MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Quality**		
Title:	**Medicaid Event Verification Procedure**		
Policy: ☐ **Procedure:** ☒ **Page: 1 of 5**	**Review Cycle:** Biennial **Author:** Chief Compliance & Quality Officer	**Adopted Date:** 01.12.2021 **Review Date:** 03.04.2025	**Related Policies:** Monitoring & Oversight Policy Medicaid Event Verification Policy

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Purpose

The purpose of this procedure is to guide Mid-State Health Network (MSHN) in the process for conducting Medicaid Event Verification, to ensure compliance with state regulations, and to establish a standardized procedure for conducting reviews in accordance with the Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Medicaid Verification Process.

Procedure

In accordance with the MSHN Medicaid Event Verification (MEV) Policy, MSHN will conduct a review of the Community Mental Health Service Program (CMHSP) Participants and the Substance Use Disorder (SUD) Treatment Provider Network.

A. A monitoring schedule will be developed yearly and distributed according to the Medicaid Event Verification Policy.
B. At least 45 days prior to the review, MSHN will develop a list of Active Medicaid, Healthy Michigan Plan and SUD Block Grant cases to determine an appropriate sample to sufficiently cover all applicable areas of the review.
C. At least 30 days prior to the review, MSHN will send out a review checklist to allow sufficient time to prepare and to submit information prior to the visit. The checklist will include at a minimum the following:
    1. List of agency contracts assigned to the Medicaid Event Verification Review.
    2. Summary of the contracts with sub-contractors that include the contract rate for services, service codes approved within the contract, and the effective dates of the contract for the subcontractors included within the sample of claims/encounters.
    3. Description of the internal controls in place to ensure verification of clean and appropriate claims/encounters prior to submission.
    4. A copy of the validations in place within the electronic medical record to ensure the verification of clean and appropriate claims/encounters prior to submission.
    5. Evidence of qualifications/credentials for each staff person providing services for the claims selected in the MEV review [if not available to public via web such as Licensing and Regulatory Agency (LARA), Michigan Certification Board for Addiction Professionals (MCBAP), etc.]
D. At least 15 business days prior to the review, MSHN will send a list of claims/encounters selected for review.
E. MSHN will ensure that the following controls objectives are met:
    1. A system in place to verify eligibility prior to a service being billed.
    2. A system in place to ensure there are not duplicative billings for a service.
    3. A system in place to ensure a person does not have more than one claim/encounter billed during the same time period.
    4. A system in place to ensure that a claim/encounter being billed is authorized within the person-centered plan.

5. A system in place to verify that codes billed are approved Medicaid, Healthy Michigan Plan and SUD Block Grant codes.
6. A system in place to ensure that invalid claims/encounters are corrected, and repayment is made for invalid claims/encounters.

F. Verification will include testing of data elements from the individual claims/encounters in the following manner:

1. Code submitted for billing is approved under the contract
2. Eligibility of the beneficiary on the date of service
3. For CMHSP Participants, the service provided is part of the beneficiary's individualized plan of service (and provided in the authorized amount, scope and duration); For SUD Providers, the service provided was provided as authorized and included in the treatment plan
4. The date and time of the service
5. Services were provided by a qualified individual and falls within the scope of the code billed and paid
6. The amount billed/paid does not exceed the standard/customary rate
7. Modifiers are used following the Healthcare Common Procedure Coding System (HCPCS) and MDHHS guidelines

G. All documentation for verification of services must be available on, or by desk review, during the day of the review. Please refer to the review checklist for examples of acceptable supporting documentation.

H. In the event that the claims/encounters tested result in accuracy less than 90%, a larger sample of the claims/encounters shall be tested. This may occur through the review of additional claims/encounters during the next scheduled full review or interim review.

MSHN shall utilize a statistically sound sampling methodology in accordance with Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) standards for verification of claims/encounters. The CMHSPs will be reviewed biannually with the sample size consisting of a non-duplicated sample of beneficiaries served within the previous two quarters. CMHSP Participant samples will include a minimum of 20 beneficiaries. The SUD Providers will have a full review completed biennially; the sample size will consist of a non-duplicated sample of the previous 4 quarters and will include a minimum of 8 beneficiaries. The SUD Providers, during the interim review, will have a minimum of 2 beneficiaries included in the sample review to ensure continued compliance with standards, and if necessary, effectiveness of implementation of corrective action.

MSHN MEV Sampling Methodology		
Provider Type	CMHSP Participant	SUD Provider
MEV Review Schedule	Biannual	Biennial
MEV Sample Size *Full* *Interim*	 20 beneficiaries (5 over-sample) 20 beneficiaries (5 over-sample)	 8 beneficiaries (2 over-sample) 2 beneficiaries (2 over-sample)
Maximum Number of Claims/Encounters Reviewed per Beneficiary	20	20

1. The claims/encounters reviewed will have a maximum of 20 claims/encounters for each beneficiary included in the random sample.
2. Any beneficiary that has been selected as part of the sample will be disallowed from the Providers sampling selection for 12 months.
3. The CMHSP review will consist of one beneficiary from each of the following program types if applicable:
    A. Assertive Community Treatment (ACT)
    B. Autism
    C. Behavior Treatment Plans
    D. Children's Crisis Intensive Stabilization Services
    E. Children's Waiver Program (CWP)
    F. Crisis Residential
    G. Habilitation Supports Waiver (HSW)
    H. Home Based Services
    I. Home and Community Based Services
    J. Self Determination
    K. Serious Emotional Disturbance Waiver (SEDW) / Wraparound
    L. Targeted Case Management (TCM)/Supports Coordination Services
4. The SUD program review will consist of at least one beneficiary from each service type the Provider provides if applicable:
    A. Case Management
    B. Co-Occuring
    C. Detox
    D. Medication Assisted Treatment
    E. Outpatient Services
    F. Peer Services
    G. Recovery Housing
    H.
    I. Residential
    J. Women's Specialty Services

I. The sample will be pulled using FastLane.
The database pulls all encounters that meet the criteria selected to include procedure codes, modifiers, funding sources, institutions and start and end date filter of encounters. Once the sample is pulled using the selected criteria, the system randomizes the list using a random sorting guide and then pulls out a sample based on the pools and weighs (various procedure codes that are grouped so that certain items are pooled or weighted given those priority in the sample). The configuration has a minimum size, maximum size and percentage of pool sample size. The system checks how many encounters are available and takes that value and multiplies it by the percentage of pool value. If that value is in the minimum-maximum range it uses that value. If it is smaller than the minimum, then the minimum is used. If it is larger than the maximum, then the maximum is used.

J. An optional entrance meeting will be offered at the beginning of the review. The entrance meeting will consist of a review of the agenda and the materials that will be reviewed.

K. An exit meeting will be scheduled at the end of the review to discuss a summary of the results of the review.

L. In accordance with the Medicaid Event Verification Policy, MSHN will provide the CMHSP Participant and the SUD Provider a written report that includes the results of the review within 30 days of the conclusion.

M. Any claims/encounters that are determined to be an inappropriate claim or a billing error will be forwarded to the MSHN finance department for possible follow up.

N. The Provider shall submit a corrective action plan within thirty (30) days of the verification review report date for any item that did not meet the compliance standard. MSHN will provide a standard template for the corrective action plan. Corrective action plans not submitted within the required time frame will be reported to the MSHN Chief Executive Officer and the Provider Participant's Chief Executive Officer/Executive Director for resolution and submission.

O. MSHN will review and respond to corrective action plans within 15 days.
   1. If additional information is required, the Provider will have 7 days to respond and provide any additional information requested to MSHN. If the response requires additional follow up MSHN will have 7 days to review and respond to the Provider.
   2. It is the expectation that all corrective actions will be fully implemented within 30 days of their approval by MSHN. In special circumstances MSHN may approve an extension for the implementation to occur.
   3. Any identified health and/or safety issue will need to be corrected immediately and will require submission of evidence that the issue has been corrected within 7 days of the review.

P. If the provider and review team cannot reach mutual agreement on a finding or on required corrective action, the provider may submit an appeal of finding and conflict resolution per the MSHN provider appeal procedure. NOTE: Recommendations do not qualify under the appeal and resolution process as they are recommendations only and do not require a corrective action plan. After a review, the MSHN provider appeal committee shall submit to the provider a determination of the appeal and copy the review team. The review team shall adjust and reissue the monitoring report as an outcome of either an informal or formal appeal that changes the report results.

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

ACT: Assertive Community Treatment
BHDDA: Behavioral Health and Developmental Disabilities Administration
CMHSP: Community Mental Health Service Program
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
CWP: Children's Waiver Program
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
HSW: Habilitation Supports Waiver
LARA: Licensing and Regulatory Agency
MCBAP: Michigan Certification Board for Addiction Professionals
MDHHS: Michigan Department of Health and Human Services
MEV: Medicaid Event Verification
MSHN: Mid-State Health Network
OIG: Office of Inspector General

Provider: 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 a corrective action.
Record Review: A method of audit includes administrative review of the consumer record.
SEDW: Serious Emotional Disturbance Waiver
SUD: Substance Use Disorder
TCM: Targeted Case Management

Other Related Materials
MSHN Medicaid Event Verification Policy

References/Legal Authority
Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Medicaid Verification Process.
MDHHS Behavioral Code Charts and Provider Qualifications

Change Log:

Date of Change	Description of Change	Responsible Party
11.2015	New Procedure	Director of Compliance, Customer Service & Quality
03.2017	Annual Review	Director of Compliance, Customer Service & Quality
03.2018	Annual Review	Director of Compliance, Customer Service & Quality
03.2019	Annual Review, Updated Sample Process	Director of Compliance, Customer Service & Quality
10.2020	Biennial Review	Quality Manager
08.2022	Biennial Review, Updated Sample Process	Chief Compliance & Quality Officer
11.2024	Biennial Review – Updated attributes and program types	Compliance Administrator