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###### **Procedure Name: Internal Audit Process**

**Purpose**

To ensure adequate documentation of services provided exists and can be accessed to support the subsequent billing by this agency for those services provided.

# Detailed Procedure(s)

* Agency staff, immediately upon hire, are charged with the responsibility of ensuring that their documentation is at all times accurate and truthful, and that it appropriately reflects the level of service(s) provided in accordance with the Person We Serves’ respective service/program plan.
* This documentation is monitored / reviewed on a daily basis per the agency’s Proof of Services  Procedure.
  + All new hire staff are required to participate in new hire Documentation Training and current staff are required to acknowledge their understanding of documentation standards on an annual basis as disseminated through the Staff Development Department
* As a result, the Quality Management Department has developed and implemented a routine internal monitoring system for all its programs; especially all those that are funded by Medicaid.
* Each program begins with a 100% sample audit. However; based on two consecutive successful audits, the same pool is then modified to a 50%, 25% or 10% audit base.
  + Each audit period covers a 6-month period span and is consecutive to the previous 6-month sample that was audited.
  + It is by this means that each segment of a calendar year is audited at some level.
  + At present, the Quality Management Department conducts both a “Current Audit” and its traditional 6-month audit.
  + A “current audit” is defined as taking a sample of 6 records from the program and auditing one full month for each of those files. The months selected are the immediate previous 6 months. For example, File A’s file will be audited for January, File B’s file for February, etc.
  + A current audit is conducted to provide more immediate corrective action to any anomaly noted vs. what can traditionally be accomplished during a routine 6-month audit. Routine 6-month audits are traditionally a more historical look behind and cover the full 6 months for EACH file selected.
  + The purpose of the current audit is to identify potential concerns, correct them in the immediacy which in turn lends to the continued success/limit of issues that could arise during a traditional 6-month audit that is not as recent.
* Each agency program audited has an assigned audit tool that is developed in conjunction with all Federal and Medicaid mandates.
  + These audit tools are routinely updated by the Quality Management Department, in consultation with the agency’s Corporate Compliance Officer, as ADM’s and OMIG guidance documents are disseminated by the state.
    - This information is discussed at length with the QM Dept. audit team and Director for Quality Management and CCO to determine what, if any, changes to the tools much occur. In many instances, the need for the change is noted directly on the audit tool, providing a timeline as to when that specific mandate occurred.
    - Once these changes are determined, meetings with the respective program(s)/staff occur to ensure their awareness, knowledge and understanding of the necessary changes.
    - Meetings additionally provide training and instruction regarding the change in expectation of the audit tool prior to their next scheduled audit. Revisions to program related documentation forms are additionally reviewed / changes made.
    - All changes to audit tools are kept in centralized binder by the Records Retention Manager / Quality Management Department to provide a comprehensive timeline of this agency’s compliance with external Medicaid billing requirements.
    - The PARC audit system stands for (P) Perfect (A) Agency (R) Regulatory and (C) Compliance standards.
  + Subsequently, the noted program audit tool is based on all Compliance, Regulatory and Agency based standards; with each area of necessity assigned a (C), (R), or (A) respectively.
  + The number of (C), (R), and (A) areas are each assigned one “point”.
  + A programs success, and subsequent frequency of future audits is determined based on citations (points) received in each of these assigned areas. The less points earned during an audit, the more successful the audit is noted to have been.
    - It is important to note that these areas are weighted accordingly (i.e. Compliance expectations are deemed a more “serious” citation than that of an agency (A) expectation that was not met.)
    - The manner in which future audits are determined is as follows:
      * If during an audit, a (C) deficit is noted, resulting in a “point” noted on the form, the program automatically requires that a repeat audit of that program occur every two months until all (C) areas of concern are systematically rectified.
      * In some instances, the program may have the required Compliance document, however; did not have filed appropriately, to which it is the QM Department’s determination; that a repeat 2 month audit is not warranted. A miss-filing of a document is deemed more of a management issue vs. the program failing to have the required document all together. These determinations are at the discretion of the Quality Management audit team.
    - Citations in other areas such as (R) and (A) warrant less frequent re-audits. Any (R) Regulatory deficiencies noted will result in a 4 month audit schedule, with (A) Agency related deficiencies resulting in a 6-month audit schedule.
    - Programs that successfully have no citations in any of the three noted areas, over the course of 2 audit cycles, will move to an 8 month audit cycle and have achieved a “perfect” PARC audit.
      * However; in the event that during any audit, even of a program that has achieved an 8 month audit cycle, that a (C) issue is noted, the program has the potential to be returned to a 2 month audit cycle and must successfully show maintenance in all areas to return to a less stringent audit review.
  + The Quality Management Departments’ Records Retention Manager is charged with the responsibility of conducting the above noted audits per the defined audit schedule. Each sample is defined by the previously selected sample to ensure that the same files are not re-audited each time.
  + Subsequent source ~~d~~ocumentation is gathered for review and comparison for those services submitted to Medicaid for reimbursement.
* Once the necessary source documentation, POS forms, as well as billing documents are obtained, the Records Retention Manager begins the process of reviewing the services billed and subsequently compares these with the documentation that was used / referenced to support its billing.
* Each day during the identified audit period is evaluated for contact to ensure that it encompasses the necessary components that meet Medicaid billing requirements.
  + Such noted areas include the completeness, accuracy and quality of the following :
    - Service / program plan
    - Case Notes
    - Monthly Progress Note
    - Goal related tracking
    - Proof of Service Provision Sheet
    - Fire Drill Records
    - Medication Administration Records
* Each area of the audit tool reflects the necessary documentation for review. (e.g. Service Plan and it’s review for applicable dates, signatures of necessary parties, etc.) Base upon the success of the program, the supporting documentation is then awarded points as defined in the audit tool.
* Once the audit sample has been completed, the Records Retention Manager then summarizes her findings through the formal Internal Audit Report.
  + Just as with the tool, each area audited is outlined in the report with any concern in that area noted.
  + The audit tool will summarize the program/sites’ respective overall score as well as further define each areas success.
  + Each area is assigned a responsible party to which a corrective action must be submitted.
* The Internal Audit Report is then forwarded to the programs’ respective Management Team as well as to the Programs’ Director, Manager of the program and applicable supervisors, as well as to the Director of Quality Management, Corporate Compliance Officer as well as the program/sites’ respective Quality Management Specialist.
* As with any formal review, the audited program must submit to the Department of Quality Management a written Plan of Corrective Action to the issues noted within the report.
  + It is at the discretion of the audited site/program to request a meeting to formally discuss the findings should questions arise / clarification needed.
  + In most instances, these meetings do not occur as the program and their staff are well versed in the expectations of the audit expectations.
* The site/programs written plan of corrective action must be approved by the Department of Quality Management before the audit can be formally closed.
  + Any plan of corrective action submitted will be re-visited for its continued use; minimally at the next regularly scheduled review.
* Once the audit and corrective action have been completed, the Records Retention Manager then inputs all the audit results into a centralized database that outlines the success / progress, etc. of each area of the programs’ respective audit process.
* These “dashboards” are vital in determining the continued monitoring, development and improvement of the agency’s Proof of Service and Internal Audit control processes.

As noted above, during the course of an audit, if an error in this agency’s billing is discovered, formal contact to the agency’s Director for Quality Management and Corporate Compliance Officer must occur. It is the responsibility of the QM Record Retention Manager to complete the attached form, documenting the discrepancy / billing error noted to ensure that prompt and immediate correction can occur. This information is then provided to the Corporate Compliance Officer that begins this agency’s “Medicaid Overpayments Void Process”. (see protocol)