

LAKESHORE BEHAVIORAL HEALTH ALLIANCE
Community Mental Health Services of Muskegon County
Community Mental Health of Ottawa County
Lakeshore Coordinating Council for Substance Abuse Services

Policy
No. 20-023

Prepared by: John North

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Approved by:

SUBJECT: Claims Verification

David Parnin, Chief Operating Officer
Community Mental Health Services of Muskegon County

I. POLICY

The CMH Agency shall review a sample of claims to determine that payments for services are properly made. This includes determining that the service claimed was provided, is eligible for payment from the claimed funding source, is identified in a person-centered plan and is properly documented.

II. PURPOSE

This policy will assure compliance with Section XII of Appendix C.1.a(2) from Michigan's Section 1915(b) Capitated Waiver Program Renewal submitted September 28 2000.

III. APPLICATION

This policy applies to all operations of the CMH Network of service providers

IV. DEFINITIONS

V. PROCEDURE

A. Base Line Development

1. CMH shall contract with a qualified external vendor to develop and implement a process for claims verification. This will include a process for selecting claims for validation, and a process for reviewing documentation.
2. CMH shall contract with the external vendor to implement the process and use information gathered as an independent baseline of claims verification.

3. CMH Network staff shall use the results for consultation, technical assistance and other actions necessary to address problems revealed in the baseline review.
- B. Service Delivered by CMH
1. CMH billing staff shall develop and implement a procedure for reviewing claims generated by CMH staff. Such procedure shall be implemented and shall include at least verification that:
 - a. A Person Centered Plan is in the chart
 - b. Funding sources are identified
 - c. The service is authorized
 - d. Services planned and delivered are eligible for payment under the funding source
 - e. Documentation is present which verifies that service was provided.
 - f. There is documentation of the number of units of service billed
 2. The Supervisor of reimbursement staff will forward results of reviews to Program Supervisors when they are completed.
 3. The Supervisors of CMH Programs will document follow-up action taken to correct problems noted in the reviews.
- C. Services delivered by independent providers
1. The CMH Division responsible for provider audits shall incorporate a process to review samples of claims from Independent providers.
 2. Information Management staff will draw a sample of claims using the basis identified in the External Baseline Study established under Section A.1 of this policy
 3. The sample of claims will be drawn from all providers and all services at least annually
 4. The audit team will notify providers in advance, but will provide identification of the specific claims to be examined 24 to 48 hours before the arrival of the review team.
 5. The audit team will summarize for each provider and service, the number of claims examined and the number found to be invalid.
 6. The audit team will provide a copy of the claims review summary to the provider agency with a request for correction. Such correction might be either providing a copy of information necessary to validate the claim or a repayment of the amount claimed.
 7. At the time of the next scheduled claims review, the team will evaluate whether actions required in the previous review were completed