BAY-ARENAC BEHAVIORAL HEALTH AUTHORITY
POLICIES AND PROCEDURES MANUAL

Chapter: 13	**Corporate Compliance**		
Section: 2	**Administrative and Operational Practices**		
Topic: 20	**Service Event Verification and Restitution**		
Page: 1 of 9	**Supersedes Date:** **Pol: 1-17-13,4-15-10** **Proc: 12-13-13, 10-26-12, 4-15-10**	**Approval Date:** **Pol: 8-17-2023** **Proc: 5-24-2023**	_____ ***Board Chairperson Signature*** _____ ***Chief Executive Officer Signature***
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to prevent fraud and abuse of Medicaid funds by ensuring the integrity of Medicaid service events reported for purposes of payment. It is the expectation of BABHA that direct and contract providers will maintain documentation for services rendered, consistent with Medicaid and other contractual requirements and paid claims shall be subject to recoupment if the required service documentation is not present.

Purpose

To define a process for identifying and remedying erroneous or inaccurate service claims and minimizing the potential for reoccurrence.

Education Applies to:

☐ All BABHA Staff
☒ Selected BABHA Staff, as follows: All Management, Contract Network Management, Finance, PI
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ Other:

Definitions

Medicaid Provider Manual: The manual generated by the Michigan Department of Health and Human Services (MDHHS) which defines covered specialty services to be provided by Community Mental Health Services Programs (CMHSP) and Pre-Paid Inpatient Health Plans (PIHP).

Primary Source Verification: Direct comparison of service encounter date, time, and service name with the documentation held in the clinical record of the consumer for which the claim or logged service activity was made.

Rendering Provider: Organizations or individuals who delivered the service to the consumer for which event verification is being performed, including contracted clinical service provider organizations, direct operated programs, individual practitioners, technicians or community living support staff.

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Service Encounter: A claim submitted by a contracted service provider to BABHA for payment or a service activity logged in the BABHA electronic health record by BABHA personnel. Service encounters are the subject of event verification.

Procedure

1. Event verification will be performed by the Mid-State Health Network, BABH's Medicaid payer, in accord with MSHN policies/procedures. Additional event verification will be performed by BABHA.
   a. Event verification will be performed by BABHA personnel who are independent of the delivery of clinical services, specifically the Quality & Compliance Coordinators, under the direction of the Quality Manager, who reports to the Corporate Compliance Officer (CCO).
   b. Where determined to be warranted by the responsible Director and CCO, Program Coordinators of selected clinical programs may be assigned responsibility to perform informal verification of service documentation. This may include contacts with consumers to confirm services were delivered as reported.
   c. A sample of service encounters are verified annually by the Finance Dept. under the oversight of a contracted auditing firm as mandated by the MDHHS for Compliance Audits.
   d. Finance staff also may perform spot checks of service documentation and/or rendering provider qualifications in conjunction with claims processing and adjudication as warranted. Circumstances which indicate the presence of fraud or abuse are referred to the Business Intelligence Department for further review.
2. A sample frame will be established by the CCO, in consultation with the Quality and Finance Managers, to determine which service encounters paid by BABHA will be chosen for event verification. The sampling frame (see Attachment: Sampling Frame) will be reviewed regularly and updated as necessary.
   a. The sampling frame will indicate whether the focal variable will be the rendering provider, the consumer receiving the service, or the encounter itself. The sampling process will avoid duplicate reviews of individual consumers, rendering staff or providers over the course of a year unless necessary to meet the sampling focal point design.
   b. The sampling frame will indicate the frequency of review warranted for each service/program area, and will be coordinated to avoid redundancy with the MSHN audits and external finance Compliance Audits.

c. The sampling frame will also indicate the look-back period for the samples.

d. The selection of consumers, providers and services for sampling will be based upon the following parameters:

   i. In general, the service encounters verified by BABHA will include those generated by direct operated clinical service programs and contracted behavioral health service providers operating within Arenac and Bay Counties.

   ii. The following service encounters may be excluded, unless a concern is identified which warrants investigation:

      1) Contracted behavioral health service providers operating outside of the BABHA geographic area may be excluded at the discretion of the CCO.

      2) Direct operated or contracted services which are nominal or point in time, including assessment only services, emergency services, respite, and OBRA.

      3) Contracted clinical service providers or direct operated programs delivering a level of service which is not significant, as follows:

         a. Service encounters valuing $25,000 or less in the past twelve months; or

         b. Services to ten or less consumers in the past twelve months.

      4) Services for which no clinical service documentation is required, such as pharmacies, durable medical equipment suppliers, environmental modification contractors, etc.

      5) Direct operated programs using BABHA's electronic health record may be excluded due to the EHR's automatic verification/business logic, unless:

         a. The use of modifiers is required by MDHHS, and event verification is necessary to ensure proper use; and/or

         b. The service provided is high-risk relative to falsification or potential inconsistency of documentation with Medicaid requirements; and/or

         c. A complaint is received.

   iii. Services given the highest priority for verification will be those presenting the greatest risk of fraud and abuse.

      1) This will be determined through the work of the BABHA Corporate Compliance Committee, such as its periodic fraud/abuse risk assessments and setting of annual Corporate Compliance Plan priorities.

2) New contracted service providers and direct operated programs will be subject to event verification during the first 3-6 months of operation to ensure the service documentation, and service claims or service activity logs are meeting requirements.

iv. The sampling frame will be adequate to return results that provide BABHA leadership with a 95% confidence level within a 5% margin of error that the results are generalizable to all service event documentation.

v. Services excluded from BABHA event verification will still be subject to compliance monitoring using monitoring reports and other record reviews as warranted per BABHA policies and procedures.

e. The Quality Manager will work with Data Analyst staff to pull record samples for review in accordance with the sampling frame.

i. The Quality and Compliance Coordinator will contact the provider 30 to 45 days in advance to schedule the audit.

ii. Fifteen days prior to the audit, the Quality and Compliance Coordinator will send the sample to the provider.

iii. The Quality and Compliance Coordinator will work with the provider to determine if it is most appropriate to complete the audit on-site or via a desk review. If a desk review audit is determined to be most appropriate, any documentation not already uploaded into PCE will need to be sent to BABHA seven (7) days prior to the day of the audit.

iv. The event verification audit may or may not be done in conjunction with the annual site review. If the event verification process is completed in conjunction with the annual site review, the annual site review process and timelines will be followed.

3. Event verification will be performed by Quality and Compliance Coordinators under the oversight of the Quality Manager for each service encounter sampled to ensure the encounter details and the clinical documentation meet the following requirements:

a. The service is a Medicaid service as defined by the MDHHS and clinical documentation identifying the service matches Medicaid Manual nomenclature.

b. The service claimed is identified in the consumer's Plan of Service.

c. There is documentation for the service that is appropriate to the service rendered, i.e., a progress note, assessment, periodic review, or other appropriate clinical documentation.

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d. The provider who rendered the service meets MDHHS qualification and/or credentialing requirements.

e. The documentation for the service includes the required elements as defined in BABHA policy and procedure C04-S10-T01 Clinical Documentation.

f. The service delivered is within the service restrictions, if any, outlined in:

   i. The MDHHS Medicaid Provider Manual and the MDHHS Behavioral Health Code Charts and Provider Qualifications as currently published on the MDHHS website.

   ii. BABHA interpretations, as follows:

Lunch Times	See G:\BABH\Corp Comp Regs-Codes-Manuals_BABH Interpretations of Requirements\Billing Lunches-Transport for Voc Serv
Travel Time	see G:\BABH\Corp Comp Regs-Codes-Manuals_BABH Interpretations of Requirements\Billing Lunches-Transport for Voc Serv
Start/Stop Time	For a single service event which has multiple claim lines, each claim line must have its own service documentation, or the service documentation must identify the start and end time for each claim.
Per Diem Services	• The beneficiary must receive at least one activity within the service for that day to be reported and the activity must relate to the goals as specified in the Plan of Service. • If at least one shift has a valid note, the absence of or errors in other shift notes will be cited as a recommendation.
Home Help Hours	CLS claims and/documentation must account for any Home Help hours through: • Separate progress notes for CLS versus Home Help hours; or • If a single progress note is used, by separating the start and stop times for CLS versus Home Help funded time or showing the entire service time but deducting the Home Help time from the total; or

	• Deducting Home Help hours from a CLS claim using a method acceptable to BABH Finance dept.
Specialized Residential	The documentation of the activity must distinctly address each service billed, i.e., personal care and/or CLS service.

4. The Quality and Compliance Coordinator will complete the event verification process within two weeks of the audit date.
   a. The Quality and Compliance Coordinator will coordinate with the provider regarding any initial findings from the audit.
   b. The provider will have one week to work with the Quality and Compliance Coordinator to clear up any of the initial findings before the final report is compiled.
   c. Findings from the event verification process will be categorized as defined in BABHA policy and procedure C13-S02-T16 False Claims
5. Once the event verification process is complete and the presence or absence of findings determined, the following actions will be taken by the Quality Manager:
   a. If the findings may be indicative of the presence of potential fraud or abuse, the Quality Manager will report the finding to the CCO for potential investigation. Investigations will be conducted by the CCO in accordance with BABHA policy and procedure C13-S02-T22 Complaint Investigations. Investigations may include additional verification of service events.
   b. If there is no indication of potential fraud and abuse, but the nature of the findings suggests there may be other claims that do not meet requirements, the Quality Manager will report to the CCO, who will determine if additional verification of service events is warranted.
   c. If additional verification of service events is warranted, the CCO in conjunction with Quality Manager will determine the records to be reviewed based on the focal point of the findings, i.e., the rendering provider, the service/program or the consumer.
      i. The CCO will determine whether a sample or all records will be reviewed.
      ii. The CCO will determine a reasonable lookback period for the additional review based on any obvious points of demarcation, such as the start date of the rendering provider, the beginning of the fiscal year, etc. Service encounters may also be reviewed progressively, working backwards in time, until a "clean" series of service encounters is identified.

iii. Federal regulations defer to state Medicaid agencies to set the maximum lookback period for Medicaid claims. As of August 2022, the MDHHS Office of Inspector General was allowing a look-back to 10/01/14, which is at least seven years after the service was delivered.

6. The Quality and Compliance Coordinator will compile a final report of the event verification process within two weeks of coordinating with the provider to determine any findings that could not be resolved.
   a. The Quality and Compliance Coordinator will send the final report to the provider. No additional changes will be made to the final report. Any finding should be addressed prior to the compilation of the final report.
   b. If there is a need for a corrective action plan, the Quality and Compliance Coordinator will send this out with the final report.
   c. The provider will have two weeks to complete the corrective action plan and return to the Quality and Compliance Coordinator.
   d. The Quality and Compliance Coordinator will send the final report and corrective action plan to the Finance Manager, Quality Manager, Director of Healthcare Accountability, and the Director of Integrated Heath that oversees the provider being reviewed.
7. For Contracted service providers service encounters (i.e., claims):
   a. Where service documentation is of poor quality, BABHA Quality and Compliance Coordinators will review documentation requirements with the provider (see C04-S10-T01 Clinical Documentation for more information).
   b. Where there is no valid service documentation:
      i. BABHA Finance Staff will void the claim(s);
      ii. Any overpayment will appear as a credit on the next claim for purposes of recoupment and will appear on the Explanation of Benefits.
   c. For overbilling and use of the wrong service codes:
      i. Quality and Compliance Coordinator(s) will provide the correct information from the service documentation.
      ii. The service provider may correct the rendering provider, service codes, dates and/or times were entered in error.
      iii. BABHA Finance staff will void and/or correct the claim.

iv. Any overpayment will appear as a credit on the next claim for purposes of recoupment and will appear on the Explanation of Benefits

v. Recoupment will be based upon service encounters reviewed, not extrapolation.

d. For underbilling:

i. BABHA Finance Staff will void the claim(s) and require the service provider to enter the correct information?

e. Contracted service providers and direct operated programs may be asked to develop and submit an improvement/action plan to address systemic issues identified during event verification that contributed to findings.

i. Completion of the improvements will be reviewed during the next event verification or site review, whichever comes first.

ii. If the findings are significant enough an interim verification may be completed to ensure the provider is meeting requirements in a timely manner and avoiding future recoupments. The provider will be notified if such a review is to occur.

8. For direct operated programs service activities:

a. Finance staff void the encounter at the request of the Program Supervisor, Director of Integrated Care, Quality Manager or the CCO.

b. For overbilling and use of the wrong service codes, the voiding of the encounter unlocks the service activity log (SAL) so it can be corrected by the rendering provider.

c. If the encounter needs to be marked unbillable/unreportable, Finance staff will do so.

d. Program Supervisors may be asked to develop and submit an improvement/action plan to address systemic issues identified during event verification that contributed to findings. Completion of the improvements will be reviewed during the next event verification or sooner if the findings warrant. The Program Supervisor and Director of Integrated Healthcare will be notified if such a review is to occur.

9. Contracted service providers wishing to appeal determinations made under this policy and procedure will be referred back to the dispute resolution or appeal provisions of their contract, provider manual, or service agreement with BABHA. Employees will be referred to the BABHA Employee Handbook.

Attachments

- MEV Audit Workbook

- Sampling Frame

Related Forms

Related Materials

- C04-S10-T01 Clinical Documentation
- C13-S02-T16 False Claims
- C13-S02-T22 Complaint Investigations

References/Legal Authority

- MDHHS Policies and Practice Guidelines; Medicaid Services Verification
- 42 CFR Part 438.242, Managed Care Rules; Health Information Systems
- MDHHS Office of Inspector General; Post Payment Audit Process; revised 08/05/22.

SUBMISSION FORM

AUTHOR/ REVIEWER	APPROVING BODY/ COMMITTEE/ SUPERVISOR	APPROVAL/REVIEW DATE	ACTION (Deletion, New, No Changes, Replacement or Revision)	REASON FOR ACTION If replacement, list policy to be replaced
J. Pinter CCO	Corp Comp Comm for Operations	02/09/10	New	
J. Pinter CCO	Corp Comp Comm for Operations	10/26/12	Revised	Update to match current practices
M. Wolber, S. Gettel, J. Steckley, B. Roszatycki, K. Lane	J. Pinter, CCO	12/13/13	Revised	Reviewed and updated to current practices.
J. Pinter; S. Holsinger; K. Amon	Corporate Compliance Committee	5/24/2023	Revised	Updated to add sampling frame, MEV workbook and revise procedures to match current practices.
K. Amon	Corporate Compliance Committee	1/30/25	No Changes	Review.