

**Genesee County Community Mental Health PIHP  
Verification of Medicaid Service Delivery  
October 31, 2008**

The Medicaid claims verification review process continues to operate, and continues to impact Genesee County CMH's billing processes and performance by providing clear expectations, identifying problem areas, and linking internal processes directly to Federal expectations for billing practices.

**METHOD**

In Fiscal 2008, PIHP QM staff reviewed 178,004 claims for services by 226 providers or groups of providers. Initial numbers suggest that approximately 949,369 encounters for mental health and substance use disorder services were delivered network-wide through the year. Thus, approximately 19% of encounters were audited.

In contrast to the method used in the past several years, a retrospective audit design was used. A sample of up to 20 cases from each provider was randomly selected, and the past six months' claims reviewed. When auditing, the clinical record was compared with agency billing reports generated from computer records of claimed events. The change from a prospective design to a retrospective one has led to an enormous increase in N, since all encounters for six months were audited, rather than a sample of the few current encounters available at audit time.

In contrast to previous years' audits, there was no stratification of the sample by provider type. Each provider was audited independently. This contributed to the increase in claims / encounters audited. The distribution of services audited also changed dramatically, since residential and day programs generate large numbers of encounters compared to clinical programs.

In all cases, claims found noncompliant were referred to the PIHP's Billing department for review and determination of restitution.

Billings were deemed compliant when the following conditions were met:

- Documentation was present, service code on the documentation matched that billed, and the service described was appropriately coded;
- Number of units billed matched those documented;
- Start and stop times were present where required;
- Service had been authorized in a valid IPOS;
- Service billed was a PIHP covered benefit that the consumer was eligible for.

Appendix B contains the audit tool.

Auditors also identified encounters documented in the record that were not associated with claims in the PIHP's data system. Note that, because of complexities in credentialing/privileging, billing, and reimbursement systems, there can be valid reasons why a documented encounter would not be billable, or the claim would not have been received by the time of the audit. It was not feasible to follow up on the details of each of these claims, because of the complexity of the issue and the number of sources of information that would be required.

For these reasons, the data gathered represent an estimate of the upper limit of unbilled encounters, and data were not reported on a per-program basis.

## RESULTS

A total of 175,440 of the reviewed claims (98.56%) were found to be covered services appropriately documented and authorized by the IPOS. This is significantly higher than last year's value of 93.5%; the 95% confidence interval for the 2008 finding is 98.50% to 98.61%<sup>1</sup>.  
the

Because group homes in particular have very small *N* and their performance can be dramatically impacted by, e.g., problems with a single staff person, for this report, where possible, performance was aggregated into a single value for corporations owning several homes in the network. (Feedback, corrective action and payback of misbilled funds were all managed on an individual home basis, however.)

Figures 1 through 7 summarize each provider's / corporation's performance. The distribution of program performance is negatively skewed, with many programs performing quite well, and only a small number poorly. Of 151 entities audited, 62 (41%) had 100% of claims fully compliant; 111 (74%) had at least 95% compliance, and 129 (85%) had at least 90% compliance. Median compliance was 99.5%.

Figure 8 presents performance by provider type. Notably, the more poorly-performing provider types tend to have overall performance lowered by a small number of more poorly-performing programs, with some or most programs performing well.

The total number of documented encounters without claim/encounter information in the PIHP's data system at the time of audit was 677, across all providers. This represents 0.38% of all encounters measured.

## ACTION STEPS

The PIHP's interventions have led to a high level of compliance. The proportion of audited claims that were compliant continues the trend of significant increase from the previous year, which has been demonstrated almost every year (Fig. 9). The majority of programs are performing well. The primary need at this point is to maintain performance.

For each claim not found compliant, the PIHP's Quality Management department forwards the information to the Business Operations department. Business Operations follows up to determine appropriate steps, including payback and/or sanction. In addition, the Quality Management department requires corrective action for all cases where performance fails to meet 95%. This includes the submission of a Corrective Action Plan to the QM department, and review and acceptance of the plan.

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<sup>1</sup> The Agresti-Coull formula was used, as described in Brown, L. D., Cai, T. T., and DasGupta, A. (2001). Interval estimation for a binomial population. *Statistical Science*, 16(2), 101-133.

The PIHP is also continuing its system of targeted audits, focused on specific services or providers where evidence suggests particular problems might be occurring. During Fiscal 2008 special compliance audits were conducted of 33 providers, sparked by staff identifying particular issues or concerns during other audits or data reviews. Examples of topics include

- claims for services by particular staff and providers where concerns had been raised about adequate documentation;
- claims submitted by group homes where billing systems failed to account for consumers being on leave from the home on a given day;
- claims billed as medical services which were provided by a nurse practitioner but not a physician.

Given the success of the current methodology, the PIHP is continuing compliance training as it has in previous years. First, audits are a major tool for educating providers about compliance issues. On an ongoing basis, details of billing irregularities are provided to each provider immediately following the audit.

Second, in 2008, as in every year, the PIHP conducted extensive compliance training. Every CMHSP staff person, supervisor and administrator, plus representatives from each of the PIHP's network providers attended required annual compliance training. Where staff could not attend, and for new staff, video of the training was provided. The CMHSP's Corporate Compliance Officer provides ongoing information in a monthly column in the PIHP's newsletter, which is sent to all providers.

The evidence suggests that, as new provider types become included, and individual providers audited more heavily, e.g. group homes, Medicaid billing compliance continues to improve.

## Appendix A

### Medicaid Claims Verification Indicators FY 2007/2008

#### **1. Is the service provided identified in the Medicaid Provider Manual?**

*The covered service or support must be listed in the Medicaid Provider Manual.*

#### **2. Is the service provided identified in the IPOS?**

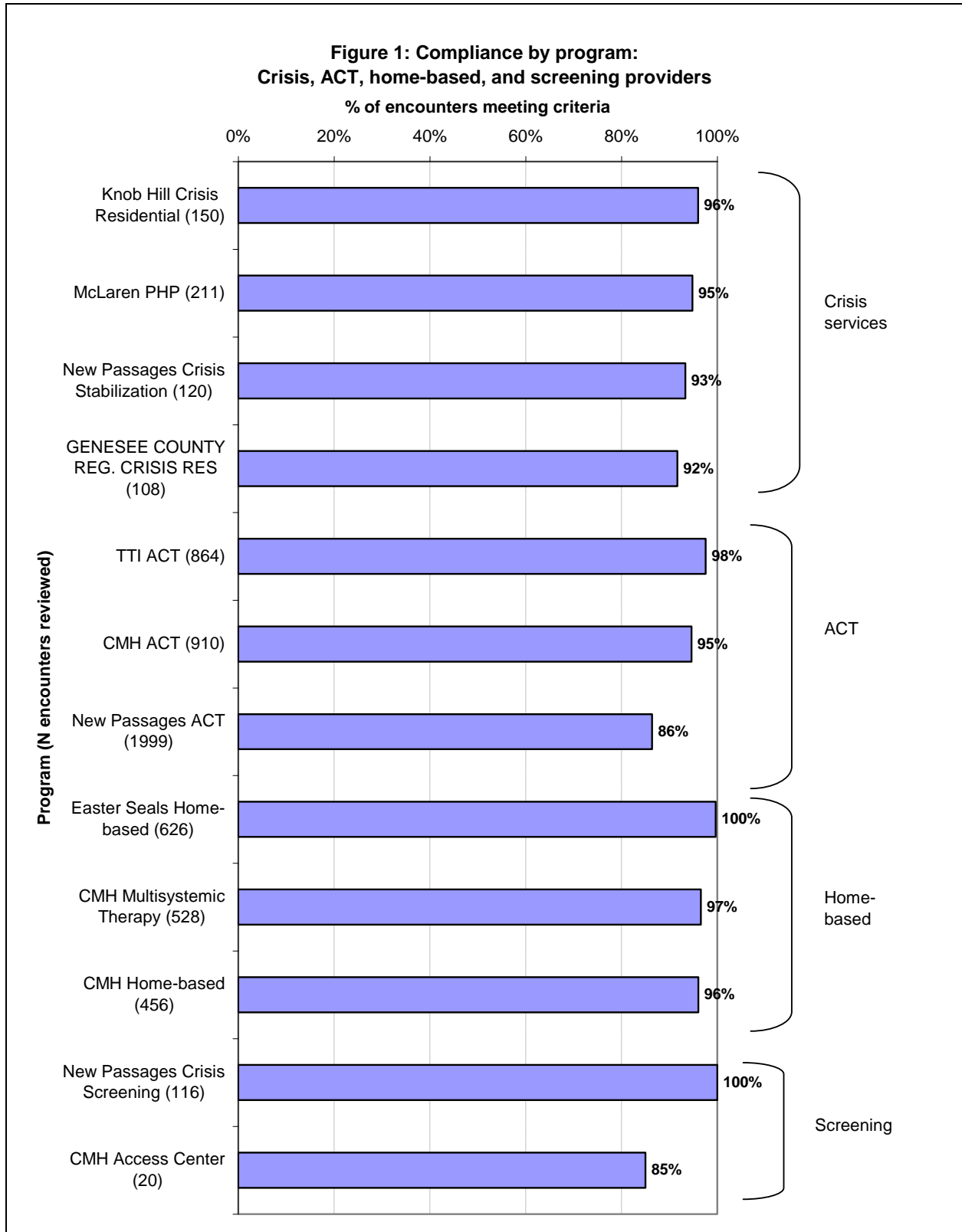
*The service is clearly specified in an IPOS, IPOS addendum, or quarterly review IPOS addendum, including the following elements:*

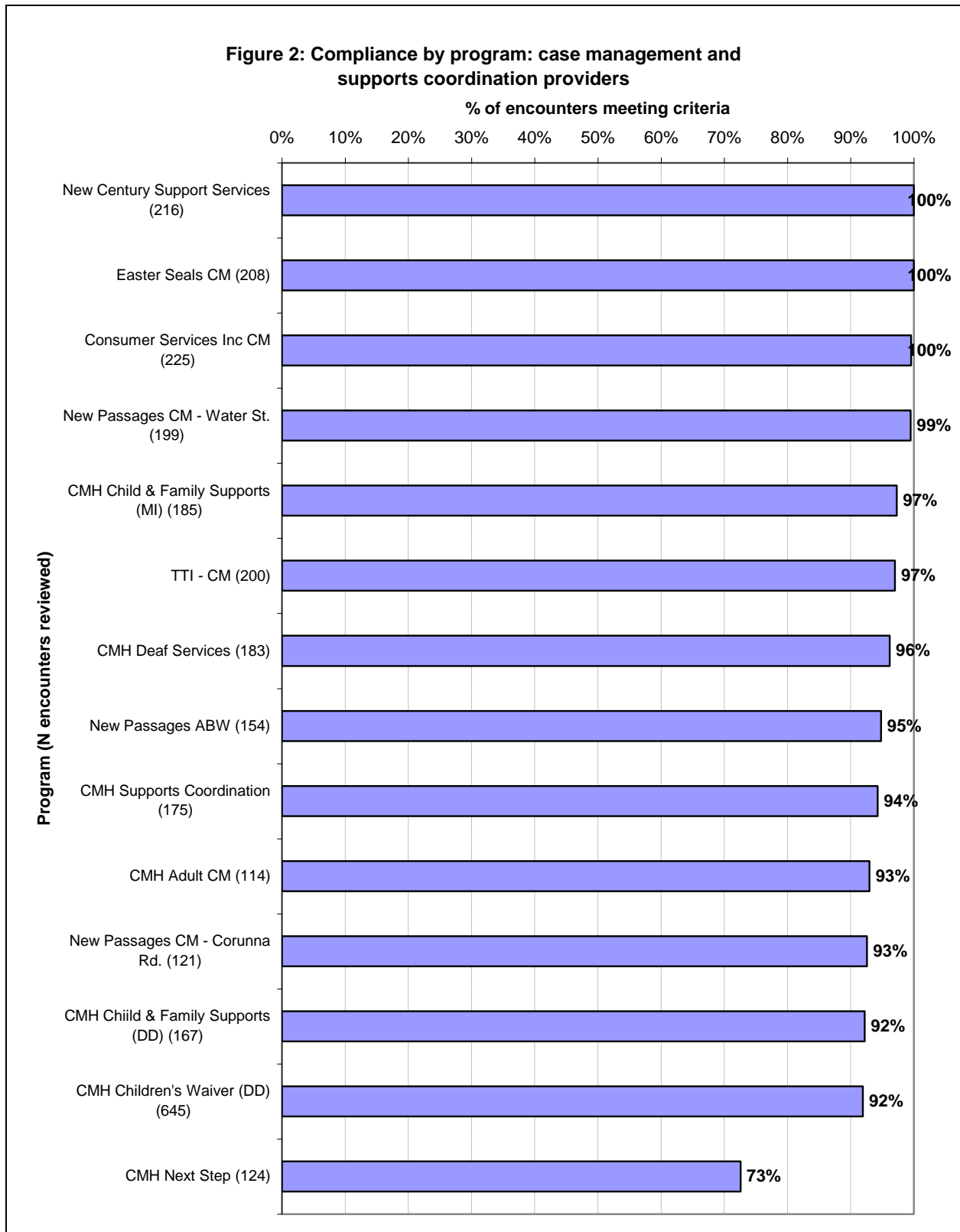
- *Identification of the service;*
- *IPOS was written within the past year;*
- *A subsequent IPOS or quarterly did not terminate authorization for the service.*

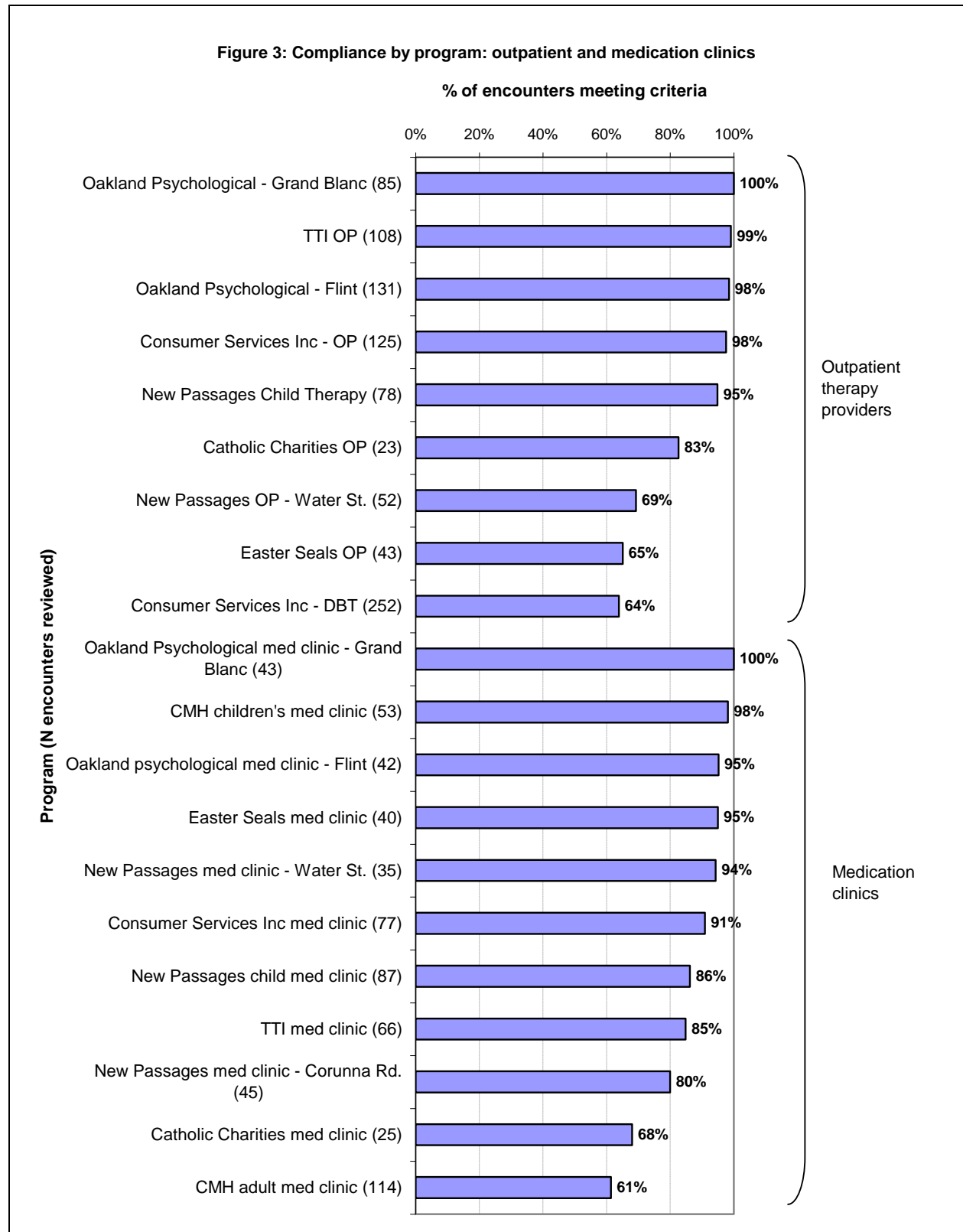
#### **3. Does the record contain evidence that the service claimed was provided?**

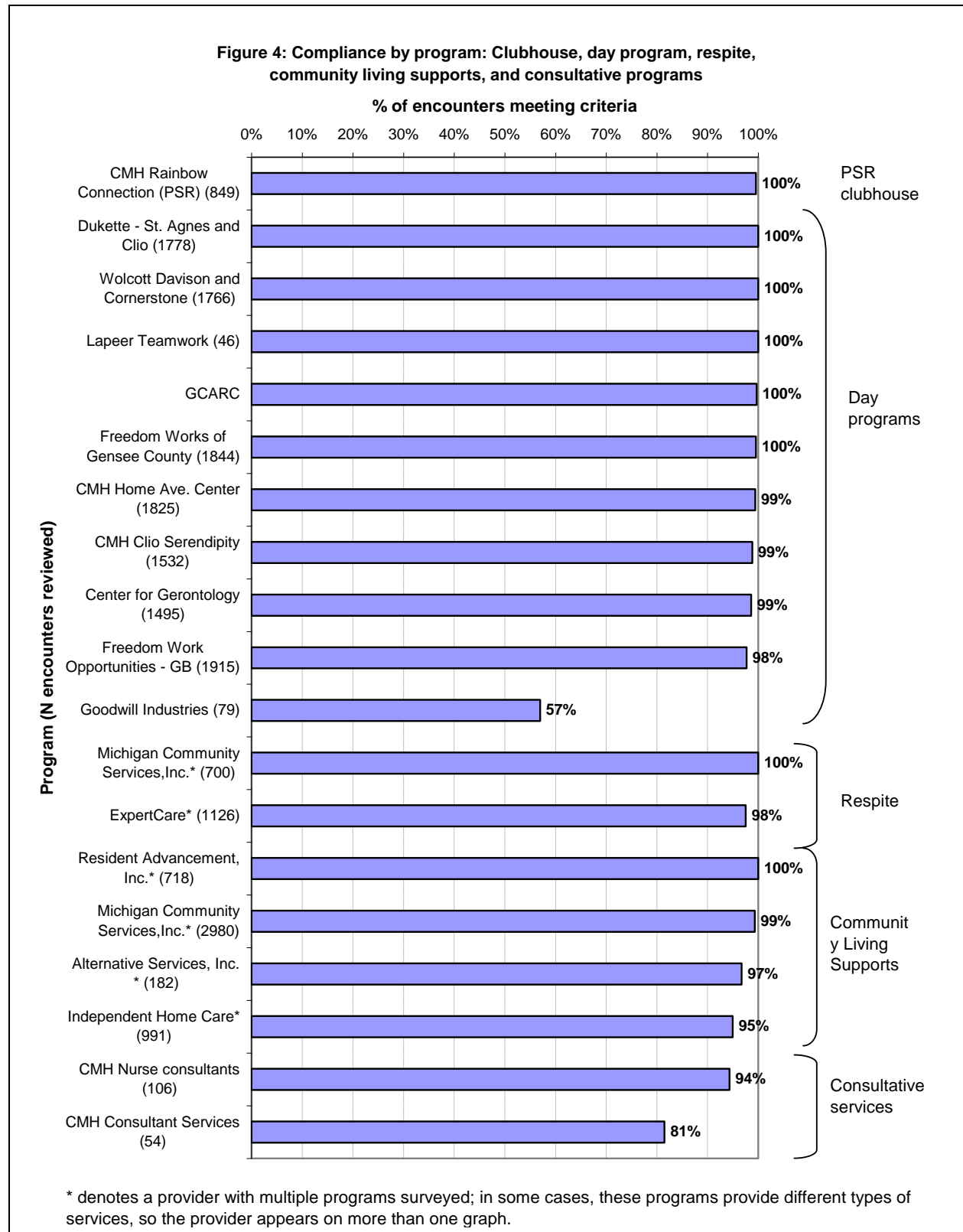
*An individual progress note or other formal documentation exists in the consumer's record, with the following components, at a minimum:*

- *documentation of code or name of service claimed;*
- *date matching claim date;*
- *times, or number of units, matching those claimed;*
- *content consistent with services that*
  - *occurred face-to-face (except Behavioral Management Review), and*
    - *Notes documenting indirect services such as phone calls or paperwork (in the absence of any indication of face-to-face contact) would not meet this standard.*
  - *were provided by the provider responsible for the claim.*
- *clinician signature.*
- *Where multiple encounters/claims are documented on the same page, each must contain all of the above.*

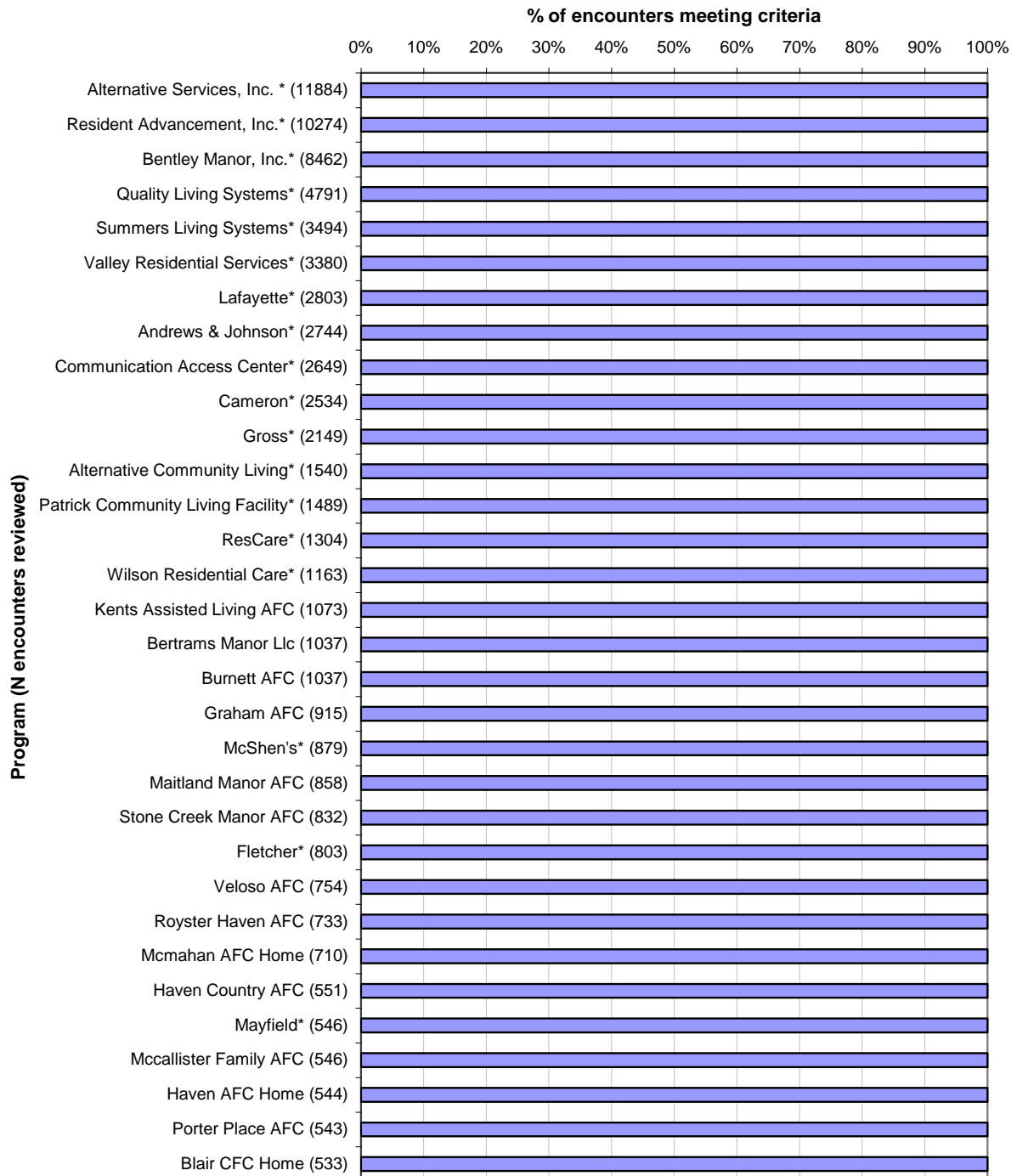






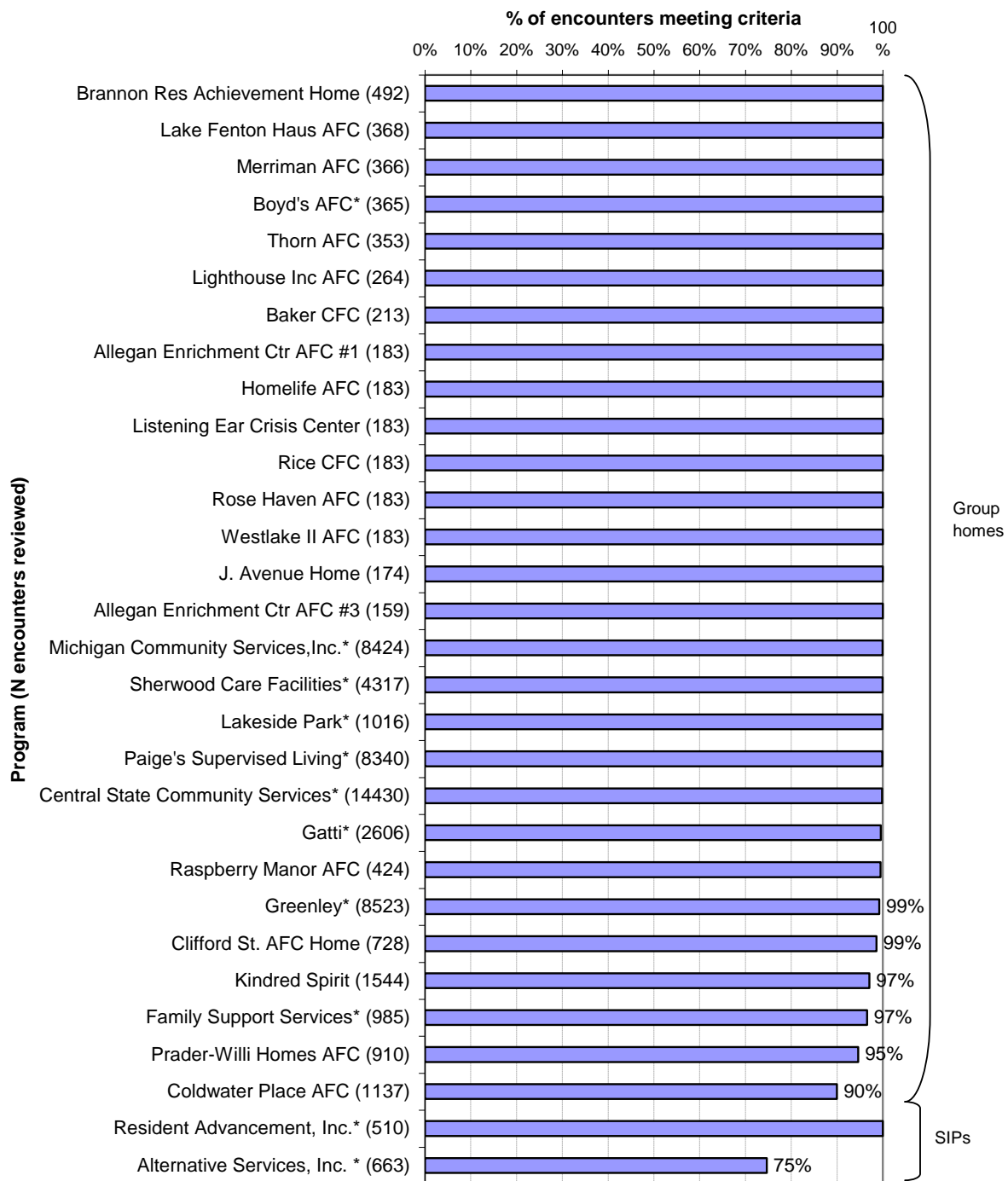


**Figure 5a: Compliance by program: Services in a residential setting (group homes):  
first part of list (for readability, bars are labeled only with scores < 100%)**

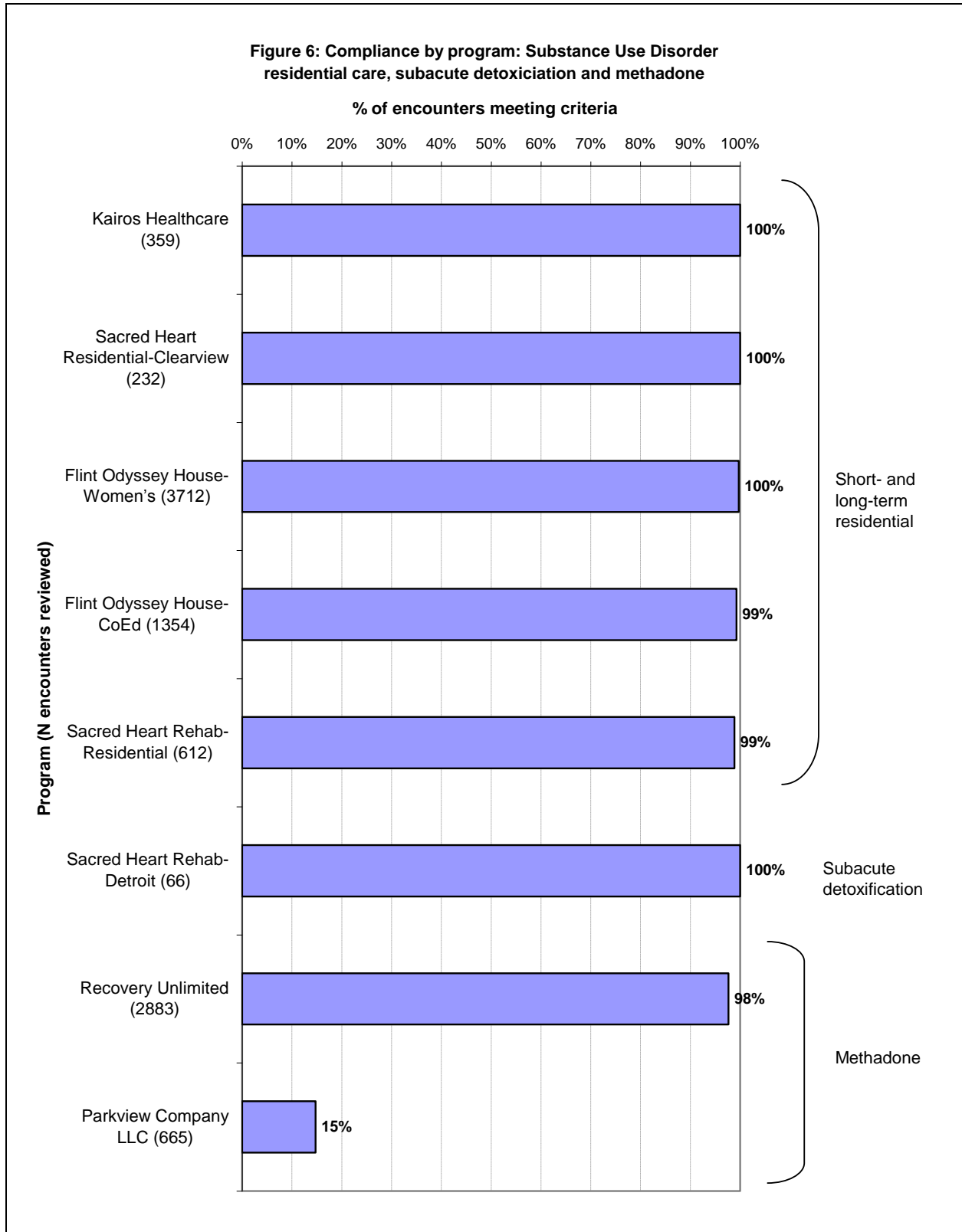


\* denotes a provider with multiple programs surveyed; in some cases, these programs provide different types of services, so the provider appears on more than one graph.

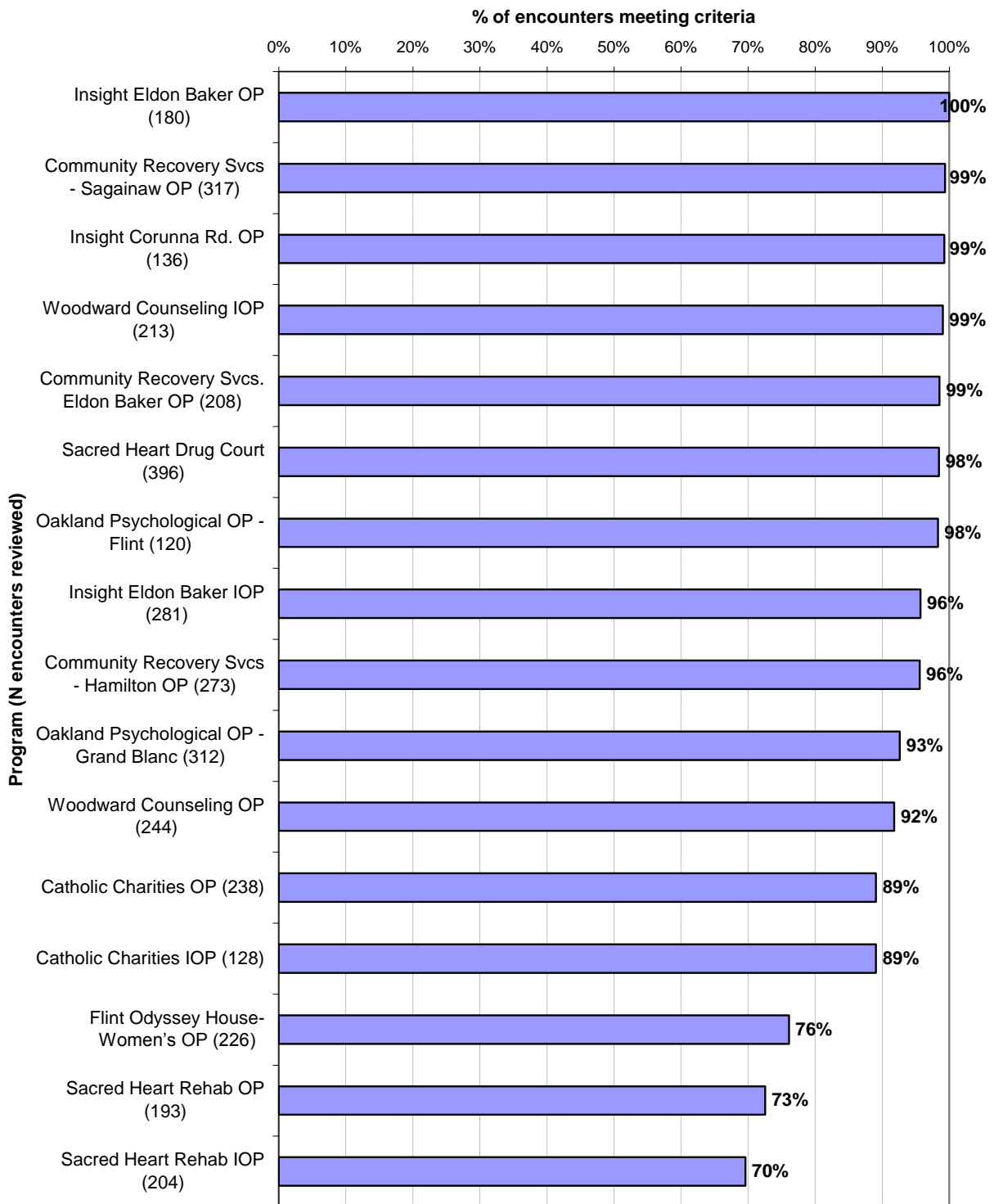
**Figure 5b: Compliance by program: Services in a residential setting (group homes / SIPs):  
second part of list (for readability, bars are labeled only with scores < 100%)**



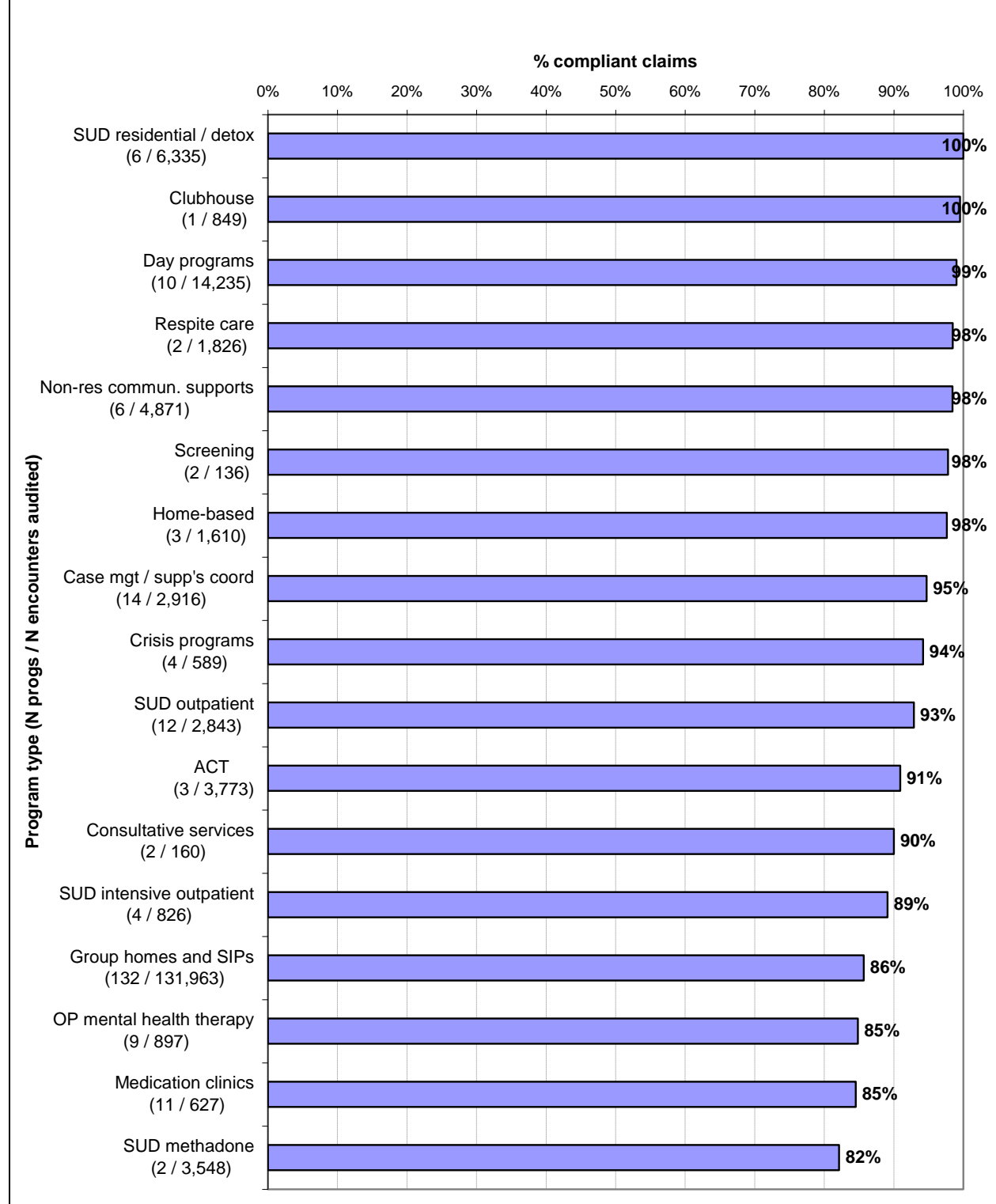
\* denotes a provider with multiple programs surveyed; in some cases, these programs provide different types of services, so the provider appears on more than one graph.



**Figure 7: Compliance by program: SUD outpatient and intensive outpatient services**



**Figure 8: Compliance rates by program type**



**Figure 9: Trend in compliance scores:  
Overall compliance and 95% confidence interval**

