

COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN	<i>Policy and Procedure</i>		
Department Finance	# of Pages: 7		
Policy Name SERVICE VERIFICATION	Type of Policy: <input type="checkbox"/> WCHO <input checked="" type="checkbox"/> Regional <input type="checkbox"/> Network		
Policy Number	Effective Date	Revision Date	Approval Date 9/19/06
Administrative/Board of Directors Sign Off			
Administrative Signature:			Date:
Board of Directors Signature:			Date:

I. PURPOSE

To establish a procedure to assure services were provided as approved and in accordance with individual Person Centered Plans.

II. APPLICATION

All agencies authorized to provide services as credentialed through the Regional Network Management Committee, and contracted with the WCHO/PIHP or its CSSNs/CSSN-Look-a-likes, and Substance Abuse Coordinating Agencies.

III. DEFINITIONS

Authorization: A form listing the CPT Code (service descriptor) of the service the provider has been contracted with to provide and is in accordance with the Person-Centered Plan for the individual consumer.

Claim: Invoice submitted for payment in accordance with the Authorization issued to the particular provider.

CPT Code: A standardized service code as listed in the Current Procedural Terminology manual issued by the American Medical Association. This manual is updated annually.

HCPCs Code: A standardized service code as listed in the Healthcare Common Procedure Coding System manual issued by the American Medical Association. This manual is updated annually.

IV. POLICY

It is the policy of the WCHO to investigate and document services provided to consumers to assure that the services were provided in accordance with Person Centered Plans and are paid for with the appropriate funding source.

V. EXHIBITS

- A. Service Verification Flow Charts: for Process; Document Review; and Reporting and Follow Up

VI. REFERENCES

- A. Balanced Budget Act: 438.608; 447.46
- B. The Deficit Reduction Act of 2005
- C. Whistleblowers Act
- D. Title 42—Public Health; Part 455—Program Integrity; Subpart A—Medicaid Fraud Detection and Investigation Program [cite: 42CFR455.17]
- E. Current Procedural Terminology (CPT) manual issued by the American Medical Association
- F. Healthcare Common Procedure Coding System (HCPCS) issued by the American Medical Association
- G. Person Centered Plan Policy
- H. Service Authorization Policy

VII. PROCEDURES

WHO

DOES WHAT

CSSN/CSSN-Look-Alike/Provider

1. Follows the Person-Centered Plan/Treatment Plan policy.
2. Issues Authorization in accordance with approved service entrance and exit criteria and appropriate CPT Code.
3. Monitors Authorizations and PCPs/Treatment Plans.
4. Documents services provided to individual consumers in a format that provides sufficient support to assure accurate claims submission.
5. Submits claims within timeframe outlined in contracts (60 days from date of service; from date of discharge for hospitals). Submission of claims for consumers on the Habilitation Service Waiver is within 30 days of service.

Local Finance Department

1. Adjudicates and Pays Claims timely. Clean Claims (i.e., error-free) are to be paid within 30 days of submission.
2. Runs monthly Reassignment Report to retroactively adjust payments to the proper Funding Source.

WHO

DOES WHAT

System Verification

3. Completes Journal Entries in financial system if Reassignment Report indicates a correction to a fund source.
4. The electronic claims payment system completed Automatic Integrity Checks. When Claim is submitted, the system verifies that the claim information matches the authorization information. The Authorization check verifies that the CPT Code was authorized, that there is a sufficient number of service units still available, submission of claim is within allowed time period, and that the Provider Contract is active.
5. System also identifies the Fund Source (insurance type) in effect at the time the service was provided.
6. The Reassignment Report provides information to retroactively adjust for retroactive changes to and Fund Source that should have been in effect at the time of the service.

PIHP Accountant

1. Completes Site Reviews of all contracted providers of the Community Mental Health Partnership of Southeastern Michigan (CMHPSM)—fifty percent the first year; the other fifty percent the second year.
2. Financial Site Review Process includes review of all Provider Documentation to determine whether or not that evidence supports that the claim paid was in accordance with the service authorization; i.e., proper CPT Code was used and units of service were actually provided.
3. Runs Claims Payment Detail Report including client-level detail of services paid.
4. Selects random sample of cases.
5. Conducts on-site review of Provider’s documentation.
6. If Financial Fraud is suspected, notifies PIHP Finance Director who then follows the Financial Fraud Investigation and Reporting Policy.
7. Monitors Financial Plan of Correction if one is required of the Provider

PIHP Provider Relations Unit

1. Conducts review of Provider Documentation to determine if Provider properly implemented the Person Centered Plan (available to Provider through electronic system, Encompass) by review of Progress Notes, Community Outing Logs, Medication Charts, Safety of Environment, Current Consent Forms, Staffing Ratios, and/or Evident of State Trainings.

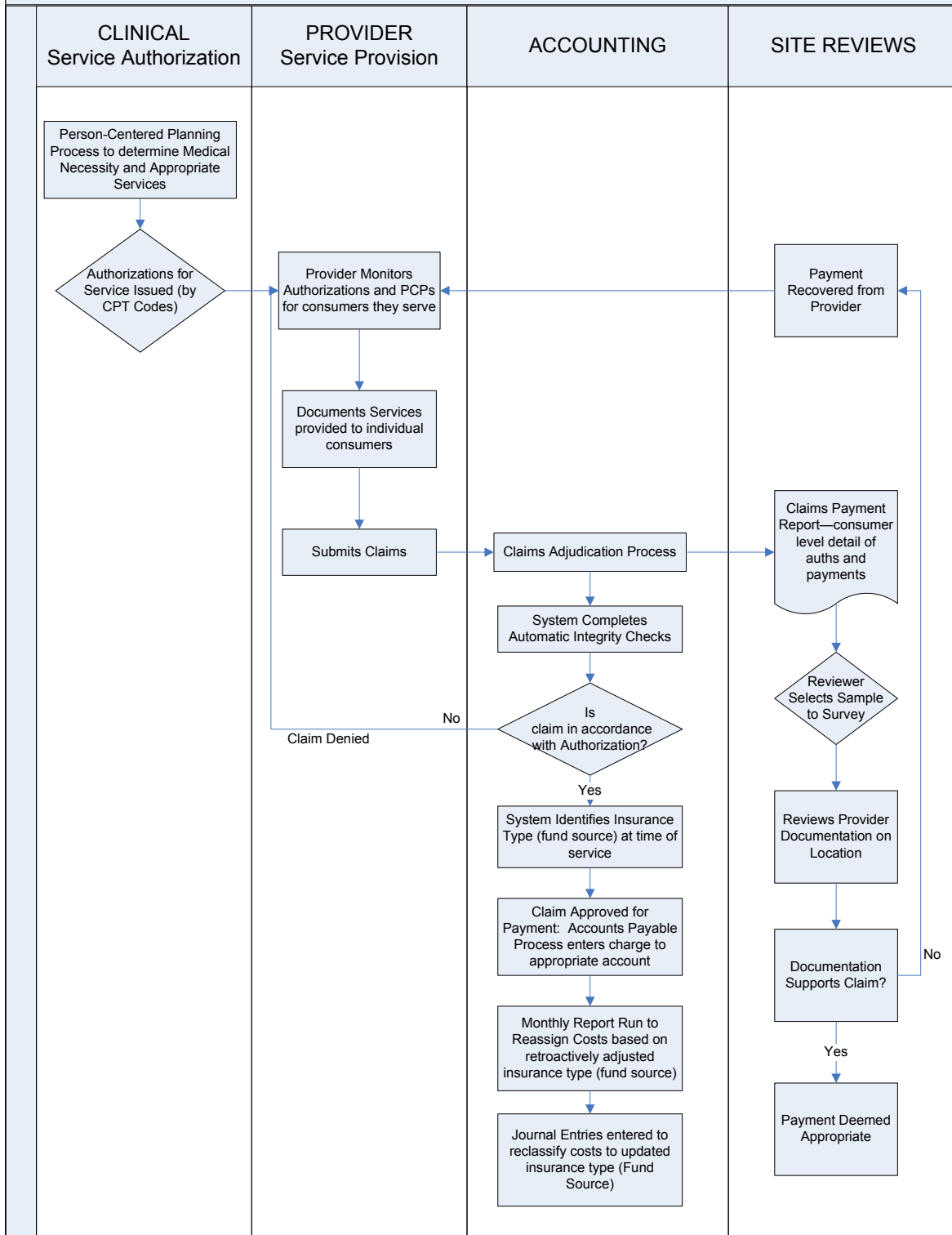
WHO

DOES WHAT

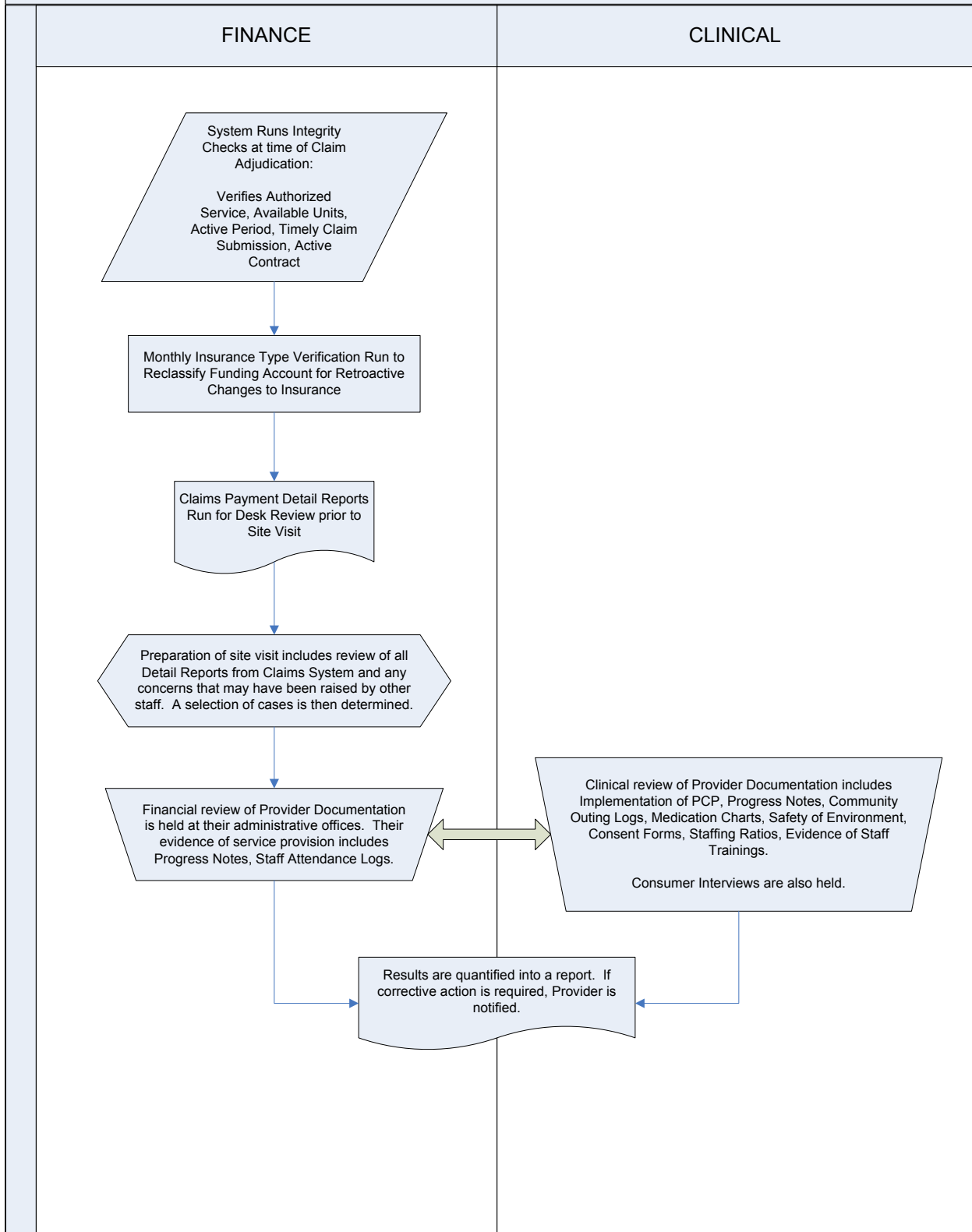
PIHP Provider Relations Unit

2. May also include Consumer Interviews during Site Review.
3. Notifies Provider of Results of Clinical and Financial Site Reviews.
4. Notifies Office of Recipient Rights if a Rights Violation may have occurred.
5. Requires and Monitors of Service Provision Plan of Correction if necessary.

SERVICE VERIFICATION--Process



SERVICE VERIFICATION—Document Review



SERVICE VERIFICATION—Reporting and Follow Up

