

SUBJECT Claims Verification		CHAPTER 04	SECTION 03	SUBJECT 02
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I. APPLICATION:

- PIHP Board
 CMH Providers
 SUD Providers
 PIHP Staff
 CMH Subcontractors

II. POLICY STATEMENT:

It is the policy of the Region 10 PIHP to conduct or have conducted claims verification reviews throughout the network in order to ensure billed services are documented in compliance with internal, state, Medicaid, and other applicable standards. It is also the policy of the PIHP to follow up on any reports of confirmed or suspected non-compliant billing or documentation practices through a focused audit process. Both audit types have the potential to result in payment recovery for claims not meeting the standards applied.

III. DEFINITIONS:

Focused Claims Audit: A claims audit that may be scheduled at any time in response to reported concerns of inappropriate billing practices.

EMR: Electronic Medical Record

Clean Claim: A valid claim submitted to the PIHP by a credentialed network provider, in the format and timeframes specified by the PIHP that can be processed without obtaining additional information from the provider or third-party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Deficient Claim: A submitted claim that does not contain the required clean claim elements.

Valid Claim: A claim for mental health and substance abuse supports and services that the PIHP is responsible for claims management and payment, either under the MDHHS Medical Specialty Service contract; or under the CMH contracts. It includes services authorized by the PIHP and services authorized by the CMH as specified in PIHP clinical protocols.

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IV. STANDARDS:

1. 100% of claims are subjected to quarterly automated review, matching claimed services with documentation in the EMR, per National Claims Coding initiative (NCCI) standards (<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>). Additionally, claims may be sampled from the provider network, both randomly and targeted, to address concerns:
 - Where potential issues are identified by automated claims verification processes;
 - Where PIHP staff or others identify potential issues; or
 - Proactively, at the PIHP's discretion.

If an onsite visit is required, the PIHP will notify the provider of an impending standard claims audit three to five days prior to the scheduled audit time, and will notify the provider of an impending focused claims audit two to 48 hours prior to the scheduled audit time. Where review takes place entirely within the EMR and no on-site visit is required, no notice need be given.

2. In order to demonstrate full compliance, clinical documentation must meet the following standards:
 - Services billed are included in an Individual Plan of Service, valid on the date of service, in the record.
 - Documentation must be in the clinical record and available to the auditor at the time of the audit and must include:
 - The exact name or code of the service billed.
 - Written documentation that the service occurred face-to-face.
 - The date of service.
 - Start and stop times for services that are time-specific.
 - The signature and credentials of the individual providing the service. Where illegible, the signature and/or credentials must be printed or typed below the handwritten signature and/or credentials. Where electronically signed information from a provider's internal electronic medical record is printed out for auditor review, a pen-and-ink signature does NOT need to be added. However, the document must explicitly identify that the form has been electronically signed.
 - The name and case number (if applicable) of the consumer receiving the service.
 - All elements of the documentation are legible.
 - The individual staff is appropriately credentialed to provide the service as required by Michigan Department of Health and Human Services (MDHHS).
3. The PIHP will report compliance findings to the appropriate PIHP department(s) on an ongoing basis. Events found to be non-compliant with any of the standards above will be reported in detail to the PIHP Contract Management department and will have the potential to result in corrective action and/or other action.

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V. PROCEDURES:

1. The Provider is responsible for:
 - Maintaining documentation that meets the above standards to support all services billed.
 - Reviewing and increasing awareness of the PIHP Claims Verification process related to their service provider type.

2. The PIHP is responsible for:
 - Annual reporting of compliance with NCCI and PIHP compliance standards.
 - Coordinating and participating with other PIHP departments to complete focused as needed in response to any concerns regarding non-compliant documentation and/or billing practices.
 - Annual review by Utilization Management Committee.
 - Reporting claims verification results to the Board of Directors and other stakeholders annually, as required by the PIHP Quality Assessment and Performance Improvement Plan.
 - Consulting Corporate Compliance Officer as appropriate.

3. The Chief Financial Officer will annually review this policy.

VI. EXHIBITS: N/A