POLICY TITLE:	**MEDICAID SERVICES VERIFICATION**	**POLICY # 7.8**		
Topic Area:	**QUALITY IMPROVEMENT**		**REVIEW DATES**	
Applies to:	All CMHSP Providers and the Provider Network	**ISSUED BY:** Chief Executive Officer **APPROVED BY:** Board of Directors	12/19/2013	3/30/2020
			8/9/2022	
Review Cycle:	Annually			
Developed and Maintained by:	Chief Executive Officer or Designee			
Supersedes:	N/A	**Effective Date:** 1/1/2014	**Revised Date:** September 15, 2022	

I. PURPOSE:

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the LRE process for conducting monitoring and oversight of the Medicaid and Healthy Michigan Plan 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 submitted for Medicaid and Healthy Michigan Plan recipients in accordance with the MDHHS Medicaid Services Verification Guidelines.

II. POLICY:

Lakeshore Regional Entity (LRE) 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 and Healthy Michigan services will be completed.

A. LRE shall conduct a full monitoring and verification process on a selected sample of claims/encounters. The reviews will be completed as follows:
   i. Community Mental Health Service Providers (CMHSPs) quarterly;
   ii. Any provider (including subcontractors of the CMHSP) that represents more than 25% of LRE claims/encounters in either unit volume or dollar value annually. The 25% of unit volume will be determined using the claims/encounters billed to LRE with each submitted claim/encounter equaling 1 unit of claims/encounters;
   iii. Any Provider that LRE directly contracts with for services that are paid utilizing Medicaid or Healthy Michigan Plan funding;
   iv. Upon termination of a Provider contract with LRE; and
   v. LRE 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:

i. 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;
ii. On-Site Audit: This component will consist of an on-site visit to the Provider Network to review and validate process requirements; and
iii. Claim/Encounter Review: The PIHP shall pull a random sample of Medicaid and Healthy Michigan Plan participants to complete verification of submitted claims/encounters.

C. Data Review and Analysis: This component includes analysis of the Provider Network. 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. LRE shall create its verification schedule at least 15 days in advance of its review.
E. Following the review, LRE shall develop a Medicaid Event Verification Report detailing the results of its verification review for the Provider. The PIHP shall submit the Medicaid Event Verification Report to the CMHSP and/or Providers within thirty (30) days of the verification audit conclusion. The Medicaid Event Verification report shall include the following:
    i. A summary detailing the PIHP's overall findings;
    ii. Details pertaining to each claim/encounter reviewed;
    iii. "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;
    iv. "Recommendations" (If applicable) pertaining to any quality improvement or best practice suggestions;
    v. All claims/encounters found to be invalid that will require correction either by resubmission or voiding; and
    vi. Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.
F. Report summary findings of the LRE Medicaid Event Verification audits shall be shared with LRE Board of Directors, Quality Improvement Regional Operations Advisory Team (QI ROAT), and other LRE ROATs, as appropriate.
G. LRE will report any suspected fraud or abuse discovered during the Medicaid Event Verification Process to MDHHS-Office of Inspector General.
H. LRE shall submit an annual report to MDHHS per the contract requirements, due December 31, covering the claims/encounter audit process, and include the following:
    i. Cover letter on PIHP letterhead;
    ii. Description of the methodology used by the PIHP, including all required elements previously described;
    iii. Summary of the results of the Medicaid event verification process performed, including:

(1) Population of providers,
(2) Number of providers tested,
(3) Number of providers put on corrective action plans,
(4) Number of providers on corrective action for repeat/continuing issues,
(5) Number of providers taken off corrective action plans,
(6) Population of claims/encounters tested (units & dollar value),
(7) Claims/Encounters tested (units & dollar value), and
(8) Invalid claims/encounters identified (units & dollar value).

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

III. APPLICABILITY AND RESPONSIBILITY:

This policy applies to the LRE, CMHSPs, and the entire Provider Network.

IV. MONITORING AND REVIEW:

The LRE Chief Executive Officer or Designee will review the policy on an annual basis.

V. 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 Provider

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

LRE: Lakeshore Regional Entity

PIHP: Prepaid Inpatient Health Plan

Provider Network: refers to a CMHSP Participant and all Behavioral Health and Substance Use Disorder Providers that are directly under contract with the LRE 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.

VI. RELATED POLICIES AND PROCEDURES

A. LRE QAPIP
B. LRE Quality Policies and Procedures
C. LRE Compliance Policies and Procedures
D. LRE Finance Policies and Procedures
E. LRE Compliance Plan

VII. REFERENCES/LEGAL AUTHORITY

A. MDHHS Medicaid Services Verification Guidelines

VIII. CHANGE LOG

Date of Change	Description of Change	Responsible Party
12/19/2013	New Policy	Chief Executive Officer
2021	Annual Update	Chief Executive Officer
08/09/2022	Annual Update	Chief Quality Officer