PROCEDURE # 7.8A		EFFECTIVE DATE	REVISED DATE
TITLE:	MEDICAID SERVICES VERIFICATION	1/1/2014	
ATTACHMENT TO		REVIEW DATES	
POLICY #:	7.8		
POLICY TITLE:	MEDICAID SERVICES VERIFICATION		
CHAPTER:	QUALITY IMPROVEMENT		

I. PURPOSE

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

II. PROCEDURE

A. LRE shall conduct a full monitoring and verification process on a random representative sample of Medicaid and Healthy Michigan Plan participants to complete verification of submitted claims. Reviews will be conducted as follows:

i. Community Mental Health Service Providers (CMHSPs)/Certified Community Behavioral Health Clinics (CCBHC) will be reviewed quarterly, including;
   (1) Network Providers that contract with CMHSPS/CCBHCs for services that are paid utilizing Medicaid or Healthy Michigan Plan funding;
   (2) Network Providers that represent more than 25% of claims submitted to LRE in either unit volume or dollar value annually. The 25%-of-unit volume will be determined using the claims submitted to LRE with each submitted claim equaling at least 1 unit

ii. Quality Site Visit Audits - an on-site visit to the Provider Network to review and validate process requirements

iii. Quality Desk Audits - a pre-review of select policies, protocols, documents and other resource material submitted by the Provider Network to the PIHP for review prior to the on-site visit

LRE reserves the right to conduct further reviews of the member CMHSPs/CCBHCs and Provider Network on an as-needed basis.

B. Monitoring Tool and Methodology: The Medicaid Verification tool shall be reviewed on an annual basis to ensure functional utility and updated as necessary to meet state and federal regulations, contract terms and operational feedback.

C. Data Review and Analysis: Overall responsibility for the claim/encounter verification and data analysis shall rest with the PIHP.

D. 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/CCBHC 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 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 determined to be invalid that will require correction either by resubmission or voiding; and
    vi. Recoupment of overpayment for any claims/encounters that are found to be invalid.

E. 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), Compliance ROAT, and other LRE ROATs as appropriate.
    i. Suspected fraud, waste, or abuse identified by the MEV Specialist or during ROAT review will be immediately reported to LRE Compliance Officer for investigation.

F. LRE Compliance Officer will report any suspected fraud, waste, or abuse discovered during the Medicaid Event Verification Process to MDHHS-Office of Inspector General.

G. LRE shall submit an annual report to MDHHS due December 31 covering the claims/encounter verification process for the prior fiscal year, which includes the following:
    i. Cover letter on LRE letterhead;
    ii. Description of the methodology used by the LRE, 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).

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

III. CHANGE LOG

Date of Change	Description of Change	Responsible Party
5/1/2025	NEW Procedure (removed from Policy	Chief Operating Officer