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:** 04/1/2024 **Last Review:** 04/1/2024 **Annual Policy Statement Review:** 05/07/2024

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:

The Corporate Compliance Department will partner with SHW's Provider Audit Workgroup to complete Annual Audits of SHW's Provider Network in conjunction with Contract Management Policy #02 – Contract Provider Review.

During the Annual Audit, a sample of claims submitted by the provider during the previous 90 days will be reviewed to ensure the following:

- 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.
- 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.
- Code is an allowable service code under the contract.
- Beneficiary is eligible on the date of service.
- Service is included in the beneficiaries individual plan of service.
- Documentation of service agrees to the claim date and start/stop time of service.

- Documentation is signed by the individual providing the service and is the same individual reflected in the claim.
- Amount billed does not exceed contractually agreed amount.
- Modifiers are used in accordance with the HCPCS guidelines.
- Documentation of service provided falls within the scope of service of the code billed.
- HCBS Requirements Met

Providers that do not meet the above standards may have to submit a formal Corrective Action Plan. Claims that do not meet the requirements for payment may be recouped.

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
04/01/2024	Policy Review, Procedure updated to reflect new process for completing claim review	Vickey Hoffman, Corporate Compliance Officer