MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	Medicaid Event Verification		
Policy: ☒ Procedure: ☐ Page: 1 of 3	Review Cycle: Biennial Author: Medicaid Event Internal Auditor and Chief Compliance & Quality Officer	Adopted Date: 01.05.2016 Review Date: 11.10.2026	Related Policies: Monitoring and Oversight

Purpose

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Mid-State Health Network (MSHN) process for conducting monitoring and oversight of the Medicaid, Healthy Michigan Plan and Substance Use Disorder (SUD) Block Grant claims/encounters submitted within the Provider Network. To ensure compliance with federal and state regulations, and to establish standardized process for review of claims/encounters in accordance with the Michigan Department of Health and Human Services (MDHHS) Medicaid Verification Process.

Policy

MSHN shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for how monitoring and oversight of any claims/encounters provided to beneficiaries of Medicaid, Healthy Michigan and SUD Block Grant services will be completed.

A. MSHN shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed as follows:
    1. Community Mental Health Service Programs (CMHSPs) bi-annually
    2. Substance Use Disorder providers annually
        - Full review biennially
        - Interim review during non-full review year
    3. Any provider (including subcontractors of the CMHSP and SUD providers) that represents more than 25% of MSHN claims/encounters in either unit volume or dollar value annually. The 25% of unit volume will be determined using the claims/encounters billed to MSHN with each submitted claim/encounter equaling 1 unit of claims/encounters.
    4. Any Provider that MSHN directly contracts with for services that are paid utilizing Medicaid, Healthy Michigan Plan, or Block Grant funding.
    5. Upon termination of a Provider contract with MSHN.

    MSHN reserves the right to conduct further reviews of the Provider Network on an as needed basis.

B. The claim/encounter review process may consist of the following components:
    1. Desk Audit: This component will consist of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the PIHP for review prior to the on-site visit. This may also include review of documentation to support submitted claims/encounters in lieu of an on-site visit.
    2. On-Site Audit: This component will consist of an on-site visit to the Provider Network to review and validate process requirements.
    3. Claim/Encounter Review: The PIHP shall pull a random sample of Medicaid, Healthy Michigan Plan and SUD Block Grant participants to complete verification of submitted claims/encounters.
    4. Data Review and Analysis: This component includes analysis of the Provider Network.

C. Overall responsibility for the claim/encounter verification and updating of the monitoring evaluation tool shall rest with the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility; and updated as necessary due to changing regulations, new contract terms and operational feedback received.

D. MSHN shall create its verification schedule at least 45 days in advance of its review.

E. Following the review, MSHN shall develop a Medicaid Event Verification Report detailing the results of its verification review for the Provider. The Medicaid Event Verification report shall include the following:
   1. A summary detailing the PIHP's overall review process and findings;
   2. Details pertaining to each claim/encounter reviewed
   3. "Findings" (if applicable) that will require corrective action for claims/encounters that are found not to be in substantial compliance with federal and state standards.
   4. "Recommendations" (If applicable) pertaining to any quality improvement or best practice suggestions. These do not require corrective action.
   5. All claims/encounters found to be invalid that will require correction either by resubmission or voiding.
   6. Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.

   The PIHP shall submit the verification report to the Provider within thirty (30) days of the verification audit conclusion.

F. Report summary findings of the MSHN Medicaid Event Verification audits shall be shared with MSHN Board of Directors, Corporate Compliance Committee, Operations Council, Quality Improvement Council, and other MSHN councils as appropriate.

G. MSHN will report any suspected fraud, waste or abuse related to claims/encounters and beneficiary utilization of authorized services discovered during the Medicaid Event Verification Process to MDHHS-Office of Inspector General as required.

H. MSHN shall submit an annual report to MDHHS per the contract requirements, due December 31, covering the claims/encounter audit process.
   1. Cover letter on PIHP letterhead
   2. Description of the methodology used by the PIHP, including all required elements previously described.
   3. Summary of the results of the Medicaid event verification process performed, including: population of the providers, number of providers tested, number of providers put on corrective action plans, number of providers on corrective action for repeat/continuing issues, number of providers taken off of corrective action plans, population of claims/encounters tested (units and dollar value), claims/encounters tested (units and dollar value), and invalid claims/encounters identified (units and dollar value).

I. MSHN will maintain all documentation supporting the verification process as required by state and federal regulation.

Applies to:

☐ All Mid-State Health Network Staff

☐ Selected MSHN Staff, as follows:

☒MSHN's CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure

☒Other: Sub-contract Providers

Definitions:

Covered Service: Any service defined by the Michigan Department of Health and Human Services as required service in the Medicaid Specialty Supports and Services benefit

CMHSP: Community Mental Health Service Program

CPT Code: Current Procedural Terminology Code (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies

and accreditation organizations.
Documentation: Documentation may be written or electronic and will correlate the service to the plan. Clinical documentation must identify the consumer and provider, must identify the service provided, date and time of the service. Administrative records might include monthly occupancy reports, shift notes, medication logs, personal care and community living support logs, assessments, or other records.
Finding: A federal or state standard found out of compliance. A finding requires a corrective action to ensure compliance with federal and state guidelines.
HCPCS: Healthcare Common Procedure Coding System: set of health care procedure codes based on the American Medical Associations Current Procedural Terminology (CPT)
MDHHS: Michigan Department of Health and Human Services
MSHN: Mid-State Health Network
PIHP: Prepaid Inpatient Health Plan
Provider Network: refers to a CMHSP Participant and all Behavioral Health Providers that are directly under contract with the MSHN PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors
Random Sample: A computer generated selection of events by provider and HCPCS, Revenue, or CPT Code or Code Category. The auditor then randomly picks the events to review from the list of events
Recommendation: A quality improvement suggestion that is meant to guide quality improvement discussion and change. A recommendation does not require corrective action.
Record Review: A method of audit includes administrative review of the consumer record.
Subcontractors: Refers to an individual or organization that is directly under contract with the CMHSP to provide service or supports
SUD: Substance Use Disorder

Other Related Materials
MSHN Medicaid Event Verification Procedure

References/Legal Authority
Medicaid Managed Specialty Supports and Services Concurrent Contract
Michigan Department of Health and Human Services (MDHHS) Medicaid Verification Process
Behavioral Code Charts and Provider Qualifications

Change Log:

Date of Change	Description of Change	Responsible Party
12.2015	New Policy	Director of Compliance, CS & Quality
03.2017	Annual Review	Director of Compliance, CS & Quality
03.2018	Annual Review	Director of Compliance, CS & Quality
03.2019	Annual Review, removed monthly review of reports of claims and encounters	Quality Manager
10.2020	Biennial Review	Quality Manager
08.2022	Biennial Review	Chief Compliance & Quality Officer
12/2024	Biennial Review	Chief Compliance and Quality Officer
05/2026	Added language for reviewing for fraud fro billings and beneficiary utilization as required by the OIG	Chief Compliance and Quality Officer