

Office of Program Integrity Operations and Procedures Manual



Revision Date 12/19/08

**Operations and Procedures Manual
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INTRODUCTION

In order to achieve the goals of deterring and detecting fraud and program abuse, improving operational quality and ensuring the provision of high quality care in the State public health system, the Arizona Department of Health Services (ADHS) has established a comprehensive corporate compliance program ("compliance program"). This program is administered by the designated Corporate Compliance Officer who is responsible for the general administration of the program and the Office of Program Integrity (OPI), which is responsible for deterring and detecting fraud and program abuse within ADHS, its contractors and subcontractors.

In accordance with the contractual requirements of ADHS with the Arizona Health Care Cost Containment System (AHCCCS), ADHS' compliance program includes the elements listed in 42 CFR §438.608 including a Compliance Plan, Compliance Officer, a Compliance Committee, training and education, communication, monitoring/auditing and written policies and procedures.

While the ADHS Corporate Compliance Committee provides oversight for the compliance program, this Operations and Procedures Manual is maintained by the OPI Office Chief and is approved by the Corporate Compliance Officer. General administrative changes and policy and procedure improvements are approved by the Compliance Officer. Substantive changes to the compliance program or instances where OPI policies or procedures are eliminated, substantially changed or waived, must be approved by the Corporate Compliance Committee or their designee. The following sections describe the compliance program and the established operational procedures for OPI.

POLICY Corporate Compliance (CC)

1. ADHS COMPLIANCE PLAN AND PROGRAM

- (a) The ADHS compliance program is based upon the ADHS Corporate Compliance Plan (“plan”). The compliance plan is intended to be a systematic process aimed at ensuring that ADHS, its contractors and subcontractors comply with applicable laws, regulations, standards and contractual obligations as related to detecting and deterring fraud and program abuse. The compliance plan serves as a guiding document in the development, implementation, evaluation and maintenance of all related fraud and program abuse operations and procedures, and it establishes a process for identifying and reducing risk and improving internal controls.
- (b) The compliance plan serves as:
 - (1) A high-level set of objectives for the organization’s corporate compliance activities.
 - (2) The guiding blueprint for development of related corporate compliance policies and procedures.
 - (3) Clear documentation that ADHS complies with required corporate compliance elements.
- (c) The compliance plan is under the direction of the ADHS Corporate Compliance Committee. The committee shall:
 - (1) Review and approve the compliance plan annually (July 1) to assure that it meets the requirements of the AHCCCS contract, 42 CFR § 438.608 and the needs of ADHS.
 - (2) Review and update the compliance plan as needed to address emerging trends and risks, changes in contracts and changes in State and Federal rules, laws and regulations.
 - (3). See Attachment A for the current compliance plan.

2. COMPLIANCE COMMITTEE

- (a) The purpose of the ADHS Compliance Committee is to provide high-level oversight and direction for the compliance program.
- (b) The Compliance Committee’s responsibilities are:
 - (1) To understand ADHS compliance program policies/procedures and to provide this information to each functional area and its employees and to ensure effective communication and understanding regarding fraud and program abuse detection and deterrence.

POLICY Corporate Compliance (CC)

- (2) To interface with the ADHS Director and Deputy Directors in regards to fraud and program abuse deterrence and detection efforts.
 - (3) To review the compliance plan annually and as needed to assure that it is meeting the needs, requirements and contractual obligations of ADHS relating to fraud and program abuse.
 - (4) Providing feedback to OPI regarding emerging fraud and program abuse trends and areas of in the public health community.
 - (5) Reviewing relevant OPI investigative and audit reports in order to become aware of findings and how those findings affect the functional areas and customers of ADHS.
 - (6) To perform periodic reviews of the effectiveness of the plan and the timeliness of compliance reporting.
- (c) The Compliance Committee's membership is made up of:
- (1) Committee Chair – Designated ADHS Corporate Compliance Officer
 - (2) Committee Staff – OPI Chief
 - (3) Committee Members - Management representatives from functional areas of ADHS. Currently constituted of DBHS/OCSHCN Senior Leadership Team.
- (d) Committee Meetings
- (1) The committee should meet as needed and the Committee Chair should call each meeting. There should be a standing quarterly meeting of the committee to review the activities of compliance program, OPI's activities and to discuss audits, trends and specified cases from the past period. It is recommended that the committee issue an annual report to the appropriate ADHS Deputy Director regarding the adequacy of the compliance program and any emerging trends in fraud and program abuse and recommendations to address these trends. Each committee meeting will include an update from the OPI Chief on cases opened, cases closed, cases referred, any noted trends and/or areas of risk in the program areas. Committee meeting agendas and notes will be maintained in the OPI administrative files.

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- (2) It is important to remember the sensitive nature of the information and topics the committee will be discussing and to assure that each member does not share information on investigations outside of the committee. In order for OPI audits and investigations to be conducted properly and to maintain the integrity of any possible future civil or criminal actions taken against a suspect, strict confidentiality must be maintained by the committee and any related ADHS employees. In the event that specific confidential, case related, information must be discussed during a committee meeting, an executive session will be declared.

3. CORPORATE COMPLIANCE OFFICER

- (a) ADHS shall have a designated Corporate Compliance Officer (CCO). The CCO is responsible for the overall administrative and operational oversight of the compliance program. The compliance officer is charged with detecting and deterring fraud and program abuse within ADHS and its contractors and training and assisting contractor's Compliance Officers as they facilitate their own compliance programs. The compliance officer is responsible for chairing the ADHS Corporate Compliance Committee, maintaining and updating the Corporate Compliance Plan, facilitating meetings with the contractors' CCOs, overseeing the activities of OPI and providing ADHS and contractor fraud and program abuse training.

4. ADHS FRAUD AND ABUSE AWARENESS PROGRAM AND TRAINING

- (a) The CCO will be responsible for providing fraud and program abuse training and awareness activities to the compliance committee, ADHS employees, managers, supervisors, and to contractor CCOs on a regular basis. All new ADHS employees will receive mandatory initial training on identifying and reporting suspected fraud and program abuse. Annual mandatory refresher training will also be made available to ADHS employees in a classroom or on-line setting. All ADHS management will receive training/awareness on fraud and program abuse during a Management Team meeting at least once per year. See Attachment F for samples of employee and management training materials.
- (b) Fraud and program abuse training will be provided to contractor CCOs at each Compliance Officers' meeting. OPI staff will attend professional training in order to maintain their understanding and expertise in the area of fraud and abuse detection, investigation and auditing. Awareness campaigns will be conducted during each year including posters, flyers and e-mails for ADHS employees.
- (c) Fraud and program abuse awareness information campaigns will be conducted periodically for ADHS employees and contractor Compliance Officers. The informational campaigns will be coordinated by the CCO.

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5. AHCCCS OPERATIONAL AND FINANCIAL REVIEW

- (a) Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of specific ADHS contracts in order to determine if there is organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to corporate compliance and fraud and program abuse. The CCO, the direct liaison for OFR and OPI, will participate and respond to all requests for information and documentation requested by AHCCCS. OPI staff will also make themselves available for interviews and questions during the OFR period. A file will be created for each OFR that OPI participates in and copies of all documents provided to OPI and all documents provided to AHCCCS will be kept in the file.
- (b) In the event that AHCCCS requires corrective action in an area of OPI or the ADHS Compliance Plan or program, the CCO will immediately develop corrective measures and notify AHCCCS of the changes by way of the communication method established by ADHS for the OFR process.

6. DRA REQUIREMENTS

- (a) As a part of the compliance program and as required by the Deficit Reduction Act (DRA) of 2005, Title 42, U.S.C., §1396(a), ADHS provides all employees training and information regarding the False Claims Act and employee whistleblower protection. This information is also found in the DBHS Employee Resource Guide, as an employee reference source. Information regarding the training provided is found in Attachment XXX and detailed information regarding the False Claims Act is found in Attachment XXX.
- (b) Information regarding the False Claims Act is also provided to ADHS' direct contractors through their designated CCO.
- (c) Citations: USC Title 31, Sections 3729 – 3733; USC Title 31, Chapter 38; public law 109-171

7. COMPLIANCE OFFICERS' WORKGROUP MEETING

- (a) In order to facilitate fraud and abuse training and communication among the contractor Compliance Officers, the ADHS Compliance Officer will convene Compliance Officers' Workgroup (Workgroup) meetings. The Workgroup meetings are intended to provide a forum for discussion of relevant fraud and program abuse topics, emerging trends, changes in ADHS policy/contract as well as a setting for formal training on methods and techniques in deterring and detecting fraud and program abuse.

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- (b) The Workgroup meeting will be scheduled as necessary and will be held at the ADHS building in Phoenix or at locations convenient for the participants. All designated contractor Compliance Officers and acting Compliance Officers are requested to attend in person. In the event a Compliance Officer cannot attend in person, they may appoint a designee to attend in their place. If conditions require, the Workgroup meeting may be held via teleconference or "Telemed," but attendance in person is preferred.
- (c) Workgroup meetings will be scheduled and the Compliance Officers notified in advance of each meeting. For each scheduled meeting, the Compliance Officer will prepare and distribute an agenda at least one week prior to the meeting date. All Compliance Officers are invited to contact the Compliance Officer to suggest items for discussion or to request presentations be placed on the agenda. All requests for items or presentations must be received by the Compliance Officer at least one month prior to the meeting date and must be approved for inclusion on the agenda. Agendas and meeting notes will be retained as part of the Compliance Officer's administrative records.

8. CONTRACTOR COMPLIANCE OFFICERS AND COMPLIANCE PLANS

- (a) All contractors are required by contract to have a designated CCO, a Corporate Compliance Plan and a comprehensive Corporate Compliance Program based upon the seven elements required in 42 CFR §438.608. The contracts state that any change of Compliance Officer is to result in ADHS being notified of the change including information regarding the new Compliance Officer and their contact information.
- (b) All contractors are to submit their Corporate Compliance Plan to the appropriate ADHS Contract Administrator annually by October 1. The Compliance Officer will review and file these annual submissions in the appropriate administrative files.

9. CONTRACTOR ADMINISTRATIVE REVIEWS

- (a) Annually, the CCO will participate in the ADHS Administrative Review of each T/RBHA as a provision of their contracts. The OPI will be responsible for the Program Integrity (PI) standard and the accompanying measurement tool. Interrogatories and on-site interviews will be conducted as needed. The current PI standard and tool is found in Attachment **XXX**.
- (b) Excluded Parties:
As outlined in 42 CFR §438.610 (see Attachment XXX), ADHS does not knowingly or maintain relationships with an individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

10. OFFICE OF PROGRAM INTEGRITY

- (a) Under the direction of the compliance officer, the Office of Program Integrity (OPI) is responsible for fraud and program abuse related audits and investigations. OPI is comprised of an Office Chief, Investigative Analysts and an Administrative Assistant.
- (b) The OPI Office Chief is responsible for creating and maintaining OPI procedures, creating and assigning reviews and audits, assigning and conducting investigations, reviewing, summarizing and reporting fraud and program abuse statistics, liaison with AHCCCS-OPI, Department of Health and Human Services, Office of Inspector General, the Arizona Attorney General's Office and other state and federal investigative agencies, maintaining audit and case related files and data, reporting fraud and program abuse trends and assuring the quality of audit and investigations. The OPI Office Chief is the single point of contact for ADHS employees reporting fraud and program abuse (related to specified programs) and for ADHS reporting fraud and program abuse to an outside agency.
- (c) An Investigative Analyst conducts regular ongoing statistical analysis of CIS/PMMIS encounter data and information searching for trends or patterns that would indicate suspected fraud or program abuse. These analyses result in regular reports to the OPI Chief. The OPI Chief summarizes these reports and provides them to the compliance officer and Compliance Committee. This Investigative Analyst also conducts desk reviews, data analysis and investigations of complaints and is fully cross-trained in field audit operations.
- (d) An Investigative Analyst conducts random and targeted field audits of contractors and providers based upon established audit programs and purpose-created audit programs. This person also conducts investigatory audits of providers that have been identified by ADHS in-house data as generating irregular encounter or billing activity. This Investigative Analyst is fully cross-trained in desk review audit operations and conducting investigations.
- (e) An Administrative Assistant provides administrative and audit support to the Investigative Analysts and the OPI Chief. This person conducts specified audit steps of established audit programs, maintains the case management system and collects and maintains audit and investigative documents and evidence.

11. OPI CASE FILE MANAGEMENT

- (a) All OPI case files will be created and maintained in a uniform and consistent manner. The goal is to have each case file in such a state that an analyst could pick up a case file and quickly determine the status and continue the audit or investigation. All audit and investigative files will be maintained in a secure file area with restricted access.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

- (b) Every case and audit will be assigned a unique case number and a case name. The name will be the name of the suspect, target or subject of an audit. Each case that is opened will have a physical file created which will be kept in the secure file area.
- (c) Only OPI staff and the Compliance Officer will have access to the secure files. Open case files will not be left out of the secure file area after work hours and will never leave the building. Closed case files will be kept in a secure area and accessed only by authorized personnel.
- (d) All case related documents, forms, memos, reports, evidence, schedules, charts and correspondence will be kept in the case file. Any collected item too large to fit in the case file will be kept in a secure area and indexed to the case file.
- (e) Preliminary analyses, notes, drafts and all unfinished work products will be kept in the auditor's working files and will not be kept in the case file. Analyst working files will be maintained in a secure manner. All electronic data and files will be transferred to CD, labeled and placed in the case file when work on the data is substantially completed. Closed case files will not be destroyed and will be maintained in the OPI secure files for 12 months and then sent to archives. Closed OPI audit files will be maintained for 12 months and then sent to archives. Case files will be organized and filed by fiscal year opened.
- (f) All files will contain copies/originals of all documents related to a case or audit. In the event of a case referral, copies or originals may be sent to the referring agency based upon the circumstances.
- (g) A case must be approved by the OPI Chief prior to opening. The OPI Administrative Assistant will assign a case number and create a physical file. The physical file will be given to the assigned analyst. All cases will have an assigned analyst and the assigned analyst is responsible for the case, case file, documents and evidence.
- (h) All audits will be assigned by the OPI Chief. The OPI Administrative Assistant will assign an audit number and create a physical file. The physical file will be given to the assigned analyst. The assigned analyst is responsible for the audit, audit file, documents, work papers report and evidence.
- (i) A case closing must be used and approved by the OPI Chief prior to closing a case. All necessary reports, forms, documents and evidence must be accounted for and placed in the file prior to closing. All closed cases must be kept in the secure files.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

12. OPI COMMUNICATIONS, MEMOS AND REPORTS

- (a) All OPI communications, reports, memos and letters will follow standardized formatting and criteria. All communications that will leave ADHS must be reviewed and approved by the OPI Chief. All case Investigation Reports and memorandums must be reviewed and approved by the OPI Chief.
- (b) All information, data, records, documents and communications related to any and all reports, complaints, audits and investigations are to be maintained in a secure and confidential manner. All information related to an official OPI investigation is to be kept confidential. Information should not be shared with any ADHS personnel unless there is a documented need to know. Information and evidence can be provided to appropriate AHCCCS-OPI and law enforcement agencies, as necessary.
- (c) All public information requests are to be directed to the ADHS Deputy Director's Office. Individuals inquiring about cases should be advised that there can be no confirmation or denial regarding any OPI investigative activity.
- (d) Field audits, desk audits, special internal assignments and non-audit administrative activity will result in memos documenting activity and findings. Memos should be to the appropriate individual or to a case file. Memos may contain opinions, recommendations and ideas. Activity involving any contractor or provider, not directly related to a complaint or case, should be documented in the form of a memo.
- (e) All non-investigative audits should result in an audit report with all related audit work papers organized and indexed to the audit program.
- (f) Investigative activity should be documented in investigative reports. Interviews, meetings, analyses, and all significant investigative activities should be recorded in the form of an investigative report. Investigative reports should contain facts, summary analyses, findings and salient points from interviews. Reports should not contain opinions, suppositions or recommendations for further action.
- (g) All letters will be on ADHS letterhead. Letters requesting documents, data, information, or communicating with other company or agency management should be under the OPI Chief's signature. Letters to audit/investigative peers and complainants should be under the analyst's signature.
- (h) Samples of standardized reports, memos and communications along with all standard forms are contained in Attachment G.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

13. EVIDENCE

- (a) All items collected as a part of an investigation will be considered potential evidence and must be maintain accordingly. All evidentiary items will be logged into the case's Collected Items List and include a description of the item, the date received, who the item was received from, and who was logging the item. When the item is given to another authorized person or entity, the transfer must be documented in order to maintain the chain of custody. When possible, a Collected Item Receipt will be provided by the auditor to the individual or entity providing the item. OPI staff should use the Collected Items List form and Collected Item Receipt form located in Attachments XXX and XXX.

14. OPI SECURITY

- (a) The activities, documents and communications of OPI are to be maintained in a secure and appropriate manner. All complaints, suspected fraud or program abuse reports or information relating to a suspected fraud or program abuse issue are to be maintained in a confidential manner. Analysts are only to discuss information regarding any of their work with appropriate employees on a "need to know" basis.
- (b) No information regarding any investigations, audits, cases or preliminary reviews is to be discussed with or provided to anyone outside of OPI without the approval of the OPI Chief. OPI staff will not confirm or deny that a complaint or report has been received or that an audit or investigation is being conducted. The OPI Chief will approve all information sharing with other agencies or individuals. If an OPI staff member intentionally or inadvertently shares, releases, distributes or provides any secure or confidential information in an unauthorized way or to an unauthorized individual or entity, these actions will be considered grounds for discipline, dismissal (per ADHS Human Resources policy) and/or referral to law enforcement.
- (c) All OPI staff that conduct audits or investigations will have credentials issued to them. These credentials are to be carried with them during business hours and when in the field. These credentials are for identification purposes to the public, contractors, providers, and other agencies. If these credentials are used inappropriately, they will be taken from the staff member and will be considered grounds for discipline or dismissal (per ADHS Human Resources policy). If credentials are lost or stolen, the OPI must open an investigation and document the loss.
- (d) All case files and completed audit files will be kept in the secure file area. All collected items and evidence will be kept in the secure file area. Only OPI staff members will have access to the secure files.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

- (e) No files, reports, documents or collected items are to be left out of the secure files at the close of business each day. All working files will be secured in the staff member's locked drawers at the close of business each day. All investigative and sensitive documents and information are to be kept out of the direct view of non-OPI staff at all times.
- (f) As a matter of physical security for OPI staff, non-ADHS employee complainants are not to be allowed into the OPI office area. All meetings with outside complainants, suspects, witnesses or any non-state or non-law enforcement employee related to an investigation should be conducted in the lobby of the building. If a private meeting is necessary, this should be done in a conference room on the ground floor of the building under the oversight of building security. If meeting with an individual is ever a security concern, additional OPI staff should accompany the primary investigating staff member.
- (g) OPI staff is not expected to enter into or remain in situations where they feel threatened or in danger. If, during an audit, investigation or interview, the staff member believes that they are in an unsafe situation, they should immediately leave and call 9-1-1. The staff member should also prepare a report to the OPI Chief detailing the events and the action they took to secure their safety.

15. OPI DOCUMENT RETENTION AND DESTRUCTION

- (a) In order to prevent the accumulation of unnecessary administrative case related documents and to maximize storage space, the following procedures are to be followed:
 - (1) All accumulated case original documents are to be considered prior to completing a case closing form. Documents are to be considered based upon whether they are originals, copies, HIPAA protected, or if the case is being referred to AHCCCS-OPI or another agency.
 - (2) If the case is not forwarded to another agency for investigation, all originals are to be returned to the rightful custodian of records from which they were originally received. Copies will be retained. If the case is referred to AHCCCS-OPI or another agency, all originals will be forwarded along with the case information.
 - (3) If the case is not forwarded to another agency for investigation, and the case is closed, the case and all related documents will comply with the OPI archive policy.
 - (4) All original work products (analyses, charts, schedules, reports, memos, letters, working papers and any type of summary) will be kept in the case file whether it is referred on or not. Copies of work products may be provided to AHCCCS-OPI or other agencies, if requested and necessary.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

- (b) The following is the procedure for destroying documents identified as needing to be disposed of:
- (1) After an audit or case has been closed for five years, the related files and collected documents may be destroyed.
 - (2) The OPI Chief must review the file and make a determination that the file is authorized to be destroyed.
 - (3) If a file is authorized for destruction, the OPI Chief prepares a destruction form.
 - (4) The destruction form, Collected Document List and transfer form is placed in an administrative file titled Destroyed Case Files.
 - (5) The documents are then placed in the confidential waste receptacle.
- (c) The following is the procedure for returning original documents to the originator or a referring agency:
- (1) After the determination for return or referral has been made regarding the documents, OPI staff completes a document transfer form. The form contains a brief summary of the documents, how they were obtained, the reason they are being transferred and the approving signature of the OPI Chief.
 - (2) These documents are hand-delivered and the recipient signs the transfer form or the documents are sent to the recipient via U.S. Postal Service, Registered Return Receipt Requested.
 - (3) The transfer form is kept in the case file with the Collected Document List.

16. OPI EQUIPMENT

- (a) The following equipment or items will be issued to OPI employees and they will be required to sign for each item. These items will be controlled and documented on a control log and as employees leave the OPI they will be required to return all issued equipment. All OPI equipment is to be used for authorized purposes and is to be safeguarded.
- (1) Credentials
 - Each member of the OPI will be issued Compliance Auditor credentials which identify them as an agent of the State of Arizona and an agent of ADHS and authorizes them to have access to HIPAA related records and information within the scope of an official audit.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

(2) Keys

- Each member of the OPI and the CCO will be issued a key to the secure files. These keys are not to be duplicated and they are not to be loaned to anyone for any reason. The OPI Chief or CCO may make duplicates as needed.

(3) Equipment

- Members of the OPI staff or ADHS employees that borrow OPI equipment out of the OPI area will sign each item out with the OPI Administrative Assistant.
- (b) The OPI has equipment for use by the OPI staff and ADHS employees. These items are to be kept in a secure area and used only for business related activities. If taken and used away from the ADHS office, these items are to be safeguarded and used only by OPI staff. Problems with any of this equipment should be reported to the OPI Chief immediately. These items may be loaned to other ADHS personnel with the permission of the OPI Chief and documentation of the loaned equipment. This equipment includes, but is not limited to:
- Laptop computer
 - Portable printer
 - Portable scanner
 - Audio recorder
 - Portable copier

17. OPERATIONS AND PROCEDURES MANUAL UPDATES AND REVISIONS

- (a) The OPI Operations and Procedures Manual will be reviewed regularly and updated as needed. The OPI Chief is responsible for maintaining this manual and should coordinate with all functional areas of ADHS when there are proposed changes. All functional areas of ADHS should coordinate with the OPI Chief regarding any changes in their policies, procedures, contracts or reference documents that may reference or affect this manual.
- (b) All substantive changes to this manual must be reviewed and approved by the CCO.

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

18. BUSINESS CONTINUITY

(a) The OPI business continuity plan is intended to provide for an initial response to a variety of scenarios that could disrupt operations. The following plans are for the initial response to an emergency, disaster or unusual disruption of OPI operations.

(1) ADHS Telephone Outage

- OPI employees will be contacted by the OPI Chief, via cell phone, to inform of telephone problems and to advise of alternative communication methods. If outage is for more than one business day, contractor compliance officers will be contacted and advised of the ADHS telephone problem and to inform them of alternative communication methods.

(2) Long-term ADHS Computer or Database Problems

- If an ADHS computer system problem or database access problem occurs and it prevents operations for more than one business day, OPI employees will be contacted by the OPI Chief to inform them of the nature and impact of the problem and any alternative automated procedures that can be used.

(b) The OPI case management database shall be backed-up on a electronic storage device every week (last workday of the week) in order to provide access to case data in the event of a database access problem. The back-up disk is to be kept in the secure files and the old previous back-up disk destroyed.

(c) If ADHS access to PMMIS is involved, the OPI chief will contact AHCCCS-Data Security and inquire about alternative methods of access to the necessary secure data systems.

(1) Loss of Power, Heating or Cooling to Building

- If electrical power is out at the building where OPI is housed for more than 4 hours, OPI staff will be contacted by the OPI Chief and advised of how to proceed. Possible alternatives could be:

(a) Telecommuting

(b) Alternative off-site state or government office space

POLICY OFFICE OF PROGRAM INTEGRITY (PI)

(2) Fire, Bomb Threat, Police Action, Unsafe Working Conditions

- In the event of any other condition that would require staff to vacate the building for more than four hours, OPI staff will be contacted by the OPI Chief and advised of how to proceed. Possible alternatives could be:
 - (a) Telecommuting
 - (b) Alternative off-site state or government office space

(3) Employee Contact List

- A list of emergency contact telephone numbers will be maintained for staff contact in the event of an emergency, disaster or unusual disruption of OPI operations. Cellular telephone numbers for each OPI staff member and related Bureau of Audit Standards members will be obtained and used for emergency contact purposes. The cell number provided should be the one that staff members believe will be the most likely to be successful in contacting them in the event of an emergency. This telephone list will be kept confidential and used only by the OPI Chief.

19. DATABASE SUBSCRIPTION SERVICES

As a resource for official audits and investigations, OPI will subscribe to and use appropriate public record database services (i.e. ChoicePoint, LexisNexis, etc.). The use of these services will also be made available to other Offices, Bureaus and Division within ADHS for official audit and investigative purposes. Access to these services will be maintained and controlled by the Chief of OPI. All requests for the use of these services must be reviewed and approved by the Chief of OPI and access to these services will be based upon the requestor meeting the following criteria:

- Request must be from an identifiable unit within DBHS.
- The requesting unit must have audits, surveys, reviews or investigations as their primary work activity/responsibility.
- The requestor must provide a case or file number and a brief justification for the request.
- The requestor must provide their name, contact number, email address, title and supervisor's name and title.
- The request must have the requestor's supervisor's approval and signature.

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(When approved for processing, a member of OPI will conduct the request and provide the requestor with the results. Non-OPI employees do not have direct access to the services.)

Use of the public record database services are for official work related activities. Misuse of these services, including using them for personal or non-work related purposes, will result in immediate termination of access to these services. Misuse of the services may also result in a complaint being filed with ADHS Human Resources and the requestor's supervisor.

POLICY FRAUD AND PROGRAM ABUSE (RE)

20. FRAUD AND ABUSE DEFINITIONS

(a) For the purposes of the ADHS' compliance program, the ADHS Compliance Plan and OPI's operational activities, the following will be used as the definition and criteria for determining suspected fraud and abuse.

(1) Fraud

- *"Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."* (42 CFR § 455.2)

(2) Elements of Fraud

- The act (evidence of wrongdoing).
- Knowledge and intent (willfully intended to commit act – generally evidenced by a pattern of wrongdoing).
- Benefit (some type of measurable benefit obtained from the act by the person committing the act).

(3) Program Abuse

- *"Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program."* (42 CFR §455.2)

(4) Elements of Program Abuse

- Inconsistency (pattern of not following known laws, rules, regulations, contracts or industry practices/procedures).
- Costs (unnecessary loss to a government program).
- Not necessary/does not meet standards (general disregard for professional or industry standards and practices).

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

(5) Understanding Medicaid Fraud and Abuse

- The phrase “fraud and abuse” is used commonly when discussing corporate compliance programs in the world of Medicaid. The terms fraud and abuse are generally used together, as if they are interchangeable and essentially the same, but they are not. In order to effectively deter and detect fraud and abuse within Arizona’s public health system and to better enable auditors and investigators to perform their duties adequately, it is necessary to examine, define and understand what these terms mean and how they are different. The obvious and subtle differences between the terms fraud and abuse are critical in the determination of suspected fraud or abuse, the collection of evidence, the elements necessary to determine which statutes apply and, ultimately, the jurisdiction.
- The terms fraud and abuse, as used in the Code of Federal Regulations, do not refer to specific offenses, but rather the nature of the statutes that can be used to prosecute or take action against an offender. If fraud were suspected, at least one of several Federal or State criminal statutes would need to be charged. The charges chosen would be based upon the facts and circumstances of the case and specific elements would need to be established in order to conduct a successful prosecution of the case.
- If abuse were suspected, at least one of several federal or state statutes or rules would need to be charged or involved. Based upon the statutes or rule chosen to charge the subject with, specific elements would need to be established in order to successfully obtain a civil judgment or monetary penalty or assessment.
- The primary difference between fraud and abuse, as they relate to chargeable offenses, is the existence or ability to prove intent on the part of the suspect. In order to charge a fraudulent act it would normally require the ability to prove criminal intent. A lower level of intent or an absence of intent would normally lead investigators or prosecutors to pursue civil/administrative action based upon the abusive activity. See Attachment B.

21. SUSPECTED FRAUD AND ABUSE DEFINITIONS

- (a) For the purposes of the ADHS’ compliance program, the ADHS Compliance Plan and OPI’s operational activities, the following will be used as the definition and criteria for determining suspected fraud and abuse.

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

- (b) ARS §36-2918.01 uses the language “suspected fraud or abuse.” This is the language that is used by ADHS in regards to their compliance program. ADHS defines suspected fraud or abuse as:

“Evidence or information that would lead a reasonable person to believe that fraud or program abuse is occurring or has occurred. This would normally involve evidence of a material loss or unnecessary expense, a pattern of occurrence and something to show intent to defraud or unsound business practices. An alternate phrase for ‘suspected fraud or abuse’ could be ‘reasonable belief of fraud or abuse’.”

22. ADHS SUSPECTED FRAUD OR PROGRAM ABUSE CRITERIA

- (a) By contract with AHCCCS, ADHS is required to report all suspected fraud or program abuse involving any Title 19/21 funds to AHCCCS-OPI within 10 business days of determination. All reports of suspected fraud or program abuse from ADHS will be in writing and mailed or faxed to AHCCCS-OPI. Any ADHS report of suspected fraud will be made based upon the findings of an OPI audit or investigation, and will meet the OPI criteria for determining suspected fraud or program abuse. The totality of the findings and the circumstances will be examined before making any determination regarding suspected fraud or program abuse.
- (b) As required by contract between ADHS and their contractors, contractors will directly report suspected fraud or program abuse involving any Title 19/21 funds to AHCCCS-OPI and notify/copy ADHS OPI of the report and information. OPI will follow up with AHCCS – OPI within 10 business days to confirm the report of the contractor as received. If a contractor becomes aware of suspected fraud or program abuse involving non-Title 19/21 funds, they must report it directly to ADHS-OPI within 10 working days.
- (c) OPI will report all suspected fraud or program abuse to AHCCCS-OPI for Title 19/21 funds, or the appropriate reporting agency for non-Title 19/21 funds, even if a contractor or provider has already taken corrective action. If there is evidence that suspected fraud or program abuse has occurred, it will be reported. OPI will not continue to investigate any matter reported to AHCCCS-OPI, whether by a contractor or ADHS-OPI. If a report or compliant is received by ADHS-OPI and it does not involve Title 19/21 funds, ADHS-OPI may investigate the matter until the appropriate jurisdiction is determined, at which time it will be referred to the appropriate authority or the committee.
- (d) The following is the OPI criteria for determining if fraud or program abuse is suspected and should be reported to AHCCCS-OPI or another reporting agency.

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

(1) At least one of the following criteria must be met:

Evidence of:

- Duplicate billings
- False claims or data
- Upcoding
- Miscoding
- Unbundling
- Misrepresentation of services

- Billing for services not rendered
- False or altered documents
- Missing documentation
- Irregularities following sanctions for same problem.
- Unlicensed or excluded professional or facility at time of services.
- Management knowledge of fraudulent or abusive activity.
- Reports of material irregularities by more than one reliable source.

(2) All of the following criteria must be met:

- Pattern of occurrence of irregularities.
- Unnecessary cost/lost to a government program.
- Loss would be considered material for nature and type of activity and contractor/provider.

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

- (3) At least one of the following criteria is met:
- Direct personal knowledge of fraudulent or abusive activity by known reliable individual.
 - ADHS/Contractor documented audit findings that show evidence of suspected fraud or program abuse.
 - Report showing evidence of suspected fraud or program abuse from another government or law enforcement agency.

23. INTERNAL ADHS EMPLOYEE REFERRALS

- (a) When a fraud or program abuse report or tip is received from an ADHS employee regarding a prospective, current or former ADHS employee, the OPI Chief will discuss the matter with the compliance officer. An initial determination should be made regarding the nature of the alleged wrongdoing. An OPI case will be opened/closed and a case number assigned to document the receipt of the complaint. No names or details of the allegations will be entered into the case management system. The physical file will be kept by the OPI Chief.
- (b) OPI does not investigate complaints regarding internal DBHS/OCSCHN employees due to the inherent conflict of interests. The ADHS Director has designated the ADHS Office of Audit and Special Investigation as the correct destination for fraud, program abuse or employee wrongdoing complaints regarding ADHS employees.
- (c) OPI will consult with the division human resources coordinator to determine if the matter is an employee-supervisor issue. If the circumstances warrant supervisor notification and intervention, the compliance officer will inform the appropriate supervisor/manager/chief/assistant/deputy director of the report or tip.
- (d) If the matter is not an employee-supervisor issue (to be resolved at the supervisor level), the matter will be considered for referral to the ADHS Office of Audit and Special Investigation. The compliance officer will contact the ADHS Office of Audit and Special Investigation Manager and advise of the intent to refer the case. The OPI Chief will prepare an interoffice memorandum from the OPI Chief to the appropriate Deputy Director through the appropriate Assistant Deputy Director, requesting that the case be referred to the ADHS Office of Audit and Special Investigation. The Deputy Director will request approval from the ADHS Director to refer the case to the ADHS Office of Audit and Special Investigation. The ADHS Office of Audit and Special Investigation Manager will advise the OPI Chief to prepare another interoffice memorandum from the OPI Chief to the ADHS Office of Audit and Special Investigation

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

Manager through the appropriate Assistant Deputy Director, referring the case and providing any related information and items.

- (e) After a referral of this type of case to the ADHS Office of Audit and Special Investigation, no further action will be taken by OPI and the case file will be kept confidential from all employees and staff.

24. REQUIREMENT TO REPORT SUSPECTED FRAUD AND ABUSE

- (a) It is required that all suspected fraud or abuse be reported based upon statute, code, policy and contract. The following cites all refer to the necessity for ADHS, all contractors and providers to report suspected fraud or program abuse:

- ARS §36-2918.01. Duty to report fraud or abuse; immunity.
- Arizona Administrative Code R9-22-511. Fraud or Abuse
- AHCCCS Policy and Procedures Manual, III.B. Reporting
- AHCCCS/ADHS Contract, Section D, Paragraph 52. Corporate Compliance

- Attachment A: Minimum ADHS Contract Provisions, 13. Fraud and Abuse
- Attachment A: Minimum ADHS Contract Provisions, Ad Hoc Reports, 1. Reports of Provider and Member Fraud and Abuse
- ADHS Provider Manual, 7.1.7. Procedures

- (b) The following is the Arizona statute that establishes the phrase “suspected fraud or abuse”:

- ARS §36-2918.01. Duty to report fraud or abuse; immunity

- (c) The details of the above referenced cites are contained within Attachment C.

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

25. SUSPECTED FRAUD AND PROGRAM ABUSE REPORTING DEFINITIONS

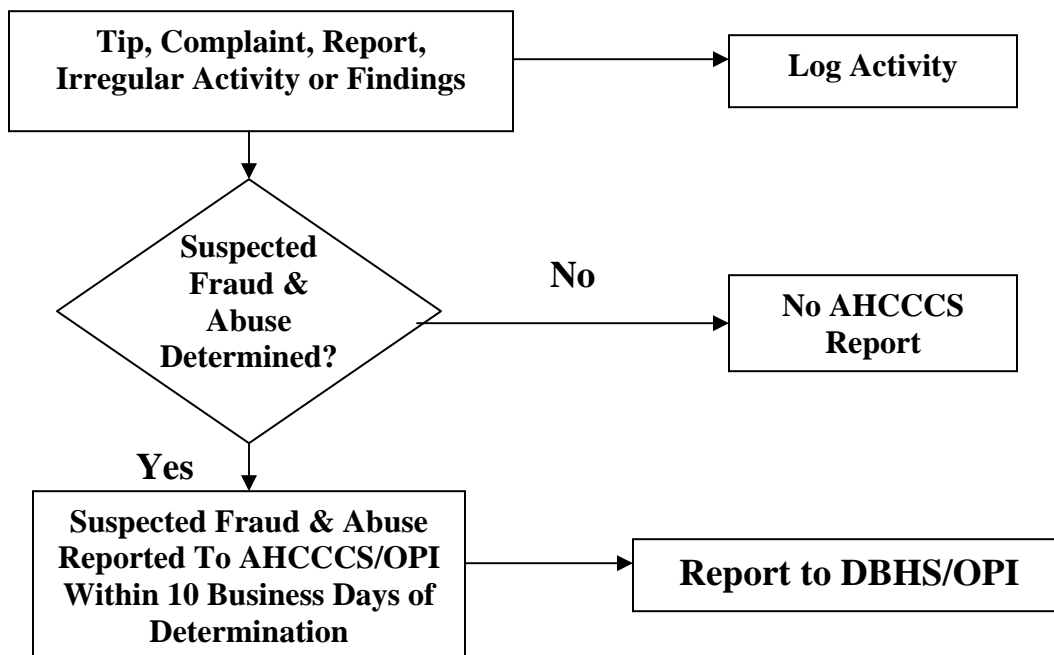
- (a) For the purposes of ADHS' compliance program, the ADHS Compliance Plan and OPI's operational activities, the following definitions will be used for the terms used in reporting suspected fraud or abuse.
- (1) **Immediately.** Defined by AHCCCS-OPI as 10 business days.
 - (2) **In Writing.** Defined by AHCCCS-OPI as a written report received by mail, faxed report with the original sent by mail or an e-mailed report with the original sent by mail.
 - (3) **Discovery.** Discovery is when it becomes clear that there is suspected fraud or program abuse. Upon discovery, the 10-day reporting period begins. Discovery generally occurs when there is a reasonable belief that fraud or abuse is happening or has happened. Anyone can report fraud or abuse; based upon anything they believe shows suspected fraud or abuse.

26. REPORTING SUSPECTED FRAUD AND PROGRAM ABUSE BY CONTRACTORS AND PROVIDERS

- (a) All instances of suspected fraud and program abuse involving Title 19/21 funds must be reported immediately within 10 business days of discovery directly to AHCCCS-OPI in writing using their forms and procedures. ADHS requests that upon reporting suspected fraud and abuse to AHCCCS-OPI, a separate report is provided to ADHS- OPI using OPI forms and procedures.
- (b) All instances of suspected fraud and program abuse involving non-Title 19/21 funds (State only or federal funds) shall be reported to the ADHS-OPI using their forms and procedures (if there is any chance that Title 19/21 funds may be involved, it must also be reported to AHCCCS-OPI). All instances of suspected fraud and program abuse investigated and/or reported to, or by a contractor, should be logged and tracked by the contractor's Compliance Officer. The log should include, but is not limited to:
- Name and address of suspect
 - Date complaint received
 - Name and contact information of complainant
 - Nature of complaint (category of fraud and abuse)
 - Potential loss amount and nature of funds (Title 19/21 and non-Title 19/21)

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

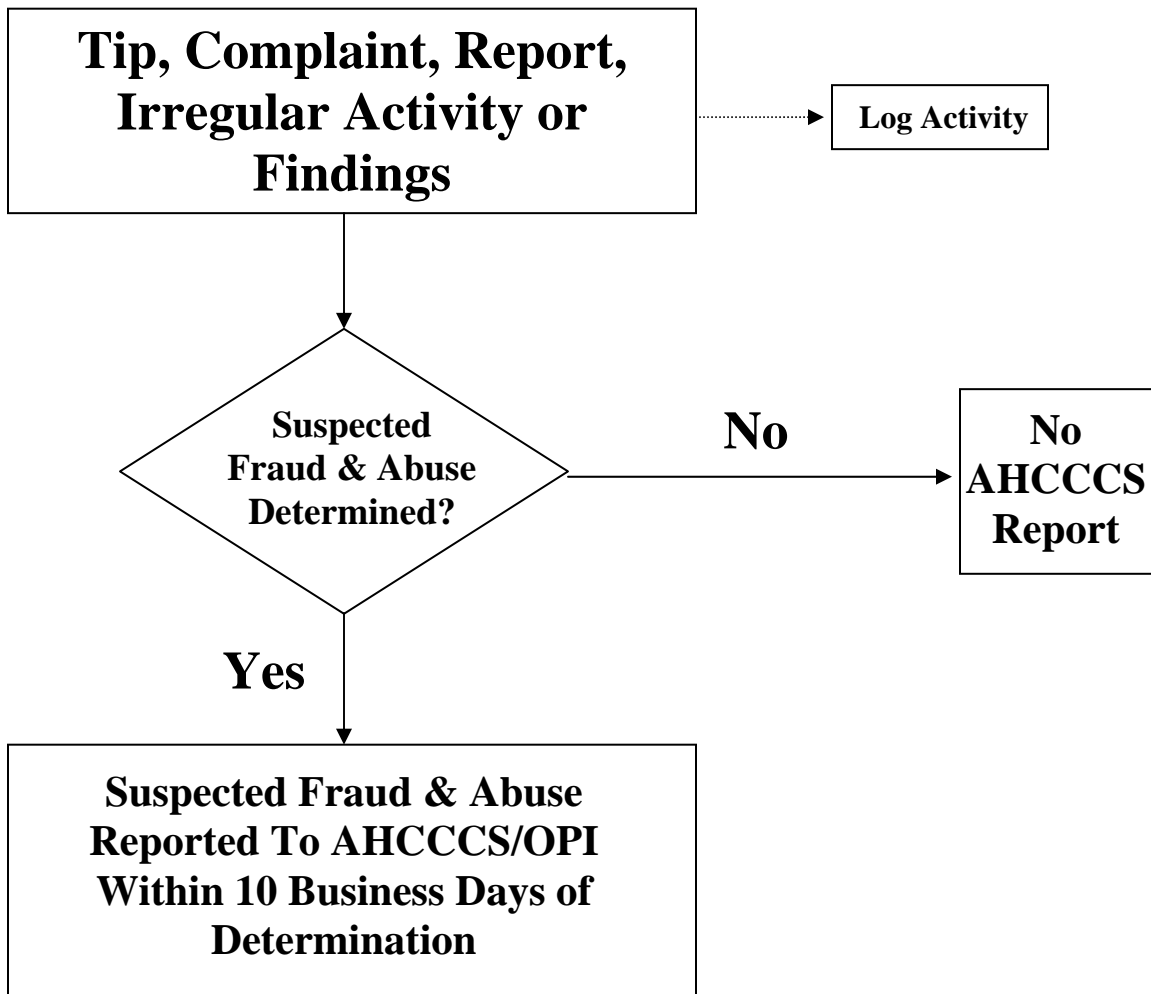
- Unique identifying number used by the contractor
 - Current status and final disposition
- (c) In the event that a contractor or provider suspects fraud or program abuse, they should not disclose to the suspect that a fraud or program abuse report is being filed. The reporting contractor or provider should not continue to audit or investigate unless directed to do so by AHCCCS-OPI or ADHS-OPI. The contractor or provider may take steps to prevent any further losses as long as it does not disclose the possibility of an investigation to the suspect and it does not compromise evidence.
- (d) The following is a flowchart of how a contractor or provider would report suspected fraud or abuse to AHCCCS-OPI.



POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

27. ADHS REPORTING OF SUSPECTED FRAUD AND PROGRAM ABUSE

- (a) All instances of suspected fraud and program abuse involving Title 19/21 funds must be reported within 10 business days of discovery directly to AHCCCS-OPI using their forms and procedures. All ADHS employee reports of suspected fraud or abuse will be reviewed and investigated by ADHS-OPI and a determination will be made regarding whether there is suspected fraud or program abuse. If suspected fraud or program abuse is determined, a report will be prepared by the OPI and sent to AHCCCS-OPI if it involves title 19/21 funds. The OPI will coordinate all investigations of fraud or program abuse reported to ADHS and will be the single point of contact for ADHS with AHCCCS-OPI.
- (b) For instances of suspected fraud or abuse involving non-Title 19/21 funds (state-only funds or federal funds) reported to ADHS, the OPI will conduct an investigation and make appropriate referrals to law enforcement based upon the findings and a determination of jurisdiction.
- (c) In the event that a contractor, provider or client reports suspected fraud or program abuse involving Title 19/21 funds directly to ADHS, the reporting party will be directed to report the suspected fraud or program abuse immediately to AHCCCS-OPI in writing and to not regard their advisement of ADHS as fulfilling their reporting requirement. In these instances, OPI will follow-up with AHCCCS-OPI, within 10 working days, to confirm that the contractor or provider filed their report.
- (d) ADHS' OPI will maintain a log of all complaints received, reviews conducted, audits performed and referrals made to other agencies. The log will be used for tracking and trending analysis of fraud and abuse reported to ADHS. The log will contain:
 - (1) Name and address of suspect
 - (2) Date complaint received
 - (3) Name and contact information of complainant
 - (4) Nature of complaint (category of fraud and abuse)
 - (5) Potential loss amount and nature of funds (Title 19/21 and non-Title 19/21)
 - (6) Unique identifying number or case number used by ADHS
 - (7) Current status and final disposition
- (e) The following is a flowchart of how ADHS would report suspected fraud or abuse to AHCCCS-OPI.



POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

28. OPI SUSPECTED FRAUD AND PROGRAM ABUSE REPORTING – INTERNAL PROCEDURES

- (a) All complaints or referrals from ADHS employees are to be initiated on the approved Suspected Fraud and Program Abuse Report form. E-mails, letters or telephonic information are acceptable if the OPI Chief receiving the complaint obtains all of the required information.
- (b) Any suspected fraud or program abuse report received from the public, a contractor or provider related to Title 19/21 funds, will immediately be provided to AHCCCS-OPI and the reporting party will be instructed to make their report directly to AHCCCS-OPI.
- (c) All ADHS Suspected Fraud and Program Abuse Reports must come through the OPI Chief for review and assignment. ADHS staff, supervisors, and managers are to submit complaints to the OPI Chief and any external complaints or referrals, regardless as to where they are originally received at ADHS, to the OPI Chief and the reporting party should be instructed to report the information directly to AHCCCS-OPI, if Title 19/21 funds are involved.
- (d) Complaints that are not on the Suspected Fraud and Abuse Report form or that do not have all of the required information may prevent the report from being reviewed accurately. All of the requested information is critical in being able to make an informed decision regarding the initial review of the report.
- (e) All reports should be from the reporting party. If contractors, providers, clients or the public are the source of the report, they should be directed to contact AHCCCS-OPI directly, if Title 19/21 funds are involved. In these instances, OPI will follow-up with AHCCCS-OPI, within 10 working days, to confirm that the complainant has filed their report.
- (f) The OPI Chief will review all reports that have been received in a manner consistent with this procedure. The manager will make an initial determination as to whether the matter should have been addressed to OPI. Record of all reports, referrals and complaints received by OPI, even if they should not have been addressed to OPI will be logged and a case number assigned utilizing the OPI Case Management system.
- (g) If the matter should not have been addressed to OPI, the OPI Chief will determine the most correct destination in ADHS for the report and forward it on.
- (h) If there appears to be material irregularities, based upon facts, the report will be assigned to an OPI Investigative Analyst for review. This review will result in a determination as to whether the facts and circumstances meet the OPI criteria of "suspected fraud or program abuse."
- (i) If, after a review by an Investigative Analyst, it is determined that fraud or program abuse is not suspected due to a lack of evidence or the matter does not meet the OPI criteria for suspected fraud, the case will be closed.
- (j) In the event that an OPI Investigative Analyst finds evidence to support suspected fraud or program abuse, a Suspected Fraud and Abuse Report form will be prepared and used to open a case.

POLICY FRAUD AND PROGRAM ABUSE REPORTING (RE)

29. EXTERNAL NON-AHCCCS REFERRALS

- (a) OPI investigations that result in a finding of suspected fraud or program abuse involving non-Title 19/21 funds will require a determination of jurisdiction. Jurisdiction should be determined based upon the nature of the offense, source of funding, likelihood of prosecution and any other relevant issues. Once case jurisdiction is determined, the compliance officer must be notified and a course of action for referring the case will be created.
- (b) If needed, ADHS' Assistant Attorney General will be consulted regarding legal issues. All non-Title 19/21 case referrals will be approved by the compliance officer and the appropriate ADHS Deputy Director advised of the intention to refer the case. If it is determined that the case has no external jurisdiction and is a civil or contractual matter, the compliance officer will take it to the compliance committee or ADHS Deputy Director for direction.
- (d) If the matter is not an employee-supervisor issue (to be resolved at the supervisor level), the matter will be considered for referral to the ADHS Office of Audit and Special Investigation. The compliance officer will contact the ADHS Office of Audit and Special Investigation Manager and advised of the intent to refer the case. The OPI Chief will prepare an interoffice memorandum from the OPI Chief to the appropriate Deputy Director through the appropriate Assistant Deputy Director, requesting that the case be referred to the ADHS Office of Audit and Special Investigation. The Deputy Director will request approval from the ADHS Director to refer the case to the ADHS Office of Audit and Special Investigation. The ADHS Office of Audit and Special Investigation Manager will advise the OPI Chief if the matter is to be referred. If the matter is approved for referral, the OPI Chief will prepare another interoffice memorandum from the OPI Chief to the ADHS Office of Audit and Special Investigation Manager through the appropriate Assistant Deputy Director, referring the case and providing any related information and items.
- (e) After a referral of a this type of case to the ADHS Office of Audit and Special Investigation, no further action will be taken by OPI and the case file will be kept confidential from all employees and staff.

POLICY PROGRAM OVERSIGHT AND INVESTIGATIONS (OI)

30. AUTHORITY TO CONDUCT AUDITS OF CONTRACTORS AND SUBCONTRACTORS

- (a) ADHS establishes its authority to conduct audits, reviews and investigations of ADHS contractors and subcontractors from the following Arizona statutes and contract provisions:
- ARS 41-2548. Right to Audit Records
 - ARS 41-2547. Right to Inspect Plant
 - ARS 35-214. Inspection and Audit of Contract Provisions
 - RBHA Contract - Uniform Terms and Conditions, Section C.3
 - Special Terms and Conditions G. Compliance Provisions, 1.a.–d.

The details of the above referenced cites are contained within Attachment D.

31. FRAUD AND PROGRAM ABUSE HOTLINE

- (a) In order to provide an anonymous and simple method for contractors, providers, clients, the public and ADHS employees to report suspected fraud and program abuse, a dedicated, toll-free hotline has been established. Information regarding this hotline is to be provided on ADHS' website and posted in prominent places in the ADHS work area and by any other method or medium that will encourage individuals to report fraud and program abuse. The hotline numbers are **866-569-4927** or **602-364-3758**. An e-mail address has also been established for individuals to report suspected fraud and abuse. The address is reportfraud@azdhs.gov.
- (b) The hotline will be answered by an OPI staff member if the call is received during business hours. A voice-mail recording will request the relevant information for those who call after business hours. All complaints, tips and reports received from the hotline will be recorded in the hotline log and reported to the OPI Chief. In the event that information received on the hotline is not related to the responsibilities of OPI, the caller and/or the call will be sent to the appropriate area within ADHS or the State. All information received from the hotline will be maintained confidentially and callers may remain anonymous.

POLICY PROGRAM OVERSIGHT AND INVESTIGATIONS (OI)

32. DESK REVIEWS AND ANALYSIS

The OPI may monitor claims and encounter data in order to identify irregular activity, suspicious patterns and concerning trends. This monitoring will be in the form of standing analytical procedures and reports as well as purpose-specific and ad hoc analyses and reports conducted by OPI staff. The analyses and reports from these monitoring activities will be tracked, trended and reported to the OPI Chief and the Compliance Committee.

33. FIELD AUDIT PROGRAMS

All OPI audits will be performed using the current OPI audit programs. All OPI audit programs and audit procedures will be based upon all applicable audit standards. Auditors may make changes in the audit program based upon their initial findings or the facts and circumstances of the audit target, but any derivations from the established program must be documented and justified. Standard audit programs may be established and added to this manual as needed. The current audit programs are included as Attachment E.

34. FIELD AUDIT PROCEDURES

The OPI will conduct field audits of contractors, subcontractors and providers in order to provide oversight of the programs administered by ADHS. Random and targeted audits will be performed in order to deter and detect fraud and program abuse. Targeted audits will be developed based upon the facts and circumstances of a complaint, desk audit findings or risk assessment. All other audits will be random and conducted on a regular ongoing basis. For the general procedures related to random audits see Attachment D.

35. OPI INVESTIGATIONS

- (a) All complaints, reports, tips and adverse audit findings received by OPI, from ADHS employees, will be investigated in order to determine if fraud or abuse is suspected. Each report will be assigned a case number and the OPI Chief will assign an auditor to conduct a preliminary investigation. All investigations resulting in a determination of suspected fraud or abuse will be reported to AHCCCS-OPI (Title 19/21 funds) or to other law enforcement/prosecuting agencies based upon jurisdiction (non-Title 19/21 funds).
- (b) All Suspected Fraud or Program Abuse Reports received by OPI which have been directly reported to AHCCCS-OPI, will have a case opened/closed and the assigned auditor will follow-up with 10 working days with AHCCCS-OPI to confirm they received the complaint.

POLICY PROGRAM OVERSIGHT AND INVESTIGATIONS (OI)

- (c) All investigations will be conducted using methods that will preserve the integrity of any evidence collected, provide documentation of all investigative activities related to the case and defer to AHCCCS-OPI on all Title 19/21 matters relating to cases of suspected fraud and program abuse. All investigations that result in no determination of fraud or abuse will be closed. Any investigation that finds problems with a certified or licensed professional or facility, regardless of suspected fraud or abuse findings, will result in the appropriate agency being notified of the verified problems.

Attachment A

DBHS Corporate Compliance Plan

INTRODUCTION

Purpose

In order to achieve the goals of reducing fraud and program abuse, improving operational quality and ensuring the provision of high quality services, the Arizona Department of Health Services (ADHS), establishes the following compliance plan ("Plan"). This Plan is intended to be a systematic process aimed at ensuring that ADHS and its Medicare/Medicaid contractors and providers comply with applicable laws, regulations, standards and contractual obligations. The Plan will serve as a guiding document in the development, implementation, evaluation and maintenance of all related fraud and program abuse policies and procedures; and will create a process for identifying and reducing risk and improving internal controls.

Basis

A compliance plan should provide a comprehensive framework for all of an organization's fraud detection/prevention policies and procedures. ADHS' Plan is based primarily on the resource materials provided by the Department of Health and Human Services (HHS), Office of the Inspector General. The unique circumstances, responsibilities and relationships related to ADHS have also been taken into consideration.

Compliance Plan Model

The Plan model selected for ADHS is based upon various compliance plans recommended in HHS' guidance documents and 42 § CFR 438.608 (Program Integrity Requirements). All of the HHS models reviewed were based upon the Federal Sentencing Guidelines'¹ recommendation of seven necessary elements of an effective compliance plan. The seven elements of the ADHS Plan are:

- High level oversight
- Standards and procedures
- Training
- Communication
- Monitoring, reviewing and auditing
- Enforcement
- Corrective action and improvement
-

Scope and Jurisdiction

ADHS' Plan applies to all Medicare/Medicaid related funds, programs, contractors, subcontractors and agencies for which ADHS has responsibility, authority and/or control. This includes contractor financial reporting, claims/encounter data systems, disbursement of funds and all other reportable activities. The general scope of ADHS' Plan covers the following:

- Regional Behavioral Health Authority & Tribal Regional Behavioral Health Authority
- Children's Rehabilitative Services
- All other related contracted and subcontracted providers
- ADHS' financial and claims/encounters systems, data security and internal controls

¹ United States Sentencing Commission - Federal Sentencing Guidelines Manuals and Appendices (2004) – Chapter Eight – Sentencing of Organizations (Effective November 1, 2004).

High Level Oversight

In order to establish oversight and responsibility of ADHS' Plan, a Compliance Committee is formed. This committee is responsible for regularly reviewing the Plan, recommending and authorizing changes as needed and assuring that related ADHS' policies and procedures are in accordance with the Plan. ***The Compliance Committee will also perform periodic reviews of the effectiveness of the Plan and the timeliness of compliance reporting.*** The Compliance Committee is comprised as follows:

- Committee Chair – ADHS' designated Corporate Compliance Officer
- Committee Staff – Corporate Compliance Officer's staff members
- Committee Members – Management representatives from relevant functional areas of ADHS as identified by the committee.

In order to facilitate the required reviews, audits and investigations, the Office of Program Integrity (OPI) has been established. The OPI functions independent of any ADHS Division and the OPI Chief is the designated Compliance Officer and reports directly to an ADHS Deputy Director. The OPI has several responsibilities, including, but not limited to:

- Establishing and maintaining all necessary policies and procedures to support the Plan
- Conducting desk reviews, field audits and investigations
- Reporting Findings to the Deputy Director and Compliance Committee
- Reporting Title XIX and Title XXI suspected fraud/abuse to the Arizona Health Care Cost Containment System (AHCCCS) – Office of Program Integrity (OPI) as required
- Reporting all non-Title XIX/XXI suspected fraud/abuse to appropriate agencies

Standards and Procedures

The establishment of relevant policies and procedures accomplishes the implementation of the Plan. Under the direction of the Deputy Director and recommendations by the Compliance Committee, the OPI will create, implement and maintain all necessary administrative, review, auditing and investigative policies and procedures. Procedures will be developed to support all existing financial reporting, claims/encounters submission and contract requirements. Policies and procedures will be developed for the following areas:

- Audit, review and investigations
- Complaints and referrals
- Reporting and documentation
- Compliance Officers' Workgroup
 - The contractors Compliance Officers' Workgroup is lead by a member of the OPI and is comprised of the designated Corporate Compliance Officers from each of the ADHS direct contractors. The purpose of this committee is to share information on fraud prevention and detection, fraud and abuse training and to provide a means of direct communication between the OPI and the contractors.
- Plan Maintenance

Training

In order to inform and update all affected employees, agencies, contractors, providers and clients, ADHS provides general training in regards to the Plan as well as detailed training on:

- Corporate Compliance programs
- Identifying fraud and abuse
- Fraud and abuse reporting

Training related to the scope of this Plan will be the primary responsibility of the OPI. Program/topic experts will be utilized as needed and training conducted as often as necessary. OPI staff will also participate in relevant training in order to maintain their technical abilities and professional status.

Communication

Effective lines of communication are established between ADHS and all of the employees, agencies, contractors, providers and clients operating under the scope of the Plan. Communication from ADHS will be relevant, timely, complete and accurate and will be conducted using the best and most appropriate means available. Communication will be conducted by way of newsletter, website, direct mail, telephone, e-mail and committee/workgroup meetings.

The establishment of this Plan and the elements contained herein will be communicated to all of the groups it covers. Each ADHS' contractor will receive a copy of this Plan and they will be encouraged to assure that their compliance plans are mutually supportive of the objectives of this Plan.

A means for the public, clients and employees of contractors to provide fraud and program abuse complaints confidentially and anonymously is also established. Tips and referrals will be encouraged and the means for communicating this information will be publicized.

Monitoring, Reviewing and Auditing

In order to detect and discourage fraud and program abuse, the OPI will ensure that appropriate monitoring, reviewing, and auditing are performed. These activities, referred to generally as audits, will be focused on identified high-risk areas and vulnerable processes and systems. Various and appropriate audit methods will be used, based upon Governmental Auditing Standards², to provide a opportunity to detect suspected fraud and program abuse. The audit methods used will include, but are not limited to:

- Automated data review, verification and validation
- Random and needs based field audits
- Desk reviews of data and documents

Existing audit and review information and findings available from ADHS, AHCCCS and other agencies will be considered and incorporated into OPI's audits. The purpose of all OPI audits will be to assess internal controls and to detect instances of suspected fraud and program abuse based upon the totality of the circumstances, information and evidence.

All OPI audits will be conducted in accordance with applicable laws, standards, policies and procedures and will result in a report detailing findings of fact. The OPI will not provide opinions or recommendations unless requested by the Compliance Committee or Deputy Director.

² United States General Accounting Office - Government Auditing Standards issued by the Comptroller General of the United States.

Enforcement

Information and evidence that supports the existence of suspected fraud or program abuse by an employee, agency, contractor, provider or client will result in an investigation of the facts by the OPI. If the investigation establishes sufficient facts regarding the allegation of fraud or program abuse, the following action shall be taken:

- If Title XIX/XXI funds are involved:
 - Immediate referral to AHCCCS (per contract, within 10 days).
 - OPI support to AHCCCS as required.
- If Non-Title XIX/XXI funds involved (state funds):
 - OPI expanded scope investigation will be conducted.
 - Based upon investigation findings, matter may be referred to the appropriate law enforcement agency and/or ADHS sanction imposed.

Corrective Action and Improvement

In order to fully benefit from the detection of material mistakes, inaccuracies and instances of fraud and program abuse, ADHS will take corrective action with those individuals and/or organizations for which they have jurisdiction. If directed by the Compliance Committee, ADHS may also recommend a process for improving the systems involved. Corrective actions recommended by ADHS for its contractors may include:

- Repayment of funds
- Fines and sanctions
- Mandatory remedial training
- Termination of employment or contract
- Referral to law enforcement

Conclusion

As the foundational document for ADHS' fraud and program abuse control activities, this Plan will be reviewed and amended as necessary. The Compliance Committee or Deputy Director will direct the OPI in regards to any Plan revisions and will have final approval for all changes.

Attachment B

Understanding Medicaid Fraud and Abuse

UNDERSTANDING MEDICAID FRAUD AND ABUSE

The phrase “fraud and abuse” is used commonly when discussing corporate compliance programs in the world of Medicaid. The terms “fraud” and “abuse” are generally used together, as if they are interchangeable and essentially the same, but they are not. In order to effectively deter and detect fraud and abuse within Arizona’s public behavioral health system and to better enable auditors and investigators to perform their duties adequately, it is necessary to examine, define and understand what these terms mean and how they are different. The obvious and subtle differences between the terms fraud and abuse are critical in the determination of suspected fraud or abuse, the collection of evidence, the elements necessary to determine which statutes apply and, ultimately, the jurisdiction.

Fraud and abuse are defined as:

Fraud

“Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.” (42 CFR § 455.2)

Abuse

“Abuse means provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.” (42 CFR § 455.2)

While the terms fraud and abuse used in relation to the Medicaid program have definitions outlined in CFR, they do not generally refer to specific, chargeable offenses. Specific civil or criminal statutes would need to be selected for prosecution based upon the facts, circumstances and evidence of the case. There are both state and federal charges of fraud, but there are several types of fraud that could be used and several non-fraud charges that could be used instead of, or in conjunction with the fraud charges. These criminal statutes comprise the action that can be taken if fraudulent activities are suspected.

There is no state or federal charge of abuse as it relates to the financial or program aspect of Medicaid (there is physical abuse of a Medicaid patient or client, but not financial), but there are several civil statutes that can be used to fine the offenders, seek a recovery of funds and restrict their participation in the Medicaid program. These civil statutes comprise the action that can be taken if abusive activities are suspected.

The terms fraud and abuse do not refer to specific offenses, but rather the nature of the statutes that can be used to prosecute or take action against a provider. If fraud were suspected (see CFR definition of fraud), at least one of several federal or state criminal statutes listed in the table below would need to be charged. The charges chosen would be based upon the facts and circumstances of the case and specific elements would need to be established in order to conduct a successful prosecution of the case.

If abuse were suspected (see CFR definition of abuse), at least one of the federal or state statutes or rules listed in the table below would need to be charged or invoked. Based upon the statutes or rule chosen to charge the subject with, specific elements would need to be established in order to successfully obtain a civil judgment or monetary penalty or assessment.

The primary difference between fraud and abuse, as they relate to chargeable offenses, is the existence or ability to prove intent on the part of the suspect. In order to charge a fraudulent act it would normally require the ability to prove criminal intent. A lower level of intent or an absence of intent would normally lead investigators or prosecutors to pursue civil/administrative abuse charges.

Though not specific to the Medicaid Program, the Governmental Accounting Office's Governmental Auditing Standards 2003 Revision (GAS) make it clear that abuse is distinct from fraud. Several sections in the GAS state that, "When abuse occurs, no law, regulation, or provision of a contract or grant agreement is violated. Rather, abuse involves behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary business practice given the facts and circumstances." (GAS 2003 Revision 4.19, 6.19, 7.25)

All complaints of suspected fraud or abuse discovered by DBHS, T/RBHA or provider, that involve Title 19/21 funds, are referred to the Arizona Health Care Cost Containment System – Office of Program Integrity (OPI). OPI opens all of their cases as criminal investigations. If their preliminary investigation indicates that the complaint is civil/administrative in nature, they can investigate and adjudicate the case entirely in-house. If their preliminary investigation determines that there is a criminal element to the case (a criminal statute could be charged), they can refer the case to the Arizona Attorney General's Office (AZ/AG) for investigation by their AHCCCS Fraud and Abuse Control Unit. If the AZ/AG's office finds an Arizona statute that can be charged, they will investigate and consider prosecution.

It is possible to pursue a case both criminally and civilly at the same time. While this presents certain difficulties related to the sharing of information and evidence, it can be done if circumstances justify it. It is conceivable that OPI could pursue a case against a provider civilly while the AZ/AG pursues a case against the same provider criminally.

If the AZ/AG's office finds that only federal criminal statutes apply, they can refer the case to one of several federal investigative agencies or the United States Attorney's Office. If the original complaint from DBHS, T/RBHA or provider involves only state funds (no Title 19/21), DBHS' Fraud and Abuse Unit investigates the complaint and refers it to the AZ/AG's office. If the matter appears to be criminal in nature, based upon state statutes, it would go to the Chief of the Criminal Division at the AZ/AG's office. If the matter appears to be civil in nature, it would be referred to DBHS's agency council for action.

Fraud		Abuse	
Statute	Title	Statute	Title
Title 18, U.S.C., § 286	Conspiracy to defraud Government with respect to claims	Title 18, U.S.C., § 1345	Injunctions against fraud
Title 18, U.S.C., § 287	False, fictitious or fraudulent claims	Title 31, U.S.C., § 3730	Civil actions for false claims
Title 18, U.S.C., § 371	Conspiracy to commit offense or to defraud United States	Title 42, U.S.C., § 1320a-7A	Civil monetary penalties
Title 18, U.S.C., § 669	Theft or embezzlement in connection with health care	A.R.S. § 36-2918	AHCCCS – Prohibited acts
Title 18, U.S.C., § 1001	Statements or entries generally (false statements)	R9-22-1101-1112	AHCCS - Civil monetary penalties and assessments for fraudulent claims
Title 18, U.S.C., § 1031	Major fraud against the United States		
Title 18, U.S.C., § 1035	False statements relating to health care matters		
Title 18, U.S.C., § 1341	Frauds and swindles (mail fraud)		
Title 18, U.S.C., § 1343	Fraud by wire		
Title 18, U.S.C., § 1347	Health care fraud		
Title 18, U.S.C., § 1518	Obstruction of criminal investigations of health care offenses		
Title 18, U.S.C., § 1956	Laundering of monetary instruments		
Title 18, U.S.C., § 1956	Engaging in monetary transactions in property derived from specified unlawful activity		
Title 18, U.S.C., § 1961 – 1968	Racketeering Influenced and Corrupt Organizations (RICO)		
Title 42, U.S.C., § 1320a-7B	Criminal penalties for acts involving Federal health care programs		
A.R.S. § 13-2310	Fraudulent schemes and artifices		
A.R.S. § 13-2311	Fraudulent schemes and artifices; willful concealment		
A.R.S. § 13-2317	Money laundering		

Attachment C

Requirement to Report Suspected Fraud and Abuse References

REQUIREMENT TO REPORT SUSPECTED FRAUD AND ABUSE REFERENCES

A.R.S. §36-2918.01. Duty to report fraud or abuse; immunity

- All contractors, subcontracted providers of care and non-contracting providers shall notify the Director or the Director's designee immediately, in a written report, of any cases of suspected fraud or abuse. The Director shall review the report and conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. If the findings of a preliminary investigation give the Director reason to believe that an incident of fraud or abuse has occurred, the matter shall be referred to the Attorney General.
- Any person making a complaint or furnishing a report, information or records in good faith pursuant to this section is immune from any civil liability by reason of that action unless that person has been charged with or is suspected of the fraud or abuse reported.
- Any contractor, subcontracted provider of care or non-contracting provider who fails to report pursuant to this section commits an act of unprofessional conduct and is subject to disciplinary action by the appropriate professional regulatory board or department.

Arizona Administrative Code R9-22-511. Fraud or Abuse

- A contractor, provider, or non-provider shall advise the Director or designee immediately, in writing, of any case of suspected fraud or abuse.
- AHCCCS Policy and Procedures Manual, III.B. Reporting.
- If a contractor discovers, or is made aware, that an incident of potential/suspected fraud and abuse has occurred, the contractor shall report, within 10 business days of the discovery, the incident to AHCCCS by completing the confidential AHCCCS Referral For Preliminary Investigation form.

AHCCCS/ADHS Contract, Section D, Paragraph 52. Corporate Compliance

- In accordance with A.R.S. Section 36-2918.01, and AHCCCS Contractor Operation Manual, Chapter 100, ADHS, the subcontractors or providers are required to notify the AHCCCS, Office of Program Integrity immediately and submit report within 10 business days of discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form for any and all suspected fraud or abuse [42 CFR 455.1(a)(1)]. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS members or funds

Attachment A: Minimum ADHS Contract Provisions, 13. Fraud and Abuse

- If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident immediately and submit report within 10 business days of discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form to AHCCCS, Office of the Director, Office of Program Integrity and the ADHS/DBHS Fraud and Abuse Unit. Incidents involving suspected member eligibility fraud should be reported to AHCCCS, Office of Program Integrity, Att: Member Fraud Unit. (ARS §36-2918.01; AAC R9-22-511.)

Attachment C: Periodic Reporting Requirements, Ad Hoc Reports, 1. Reports of Provider and Member Fraud and Abuse

- As stated in Section D, Paragraph 52, Corporate Compliance, ADHS is required to report all cases of suspected (and actual) fraud and abuse involving AHCCCS members or funds by subcontractors, members or employees immediately and submit report within 10 business days upon discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form

DBHS Provider Manual, 7.1.7. Procedures

7.1.7.-A. Reporting of fraud and abuse involving Title XIX/XXI funds or AHCCCS registered providers

- Upon becoming aware of a suspected incident of fraud or abuse, including a suspected incident committed by the T/RBHA, a T/RBHA or provider has 10 working days to inform the AHCCCS Office of Program Integrity of the suspected fraud or abuse in writing to the address below or by submitting an online form accessible at the link below.

Arizona Department of Health Services
AHCCCS Office of Program Integrity
801 E. Jefferson Street
Phoenix, Arizona 85034
<http://www.azahcccs.gov/Site/RptFraud.asp>

In addition, T/RBHAs or providers should advise the ADHS/DBHS Corporate Compliance Officer of the report to AHCCCS by calling or writing to the contact information below.

ADHS/DBHS

Corporate Compliance Officer
150 N. 18th Avenue, Suite 280
Phoenix, Arizona 85007
(602) 364-3758 or 1-866-569-4927
Fax number: (602) 364-4736

7.1.7.-B. Reporting of fraud and abuse involving state-only funds, ADHS/DBHS registered providers or other providers.

- Upon becoming aware of a suspected incident of fraud or abuse, including a suspected incident committed by the T/RBHA, a T/RBHA or provider has 10 working days to inform the ADHS/DBHS Corporate Compliance Officer by completing PM Form 7.1.1, Suspected Fraud or Abuse Report and faxing or mailing it to ADHS/DBHS. Reports of fraud or abuse may also be taken over the phone at (602) 364-3758 or 1-866-569-4927.

7.1.7.-C. Reporting of fraud and abuse to the T/RBHA.

- In addition to notifying ADHS or AHCCCS, behavioral health providers may need to notify their contracted T/RBHA of all suspected incidents of fraud or abuse. [T/RBHAs may insert specific instructions and include any forms providers must submit here.]

DBHS Authority to Conduct Audits of Contractors and Subcontractors

DBHS AUTHORITY TO CONDUCT AUDITS OF CONTRACTORS AND SUBCONTRACTORS

A.R.S. 41-2548. Right to Audit Records

- The state may, at reasonable times and places, audit the books and records of any person who submits cost or pricing data as provided in Section 41-2543 to the extent that the books and records relate to the cost or pricing data. Any person who receives a contract, change order or contract modification for which cost or pricing data is required shall maintain the books and records that relate to the cost or pricing data for five years after the completion of the contract pursuant to Section 35-214.
- The state is entitled to audit the books and records of a contractor or any subcontractor under any contract or subcontract to the extent that the books and records relate to the performance of the contract or subcontract. The books and records shall be maintained by the contractor for a period of five years after the completion of the prime contract pursuant to Section 35-214 and by the subcontractor for a period of five years after the completion of the subcontract pursuant to Section 35-214.

A.R.S. 41-2547. Right to Inspect Plant

- The state may at reasonable times inspect the part of the plant or place of business of a contractor or any subcontractor, which is related to the performance of any contract awarded or to be awarded by this state.

A.R.S. 35-214. Inspection and Audit of Contract Provisions

- Except as provided in subsection C, in all contracts and subcontracts for the furnishing of goods, equipment, labor, materials or services to the state, or any of its agencies, boards, commissions or departments, there shall be a provision that all books, accounts, reports, files and other records relating to the contract shall be subject at all reasonable times to inspection and audit by the state for five years after completion of the contract. The contract provision shall also require that such records be produced at such state offices as designated by the state in the contract.
- Nothing in subsection A shall preclude a more stringent audit requirement agreed to by the parties in any state contract, and no rule of procedure shall limit the authority of the state to exercise its rights under this section.
- This section does not apply to contracts or subcontracts for the furnishing of goods, equipment, materials or services to any agency, board, commission or department of this state by another agency, board, commission or department of this state or a political subdivision of this state.

RBHA Contract - Special Terms and Conditions, Section B.5

Audits

- Audits may be conducted periodically to determine the Contractor's and subcontractors' compliance with Federal and State codes, rules, regulations and requirements. The Contractor shall submit data, reports and information for audits upon request from ADHS and in accordance with Exhibit A of this Contract. These audits include, but are not limited to, the following:

- a. Auditor General Audits. Contractor and its subcontractors shall comply with and participate as required in the Performance Audit and other audits conducted by the Arizona Auditor General.
- b. Other Federal and State Audits. Contractor and its subcontractors shall comply with and participate as required in other Federal and State audits, including the audit of an inpatient facility.

RBHA Contract - Uniform Terms and Conditions, Section C.3

- Audit. Pursuant to A.R.S. § 35-214, at any time during the term of this Contract and six years thereafter, the Contractor's or any subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract.

RBHA Contract - Special Terms and Conditions G. Compliance Provisions, 1.a. – d.

Audits, Surveys, Inspections and Reviews

- If more than one GSA is awarded under this contract, there may be requirements for audit, survey, inspection and review activities by each GSA. In addition to the Uniform Terms and Conditions, Section C.3 Audit, the following terms and conditions shall apply.
- Contractor and its Subcontractors shall comply with all Federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this contract without limitation to those designated within this contract.
- Contractor and its Subcontractors shall comply with all applicable AHCCCS Rules and Audit Guide, policies and procedures relating to the audit of Contractor's records, medical audit protocols, the inspection of Contractor's facilities, the survey of behavioral health recipients and providers and reviews.
- At any time during the term of this Contract, Contractor and its subcontractors shall fully cooperate with DBHS, AHCCCS, the U.S. Department of Health and Human Services, the U.S. Office of Civil Rights, The Center for Medicaid and Medicare Services or any authorized representative of the state or federal governments and allow them:
 - Access to Contractor's and Subcontractors' staff and behavioral health recipients.
 - Access to, inspection and reproduction of books and records related to the performance of the Contract or Subcontracts.
 - Through on-site inspection, or other means, to evaluate the quality, appropriateness and timeliness of services performed under this Contract.
 - DBHS, its contractor, or other state or federal agency shall conduct the following audits, surveys, inspections and reviews.
- Audits may be conducted periodically to determine Contractor and Subcontractor's compliance with state and federal codes, rules, regulations and requirements. These audits include, but are not limited to, the following:

- Auditor General Audits – Contractor and its subcontractors shall comply with and participate as required in the Performance Audit and other audits conducted by the Arizona Auditor General.
- Other Federal and State Audits –The Contractor and its subcontractors shall comply with and participate as required in other federal and state audits including the audit of an inpatient facility.
- Encounter Validation Study - Contractor and its Subcontractors shall participate in the required Center for Medicaid and Medicare Services (CMS) data validation studies conducted by AHCCCS and other validation studies as may be required by DBHS. Any and all covered services may be validated as part of the studies. Center for Medicaid and Medicare Services data validation studies shall be conducted at least annually.
 - Per CMS requirement, AHCCCS conducts encounter validation studies of the Title XIX and XXI encounter submissions sent to AHCCCS from Contractor via DBHS and compares this to the information in the medical or other record to assess for timeliness, correctness and omissions of data. The ADHS/DBHS Program Support Procedures Manual contains specifications regarding this encounter validation study. AHCCCS has reserved the right to revise the study methodology, timeliness, and sanction amounts based on its review or as a result of consultations with CMS. Contractor shall be notified in writing of any significant change in study methodology.
 - All sanctions imposed against DBHS by AHCCCS as a result of data validation studies to DBHS from AHCCCS shall be passed on to Contractor according to the Special Terms and Conditions Paragraph H.4 Corrective Actions and Sanctions. DBHS shall notify Contractor in writing of the sanction amounts.
- Surveys
 - Behavioral Health Recipient Satisfaction Survey - The Contractor and its Subcontractors, as applicable, shall actively participate in the development and implementation of the behavioral health recipient biennial satisfaction survey. Participation may include, but is not limited to, attending planning meetings and assisting with the distribution of surveys to behavioral health recipients. The Contractor shall use findings from the Satisfaction Survey to improve care for behavioral health recipients.
- Inspections
 - General Inspections - Contractor agrees to make available at the office of Contractor, at all reasonable times, any of its records for inspection, audit or reproduction, by any authorized representative of the state or federal governments.
 - Inspections of Service Delivery Sites - Contractor and subcontractors shall allow an authorized representative of the state or federal government access to inspect any service delivery site for the purpose of determining the quality and safety of services being delivered. This shall be conducted at reasonable times unless the situation warrants otherwise.

- Reviews
 - Annual Administrative Review - DBHS shall conduct an Annual Administrative Review of the Contractor for the purpose of ensuring operational and financial program compliance for all programs, including but not limited to the following:
 - Compliance with state, federal and contractual requirements.
 - A review of clinical and business practices and policies.
 - A review of financial reporting systems.
 - The quality outcomes, timeliness, and access to healthcare services.
 - Any other operational and program areas identified by DBHS.
- The reviews shall be conducted to identify areas where improvements can be made and make recommendations accordingly, monitor Contractor's progress toward implementing mandated programs and corrective action plans, and provide Contractor with technical assistance if necessary.
 - The type and duration of the Administrative Review shall be solely at the discretion of DBHS. In preparation for the on-site Administrative Review, Contractor shall fully cooperate with the DBHS Review Team by forwarding, in advance, policies, procedures, job descriptions, contracts, logs, and other information that DBHS may request. Contractor shall have all requested medical records available. Any documents not requested in advance by DBHS shall be made available upon request of the Review Team during the course of the review. Contractor personnel, as identified in advance, shall be available to the Review Team at all times during DBHS on-site review activities. While on-site, Contractor shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.
 - Contractor shall be furnished a copy of the Administrative Review Report and given an opportunity to comment on any review findings prior to DBHS publishing the final report. Recommendations made by the Review Team shall be implemented by Contractor to bring Contractor into compliance with Federal, State, AHCCCS, DBHS, and/or Contract requirements. DBHS may conduct follow-up Administrative Reviews to determine Contractor's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial Administrative Review. Contractor shall submit the Status of Administrative Review Corrective Actions Report by June 15 of each year to the Office for Compliance.
- AHCCCS Operational and Financial Reviews of DBHS - Contractor and its Subcontractors shall comply with these reviews and participate as required in the AHCCCS/ADHS contract in accordance with CMS requirements for the purpose of, but not limited to, ensuring operational and financial program compliance for Title XIX and Title XXI programs. The reviews identify areas where improvements can be made and make recommendations accordingly, monitor DBHS and Contractor's progress toward implementing mandated programs and provide DBHS with technical assistance, if necessary. Contractor and its Subcontractors shall comply with all audit provisions as required by AHCCCS.

- Independent Case Review (ICR) - The Contractor shall make available records and other documentation, and ensure Subcontractor's participation in, and cooperation with, the ICR. This may include participation in staff interviews and facilitation of behavioral health recipient/family member and subcontractor interviews. The Contractor shall use findings from the ICR to improve care for enrollees.
- SAMHSA Core Reviews (SAPT and CMHS Block Grants) - The Contractor and its Subcontractors shall comply with and participate as required in DBHS and federal audits and Core Reviews of services and programs funded through the Substance Abuse Prevention and Treatment and Community Mental Health Services Performance Partnership Grants. Core Review findings shall be used to enhance and improve the delivery of Grant-required services for behavioral health recipients.

Attachment E

Field Audit Programs

(Please note: No audit programs will be represented in a public access version of this manual. Any programs are investigative in nature and are for confidential internal purposes only.)

Overview

As a part of the Division of Behavioral Health Services' (DBHS) Corporate Compliance Plan, contractors and providers are audited by DBHS in order to assess internal controls and compliance with applicable laws, regulations and contract requirements. DBHS is authorized to conduct audits of their contractors and subcontractors by Arizona Revised Statutes (A.R.S. § 41-2547, A.R.S. § 41-2548, A.R.S. § 35-214) and the Uniform and Special Terms and Conditions contained within the DBHS Regional Behavioral Health Authority (RBHA) contracts.

Audit Methodology

A RBHA is first selected from among the existing RBHAs under contract with DBHS from this RBHA. One outpatient provider with a minimum of 750 encounter lines for a twelve month period ending 3 months prior to the selection date was identified. As a result of this process, ██████████, Arizona was selected. The field audit was conducted on December 20, 2007. In consideration of the audit period selected, this report will refer to the RBHA as ██████████.

As a part of the audit, ██████████ responded to an internal controls assessment survey provided by DHBS. During the on-site portion of the field audit, ██████████ provided the auditor with an overview of the process from the time a client requests services to the billing of those services and internal controls associated with this process.

Based upon my assessment of internal controls, the audit program required me to randomly select 36 clients for review from the relevant population contained in a report created prior to the onsite visit. The report was generated from the DBHS' Client Information System (CIS) database and displayed encounters submitted by ██████████ from February 2007 to April 2007.

Auditors found and copied client progress notes, assessments, diagnoses, and relevant treatment plans from the 36 client files selected for services provided from February 2007 to April 2007. ██████████ staff also provided copies of encounter service logs (ESLs) which also serve as a means of recording staff work hours and provider summary vouchers (PSVs) which represent clinic encounters paid by ██████████. It should be noted that one encounter may include several errors. Therefore, encounter discrepancies may be counted more than once with the exception of Findings 1, 4, 5, 6, 8, and 9.

Findings

1. **Progress notes were not found for 9 of the 734 encountered services.** These services encountered had no corresponding progress note in the physical file provided although many had some type of clinic internal documentation related to the encounter. A comparison of the encounter data contained within the DBHS report, ██████████ patient progress notes, ESLs, and PSVs was conducted. ██████████'s procedure for documenting services provided is to produce a progress note and an ESL for each service provided. Discrepancies are listed below:
 - a. 8 services encountered did not have a corresponding progress note. However, ESLs showed that the service was provided.
 - b. 1 service encountered did not have a corresponding progress note or corresponding ESL. However, the PSV report indicates that services were provided.

According to the Arizona Administrative Code (A.A.C.) Title 9, Chapter 20, Article 2, Section 211 (D) (20) A licensee shall ensure that a client record contains ... documentation of behavioral health services provided to the client. [Audit Program 18]

2. **11 out of 734 encountered services did not have an ESL as required by internal procedures.** These services were all documented on progress notes. According to [REDACTED]'s description of internal control procedures, a progress note and an ESL is required for each service provided. ESLs are used by the Administrative Manager (AM) to enter data into a spreadsheet used to track billable and non-billable hours and services. ESLs are also used by [REDACTED]'s Support Center to enter billing data which is electronically submitted to [REDACTED]. [Audit Program 18]
3. **180 out of 734 encountered services contained a total of 196 variances of place of service codes and/or procedure codes reported.**
 - **In 3 instances, the place of service code discrepancies resulted in the clinic receiving inflated amounts for the services documented.** Examples include services provided at the office but billed under a different place of service which results in higher rates.
 - **In 6 instances, the place of service code was not documented on the ESL, but was noted on the progress note.** These errors did not affect the rate amounts.
 - **In 145 instances, the place of service encountered was different than the place of service documented on progress notes and/or ESLs.** Neither of these services resulted in an increase or decrease in the rate amounts.
 - **In 39 instances, the procedure code was not documented on the progress note but was noted on the ESL.** These errors did not result in an increase or decrease in the rate amounts.
 - **In 3 instances, the procedure code documented varied between documents (DBHS encounter data, progress notes, ESLs, and the PSV report of billed services).** The rate amounts were not affected by these errors.
4. **Based upon a review of [REDACTED]'s contract with [REDACTED] and DBHS encounter data, variances were found in 7 out of 734 encountered services. The encountered amounts for these services were \$30.75/unit less than the clinic's contracted amount.** Procedure code H0031 was encountered at \$30.75/unit. Per contract Exhibit B – Fee Schedule, the rate for this service is \$61.50/unit.
5. **In 29 instances, documentation of services (progress note and/or ESL) was provided, but no encounter data was reflected in the DBHS report, indicating that services provided were not encountered.** According to the Covered Services Guide (CSG) Version 5.9 effective 10/31/01, Section F. Billing for Services, 7.a.4, "A provider should bill all time spent in directly providing actual service, regardless of the assumption made in the rate model."
6. **In 189 instances, encountered services were voided although a corresponding progress note and/or an ESL indicated a service was provided. These encounters represent \$43,917.60.** According to the Covered Services Guide (CSG) Version 5.9 effective 10/31/01, Section F. Billing for Services, 7.a.4, "A provider should bill all time spent in directly providing actual service, regardless of the assumption made in the rate model."
7. **Based upon a review of units encountered (DBHS encounter data) and units documented on patient progress notes and ESLs, the following 18 discrepancies were found:**
 - In 4 instances, the number of units encountered was more than what was supported by a progress note resulting in the clinic receiving inflated amounts for actual services provided.
 - In 1 instance, the number of units encountered was less than the number of units supported by progress notes resulting in the clinic receiving lower amounts for actual services provided.

- In 13 instances, the units were encountered were supported by the duration documented on the progress notes and/or the ESL, but were not recorded at all or incorrectly on one of the two documents. Examples include duration of one hour and 4 units is documented on the progress note, but documented on the ESL as one hour and 3 units.

8. **A clinical review of medical records revealed instances of either missing or incomplete referrals, diagnoses, intakes, assessments, and/or treatment plans.** The audit program included a clinical review of assessments, diagnoses, and treatment plans of the selected clients. Copies of referrals, assessments, diagnoses, and treatment plan documentation relevant to services provided from February 2007 to April 2007 were obtained. The referral, assessment, diagnosis, and treatment plan documentation was reviewed by DBHS clinical staff to determine whether the client diagnosis is accurate based upon the assessment documentation, the treatment plan is in line with and addresses the diagnosis, and services provided are supported by the treatment plan.

According to [REDACTED]'s description of internal control procedures, services are initiated by a referral from [REDACTED] or other RBHAs. The referral includes a diagnosis and [REDACTED] services are based on the diagnosis provided by the referring agency. [REDACTED] staff conducts an intake and assessment to determine the level of service. The Program Director or designee completes the initial treatment plan based on the intake and assessment. [Audit Program 21]

a. **A diagnosis was not indicated on the referral form for client ID # [REDACTED].** According to written policies, referrals for services are received from [REDACTED] and any other RBHA. This referral contains the diagnosis of each client and also initiates the intake, assessment, and treatment plan processes resulting in services. [REDACTED]'s description of internal control procedures indicate that services are based on the diagnosis provided by the referring agency.

b. **An incomplete assessment was contained in the medical record for Client ID# [REDACTED].**

A.A.C. R9-20-209 E (1-7), states that an assessment shall include the following: A description of the client's presenting issue; An identification of the client's behavioral health symptoms and of each behavioral health issue that requires treatment; A description of the medical symptoms reported by the client and medical referrals needed by the client, if any; Recommendations for further assessment or examination of the client's needs; Recommendations for treatment needed by the client; Recommendations for ancillary services or other services needed by the client; and the signature, professional credential or job title, and date signed of: the staff member conducting the assessment or, if the assessment information was documented by a behavioral health technician, the behavioral health professional who reviewed the assessment information.

c. **Treatment plans for the following 5 clients could not be found: client ID # [REDACTED], client ID # [REDACTED], client ID # [REDACTED], client ID # [REDACTED], client ID # [REDACTED].**

According to A.A.C. R9-20-209 (J)(7) A licensee shall ensure that a treatment plan is developed for each client and that the treatment plan is reviewed and updated on an ongoing basis...

A.A.C. R9-20-209 (H) also states that a licensee shall ensure that policies and procedures for developing, implementing, monitoring, and updating a treatment plan are developed, implemented, and complied with.

9. **Of the 16 behavioral health technician/paraprofessional employee clinical supervision records provided by the clinic, 2 full-time employees did not receive the required number of clinical supervision hours. The clinic subsequently provided clinical supervision documentation for 2 part-time employees previously unable to be located by the clinic.**

According to AAC R9-20-205 (D) a licensee shall ensure that: 1. A behavioral health technician or a behavioral health professional who works full time receives at least four hours of clinical supervision in a calendar month. 2. A behavioral health technician or a behavioral health professional who works part time receives at least one hour of clinical supervision for every 40 hours worked.

It should be noted that all clinical supervision was provided by a staff member whose skills and knowledge to provide clinical supervision were not verified prior to providing clinical supervision according to the Summary Statement of Deficiencies in a survey completed on 9/22/06 by the Office of Behavioral Health and Licensing.

<p>Request for Information Instructions – Onsite Checklist</p>

Provider:

- | <u>Task</u> | <u>Completed</u> |
|--|------------------|
| 1. Obtain a copy of contract and amendments for the audit period June 2, 1007 through October 2007 . Including fee/rate schedule for services provided/encountered. | |
| If codes other than Current Procedural Terminology (CPT) manual or Common Procedural Coding System (HCPCS) codes are used on clinic documentation, please provide the appropriate matrix/crosswalk listing the equivalent codes. | |
| 2. Describe the contractual relationship with those that handle your encounters which are submitted to DBHS. Specify whether contract is related to the RBHA or a network. | |
| 3. VERIFY: Because the provider has received \$5 million or more in Title 19/21 funds during the previous 12 months, obtain the following: <ul style="list-style-type: none"> a) A copy of the compliance plan b) A copy of written policies and procedures/employee handbook regarding the False Claims Act and whistleblower protections for employees | |
| 4. Obtain copies of the following supporting documentation: <ul style="list-style-type: none"> - Diagnosis, assessment, and treatment plans associated with the services - All related case notes or documentation supporting encountered services for the consumers - selected (i.e. transportation logs, mileage tickets, vouchers, etc. if not provided in the form of a progress note) - Note whether case notes were provided electronically or found in the physical chart | |
| 5. Request that the clinic insert the names and credentials on Form A (attached) of personnel who provided services to the selected consumers during the audit period. | |

I certify that all documentation provided to auditors is accurate and true to the best of my knowledge:

 Name and Title [Please print]

 Signature

 Date

Sandra Reyes
 Signature
 Investigative Analyst
 Arizona Department of Health Services
 Office of Program Integrity
 150 N. 18th Avenue, Ste. 280
 Phoenix, AZ 85007
 Phone: (602) 364-4426
 Fax: (602) 364-4736
 E-mail: reyess@azdhs.gov

Request for Information Instructions

Please submit the following information requested within seven calendar days, from the date on the letter, using the enclosed FedEx US Airbill. A self-addressed airbill is attached for your convenience. Simply affix the Airbill to your envelope, box or packaging and check the appropriate box in section 5 so that charges are covered by ADHS. We know that 5 working days is a short timeframe, however, it is important to complete this request as thoroughly and accurately as possible to the best of your ability.

Feel free to contact Sandra Reyes, Investigative Analyst at (602) 364-4426 should any questions arise. Thank you in advance for your time.

1. Please submit a copy of your contract and amendments for the audit period **[month/day/year to month/day/year]**. Include a fee/rate schedule for services you provide/encounter.

If codes other than Current Procedural Terminology (CPT) manual or Common Procedural Coding System (HCPCS) codes are used on clinic documentation, please provide the appropriate matrix/crosswalk listing the equivalent codes.

2. Describe the contractual relationship with those that handle your encounters which are submitted to DBHS. Specify whether contract is related to the RBHA or a network.

3. **VERIFY:** Because you have received \$5 million or more in Title 19/21 funds during the previous 12 months, please submit the following:

- 1) A copy of your compliance plan
- 2) A copy of written policies and procedures/employee handbook regarding the False Claims Act and whistleblower protections for employees

4. For each service provided by your clinic to the consumers identified in the attached list please provide copies of the following supporting documentation:

- Diagnosis, assessment, and treatment plans associated with the services
- All related case notes or documentation supporting encountered services for the consumers selected
- Please note whether case notes were provided electronically or found in the physical chart

5. Please insert the names and credentials on Form A (attached) of personnel who provided services to the selected consumers during the audit period.

I certify that all attached documentation is accurate and true to the best of my knowledge:

Name and Title [Please print]

Signature

Date

Sandra Reyes
Investigative Analyst
Arizona Department of Health Services
Office of Program Integrity
150 N. 18th Avenue, Ste. 280
Phoenix, AZ 85007
Phone: (602) 364-4426
Fax: (602) 364-4736
E-mail: reyess@azdhs.gov

PROVIDER NAME AND ID]

ADHS/ODD/Office of Program Integrity Audit Number : _____

Outpatient Services Audit Program

Audit Step	Completed	WP
2. Select one RBHA outpatient provider and a three-month audit period (ending 6 months from selection date). Determine whether audit period is adequate.		
3. Randomly select 20 consumers with at least one encounter line from the total population during the audit period selected. The selection will be made from a reasonable portion of the population.		
4. Conduct an analysis of the provider's encounter data for the 12 months ending 6 months from the selection date. The analysis should include: <ul style="list-style-type: none"> a. Case management units avg, per encounter, per month b. Voided, deleted, overridden encounters c. Crisis mgt units, by recipient, by month d. Total encounter dollars billed by category, by month e. Total number of consumers served, by month 		
5. Determine whether the provider received \$5 million or more in Title 19/21 funds during the previous 12 months. If so, include the following in the request for information: <ul style="list-style-type: none"> 1) fraud and abuse policies and procedures, 2) written policies and procedures/employee handbook which should include information in regard to the False Claims Act and whistleblower protections for employees If the provider has received less than \$5 million, mark n/a for this step		
6. Determine whether scope of audit is adequate based on information received in the previous step. Document any variations from the audit program.		
7. Based upon review and scope of audit, determine whether onsite access of files is necessary.		
8. Send notification letter to provider and Request for Information. [Note: This Request for Information should not be sent if the audit is conducted onsite.]		
9. Contact provider to schedule audit within 5 business days of the date of the notification letter. [Note: If the audit is conducted onsite, request that a copy of the clinic's contract with the RBHA and fee schedule be available during the schedule onsite audit.]		

Audit Step	Completed	WP
<p>10. Review the following for relevant information related to the provider for a 12 month period (ending 6 months from the selection date):</p> <ul style="list-style-type: none"> a. Data validation study reports b. AHCCCS investigations c. ADHS/OPI d. Bureau of Consumer Rights-Grievance & Appeals and Customer Service complaints e. Licensing Division f. Any other audit reports available from DBHS g. HHS/OIG excluded provider list and corporate integrity agreements 		
<p>11. Review and confirm provider had current Provider Manual available during audit period.</p>		
<p>12. Obtain pre-selected medical records and conduct testing. Review, confirm and agree progress notes, encounter data, relevant treatment plans, and supporting business documents.</p> <ul style="list-style-type: none"> a. List all instances of no documentation of service b. List all instances of documentation not supporting submitted encounter data c. List all instances of encounters that are not in agreement with the relevant Covered Services Guide d. List all instances of encounters not supported by treatment plan (determined as a result of clinical's review) e. List instances where medical records are not available and explain f. List all instances of services provided and not billed (request billing documentation/status of encounter from RBHA) g. List all variances between the amounts contracted, billed, and encountered. h. List all instances of assessments not conducted in accordance with A.A.C. R9-20-209 (B) (i.e. assessments conducted by BHPs or supervised BHTs) 		
<p>13. Request technical assistance from clinical to review and confirm that treatment plans address diagnoses, diagnoses are correct based on assessments and services provided are supported by treatment plans.</p>		
<p>14. Request review and assistance on any unresolved matters related to Fieldwork #10.</p>		
<p>15. Confirm the eligibility status of each consumer reviewed during audit period (verify consumer is not in-patient during period).</p>		

Audit Step	Completed	WP
<p>16. Confirm license, certification, excluded parties list, accreditation and status of the provider and each professional providing services during audit period including those involved with the initial evaluation/diagnosis and the relevant treatment plan.</p> <ul style="list-style-type: none"> a. If matches in databases are found, send request for confirmation to clinic b. Forward confirmations to AHCCCS. 		

Attachment F

Fraud and Abuse Training Programs

Attachment G

OPI Forms and Reports

(Please note: Not all forms and reports will be represented in a public access version of this manual. Any excluded forms and reports are investigative in nature and are for confidential internal purposes only.)

Office of Program Integrity Record Retention Schedule

RECORDS RETENTION AND DISPOSITION SCHEDULE



Arizona State Library, Archives and Public Records
RECORDS MANAGEMENT DIVISION
1919 West Jefferson Street

Phoenix, Arizona 85009

Phone: 602-542-3741 Fax: 602-542-3890
E-mail: rmd@lib.az.us

PAGE 1 of

State Agency Password A0H-OPI	Political Subdivision	Agency Name AZ. Department of Health Services			
Org. Unit/Division Behavioral Health Services		Office Office of Program Integrity		Phone	
Address 150 N. 18th Avenue # 280		City Phoenix		AZ	Zip 85016
Submitted By (Name) Bobby Rivera		Title Office Chief		Signature X	

Pursuant to A.R.S. §41-1351, The following records retention periods are finite and absolute. They are *not* minimum retention periods or guidelines. Records may be kept beyond their designated retention periods only where required by law or regulation, or if they are needed in current or pending litigation.

No	RECORD SERIES	R.S. RETENTION (YR.)				REMARKS (Include start point of retention.)
		Code	Off.	R.C.	Total	
1.	Fraud & Abuse Audits/BHS Providers		1	9	10	
2.	Investigations- (Substantiated) Public, Internal, HealthCare providers or clients		5	15	20	After case closed or upon closure of facility.
2 a	Investigations-(Unsubstantiated) Public, Internal, HealthCare providers or clients		1	4	5	After case closed.
3.	Complaints Public, Internal, HealthCare providers or clients		1	4	5	After case closed.
4.	Case files		1	4	5	After case closed

5.	Newsletters		1.5	2.5	4	On January 1, archive previous FY **Newsletters must be maintained until our agency's Administrative review is completed.
6.	Training (provided by agency) syllabi, handouts & presentation material		1	2	3	Archive after calendar year.

Approved by: X Director, Arizona State Library, Archives and Public Records	Approval Date:
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RMC-2 R8/00

