

**Maryland Public Mental Health System  
Mental Hygiene Administration**

**Policy and Procedures for Inpatient Retroactive Chart Audit  
within the Public Mental Health System (PMHS)**

**01. Purpose**

The purpose of this policy is to outline the roles, lines of communication and collaboration among agencies and procedures for the retroactive chart audits of acute inpatient services within the Public Mental Health System (PMHS). This audit process is designed to retroactively review the selected inpatient records for medical necessity.

**02. Scope**

This procedure applies to all acute inpatient providers within the Public Mental Health System.

**03. Definitions**

- A. Public Mental Health System- a coordinated system for the delivery of mental health services to eligible individuals. A key component of this system of care is to ensure consumers have access to mental health services that are high-quality and cost effective.
- B. Audit- an examination of the appropriateness of acute inpatient services delivered to consumers within the PMHS to determine whether the services were billed accurately and meet medical necessity criteria as supported through documentation in the medical record.
- C. Auditor(s) are individuals approved by the Mental Hygiene Administration to conduct audits pursuant to this policy.
- D. Mental Health Administration (MHA) is the mental health authority for the state with overall responsibility for implementing and maintaining this policy.
- E. Core Service Agency (CSA) is the county, multi-county authority or private non-profit entity, designated under Md. Ann Code, Health General §10-1201 et. seq., responsible for planning, managing and monitoring publicly funded mental health programs.
- F. Administrative Service Organization (ASO) is a contracted organization, selected and approved by the Department of Health and Mental Hygiene, to provide administrative services as determined by MHA, including but not limited to, auditing providers within the PMHS and quality designated activities. The ASO maintains administrative databases that are useful in identifying trends in service provision in the PMHS.

#### **04. Selection of Providers for Review**

- A. The ASO will determine which providers shall be audited utilizing one or more of the following criteria (list not all-inclusive):
  - 1) High volume service providers in identified geographic regions
  - 2) High cost services based on length of stay
  - 3) Acute inpatient facilities with dual diagnosis units
  - 4) Random selection
- B. The ASO will develop coordination and communication among all parties involved in audit activities.
- C. The MHA Deputy Director and Clinical Director will be apprised of the audit schedule on a quarterly basis, as well as being advised of the basis for provider and sample selection for the audits.
- D. The MHA Deputy Director and Clinical Director will review the quarterly schedule, discuss and review significant issues from prior audits and disseminate information to all relevant parties.

#### **05. Procedures for Conducting an Audit**

- A. Each auditor will use the following procedures to conduct an audit activity.
  - (1) Select consumer names that will undergo a comprehensive medical record review.
    - (a) Consumers shall be identified through random selection, or based upon an identified methodology.
    - (b) An audit shall consist of a minimum of 10 medical records or a number designated by the ASO Medical Director or MHA Deputy Director or Clinical Director. The auditor maintains the discretion to audit additional records.
  - (2) Notify the provider (verbally and by certified letter) 10 business days prior to the date of the audit with a copy to the MHA Deputy Director and the CSA in which the acute care facility resides.
    - (a) The names of consumer records to be reviewed shall be provided to the program with the notification letter.

- (3) Request that the provider mail complete copies of the consumer records to the ASO lead auditor.
- (4) Review the provider's paid claims data and ASO Utilization Management System entries for the identified consumers.
- (5) Upon receipt of the consumer medical records:
  - (a) Review the selected medical records for medical necessity and document the finding.
- (6) The MHA Deputy Director and Clinical Director will be notified of all providers who do not comply with the request for medical records.
- (7) If at anytime during the audit, the auditor has reason to believe criminal action or intentional fraudulent activities may have occurred, or that there are quality of care issues that present an immediate risk of harm to consumers, the auditor shall immediately notify the MHA Deputy Director. If criminal action or fraudulent activities are suspected, the audit may be suspended and MHA may refer the matter to the Office of the Attorney General - Medicaid Fraud Unit. If MHA decides to further investigate suspected fraudulent activities, MHA reserves the right not to disclose the details of the investigation until the matter has been resolved.
- (8) If the auditor determines that some or all inpatient days did not meet the PMHS criteria for Medical Necessity, the medical record will be reviewed and a determination made by the ASO Medical Director or consulting physician advisor.
- (8) The ASO auditor will:
  - (a) Within 30 calendar days after completion of the audit, submit a written report to the provider. Reports may be submitted sooner than 30 days if completed. The provider will have 30 calendar days after receipt of the audit report to review and provide comments to the written report.

## **.06 Post Audit Procedures**

- A. Audit findings will result in one of two possible outcomes:
  - (1) No or minimal action required - may require minor corrective actions.
  - (2) Action and Sanctions required
- B. The MHA Deputy Director will issue a letter of determination within 45 days *after receipt of audit report* that includes the following:
  - (a) Audit findings and recommendations;

- (b) Date of services or services not supported due to insufficient/improper documentation or failure to meet the PMHS medical necessity criteria;
  - (c) Regulatory or statutory citations/deficiencies;
  - (d) The amount of funds paid by the ASO for unsupported services.
- C. The MHA Deputy Director will notify the provider of retraction of funds paid by the ASO if the audit report finds that claims were paid which were not properly supported by the medical record. This letter will be copied to the ASO and to the CSA in which the acute inpatient facility resides.
- D. Timelines for the audit and MHA reviews may be extended if issues require additional investigation.
- E. The MHA Deputy Director will copy the CSA and ASO on all correspondence regarding the audit: the determination letter and retraction report. However, MHA reserves the right not to provide correspondence if an investigation of the provider has commenced. MHA will inform the agency(s) performance and audit of the results of the investigation.

## **07. Appeals**

- A. A provider may submit an appeal by sending written notice of appeal to the MHA Deputy Director within 30 days of the date on the notice of the letter of determination.
- B. The MHA Deputy Director will advise the provider of the right to appeal the findings to the Office of Administrative Hearings.
- C. If the provider does not file an appeal within 30 days of receipt of the MHA findings, the MHA Deputy Director shall instruct the ASO, in writing, to retract from the provider the amount of funds identified in the report.
- D. Timelines for MHA and the auditor are discretionary, and not mandatory, and may not be used by the provider to nullify findings or penalties.