POLICY AND PROCEDURE MANUAL

SUBJECT: Medicaid Services Verification	ACCOUNTABILITY NMRE, NMRE Provider Network	Effective Date: April 25, 2018	Pages: 3
REQUIRED BY MDHHS Medicaid Verification Process Technical Requirement	Managed Care Rules: 42 CFR, Section 438.608, MDHHS/PIHP Contract: Other:	Last Review Date: 3/17/2026	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Annual Author: NMRE Chief Clinical Officer	Responsible Department: Compliance	Reviewers: NMRE Operations

Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or clinical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR § 455.2)

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or their representative.

Community Health Automated Medicaid Processing System (CHAMPS): The Michigan Department of Health and Human Services (MDHHS) web-based, rules-driven, real-time Medicaid Management System.

Electronic Health Record (EHR): a digital version of a patient's medical history and health information.

Fraud: (Federal False Claims Act): An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law including but not limited to the Federal False Claims Act and the Michigan False Claims Act. (42 CFR § 455.2) (per Michigan statute and case law interpreting same): Under Michigan law, a finding of Medicaid fraud can be based upon evidence that a person "should have been aware that the nature of his or her conduct constituted a false claim for Medicaid benefits, akin to constructive knowledge." But errors or mistakes do not

constitute "knowing" conduct necessary to establish Medicaid fraud, unless the person's "course

of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present."

Individual Plan of Services (IPOS): The written details of the supports, activities, and resources required for the individual to achieve personal goals. An individual and his/her team are responsible for developing the individual plan of services.

Healthcare Common Procedural Coding System (HCPCS): a standardized, alphanumeric coding system used primarily to bill Medicare and private insurers for non-physician services, medical supplies, durable medical equipment (DME), and drugs maintained by the Centers for Medicare and Medicaid Services (CMS).

Waste: Overutilization of services, or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources.

Network Provider: Any provider, group of providers, or entity that has a provider agreement with the NMRE or its CMHSPs, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the NMRE's Specialty Supports and Services Contract with the State.

Office of the Inspector General (OIG): An agency in the Michigan Department of Health and Human Services (MDHHS) that investigates cases of fraud within the Department [MCL 400.43b].

Person-centered Planning: The process for planning and supporting the individual receiving services. It builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities.

Progress Note: a clinical document that records service contacts, documenting the interaction between a provider and a beneficiary

Recoupment/Retraction/Voids: Depending on which program/department this is proof of how the money was taken out of the Medicaid "funds".

Review Completed: When NMRE and CMHSP/SUD PROVIDERS agree and/or EXIT interview if findings occur.

Subcontractor: For the purposes of this policy, a subcontract is any person or entity that performs required, ongoing administrative or Health Benefit management functions.

Worksheets: Excel spreadsheets documenting the samples provided by the NMRE before the verification can begin.

Purpose

The purpose of this policy is for the NMRE, as the Prepaid Inpatient Health Plan (PIHP), to develop and implement processes for conducting verification of the Medicaid and Healthy Michigan Plan claims/encounters submitted within the Provider Network; to ensure compliance with federal and state regulations, in accordance with the Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program Attachment Medicaid Services Verification-Technical requirements; and to provide direction to NMRE Network Providers.

Policy

It is the policy of the Northern Michigan Regional Entity (NMRE) to ensure the accuracy, validity, and integrity of all Medicaid and Healthy Michigan Plan claims and encounters submitted within the NMRE Provider Network. NMRE will implement and maintain a comprehensive verification process that confirms services were authorized, delivered, documented, and billed in accordance with federal and state requirements, including 42 CFR §438.608 and MDHHS Medicaid Services Verification Technical Requirements.

NMRE is committed to preventing fraud, waste, and abuse by verifying beneficiary eligibility, service authorization, provider qualifications, proper coding, and adherence to contract requirements. All claims must be supported by complete and timely documentation within the Electronic Health Record (EHR) and must reflect services actually rendered prior to payment. Invalid or inaccurate encounters will be corrected, voided, or recouped as required.

Through quarterly reviews, data analytics, and statistically valid sampling, NMRE will monitor provider compliance, identify systemic issues, and require corrective action when accuracy thresholds are not met. NMRE will report suspected fraud or abuse to the Office of Inspector General (OIG) and maintain all verification documentation for seven years.

This policy ensures NMRE fulfills its obligations as a Prepaid Inpatient Health Plan (PIHP) to safeguard Medicaid resources, uphold program integrity, and support high-quality service delivery across the Provider Network.

SUBJECT: Medicaid Services Verification	ACCOUNTABILITY NMRE, NMRE Network Providers	Effective Date: April 25, 2018	Pages: 4
REQUIRED BY MDHHS Medicaid Verification Process Technical Requirement	Managed Care Rules: 2 CFR, Section 438.608 MDHHS/PIHP Contract: Schedule A (1)(C)(4) Other:	Last Review Date: 3/14/26	Past Review Date:
Policy ☐ Procedure ☒	Review Cycle: Annual Author: NMRE Chief Clinical Officer	Responsible Department: Compliance	Reviewers: NMRE Operations

Procedure

The NMRE verification methodology will include testing data elements from individual encounters against the EHR and the use of data analytics, as defined within the MDHHS Medicaid Services Verification Technical Requirement. Additional elements may be included to support the NMRE's quality improvement efforts around encounter data.

A. Quarterly Schedule of Verification

Review Period	Months Reviewed	Review Conducted	Providers Reviewed
Quarter 1	October-December	February-April	CMHSP, SUD Providers
Quarter 2	January-March	May-July	CMHSP, SUD Providers
Quarter 3	April-June	August-October	CMHSP, SUD Providers
Quarter 4	July – September	November	CMHSP, SUD Providers

1. Medicaid Service Verification will include the following – **Documents NEEDED are noted in parentheses**

    a. The service code reported is approved under PIHP/MDHHS Contract **(PLAN/HCPCS)**

    b. Beneficiary was eligible for Medicaid/HMP on the date of service [**CHAMPS (Provider)]**

    c. Service was authorized in the consumer's individual plan of service/SUD Treatment Plan (**PLAN)**

    d. The date/time of service is documented (**PROGRESS NOTE)**

    The service was provided by a qualified practitioner that falls within their scope of practice for the code reported (**PROGRESS NOTE/Plan)**

e. The amount reported/paid does not exceed the payer (PIHP or CMHSP) contracted amount.

NEW 2018 – The contracts with sub-contractors will include: contract rate for services, service codes approved in the contract, and the effective dates of the contract for only those included in the sample**.** (**CONTRACT)**

f. Other criteria may be added, as determined by the NMRE Quality and Compliance Oversight Committee (QOC).

i For unit-based services, the appropriate units were reported;

ii Person-centered Planning process: client signature (if verbal, progress note/IPOS to determine reasons (see Person Centered Planning policy.)

iii No edits to documentation will be made once the provider receives the sample (such as changing note content, creating documentation, adding signatures etc.).

2. Medicaid Service Review – New 2018 – **Documents needed: Policies and Procedures**

a. Annually the NMRE will ensure systems are in place to:

i Verify Medicaid or Healthy Michigan Plan (HMP) eligibility prior to a service being billed.

ii Ensure there are no duplicative billings for a service.

iii Ensure that a claim/encounter being billed is authorized within the Individual Plan of Services.

iv Verify that codes billed are approved Medicaid or HMP codes.

v Ensure that invalid claims/encounters are corrected, and repayment is made for invalid claims/encounters.

B. Timeline of Quarterly Audits

Provider receives data worksheets	Begin review
NMRE EHR access	3 days after receiving worksheets
Documents requested:	3 days after receiving worksheets
Contract summaries	
CHAMPS verification	
Missing documents	24 hours after requested
Recoupments/disallow	3 days after identified error
SUD retractions/reconsideration report	2 weeks after identified error
Corrective Action Plans	30 days after final memo
NMRE Final Memo – each quarter	Within 30 days after review completed
Appeal – CMHSP/SUD	30 days after Final Memo
Appeal decision by NMRE	30 days after receiving appeal

Once complete, the NMRE reviewer will send a memo/report to the NMRE CEO, CMHSP Executive Director/CEO, SUD Director, and SUD Provider, as applicable. Annually (December 31st) reports will go to MDHHS (Contractor's MDHHS-OIG sFTP Area and/or Case Management System).

This report will encompass/include the following items:

- Cover letter on PIHP letterhead.
- Description of 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 & dollar value), and
  - Invalid claims/encounters identified (units & dollar value).

C. Sampling Methodology

Statistically representative sample requirements will meet OIG standards. The NMRE sampling process will use Microsoft SQL and Excel. If an audited sample yields less than 95% accuracy, a Plan of Correction will be required. If an audited population falls below 90% accuracy during a 12-month period, a stratified sample will be pulled, and a Plan of Correction will be required. The following is an outline of the populations and samples to be audited;

1. CMHSP Direct Provided Services Population (5 Total)
   - 40 Services per year/10 per Quarter
2. CMHSP Subcontractor Provided Services Population (5 Total)
   - 40 Services per year/10 per Quarter
3. SUS Provider Population
   - 60 Services per year/15 per Quarter
4. Financially Significant Population (3 SUD, 0 CMHSP)
   - 40 Services per year/10 per Quarter
   - At least the top three providers accounting for more than 10% of the total SUD budget, or any additional providers that are meeting or exceeding 10% of the total SUD budget accordingly.

5. Stratified Population – if reviews yield less than 90% accuracy

D. Corrective Action – Recoupment – Appeals

Scores falling below 95% accuracy for each quarterly review will result in a Plan of Correction. The Plan of Correction template will be emailed along with the final memo. The provider will fill in criteria and strategies for the NMRE to review. Once approved, the NMRE will monitor as specified within the Plan of Correction. If a Plan of Correction is already in place for a provider falling below 95%, an addendum to the current plan will be needed. If any service is found invalid, the provider will be required to void the encounter from Medicaid funds and send proof to the NMRE Compliance Officer within 3 days of the finding or end of review period. For SUD providers, proof of a retraction would be submitted as a reconsideration report, sent within 2 weeks of final report. A provider may appeal findings, in writing to the NMRE Compliance Officer who will seek consultation and render a decision within 2 weeks from receiving the appeal.

E. Suspicion of Fraud and/or Abuse

If there is suspicion of fraud and/or abuse, the NMRE Compliance Officer will notify the NMRE Chief Executive Officer (CEO) and the provider's CEO/Executive Director of the alleged issue. The NMRE CEO will report the suspicion to Office of Inspector General (OIG) as required by the MDHHS- PIHP contract. No attempt to further investigate or resolve the issue(s) will be made by the NMRE or the provider once the issue has been reported to the OIG.

D. **Documentation**

The PIHP will maintain all documentation supporting the verification process for seven years.

Approval Signature

Chief Executive Officer

April 1, 2026
Date