



Section: Compliance	Policy Name: Routine Audit & Monitoring	Policy Number: 10.15
Owner: Chief Compliance Officer	Reviewed By: Mila C. Todd	Total Pages: 5
Required By: <input type="checkbox"/> BBA <input type="checkbox"/> MDHHS <input type="checkbox"/> NCQA <input type="checkbox"/> Other (please specify): <hr/>	Final Approval By: <i>Mila C. Todd</i>	Date Approved: 07/01/2020
Application: <input checked="" type="checkbox"/> SWMBH Staff/Ops <input checked="" type="checkbox"/> Participant CMHSPs <input checked="" type="checkbox"/> SUD Providers <input checked="" type="checkbox"/> MH/IDD Providers <input checked="" type="checkbox"/> Other (please specify): <u>MHL Providers</u>	Line of Business: <input checked="" type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify): <hr/> <input checked="" type="checkbox"/> Healthy Michigan <input checked="" type="checkbox"/> SUD Block Grant <input checked="" type="checkbox"/> SUD Medicaid <input checked="" type="checkbox"/> MI Health Link	Effective Date: 03-21-2014

Policy: It is the policy of Southwest Michigan Behavioral Health (SWMBH) that all Medicaid and Medicare reimbursed services will be documented in accordance with applicable SWMBH clinical documentation policies as well as all related State and Federal regulations. Additionally, it is the policy of SWMBH that all contracted and subcontracted providers within the SWMBH provider network will adhere to SWMBH policies and procedures in place to facilitate clinical documentation that supports the medical necessity of the services paid directly or indirectly using SWMBH Medicaid and/or Medicare (specific to the dual eligible's demonstration project) funds and that demonstrate the delivery of services consistent with the consumer's treatment plan and individualized needs.

Purpose: A consistent and comprehensive clinical documentation review process will assist SWMBH in monitoring for and preventing Medicare and Medicaid waste, fraud and abuse. An ongoing review process that monitors the quality of clinical documentation is a component of SWMBH's Board approved compliance plan. In order to facilitate SWMBH's efforts toward ensuring compliance with State and Federal regulations, our Prepaid Inpatient Health Plan (PIHP) contractual obligations, the highest quality clinical care, and documentation best practices, routine ongoing documentation reviews will be conducted consistent with SWMBH's Annual Compliance Audit and Monitoring Plan for all provider types within SWMBH's provider network. The results of the documentation reviews will be reported to the SWMBH Board of Directors a minimum of annually.

Scope: SWMBH Program Integrity & Compliance Department



Responsibilities:

The SWMBH Program Integrity & Compliance Department has a responsibility to develop the Annual Compliance Audit & Monitoring Plan, implement it, and periodically report out on audit findings.

Definitions: None.

Standards and Guidelines:

A. The following procedures shall be used to conduct clinical documentation reviews within SWMBH's PIHP region.

1. Review Schedule

Clinical documentation reviews will be conducted annually for all provider types within SWMBH's provider network per SWMBH's Annual Compliance Audit and Monitoring Plan developed each year by the Chief Compliance Officer and approved by the SWMBH Corporate Compliance Committee.

2. Sample Selection

The sample of clinical cases to be reviewed annually will be selected using the sample specifications and consistent with the processes outlined in SWMBH's Annual Compliance Audit and Monitoring Plan.

3. Audit Forms and Records

The review tools to be used to conduct the clinical documentation reviews will be developed and updated annually by the SWMBH Program Integrity – Compliance department prior to implementation of the Annual Compliance Auditing and Monitoring Plan. All Participant CMHSP consumer medical records, contracted provider consumer medical records and subcontracted provider consumer medical records will be reviewed using the applicable program integrity - compliance review tool.

4. Review and Reporting Process

The SWMBH Chief Compliance Officer, and/or his/her designee, will coordinate all clinical documentation reviews required for the purposes of SWMBH's Annual Compliance Audit and Monitoring Plan with the SWMBH Provider Network and Clinical Improvement and the Participant CMHSP's Compliance Officers. All clinical documentation reviews will be scheduled and conducted as specified in SWMBH's Annual Compliance Audit and Monitoring Plan.

Within seven (7) business days of completion, a clinical documentation review conducted by a SWMBH reviewer, the reviewer or the SWMBH Chief Compliance Officer shall offer the applicable agency or provider an exit conference in person or via telephone conference at which time the review process and preliminary findings can be reviewed. This conference will provide an opportunity for overlooked or misfiled documentation to be located and review findings will be adjusted accordingly. A written report summarizing the findings of the review will be completed and sent to the provider/agency within thirty (30) days of the date the review was completed.



The detailed results of all clinical documentation reviews completed by SWMBH Program Integrity - Compliance personnel for the purposes of implementing and completing SWMBH's Annual Compliance Audit and monitoring Plan will be submitted to the SWMBH Chief Compliance Officer at the time the reviews are completed. All review results will be evaluated and summarized by the SWMBH Chief Compliance Officer and a rate of compliance will be determined. The rate of compliance will be reported to the SWMBH Corporate Compliance Committee and Board of Directors a minimum of annually or more often as determined by the SWMBH Executive Officer.

5. Appeals Mechanism

When an agency's or provider's clinical documentation has been determined to be non-compliant with SWMBH policies or State/Federal regulations, and the agency or provider disagrees with the determination, an appeal may be made with the SWMBH Corporate Compliance Committee through the Chief Compliance Officer within thirty (30) working days of the receipt of the written review results. Failure to file an appeal within the time specified will result in the loss of the appeal privilege.

If notified within the time specified, the Chief Compliance Officer may coordinate a second review of the applicable records. If a second review is determined to be necessary, it will be completed by a second reviewer via a desk/remote review process. For any applicable medical records necessary in order to conduct the second review that are not available via remote access, the agency/provider will submit hard copies to the SWMBH Chief Compliance Officer in order to facilitate the desk review process.

The SWMBH Chief Compliance Officer and SWMBH Corporate Compliance Committee will review the findings of any second clinical record reviews determined to be necessary in order to ascertain the agency's/provider's compliance with SWMBH policies and State/Federal regulations. All applicable reports will be adjusted accordingly.

6. Corrective Action Mechanisms

All Provider CMHSPs, contracted providers, and subcontracted providers whose aggregate documentation review scores are below the SWMBH established standard/threshold will be required to submit a corrective action plan documenting the specific efforts performed/planned in order to correct any documentation deficiencies noted through the clinical record review process. Any corrective action measures reported that are planned but have not yet been performed will require the date the task will be completed and the person responsible. Any training provided as a corrective action measure will require a summary of the training to be reported with the corrective action plan.

All corrective action plans must be returned to the SWMBH Chief Compliance Officer within thirty (30) days of the receipt of the review findings. All corrective action plans will be reviewed by the SWMBH Corporate Compliance Committee. Any corrective action plans found to be deficient by the Committee will be returned to the agency/provider for appropriate modification.



References: None.

Attachments: None.



Revision History