ALAMEDA COUNTY Behavioral Health Care Services	**Date Approved:** 10/08/15 **By:** Manuel J. Jimenez, Jr. MA, MFT Behavioral Health Director
POLICY TITLE **Service Verification for Medi-Cal Reimbursed Services**	**Policy No:** 1703-1-1 **Date Effective: October 5, 2015** **Date Revised:**

PURPOSE

This policy addresses the Federal and State requirements that a method be established and in place to verify whether services reimbursed by Medicaid (aka Medi-Cal in California) were actually furnished to beneficiaries.

AUTHORITY

California Department of Health Care Services MHP Contract: Exhibit A, Attachment I, Section 18.F. Program Integrity Requirements; CFR, Title 42, sections 455.1(a)(2) and 455.20(a); Social Security Act, Subpart A, Sections 1902(a)(4), 1903(i)(2) and 1909.

SCOPE

All Alameda County Behavioral Health Care Services (ACBHCS) county-operated programs in addition to entities, individuals and programs providing Medi-Cal funded services under a contract or subcontract with ACBHCS.

POLICY

This policy establishes a method to verify whether services reimbursed by Medi-Cal were actually furnished to beneficiaries. It establishes procedures to identify, investigate and refer suspected fraud and abuse cases in regards to the actual receipt of services.

PROCEDURE

A. On at least a quarterly basis, ACBHCS will pull a minimum 5% sampling of Medi-Cal beneficiaries that received Medi-Cal funded services during a designated period during that quarter. The designated period can range from a minimum of one month and up to three months.

B. Each of the beneficiares pulled in the sampling will receive a Statement of Services which summarizes the direct services received by the beneficiary during the designated

period. The Statement of Service will NOT be mailed out to beneficiaries with an incomplete address or with no address on record.

C. In the case of returned mail, the provider will be contacted to provide an updated address and directed to update the beneficiary's address in ACBHCS' billing system.

D. Providers will verify beneficiaries' mailing addresses on a regular basis, and at least annually, and will update the information in ACBHCS's billing system.

E. Beneficiaries will have the opportunity to contact ACHBCS should they disagree with the information on the Statement of Services, or have questions regarding the information.

F. Quality Management Program staff will follow-up with the beneficiaries, or their legal representatives, who indicate that they did not receive the service.

G. ACBHCS may choose alternate methods to verify services including such methods as calling beneficiaries or collecting the beneficiaries signature at the time of service. An alternate method other than the Statement of Services may be used in such circumstances where it is inappropriate, due to confidentiality issues, to send a Statement of Services.

H. Outcome of all beneficiary contacts will be logged and tracked.

I. Upon discovery that Medi-Cal reimbursed services were not received by a beneficiary, the following will occur:

i. The Quality Mangement Program will conduct an internal investigation to determine the validity of billed services. This may include, but not be limited to, the following:

a. Interviewing the beneficiary
b. Interviewing the provider
c. Ad hoc chart reviews
d. Data mining and analysis of claims
e. Reviewing provider timesheets, call logs, county vehicle sign-out logs, and mileage reimbursement claims.

ii. If fraud and/or abuse is suspected, the Quality Management Program will develop and implement corrective action. The majority of potential fraud or abuse items are expected to be resolved at the ACBHCS level.

iii. Services reimbursed by Medi-Cal that were not received by the beneficiary will be recouped.

iv. If the Quality Management Program's internal investigation concludes that fraud or abuse has occurred or is suspected and the issue is egregious, or beyond the scope of ACBHCS's ability to pursue, ACBHCS shall consult County Counsel for next steps and possible reporting to a higher authority such as the California DHCS.

CONTACT

BHCS Office	Current as of	Email
Quality Assurance	October 2015	qaoffice@acbhcs.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBHCS Staff
- ACBHCS County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Original Author: Donna Fone, Interim Quality Assurance Administrator
Original Date of Approval: 10/05/2015 by Manuel Jimenez Jr MA.MFT

Revise Author	Reason for Revise	Date of Approval by (Name)

DEFINITIONS

Term	Definition
Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medi-Cal program.
Beneficiary	The individual currently receiving or requesting services or supports from Alameda County Behavioral Health Care Services (ACBHCS) and/or paid for by ACBHCS . The term 'beneficiary' is also synonymous with 'consumer,' 'patient,' or 'client'.
DHCS	California Department of Health Care Services

Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.
Medicaid	A US Federally-funded health insurance program
Medi-Cal	The name of California's Medicaid program
Statement of Services	A statement of services that summarizes date of service, services received, agency name, and provider name.
Service Verification	Having an established method to verify whether or not services reimbursed by Medi-Cal were actually furnished to beneficiaries.