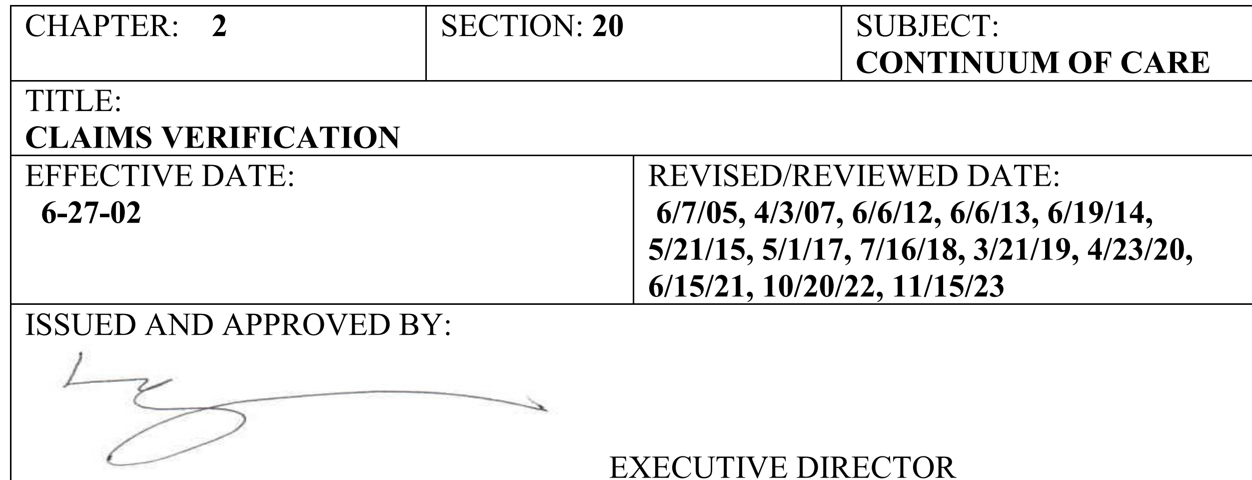

CHAPTER: **2**	SECTION: **20**	SUBJECT: **CONTINUUM OF CARE**
TITLE: **CLAIMS VERIFICATION**		
EFFECTIVE DATE: **6-27-02**	REVISED/REVIEWED DATE: **6/7/05, 4/3/07, 6/6/12, 6/6/13, 6/19/14, 5/21/15, 5/1/17, 7/16/18, 3/21/19, 4/23/20, 6/15/21, 10/20/22, 11/15/23**	
ISSUED AND APPROVED BY: EXECUTIVE DIRECTOR		

I. 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.

II. APPLICATION:
This policy applies to all operations of the Community Mental Health of Ottawa County (CMHOC) and of its contracted network providers.

III. DEFINITIONS:
None Applicable.

IV. POLICY:
CMHOC will review a sample of claims to determine that payments for services are properly made. This includes determining that the service claimed was provided, eligible for payment from the claimed funding source, is identified in an Individual Plan of Service (IPOS), and is properly documented.

V. PROCEDURE:

A. Service Delivered by CMHOC

1. CMHOC staff will review claims generated by CMHOC staff. They will verify at a minimum:
   a. An Individual Plan of Service is in the chart
   b. Funding sources are identified
   c. Services planned and delivered are eligible for payment under the funding source
   d. Documentation is present which verifies that service was provided

2. The CMHOC staff will forward results of reviews to supervisors when completed.

3. The supervisors of CMHOC programs will document follow-up action taken to correct problems noted in the reviews.

4. In the event that services are not authorized in a current treatment plan, the QI Unit will produce a report which specifies which services are not eligible for Medicaid payment. The report is submitted to Fiscal Services. These services will be amended to assure that Medicaid is not billed for unauthorized services.

5. All services that do meet the standard will be amended to assure that no Medicaid or other payor is inappropriately billed for services.

B. Services Delivered by Network Providers

1. The QI Unit shall incorporate a process to review samples of claims from network providers.

2. The QI Unit will draw a sample of claims.

3. The sample of claims will be drawn from all network providers and all services at least annually.

4. The audit team will summarize for each network provider and service, the number of claims reviewed and the number found to be invalid.

5. The audit team will provide a copy of the claims review summary to the network provider agency with a request for correction. Such correction may include either providing a copy of information necessary to validate the claim or a repayment of the amount claimed.

6. In the event that services are not authorized in a current treatment plan, the audit team will produce a report which specifies which services are not eligible for Medicaid payment. The report is submitted to Fiscal Services. These services will be amended to assure that Medicaid is not billed for unauthorized services. In the event that the network provider is responsible for treatment plan development, repayment of claims will be pursued.

C. A summary of findings will be reported, at least semi-annually, to CMHOC's Leadership Group and Compliance Committee.

VI. ATTACHMENT:
Billing Adjustment Form

VII. REFERENCE: