OPERATING POLICY & PROCEDURE

Subject: **Provider Network Monitoring**		Application: **All Departments & Providers**
First Effective 1/04/14	Revised 02/22/16	Review 2/13/2023

PURPOSE

To provide an overview of the means and processes used by Pivotal for monitoring the compliance of service providers with contract and other requirements and to assure the highest quality of services to individuals served by Pivotal.

DEFINITIONS

Single Audit/Sub-Recipient Monitoring
Agencies that expend $500,000 or more in Federal awards during a fiscal year must obtain a single audit or program-specific audit (when administering only one federal program) in accordance with the Code of Federal Regulations (CFR), Title 45, Part 96.31; the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507); and updated Office of Management and Budget (OMB) Circular A-133 "Audits of State, Local Governments, and Non-Profit Organizations". The Single Audit also applies to a Sub-Recipient (a non-federal entity that expends federal awards received from a pass-through entity to carry out a federal program but does not include an individual who is a beneficiary of such a program; a sub-recipient may also be a recipient of other federal awards directly from a federal awarding agency).

POLICY

It is the policy of Pivotal to ensure the performance, quality, regulatory and contract compliance of each entity that holds a contract with Pivotal.

STANDARDS

A. Individuals and organizations under contract with Pivotal for the provision of services:

1. Must be credentialed prior to finalizing an initial contract. Organizations must provide evidence that there are adequate processes in place for credentialing and re-credentialing their staff (refer to policies 02.05 & 02.06 on Credentialing and Re-credentialing).

2. Are subject to the ongoing monitoring by Pivotal.

3. Are required to implement improvement plans as indicated through identified deficiencies or areas needing improvement.

B. The components and tools utilized in provider monitoring review processes are outlined in exhibit A.

C. Provider Monitoring Reviews (PMR) are a significant part of reviewing providers. A PMR of a provider may include one or more of the following components:

1. Clinical Record Review (CRR)

2. Utilization Management Reviews (UM)

3. (Administrative/Organizational) Site Review (ASR)

4. Claims Verification Review (CVR)

5. Residential Funds Review (RFR)

D. PMRs are to:

1. Include a representative sampling of cases.

2. Be conducted by individuals who have the expertise and qualifications for assessing the quality of the area being reviewed.

3. Be conducted with minimal disruption to services.

4. Provide accurate, timely and useful information.

5. Include clear recommendations for improvement where needed.

E. Pivotal will work with SWMBH and the CMHSP's within the region to coordinate and reciprocate provider reviews and minimize redundancies within our region.

F. Pivotal will maintain copies of the provider review tools that are currently being utilized on its website.

G. Other applicable components of the provider monitoring review process (i.e., Targeted Utilization Management, or a Recipient Rights Review) may be conducted in conjunction with the PMR.

H. Provider monitoring will result in summary performance reports that will be presented to the Manager/Supervisor Team and other applicable teams and

individuals for consideration and decision-making. The Pivotal Manager/Supervisor Team will review the aggregate results for opportunities for system improvement.

I. All instances of fraud and/or abuse discovered during a provider monitoring review will be reported as required to the Program Investigations Section (per MDHHS contractual requirement, section 10.0) and the Southwest Michigan Behavioral Health (SWMBH).

J. Pivotal will take firm and expedient action in the event of significant non-compliance as outlined in policy 02.04 (Contract Compliance).

K. Disagreement with any aspect of the provider monitoring review process or findings may be addressed informally and/or formally.

1. The informal process consists of :
    a. Contacting the lead reviewer with:
        1) A description of the disagreement (i.e., specific case #, specific PMR item #)
        2) Remedy sought
        3) A rationale for the change, including substantiating documentation
    b. The lead reviewer may request additional information or may research the issue, but must respond within 10 days of the initial contact.
    c. The informal process must be initiated before the date a Plan for Improvement is due.

2. The formal process consists of following policy 02.02 (Provider Grievance and Appeals [non-clinical]).

REFERENCES

- Balanced Budget Act 438.230(b)(3)-(4)

- MDHHS Contract Attachment on Requirements a CMHSP Quality Improvement Program and Compliance Examination Guidelines

- Pivotal Policy
    - 02.01 (Procurement of MH and SA Services or General Management Services)
    - 02.04 (Provider Contract Compliance)
    - 02.05 (Credentialing of Individual Providers)
    - 02.06 (Credentialing of Organizational Providers)

- Southwest Michigan Behavioral Health Policy

- 2.13 (Provider Network Monitoring)

EXHIBITS

- 2.08A - Provider Monitoring Matrix
- 2.08B - Provider Monitoring Review Process