

Community Mental Health Affiliation of Mid-Michigan

**Affiliation QI -- Medicaid Claims Verification
Meeting Minutes****October 17, 2003, 9am – Noon
Gratiot CMH**

Present: Chip Johnston (M-B), Lynn Charping (G) Valerie Smith (C), Roslin Griffin (C), Nathan Derusha (C), Susan Kilgore (N), Sue Bedford (N), Jill Anuci (N), Deb Cline (N), Heather Betts (G), Terri Conroy (G), Paul Duff (C), Tammy Quillan (I), Karen Blonshine (I), Liz Holcomb (C), Pamela Stants (C), Roger Caris (G)

1. Problem Identification

Affiliates identified problems and/or questions they would like to discuss. There were as follows:

- When is something authorized?
- How specific does wording in the PCP need to be?
- Clarify volume
- Time consuming
- Who is a provider?
- What is the process for review of inpatient claims?
- How are we handling deficiencies?
- What is an inpatient claim?

2. Methodologies

Affiliates shared their methodologies, as follows:

- M-B: Clinicians reviewed annual (divided up over the four quarters); all claims for all services are reviewed for the month in 3% of the clinician's cases. Inpatient claims reviewed annually, onsite.
- I: 3% of claims reviewed per provider (internal and external) per month with a minimum of two claims (usually results in 4-5% of overall claims being reviewed). Inpatient claims reviewed annually, onsite.
- N: Reviews one case per provider (internal and external) per quarter; all claims for that provider are reviewed for the quarter. Inpatient claims are review quarterly via copy of charts from hospital.
- G: 5% of all claims reviewed monthly; claims for the provider are reviewed from one or more cases per provider until reaches the 5%. Inpatient claims reviewed annually.
- C: Quarterly, one case per primary clinician; one month's claims reviewed for all providers. Inpatient claims reviewed annually.

3. Standardized Methodology

After much discussion, it was agreed that the following would be the affiliation's standardized methodology for Medicaid claims verification:

- Annually review one case per clinician (primary clinicians only), 100% of the claims for a one month period of time, ¼ of clinicians to be reviewed each quarter.
- Inpatient: Reviewed annually, 2-3% of claims (claim = 1 day).
- Residential/Day Treatment Providers: one case per provider per year, review all claims for one month (claim = 1 day of occupancy or service).

This new methodology will be implemented effective 9/1/03. The reporting quarters will remain the same (Qtr1: Sep-Nov; Qtr2: Dec-Feb; Qtr3: Mar-May; Qtr4: Jun-Aug).

4. Problem Solving

Outpatient therapy: PCP must state specific service to be authorized (i.e., individual, group, family). The PCP must identify the services (not the goals or objectives). The PCP must be current and in the chart within 15 days following the PCP meeting to be in compliance. If the PCP is not in the chart within the 15 days, all services are minimally deficient for missing documentation until the PCP is filed (services are authorized back to the date of the PCP).

Correctable deficiencies such as missing documentation can be corrected but must remain on the deficiency report.

Each affiliate will individually decide how to best follow up on deficiencies.

5. Other

Attached is the Affiliation's Medicaid Claims Data Verification Standards as first drafted in March 2003. If you have comments or additions, please submit them to Tammy Quillan at tquillan@ioniacmhs.org.

6. Future Meetings

It was agreed that the meeting was very helpful to those performing the claims verification. The affiliation will work to meet annually to share information and updates on the process.