SHIAWASSEE HEALTH AND WELLNESS
POLICY MANUAL

Title:	Provider Network Claims and Event Verification
Section:	Corporate Compliance
Policy Number:	6
Issued By:	Corporate Compliance Officer
Approved by: Corporate Compliance Committee **Approved on:** 04/26/2023	**Effective Date:** 2/27/17 **Last Revision:** 03/14/2023 **Last Review:** 03/14/2023

POLICY STATEMENT:

Shiawassee Health and Wellness (SHW) 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/encounters provided to beneficiaries of Medicaid or Healthy Michigan services will be completed.

PURPOSE:

To establish guidelines as the Community Mental Health Services Provider (CMHSP) for the development and implementation of the process for conducting monitoring and oversight of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the Provider Network. The Medicaid Services Verification Technical Requirement is specific to the Pre-Paid Inpatient Health Plans (PIHP) and is not delegated to the CMHSP's. However, as part of a Corporate Compliance Plan, SHW Corporate Compliance Policy #1, and in accordance with the Provider Network Contract Agreement Section 7.3, SHW will conduct periodic reviews and audits to ensure the provider network has implemented the requirements of the Agreement as well as demonstrating compliance to federal and state regulations. This will be carried out by establishing a standardized process for review of claims/encounters submitted for Medicaid and Healthy Michigan Plan recipients.

APPLICATION:

This policy will apply to all Shiawassee Health and Wellness (SHW) programs and services and contracted network providers.

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 the service was provided, the start and stop time of the service. The clinical documentation must contain a clearly legible signature of the individual who provided 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 Participant and all Behavioral Health Providers that are directly under contract with SHW to provide services and/or supports through direct operations or through the CMHSP's subcontractors.

Random Sample: A computer generated selection of events by provider and HCPC, Revenue, or CBT Code or Code Category. The auditor then randomly picks the events to review from the list of events as part of a retrospective or prospective review format.

Record Review: A method of audit includes administrative review of the consumer record with the intent documentation supports the services provided. This includes applicability to the services outlined in the person centered plan.

PROCEDURE:

Prospective Provider Claims Audits

A. No less than once per month, SHW will complete a claims submission audit of contracted providers.
B. The reviews are to be completed by Performance Improvement, Compliance, Finance, Contract Management, Utilization Management, and/or support staff that have been trained in the process.
C. During the first week of the month a claim submission will be selected for auditing.
    1. Using the SHIMER EMR module batches of claims will be selected from Claims Management (AP). The batch will be selected based on an established provider rotation.
        i. If no claims have been submitted for that targeted provider, then the auditor will move to the next provider on the list.
    2. In order to support timely claims processing, samples from batch submission will be selected on a Thursday, Friday, or Monday.
    3. The Auditor will determine the number of claims to be audited,
        i. No less than 10% of the claims submitted by the selected provider.

D. Once claim lines are selected, the auditor will use the Provider Audit Template to review documentation and training against the following 10 standards:
    1. Provider who has rendered the services for which the claims were submitted meets the qualifications as outlined in the Medicaid Manual effective the date services were rendered (Column H of the audit template).
    2. Evidence will be made available that will reflect the provider who has rendered the services for which the claims were submitted, has been trained on the Person-Centered Plan that was in effect at the date the services were rendered (Column I of the audit template).
    3. Code is an allowable service code under the contract (Column J of the audit template).
    4. Beneficiary is eligible on the date of service (Column K of the audit template).
    5. Service is included in the beneficiaries' individual plan of service (Column L of the audit template).
    6. Documentation of service agrees to the claim date and start/stop time of service (Column M of the audit template).
    7. Documentation is signed by the individual providing the service and is the same individual reflected in the claim (Column N of the audit template).
    8. Amount billed does not exceed contractually agreed amount (Column O of the audit template).
    9. Modifiers are used in accordance with the HCPCS guidelines (Column P of the audit template).
    10. Documentation of service provided falls within the scope of service of the code billed (Column Q of the audit template).

E. SHW does not plan to withhold payment solely based on training non-compliance, at the time of this procedure revision.
    1. All training non-compliance will require a formal corrective action plan to address staff currently out of compliance as well as the provider's plan for systemic improvements to maintain compliance.

F. Following the audit, SHW shall author an E Audit Report detailing the results of the verification review for the selected provider. The Audit Report will be completed no more than ten days after the batch submission and shall include the following:
    1. A summary detailing SHW's overall review process and findings.
    2. Detailed findings pertaining to each claim/encounter reviewed.
    3. Identification of items that must be corrected prior to payment.
        i. Providers will be allowed to make corrections before the 20th day after the initial batch was submitted for payment.

G. A secondary audit of claim lines that were deemed out of compliance during the initial audit will be conducted on the 20th day following the initial batch submission to ensure payment before the 30-day requirement.
    1. Clean claims will be paid in full.
    2. Claims that are deemed out of compliance after this time will be denied and require a formal corrective action plan.

H. Upon completion of the secondary audit, SHW shall author a secondary Audit Report detailing the completed audit. The secondary Audit Report shall include:

1. A detailed overview of SHW's process and findings. Including:
    i. If all claim lines are clean and payment is authorized.
    ii. If claim lines are out of compliance and payment is denied.
        1. The total amount being withheld will be disclosed.
    iii. If a formal corrective action plan is required and the timeline associated with the corrective action plan..
    iv. The process to appeal denied claims as specified in provider contracts.

I. Providers will be given 14 days from the date the secondary Audit Report is provided to complete and submit a formal CAP.
    1. SHW will provide a CAP template to the provider.
J. SHW will have 7 days from receipt of the CAP to review and approve the plan. If SHW does not respond with recommendations to the provider in writing within 30 days of receiving the correction the plan (CAP),the plan will be accepted as is.
K. If a provider makes an appeal of the audit results, a review process shall include a re-review of no less than 10% of the sample by another staff person trained in the record verification process.
    1. The claim lines chosen should be selected as randomly as possible, without regard to the results of the initial review.

Retrospective Provider Claims Audits

A. Providers found in non-compliance during an initial audit will be re-audited in 60 days to confirm that corrective action is occurring to gain and maintain compliance.
B. SHW will send notification to the provider requesting documentation for a specified time frame if the documentation is not entered directly into the electronic medical record. Depending on the provider and the amount of services provided the time could vary to ensure reasonable sampling criteria is met.
C. The provider will be afforded no less than 15 business days to submit the required documentation.
D. Providers will not be provided additional opportunities for documentation submission once the audit has begun.
E. Providers found in non-compliance at this time could be subject to monetary take-backs or financial sanctions as outlined in the provider's contract.

Post Provider Claims Audits

1. In the event of recoupment of payment, due to ongoing non-compliance, SHW will include this information on the next OIG quarterly report to MSHN.

B. Report summary findings of the SHW Event Verification audits shall be reviewed at the Corporate Compliance committee. It will be shared with SHW Board of Directors, Leadership Team, Management Team, and other SHW councils/committees as deemed appropriate.

C. Upon completion of each Provider Network Event Verification Audit, a copy of the Audit Report, including audit findings, requests for CAP and Provider responses to CAP will be forwarded to Provider Network/Contract Manager for retention in the contract file.
D. SHW shall submit a report to the PIHP per the contract requirements or in accordance with guidelines and intervals set in place by the PIHP. This report will convey any suspected fraud or abuse discovered during the verification audit process.
E. SHW will maintain all documentation supporting the verification process as required by state and federal regulation.

Change Log:

Date of Change	Description of Change	Responsible Party
05/17/18	Title Changes	Dirk Love, Corporate Compliance Officer
12/26/18	Format Changes	Jamie Burke, Executive Assistant
6/9/20	Policy Review, Procedure Review	Dirk Love, Corporate Compliance Officer.
4/20/2022	Policy Review, Procedure Revision	Dirk Love, Corporate Compliance Officer.
3/14/2023	Policy Review, Procedure Revision	Vickey Hoffman, Corporate Compliance Specialist Becky Caperton-Stieler, Director of Strategic Services