**WOODLANDS BEHAVIORAL HEALTHCARE NETWORK**

**POLICY & PROCEDURE**

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| **Title:** | | | | **Section:** |
| **Claims Management** | | | | **Finance** |
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| **Applies to:** | | | | **Page:** |
| WBHN Staff WBHN Contract Providers | | | |  |
| **Doc. Number:** | **Effective Date:** | **Revised Date:** | **Annual Review:** | **Responsible Staff:** |
| 7-005 | 09/2022 | 01/2024 | 05/2023 | CFO |

**Purpose**

To communicate the claims management policy, procedures, and standards.

**Policy**

It is the policy of Woodlands Behavioral Healthcare Network (WBHN) to process claims in a timely and accurate manner consistent with the Michigan Department of Health and Human Services (MDHHS), as well as all State and Federal Regulations, Rules, and Law regarding processing of Medicaid claims.

**Procedure**

1. All WBHN claims will be adjudicated based on Southwest Michigan Behavioral Health (SWMBH) standards while adhering to Federal and State requirements and business industry standards surrounding claims processing.
2. WBHN claims staff will adhere to SWMBH procedures regarding the Overpayment and Refund of claims payments as established while also adhering to Federal and State Requirements.
3. All claims shall be filed using the current WBHN system unless provider is granted a waiver to submit claims via paper method.
4. WBHN shall ensure that all WBHN contract providers are kept informed of all necessary information regarding claims policies and procedures on a timely basis.
5. Providers have the right to appeal adverse actions taken by WBHN. Generally, the reconsideration process can be either an “appeal” or a “claim dispute”. Customer rights regarding appeals and grievances will be afforded via the Provider Appeals & Grievances policy and procedures (Policy 7-011).
6. WBHN shall make timely payments to all providers for clean claims. This includes payment at 90% or higher of all clean claims from participant CMHSPs and sub-contracted providers within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a subcontract in which other timeliness standards have been specified and agreed to by both parties.
7. SWMBH or WBHN shall not require any co-payments, deductibles, or any other cost sharing arrangements by enrollees of Medicaid.
8. When WBHN receives a claim as a secondary payer, a valid EOB must be attached from the primary payer.
9. Claims submitted beyond 365 days post service date will not be considered for payment or appeal.

**Claims Adjudication Standards**

1. Adjudication Rules and Edits
2. The system will compare the following data elements of the claim to system information or logic:
3. Compares the CPT code billed to the care authorized
4. Compares the date of service to authorization effective and termination dates
5. Validates insurance coverage was in effect for each date of service
6. Searches for other insurance information
7. Searches for duplicate claim lines
8. Validates that the service was covered in the provider agreement for the date of service billed
9. Validates the provider’s current rate and the number of units authorized
10. Paper claims will receive an EOB with their check
11. Participant Responsibility
12. WBHN will perform batch adjudication on a timely basis.
13. Claims that are denied or only partially approved will be returned to the provider through the VieWPoint system for correction. WBHN will ensure that denial notifications are sent to external providers in accordance with policy within 30 days of denial. Only those providers who have received a waiver to submit paper claims will receive paper letters. All other providers can find their denials or partial approvals within the VIEWPOINT system at any time.
14. Explanation of Benefits
15. WBHN will ensure that an Explanation of Benefits (EOB) is mailed to a minimum of 5% of the Medicaid Consumers served by WBHN annually.

**Claims overpayment and Refund Standards and Guidelines**

1. Reasons for overpayments
2. There are numerous reasons why claim payments can be overpaid. The most common:
3. Claim was overpaid due to processing error, such as entering the wrong number of units
4. Claim was paid twice. Duplicate payment was not identified by the system
5. Provider received payment from another carrier or Medicare is primary
6. The incorrect provider was selected in processing the claim
7. There may be an error in the provider fee schedule/contract or misunderstanding regarding payment terms. A change in payment terms may have occurred which has not been updated
8. There may be an error in the member’s benefit eligibility allowing claims to pay that should not
9. Other human error
10. Notification/Review Process
11. Claims Management will coordinate the review and recovery of overpaid claims. This individual will:
12. Review the claim for all needed elements, such as claim number, member ID, date of service. If information is needed, it may be requested from the provider or from the individual who identified the overpayment.
13. Review the claim for processing accuracy.
14. If the claim is determined to have been processed correctly, send notification back to the individual who identified the overpayment with an explanation as to why the claim is processed correctly.
15. Correct the claim in VieWPoint and determine if the overpayment can be recovered through offset.
16. Offsetting Future Claims Payments
17. Collection of overpayments through offset is the preferred method of recovery. However, offsetting cannot be used when there will be no future claims submitted by the overpaid provider or under the provider ID which generated the overpayment. This may occur when providers terminate their participating status or change their billing arrangements
18. If the overpayment can be collected through offset, correct the claim in VieWPoint and notify provider that the claim should be denied with reason provided.
19. WBHN will ensure proper communication to WBHN providers. If the provider remittance advice generated from VieWPoint will not fully explain the reason for offset, the provider must be contacted. Records should be kept supporting how this notification occurred.
20. Refund Checks
21. If the overpayment cannot be collected through offset, the WBHN will notify the provider of the amount overpaid and reason. Notify the provider in writing. Phone calls can be made to discuss the overpayment and collection follow-up but are not used as the primary notification
22. Allow 30 days for the refund to be received.
23. If payment is not received in 30 days, generate a “Second Request” in writing.
24. If payment is not received in 60 days, place a phone call to establish a date for refund or resolve any disputes.
25. Issue overpayment demand letter to provider that includes the following details: (42 CFR 433.316)
26. That an overpayment was made
27. The interest will begin to accrue if the overpayment is not paid in full within 30 days
28. The name and member identification number of the member/patient involved
29. How the overpayment was calculated
30. Why it is liable for recovery of overpayment (i.e. the reasons for finding the provider at fault)
31. That recoupment of the overpayment from all available payments is occurring
32. A description of the appeal process.
33. If provider refuses to refund monies due to WBHN further action may be taken including contract termination, civil suit and/or reporting of provider to the Michigan Office of the Medicaid Inspector General.
34. Security of “Live” (Negotiable) Checks
35. Checks should be secured in a lock box or safe until they are ready for deposit. Returned checks related to claims processing may require time to research, update VieWPoint and possibly correct the claims payment. In these cases, the original check should be deposited and/or secured in the safe. A copy of the check and any attached documentation should be used to complete the claims research. “Live” checks should not be left on desk surfaces, in-boxes, or work files.
36. Checks returned by the postal system for insufficient postage or address correction can be corrected and re-mailed. Incorrect addresses need to be updated in VIEWPOINT to ensure future checks are not returned.
37. Claim Denial
38. WBHN will determine if the patient on claim is eligible by reviewing the client file. The following information will be reviewed:
39. The contract associated with clients place of service
40. The dates in which a claim was filed
41. The dates authorized for client
42. The insurance coverage for client
43. If patient on claim is eligible for coverage, claim will adjudicate accordingly. If coverage ended on a month prior to the current month of claim, or if the service is not covered by contract, the claim will be denied.
44. A notice will be sent to claim issuer utilizing a Claims Denial Letter. The form will then be filled out and sent to the CFO.
45. Claim Appeals must be submitted within 30 days of receipt of denial letter. Appeals will not be accepted after 180 days post denial date; any claims denied beyond this period are considered to have reached a FINAL resolution.
46. Within 10 days after a provider appeal request, Claims Management will do a preliminary review of the claim and appeal details to determine if additional information from provider is required. If additional information is required, the provider will be notified in writing.
47. The Provider must submit all documents, written statements, and other documentation that supports the appeal within 10 days from the receipt of the request. The provider should also include a copy of any denial notice/remittance advice and the dollar amount of the claim for each disputed claim.
48. Claims Management will review all information submitted and determine if the original denial should be overturned in their opinion. If Claims Management upholds the original denial, they will submit all appeals and documentation to the Chief Executive Officer. The decision of the Chief Executive Officer is considered final.
49. Should the provider feel that this denial has still not been handled appropriately; the provider may submit your appeal to SWMBH.

**Electronic Claims Submission Standards**

1. Acceptable Standard Billing Formats
2. HIPAA 837 File Format

Providers who wish to utilize this format may do so by utilizing the file upload process through VieWPoint. Providers will be required to successfully submit test claims batches before access to the production system will be granted.

1. Provider Access for Claim Entry

Providers utilizing this system must obtain usernames and passwords to the system from “Provider Support”. The request form is available on the WBHN Website under the ‘Providers’ Tab. VieWPoint requires the use of Internet Explorer 10.0 or higher, Chrome, or Mozilla Firefox and the following claim fields are required:

• Customer name

• Dates of service

• Procedure code and modifiers

• Start/stop times (as required)

• Total Charges

• Place of Service

• Units

• Rendering Provider name and NPI (as required)

• Any third-party payment (if applicable)

**Provider Communications Standards**

1. WBHN will ensure their contracted network providers have access to the following information, either through their contract, Provider Manual or through other documentation including electronic media.
2. Address to file claims (both electronic and paper)
3. Telephone contact numbers
4. Information that must be contained in a claim for it to be considered “clean”
5. Acceptable standard billing formats
6. Dates by which claims must be filed to be considered for payment
7. Process for appealing a denied claim
8. Names and addresses of delegated claims processors
9. Contracted providers must be given 30 days written prior notice to all changes. Failure to give required notice of address change could result in delayed or lost claim filings. The contracted claims filing limit will be excused and payment allowed when required notice of address change is not provided.

**State Regulations Standards and Guidelines**

1. Clean Claims

Clean claims are defined by Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 (14) as claims that do all the following:

* Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
* Sufficiently identifies the patient and CMHSP subscriber.
* Lists the date and place of service.
* Is billing for covered services for an eligible individual.
* If necessary, substantiates the medical necessity and appropriateness of the service provided.
* If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
* Identifies the service rendered using a generally accepted system of procedure or service coding.
* Includes additional documentation based upon services rendered as reasonably required by the CMHSP.

1. Requesting Missing Information
2. Claim processor must advise the provider what information is needed to complete the claim. The notice must be in writing and must be issued within 30 days of receipt of the claim.
3. The CMHSP shall not deny the entire claim because 1 or more other services listed on the claim are defective.
4. The requirement of written notice can be met with a Remittance Advice that is sent to the provider with the payment of other claimed amounts that indicates the denied claim and its denial reason.
5. If the claim is denied, a letter must be sent with the returned claim. The provider has 45 days from the date the notice is received to correct the defects and ensure the information is received by the CMHSP.
6. If the claim is made clean, the CMHSP will have 45 days from the receipt of the additional information to finalize the claim.
7. If the claim is not made clean, the CMHSP will have 45 days to advise the provider of the adverse determination.
8. Interest Due for Late Claims Payments
9. Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute.
10. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.
11. The interest shall be paid in addition to and at the time of payment of the claim.
12. A civil fine can be imposed of not more than $1,000 per violation for failing to pay claims timely. The aggregate fine for multiple violations will not exceed $10,000.
13. Assessment of a civil fine does not preclude a health professional or facility from seeking court action.

**Paper Claims Standards and Guidelines**

1. Paper claim submissions have separate and more stringent internal controls necessary to maintain proofs of meeting claims standards and for external audit purposes which cannot be proven in any electronic format. *(See Appendix A)*
   1. Claims are considered “received” on the date delivered by the postal service, email, or other carrier.
   2. Claims mail must be date stamped on the face of the claim with the date received or if the envelope is date stamped, the envelope must be attached to the claim.
   3. Un-entered claims should be kept in a secure location.
   4. Original claim documents are filed by provider.
   5. All claims for which SWMBH or WBHN has a real or purported accountability will be entered into VieWPoint.
   6. Staff will enter all data as it appears on the claim form.
   7. Claims Management is responsible for ensuring appropriate Medicaid eligibility exists within the system and for verifying and accounting for any third-party liability.
2. Confidentiality of Claim Documents
   1. Claim documents must not be left on desk surfaces and in open areas accessible by customers, visitors or staff members not involved in the processing of the claim.
   2. Claim documents should be kept secured when not being worked/used.
   3. The Health Insurance Portability and Accountability Act (HIPAA) require that all personal health information be protected and kept confidential. The contents of 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.

Appendix A:

**Paper Claims Process**

1. Paper claim is received by accounting clerk via fax/mail and date stamped with the present date. The paper claim will then be routed to the claims processor for data entry.
2. For Institutional Claims, the following information will be entered within the appropriate screens in the Claims System:
3. Select: Claim Management (AP)
4. Select: (1) Claim Entry – Enter Paper Claims for Provider
5. Select: Provider
6. Select: Consumer Authorization
7. From Date
8. To Date
9. Patient Account Information/Revenue Code
10. Place of Service
11. Units
12. Total Charge Amount
13. Diagnosis Codes
    1. Principle diagnosis code
    2. Admitting diagnosis code
14. Third Party Payor Information (if applicable)
    1. Total prior paid amount
    2. Co-Insurance amount
15. For Professional Claims (i.e., HCFA 1500), enter the following information:
16. Select: Claim Management (AP)
17. Select: (1) Claim Entry – Enter Paper Claims for Provider
18. Select: Provider
19. Select: Consumer Authorization
20. Diagnosis Codes
21. From Date
22. To Date
23. Procedure Code
24. Place of Service
25. Charges
26. Units
27. Time of Service (if applicable)
28. Rendering Provider (if applicable)
29. Process adjudication report.
30. Check/resolve errors.
31. No errors, select: (2) Send Batch of Entered Claims for Processing
    1. Select “send for adjudication” under batch
32. Allow claim to adjudicate through system to hit appropriate edits (i.e. State Medicaid Specific edits, NCCI, coding edits)

1. Once claim has adjudicated to end, claim will be saved in claims system and remittance advice/EOB/check will be issued within 30 days of a clean claim date.

Definitions

1. Adjudicate

The progression of claims going through the payment process.

1. Claim

A provider submitted record, representing an episode of care provided, utilizing the approved form(s) and correct coding.

1. Data Entry

The process of manually entering data from paper claims into the claims processing system.

1. Provider

Any individual or entity furnishing Medicaid Services under a provider agreement with the Medicaid Agency.