Billing Verification Audits

Macomb County Community Mental Health is the designated PIHP for substance use disorder services for Macomb County and manages the Community Grant and Medicaid substance use disorder plan through its Macomb County Community Mental Health Substance Use Services Department (MCCMH-SUD).

MCCMH-SUD monitors subcontract providers each fiscal year to ensure compliance with Financial and Billing completeness and accuracy, and related contract requirements.

To meet this objective, MCCMH-SUD contracts with a professional finance firm to complete Billing Verification audits of fee-for- service reimbursement treatment provider agencies. These audits principally focus on the following requirements:

- A Fee Agreement is properly completed, signed by the consumer, and retained on file.
- Adequate documentation is on file to support the services claimed.
- Service provider align with ASAM Level of care requirements.

Audit Methodology

Providers are sent written notice at least 24 hours in advance with the specific audit date and a list of the consumer records to be audited. Auditors provide the specific claims to be audited upon the commencement of fieldwork.

The auditor records claims data and any exceptions on a Billing Verification Audit form and reviews the results with a provider representative. The provider representative signs the Billing Verification Audit form to acknowledge they are provided an opportunity to review results with the auditor. Each provider is given a printed and/or electronic copy of the audit results. The auditing company provides MCCMH-SUD with individual and collective summary sheets, Billing Verification Audit forms, and documentation to support exceptions. MCCMH-SUD uses this information to complete the Medicaid Billing Verification report.

Sampling Methodology

The Auditing firm utilizes approved software to stratify data provided by MCCMH-SUD by provider and to select a sample of claims for each provider. Prior to sample selection, each provider sample is further stratified to achieve proportionate representation from each funding source/program, with a minimum of 1 sample per funding source. Random samples are selected representing five percent of the number of claims for each provider, with a minimum of 20 claims per provider. For those providers with less than 20 claims, all claims were included in the sample. For those providers whose claims population exceeded 6,000, a statistical sample with parameters of 95% confidence and ±1% margin of error, with a maximum sample size of 300 is used.

As part of the monitoring process, MCCMH-SUD also conducts an annual Financial Review for all non-fee for service contracts. MCCMH-SUD pays these providers based on a budget with specific line items, such as salary, travel, mileage, and supplies. The audit consists of reviewing for one month of reimbursement, chosen randomly. All amounts reimbursed are

verifying using the provider's General Ledger, invoices paid, and cancelled checks for the chosen month. Payroll records are also reviewed, and allocations are verified for accuracy.