NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: Two – Quality Improvement
PROCEDURE NAME: CLAIMS VALIDATION AND RECORD REVIEW
EFFECTIVE DATE: June 1, 2013

PURPOSE

To ensure that services provided and claimed or reported to funding sources meet the documentation requirements of the funder, e.g. Medicaid, MDCH or third party payers.

APPLICATION

North Country Community Mental Health Provider Operations

PROCEDURE

The Clinical Liaison will review records and audit claimed services provided by NCCMH employees and contract providers according to the following guidelines:

A. NCCMH Service Providers (includes employees and contract professionals that provide services through NCCMH operated programs)

A random sample of service claims provided by NCCMH employees are audited quarterly by the Northern Affiliation. The results are sent to North Country's Clinical Liaison for corrective action. Audit findings are tracked in a database for trend analysis and for identifying staff training needs. Staff are responsible for taking corrective action to bring the clinical record into compliance.

B. Residential and Day Service Contract Providers (in catchment)

1. A claims validation audit will be conducted annually for in-catchment day program providers and alternate years for a sample of contract residential providers, and semi-independent living supports providers. Providers that have no findings for two consecutive years will be reviewed tri-annually.
2. The sample will minimally consist of one client per contractor for residential contractors. For residential contractors with multiple facilities, the sample will consist of one client from each facility.
3. The sample for semi-independent living supports providers will minimally consist of 10% of the total clients served during the past year.
4. The audit will validate that:
   a. Documentation supports the service billed.
   b. Services were provided consistent with the amount, frequency and duration in the Plan of Service and consistent with the provider's contract.
5. Findings will be reviewed with the contract provider's designee on the day of the audit. A report of the findings will be sent to the contract provider within five workdays. A corrective action plan will be required if the contractor scores below 95% compliance or has a significant finding, as determined by the Compliance Leader.
6. Claims that are not validated will be adjusted and evidence will be provided to the Clinical Liaison.
7. The contract provider and NCCMH staff, as appropriate, shall be responsible for taking corrective action to bring the clinical record into compliance.
8. A summary report will be provided to the Compliance Leader annually to assess the need for additional training or corrective action by providers.

C. Contract Professional Services

1. A prospective audit will be conducted as claims are received for payment.

2. Providers with no findings for twelve consecutive months will be audited semi-annually.
3. Clinical documentation supporting each claim will be audited utilizing the Northern Affiliation's claims validation criteria.
4. Findings of invalidated claims will be reported to the accounting department.
5. The contract provider will be notified in writing within one business day of any claim determined to be invalid and for which payment is withheld. A corrective action plan will be required if the provider scores below 95% compliance or if a significant finding is identified.
6. The contract provider and NCCMH staff, as appropriate, shall be responsible for taking corrective action to ensure clinical documentation compliance.
7. A summary report will be provided to the Compliance Leader annually to assess the need for additional training or corrective action by providers.

D. Retrospective Audit of Closed Cases

1. An audit will be conducted quarterly on closed cases for appropriate level of service utilization and compliance with discharge procedure.
2. The sample will include one case randomly selected from each of the following programs: ACT, CSS/MI, CSS/DD, Outpatient and OAS.
3. Findings will be reported to the UM Committee quarterly and used for staff training, as needed.

The Program Supervisor, or Contract Provider, and the Clinical Liaison will ensure that appropriate corrective action is taken following the review. Data will be tracked by the Clinical Liaison to identify trends for training and education or other areas of quality improvement. A focused audit may be conducted based on findings from any of the routine audits. The Compliance Leader will submit a report to Leadership annually on findings, trends and corrective actions.

REFERENCE: Medicaid Provider Manual
NCCMH Regulatory Compliance Plan

REVISED: 4/13/09;11/5/10; May 6, 2013

APPROVED BY SIGNATURE:

Christine Gerhardt — Administrative Services Director — Date: 6/18/13

Alexis Kaczynski — Director — Date: 6/13/13