CLAIM INFORMATION & PROCEDURES

A. ADJUDICATION REPORT:

1. After claims are processed, claims staff creates adjudication reports for healthcare providers that do not have access to the FOCUS system.
2. Healthcare providers that have access to the FOCUS system may view claims at any time.

B. AUTHORIZED UNITS

1. At the time of adjudication, Units Available are transferred to Units Claimed.
2. Units are transferred to Paid to Date when they become approved for payment.

C. BATCHES

1. Upon entering claims into the FOCUS system, a batch is created. The batch is created with a system assigned number.
   a. Providers continue to add claims to a batch. (*Recommended: All claims for the month added to one batch*).
   b. It is acceptable for providers to create new batches but it is not preferred.
   c. Batches must be separated by programs.

2. Upon batch completion, but prior to MCCMH submission, providers are required to adjudicate and review claims to target claim errors.
   a. Once a batch is sent to MCCMH by a provider, the provider no longer has access to the batch unless a claims staff returns it.
   b. A provider can view their batch status at any time.
   c. Providers can see whether their batch status has been accepted or rejected when it is sent to MCCMH for processing.

D. BATCH STATUS

1. **Claim Data Entry**
   Claims are being entered into a batch by the provider. MCCMH has not received the batch for review.

2. **Not Adjudicated**
   The batch sent to MCCMH; claims staff has not reviewed the batch.

3. **Adjudicated - Ready**
   a. A batch is adjudicated and has been reviewed by claims staff. The batch is returned to the provider for errors or questions.
   b. A batch is returned in its entirety, as the claims staff were unable to separate a batch.

4. **Adjudicated – Pending Approval**
   Review is complete and the batch is forwarded to an accountant for processing. The batch may be sent back to the provider.

5. **Approved For Payment – Released to Accounting**
   a. Batch has been approved by an accountant and forwarded to an account clerk. Checks are obtained from the Macomb County IFAS system.
   b. During this step, a batch cannot be returned to a provider. If a provider finds an error, a Claim Reconsideration is completed.
   c. All clean claims are paid within 30 days from receipt.

6. **Approved for Payment**
   a. The batch is complete. The Account Clerk has received a check from IFAS and all pertinent information is entered into FOCUS.
   b. Providers can view each claim and/or batch for date of completion and check number.
   c. Once a provider receives a check, it is the provider's responsibility to view and/or print the EOP.
   d. *Approved for Payment* status does not indicate a provider's check is in the mail.
   e. MCCMH has 30 days from the batch Receive Date for completion.

E. CLAIMS

1. **Claim Staff Processing – Log into FOCUS**
   a. Claims are visible in *Adjudicated – Ready* status (*see Sec. D; number 3*) and sorted into date order; oldest claims appearing first.
   b. The claims staff manually manages the claims inventory.
   c. Claims are held in inventory for no more than 20 days.
   d. Clean claim batches are adjudicated within 48 hours of the submission date. To adjudicate a batch, the claims staff must elect the batch by placing a check box in the appropriate box followed by clicking the hyperlink to adjudicate. Once batches have been adjudicated, they move to *Adjudicated – Pending Approval* status (*see Sec. D; number 4*).
   e. Misdirected claims are addressed by the billing diagnosis and are not accepted into the system.

2. **Claim Status**
   a. Claims staff must report the status of any claim a provider is inquiring about in a timely manner. In the instance where a provider is inquiring about the authorization itself, the provider is directed to the Access Center.

3. **Claims Review**
   a. Accountants review the claims adjudication report prior to preparing and authorizing check requests.
   b. Accountants run monthly reports to review verifying standard payment accuracy and high-dollar amount claims thresholds.
   c. The FOCUS system and adjudication process control the claim payment amounts.
   d. Any questionable claims issues identified by claims staff or finance staff are referred to the MCCMH corporate compliance division for investigation.

F. COMMENT FIELD

1. The comment field is used to address any pertinent information by providers and claims staff.

G. EDITS

1. Batches must be adjudicated by providers prior to forwarding them to MCCMH, as to avoid prolonged payment on a claim or a batch return. Edits may include, but are not limited to:
   a. No Open Admission
   b. Units Exhausted
   c. No Authorization Found (837 Format)
   d. Duplicates
   e. Conflicting Services
   f. Discharge Summaries – Hospitals Only

2. An edit may arise at the time of adjudication, warranting a removal of the individual claim from the batch. Providers can delete this claim or claim a new batch number. Once an edit is corrected, providers can re-enter the claim to its assigned batch for submission.

3. The following describes the most common edits encountered, in addition to how they should be addressed:

   a. **No Open Admission**
   Access Center has not received completed documentation from the provider to open the consumer's record. The Access Center must be contacted to update the system. If a provider fails to do so, claims staff will forward an email for review.

   b. **Units Exhausted**
   Units are exhausted when there are no longer any available units to claim against an authorization The Access Center must be contacted for new authorization.

   c. **No Authorization Found**
   There must be a valid authorization with Direct Data Entry in order to process a claim. An invalid authorization or expired authorization may occur in the field with the 837 format. If this edit is received, a provider can review the consumer's authorizations for validity. If an authorization is unavailable, the Access Center must be contacted for a new authorization.

   d. **Duplicates**
   The FOCUS system allows for specific codes to be claimed during a specific time frame. A duplicate edit will occur when a provider claims a service code during a specific time period in which another provider has already claimed a service. Codes which are not allowed to be claimed will be denied. It is the provider's responsibility to properly submit a claim. In the event that a duplicate

edit occurs, the provider must resolve the issue in accordance with the Overlapping Services Protocol (Exhibit D).

e. **Conflicting Services**
Conflicting Services occurs when two or more authorization service codes overlap with another provider during the same time frame or when service codes overlap with the same provider that are not allowed within the system.

i. A conflicting service edit can occur as a result of a data entry error. If it is not the result of a data error, the provider must submit supporting documentation with the claim.
ii. In some instances, a conflicting service error can occur when two different codes of service are allowed on the same date. Claims staff must verify this prior to payment and require the provider to provide supporting documentation to the appropriateness of the claim

f. **Discharge Summaries – Hospitals Only**
Claims will be denied if necessary paperwork has not been submitted to the Access Center by the provider. Once paperwork is received by the Access Center, the discharge date will be entered into the system.

H. FISCAL YEAR

1. The fiscal year is a twelve month period which begins on October 1st of each year..
2. Batches must be separated into fiscal years in order to process. The FOCUS system will not allow two fiscal years in one batch. An inpatient consumer, with crossing fiscal years, must have the charges and payments divided to equal both claims. For hospital Medicare/Medicaid split year claims, the provider must contact claims staff so that authorization is updated with date ranges and units. This must be done before claims can be entered into the FOCUS system.
3. Letters are mailed to all contact providers with guidelines for the end of the fiscal year timely submission of claims. Any claim that does not comply with the guidelines will be returned to the provider with an explanation stated in the *comments* section. These claims are not processed through the FOCUS system. In the event that one claim within a batch does not comply, the entire batch will be returned with instructions stated in the *comments* section.
4. Claims staff does not have the ability to split any batch apart.
5. Only non-contracted hospitals can continue to have one fiscal year from the date of discharge to submit claims for processing.
6. All providers must adhere to the timely filing standard of 60 days. Please refer to MCO Policy 7-010 Section V.

I. GENERAL INFORMATION

1. Claims can be entered into the FOCUS system in either Direct Data Entry format or 837 Electronic File format.
2. Contract providers, where on-going services are limited and/or sporadic, do not enter claims into the FOCUS system. Claims must be mailed to MCCMH Administration for Direct Data Entry. Claims are date stamped upon receipt, and then entered into the FOCUS system by claims staff.

3. Direct Data Entry consists of HCFA 1500 or UB04 claim forms. Providers enter claims for professional services on the HCFA 1500 or 837P, if electronically and claims for institutional services on the UB04.
4. Providers only have access to consumers associated with their program. In the event a provider comes across a consumer that is not associated with their program, they must contact the Access Center immediately. The Access Center must also be contacted in the event a service provider cannot view a consumer in the FOCUS system.

J. HOSPITALS

1. All hospitals utilize the UB04 claim form for institutional events, which consist of inpatient stays or partial days. These may include authorized ECT treatments. Inpatient stays are billable when the consumer is in the hospital from midnight to midnight.
2. With authorization, the first day of admission is payable; discharge date (the last day a consumer is in a hospital) is not.
3. All MI Health Link inpatient claims for hospitalization services will be priced using the CMS pricer to determine the correct allowed amount.
4. Partial days may consist of any day except weekends. The first and last day for partial days are payable with authorization.
5. The HCFA 1500 claim form for is utilized for Emergency Psychiatric Evaluation services. These services consist of Facility Charge and/or Psychiatric Evaluation.

K. NON-CONTRACTED PROVIDER

1. The Access Center must be contacted by provider to obtain authorization in order to utilize the FOCUS system. A Provider ID number (PID) is generated, which allows the Access Center to complete the authorization process, as well as complete any necessary information in the FOCUS system.
2. The processes for authorizing non-contracted provider services are found in Exhibit B, Process for New Hospitals and Exhibit C, Process for Non-Hospital Providers.

L. OVERRIDES

Claims staff can override events within a claim where appropriate. In the event claim staff overrides a particular event prior to realizing a batch needs to be returned to the provider, the batch must be adjudicated prior to returning in order for overrides to hold. Said overrides may include, but are not limited to:

1. **Duplicate Claims**
   Overriding of duplicates has decreased due to time element requirements on claims. If clinically approved, claims staff must receive email notification from the Access Center allowing the claims staff to override. Third party situations must have documentation supporting an override. Claims staff must check to ensure units are not over-stated for the particular event prior to overriding.

2. **Partial Day Services**
   These services can be provided along with residential and/or inpatient.

3. **Rate**
   A consumer may have a higher per diem rate than set in place by the fee schedule. This is indicated in the consumer's authorization.