POLICY AND PROCEDURE MANUAL

SUBJECT: Medicaid Service Verification	ACCOUNTABILITY NMRE, NMRE Provider Network	Effective Date: April 25, 2018	Pages: 2
REQUIRED BY	BBA Section: PIHP Contract Section: P6.4.1, "Medicaid Services Verification Technical Requirement" Other: 42 CFR, Section 438.608, "Program Integrity"	Last Review Date:	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: Regional Compliance Coordinator	Responsible Department: Compliance	Reviewers: NMRE Board of Directors

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical 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 professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Fraud: (Federal False Claims Act): An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2) (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not

constitute "knowing" conduct necessary to establish Medicaid fraud, unless the person's "course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

Contractor: All provider agencies that receive Medicaid funds

Recoupment/Retraction/Voids: Depending on which program/department this is proof of how the money was taken out of the Medicaid "funds".

Review Completed: When NMRE and CMHSP/SUD PROVIDERS agree and/or EXIT interview if findings occur.

Worksheets: Excel spreadsheets documenting the samples provided by the NMRE before the verification can begin.

Purpose

The purpose is to establish consistent methodology as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of responsibilities for verification of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the Provider Network; to ensure compliance with federal and state regulations, in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program Attachment Medicaid Services Verification-Technical requirements; and to provide direction to NMRE Network Providers.

Policy

It is the policy of the NMRE to ensure that all claims for services are properly documented and services were provided prior to payment. Verification procedures may not be delegated to providers or CMHSPs.

Approval Signature

NMRE Chief Executive Officer

4/25/18

Date

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Procedure

The NMRE verification methodology will include testing data elements from individual encounters against EHR and the use of data analytics, as defined within the MDHHS Technical Requirement. Additional elements may be included to support the NMRE quality improvement efforts around encounter data.

A. Quarterly Schedule of Verification

Review Period	Months Reviewed	Review Conducted	Providers Reviewed
Quarter 1	October-December	February-April	CMHSP, SUD Providers
Quarter 2	January-March	May-July	CMHSP, SUD Providers
Quarter 3	April-June	August-October	CMHSP, SUD Providers
Quarter 4	July - September	November	CMHSP, SUD Providers

1. Medicaid Service Verification will include the following – **Documents NEEDED are noted in parentheses**
    a. The service code reported is approved under PIHP/MDHHS Contract **(PLAN/HCPCS)**
    b. Beneficiary was eligible for Medicaid/HMP on the date of service [**CHAMPS (Provider)]**
    c. Service was authorized in the consumer's individual plan of service/SUD Treatment Plan (**PLAN)**
    d. The date/time of service is documented (**PROGRESS NOTE)**
    e. The service was provided by a qualified practitioner that falls within their scope of practice for the code reported (**PROGRESS NOTE/Plan)**

f. Amount reported/paid does not exceed the payer (PIHP or CMHSP) contracted amount

NEW 2018 – The contracts with sub-contractors will include: contract rate for services, service codes approved in the contract, and the effective dates of the contract for only those included in the sample**.** (**CONTRACT)**

g. Other criteria may be added, as outlined within the NMRE Compliance Committee.

i For unit-based services, the appropriate units were reported;

ii Person-centered Planning process: client signature (if verbal, progress note/IPOS to determine reasons (see PCP policy.)

2. Medicaid Service Review – New 2018 – **Documents needed: Policies and Procedures**

a. Annually the NMRE will ensure systems are in place to:

i Verify Medicaid or Healthy Michigan Plan (HMP) eligibility prior to a service being billed.

ii Ensure there are not duplicative billings for a service.

iii Ensure that a claim/encounter being billed is authorized within the Individual Plan of Services.

iv Verify that codes billed are approved Medicaid or HMP codes.

v Ensure that invalid claims/encounters are corrected, and repayment is made for invalid claims/encounter.

B. Timeline of Quarterly Audits

Provider receives data worksheets	Begin review
NMRE EHR access	3 days after receiving worksheets
Documents requested:	3 days after receiving worksheets
Contract summaries	
CHAMPS verification	
Missing documents	24 hours after requested
Recoupments/disallow	3 days after identified error
SUD retractions/reconsideration report	2 weeks after identified error
Corrective Action Plans	30 days after final memo
NMRE Final Memo – each quarter	Within 30 days after review completed
Appeal – CMHSP/SUD	30 days after Final Memo
Appeal decision by NMRE	30 days after receiving appeal

Once the review is complete the NMRE Compliance Officer will send a memo/report to the NMRE CEO, CMHSP Directors/CEO, SUD Director and SUD Providers. Annually (December 31st) reports will go to MDHHS (MDHHS-BHDDA-Contracts-MGMT@michigan.gov) and the NMRE Governing Board.

The memo/report will:

1. Analyze findings,
2. Identify trends,
3. Note concerns with documentation,
4. Suggest recommendations,
5. Request plans of correction as needed, and
6. Explain the appeals process.

C. Sampling Methodology

Statistically representative sample requirements will meet OIG standards. The NMRE sampling process uses Microsoft SQL and Excel. If an audited sample yields less than 95% accuracy, a Plan of Correction is required. If an audited population falls below 90% accuracy during a 12-month period, a stratified sample will be pulled, and a Plan of Correction is required. The following is an outline of the populations and samples to be audited;

1. CMHSP Direct Provided Services Population (5 Total)
   → 40 Services per year/10 per Quarter
2. CMHSP Subcontractor Provided Services Population (5 Total)
   → 40 Services per year/10 per Quarter
3. SUS Provider Population
   → 60 Services per year/15 per Quarter
4. Financially Significant Population (3 SUD, 0 CMHSP) →
   → 40 Services per year/10 per Quarter
   → Any single provider that accounts for more than 10% of the total MH or SUD budgets accordingly.
5. Stratified Population – if reviews yield less than 90% accuracy

D. Corrective Action – Recoupment – Appeals

Scores falling below 95% accuracy for each quarterly review will a Plan of Correction. The Plan of Correction template will be emailed along with the final memo. The Provider will fill in criteria and strategies for the NMRE to review, once approved the NMRE will monitor as specified within the Plan of Correction. If any service is found invalid, it is required to void the encounter from

Medicaid funds and send proof to the NMRE Compliance Officer within 3 days of the finding or end of review period. SUD Proof of retractions would come as a reconsideration report, sent within 2 weeks of final report. A provider may appeal findings, in writing to the NMRE Compliance Officer who will seek consultation and render a decision within 2 weeks from receiving the appeal.

E. Suspicion of Fraud and/or Abuse

If there is suspicion of fraud and/or abuse, the NMRE Compliance Officer will notify the NMRE Chief Executive Officer (CEO) and the Provider's CEO/Executive Director of the alleged issue. The NMRE CEO will report the suspicion to Health Services Office of Inspector General (HSOIG) as required by the MDHHS- PIHP contract. No attempt to further investigate or resolve the issue(s) will be made by the NMRE or the Provider once the issue has been reported to the HSOIG.

Approval Signature

NMRE Chief Executive Officer

4/25/18

Date