MCCMH Overlapping Service Code Protocol and Time Line

1. MCCMH has instituted a process to ensure the integrity of the claims payment system by establishing claims payment edits that will identify services that are overlapping. We have developed a protocol and timeline for providers to use in an effort to resolve instances where providers have been denied payment for services due to overlapping service edits.

2. The PCE claims Payment System provides timely information to providers regarding overlapping service codes as follows:

    a. Before submitting claims batches to MCCMH, providers should adjudicate their batches to determine what errors have been identified. The edit language related to overlapping services will contain the necessary information for providers to be able to determine how they can resolve the error.

    b. For example, error number LA09 will read:

        i. Duplicate and/or overlapping service already claimed on this date. See Claim # (Claim it is duping against) from Provider # (Provider ID) (Provider name).

3. This information will allow the contract provider to contact the other provider in question and resolve the overlapping issue. It is highly recommended that the claims with overlapping denials be segregated into a separate batch and "clean claims" be submitted as to not hold up the entire batch while the duplicate issues are being resolved.

    a. Providers must resolve and submit clean claims within 60 days of the Date of Service following the regular claims submission guidelines.

    b. If the provider is unable to resolve the overlap they must contact MCCMH Administration for review within 60 days of the Date of Service. During investigation the claims are considered pended, and then must be submitted within 15 days of resolution.

4. The provider that submitted a claim incorrectly must reconsider its claim in situations where provider claims for services overlap and there is agreement between the two providers regarding which entity submitted its claim inappropriately. Once the reconsideration is submitted and cleared by the Claims Department in the FOCUS system, the other provider can then submit their claim. See the "Claims Reconsideration Process".

5. If the two providers believe that the overlapping services should be allowed due to the nature of the services or medical necessity, or the two providers are unable to come to agreement, contact overlapreview@mccmh.net. Provide the batch number, claim number, consumer, DOS, any pertinent information already collected, documentation (if not in FOCUS) in the request. MCCMH Finance and Budget staff will review the claim for coding/billing compliance. If the overlap scenario is requiring review for medical necessity, the review request will be forwarded to MCCMH ACCESS clinical staff.

a. If the overlap is approved for payment, the MCCMH staff responding with the determination will instruct the provider on proper claims submission.

b. If the overlap is denied, the provider in compliance with all local, State, and Federal coding and billing regulations will be paid. The provider out of compliance will need to reconsider their claim and accept denial of payment.