MCCMH MCO Policy 7-010

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

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Executive Director Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health Agency (MCCMH) as it applies to its processing and storage of claims as a managed care entity.

II. APPLICATION

This policy shall apply to the workforce members of: MCCMH Administration, contracted software vendors, and all directly operated, contracted network, and non-paneled providers of the MCCMH Board of Directors (MCCMH Board).

III. POLICY

It is the policy of the MCCMH Board to ensure that all claims received are documented and processed based on consumer needs. It is the goal of the MCCMH Board 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 all 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 or on the CMS-1500, UB-04, or their successor forms.

C. **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 the requirements for encounter data, or a particular circumstance requiring special treatment that prevents timely payment. 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.

D. **CMS**
Centers for Medicare & Medicaid Services, an agency of HHS, responsible for the administration of Medicare and Medicaid under Title XVIII and Title XIX of the Social Security Act, respectively.

E. **CMS Pricer**
A CMS electronic tool used to estimate Medicare PPS payments. MCCMH uses the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) PC PRICER.

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 has met the dual eligibility requirements for health care coverage of both Medicare and Medicaid services and met specific qualification criteria for services under MI Health Link.

G. **EOB**
Explanation of Benefits

H. **EOP**
Explanation of Payment

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

J. **HIPAA**
Health Insurance Portability and Accountability Act of 1996

K. **HITECH**
Health Information Technology for Economic and Clinical Health Act of 2009

L. **ICO**
Integrated Care Organization

M. **IFAS**
Integrated Financial and Administrative Solution is Macomb County's finance/general ledger system.

N. **Managed Care Entity (MCE)**
MCEs include MCOs and PIHPs as defined in 42 C.F.R.438.2.

O. **Managed Care Organization (MCO)**
Managed Care Organization has the meaning specified in 42 C.F.R. 438.2.

P. **MDHHS**
Michigan Department of Health and Human Services

Q. **MPHI**
Michigan Public Health Institute

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

S. **WPS**
Wisconsin Physicians Service Insurance Corporation is 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.

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

V. STANDARDS

A. **Benefit Limitations**
Benefit limitations are tracked and controlled through the use of 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. **Claims**

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

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

3. Unbundled services will be addressed during the standard claim adjudication process.

4. MCCMH, as a contracted provider of administrative functions to a managed care organization, will 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.

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

   a. Adjustments
      i. MCCMH will maintain, within the FOCUS system, the claim adjustment reason codes as published by the Washington Publishing Company. These codes will be utilized for the Explanation of Payments given to providers.

      ii. Claim adjustments will result in voided encounters which will be submitted though the encounter submission process.

   b. Overpayments
      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 check. In the event that the provider does not receive a check, that provider will need to immediately remit payment to MCCMH via check. See Exhibit E, Reconsideration Procedure, for the process of returning identified overpayments.

   c. Denial of Claims from an MCCMH Paneled Provider

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

      ii. Appeals of denied claims will be reviewed by the MCCMH Access Center. Providers may contact the Access Center staff to have the medical necessity of the service reviewed as an appeal, so that providers can resolve disputes and move toward a resolution. For more specific information, see MCCMH Policy 2-006, "Service Provider Appeals".

      iii. Any service deemed to be non-covered will be denied in the claims system and the beneficiary will be held harmless.

      iv. 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 appeal notice.

      v. 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
   i. Members are able to track, electronically or by phone, the status of their claims during the claims process and are able to obtain the date a claim was paid.

   ii. MCCMH pays all clean claims within 30 days of receipt.

   iii. MCCMH will pay out of network providers of emergency and post-stabilization care within 60 days of claim submission when all required paperwork is received free of errors.

   iv. MCCMH will not make claims payments to providers who are terminated or suspended from participating in the MI Medicaid Program, Medicare or any other state's Medicaid program.

   v. MCCMH will calculate and pay simple interest on any clean claim processed after 90 days.

e. Pending
   i. MCCMH will make every effort to process pending claims within 60 days. Claims staff will monitor for compliance with this standard and manually track pending claims.

   ii. Payment determination on claims pended for medical review will be made within 60 days.

f. Storage/Inventory
   i. 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.

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

   iii. The Claims Supervisor monitors for backlog claims, the status of pending claims, and the timeliness of payments.

g. Timely Filing
   i. The maximum time period for submission of any claim is 60 calendar days from the date the service was rendered.
   ii. For claims which are 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.
   iii. For contract hospitals, claims are to be submitted within 60 calendar days of the date of discharge.

C. **Non Paneled Provider Claims**

1. The MCCMH Business Management Division manually reviews and processes paper claims. In the event an ER claim is pending, Business Management will obtain medical record information to make a determination using the prudent layperson standard.

2. Emergency Services will not be refused based on a provider's failure to notify the primary care physician of an Enrollee's screening and treatment within a specified timeframe.

D. **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.

E. **Non-Contracted Provider Procedure**

In order to obtain payment, non-paneled hospital providers must follow the Process for New Hospitals (Exhibit B). Non-paneled non-hospital providers must follow the Process for Non-Hospital Providers (Exhibit C).

F. **Provider Rates**

Provider rates will be reviewed annually or upon renewal of the contract.

G. **Storage**

1. MCCMH maintains one-hundred percent (100%) encounter data for all covered services provided to Enrollees, including any sub-capitated sources (downstream and related entities). Such data is linked to the 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, as well as the MDHHS 270/271 transaction files on a monthly basis.

4. MCCMH stores and maintains all transaction history.

H. **Claims Auditing**

1. Claims will be audited by claims processors upon receipt.

2. A sample of claims submitted as encounters will be reviewed monthly by a certified coder for coding compliance and documentation. The sample will contain 10% of the encounters in the system.

3. Claims reports will be monitored by the MCCMH Finance and Budget Division to audit for high dollar claims on a quarterly basis. Claims will be monitored for errors and to ensure that the payment is made according to the claims processing system configuration.

4. Any services that are found to have been paid in error will immediately be forwarded to the MCCMH Office of Corporate Compliance for further review and corrective action.

5. Audit results will be logged in an audit log book for tracking and trending, including actions taken against a provider. Logged results shall include, but are not limited to, provider recoupment. Actions taken regarding recoupment will be forwarded to MCCMH Office of Corporate Compliance for further review.

6. An Overlapping Services Protocol is used in circumstances in which more than one provider has submitted a claim for payment which occurred during the same time frame. (See Exhibit D).

VI. PROCEDURES

See Exhibits

VII. REFERENCES/ LEGAL AUTHORITY

A. National Committee for Quality Assurance (NCQA)

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)

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 Services Protocol

E. Reconsideration Procedure