STATE OF CONNECTICUT
Department of Mental Health & Addiction Services

dmhas
A Healthcare
Service Agency

Commissioner's Policy Statement and Implementing Procedures

SUBJECT:	Audit of Inpatient and Outpatient Services of Paid Claims
P & P NUMBER:	Chapter 3.7
APPROVED:	Miriam Delphin-Rittmon, Commissioner Date: 10/15/2015
EFFECTIVE DATE:	October 15, 2015
REVISED:	11/1/2009
REFERENCES:	Agency Compliance Plan
FORMS AND ATTACHMENTS:	

STATEMENT OF PURPOSE: The purpose of this policy is to provide guidelines for the establishment of an audit policy for monitoring inpatient and outpatient services billed and paid by third-party payers including all federal, state and private entities in accordance with established clinical criteria.

POLICY: The Department of Mental Health and Addiction Services' (DMHAS) Audit Division shall conduct periodic reviews of paid claims and supporting documentation in clinical records throughout DMHAS' facilities. This process will ensure the integrity and effectiveness of the agencies billing practices.

PROCEDURE: Examination and evaluation of clinical charts is the primary function of the audit process under this policy. Parameters are established for applying consistent audit methodology. Review of client charts should be examined to ascertain the accuracy of the services rendered and to support services billed. Reviewing all medical and clinical charts would be deemed impractical and unnecessary due to the volume of services and records maintained. Therefore, a sample of charts is to be selected and reviewed under an established methodology that represents a universe of services billed within a defined time period. This selection of a representative sample of charts shall be known as "the sample." The sample shall be selected from services billed within a specific time period which shall be known as the "universe."

Moreover, criteria is established which supports the statistical validity of the charts selected. At a minimum, this includes a confidence level and margin of error. Furthermore, since all charts

document care prescribed and treatment rendered, the services documented should be measured against accepted practices as stipulated by "Current Procedural Terminology" codes promulgated by the American Medical Association as well as other appropriate codes used for billing.

Audits should be performed, at a minimum, on a quarterly basis or in accordance with payer policies or other accepted practices.

Auditor qualifications:
Personnel performing audits should have, at a minimum, the requisite experience and knowledge to evaluate clinical/medical charts, and have general knowledge of billing practices and compliance issues.

Results of audits:
Written reports are to be prepared noting exceptions found during an audit. Exceptions are defined as non-documented or insufficiently documented clinical and/or medical services; insufficient or non documented treatment plans, lack of or insufficient documentation required upon admission, lack of Medicare certification (as applicable for Medicare clients); non licensure of staff performing services, or other matters that come to the attention of the auditor.

If initial findings note improprieties or exceptions consultation must be undertaken with the DMHAS facility Compliance Officer, CEO and the DMHAS Agency Compliance Officer to ascertain what additional actions, if any, need to be taken. This will include a plan of corrective action to mitigate future recurrence of errors, omissions or other findings.

Audit Procedures: Written procedures developed will be used by the auditor to document evidence of charts examined and results found. Procedures will include a checklist and made part of audit work papers created and retained. The procedures document the test period examined, the universe of charts eligible for selection, the number of charts selected for test work from the universe of charts, and the types of exceptions found, if any.