MEDICAID SERVICES VERIFICATION – TECHNICAL REQUIREMENTS

I. SUMMARY

This guideline establishes operational policy; minimum procedures and reporting requirements for verification of Medicaid/Healthy Michigan claims/encounters provided to beneficiaries under this contract. Sampling Universe shall be in a fiscal year period of Medicaid/Healthy Michigan claims/encounters.

II. APPLICATION

Prepaid Inpatient Health Plans (PIHPs) and Medicaid/Healthy Michigan Programs only. It does not apply to Substance Use Disorder Block Grant and P.A. 2 funded services.

III. PROCEDURES

A. Verification procedures must be performed by qualified PIHP staff as determined by the PIHP or a qualified contract agency, including another PIHP as determined by the PIHP. Verification procedures may not be delegated to providers, Core Providers, CMHSPs, or MCPNs. PIHPs must perform or contract for this function for ALL Providers including those under contract to the agencies listed above.

- PIHP methodology must include a process for identifying staff or contracted agencies that may have a conflict of interest regarding the provider of services being verified.

- PIHP/CMHSP stand-alone agencies (counties of Wayne, Oakland, and Macomb) may have an inherent conflict of interest related to any of its staff and internally provided services. A qualified independent contractor, including a PIHP, must be selected to perform verification procedures in these circumstances.

B. Verification procedures must include testing of claims/encounters to determine validity.

- PIHP methodology must include data analytics to identify claims/encounters that cannot be valid or are more likely not valid.

  Examples: Multiple per diem inpatient claims/encounters on the same day, multiple providers providing the same service to the consumer in one day, individual clinicians providing an unexpectedly high daily volume.

- PIHP methodology must include testing data elements from individual claims/encounters to be validated against clinical records. The PIHP must include/test a) code is approved under this contract, b) eligibility of the beneficiary on the date of service, c) service is included in the beneficiaries

individual plan of service, d) the date/time of service, e) service provided by a qualified practitioner and falls within the scope of the code billed/paid, f) amount billed does not exceed the payer (PIHP or CMHSP) contracted amount, and g) amount paid does not exceed the payer (PIHP or CMHSP) contracted amount.

Note: The PIHPs are encouraged to include additional elements in this review to support the PIHP's quality improvement efforts around claims/encounters data.

C. Verification procedures must utilize statistically sound sampling methodology in accordance with OIG standards.

- PIHP methodology must identify and document the sampling methodology used to determine sampling and describe any tools used to assist in the sample determination process.

  Note: The OIG of HHS provides a tool to assist users in selecting random samples which can be obtained at https://oig.hhs.gov/compliance/rat-stats/index.asp. PIHPs are not required to utilize this tool.

- In general, minimum sample sizes for testing of claims/encounters must comply with the OIG standards. Alternative minimum sample sizes should be documented to indicate how an acceptable confidence level is achieved.

- Probe samples and claims verifications are to be used. In the event a probe sample result is less than 90% accurate, a larger sample with greater veracity shall occur, per HHS-OIG claims verification guidance.

D. Verification procedures must take into consideration significant variations in the source of the claims/encounters.

- Separate sampling and verification must be performed at each major provider in the PIHP network, as well as a single test encompassing all remaining providers. Major providers include ALL providers paid via a sub-capitation arrangement and any other providers that represent more than 25% of the PIHP claims/encounters in either unit volume or dollar value, whether direct contracted through the PIHP or subcontracted through a CMH, Core Provider, or MCPN.

- Separate sampling and verification must be performed for claims/encounters generated by a provider's employees and claims/encounters generated through subcontracts of the provider.

IV. CORRECTIVE ACTION AND RECOUPMENT

A. Corrective actions are required for providers who are found not to be in substantial compliance in their Medicaid Verification scores.

- PIHP methodology must describe the corrective action process, including method of communication, timeframes for correction and follow up review, penalties for inaction, and an appeals process.

B. Recoupment must be required and collected from providers whose claims/encounters are determined to be invalid.

- PIHP methodology must describe the recoupment process, including method of communication, timeframes for recovery of funds, any appeals process, and how the recoupment will be reflected as a credit against the MDHHS contract.

V. REPORTING

The PIHP is required to submit an annual report, due December 31, covering the claims/encounters verification process for the prior fiscal year. This report must encompass/include the following items:

- Cover letter on PIHP letterhead
- Describe the methodology used by the PIHP, including all required elements previously described.
- Summary of the results of procedures performed, including:
  - Population of providers
  - Number of providers tested
  - Number of providers put on corrective action plans
  - Number of providers on corrective action for repeat/continuing issues
  - Number of providers taken off corrective action plans
  - Population of claims/encounters tested (units & dollar value)
  - Claims/Encounters tested (units & value)
  - Invalid claims/encounters identified (units & dollar value)

VI. DOCUMENTATION

The PIHP must maintain all documentation supporting the verification process for 7 years.