Overpayments (See Claims Sample Details below) |
| 🗸 |  | 1. Check Mailing Attestation Log (See Claims Sample Details below) |
| 🗸 |  | 1. Redirected Claims (See Claims Sample Details below) |
| 🗸 |  | Claims Processing Systems Review |
| 🗸 |  | Operational Review |

## Claims

| **DESKTOP** | **ON-SITE** | **COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM (Look back period of 1 year)** |
| --- | --- | --- |
| 🗸 |  | Compliance policies and procedures |
| 🗸 |  | Fraud, Waste and Abuse Policies and procedures |
| 🗸 |  | Sanction/Exclusion Screening Process policies and procedures |
| 🗸 |  | Standards/Code of Conduct |
| 🗸 |  | Copies of Compliance and FWA Training provided during the audit period |
| 🗸 |  | Compliance Committee Meeting minutes from the last 12 months to include agenda and sign-in sheet (attendance) |
| 🗸 |  | Annual Compliance Work Plan |
| 🗸 |  | Annual Audit and Monitoring Plan  If one does not exist, please complete Tab A-A&M Activities Universe of Compliance and FWA Audit Tool. |
| 🗸 |  | Annual Risk Assessment Report |
| 🗸 |  | Employee Universe: Submit in excel a list of all current employees, including job title, department and start date who have performed job duties related to IEHP's lines of business. This includes anyone with administrative responsibilities in managing the IPA in any capacity, including but not limited to, UM, claims, Case Management, compliance staff, Medical Directors, and anyone with clinical decision-making authority. The definition of employees includes full and part time employees as well as temporary employees, interns, or volunteers. Members of the Governing Body/Board of Directors should also be included. Refer to *Employee Universe* Template |
| 🗸 |  | Downstream Entity/Subcontractors Universe: Submit a list of all downstream entities/subcontractors contracted with the IPA and/or MSO anytime during the audit period, including Individual/Entity Name, detailed description of services providedcontract start and end dates, Refer to tab B. *Universe\_Subcontractors* of the Compliance and FWA Audit tool for required template. |
| 🗸 |  | A sample\* of (10) ten employees (5 hired within the audit period and 5 hired prior to the audit period): will be selected from the Employee Universe by the IEHP Auditor for which evidence of the following will be requested.   1. New Hires: 2. Pre-hire exclusion check of the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), and Medi-Cal Suspended & Ineligible Provider List (S&I) 3. Completion of Compliance, FWA, within ninety (90) days of hire or start. 4. Standards/Code of Conduct distribution 5. Established Employees: 6. Monthly exclusion checks performed of OIG LEIE, GSA SAM, and Medi-Cal S&I for a sample of (3) three consecutive months. 7. Completion of Annual Compliance and FWA training |
|  |  | A sample of five (5) audits and/or monitoring activities will be selected from the IPA’s Audit and Monitoring Plan or A&M Activities Universe. Evidence of the following will be required: **(Desk Review)\***   1. Results/Findings Reports 2. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors and corrective actions were developed and implemented, as applicable. |
|  |  | A sample of three (3) Downstream Entities/Subcontractors will be selected in tab 4. File Review\_FDR Oversight. Evidence of the following will be required: **(Desk Review)\***   1. Auditing or monitoring oversight activities; 2. Activity outcomes were reported to an oversight body, senior leadership, and/or the board of directors; and corrective actions, if applicable. |

## COMPLIANCE AND FRAUD, WASTE AND ABUSE PROGRAM

## (Look back period of 1 year)

|  |  |  |
| --- | --- | --- |
| **DESKTOP** | **ON-SITE** | **HIPAA PRIVACY PROGRAM** |
| 🗸 |  | HIPAA Privacy Program policies and procedures |
| 🗸 |  | Copies of HIPAA Privacy Training provided during the audit period |
| 🗸 |  | Privacy Incident Universe: Submit a list of reported suspected privacy incidents impacting IEHP lines of business. Include reports such as but not limited to, hotline reports, walk-ins, on-line reports, incidents reported to regulators, and/or investigation outcomes. Include incidents that were received and/or closed during the audit period. Refer to tab A*. Universe\_Privacy Incidents* of the HIPAA Privacy tool for required template. |
| 🗸 |  | A sample\* of 10 employees (5 hired within the audit period and 5 hired prior to the audit period) will be selected from the *Employee Universe* by the IEHP Auditor for which evidence of the following will be requested: New Hires:   1. Completion of HIPAA Privacy & Security Training upon hire/start 2. Completion of Confidentiality Statement prior to access to PHI 3. Established Employees: 4. Completion of HIPAA Privacy & Security Training 5. Annual completion of Confidentiality Statement |
| 🗸 |  | A sample of five (5) privacy incidents will be selected from the *Privacy Incidents Universe*. Evidence of the following will be required:   1. Date incident was reported to the Privacy/Compliance Officer; 2. Completion of a Risk Assessment for issue/investigation; 3. Notification was sent to IEHP with HIPAA BAA Requirements of discovery of a suspected breach; and 4. Corrective actions taken, if applicable. |

| **HIPAA PRIVACY PROGRAM** |
| --- |

1. completion of Confidentiality Statement

| **DESKTOP** | **ON-SITE** | **IT SECURITY** |
| --- | --- | --- |
| 🗸 |  | The name of the medical management system(s) used for the utilization management, care management, and claims functions. |

|  |
| --- |
| IT SECURITY |

**Note: \*- Denotes items to be sent to IEHP for desk review prior to the audit.**

**Claims Sample Details**

|  |  |
| --- | --- |
| Applicant Entity Name: | |
| Audit Date: |  |
|  |  |
| PROVIDE THE FOLLOWING DOCUMENTS FOR CLAIMS REVIEW: | |
| 1 | **Paid/Denied (5 paid non-contracted provider clean claims; 5 paid non-contracted provider unclean claims; 5 paid contracted provider claims; 3 denied claims with member liability; 2 denied claims with provider liability; include a mix of inpatient & outpatient hospital, emergency claims, professional, radiology, labs, anesthesia claims paid/denied in past 90 days)** |
|  | a. Actual Claim Form and supporting documentation submitted with claim |
| b. Provider explanation of benefits or remittance advice for claims |
| c. Copy of check with documentation regarding date the check was cashed |
| d. Denial letters |
| e. Acknowledgement of Receipt or Proof of Date Entered in System |
| f. Any correspondence and/or pertinent information related to the claim, including evidence of medical review, eligibility screens, authorizations, information request letters, overpayment/adjustment requests, claim appeal documentation, original claim information for provider payment disputes (including claim and EOB/RA), documentation of overpayment requests, applied overpayments (refunds or retractions), etc. |
| g. Copy of fee schedule or contract rate applied to each claim. This can be in the form of a page from a contract or a screen print identifying the type of schedule applied (i.e., Medi-Cal, Medicare, etc.). For non-contracted providers, a copy of the policy identifying basis for payment. |
| h. Copies of contracts or letters of agreement for any providers of service wherein provider has agreed to upcoding or downcoding of services rendered; claims submission or payment timeframes that supersede regulatory requirements; or retraction of overpayments, if applicable. |
| 2 | **Provider Payment Disputes (5 provider payment disputes; include a mix of favorable & unfavorable disputes for contracted & non-contracted providers within past 90 days)** |
|  | a. Provider payment dispute and supporting documentation |
| b. Original Claim (face sheet with date of receipt visible) and EOB/RA |
| c. EOB/RA of the Dispute |
| d. Written Notice of the dispute |
| e. Other supporting documentation or correspondence pertinent to the outcome of the dispute and related adjustment, as applicable. |

**Report /Log Required Fields**

|  |  |
| --- | --- |
| Type of Report | Required fields |
| Paid Claims | * Member name * Member ID# * Date of Service * Provider of Service * Provider Contract Status * Amount Billed * Date claim received * Claim Number * Amount paid * Date claim paid * Age of claim |
| Denied Claims | * Member Name * Member ID # * Date of service * Provider of service * Provider Contract Status * Amount billed * Date claim received * Claim Number * Date claim denied * Reason for denial * Age of claim |
| Pended Claims | * Member name * Member ID# * Date of service * Provider of service * Amount billed * Date claim received * Claim Number * Date claim pended * Pend Reason (must separately identify requests for ER Notes, Medical Records and all other information) * Age of claim * Processor Initials |
| Open Claims/Inventory | * Member name * Member ID# * Date of Service * Provider of Service * Amount Billed * Date claim received * Status of claim |
| Overpayments | * + Member Name   + Member ID#   + Original Claim #   + Date original claim Paid   + Provider of service   + Provider Contract Status   + Date of request for overpayment   + Date overpayment processed in System   + Recovery Type (i.e., withhold, refund, none)   + Total Dollars Recovered |
| Provider Payment Disputes | * + Date of Service   + Original Claim #   + Date Provider Payment Dispute Received   + Provider Payment Dispute Claim #   + Date Provider Payment Dispute Acknowledged   + Provider of Service Submitting Payment Dispute Request   + Determination Decision (i.e., upheld, overturned, goodwill)   + Date Provider Payment Dispute Resolved   + Date Dispute Payment Made |
| Redirected Claims | * Date Received * Billing Provider of Service * Date of Service * Patient Identifier (name, ID#, etc.) * Date Redirected * Where Redirected * Claim # (if applicable) |
| Check Mailing Attestation Log | * Check # * Check Date * Check Amount * Payee * Signature * Title of Signee * Date Mailed |