



Origination 10/4/2021
Last Approved 12/8/2025
Effective 12/8/2025
Last Revised 12/8/2025
Next Review 12/8/2026

Owner Samuel
Shea:
GOBHI
Operations
and
Compliance
Senior
Manager

Area GOBHI
Compliance

Applicability Greater
Oregon
Behavioral
Health, Inc.

References Behavioral
Health,
Compliance

GOBHI Payment Integrity Monitoring, Auditing, and Overpayment Policy

I. Policy Statement and Purpose

- A. GOBHI will maintain a Payment Integrity Program including monitoring, auditing, and identifying and recouping overpayments. GOBHI will engage in ongoing monitoring of risk indicators to identify potential overpayments to individual providers as well as specific CPT/ HCPCS code usage concerns among the provider network.
- B. GOBHI will engage in routine and ad hoc Payment Integrity Audits. GOBHI will develop an adequate formal annual routine audit plan, including scope and estimated auditing timeline based on GOBHIs audit capacity including potential for ad hoc audits. This plan will be documented in the approved Annual Compliance Plan.
- C. This policy applies to routine Payment Integrity Audits for capitated and fee for service providers, as well as audits as a result of Fraud, Waste, and Abuse Notifications. The results of these monitoring and auditing activities will be reported quarterly to the GOBHI Chief Executive Officer and the board of directors.

II. Definitions

- A. **Administrative Finding:** Minimal documentation standards were not met but the error did not cause the claim/encounter to a full or partial overpayment.
- B. **Capitated Provider:** A provider that receives a fixed, predetermined payment from GOBHI to deliver a defined set of services to enrolled members for a specified period of time, regardless of the volume or cost of services actually provided.
- C. **Claims:** Billable services including diagnosis (ICD-10 codes), Federal CPT/ HCPCS codes, date of service, units of service, and rendering provider for both in and out of network services.
- D. **Corrective Action Plan (CAP):** A Corrective Action Plan (CAP) is a formal, structured plan developed by a provider in response to audit findings outlining the specific actions the provider will take to mitigate the findings within defined timeframes.
- E. **Encounters:** Billable services including diagnosis, Federal CPT/ HCPCS codes, date of service, units of service, and rendering provider capitated services.
- F. **Extrapolation Audit:** A statistically valid auditing method used to estimate the total amount of overpayment or error in a full population of claims based on the results of a sample. 95% confidence level is applied, meaning the calculated overpayment amount is statistically expected to fall within the constructed confidence interval at least 95% of the time if the audit were repeated under the same conditions.
- G. **Extrapolated Overpayment:** Overpayment determined by extrapolating the actual overpayment over the provider target population using valid statistical methods.
- H. **Fee for Service Provider:** A provider that is reimbursed by GOBHI based on the number and type of covered services delivered. Payment is made per service, procedure, or encounter, according to an established fee schedule, billing code set, or contractual rate.
- I. **Financial Finding:** Material clinical documentation standards were not met resulting in the claim/encounter being considered a full/partial overpayment.
- J. **Mitigation Monitoring Audit:** An audit to determine the mitigation of prior administrative and financial findings and completion of corrective action plans.
- K. **Overpayment:** An overpayment is any payment made by the organization to a provider that exceeds the amount the provider is legally, contractually, or entitled to receive, regardless of intent. An overpayment may result from errors, omissions, misinterpretations, or actions that are intentional or unintentional
- L. **Payment Integrity:** The framework of processes, controls, reviews, and auditing activities designed to ensure that all payments made by the organization are accurate, medically necessary, properly supported, and compliant with federal and state regulations, contractual obligations, and established coding and documentation standards.

III. Procedure

- A. Monitoring
 - 1. GOBHI will conduct ongoing monitoring of data to identify risk areas following the following sources: all paid claims reports, claims flag report, and utilization management data.

2. GOBHI will monitor regulatory risk sources including; Office of Inspector General (OIG), Center for Medicare and Medicaid Services (CMS), and The Oregon Health Authority (OHA) including the Office of Payment Integrity (OPI) communications.
3. GOBHI will inform its audit scope in the annual Compliance Work plan from ongoing monitoring to include high cost / volume codes, codes vulnerable to improper payment, emergent outliers, duplicate billing, and patterns of unbundling or upcoding.

B. Routine Provider Audits

1. GOBHI will conduct routine provider audits, including Payment Integrity or Mitigation Monitoring, reviewing clinical records necessary to establish a pattern of compliance or noncompliance for the claims/encounters selected for audit.
 - a. GOBHI will engage in Payment Integrity or Mitigation Monitoring audits of *capitated* providers annually.
 - b. GOBHI will engage in Payment Integrity or Mitigation Monitoring Audits of contracted *fee for service* providers no less than every three years.
 - c. GOBHI will engage in Payment Integrity or Mitigation Monitoring audits of *non contracted fee for service* providers as needed.

C. Ad Hoc Provider Audits

1. GOBHI will conduct ad hoc provider audits, reviewing clinical records necessary to establish a pattern of compliance or noncompliance for the claims/encounters identified for audit based upon Fraud, Waste, Abuse concerns or reports, including Oregon Office of Payment Integrity (OPI) Notifications of Potential Overpayment.

D. Audit Scope

1. GOBHI will primarily use non-statistical samples for routine audits that are representative of services provided, including Mental Health and Substance Use Disorder services when appropriate. Claims/ Encounters selection will be completed by the GOBHI Data Team.
2. GOBHI may engage in an extrapolation audit when appropriate, with 95% confidence interval for audits of 100 or more Claims/ Encounters.
3. The auditor will review clinical records to determine if documentation meets the minimum requirements for Medicaid payment, including clinical documentation standards incorporated therein OARs Chapters 309 and 410, as applicable based on provider type.
4. The audit tool(s) will be based on the laws, regulations, coding guidelines, and medical necessity standards, that were in effect on the date the service was rendered.
5. The audit review period will be informed by Claims Run Outs in order to select claims / encounters as close to the date of the audit as possible. The review period will be dependent on submission volume in order to ensure a pattern of compliance or non-compliance can be established.
6. During the audit, the auditor will review to ensure that providers furnishing services to

members maintain and share, as appropriate, a member health record in accordance with professional standards in the delivery of care and coordinating services for members per 42 CFR 438.208 (b)(5) to:

- a. Ensure release of information is obtained when applicable.
- b. In review of member chart information, ensure sharing of information for care coordination purposes aligns with HIPAA guidelines and protected health information is maintained appropriately.
- c. Provider violations will be reported to GOBHI Privacy Officer for appropriate followup.

E. Audit Process

1. GOBHI will notify providers of the intent to audit including: audit structure and timeline, claims selection overview, request for records access, data validation overview, the document components included in the audit, potential findings types, and a copy of the audit tool.
2. GOBHI will complete a written Preliminary Report documenting initial findings that will be delivered to the provider. If the auditor identifies findings, the details of those findings will include a general description, the corresponding rule(s), and whether each finding is an Administrative Finding or a Financial Finding. The Preliminary Report will include a detailed claim/encounter report in which each specific claim/encounter is reviewed and linked with the corresponding finding, as well as an estimate of the overpayment.
3. The provider will have thirty (30) calendar days to review and respond to the Preliminary Audit Report and provide any additional materials or information related to the findings. Providers may request a meeting to discuss findings, and GOBHI will accommodate these meetings whenever possible. Providers may request an extension due to specific barriers to meeting the response timeline and must provide an intended response date. GOBHI maintains the right to approve or deny extensions at its sole discretion.
4. GOBHI will review the provider response to Preliminary Findings and additional information provided to support the validity of claims/encounters, and issue a Final Report to the provider. The Final Report will include an updated detailed claim/encounter report as applicable in which each specific claim encounter reviewed and the corresponding finding, an estimate of the overpayment, and payback process overview.
5. The provider will have thirty 30 calendar days from the Final Report to submit an appeal against the findings. Providers must submit a formal notification to appeal in writing. The appeal must use the detailed claim/ encounter report to indicate which specific claims are being appealed, including the reason for appeal, and or the supporting documentation being submitted to overturn the finding. Providers may request an extension with specific barriers to meeting the response timeline and must provide an intended response date. GOBHI maintains the right to approve or deny extensions at its sole discretion.
6. If no appeal is made, the provider will have 30 calendar days from the required appeal notification date to submit a Corrective Action Plan (CAP). GOBHI will review

the submitted CAP and approve, approve with additional actions, or deny based upon the adequacy of the plan to mitigate findings. Providers may request an extension with specific barriers to meeting the response timeline and must provide an intended response date. GOBHI maintains the right to approve or deny extensions at its sole discretion.

7. The appeal review will be conducted by an individual who was not involved in the original audit, and did not participate in the audit findings.
8. The assigned appeal reviewer will complete the appeal review and issue an Appeal Response Letter indicating whether findings were upheld, partially upheld, or overturned. The Appeal Response Letter will provide a written explanation of the appeal reviewer's decision as well as the detailed claim/encounter report as applicable in which each specific claim/encounter reviewed reflects the appeal decision, corresponding finding, and an updated estimate of the overpayment and payback process overview.
9. Following the appeal review the provider will have 30 calendar days from the appeal response date to submit a Corrective Action Plan (CAP). GOBHI will review the submitted CAP and approve, approve with additional actions, or deny based upon the adequacy of the plan to mitigate findings. Providers may request an extension with specific barriers to meeting the response timeline and must provide an intended response date. GOBHI maintains the right to approve or deny extensions at its sole discretion.

F. Financial Findings and Overpayment Recoupment

1. *Fee for Service*: When audits result in Financial Findings, the provider will refund the amount paid by voiding or rebilling the claim as determined by the Final Report or Appeal Response in compliance with the Overpayment Notice. To the extent the provider does not make timely repayment of the amounts owed, GOBHI may also recoup amounts paid from other payments owed the provider as permitted by the Provider Agreement.
2. *Capitated Services*: When audits result in Financial Findings, the provider will adjust, void or replace the encounter, as appropriate within the later of thirty (30) calendar days of receiving the final report or resolution of the provider's appeal, if any. If Financial Findings occur on more than 30% of sampled claims, GOBHI may also seek repayment of the value of the encounters that resulted in Financial Findings. The value will be determined using the OHA Behavioral Health fee schedule without extrapolation.
3. Financial findings resulting in overpayments:
 - a. GOBHI will follow the GOBHI Reporting Overpayments Policy.
 - b. GOBHI Auditor sends written notification to GOBHI Data Liaison including; Specific claims/encounters to be voided in claims system.
 - c. GOBHI Data Liaison notifies EOCCO/MODA Claims Team with a list of voided claims/encounters.
 - d. EOCCO/MODA Claims Team sends a written invoice list to affected providers including payback process details and contact information.

4. As a result of Mitigation Monitoring audits GOBHI may re-audit a sample of records after an appropriate period of time to determine if the corrective action has been effective. If the audit reveals that the corrective action plan has not been effective, GOBHI may take additional corrective action as permitted by the Provider Agreement including new administrative or financial findings.
- G. At GOBHI, we acknowledge and address the historical and ongoing injustices and discrimination faced by individuals based on age, color, disability, gender, gender identity, language, national origin, race, religion, and sexual orientation. We firmly believe that the diverse cultures, ethnicities, backgrounds, and experiences of our staff and the individuals we serve are invaluable assets in shaping and improving our policies and procedures for the advancement of diversity, equity, and inclusion (DEI) practices in our daily work.

IV. Related Policies & Procedures, Forms and References

- A. 42 CFR 438.208 (b)(5)
- B. Federal Sentencing Guidelines §8B2.1.(5)(B)
- C. GOBHI Reporting Overpayments Policy
- D. OAR 309-018-0140 through OAR 309-018-0150
- E. OAR 309-019-0135 through OAR 309-019-0140
- F. OAR 410-120-1560 to OAR 410-120-1700
- G. OAR 410-141-3890

V. Affected Departments:

- A. Compliance Department

Approval Signatures

Step Description	Approver	Date
Policy Owner	Samuel Shea: GOBHI Operations and Compliance Senior Manager	12/8/2025

Applicability

GOBHI