ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

Date Issued 5/24

CHAPTER Access to Services		**CHAPTER** 02	**SECTION** 003	**SUBJECT** 0020
SECTION Utilization Management	**SUBJECT** Claims Verification			
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct Operated Programs
- ☒ Community Agency Contractors
- ☐ Residential Programs
- ☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair Community Mental Health Authority (SCCCMHA) shall manage its claims management system in accordance with federal and state regulations as required by the Michigan Department of Health and Human Services (MDHHS) Contract.

III. DEFINITIONS:

A. Clean Claim: a valid claim submitted to the CMH by a credentialed network provider, in the format and timeframes specified by the CMH that can be processed without obtaining additional information from the provider or a 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. (For further detail, refer to Administrative Procedure #07-002-0025, Claims Payment Appeals.)

B. Deficient Claim: a submitted claim that does not contain the required clean claim elements as described by SCCCMHA administrative procedure definition contained in #07-002-0025; or upon medical chart review, required documentation is not available that supports the submitted claim that had been paid by the CMH to the provider.

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

D. Data Entry System (DES): (1) the practice management software system to which the provider electronically enters service encounter information, which generates billings via an 837 file submitted into the CMH, and (2) the managed care software system by which claims are managed by the CMH with an 835 file issued back to the provider.

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E. Utilization Management (UM): the Care Management system which consists of a set of functions and activities focused on ensuring that eligible consumers receive clinically appropriate, cost effective services delivered according to clinical best practice guidelines, focused on obtaining the best possible outcomes.

F. Utilization Review (UR): The medical record review process established to ensure that the Utilization Management Program's service standards, protocols, practice guidelines, authorization and billing procedures are adhered to by all network service providers.

IV. STANDARDS:

A. The SCCCMHA shall implement a post-payment review process of valid claims that have been authorized for payment by the CMH. It shall be the goal to review the claims of a minimum of two and a half (2.5%) of Individuals served directly by SCCCMHA during prior fiscal year. The CMH shall review the claims of a minimum of 5% of contract agency claims for Individuals served during the prior fiscal year in each Primary Caseholder location, (PCC, New Oakland and Norserv). Non-Primary Caseholder Contract location will be reviewed upon request.

B. The Claims Verification process shall concentrate on the following aspects within its post-payment review methodologies. Such verification shall consist of a review of the electronic health record, OASIS to verify supporting clinical evidence of the paid claim exists in OASIS for the date of the service encounter/claim. Verification methodologies include:

1. Verification that the clinical document supporting the claim is appropriately completed and signed (credentialed) in OASIS.
2. Verification that the service/support was identified in the consumer's individual treatment plan.

C. Claims Verification reviews shall occur concomitantly with clinical utilization review for all Direct Operated locations and Primary Caseholder Audits (PCC, New Oakland and Norserv).

D. Special program reviews or staff reviews may be requested more frequently as determined necessary by SCCCMHA staff.

E. All sub-network medical charts shall comply with existing standards, rules or interpretative guidelines as defined by the SCCCMHA, MDHHS, Medicaid, Medicare, and other insurance companies.

1. Any clinical review that falls below 95% will receive an additional review by the program director.

F. Claim Verifications review findings shall be presented to the designated UM financial/data staff prior to recommendations being issued to improve local processes, and/or a denial of any paid claim.

G. The SCCCMHA may appeal any claim verification finding, following the appeal process delineated in Administrative Procedure, #02-003-0011 Utilization Management.

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V. PROCEDURES:

Data Management Technician

1. Identifies prospective medical charts and related claims to review, using the utilization review priorities of the St. Clair UM Team.

Staff

2. Identifies special program/claims reviews as identified by the SCCCMHA.

Data Management Technician

3. Pulls service data on cases selected for utilization review and sets up claims verification worksheet.

4. Performs Claims Verification Review on selected medical charts.

5. Completes demographic area and compliance areas of Clinical Utilization Review document prior to Clinical Review.

6. Following completion of Claims Verification Review, prepares Final Claims Verification Report and Final Overall Counts with Percentages Report and forwards to the appropriate directors.

Utilization Management Designated Staff

7. Reviews Claims Verification Report. See Administrative Procedure #02-003-0011, Utilization Management for action steps.

8. Issues approved Claims Verification Report to the SCCCMHA for follow-up action, if necessary.

Data Management Technician/Designee

9. Prepares statement for claims adjustments based on the report findings, if necessary. Forwards claims adjustment request to finance director and supports services director for final approval.

Data Management Technician

10. Prepares annual Medicaid Service Claims Verification Report for distribution to MDHHS, SCCCMHA Board, and SCCCMHA UM staff.

VI. REFERENCES:

None Available

VII. EXHIBITS:

None Available

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VIII. REVISION HISTORY:

Date issued 08/03, 08/05, 05/08, 10/11, 05/13, 05/14, 07/15, 11/16, 11/17, 05/19, 05/21, 05/22, 05/23.