

NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES (NNAMHS)
POLICY AND PROCEDURE

SUBJECT: MEDICATION CLINIC PROCESS FOR AUDITING CLINICAL
PRESCRIBERS

NUMBER: NN- FM-13

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ORIGINAL DATE: 2/17/11

REVIEW/REVISED DATE: 1/16/14

APPROVAL: _____ Cody L. Phinney _____, Agency Director

I. PURPOSE

Establish a procedure for the medication clinic for auditing the clinical prescribers (MD/APN/DO) documentation to meet criteria of services billed.

II. POLICY

Documentation will be audited to ensure that for each bill generated from a service provided, there is a corresponding progress note completed by the clinician meeting the criteria for the billable service.

III. REFERENCES

1. MHDS Policy IMRT-2.01 Basic Documentation Guidelines for Medical Records
2. NNAMHS Policy NN-IM-MR-20 Medical Records, Basic Charting Standards.

IV. PROCEDURE

1. The master schedule listing consumers seen the previous day, those who did not keep their appointments, the sign-in list for scheduled as well as walk-ins, and the walk-in slips of those seen is collected and reviewed.
2. A list of billable services in the medication clinic is obtained from the Electronic Medical Record (EMR).
3. The administrative assistant then compares the billable service provided to the MHDS progress note to ensure that the two match.
4. If there is a discrepancy between the billed service and documentation then the clinic supervisor is notified by e-mail attaching the billed service and progress note to compare.
5. Corrections are then made as needed.
6. Auditing the content of the documentation for appropriateness occurs in two ways:
 - a. At each visit the nurse reviews the progress note written by the clinician at the previous visit. Any issue regarding documentation is reviewed by the clinic supervisor for appropriate action.
 - b. The clinic supervisor then forwarded to the Agency Medical Director for follow-up of any issues involving clinical staff..
 - c. The clinic supervisor, during the course of business each day, reviews four or five prescriber notes in the electronic medical record. Any discrepancy or issues are brought to the attention of the prescriber, I.T. and Medical Director as appropriate.
7. Productivity reports are run the following day to also ensure that there are no discrepancies with double billing, incorrect coding for no shows or omissions of a note generating a bill.
8. Once a month med staff will perform a peer review.