MSHN Medicaid Event Verification (MEV) Review Guide

for Substance Use Disorder Providers

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

Applies to: MSHN SUD Provider Network

Responsible: Bria Perkins

Contents

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?
Are the service codes billed located on the MSHN fee schedule (SUD)?

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? 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?

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.

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

1. *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.
2. *Claims that were identified as invalid, but had evidence uploaded during the CAP that proved validity.*

Recoupment Process (SUD only)

Claims that require voiding due to not meeting compliance with identified attribute(s) will be completed by the MSHN Finance Department. Providers **should not** contact the MSHN Finance Department directly for voids stemming from the MEV review. Any findings requiring voids will go through the following process:

1. The MEV Auditor will notify the provider of all findings in the Initial Findings email.
2. Findings that remain after the report is finalized will be added to the Corrective Action Plan (CAP) to be addressed by the provider. The provider will also be provided with a Void-Recoupment Letter that identifies the preliminary number of claims to be voided and amount of dollars to be recouped.
3. If the provider can submit evidence with the CAP that shows compliance with the identified attribute(s) that had a finding, MSHN will not require the void(s). If the provider is unable to do so, MSHN will require the void(s).
4. After the CAP has been accepted/approved by the MEV Auditor, the MEV Auditor will reach out to the MSHN Finance Department to complete all required voids/recoupments that were not able to be addressed as part of the CAP.
5. MSHN will recoup all funds beginning with the next scheduled payment disbursement date (unless an extended pay-back period is requested by the provider following the instructions identified on the void/recoupment letter) until the full amount owed is recovered.
6. Recoupments will appear on the remittance advice which would provide confirmation of the voids. Once the recoupments are completed, the provider can submit a rebill for any claims/encounters that are able to be corrected.

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. **Certified Peer Recovery Coach (CPRC) Certification** for certified peers. There should be evidence of certification provided either via MDHHS certificate or MDHHS letter.
2. **CCAR Certification** There should be evidence of certification provided.

Common Findings

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

1. Modifier Errors (staff credential modifier errors, group modifier errors, etc.)
2. Date/Time (Unit) Billing Errors
3. Incorrect Service Code Billed
4. Service provided outside of a valid treatment plan
5. Residential treatment hours not met (for residential treatment providers)

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. How are Core hours and Life Skills/Self Care hours calculated in an MEV review for SUD residential treatment providers?
   For any claim line with residential services (H0018, H0019) billed, MSHN will need documentation to ensure that weekly Core service hours and weekly Life Skills/Self Care hours were provided and met as required for the identified level of care.

   The MEV Auditor reviews these hours by looking at a claim's service date, number of units (days) billed, level of care and supporting documentation. The MEV Auditor calculates hours by reviewing the supporting documentation and counting out the number of Core hours provided per week and the number of Life Skills/Self Care hours provided per week. If hours were not met for the week(s) reviewed without justification documented in the client record, there would be a finding and voiding/recoupment would be required.

   Providers are encouraged to document the hours on a spreadsheet for the claims selected ahead of the review. The MEV Auditor will review the provider's spreadsheet against documentation found in the chart to ensure that hours were met.

It should be noted that MSHN allows Core hours to be used to supplement the required Life Skills/Self Care hours per week, but Life Skills/Self Care hours cannot be used to supplement Core hours.

See MSHN-Provider Network->Provider Trainings webpage to view MEV- SUD Residential Treatment Hours PowerPoint for further detail on how hours are verified during an MEV review. See MDHHS SUD Treatment Policy #10 for additional information.

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.

3. SUD Provider Newsletters – MSHN sends weekly communications to the SUD provider network including regional updates, MSHN and state policies, regional training opportunities, provider meeting details, grant and other funding opportunities, and relevant resources. We encourage all provider staff to subscribe to the weekly newsletter by completing the quick and easy registration process. Please sign up here: SUD Provider Newsletters - Mid-State Health Network (midstatehealthnetwork.org).