POLICY TITLE:	MEDICAID SERVICES VERIFICATION	POLICY # 7.8	REVIEW DATES	
Topic Area:	**QUALITY IMPROVEMENT**	**ISSUED BY:** Chief Operating Officer	12/19/13	3/30/20
Applies to:	LRE, Member CMHSPs, Network Providers		9/15/22	5/1/25
			7/1/26	
Developed and Maintained by:	Chief Operating Officer	**APPROVED BY:** Chief Executive Officer		
Supersedes:	N/A	**Effective Date:** 1/1/2014	**Revised Date:** 5/7/2026	

I. PURPOSE:

A. To establish guidelines for monitoring and overseeing submitted Medicaid and Healthy Michigan Plan claims.

B. To ensure compliance with federal and state regulations and establish a standardized process for the review of claims submitted for Medicaid and Healthy Michigan Plan beneficiaries in accordance with the MDHHS Medicaid Services Verification Guidelines.

C. To monitor for occurrences of fraud, waste, and abuse.

II. POLICY:

Lakeshore Regional Entity (LRE) shall implement and maintain a process to monitor and evaluate Member Community Mental Health Service Programs (CMHSPs) and Network Providers to ensure compliance with MDHHS Medicaid Verification Process and all federal and state regulations.

III. APPLICABILITY AND RESPONSIBILITY:

This policy applies to the LRE, Member CMHSPs, and Network Providers.

IV. MONITORING AND REVIEW:

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

V. DEFINITIONS

Abuse: As defined in 42 CFR 455.2, provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet the professionally recognized standards for health care.

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

Community Mental Health Service Program (**CMHSP)** A program that contracts with the State to provide comprehensive behavioral health services in specific geographic service

areas, regardless of an individual's ability to pay. (Michigan Mental Health Code 330.1100a, 330.1206)

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.

Fraud: As defined in 42 CFR 455.2, the intentional deception or misinterpretation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or another person. It includes any act that constitutes fraud under any applicable federal or State Law.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with Member CMHSP that receives Medicaid funding directly or indirectly to order, refer or render covered services as a result. A network provider is not a subcontractor by virtue of the network provider agreement, unless the network provider is responsible for services other than those that could be covered in a network provider agreement related to the delivery, ordering, or referring of covered services to a beneficiary.

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.

Waste: The thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the U.S. government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls. (https://oig.usaid.gov/node/221).

VI. REFERENCES AND SUPPORTING DOCUMENTS

- MDHHS Medicaid Verification Process
- LRE QAPIP
- LRE Compliance Plan

VII. RELATED POLICIES AND PROCEDURES

- LRE Quality Policies and Procedures
- LRE Compliance Policies and Procedures
- LRE Finance Policies and Procedures

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
9/15/2022	Annual Update	Chief Quality Officer
5/1/2025	Annual Review – removed procedure, added definitions, minor revisions	Chief Operating Officer
5/7/2026	Removed references to CCBHC	Chief Operating Officer