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| **MONTCALM CARE NETWORK PROCEDURE 611 North State Street, Stanton, MI 48888** |
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| SUBJECT: Record Review | Section: 5300A |
| Effective Date: June 24, 1997 | Revised Date: June 10, 2024 |

The Record Review will be used to help assess the competency of and to provide performance feedback to clerical, clinical and billing staff and to evaluate organization-wide performance. Data from these reviews will be collected from a selection of cases in a quantity sufficient to provide feedback to each staff person providing record keeping, billing or clinical services. The Record Review consists of fourcomponents:

* Record Keeping Review- focuses on the technical aspects of the record to ensure adherence to standards.
* Clinical/Peer Review - focuses on the quality of clinical performance care and documentation through a review of the adequacy of assessment, service planning, treatment and care including use of Evidence Based Best Practices, termination and follow-up.
* Utilization Review - focuses on the appropriateness of admission, continued stay, discharge and after-care to ensure that established medical necessity and other eligibility or utilization criteria are followed throughout treatment. This is completed during the Clinical Review processes.
* Claims Review - is completed in conjunction with the regional authority and focuses on verification that services provided or purchased were delivered as authorized within the person-centered plan, are thoroughly documented, and systems are in place to verify Medicaid/Healthy Michigan Plan eligibility, to prevent errors in use of billing codes and modifiers, and to ensure invalid claims/encounters are corrected and repayments made as indicated.

Aggregate and provider level data is available to Supervisors and Administrative Staff as needed to assist with staff competency assessments, staff development activities, privileging and contracting decisions.

Review Processes

1. Record Keeping and Clinical Peer Reviews:
	1. A random sample of open and closed cases per program

(Community Services and Outpatient Services) are reviewed each quarter. Each case represents a different clinical provider..

* 1. Clinical Peer Reviews are reviewed by the supervisor and the clinician assigned to the case during regularly scheduled supervision. Record Keeping Reviews are conducted by the Medical Records Specialists.

* 1. The case is reviewed tracing the entire case from admission through current care and including termination if applicable, or for cases that have been open for multiple years, minimally the past year of services is reviewed.
	2. Findings from the review are used to assess the current competency and training needs of the individual clinician.
	3. Aggregated data is reported to Clinical Care Committee on a quarterly basis. The Committee analyzes this data for trends and identifies needs for system modifications or other interventions.
1. Physician Peer Reviews:
	1. A sample of open cases for each physician is reviewed minimally quarterly by a physician peer.
	2. Individual data collected through this process is reported to the physician who was reviewed. This data is used to provide feedback to the prescriber.
	3. Aggregated data is reported to Clinical Care Committee on a quarterly basis. The Committee analyzes this data for trends and identifies needs for system modifications or other interventions.
2. Claims Reviews:

Regional Review Processes:

* 1. The regional authority will identify claims for auditing on a semi-annual basis utilizing the regional sampling methodology.
	2. Designated MCN staff shall participate with the regional authority auditing.
	3. Deficiencies are reported to clinical and billing supervisors for follow-up as needed.
	4. Results are reported to the Compliance Committee at least annually.

Internal Review Processes:

* 1. A sample of cases is audited by finance staff prior to claim submission. MCN may conduct additional reviews using the regional authority’s sampling processes at its discretion.
	2. Designated staff participate in auditing these samples of claims.
	3. Deficiencies are reported to the appropriate staff for follow-up as needed.
	4. Results are reported to the Compliance Officer minimally quarterly.

Daily Operations:

The agency utilizes a number of internal controls and electronic health record (EHR) validations to ensure the verification of clean and appropriate claims and encounters prior to submission to regional and state entities. These include:

* 1. Validations on encounter and claim dates, times, service codes, programs, service units, service documentation, and billing diagnoses.
	2. Validations to protect against overlapping or duplicate services.
	3. Validations to assure services billed are authorized in the plan of service.
	4. Automated verification of eligibility/coverage.
	5. Processes for assuring coding is kept current with State requirements.
	6. Provision of new and ongoing staff & contractor training on documentation and coding.
	7. Use of various reports in the EHR to track billing and service errors.
	8. Use of various reports after claim/encounter.