CHAPTER 4

GENERAL INFORMATION

Provider Audits: Medical Records, Treatment Plans, Authorization Plans, and Coordination of Care

1) Providers who accept Medicaid reimbursement are required to comply with the applicable medical records and documentation requirements.

2) Providers in the PMHS are subject to random and scheduled on-site audits.

3) The following information regarding the audit process can be accessed at:

This site includes:

- MHA Compliance Policies and Procedures
- Audit Tools by Program/Agency/Provider Type
- Billing Review
- Definitions
- Resources:
  - Audit Overview
  - Staffing Requirements
  - Audit Notification Letter
  - Required Components of a PRP Rehabilitation Assessment
  - Required Components of an OMHC Comprehensive Assessment
  - Plans for Improvement
  - RTC Seclusion and Restraint Definitions

ValueOptions® Maryland Provider Manual
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4.2 Alternative or Additional Services

It is the treating provider’s responsibility to contact ValueOptions® Maryland for authorization prior to referring a consumer for consultation services or a new level of care. In all cases, other than emergencies, care must be preauthorized.

4.3 Authorization Requests

For individual practitioners, including those individuals in group practices, pre-authorization is specific to the provider enrolled in ProviderConnect. ValueOptions® Maryland requires that all treatment be provided by the specific therapist to whom services were authorized. Providers with group practices should request authorization specific to the individual Medicaid provider number under the practice group’s Medicaid number.

4.4 Consumers with Private Insurance and Medical Assistance (Dually Eligible Consumers)

If a private carrier denies a level of care, the provider must go through all available levels of the appeal process with the private insurer. If the final decision by the private carrier is to deny the services, the provider should contact ValueOptions® for a retrospective review. Refer to Chapter 10 of this manual for details.