

NORTHCARE NETWORK

POLICY TITLE: Medicaid Services Verification	CATEGORY: Compliance	
EFFECTIVE DATE: 10/1/16	BOARD APPROVAL DATE: 11/9/16	
REVIEW DATE: 9/16/26	REVISION(S) TO POLICY STATEMENT: ☒ Yes ☐ No	OTHER REVISION(S): ☒ Yes ☐ No
RESPONSIBLE PARTY: Compliance & Privacy Officer	CEO APPROVAL DATE: 10/6/26 Megan Rooney, CEO	

APPLIES TO

NorthCare Personnel
Network Providers

POLICY

NorthCare Network (NorthCare) shall conduct an annual Medicaid Services Verification in compliance with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) and Michigan Department of Health and Human Services (MDHHS) standards and reporting requirements for Medicaid/Healthy Michigan claims/encounters as contractually required.

PURPOSE

To establish guidelines for NorthCare 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 a standardized process for review of claims/encounters submitted for Medicaid and Healthy Michigan Plan recipients in accordance with the MDHHS Medicaid Verification Process.

DEFINITIONS

- **Claims Universe:** The entirety of claims/encounters paid through NorthCare from Medicaid and Healthy Michigan dollars in the applicable fiscal year.
- **Covered Service:** Services included in the MDHHS applicable Fiscal Year (FY) Behavioral Health Code Sets, Charts, and Provider Qualifications workbook as covered services in the Medicaid Specialty Mental Health and Substance Use Disorder 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
- **Network Providers:** Member CMHSPs, substance use disorder treatment providers, hospitals, and any other provider that has a network provider agreement with NorthCare and receives Medicaid funding to provide Medicaid covered mental health and substance use disorder services

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

REFERENCES

- MDHHS/PIHP Contract
- MDHHS Policies & Practice Guidelines <https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/mentalhealth/practiceguidelines>
 - Medicaid Services Verification: Medicaid Verification Process
- NorthCare QAPIP
- Compliance Review and Investigation Policy
- Compliance Monitoring & Auditing Policy
- U.S. Department of Health and Human Services, Office of Inspector General RAT-STATS – Statistical Software. [RAT-STATS - Statistical Software | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services](#)

HISTORY

NEW POLICY 10/1/16

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, 8/26/24, 2/23/26, 9/16/26

REVISION DATE: 3/25/19, 1/21/20, 11/17/20, 7/18/22, 5/24/23, 8/26/24, 2/23/26, 9/16/26

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, 9/3/24, 3/3/26, 10/6/26

BOARD APPROVAL DATE: 11/9/16

PROCEDURES

A. Determination of Universe:

- A full data set of all original paid claims and encounters, with Medicaid as the payer is pulled from the Electronic Health Record (EHR).
- Sub-universes:
 - All paid CMHSP claims and service activity logs
 - All paid Substance Use Disorder (SUD) and Health Home claims
 - All paid CMHSP subcontractor claims – claims which go through CMHSP contracts to the PIHP for payment
 - All paid inpatient hospitalizations
- Excludes:
 - SUD block grant funded services
 - P.A. 2 funded services
 - Inpatient hospitalization single case agreements
 - \$0 claims/encounters
 - General Fund expenditures
 - 15-minute increments of per diem claims are rolled up into the claim header to eliminate over counting the volume of these services. The documentation review encompasses the full day/month/unit of time from the claim header.

B. Sampling Methodology

- a. Following MDHHS Medicaid Verification Process Policy, NorthCare utilizes sampling methodology in accordance with the OIG standards.
 - i. NorthCare determines the minimum sample size for each sub-universe with OIG's RAT-STATS tool to determine a statistically sound probe sample for each sub-universe.
 - ii. Each sub universe probe sample is determined through a calculation in the variable probe sample containing the frame size, frame mean, and standard deviation, a 90% confidence interval and 25% precision are applied in RAT-STATS.
- b. Samples are reviewed to ensure all providers with 25% of volume of claims and 25% cost of claims in each universe are included.
- c. A random sampling of Medicaid services which applies the percentage of volume/persons served at each CMHSP is applied to ensure accurate and fair representation across the regional universe of claims
- d. Psychiatric Inpatient Hospital Claims are manipulated to ensure at least 6 claims are included from all contracted hospitalizations, all other selection criteria are randomized.

C. Verification Processes - Claims and encounters are evaluated to determine validity by:

- a. Data Analytics
 - i. 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:
 - a. 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.
 - b. Service Activity overlapping logic prevents services by the same staff at the same time with a specific list of exceptions.
 - c. 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 MDHHS/PIHP contract are available for use – the code used is approved under the MDHHS/PIHP contract
 2. A PIHP level consolidated service data model is used to validate various front-end edits and additional data analytics such as to:
 - a. Ensure consumers do not receive a volume of service outside of the acceptable range, i.e., not to exceed 365 days of residential CLS.
 - b. Ensure providers have not recorded more than normal working hours/days volume of services.
 - ii. All beneficiaries are eligible (Medicaid Enrolled) on the date of service
 - iii. The amount billed does not exceed the contractually agreed upon amount; and, the amount paid does not exceed the contractually agree upon amounts. Ensuring fee schedules are applied correctly.

b. Documentation Review

- i. 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. Service is included in the beneficiary's individual plan of service/treatment plan. Additionally, the following Clinical/Quality Improvement elements are reviewed:
 - a. The documentation relates to the goals and objectives in the plan
 - b. Documentation incorporates the golden thread, linking assessments and previous services into treatment provision
 2. Documentation of the service matches the billed date and time of the service.
 3. The practitioner providing the service is qualified to provide that service
 4. Service provided falls within the scope of the service code billed/paid. Additionally, the following Clinical/Quality Improvement elements are reviewed:
 - a. The narrative supports/matches the service delivery to the code used.
 - b. The documentation reflects the staff action/intervention
- ii. The documentation reflects progress or lack thereof made by the beneficiary to their goal/objective. Additional Quality Improvement Elements may be applied to this random sample, including, but not limited to:
 1. Site review standards
 2. Documentation reflecting beneficiary preference
 3. Documentation reflecting next steps/plans for treatment
 4. Documentation is fact driven, uses observations and evidence, rather than judgement language
- iii. The electronic health and billing records (ELMER) is the primary source used to conduct the Medicaid service verification.
- iv. 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.
- v. Frequency: Validation of claims/encounters against clinical records will be conducted at least twice per fiscal year.

D. 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 and credentialed 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.

E. Scoring, Corrective Action and Recoupment

- a. 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.
- b. 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.
- c. Any service reviewed out of compliance will be referred to the NorthCare Compliance and Privacy Officer.

F. Documentation and Provider Reports

- a. Documentation – All documentation supporting the verification process will be filed electronically for seven years.
- b. 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.
 - i. 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 limits for corrective action and any follow-up activities.
- c. 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.
- d. NorthCare Network shall report any suspected fraud, waste or abuse discovered during the Medicaid Service Verification to MDHHS-OIG.

G. Recoupment of Claim/Void of Encounter

- a. The provider will refund claims to NorthCare, within 30 days of learning of an overpayment.
- b. Encounters will be voided within 60 days of learning of over reporting.

H. Annual Report to 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:

- a. A cover letter on PIHP letterhead.
- b. Description of the methodology used by the PIHP, including all required elements previously described.
- c. A summary of the results of procedures performed, including:
 - i. Population of providers, which is: All contracted Network Providers and Subcontracted Providers
 - ii. Number of providers assessed.

- iii. Number of providers put on corrective action plans.
- iv. Number of providers on corrective action for repeat/continuing issues
- v. Number of providers taken off corrective actions plans.
 - 1. Universe of claims/encounters assessed.
- vi. Claims/Encounters assessed (units & dollar value)
- vii. Invalid claims/encounters identified (units & dollar value)