Predictive Modeling FAQs

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1. **What is the Predictive Modeling process and why is MDHHS implementing a Predictive Modeling system?**
   The goal for MDHHS is to provide the best quality of care for all covered individuals. This includes monitoring the accuracy, appropriate coding, and submission of claims for services provided and billed. Predictive modeling is a way to ensure that goal.

2. **When did Predictive Modeling editing begin?**
   Predictive Modeling editing began February 2, 2013. Documentation will be requested for a review on all claims that are currently suspending for Predictive Modeling. Providers will need to verify their correspondence address listed within their CHAMPS Provider Enrollment file to ensure that MDHHS is sending documentation request correspondence to the appropriate address. Providers can also obtain a copy of the letter in their CHAMPS "My Inbox" within the Archived Documents function, document type "MP Predictive Modeling". The medical records request letter is also stored as an attachment in the CHAMPS Document Management Portal (DMP).

3. **How should a provider submit the requested documentation?**
   Documentation must be submitted within 45 calendar days from the date of the Request for Documentation letter. Providers must work with their internal information technology staff to ensure documentation is uploaded into the DMP to maximize efficiency and condensing files accordingly. The DMP maximum capacity per each upload has been increased to 30 MB. Organized documentation will ensure a lesser administrative burden to both the provider and to the State of Michigan. Information and tutorials pertaining to the Document Management Portal are available on the MDHHS website.

4. **What documents should be submitted?**
   In order to process the pending claim(s), please submit all pertinent medical records for services provided.
   Per the Michigan Medicaid Provider Manual, General Information for Providers, Section 15.7 Clinical Records "The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed."
   Medical documentation must be received within 45 calendar days from the date of the Medical Request letter. A determination will be made on the claim within 60 days after the requested information is received. If the requested information is not received within the requested timeframe, the claim will be denied. For more detailed information regarding documentation requirements please see our Provider Tips.

5. **Messaging capabilities within Document Management Portal**
   In an attempt to reduce denials for missing document(s) after the initial review of submitted documentation is complete, MDHHS offers a messaging function within the DMP. The message function is only utilized for medical documentation submitted via DMP. It's not available for documentation submitted via mail or fax.
   DMP has the capability to message providers directly about specific predictive modeling claim documentation. The message will be attached to the documentation with the DMP.
   The provider will receive an email notification when a new message is in the DMP message inbox- the email notification is sent to the email address associated to the MILogin user ID in CHAMPS.
   Once you receive an email notifying you there is a message, you have 10 business days to upload additional requested documentation. If you believe the documentation requested is already within your original submission, respond via messaging within 10 business days specifying the location of this documentation.

6. **Provider requests to submit supporting documentation do not need a beneficiary signed consent**
   Per the Medicaid Provider Manual, General Information for Providers Chapter, Section 15.4 states: Providers are required to permit MDHHS personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary because the purpose for the disclosure is permitted under the HIPAA Privacy rule. Health plans contracting with the MDHHS must be permitted access to all information relating to services reimbursed by the health plan. Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying any record that must be maintained. (Failure to make requested copies available may result in the provider's suspension from Medicaid.) Records may only be released to other individuals if they have a release signed by the beneficiary authorizing access to his records or if the disclosure is for a permitted purpose under all applicable confidentiality laws.

7. **What happens after a claim denies for Predictive Modeling?**
   To determine the reason for the TCN(s) denial(s), review the Claim Adjustment Reason Codes and Remittance Advice Remark Codes located on the Remittance Advice. Providers also need to review their claim(s) and the documentation submitted for the audit which is attached to the TCN for appropriate coding and verify that ALL documentation was sent to support the services billed. If providers find any error(s) or omission(s) within this review, the claim(s) will need to be resubmitted. The provider must wait for the claim to suspend again for Predictive Modeling. The provider must wait to receive a new Request for Medical Document letter before uploading documentation. If the service was not properly documented within the patient's medical record, the charges may not be billed to Medicaid or the beneficiary. If you remain unsure of the reason of the TCN denial, please email Providersupport@michigan.gov .

8. **How do I dispute a Predictive Modeling denial?**
   A provider may submit an inquiry to Provider Support to dispute the denial of their TCN(s) and have the claim re-reviewed. The provider is responsible to point to the areas(s) within their documentation that supports or conflicts with the denial reason.