NORTH COUNTRY COMMUNITY MENTAL HEALTH
ADMINISTRATIVE MANUAL

CHAPTER: Two – Quality Improvement
PROCEDURE NAME: CLAIMS VERIFICATION AND RECORD REVIEW
EFFECTIVE DATE: February 1, 2016

PURPOSE

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

APPLICATION

North Country Community Mental Health Programs

PROCEDURE

Medicaid claims audits are performed quarterly by the Northern Michigan Regional Entity on a random sample of at least 2% of all Medicaid claims and 5% of community inpatient services claims.

The Reimbursement Supervisor or Chief Clinical Officer review and respond to the quarterly Medicaid audits performed by the NMRE. Review and Response Includes:

- Assurance that all needed documentation is available for the auditor
- Assurance that claims corrections are completed within specified time frame
- Provision of documentation proving claims corrections were made
- Audit findings are shared with involved staff
- A summary of corrections is provided to Chief Operating Officer and Executive Team.

Data is tracked by the Chief Quality Officer to identify trends for training and education or other areas of quality improvement.

The Reimbursement Supervisor runs monthly reports to identify the following claims for correction or adjustment prior to State reporting:

- Concurrent services
- Services posted without an associated current Plan of Service
- Services posted with incorrect time span/duration

Claims submitted by other CMHSPs and professional service contractors are required to be accompanied with associated documentation.

Claims and documentation by new contractors and staff is reviewed during the first 30 days of service provision. Additional training and claims adjustments are provided as needed.

A focused audit may be conducted based on findings from any claim's validation audit.

Periodic review of closed cases is done to ascertain compliance with person-centered planning, review of progress, and other clinical documentation requirements.

The Chief Operating Officer submits a report to the Executive Team annually on findings, trends and corrective actions.

REFERENCE: Medicaid Provider Manual
NCCMH Regulatory Compliance Plan

REVIEWED: 10/06/08; 12/12/14; May 7, 2020

REVISED: 02/12/07; 04/13/09; 11/05/10; 05/06/13; 01/25/16

APPROVED BY SIGNATURE:

Christine Gebhard	*1/26/16*
Chief Operating Officer	Date
Alexis Kaczynski	*1/28/16*
Director	Date