MSHN Medicaid Event Verification (MEV) Review Guide

for Community Mental Health Service Providers

Purpose: To provide guidance to the MSHN CMHSP Network on how claims are audited for the Medicaid Event Verification (MEV) review.

Applies to: MSHN CMH Provider Network

Responsible: Bria Perkins

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Overview

The MEV review is conducted utilizing a sampling methodology from which a random case selection is selected. The review involves a claims test where 7 attributes are tested for compliance per the MDHHS Medicaid Verification Process. The test can either yield a Y, N, or NA (for Attribute G) response. The attributes tested are as follows:

A. Code is an allowable service code under the contract
B. Beneficiary is eligible on the date of service
C. Service is included in the beneficiary's individual plan of service
D. Documentation of the service agrees to the claim date and time of service
E. Documentation of the service provided falls within the scope of the service code billed
F. Amount billed/paid does not exceed contractually agreed amount
G. Modifiers are used in accordance with the HCPCS/MDHHS guidelines

For more information, please see the Medicaid Event Verification Policy, Medicaid Event Verification Procedure, and MDHHS Medicaid Verification Process.

Objective

To ensure that compliance with each attribute is met, the MEV Auditor will look for the following:

A. Code is an allowable service code under the contract
Is there a signed contract that covers the claim dates of service (for CMHSP providers, CMHSP subcontracted providers)?

B. Beneficiary is eligible on the date of service
Can the beneficiary's Medicaid eligibility be verified in REMI for the dates of service being reviewed?

C. Service is included in the beneficiary's individual plan of service
Is there an individual plan of service/treatment plan in effect for the dates of service? Are the services provided and authorized as identified in the individual plan of service/treatment plan with the appropriate amount, scope, and duration of service? Is the treatment plan signed by both the provider and consumer?

D. Documentation of the service agrees to the claim date and time of service
Is there documentation to support the claim? Does the documentation support the date billed? Does the documentation start/stop time match the start/stop time billed? Do the units billed agree with the documentation start/stop time?

E. Documentation of the service provided falls within the scope of the service code billed
Is there documentation to support the claim? Is the service code billed using the correct code? Does the provider completing the service have the required training/credentials/certification, etc.

with evidence if needed (example: IPOS training, RBT training, etc.)? Does the provider completing the service/listed on the documentation match the one billed? Does the documentation include a progress note/narrative of what occurred during the service?

F. Amount billed/paid does not exceed contractually agreed amount
Was the correct amount paid according to the unit rate on the contract and/or fee schedule? If not, is there an amendment/authorization/budget to justify the billed amount?

G. Modifiers are used in accordance with the HCPCS/MDHHS guidelines
Is a modifier required for this claim per the contract with MSHN and/or per the MDHHS Behavioral Health Code Sets, Charts and Provider Qualifications and Encounter Reporting HCPCS and Revenue Codes in effect during the timeframe of the claims reviewed? Are the modifier(s) billed correctly? Does the documentation identify a modifier that is not included in the submitted billing? Are there any modifiers missing? Are there any modifiers billed in error?

Initial Findings

The MEV Auditor will review the claims in the case selection and email all initial findings to the site review/audit contact person. This will be done in a single email. There will be 1 week allowed for the contact person to ask questions, offer any clarifications, and/or upload any additional or missing documentation to Box or the EHR. After that point, the MEV Auditor will edit any findings, complete the audit, and finalize the report.

NOTE: Claims that were deemed invalid during the initial audit but have acceptable evidence submitted that shows compliance with the identified attribute(s)before the final report will not have a finding on the final report. However, this does not include claims that were corrected by means of voiding/rebilling during the time of the review. These claims will still have a finding as they were invalid during the time of the review. Evidence of these corrections can be added as part of the CAP.

Voiding

Invalid claims (claims that fail to meet compliance with all attributes tested) are required to be addressed by means of a corrective action plan (CAP), voiding, or both. Voiding of invalid claims should be completely timely and evidence of voided encounters should be uploaded to Box along with the CAP.

What does ***not*** require a void? (However, will still require a finding and CAP.)

1. Lack of IPOS training documentation.
2. Corrections made to documentation that result in compliance with identified attribute(s)
   NOTE: Corrections made to billing or that require voiding/re-billing will still have a finding. Evidence of these corrections can be added as part of the CAP.
3. Claims that were identified as invalid, but had evidence uploaded during the CAP that proved validity.

Cost-Settlement (CMHSP only)

Claims that require voiding will be completed by the CMHSP. MSHN does not recoup the funds associated as CMHSPs are cost-settled at the end of each fiscal year. For more information, please see the Cash Management-Cost Settlement Policy.

Appeal Process

For appeals, please see the Provider Appeal Procedure (midstatehealthnetwork.org).

Credentialing

Depending on the claims selected for review, the MEV Auditor may look for documentation to verify staff credentialing, training, certification, licensure, etc. The MEV Auditor will check to see that credentialing, training, certification, licensing etc. was current and occurred prior to services rendered. Licensure and certification that can be verified via LARA or MCBAP will not require additional documentation from the provider. Note: If the staff is not fully trained/credentialed, then they have to be supervised by a fully credentialed person.

If applicable, the MEV Auditor will need to be able to locate the following staff documentation via Box or EMR (depending on service code/modifier(s) billed).

1. **Individual Plan of Service (IPOS) Training Documentation** for non-professional/aide level staff. This should include the four elements required by MDHHS (date of training, content of training, who was trained (printed or legible signature), who did the training (printed or legible signature) with credentials.) For clarity, the document should reflect that training took place, rather than verbiages such as "I have read and understand," and the trainer should include their title.

2. **Certified Peer Support Specialist (CPSS) Certification** for certified peers. There should be evidence of certification provided either via MDHHS certificate or MDHHS letter.

3. **Registered Behavior Technician (RBT) Training Documentation** for Applied Behavior Analysis (ABA) Behavior Technician staff. There should be evidence of 40-hour RBT training via RBT certificate or Relias training. (BCAT certification alone is not sufficient.)

4. **Wraparound Training Documentation** for Wraparound facilitators and Wraparound supervisors as identified in the Medicaid Provider Manual (michigan.gov)

5. **CMHP, MHP QIDP, QBHP, QMHP, etc.** The provider's signature should include this qualification. The MEV auditor may request supporting documentation to verify the qualifications. This can be in the form of a letter on letterhead from the CMHSP.

Common Findings

Most findings seem to occur within Attributes E and G. The following are common findings seen in CMHSP MEV reviews (in no particular order):

1. Lack of IPOS training documentation
2. Modifier Errors (staff credential modifier errors, group modifier errors, etc.)
3. Missing Documentation
4. Incorrect Service Code Billed
5. Date/Time (Unit) Billing Errors

Frequently Asked Questions (FAQ)

1. What validations are you looking for to ensure the verification of clean and appropriate claims/encounters?
   We are looking to verify that providers have processes in place to verify clean claims/encounters. This can be in the form of a policy, procedure, etc.

2. How is the overall review percentage calculated?
   The "Percentage of Valid Claims Reviewed" is calculated by taking the total number of valid claims divided by the total number of claims reviewed. A claim is deemed "valid" if compliance is met in all 7 MEV attributes. For example, if a review yields 300 valid claims out of 350 claims reviewed, the overall score would be 85.71%. It should be noted that this percentage is not an average of the scores for all the attributes.

3. Which staff training documents need to be uploaded to Box?
   The main documents I need are listed in the 'Credentialing' section of this document (IPOS training, RBT trainings are most commonly asked for). Staff should be signing with their qualifications and/or credentials on supporting documentation. If there are instances where a staff is not signing (for example, if a service requires a bachelor's degree level and the staff does not sign with the degree), then I ask that evidence be uploaded to support (transcript, degree, etc.).

4. Would this documentation be acceptable during a Medicaid Event Verification review?
   Please feel free to email any questions on acceptable documentation to my email address: bria.perkins@midstatehealthnetwork.org and I would be happy to assist!

Resources

Here are some additional resources:

1. **MDHHS Medicaid Provider Manual** – Please check Medicaid Provider Manual (michigan.gov) for the most up-to-date version.

2. **State of Michigan, Department of Health and Human Services Behavioral Health Code Sets, Charts and Provider Qualifications – Qualifications and Encounter Reporting HCPCS and Revenue Codes** – This workbook is designed to incorporate multiple service code and modifier information sources into one document to facilitate access to key information needed in support of capturing services provided by MDHHS beneficiaries. This is updated regularly. Please check Reporting Requirements (michigan.gov) for the most up-to-date version.