Policy: External Claim Adjudication 10-B		Application: BCCMHA Staff & Providers
Reviewed 12/20/2023	Revised 5/3/2023	First Effective 03/28/2006

I. PURPOSE

To establish guidelines for the administration of claims processing by Barry County Community Mental Health Authority (BCCMHA), incorporating all applicable state and federal regulations relative to the processing of behavioral health services claims.

II. POLICY

BCCMHA is responsible for the administration of claims processing for services provided and purchased through contracted providers.

Claims received shall be filed using current data layout in accordance with HIPAA transaction standards or via the Electronic Health Record (EHR) software system unless the provider is granted permission to submit claims in a paper format.

III. STANDARDS

The following information is critical to the submission and payment of valid claims:

1. Address to file claims
2. Telephone contact numbers
3. Information that must be contained in a claim in order for it to be considered valid or "clean"
4. Acceptable standard billing formats
5. Dates by which claims must be filed to be considered for payment
6. Process for appealing a denied claim
7. Names and addresses of delegated claims processors

All provider submitted claims must be billed using electronic 837, or manual entry into the BEHRI claims system. The only exception to this is secondary claims, which must be submitted with EOB. Any deviation from these forms or formats must be pre-approved. All elements of a clean claim are required to enter the claim and identify the "clean claim date":

1. Hospital claims, with prior approval, to submit on paper shall be billed on the UB04 using Medicaid billing rules.
2. All other claims, with prior approval, to submit on paper shall be billed on the CMS 1500 using Medicaid billing rules.

All external providers must enter claims using BEHRI unless prior arrangements are made with the Reimbursement Department at BCCMHA.

For new providers, external provider shall request a log in from designated BCCMHA staff. BCCMHA will supply provider with this information within two weeks of initial request. New

provider will also receive a training packet from BCCMHA. Providers will contact BCCMHA with any navigational questions.

Claims submitted for reimbursement must be initially received and acknowledged by BCCMHA within 90 days from the date of service when BCCMHA is the primary payer. In addition, denied claims must be re-billed within 30 days from the date of the last rejection.

Exceptions to the 90-day filing limit will be considered under the following circumstances: administrative error by BCCMHA; Medicaid beneficiary eligibility was established retroactively; judicial action/mandate in which a court or departmental administrative law judge ordering payment of the claim; involvement of a third-party payer (TPL) such as when commercial insurance is primary; and Medicare processing delays. TPL claims must be submitted to TPL plan within 90 days of the date of service and submitted to BCCMHA within 30 days of the claim resolution. All TPL claims must be accompanied by the primary payer's EOB.

Contracted providers will be given 30 days' written notice prior to all changes. The 90-day claim-filing limit will be excused and payment allowed when required written notice of change was not provided.

Claim Timeliness

All claims will be processed by BCCMHA within 30 days, 90% of the time and within 45 days 99% of the time from the time a clean claim is received. Claims lacking necessary information will be returned requesting the necessary information within 30 days from receipt of claim. BCCMA will keep a file of all denied claims.

Late Claim Payments

Failure to pay claims in a timely manner is considered an unfair trade practice unless the claim is reasonably in dispute. As outlined in the Michigan Insurance Code, a claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum. The interest shall be paid in addition to and at the time of payment of the claim. Failure to pay claims in a timely manner may result in a civil fine and/or the health professional or facility seeking court action.

Valid Codes

BEHRI is updated as needed with valid billable codes through collaborative efforts with PCE, BCCMHA, SWMBH the MDHHS prepaid inpatient health plan for Medicaid.

Authorization

1. Claims cannot be submitted until the claim matches the units and CPT code authorized.
2. BCCMHA Clinical Staff will enter the first three days of authorization into the client EHR at time of inpatient placement.
3. Provider shall contact Utilization Management (UM) Department at BCMHA if the authorization is lacking units.
4. UM will determine if extra authorization units are required and after the receipt of discharge documentation from the inpatient hospital.

IV. PROCEDURES

BEHRI Claim Submission

Provider will be unable to enter a claim until BEHRI EHR has an authorization in place. Provider claim must have the following information before the claim can be entered and submitted:

1. CPT code billed must match CPT code authorized.
2. Date of service must match authorization dates.
3. Supporting documentation must be uploaded.
4. The service must be covered in the provider agreement for the dates of service billed.

Hospital Claim Authorization and Payment

1. Primary claims have first three authorizations generated by BEHRI prescreen.
2. BCCMHA must be in receipt of discharge summary to authorize the additional units.
3. BCCMHA has 30 days from receipt of claim to pay for or deny claim.
4. Denial letters, or request for correction, will be sent to provider using the USPS or via BEHRI.
5. Questions or Status of claim shall be done within the BEHRI EHR emailing system.

Medicaid Primary Payer

1. Provider submits claim directly into BEHRI, manually or electronically.
2. If provider requires a log in account, contact the BCCMHA Provider Network Specialist.
3. Search for client name, this will populate all authorizations for client.

Medicaid Secondary Payer

1. Secondary claims are to be mailed to BCCMHA, 500 Barfield, Hastings, MI 49058 or sent electronically in a secure manner. When received by BCCMHA, the date received recorded and documented in Claim Received log.
2. TPL remittance advice must be included with claim.
3. BCCMHA will determine the allowable Medicaid amount and determine if further payment is required.
4. If claim is denied, denial and appeal information will be sent via USPS by BCCMHA or sent via BENRI email system.
5. If claim is approved for a secondary payment, BCCMHA UM will verify authorization in Smart Care 4.0 and will update such in BEHRI EHR.
6. Pended claims will be stored by BCCMHA in a secure location and reviewed on a weekly basis.
7. BCCMHA staff will enter approved claims into BEHRI.

Third Party/Other Insurance

Claims received for secondary consideration with an EOB attached, should pay for the contracted amount less the payment by the primary carrier, or patient responsibility, whichever is less If payment from the primary carrier exceeds the contracted amount, no additional payment is due and a denial letter will be sent to the provider.

All Other External Claims

1. External authorizations will be requested by author of a plan, addendum or standalone within the BEHRI EHR.
2. Upload supporting documentation prior to adding claim.
3. Provider will enter, adjudicate and submit claim in the BEHRI EHR.
4. Provider should run the adjudication report prior to submitting the claim for payment to determine if errors or issues exist so that they may be resolved.

Processing External Claims

1. Claim batch will be processed on a daily basis.
2. Claims will be denied and returned to provider if errors are contained in claim via the BEHRI EHR.
3. Provider can correct claims, adjudicate and resubmit.
4. Clean claims will be forwarded to designated staff for approval.
5. On a weekly basis, designated staff will approve batch for payment, print request for payment and provide to accounting department to process check.
6. Check number and claims will be added to BEHRI EHR within a day of checks being signed. Provider may access check remittance within the BEHRI EHR. Hospital remittances are sent with check.

Pended/Denied Claims

Electronic claims will be denied and returned to the external provider within 30 days from the date of claim entry. Provider will make corrections to denied claim and resubmit using BEHRI EHR.

Secondary claims that pend or deny during initial adjudication will be reviewed by staff. Providers will be notified in writing within 30 days from receipt date of the claim. This correspondence will either provide an explanation of denial or a request for additional information.

The provider will have 30 days from the date on the denial letter to correct the error and resubmit. If the claim is made "clean", then BCCMHA will have 30 days from the receipt of the additional information to finalize the claim.

Re-Adjudication of Claims

Occasionally a claim that has been adjudicated in the system will require re-handling. Staff will:

1. Request the provider investigate the issue if on their end and resubmit.
2. Resolve any issues at BCCMHA as applicable. Re-adjudicate the claim.

Explanations of Benefits

BCCMHA will ensure that an EOB is mailed to a minimum of 5% of the clients served with Medicaid benefits annually.

Claims Denied for Duplicate Service

If providers are aware that a claim may deny due to a duplicate service issue, the claim should be submitted individually to be reviewed by BCCMHA staff. Designated staff will log these claims and

review the details. If the claim is able to be paid immediately after review, the claim will be processed with notes added specific to the situation. If more review is needed, i.e. Corporate Compliance Officer, the claim will be forwarded for further review and additional documentation may be requested from both service providers. If additional information is requested, providers will have 7 business days to submit. A final decision will be made on payment. If payment is warranted, the claim will be paid and log noted with details of the decision. If the claim will not be paid, it will be formally denied following the normal process. If the decision results in a take back from another provider, designated staff will process the take back, notifying the other provider following the normal process. If extensive review is needed to arrive at a decision, BCCMHA staff involved will meet to review the details surrounding the duplicate service to arrive at a decision.

Confidentiality of Claim Documents

The Michigan Mental Health Code, 42 CFR Part 2, and Health Insurance Portability and Accountability Act (HIPAA) require that all personal health information be protected and kept confidential. The contents of behavioral health/medical claims cannot be shared with individuals not involved in the delivery of services or directly involved in the processing of the claim without authorization from the member or legal guardian. All claim documents will be kept secured, noting that these documents must not be left on desk surfaces and in open areas accessible by clients, visitors, or staff members not involved in the process of the claim. See Confidentiality Policy.

Retention and Retrieval of Claims

Secondary claims will be kept in active files for one year, and original claim documents kept for seven years in accordance with industry standards for retention or government established retention schedule.

Over Payments

NOTE: The Patient Protection and Affordable Care Act (Health Reform Law) requires providers to return and report "overpayments" from the Medicare or Medicaid Programs within 60 days of identification.

Staff will coordinate the review and recovery of overpaid claims and appropriately document the claim overpayment on electronic claim form. The claim will be corrected in the system and appropriate parties notified. Recoupment will be collected through offset whenever possible

If the overpayment cannot be collected through offset, the facility must notify the provider of the amount and reason for overpayment and allow 30 days for the refund to be received. A note will be added to the electronic claim to alert others that the request has been initiated. If payment is not received within 30 days, a second request will be made in writing. If payment has not been received after 60 days, a phone call will be placed by designated staff to establish a date for refund and/or resolve any disputes. If provider refuses to refund BCCMHA, further action may be taken, including contract termination, civil suit and/or reporting provider to the Michigan Office of the Medicaid Inspector General.

REFERENCES

Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006
Michigan Mental Health Code
Michigan Medicaid Manual
Health Insurance Portability and Accountability Act of 1997
Patient Protection and Affordable Care Act (Health Reform Law)

APPROVED BY:

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