8.02 OPERATING POLICY & PROCEDURE

Subject: **Claims Management**		Application: **All Departments**
First Effective 4/30/14	Revised 2/1/2023	Review 2/1/2023

PURPOSE

To communicate the claims management policy, procedures and standards.

POLICY

It is the policy of Pivotal 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 in regards to processing of Medicaid claims.

PROCEDURE

A. All Pivotal 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.

B. Pivotal 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.

C. All claims shall be filed using the current Pivotal JOE-E system unless provider is granted a waiver to submit claims via paper method.

D. Pivotal shall ensure that all Pivotal contract providers are kept informed of all necessary information regarding claims policies and procedures on a timely basis.

E. Providers have the right to appeal adverse actions taken by Pivotal. Generally the reconsideration process can be either an “appeal” or a “claim dispute”. Customer rights regarding appeals and grievances will be afforded via the Customer Service policies and procedures (Pivotal Policy 2.02.)

F. Pivotal 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.

G. SWMBH or Pivotal shall not require any co-payments, deductibles or any other cost sharing arrangements by enrollees of Medicaid or the Medicare/Medicaid duals demonstration project.
H. When Pivotal receives a claim as a secondary payer, a valid EOB must be attached from the primary payer.

CLAIMS ADJUDICATION STANDARDS

A. Adjudication rules and edits

The system will compare the following data elements of the claim to system information or logic:

1. Compares the CPT code billed to the care authorized
2. Compares the date of service to authorization effective and termination dates
3. Validates insurance coverage was in effect for each date of service
4. Searches for other insurance information
5. Searches for duplicate claim lines.
6. Validates that the service was covered in the provider agreement for the date of service billed
7. Validates the provider's current rate and the number of units authorized.
8. Paper claims will receive an EOB with their check.

B. Participant Responsibility

1. Pivotal will perform batch adjudication on a timely basis.
2. Claims that are denied or only partially approved will be returned to the provider through the JOE-E system for correction. Pivotal 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 JOE-E system at any time.

C. Explanation of Benefits

Pivotal will ensure that an Explanation of Benefits (EOB) is mailed to a minimum of 5% of the Medicaid Consumers served by Pivotal annually.

CLAIMS OVERPAYMENT AND REFUND STANDARDS AND GUIDELINES

A. Reasons for Overpayments

There are numerous reasons why claim payments can be overpaid. The most common:

1. Claim was overpaid due to processing error, such as entering the wrong number of units.

2. Claim was paid twice. Duplicate payment was not identified by the system.
3. Provider received payment from another carrier or Medicare is primary.
4. The incorrect provider was selected in processing the claim.
5. 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.
6. There may be an error in the member's benefit eligibility allowing claims to pay that should not.
7. Other human error.

B. Notification/Review Process

Claims Management will coordinate the review and recovery of overpaid claims. This individual will:

1. 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.

2. Review the claim for processing accuracy.

   a. 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.

   b. Correct the claim in JOE-E and determine if the overpayment can be recovered through offset.

3. Offsetting Future Claims Payments

   a. 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.

   b. If the overpayment can be collected through offset, correct the claim in JOE-E and notify provider that the claim should be denied with reason provided.

   c. CMHSAS-SJC will ensure proper communication to Pivotal providers. If the provider remittance advice generated from JOE-E will not fully explain the reason for offset, the provider must be contacted. Record should be kept to support how this notification occurred.

C. Refund Checks

1. If the overpayment cannot be collected through offset, the CMHSAS-SJC 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.
2. Allow 30 days for the refund to be received.
3. If payment is not received in 30 days, generate a “Second Request” in writing.
4. If payment is not received in 60 days, place a phone call to establish a date for refund or resolve any disputes. Additionally, a letter will be sent informing the provider of Notice of Funds not received. Letter will be copied and supplied to Corporate Compliance for additional follow up.
5. If provider refuses to refund monies due to CMHSAS-SJC further action may be taken including contract termination, civil suit and/or reporting of provider to the Michigan Office of the Medicaid Inspector General.

D. Security of “Live” (Negotiable) Checks

1. 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 JOE-E 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.
2. 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 JOE-E to ensure future checks are not returned.

E. Claim Denial

a. Pivotal will determine if the patient on claim is eligible by reviewing the client file. The following information will be reviewed:

    i. The contract associated with clients place of service
    ii. The dates in which a claim was filed.
    iii. The dates authorized for client
    iv. The insurance coverage for client

b. 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.

c. A notice will be sent to claim issuer utilizing form 08.02A Claims Denial Letter. The form will then be filled out, and scanned into the computer system under the “S Drive” – “Finance” – Claim Denials.

d. 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.

e. 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.

f. 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.

g. Claims Management will review all information submitted and determine if the original denial should be overturned in their opinion..

h. 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

A. Acceptable standard billing formats

1. HIPAA 837 File Format

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

2. Provider Access for Claim Entry

Providers utilizing this system must obtain user names and passwords to the system from Techsupport@stjoecmh.org. JOE-E 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 COMMUNICATION STANDARDS

A. Pivotal 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.

1. Address to file claims (both electronic and paper)
2. Telephone contact numbers
3. Information that must be contained in a claim in order for it to be considered “clean”
4. Acceptable standard billing formats
5. Dates by which claims must be filed to be considered for payment
6. Process for appealing a denied claim
7. Names and addresses of delegated claims processors

B. 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 REGULATION STANDARDS AND GUIDELINES

A. Clean Claims

1. Clean claims are defined by Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 (14) as claims that do all of the following:
2. Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
3. Sufficiently identifies the patient and CMHSP subscriber.
4. Lists the date and place of service.
5. Is billing for covered services for an eligible individual.
6. If necessary, substantiates the medical necessity and appropriateness of the service provided.
7. If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
8. Identifies the service rendered using a generally accepted system of procedure or service coding.
9. Includes additional documentation based upon services rendered as reasonably required by the CMHSP.

B. Requesting Missing Information

1. 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.

2. The CMHSP shall not deny the entire claim because 1 or more other services listed on the claim are defective.

3. 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.

4. 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.

5. If the claim is made clean, the CMHSP will have 45 days from the receipt of the additional information to finalize the claim.

6. If the claim is not made clean, the CMHSP will have 45 days to advise the provider of the adverse determination.

C. Interest Due for Late Claims Payments

1. Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute.

2. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.

3. The interest shall be paid *in addition to* and *at the time of payment* of the claim.

4. 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.

5. Assessment of a civil fine does not preclude a health professional or facility from seeking court action.

PAPER CLAIMS STANDARDS AND GUIDELINES

A. 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.

1. Claims are considered “received” on the date delivered by the postal service 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 Pivotal has a real or purported accountability will be entered into JOE-E.

6. Staff will enter all data as it appears on the claim form without alteration.

7. Claims Management is responsible for ensuring appropriate Medicaid eligibility exists within the system and for verifying and accounting for any third party liability.

B. 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.

ENROLLEE COST SHARING PROHIBITION STANDARDS AND GUIDELINES FOR DUAL ELIGIBLE PROJECT

A. Refer to SWMBH policy 9.8 on "Enrollee Cost Sharing Prohibition" to ensure the most current communication on this subject matter.

REFERENCES

A. The Health Insurance Portability and Accountability Act (HIPAA) Michigan Mental Health Code

B. Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 Social Security Act 1902 (a) (37)(A)

C. Southwest Michigan Behavioral Health Policy
- 9.1 (Claims Adjudication)
- 9.2 (Claims Overpayment and Refunds)
- 9.3 (Electronic Claims Submission)
- 9.4 (Provider Communication – Claims)
- 9.5 (Provider Claims and Grievances and Appeals)
- 9.6 (State Regulations)
- 9.7 (Paper Claims Control)
- 9.11 (Claim Denials)

EXHIBIT

08.02a- 08.02A Claims Denial Letter.