NORTHCARE NETWORK

POLICY TITLE: Medicaid Service Verification	**CATEGORY:** Quality Management/Compliance	
EFFECTIVE DATE: 10/1/16	**BOARD APPROVAL DATE:** 11/9/16	
REVIEW DATE: 5/24/23	**REVISION(S) TO POLICY STATEMENT:** ☐ **Yes** ☒ **No**	**OTHER REVISION(S):** ☒ **Yes** ☐ **No**
RESPONSIBLE PARTY: Compliance and Privacy Officer	**CEO APPROVAL DATE:** 6/5/23 Megan Rooney, Interim CEO	

APPLIES TO

NorthCare Personnel
Network Providers

POLICY

NorthCare Network shall comply with minimum standards and reporting requirements for the verification of Medicaid/Healthy Michigan claims/encounters for services provided to beneficiaries as required by contract with the Michigan Department of Health and Human Services (MDHHS).

PURPOSE

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for conducting oversight and monitoring of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the Provider Network. To ensure compliance with federal and state regulations, and to establish standardized process for review of claims/encounters submitted for Medicaid and Healthy Michigan Plan recipients in accordance with the Michigan Department of Health and Human Services (BHDDA) Medicaid Verification Process.

DEFINITIONS

- 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.
- CMHSP: Community Mental Health Service Program
- 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.
- MDHHS: Michigan Department of Health and Human Services
- PIHP: Prepaid Inpatient Health Plan
- Provider Network: refers to a Member CMHSP and all Behavioral Health Providers and Substance Use Disorder Providers that are directly under contract with the PIHP to provide services and/or supports through direct operations or through the CMHSP's subcontractors.
- Random Sample: A computer generated random selection of claims/encounters/events by provider and/or HCPC Code and/or Revenue and/or CPT Code and/or Code Category.

- Record Review: A method of internal inspection that includes administrative and/or clinical review of the consumer record.
- Subcontractors: Any individual or organization that is directly under contract with a Member CMHSP to provide service or supports

REFERENCES

- MDHHS/PIHP Contract
- MDHHS QAPIP for Specialty PIHPs, Section XII (A-B) [BH and DD Administration, Quality Assessment and Performance Improvement Programs for Specialty Prepaid Inpatient Health Plans (michigan.gov)]
- MDHHS – Policies & Practice Guidelines Medicaid Verification Process [Behavioral Health and Developmental Disabilities Administration, Medicaid Services Verification (michigan.gov)]
- NorthCare QAPIP [TABLE OF CONTENTS (northcarenetwork.org)]
- Network Provider Claim Dispute Resolution Policy

HISTORY

NEW POLICY 10/1/16
REVISION DATE: 3/25/19, 1/21/20, 11/17/20, 7/18/22, 5/24/23
REVIEW DATE: 8/11/17, 5/23/18, 3/25/19, 1/21/20,11/17/20, 9/23/21, 7/18/22, 5/24/23
CEO APPROVAL DATE: 9/12/17, 6/5/18, 4/1/19, 2/4/20, 12/1/20, 10/5/21, 8/2/22, 6/5/23
BOARD APPROVAL DATE: 11/9/16

PROCEDURES

A. Sampling Methodology - Statistically sound sampling methodology, in accordance with OIG standards, shall be used to determine sampling.
   1. Methodology – Separate sampling and verification shall be performed of each provider paid via a sub-capitation arrangement and any other provider that represent more than 25% of all claims/encounters in either unit volume or dollar value, whether direct contract of the PIHP or sub-contracted through a Member CMHSP. Separate sampling and verification shall be conducted for claims/encounters generated by a provider's employees and claims/encounters generated through subcontracts of the provider.
      a) This will consist of five (5) extracts, one for each CMHSP SAL data (which represents the internal staff encounters); Five (5) extracts, one for each of the CMHSP claims data (subcontractors); and one (1) extract for the SUD provider claims data.
      b) Each of these extracts (11 files) will have a column to assign a "random number" which is sorted, and the top ten claims and ten encounters will be selected as the probe sample.
   2. Probe samples of ten claims and ten encounters will be examined for each CMHSP and SUD provider group per quarter. An over sample of five claims and five encounters will be included with each extract. This will provide a total of forty claims and forty encounters per CMHSP and SUD provider group to be reviewed for the year. In the event a probe sample result is less than 90% accurate, a larger sample shall be extracted and reviewed.
   3. To obtain a larger sample size, the next ten claims and/or encounters will be audited. Sampling may be done for a smaller subset of the data if the findings indicate errors occurring in a separate program or with separate staff.

4. The minimum sample sizes used in the probe sample meet the OIG requirement of 90% confidence level at 25% precision.

B. Verification Processes - Claims and encounters are evaluated to determine validity by:
   1. Data Analytics
      a) Testing includes data analytics to identify claims/encounters that cannot be valid or are more likely not valid. This testing is completed by:
         1. Front end edits in the electronic health and billing/encounter system such as:
            - Service Activity overlapping logic prevents the recording of face-to-face services for the same consumer and same time with a specific list of exceptions.
            - Service Activity overlapping logic prevents services by the same staff at the same time with a specific list of exceptions.
            - Adjudication Process Edits cover numerous edits including COB (Coordination of Benefits) logic, validation of a fee schedule, over lapping logic, unit calculation, etc. All Codes are set up in the electronic system by the PIHP to assure only those codes approved under the PIHP/MDHHS contract are available for use.
         2. A PIHP level consolidated service data model (Diver tool) is used to validate various front-end edits and additional data analytics such as to:
            - Assure consumers do not receive a volume of service out-side of the acceptable range, i.e., not to exceed 365 days of residential CLS.
            - Assure providers have not recorded more than normal working hours/days volume of services.

   2. Validation of the Clinical Record
      a) Testing data elements from individual claims/encounters are validated against clinical records. Review of the following data is included in this validation; however, additional elements to support quality improvement efforts around claims/encounters may be included.
         1. Code is approved under the PIHP/MDHHS contract.
         2. Eligibility of the beneficiary on the date of service.
         3. Service is included in the beneficiaries' individual plan of service.
         4. Date and time of the service.
         5. A qualified practitioner provided service.
         6. Service falls within the scope of the code billed/paid.
         7. Amount billed does not exceed the payer (PIHP/CMHSP) contracted amount; and
         8. Amount paid does not exceed the payer (PIHP/CMHSP) contracted amount.

      b) The electronic health and billing records (Elmer) will be the primary source used to conduct the Medicaid service verification.
      c) Each provider is required to submit additional documentation needed to complete validation, if not entered/scanned into Elmer. This includes documentation completed by subcontractors as applicable for validation.
      d) Frequency: Validation of claims/encounters against clinical records will be conducted quarterly.

C. Staff Qualifications and Disclosure
   a) Qualified staff for data analytics testing will include individuals who have had training and/or professional experience in the areas of billing/coding, finance, compliance, analytics, and/or auditing.
   b) Qualified staff for consultation and/or the validation of the clinical record will include professional staff who are clinically trained in the health care and/or human service field. Additional staff may include individuals who have had training and/or professional experience in the areas of billing/coding, finance, compliance, analytics, and/or auditing.
   c) Staff assigned service verification responsibilities must disclose, in writing to the NorthCare CEO and/or Compliance and Privacy Officer, any potential or known conflicts of interest regarding any provider of services being verified prior to the start of such review.

D. Scoring, Corrective Action and Recoupment
   1. It is expected that all claims/encounters are in full compliance with testing methodology. Claims/encounters that are found to be invalid will require appropriate corrective action up to and including recoupment of a paid claim or voiding of a reported encounter as noted below.
   2. Corrective Action – A formal written corrective action plan is required for any provider scoring below 95% of total claims/encounters assessed and must address all data elements found to be invalid. This corrective action plan is due to NorthCare within 30 days of receiving a service verification report.

E. Documentation and Provider Reports
   1. Documentation – All documentation supporting the verification process will be filed electronically for seven years.
   2. Provider Reports – Results of Medicaid service verification will be communicated to each provider CEO or designee, via a written Medicaid Service Verification report no later than 30 days after completion of all verification activities.
      a) Content of Reports – Reports will include:
         1. A summary detailing the overall review process and findings.
         2. Detail pertaining to claims/encounters reviewed.
         3. Recommendations, as applicable, pertaining to any finding that will require corrective action for claims/encounters that are found not to comply.
         4. Time frames for corrective action and any follow-up activities.
      b) A summary of findings shall be shared with NorthCare Board of Directors, Compliance Oversight and Risk Management Committee, Quality Management Committee and other NorthCare committees as appropriate.
      c) NorthCare Network shall report any suspected fraud, waste or abuse discovered during the Medicaid Service Verification to MDHHS-OIG.

F. Recoupment of Claim/Void of Encounter
   1. Provider will refund claims, to NorthCare, within 30 days of learning of an overpayment.
   2. Encounters will be voided within 60 days of learning of over reporting.

G. Network Provider Claim Dispute Resolution Process – NorthCare Network's claim appeal process is outlined in the Network Provider Claim Dispute Resolution Policy.

H. Annual Report to Michigan Department of Health and Human Services (MDHHS) NorthCare Network shall submit an annual report to MDHHS per the contract requirements on or before December 31 of each year. This report shall include the following:
   1. A cover letter on PIHP letterhead.
   2. Description of the methodology used by the PIHP, including all required elements previously described.
   3. A summary of the results of procedures performed, including:
      a) Population of providers, which is: Member CMHSPs and All Others
      b) Number of providers assessed.
      c) Number of providers put on corrective action plans.
      d) Number of providers on corrective action for repeat/continuing issues
      e) Number of providers taken off corrective actions plans.
      f) Population of claims/encounters assessed (units & dollar value) - population is identified by 11 sub-groups: Copper Employee claims/encounters; Copper Sub-contract claims/encounters; Gogebic Employee claims/encounters; Gogebic Sub-contract claims/encounters; Hiawatha Employee claims/encounters; Hiawatha Sub-contract claims/encounters; Northpointe Employee claims/encounters; Northpointe Sub-contract claims/encounters; Pathways Employee claims/encounters; Pathways Sub-contract claims/encounters; and all others (includes SUD providers).
      g) Claims/Encounters assessed (units & dollar value)
      h) Invalid claims/encounters identified (units & dollar value)