NORTHERN MICHIGAN REGIONAL ENTITY
ADMINISTRATIVE MANUAL

PROCEDURE NAME: MEDICAID ENCOUNTERS VERIFICATION PROCEDURE
CHAPTER: FOUR – QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT
PROCEDURE #: 04-02-003
EFFECTIVE DATE: May 27, 2014

PURPOSE

To establish and maintain a process to verify that authorized Medicaid services the PIHP reported to MDHHS were properly performed and documented. Assure that all services delivered and documented have been properly reported. Identify trends for improving services and provide a means to identify circumstances and situations of non-compliance.

APPLICATION

This policy applies to the five Member Community Mental Health Services Programs (CMHSPs), all contracted Community Inpatient Facilities, and the NMRE Substance Use Disorder Services provider panel.

PROCEDURE

1) Medicaid Encounters Verification Review Schedule:

Reporting Period	Service Months Being Reviewed	Audit Review Time Frame	Providers To Be Reviewed
Quarter 1	July-September	10/1-12/31	CMHSP, SUD
Quarter 2	October-December	1/1-3-31	CMHSP, SUD
Quarter 3	January-March	4/1-6/30	CMHSP, SUD
Quarter 4	April-June	7/1-9/30	CMHSP, SUD
Quarter 4	July - June	7/1 – 9/30	Community IP Hospitals

2) The PIHP verification methodology will include the testing of data elements from individual encounters to be validated against clinical records:
   a. The service code reported/claimed is approved under PIHP/MDHHS Contract;
   b. Beneficiary was eligible for Medicaid/HMP on the date of service;
   c. Service was authorized in the consumer's individual plan of service;
   d. The date/time of service is documented;
   e. For unit-based services, the appropriate units were reported;
   f. The service was provided by a qualified practitioner and falls within their scope of practice for the code reported/claimed; and
   g. Amount reported/paid does not exceed the payer (PIHP or CMHSP) contracted amount (applicable to community inpatient claims only).
   h. Other criteria may be added, as outlined within the NMRE Annual Compliance Work Plan.

3) Data analytics will also be used to identify encounters that cannot be valid, or more likely not valid. Examples include:
   a. Multiple per diem encounters reported/claimed on the same day;
   b. Multiple providers providing the same service to the consumer in one day;
   c. Individual clinicians providing an unexpectedly high daily volume;
   d. Other criteria may be added, as outlined within the NMRE Annual Compliance Work Plan.

4) Sampling Methodology:
   a. The PIHP will use designated sampling software to assist in the sample determination process.
   b. A sampling plan will be designed for each audit and provider type with efforts to meet OIG standards for 90% confidence level and 25% precision/error rate. Usually a simple random sample will be used.
      - Separate sampling and verification will be performed at each CMHSP in the PIHP network as scheduled. The minimum sample size will be 100 encounters from each CMHSP for each audit period.
      - A sample encompassing all claims submitted by SUD providers will be selected each audit period. The minimum sample will be of 100 encounters for each audit period.
      - The single sample of encounters from contracted Community Inpatient Facilities will be done at least annually. The minimum sample size will be 50 claims annually.
      - Separate sampling and verification will be performed for encounters generated by CMHSPs employees and encounters generated through subcontracts of the CMHSPs.

5) Verification Review Timeline and Documentation Standards:
   a. The PIHP Reviewer will communicate the list of cases to be audited to the Designated CMHSP/ Provider Representative no more than three (3) days prior to conducting the audit.
   b. The Reviewer will conduct the audit by reviewing the consumer's clinical record (EHR) and/or any other relevant documentation made available to the Reviewer.
   c. For services reported by CMHSPs sub-contractor(s), the PIHP will work directly with the provider to verify encounters.
   d. For all encounters, the Designate Provider Representative must provide the requested documentation for all encounters within 24 hours of the request.
   e. If documentation is not submitted within the deadline, then the PIHP Reviewer will invalidate the encounter(s).

6) Reporting and Corrective Action:
   a. The PIHP Reviewer will provide a written report of the findings of the PIHP Medicaid Encounters Verification Review to each CMHSP/Contract Provider and the NMRE CEO within 30 days of the review. The report will include:
      - Summary of findings, including analysis of any trends;
      - Data reports with details for all invalid encounters;
      - Timelines for response and appeal process;
      - Recommendations and timelines for corrective action;

   b. A provider may appeal the findings of the PIHP Medicaid Encounters Verification Review to the NMRE CEO. This must be done in writing and within 30 days of receiving notice of the findings. The NMRE CEO will review the appeal, seek consultation (if appropriate), and render a decision within 30 days of receipt of the request for appeal. The CEO's decision will be final.

   c. All invalid encounters identified in the report findings require corrective action.
      - For all invalid encounters/claims, the CMHSP or contract provider will be required to transmit the voided encounter to the PIHP within 30 days of the report date, or within 30 days after receipt of an appeal decision notification, whichever is the latter.

- Recoupment will be required for any/all invalid encounters. The PIHP will recoup the total dollar value of any/all invalid encounters from the designated provider within 60 days of the report date. In the event of an appeal, the PIHP will recoup the total dollar value of any/all encounters 30 days after the receipt of the appeal decision notification. The PIHP will notify MDHHS of all recoupments, according to current PIHP finance policy and procedure.

- For findings less than 95%, a formal Corrective Action Initiative (CAI) will be required. The CAI will indicate a due date of thirty (30) days from the date the report was received for responding and developing a corrective action initiative (CAI). The provider will send a copy of the CAI to the NMRE Regulatory Compliance Coordinator. The provider will have thirty (30) days to develop and thirty (30) days to implement a performance improvement plan. The PIHP will conduct a follow-up review ninety (90) to one hundred twenty (120) days after the report date to validate the CAI has been implemented.

- For findings less than 90%, the PIHP will select a larger sample and require additional training and monitoring elements within the formal corrective action initiative (CAI), including targeted monitoring activities by the PIHP.

- Failure to respond within the designated timelines to audit findings, or a request for corrective action, or voiding encounters will result in sanctions by the PIHP.

7) Suspicion of fraud and/or abuse: When unusual errors are detected, an additional sample will be selected. If, upon completion of the review of the additional sample, the PIHP Reviewer believes that the detected errors *may* be Medicaid fraud or abuse, the Reviewer will notify the NMRE Chief Executive Officer (CEO). The PIHP CEO will report the suspicion to State of Michigan Office of Health Services Office of Inspector General (HSOIG), as required in the Medicaid Specialty Services and Supports Contract. The PIHP will follow instructions from the HSOIG regarding the appropriateness of any/all notifications to the CMHSP/Provider and will cease taking any further actions to investigate or make inquiries.

8) The PIHP will submit the Annual Medicaid Verification of Services Report to DHHS, as prescribed within the DHHS/PIHP Contract Attachment – Technical Requirements, within designated deadline and described contents for submission.

9) The PIHP will maintain all documentation supporting the verification process for seven (7) years.

REFERENCE

Section 1.0 MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b) (c) Waiver Contract - Medicaid Services Verification – Technical Requirements (September 30, 2015)
Office of Inspector General, Health and Human Services, Corporate Integrity Agreement Requirements - Claims Review Process, January 2016.
Office of Inspector General, Health and Human Services, Provider Self-Disclosure Protocol – Self-Assessment Guidelines, April 17, 2013.

REVISED: **April 16, 2016**

REVIEWED:

APPROVED: **May 27, 2014**

Signed copy is on file with NMRE

Dave Schneider
Northern Michigan Regional Entity Chief Executive Officer

Date