SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Policy:	**24-04**
Subject:	**Service Verifications**
Authority:	California Department of Health Care Services (DHCS) Contracts with MHP and DMC-ODS; Title 42 C.F.R. 455.l(a)(2) and 455.20 (a)
Original Policy Date:	June 17, 2024
Amended:	N/A
Supersedes:	N/A
Attachments:	**Attachment A:** Sample Verification Letter **Attachment B:** Sample Phone Verification Script **Attachment C:** Sample Service Verification Report

PURPOSE

This policy establishes a method to address the Federal and State requirements to verify whether services reimbursed by Medicare/Medicaid (Medi-Cal) were actually furnished to Members. This method can be used for the verification of services for any program, especially those that are federally funded, as a best practice to detect and avoid fraud, waste, and abuse.

POLICY

San Mateo County Behavioral Health and Recovery Services (BHRS) maintaining an effective compliance program which, at a minimum, adheres to the Program Integrity requirements of the Centers for Medicare and Medicaid Services (CMS). An element of Program Integrity is to establish a system or process to verify whether services reimbursed by Medicare or Medi-Cal were actually furnished to beneficiaries. BHRS Quality Management and the Compliance Program have established the following procedures to identity, investigate, and refer suspected fraud, waste, and abuse activities.

RESPONSIBILITY

BHRS Quality Management (QM)
BHRS Compliance Program
BHRS Management Information System (MIS)
BHRS Program Contract Monitors/Program Manager

PROCEDURE/PROTOCOL

1. BHRS Management Information System (MIS) has created a report of all services rendered for Medicare and/or Medi-Cal beneficiaries by BHRS Mental Health and Alcohol & Other Drug Services (AOD) that can be generated as needed by the BHRS Quality Management and relevant program staff. Service verifications should be done no less than once per quarter, should cover 2% of services rendered in the quarter (calculated based on the number of verifications issued successfully), and should be completed for all programs within the year.

2. The staff using the report will select a random sample of services rendered for the quarter for which service verifications will be generated. BHRS may choose alternative methods to verify services including calling the member, sending text or email verification surveys, and conducting on-site visits to verify progress notes and review client sign-in sheets, using check in records completed by persons independent of the provider.

3. Quality Management, MIS, and program managers will generate service verification letters and will mail them to beneficiaries or their legal representatives, along with BHRS pre-paid return envelopes.

4. Members, or their legal representatives, are instructed to contact the Quality Management Program if they feel there are any discrepancies in the services indicated on the letter.

5. Letters determined undeliverable due to incorrect address will be forwarded to the Provider for updating the Member's address in the BHRS billing system. These will not count towards the 2% goal.

6. A report shall be generated each time verifications are done indicating the total number of contacts made, the number resulting in a response, the number of responses that resulted in an investigation.

7. Quality Management or the relevant Program Manager will conduct an investigation under the guidance of the Compliance Officer if a Member indicates that the service was not received. This process may include:

    a. Contacting the Member, or their legal representative for additional information.
    b. Contacting the Provider regarding the service in question.
    c. Review of the service in question by Quality Management or by the Program Manager, as applicable.
    d. Reviewing additional evidence from the Provider regarding whether services

were rendered, including but not limited to progress notes, client sign-in sheets, and call logs.

8. Outcomes of investigations will be logged by BHRS Compliance Officer.

9. Services reimbursed by Medicare and/or Medi-Cal that were not received by the Member will be recouped, reported, and returned to CMS and/or DHCS, in accordance with overpayment regulations.

10. Any indication of fraud, waste or abuse will be investigated by the BHRS Compliance Program and will result in a corrective action plan leading up to termination of Provider and/or contract. Any termination of a provider or contract for reasons of Fraud will be reported to DHCS in accordance with the DHCS/MHP or DHCS/DMC-ODS contract.

11. BHRS will promptly report any potential fraud, waste or abuse that is identified to the directly to the State Medicaid Fraud Control Unit. This shall be done via the DHCS Medi-Cal Fraud Hotline (l-800-822-6222), via email at Fraud@dhcs.ca.gov or via mail at Medi-Cal Fraud Complaint-Intake Unit, Audits and Investigations, PO Box 997413, MS 2500, Sacramento, CA 95899-7413.

Approved: *Signature on File*
Scott Gruendl, MPA
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Compliance Officer

Approved: *Signature on File*
Dr. Jei Africa, PsyD, FACHE
BHRS Director

ANNUAL REVIEW OF COMPLIANCE POLICY			
Next Review Due:	June 2025		
Last Reviewed by:	Scott Gruendl, Compliance Officer	**Date:**	June 17,2024