Community Mental Health Partnership of Southeast Michigan/PIHP	*Policy* *Service Verification*
Committee/Department: Regional Finance Committee	**Local Policy Number (if used)**
Implementation Date 07/08/2022	**Regional Approval Date** 06/24/2022

Reviewed by:	**Recommendation Date:**
ROC	05/02/2022
CMH Board:	**Approval Date:**
Lenawee	05/26/2022
Livingston	05/31/2022
Monroe	05/18/2022
Washtenaw	06/24/2022

I. PURPOSE

To establish guidelines as the Pre-Paid Inpatient Health Plan (PIHP) for the development and implementation of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) process for conducting the monitoring and oversight of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the CMHPSM Provider Network. To assess for conflict-of-interest situations across the Provider Network and remove them. To ensure compliance with federal and state regulations and to establish a standardized process for the review of claims/encounters submitted for Medicaid and Healthy Michigan Plan beneficiaries in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)(c) Waiver Program Medicaid services Verification Technical Requirements.

II. REVISION HISTORY

06/11/2014	Revised to reflect the new regional entity effective
2019	Language updated to reflect PIHP/state contract
06/24/2022	3-year review by Regional Finance

III. APPLICATION

This policy applies to all staff, students, volunteers, individual contractors, and contractual organizations within the provider network of the Community Mental Health Partnership of Southeast Michigan (CMHPSM) that submit claims/encounters for services provided to Medicaid and Healthy Michigan Plan beneficiaries.

IV. POLICY

The CMHPSM shall create, implement and maintain a published process to monitor and evaluate its Provider Network to ensure compliance with federal and state regulations. This includes protocol for monitoring and oversight of any claims/encounter provided to beneficiaries of Medicaid or Healthy Michigan services will be completed.

V. DEFINITIONS

Authorization: The documented formal approval of a service(s), with a designated CPT code(s) and specified amount scope and duration.

Beneficiary: An individual who has been determined eligible by the MDHHS according to state and federal rules and regulations for medical and behavioral healthcare coverage under Medicaid or Healthy Michigan Plan programs.

Claim: Invoice submitted for payment in accordance with the authorization issued to the particular contract provider.

Community Mental Health Partnership of Southeast Michigan (CMHPSM):
The Regional Entity that serves as the PIHP for Lenawee, Livingston, Monroe and Washtenaw for mental health, developmental disabilities, and substance use disorder services.

Community Mental Health Services Program (CMHSP): A program operated under chapter 2 of the Mental Health Code as a county community mental health agency, a community mental health authority, or a community mental health organization.

Core Provider: A local provider of substance abuse services utilizing the ROSC model that provides for and/or coordinates all levels of care for clients with substance use disorders.

CPT Code: A standardized service code as listed in the Current Procedural Terminology manual issued by the American Medical Association. This manual is updated annually.

Encounter Data: An electronic submission of services directly provided by a CMHSP in accordance with the related authorization.

HCPCs Code: A standardized service code as listed in the Healthcare Common Procedure Coding System manual issued by the American Medical Association. This manual is updated annually.

Regional Entity: The entity established under section 204b of the Michigan Mental Health Code to provide specialty services and supports for people with mental health, developmental disabilities, and substance use disorder needs.

Service Verification: Confirmation that services are medically necessary, provided by qualified staff, documented in accordance with the service definition (CPT code), connected to the consumer's IPOS goals, and meet timeliness standards.

VI. STANDARDS

A. The CMHPSM shall conduct a full monitoring and verification process on a selected

sample of claims/encounters. The reviews will be completed bi-annually. CMHPSM reserves the right to conduct further reviews of the Provider Network on an as needed basis.

B. Each CMHSP and ROSC Core Provider shall ensure services provided to consumers are documented in formats that provide sufficient support to assure accurate submissions of claims/encounters.

C. The Medicaid/Healthy Michigan claim/encounter review process may consist of the following components:

1. Desk Audit: consists of a pre-review of select policies, protocols, and documents and other resource material submitted by the Provider Network to the CMHPSM for review prior to the on-site visit. In addition, a review of whether the provider meets state and federal, standards for staff training requirements and for ongoing status as a provider with which the CMHSP/PIHP can maintain a contractual relationship
2. On-Site Audit: consists of an on-site visit to the Provider Network to review and validate process requirements as needed.
3. Claim/Encounter Review: the PIHP shall pull a random sample of Medicaid and Healthy Michigan Plan participants to complete verification of submitted claims/encounters
4. Data Review and Analysis includes analysis of the Provider Network

D. The overall responsibility for the verification of Medicaid and Healthy Michigan Plan claim/encounter verification and updating of the monitoring evaluation tool shall rest with the CMHPSM as the PIHP. The tool shall be reviewed on an annual basis to ensure functional utility and updated as necessary due to changing regulations, new contract terms and operational feedback received.

E. Each CMHSP and ROSC core providers shall submit encounters and/or claims within timeframe outlined in contracts (60 days from date of service: from date of discharge for hospitals). Submission of claims for consumers on the Habilitation Supports Waiver is within 30 days of service.

F. Each CMHSP and ROSC core providers shall have a service verification system in place to validate that services are provided to consumers according to their IPOS.

G. Each CMHSP and ROSC core providers shall adjudicate and pay claims timely; clean claims (i.e., error-free) are to be paid within 30 days of submission.

H. Any electronic claims payment system used by the CMHSPM shall have the following automatic integrity checks:

- when a claim is submitted the system verifies that the claim information matches the authorization information
- the claim submitted is within the allowed time period
- the provider contract is active
- the system verifies that the code(s) submitted in the claim match the code(s) on the authorization and that there is a sufficient number of authorized units still

available

- the system identifies the insurance type/funding source and verifies it was in effect at the time the service was provided
- the system provides information to retrospectively adjust for any retroactive changes to the fund source that were in effect at the time of the services
- a report is run monthly to retroactively adjust payments to the proper funding source. If the report indicates a correction to a fund source, journal entries are completed.

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I. Each CMHSP shall conduct service verification activities of their contractual providers separately from the Medicaid Event Verification review by the CMHPSM.

J. Following the review, the CMHPSM shall develop a Medicaid Event Verification Report detailing the results of its verification review. Copies of this report shall be provided to the CMHSPs and all other Network Providers whose claims/encounters were included in the verification review. This report will include any corrective action plans (CAPS) that are required and the date the CAP is due back to the CMHPSM.

1) A summary detailing the PIHP's overall review process and findings;
2) Detailed findings pertaining to each claim/encounter reviewed
3) "Recommendations" (if applicable) pertaining to any finding that will require corrective action for claims/encounters that are found not to be in substantial compliance with Medicaid verification scores
4) All claims/encounters found to be invalid will require correction either by resubmission or voiding.
5) Recoupment of funds for any fee for service provider for any claims/encounters that are found to be invalid.

K. Any suspected fraud or abuse discovered during the Medicaid Event Verification Process will be reported to MDHHS and a required to the Office of the Inspector General (OIG).

L. Summary findings of the Medicaid Event Verification audits shall be shared with the CMHPSM Regional Operations Committee and other regional committees as appropriate**.**

VII. REFERENCES

A. Balanced Budget Act: 438.608; 447.46
B. The Deficit Reduction Act of 2005
C. Affordable Care Act of 2010
D. MDCH PIHP Contract
E. MDCH CMHSP Contract
F. Whistleblowers Protection Act of 1989
G. Title 42—Public Health; Part 455—Program Integrity; Subpart A—Medicaid Fraud Detection and Investigation Program [cite: 42CFR455.17]

H. Current Procedural Terminology (CPT) manual issued by the American Medical Association
I. Healthcare Common Procedure Coding System (HCPCS) issued by the American Medical Association
J. Person Centered Plan Policy
K. Service Authorization Policy