MCCMH MCO Policy 7-010

Chapter: **FINANCE**
Title: **CLAIMS PROCESS**

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Chief Executive Officer Date

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I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, on the processing and storage of claims.

II. APPLICATION

This policy shall apply to the workforce members of MCCMH Administration; contracted software vendors; and all directly operated, contract, and non-paneled providers of MCCMH.

III. POLICY

It is the policy of MCCMH to ensure that all claims received are documented and processed based on the needs of persons served. It is the goal of MCCMH to ensure that all claims are processed in a timely manner that is in accordance with applicable law, standards, and contractual obligations. All activities related to claims processing and storage will comply with current applicable laws including HIPAA, HITECH, and the HIPAA/HITECH Omnibus Final Rule of 2013.

IV. DEFINITIONS

A. Certificate of Need
The document used to request approval of inpatient hospitalization.

B. Claim
An itemized statement of services rendered by health care providers billed electronically in the FOCUS system.

C. CCBHC

A demonstration program to improve community mental health services funded using a Prospective Payment System (PPS) rate for qualifying encounters provided to Medicaid beneficiaries.

D. Clean Claim

A claim that has no defect, impropriety, or lack of any required substantiating documentation including a lack of the substantiation documentation needed to meet requirements for encounter data, or a particular circumstance requiring special treatment that prevents timely payment. Such claims must have all appropriately appended modifiers per payer regulations. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

E. Centers for Medicare & Medicaid Services (CMS)

An agency of the U.S. Department of Health and Human Services (HHS), responsible for the administration of Medicare and Medicaid under Title XVIII and Title XIX of the Social Security Act, respectively.

F. Enrollee

An individual who is eligible for and receives benefits under the Medicaid government health care insurance program. For purposes of MI Health Link, an individual who met the dual eligibility requirements for health care coverage of Medicare and Medicaid services and met specific qualification criteria for services under MI Health Link.

G. FOCUS

The MCCMH online software portal system used to enter, edit, maintain, and review claims and other protected health information.

H. HIPAA

Health Insurance Portability and Accountability Act of 1996

I. HITECH

Health Information Technology for Economic and Clinical Health Act of 2009

J. Integrated Care Organization (ICO)

A health insurance-based organization contractually responsible and accountable for providing integrated care to people eligible for both Medicare and Medicaid.

K. Managed Care Entity (MCE)

MCEs include Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) as defined in 42 C.F.R.438.2.

L. MI Health Link

A health care option for Michigan adults, age 21 or older, who are enrolled in both Medicare and Medicaid.

M. Subrogation
The substitution of one person into the place of another with respect to rights, claims, or securities.

N. Timely Filing
The time period within which a claim must be submitted in order to be paid.

O. Wisconsin Physicians Service Insurance Corporation (WPS)
The multi-state, regional Medicare Administrative Contractor responsible for administering both Medicare Part A and Medicare Part B claims for the J8 region which includes both Indiana and Michigan.

P. Workforce Member
Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for MCCMH, is under the direct control of MCCMH, whether or not they are paid by MCCMH.

V. STANDARDS

A. Benefit limitations shall be tracked and controlled through provider fee schedules within the FOCUS system, which are maintained and updated at least annually in accordance with the Local and National Coverage Determinations as published by CMS and WPS. Inpatient days are tracked through the system via the Certificate of Need document.

B. Pursuant to the MI Health Link Three Way Contract, MCCMH shall adopt the following subrogation standards. Subject to CMS and MDHHS lien and third-party recovery rights, MCCMH must:

1. Be subrogated and succeeded to any right of recovery an enrollee has against any person or organization (for any services, supplies, or both provided under the Three-Way Contract) up to the amount of the benefits provided.

2. Require that the enrollee pay to MCCMH all such amounts recovered by suit, settlement, or otherwise from any third person or his/her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided. MCCMH may ask the enrollee to:

    a) Take action, furnish information and assistance, and execute such instruments as MCCMH may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of MCCMH; and

    b) Notify and authorize MCCMH to make such investigations and take such actions deemed appropriate to protect its rights whether or not such notice is given.

C. Claims

1. MCCMH uses HIPAA compliant formats for all claims, submissions, and transactions. All claims information is considered confidential Protected Health Information (PHI), and HIPAA, HITECH, and HIPAA/HITECH Omnibus Final Rule of 2013 standards apply.

2. As determined by MCCMH, start and stop times for services rendered must be included on claims and match submitted documentation.

3. Any instance of suspected fraud or fraudulent claim activity shall immediately be reported to the MCCMH Office of Corporate Compliance for investigation.

4. Unbundled services shall be addressed during the standard claim adjudication process.

5. MCCMH, as a contracted provider of administrative functions to a managed care organization, shall provide to the appropriate managed care organization monthly statements of paid claims, aging of unpaid claims, and denied claims in the format specified by MDHHS.

6. Amounts billed through claims should be billed at the usual and customary rate for each code as determined by the provider.

7. MCCMH utilizes a claims processing procedure for documents, claims, and procedures which is available for claims examiners. (See Exhibit A, "Claim Information and Procedures")

    a) Adjustments

        1) MCCMH shall maintain, within the FOCUS system, the claim adjustment reason codes as published by the Washington Publishing Company. These codes are utilized for the Explanation of Payments given to providers.

        2) Claim adjustments shall result in voided encounters which will be submitted through the encounter submission process.

    b) Overpayments

        1) Overpayments identified by the provider will result in a void of the claim. This void will result in the deduction of payments for the voided or overpaid services from the provider's next payment.

        2) In the event a provider identifies an overpayment due to a billing error, the provider must submit a claim reconsideration (See Exhibit

E). If the service is within the current fiscal year, a corrected claim may be submitted for payment. No payment will be made for prior fiscal years if not submitted within 60 calendar days of the end of MCCMH's fiscal year.

3) If the provider does not receive a payment, that provider shall immediately remit payment to MCCMH via check. See Exhibit E, "Claim Reconsideration Information and Procedure," for the process of returning identified overpayments.

c) Denial of Claims from an MCCMH Paneled Provider

1) Providers are notified of claim denials through the FOCUS system. Denial codes appear on the Explanation of Payments (EOP) and contact information for the provider appeals process is included on the EOP.

2) Appeals of denied claims can be submitted through the FOCUS system for consideration by MCCMH via the claims appeal module.

3) Should a provider submit the same batch three times without changing documentation, offering further explanation, or providing the information requested by MCCMH, that claim will be considered denied and no further appeals/documents related to that claim will be reviewed.

4) Any service deemed to be non-covered will be denied and notification sent out from FOCUS with explanation of decision in comment of the claim appeal. The enrollee shall be held harmless.

5) Providers can submit a written second level appeal to their contract manager for consideration of any claims denied through the claims appeal module. Decisions will be communicated in writing.

6) MCCMH, as a contracted provider of administrative functions to a managed care organization, will report denied Medicare claims in the 837-encounter file to the appropriate managed care organization. MI Health Link enrollees will be notified of denied claims through the integrated denial notice.

7) MCCMH, as a contracted provider of administrative functions to a managed care organization, will provide, to the appropriate managed care organization, an electronic, monthly claims report summary that includes a log of denied claims.

d) Payments

1) Persons served can track, through the FOCUS system, the status of their claims during the claims process and are able to obtain the date a claim was paid.

2) MCCMH pays all clean claims within 30 calendar days of receipt. If MCCMH needs to request additional claim information or documentation to make a payment determination, MCCMH will request the additional information in writing within 30 calendar days of receipt of the claim, and then pay or deny the claim within 30 calendar days of receipt of the additional information from the provider.

3) MCCMH shall not make claims payments to providers who are terminated or suspended from participating in the Michigan Medicaid Program, Medicare, or any other state's Medicaid program.

4) MCCMH calculates and pays simple interest on clean claims not processed within 30 calendar days of date of receipt, as indicated in 42 CFR 422.520 unless otherwise written in PIHP contract with providers.

5) Interest is not paid on:

(a) Claims requiring external investigation or additional information to process claim

(b) Claims on which no payment is due

(c) Full denials

e) Pending

1) MCCMH shall make every effort to process pending claims within 60 calendar days. Claims staff monitor for compliance with this standard and manually track pending claims.

2) Payment determination on claims pended for medical review shall be made within 60 calendar days.

f) Storage/Inventory

1) All claims entered into the FOCUS system are stored within the system by MCCMH's software vendor and are not archived. These claims are readily available for examination or audit.

2) MCCMH manually manages the claims inventory and does not hold clean claims in inventory for more than 20 calendar days.

3) Senior finance staff monitor for backlog claims, the status of pending claims, and the timeliness of payments.

g) Timeliness of Claims

1) The maximum time period for submission of any MI Health Link claim is 1 calendar year after the date of service.

2) For claims billable to other Third-Party payers, claims are to be submitted within 60 calendar days of the final disposition of payment by the Third Party(ies) involved to be considered for payment. For claims which are billable to other Third-Party payers, a copy of the Explanation of Benefits (EOB) from the other Third-Party payer must be sent with the batch.

3) The maximum time period for submission of any claim, other than for MI Health Link, is 60 calendar days from the date the service was rendered.

4) Claims for hospitals, other than those covered in items 1 and 2 above, are to be submitted within 60 calendar days of the date of discharge.

5) Providers have 60 calendar days from the date of the MCCMH EOP to file a claim appeal. (Claims adjustment requests for rate issues, rate changes, denied claims due to overlaps, duplicate claims, fund source issues)

D. Non-Paneled Provider Claims

Claims from non-paneled providers shall be submitted through FOCUS and follow the guidelines included in this document.

E. Excluded Providers

MCCMH Office of Corporate Compliance notifies MCCMH Finance and Budget Division of provider exclusions under Medicare and/or Medicaid. MCCMH is prohibited from paying claims to providers excluded from participation under Medicare and/or Medicaid.

F. Revision Determinations of Claims

1. For MI Health Link enrollees, claim reopening, revision determinations, and claim decisions shall include timeframes for reopening and revision for Good Cause, that are established when there is new evidence, that was not available or known at the time of the determination, which may result in a different conclusion; or the evidence that was considered in making the determination shows that an error was made at the time of the determination.

2. When any determination is reopened and revised, the rationale, basis for the reopening and revision, and right to appeal shall be provided to the MI Health Link enrollee at their last known address.

G. Storage

1. MCCMH maintains one hundred percent (100%) encounter data for all covered services provided to persons served, including any sub-capitated sources (downstream and related entities). Such data is linked to the Michigan Public Health Institute (MPHI) and MDHHS eligibility data.

2. MCCMH's software vendor provides data storage for MCCMH and is responsible for ensuring against data loss from system failure and fire and is responsible for restoring data from regular backups.

3. MCCMH maintains eligibility verification through an automatic upload of MDHHS 834 files, which enroll members in a healthcare benefit plan, and MDHHS 270/271 transaction files which request and respond to inquiries regarding health care benefits and eligibility. These forms are uploaded monthly.

4. MCCMH stores and maintains all transaction history.

VI. PROCEDURES

See exhibit documents referenced below.

VII. REFERENCES / LEGAL AUTHORITY

A. National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization (MBHO) Standards

B. MI Health Link Three Way Contract between CMS, MDHHS, and ICO
C. MCCMH-MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915 (b)/(c) Waiver Program Contract
D. Commission on Accreditation of Rehabilitation Facilities (CARF) Standards
E. Centers for Medicaid and Medicare Services
F. Medicare Managed Care Claims Manual
G. Medicare Claims Processing Manual
H. Wisconsin Physicians Service Insurance Corporation

VIII. EXHIBITS

A. Claims Information and Procedures
B. Process for New Hospitals
C. Process for Non-Hospital Providers
D. Overlapping Service Code Protocol
E. Claim Reconsideration Information