BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: Claims Adjudication	SECTION: 07-11-04 Page 1 of 3
APPLICATIONS: Internal MCO EFFECTIVE DATE: October 2016 APPROVED BY: Chief Executive Officer REVISED: 3/18, 3/19, 2/2020 5/2021, 2/2022, 2/2023, 2/2024, 6/2025, 2/2026	REQUIRED BY: MDHHS SWMBH 9.01 and 9.07

PURPOSE

To articulate BMHA standards regarding Claims Adjudication.

POLICY

Berrien Mental Health Authority (BMHA) will adjudicate all claims based on specified requirements while adhering to business industry standards surrounding claims processing.

STANDARD

A. Adjudication rules and edits:

IRIS, BMHA's electronic health record and claims adjudication system will at a minimum compare the following data elements of the claim to system information or logic:

1. Compares the HCPCS and CPT code billed to the care authorized.
2. Compares the date of service to authorization effective and termination dates.
3. Validates eligible coverage was in effect for each date of service.
4. Searches for other insurance information.
5. Searches for duplicate and conflicting 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 for a particular consumer.
8. Validates the claimed amount against the agreement amount field if a maximum agreement amount for a provider agreement is entered.
9. Validates the service was submitted within the time frame allowed per individual provider contracts.
10. Validates the service does not exceed the frequency allowed if such is specified in the contract.
11. Ensures claims for secondary processing have primary payment and co-insurance information entered from an Explanation of Benefits (EOB).

B. Timely Payment of Medicaid Claims – Payment shall be made to providers within 30 days of receipt of a "clean claim". 99% of claims meeting the definition shall be paid within 90 days of receipt.

C. BMHA Responsibility

1. Claims Specialist will perform batch adjudication on a timely basis
2. Clean claims that are denied or only partially approved will be clearly marked along with the reason for the denial or partial approval.
3. Ensure that denial and partially approved notification are sent to consumers and external providers in accordance with policy External Professional Claims Payment and Appeal Process 07-80-01 within thirty (30) days of denial (zero paid status) or partially approved (partially paid) status. Only those providers who have received a waiver to submit paper claims will receive paper explanation of payment or letter of denial. All other denials/approvals and claim status may be found within IRIS by the provider.
4. In the event a Medicaid or Healthy Michigan Plan clean claim is denied from a contracted or non-contracted provider, the Claims Specialist will notify Customer Service and Medical Records per procedure 07-07-01 Denial Notification Procedure.

D. Pended Claims

Claims may pend in IRIS during the adjudication process for the following reasons:
1. Member has a primary insurer who may be liable for all or part of claimed amount.
2. Member has Medicaid "pending" status in system.
3. Member has no Medicaid coverage and General Fund coverage is being determined.
4. Conflicting service previously claimed on this date of service
5. Clean claims that are in the same Batch as claim(s) that are duplicate or conflicting will be pended until the conflict is resolved. See Procedure 07-80-01
6. Claims with pending status, 30 days' post adjudication shall be denied as a matter of course if the claim cannot be approved due to missing information or authorization.

E. Explanation of Benefits (EOB)

1. EOB will be required for all claims where the consumer has a primary insurance carrier.
2. BMHA will determine secondary insurance responsibility, and a letter will be sent to the Provider informing them of payment or denial.

F. BMHA Explanation of Benefits (EOB)

BMHA's Reimbursement Office will ensure that an EOB is mailed annually by following the process below:

1. The "AP Claim Detail Report", which is found under the "Reports and Downloads" banner will be generated using the date range of 10/1 - 9/30 of the previous year.
2. The report will be filtered by funding sources MHCW, MHHMP, MHMA, MHSEDW, MHHMPC, MHHSW, and MHMAC.
3. A sample size equalling a minimum of 10% of the resulting list will be chosen to be issued EOBs.
4. The case numbers will be entered into the "History of Consumer EOB/Summary of Services Reports" module, which will produce the EOBs that will be sent to the consumers.

Reviewer: Director of Provider Network and Chief Financial Officer

Reviewed: 2/17, 3/18, 3/19, 2/2020, 5/2021, 2/2022, 2/2023, 2/2024, 6/2025, 2/2026