MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	Quality		
Title:	**Medicaid Event Verification Procedure**		
Policy: ☐ **Procedure:** ☒ **Version: 2.0** **Page: 1 of5**	**Review Cycle: Annually** **Author: Director of Compliance, Customer Service & Compliance**	**Adopted Date: 11.2015** **Review Date:** 03.2018 **Revision Eff. Date:**	**Related Policies:** Monitoring & Oversight Policy Medicaid Event Verification Policy

DO NOT WRITE IN SHADED AREA ABOVE

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 site reviews in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY16- Attachment P6.4.1. Medicaid Services Verification – Technical Requirements.

Procedure

In accordance with the MSHN Medicaid Event Verification Policy, MSHN will conduct an on-site review of the CMHPS 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 site review, MSHN will develop a list of Active Medicaid and Healthy Michigan Plan Cases to determine an appropriate sample to sufficiently cover all applicable areas of the review.

C. At least 30 days prior to the site review, MSHN will send out a review checklist to allow sufficient time to prepare and to submit information prior to the site visit. The checklist will include at a minimum the following:
   Note: Some items MSHN may have already obtained through the desk audit, therefore the provider may attest to no item changes in the process by checking the appropriate box.
   1. List of agency contracts assigned to the Medicaid Event Verification Site 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 sub-contractors 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.

D. At least 15 business days prior to the review, MSHN will send a list of Medicaid and Healthy Michigan Plan claims/encounters selected for review.

E. MSHN will ensure that the following controls objectives are met:
   1. A system in place to verify Medicaid or Healthy Michigan Plan 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 or Healthy Michigan Plan codes.
6. A system in place to ensure that invalid claims/encounters are corrected, and repayment is made for invalid claims/encounters.

F. Verification for Medicaid and Healthy Michigan Plan 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 contract amount
   7. Modifiers are used following the HCPCS guidelines

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

H. In the event that that claims/encounters tested result in accuracy less than 90%, a larger sample of the claims/encounters shall be tested.

I. MSHN shall utilize a statistically sound sampling methodology in accordance with federal DHHS OIG standards for verification of Medicaid and Healthy Michigan Plan claims/encounters. The sample size will consist of a non-duplicated sample of 5% of the beneficiaries served within the previous two quarters. However, the sample will not exceed a maximum of 50 and a minimum of 20 beneficiaries.
   1. The claims/encounters reviewed will have a maximum of 50 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. Crisis Residential
      D. Home Based Services
      E. Habilitation Supports Waiver (HSW)
      F. Self Determination
      G. Targeted Case Management (TCM)/Supports Coordination Services
      H. Wraparound

4. The SUD program review will consist of at least one beneficiary from each service type the Provider provides if applicable:
    A. Detox
    B. Stabilization
    C. Residential
    D. Out-Patient Services
    E. Medication Assisted Treatment

J. The sample will be pulled using Microsoft Sequel Server and Excel.
1. Microsoft Server Sequel will use program scripts to pull the beneficiaries served during the previous two quarters from the MSHN Data Warehouse.
2. Every beneficiary will then be assigned a random number within Excel.
3. An additional column will then be created within Excel and the formula "=rand()" will then be used to select the random 6% of beneficiaries.
4. Only the top 5 % of beneficiaries will be used to complete the sample for the review if all of the required program types are met.
5. If the sample does not include one beneficiary from each required program type the last beneficiary will be removed from the 5% sample and the next beneficiary on the sample list that meets the criteria will be used.
6. If all of the program types are not met with the 6% sample pulled, the process will be run again to select additional beneficiaries. This will be done until all the required program types are selected.

K. An entrance meeting will be scheduled at the beginning of the review. The entrance meeting will consist of a review of the agenda and the materials that will be reviewed.

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

M. 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.

N. 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.

O. The Provider shall submit a remedial action/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 plan of correction. 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.

P. MSHN will review and respond to plans of correction 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. Once a corrective action plan has been accepted by MSHN, the service code identified in the CAP will be removed from the following sample to allow the corrective action to be implemented. The service code will only be removed from the sample for the Provider where the service code was identified as a finding.
4. 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 site review.

Q. 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.

R. A survey will be sent to the Provider within 30 days of completion to allow feedback regarding the Medicaid Event Verification Review and to ensure MSHN provides an opportunity for continuous quality improvement.

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

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
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.
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.

Other Related Materials

MSHN Medicaid Event Verification Policy

References/Legal Authority

Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program FY18- Attachment P6.4.1. Medicaid Services Verification-Technical Requirements

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