

CHELAN-DOUGLAS RSN/PIHP POLICY AND PROCEDURE MANUAL		Chapter:	6.3.5.3
Title:	MANAGEMENT INFORMATION SYSTEMS	Page:	1 of 2
		Date Effective:	July 1, 2009
Subject:	DECERTIFICATION OF DATA FORM SUBMITTED TO CDRSN/PIHP/PIHP BY CONTRACTING PROVIDER	Date Revised:	June 27, 2011
		Authorizing Signature: Formally Adopted	

PURPOSE: To delineate the Chelan-Douglas RSN/PIHP process for provider de-certification of data due to required error resolution and data re-submission.

DEFINITION: Federal regulations require that utilization data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

PROCESS/PROCEDURES:

1. For Errors that need to be mitigated by CDRSN/PIHP to Provider One.
 - A. CDRSN/PIHP/PIHP will place Unresolved Error Report for providers out on the Secure FTP Site for provider to pick up and resolution. Once errors have been resolved the provider will place copy of the Unresolved Error Report with Name and Date of Resolution out on the FTP Site for CDRSN/PIHP to pick up and archive.
 - B. If the error requires a De-Certification to correct data sent to Provider One for Mitigation. CDRSN/PIHP will send Provider a De-Certification Form with Transaction Message of error being mitigated.
 - C. Provider will sign De-Certification and mail/drop off at CDRSN/PIHP office.
 - D. To ensure that the CDRSN/PIHP/PIHP Contracting Providers submits a completed form of 'DECERTIFICATION OF UTILIZATION INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM' when CDRSN/PIHP/PIHP send DECERTIFICATION to PROVIDERONE.
 - E. The form of the Decertification Letter is as follows:

CDRSN/PIHP PIHP NETWORK

DE-CERTIFICATION OF UTILIZATION INFORMATION RELATING TO PAYMENT UNDER THE MEDICAID PROGRAM

DECERTIFICATION

Pursuant to the contract(s) between the Chelan-Douglas Regional Support Network, a Prepaid Inpatient Health Plan (PIHP) and MHA's, a licensed Mental Health Agency. MHA certifies that it is a contracted

qualified provider and authorized to participate in the Washington State Medical Assistance Program as a licensed Mental Health Agency within the CDRSN/PIHP/PIHP Network, providing data to CDRSN/PIHP/PIHP and using the report unit identifier [REDACTED]. The MHA acknowledges that the PIHP data, using Federal regulations require that utilization data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The PIHP makes the following de-certification to the state of Washington:

The **MHA's** has reported outpatient mental health utilization data to PIHP/Washington State for the month of _____, 20___. The **MHA** has reviewed the utilization data for this month and I _____, attest that based on best knowledge, information, and belief as of the month indicated above, all information submitted to PIHP/Washington State **requires a resubmission due to the following reason:**

Transaction Message:

NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I _____ DELAGATE ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE PIHP. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.

_____ **On behalf of (MHA's NAME)**
(Indicate Name and Title (CFO, CEO, or Delegate))

Date: _____