| Governing Body: | Function: | |
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| **MARION COUNTY COMMUNITY AND PROVIDER SERVICES (CAPS)** | **INTEGRATED DELIVERY SYSTEM (IDS) HANDBOOK** | |
| **Subject:** **Reconciliation Audit** | **Prepared By:** **CAPS** | **Original Date: 10/01/2007** **Revised Date: 02/01/2009** |

## PURPOSE AND SIGNIFICANCE:

Reconciliation audits will be scheduled at each IDS Provider initially on a biannual basis. Community and Provider Services (CAPS) staff will schedule the reviews and will request participation by the agency Director or representative, Clinical Supervisor(s), and other key staff identified by the agency. The reconciliation audit process is designed to:

- Assure that utilization of mental health services is consistent with the treatment service needs of the Member;
- Assure that community resources are consistently used to meet the treatment needs of the Member;
- Assure that treatment services are provided in compliance with the Oregon Administrative Rule;
- Assure that the services provided are in compliance with the Office of Medical Assistance Programs (OMAP) definitions;
- Assure that services are provided in the least restrictive, most cost-effective setting addressing the clinical appropriateness and necessity of the level of care required by the Member;
- Identify areas of training and/or technical support needed by the agency; and
- Identify areas of correction and/or refund situations that an agency may need to provide a response.

## PROCESS AND/OR PROCEDURE:

CAPS will conduct biannual reconciliation audits at all IDS Providers. These reviews will occur in the months of July and January. IDS Providers will be notified in writing 30-45 days in advance to schedule dates for the review.

The names of 5% or 30 Members, whichever is less, with a minimum of 15, will be selected for review. CAPS will randomly select half of the Members for review and the agency will be responsible for identifying the other half. The list of selected Members will be generated from the Mid-Valley Independent Physician's Association (MVIPA) website and may include all or any of the following:

- Members who were enrolled within the agency prior to the current service year and are still in service;
- Members who were enrolled after the current service year began;

- Members who have been closed/terminated by the agency during the current service year;
- Members representing a range of cost-to-date totals on their MVIPA authorizations;
- Members who are receiving services through a secondary authorization from the primary IDS Provider.

The review will consist of a Clinical Record Review of the following clinical documents required by Oregon Administrative Rules:

- Mental Health Assessment including:
  - Mental Status
  - 5 Axis Diagnoses and Diagnosis Summary
  - Symptoms Supporting Diagnosis
  - Screening for Trauma
  - Clinical Formulation that provides a description of:
    - Presenting Problem
    - Biological, cultural, psychological and social factors that are a priority for intervention trauma
    - Clinical events and/or course of illness including onset, duration, and severity of presenting concerns
    - Client and/or family expectations for recovery
    - Issues/concerns that warrant treatment or management
    - Justification for treatment and prognosis
  - 24-Hours Crisis Plan if applicable
  - Medical Involvement
  - LMP reviewed and approved Mental Health Assessment at least annually and all Treatment Plans per OAR 309-016-0075.
  - Treatment Plan including:
    - Goals based upon assessed needs
    - Goals and objectives that are individualized, measurable, and appropriate to the client's identified services needs
    - Documentation demonstrating client, parent, guardian involvement in treatment
    - Documentation demonstrating the treatment plan has been updated at least annually or in response to the client's request or treatment needs. Changes have been reviewed and approved by an LMP. (OAR 309-016-0075)

Billing and progress note documentation for services delivered during the current service year will also be reviewed. Services for each Member will be pulled from the client's claim files on the MVIPA website. Each progress note will be reviewed for the following as required by Oregon Administrative Rules:

- Service Date matching Claim Date
- Procedure Code matching Procedure Code on Claim
- Correct number of units
- Setting of Service
- Duration of Service
- Member's response toward meeting goals identified in the treatment plan or significant changes in the client's functioning or significant events and their effect on the client.

- Procedure Code used is appropriate to the content of the progress note.
- Content of the progress note offers an adequate description of the services rendered.
- The IDS Provider has signed the note and the provider's credentials are present.

Any missing or incomplete documents will result in a correction plan for the agency and/or refunds for services delivered. In addition, if any of the progress note elements are missing or determined to be inadequate, a refund will be requested for the specific service.

Once the review process is complete, CAPS will send the Provider an official report that identifies the Provider's strengths, recommendations, and findings. Findings will result in corrective action plans and/or refunds that will need to be formally addressed by the Provider. The Provider will have 30 days to respond to the findings. If an IDS Provider disagrees with CAPS' findings, additional review can be requested. The IDS Provider must state in writing, with justification, why they disagree with the findings. CAPS and the Community Mental Health Director will review the request and provide a written response within 30 days. There are no appeals once a decision has been issued. CAPS will make every attempt to work with and provide support to the IDS Provider on any findings.