Chapter Title	Chapter #		Subject #
Fiscal Resources	F		200.2
Subject Title **Verification of the Delivery of Medicaid Services**	Adopted 8/20/15	Last Revised 3/17/17	Reviewed 3/17/17; 9/3/19; 9/15/20; 9/16/21

PROCEDURE

Application

This procedure shall apply to The Right Door for Hope, Recovery and Wellness (The Right Door).

1.0 Intent

The verification of billable services is required through the Michigan Department of Health and Human Services (MDHHS) Master Contracts with the PIHP's for Medicaid Services, as well as through accreditation standards and in accordance with corporate compliance management activities. MDHHS has issued specifications for the performance of such reviews. These specifications require the validation of compliance with Medicaid requirements. The Right Door is utilizing the same specifications related to all billable services, regardless of funding source. Selected event verification audit results may reflect high levels of compliance on an ongoing basis due to system controls that preclude non-compliance. However, the specifications for event verification require such validation.

The concept of the event verification audit process is to work backward from the paid claim to validate the claim via the clinical record. The content of the clinical record is compared to the claim and where the record does not match the claim, a non-compliant finding is noted. This is consistent with the process used by external auditing and reviewing bodies such as financial auditors and the Office of the Inspector General for the Centers for Medicaid and Medicare Services.

2.0 Electronic Health Record Automatic Validation Process

The EHR system is set up to assure appropriate documentation of services billed, and to automatically provide multiple validations for the claims that are billed. These processes are considered automatic validation of claims in the following areas.

1. Process for ensuring that there are not duplicative billings for a service: Date, Time, Procedure Code, Program, and Service Units - These facets of the claims are obtained directly from the service notes completed by staff. There is no

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duplicate entry of this information into the system. Therefore, these items of the claim are always supported in the service documentation.

2. Process for ensuring codes billed are approved Medicaid or Healthy Michigan Plan codes: Procedure Codes and Programs are set up in the EHR according to proper Medicaid, Healthy Michigan Plan and HCPC coding, and staff have access to only those codes and programs that are applicable to their scope of service.

3. Service Documentation: The claim cannot be processed for billing unless the service note is completed and signed by the clinician for this event.

4. Billing Diagnosis: The claim cannot be processed for billing unless there is an identified billable diagnosis in the system associated with the event.

5. Overlapping Services/Duplicate Services: The claim cannot be processed for billing if there is an overlapping or duplicate billable event for the client or the clinician.

6. Connection of Service to Treatment Plan Goals: The service notes require the clinician to select the goal(s) that is/are being addressed in that service event.

7. Service is Authorized in the Plan of Service: When a Plan of Service is completed and signed an Authorization request is generated electronically for each Supervisor to approve. The authorizations are services that are being requested within the Plan of Service.

8. Verification of Benefit Plan**:** Each month, the MIS department will generate a list of active consumers. Of that list, 35% will be verified for correct insurance. Each month those 35% will be eliminated from the next data set and 35% of the remaining consumers will be selected for verification. By the end of the 3 months, all consumers will have been verified. Each quarter, we will repeat this process.

   Our Payment Specialist will verify the insurance eligibility through WebDenis and make any changes necessary. The WebDenis sheet indicating a change is necessary will be filed within the consumer EHR and notification will be made to fiscal for any necessary adjustments to services, etc.

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Fiscal Resources	F		200.2
Subject Title **Verification of the Delivery of Medicaid Services**	Adopted 8/20/15	Last Revised 3/17/17	Reviewed 3/17/17; 9/3/19; 9/15/20; 9/16/21

9. The Right Door for Hope, Recovery and Wellness uses the Service/Claims/Charges Error reports in SmartCare to monitor errors, warnings and flags on service notes and claims. These reports indicate the validation errors that are holding up potentially billable claims from being processed for billing. These reports are pulled by IS/IT staff on a weekly basis. IS/IT & QI staff work with supervisors and direct service staff to make corrections as indicated so that services can be billed appropriately.

3.0 Manual Review of Medicaid Claims

3.1 There are some aspects of a claim that cannot be validated as yet by the EHR or are reviewed for QI purposes. These aspects are reviewed by conducting a manual review of the medical record. This includes:

3.1.1 Verification that the Person-Centered Plan has been signed by the consumer.
3.1.2 Verification of documentation confirming the authorized frequency, and duration of services was provided.
3.1.3 Verification that documentation is on file for billed activities (ie. CLS Notes, Respite time sheets, behavior treatment plans, etc.).

3.2 The chart reviews are to be completed by QI, compliance, medical records, or support staff that have been trained on the process.

4.0 Sampling

4.1 The PIHP, Mid-State Health Network (MSHN) completes Medicaid Event Verification audits twice a year on all quarters, reviewing two quarters each time they audit. Thus, with our 2 audits, and the two audits from MSHN, we will meet the CARF requirement of quarterly claims reviews. In FY17 we will complete claims audits in December of 2016 (Q1), March of 2016 (Q2) and in September of 2016 (Q4). We will work with MSHN to audit claims in June of 2017 (Q1 and Q2 audit) and December of 2017 (Q3 & Q4 audit).

4.2 5% of all consumers per listed program with billed claims per quarter 1 and quarter 2 are reviewed by randomly selecting Medicaid cases. However, the sample will not exceed a maximum of 50 and a minimum of 20 beneficiaries.

Chapter Title	Chapter #		Subject #
Fiscal Resources	F		200.2
Subject Title **Verification of the Delivery of Medicaid Services**	Adopted 8/20/15	Last Revised 3/17/17	Reviewed 3/17/17; 9/3/19; 9/15/20; 9/16/21

4.2.1 The review will consist of one beneficiary (at a minimum) from each of the following program types as applicable. The claims/encounters reviewed will have a maximum of 50 claims/encounters for each beneficiary included in the random sample:

4.2.1.1 ACT
4.2.1.2 Autism
4.2.1.3 Habilitation Supports Waiver
4.2.1.4 Home Based Services
4.2.1.5 Infant Mental Health
4.2.1.6 Outpatient
4.2.1.7 Targeted Case Management/Supports Coordination Services
4.2.1.8 Intensive Case Management
4.2.1.9 Children's Waiver
4.2.1.10 Specialized Residential/SIP
4.2.1.11 SUD – Outpatient
4.2.1.12 SUD – Case Management

4.3 The sample will be pulled using Microsoft Sequel Server and Excel.

4.4 Select at a minimum one consumer per primary clinician, per fiscal year and review all Medicaid claims for one month during the service months being reviewed.

4.5 Each quarter, a minimum of one consumer per primary clinician is selected. Then one month in the quarter is selected. Then, all Medicaid claims for the specific consumer, for that one month are reviewed.

5.0 Follow Up and Corrective Actions on Manual Record Reviews

5.1 Claims/Service Validation: Staff and supervisors of assigned primary programs are notified of any claims that are found to be in non-compliance following the manual record review process. The staff conducts a review to verify the non-compliance. The supervisor and involved staff correct all records/claims issues as soon as possible if remediation is possible.

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Fiscal Resources	F		200.2
Subject Title **Verification of the Delivery of Medicaid Services**	Adopted 8/20/15	Last Revised 3/17/17	Reviewed 3/17/17; 9/3/19; 9/15/20; 9/16/21

5.2 QI Verifications: QI Staff/supervisors of assigned primary programs are notified of any records that are found to be in non-compliance following the manual record review process. The QI staff and supervisor identify if there is a process issue, and address this as appropriate with involved staff to correct the issue.

5.3 The QI staff provides a quarterly report to Administrative Staff of the findings of the reviews, a report as needed to the Right Door for Hope, Recovery and Wellness Compliance Committee to address agency wide compliance issues, and an annual report will be submitted to MSHN and the Board of Directors as requested.

5.4 A final report is sent to the CFO, Clinical Supervisors, and Leadership.

5.5 The QI Directory provides a review of the biannual report and findings to the Quality Council.

5.6 An annual report is submitted to the PIHP and the board of directors.

Kerry Possehn, Chief Executive Officer	Date		