Community Mental Health Affiliation
of Mid-Michigan

PROCEDURE: 4.7	Page 1 of 4	**SUBJECT:** Medicaid Claim Verification
Related Policies: 4.0 7.0		**SUBJECT:** Quality Improvement Finance
Issuing Directors: Director of Quality, Customer Service and Recipient Rights, and Director of Affiliation Operations		**Original Effective Date:** 10-01-2002

REVISED DATE

08/08/08

Review Date(s)

2-16-07					
8/4/09					

I. PURPOSE:

To establish and maintain a process to verify that authorized services billed to Medicaid actually were provided.

II. STANDARDS:

A. Section 1.0 MDCH Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Contract.

III. DEFINITIONS:

A. **Medicaid Claims Verification Primary Review:**
Review by the CMHSP or CA of a sample of Medicaid claims paid.

B. **Medicaid Claims Verification Secondary Review:**
Review by PIHP of a sample of the Medicaid Claims Verification Primary Review done by the CMHSPor CA.

IV. PROCEDURES:

A. Responsibility for primary Medicaid Claims Verification is delegated to the CMHSPs/CAs.

B. Medicaid Claims Verification Primary Review Methodology

1. Schedule:

a. Claims will be reviewed quarterly by each CMHSP/CA utilizing the following schedule:

Reporting Period	Service Months Being Reviewed	Audit Review Time Frame	Data Due to PIHP
Quarter 1	Jul-Sep	10/1-12/31	12/31
Quarter 2	Oct-Dec	1/1-3/31	3/31
Quarter 3	Jan-Mar	4/1-6/30	6/30
Quarter 4	Apr-Jun	7/1-9/30	9/30

b. The PIHP will complete the annual report to MDCH.

2. **Sampling:**
   a. Day Treatment/Residential – select 1 consumer per site per year (quarterly, select 1 consumer from 25 % of the day treatment/residential sites) and review all day treatment/residential claims for one month during the service months being reviewed. One day of service/occupancy = 1 claim.
   b. Community Inpatient – select 2-3% of each contract provider's claim per year (reviews can be completed quarterly or annually). One day of service/occupancy = 1 claim.
   c. Other Services – select 1 consumer per primary clinician per year (quarterly, select 1consumer from 25% of the primary clinicians) and review all Medicaid provided services for one month during the service months being reviewed.

3. **Verification:**
   a. Day Treatment/Residential:
      i. Verify Medicaid eligibility on date of service.
      ii. Verify 3rd Party fees collected are offset against Medicaid expense.
      iii. Verify service provided via attendance logs or monthly home occupancy report.
      iv. Verify service authorized in individual's PCP.
      v. Verify documentation confirming that the authorized frequency, and duration of services was provided.
      vi. Verify service was delivered by a staff with the appropriate credentials.
   b. Community Inpatient:
      i. Verify Medicaid eligibility on date of service.
      ii. Verify 3rd party fees collected are offset against Medicaid expense.
      iii. Verify service authorized by Access/UM for payment.
      iv. Verify service provided via review of hospital chart (either request copy of chart or conduct on-site review).
      v. Verify documentation confirming that the authorized frequency, and duration of services was provided.
      vi. Verify service was delivered by a staff with the appropriate credentials.
   c. Other Services:
      i. Verify Medicaid eligibility on date of service.
      ii. Verify 3rd party fees collected are offset against Medicaid expense.
      iii. Verify service provided via appropriate documentation contained in the medical record.
      iv. Verify service was authorized in the consumer's PCP
      v. Verify documentation confirming that the authorized frequency, and duration of services was provided.
      vi. Verify service was delivered by a staff with the appropriate credentials.

4. **Suspicion of fraud and/or abuse**
   a. When unusual errors are detected additional cases from the same provider will be reviewed.
   b. If, upon completion of the review of the additional cases, the CMHSP reviewer believes that the detected errors *may* be Medicaid fraud or abuse, the reviewer will notify the CMHSP CEO, the PIHP Director of Affiliation Operations (DAO) and the Affiliation Compliance Administrator.
   c. The PIHP DAO will report the suspicion to MDCH as required in the Medicaid Specialty Services and Supports Contract.

5. **Providing Notice to the Provider/Sub-contractor**

a. When there is suspicion of provider/subcontractor Medicaid fraud or abuse, the CEO/CFO or designee will immediately notify in writing the provider/sub-contractor of deficiencies identified.
b. The provider will have one week to provide an explanation for the deficiencies.
c. The provider will have an additional week to correct any deficiencies correctable by Affiliation Standards.
d. A plan of correction may be requested of the Provider/sub-contractor by the CEO/CFO.

C. Medicaid Claims Verification Secondary Review

1. Annually, the PIHP will conduct a secondary verification of 5% of the claims that were audited by the CMHSPs and CAs during the fiscal year.

2. The PIHP Audit Team will be designated by the Director of Affiliation Operations.

3. Process.
   a. The review will occur during September and October, during PIHP annual QI site visits.
   b. Approximately 4 weeks prior to the audit, the PIHP Compliance Officer will request, of the CMHSP/CA Chief Financial Officer, a list (identified only by case #) of CMHSP/CA and subcontractors cases reviewed during the previous 4 quarters.
   c. Upon receipt of the list, the Compliance Officer using a stratified random selection process, will identify 5% of the claims for secondary review.
   d. The review will encompass cases for children and adults with mental illness, severe emotional disturbance and developmental disabilities. The review will also cover adults with substance abuse disorders.
   e. The PIHP Compliance Administrator will notify the CMHSP/CA of the cases to be audited.
   f. The CMHSP/CA designee will prepare a list of all claims previously reviewed, and copies of the review findings for each claim including required corrections. The related clinical record will be available for the audit team for review.

4. Verification of the Primary claim review:
   Each claim will be re-verified by determining the following:
   a. Was the service provided a Medicaid or alternate covered service?
   b. Verify 3rd party fees collected are offset against Medicaid expense.
   c. Was the service authorized in the person-centered plan?
   d. Is there documentation to confirm that the authorized amount, scope, frequency, and duration was provided?
   e. Did a staff with appropriate credentials deliver the service?

5. Analysis of the data:
   a. Claim deficiencies identified during the secondary review will be compared to the CMHSP Verification findings for the same case.
   b. Discrepancies in numbers and types of deficiencies will be noted.
   c. Evidence will be sought to confirm CMHSP deficiencies reported as corrected during the local primary review have occurred.

6. Suspicion of fraud and/or abuse
   a. When unusual errors are detected additional cases from the same provider will be reviewed.

b. If, upon completion of the review of the additional cases, the PIHP Director of Quality believes that the detected error *may* be Medicaid fraud or abuse, the QI Director will notify the CMHSP CEO, the PIHP DAO, and the Affiliation Compliance Administrator.
c. The PIHP DAO will report the suspicion to MDCH as required in the Medicaid Specialty Services and Supports Contact.

7. The PIHP Director of Quality Improvement will provide a written report of the findings of the PIHP Medicaid Claims Verification Secondary Review to the CMHSP CEO within 30 days of the review.

8. A provider may appeal the findings of the PIHP Medicaid Claims Verification Secondary Review findings to the DAO.
   a. This must be done in writing and within 30 days of receiving notice of the findings.
   b. The DAO will review the appeal and render a decision within 30 days of receipt of the appeal.

V. APPLICATION:

All CMHAMM CMHSP's/CA's and contractors who provide Medicaid Covered Services.

VI. MONITOR AND REVIEW:

PIHP Director of Quality, Customer Service and Recipient Rights and the Finance Director shall monitor CMHSP/CA compliance with these procedures and will review this procedure annually. External review will include MDCH and CMS site visits and reporting.

VII. RELATED POLICIES AND PROCEDURES:

CMHAMM Policy	4.0	Quality Improvement
CMHAMM Policy	7.0	Finance