BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: External Professional Claims Payment & Appeal Process	SECTION: 07-80-01 Page 1 of 10
APPLICATIONS: Accounting Department, Reimbursement Office, Internal MCO EFFECTIVE DATE: 04/01/03 APPROVED BY: Chief Executive Officer REVISED: 2/05, 4/07, 8/07, 9/09, 10/09, 9/10, 2/11, 5/11, 2/12, 3/12, 7/13, 4/16, 9/16, 12/16, 2/17, 6/17, 3/18, 3/19, 4/19, 2/2020, 2/2022, 2/2023, 2/2024 6/2025, 2/2026	REQUIRED BY: MDHHS Contract SWMBH Contract SWMBH Policies: 9.05, 9.06 and 9.07

PURPOSE: To ensure a timely claims reimbursement process for authorized health care services. Professional external claims must be received/submitted within the contractual time limit specified by each provider's contract from the Date of Service in order to be considered for payment. All professional external claims that meet the "Clean Claim" criteria shall be reimbursed within thirty (30) days of receipt.

POLICY: It is the policy of the Berrien Mental Health Authority (BMHA) that a claims system shall be developed and maintained for the purpose of paying professional external claims. And shall adhere to federal and state regulations regarding the processing of claims for payments of services to consumers.

DEFINITIONS:

Adjudicate: is a word used in the insurance industry to refer to the process of paying claims submitted or denying them after comparing claims to the benefit or coverage requirements.

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

Clean Claim: A clean claim is defined by the Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006(14) and must meet <u>all</u> the following criteria:

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

COB: Coordination of Benefits is part of the insurance payment process for when more than one insurance plan potentially covers the service provided.

Forms: Providers who have been approved to submit paper claim forms may use HCFA-1500 or another BMHA approved format.

HIPAA 837: File format established to meet HIPAA requirements for the electronic submission of healthcare claim information.

IRIS: Integrated Records Information Source. Berrien Mental Health Authority's electronic health and billing system

PCE: Peter Chang Enterprises is a software vendor BMHA contracts with for its electronic health and billing system.

Provider: An individual or entity furnishing Medicaid services under a provider agreement with a Medicaid agency.

SAL: Service Activity Log. It contains service time, reporting unit, attendance, CPT code, etc. for internal BMHA services.

PROCEDURE(S):

I. General Requirements:

A clean claim meets all the following criteria:

1. The services that constitute the claim have been authorized.
2. The services have been provided and properly documented (including accurate start and stop times when required by code) according to source document requirements.
3. The services must be reimbursable as defined in the master contract between BMHA and the provider.
4. Diagnoses, universal codes, and any relevant modifiers identifying the number and type of service or treatment provided are included as required by contract.
5. All data elements required contractually are complete for the consumer.
6. Ensures claims for secondary processing have COB information entered from an Explanation of Benefits (EOB) and include the EOB. EOBs must be sent via fax, secure email, or first-class mail to BMHA.
7. The claim has been received by BMHA within the filing limit identified within the Provider's contract.
8. Secondary claims need to be received by BMHA within the time identified in the Provider's contract with BMHA. Using the date of the primary insurance EOB adjudication date.

9. The service for a consumer cannot overlap with another provider for the same date/time of service unless permissible by the service code.

II. Acceptable Standard Billing Formats:

A. IRIS – Direct Entry Electronic Claims Submission

1. Providers utilizing IRIS system must attend a BMHA sponsored training or be approved by the Director of Provider Network (or designee) before usernames and passwords will be provided to access the system. A written request must be sent by the billing staff member's supervisor to the Internal MCO Department utilizing the BMHA form.

2. All claims must be submitted into IRIS within the contractual filing limit set forth in the Provider's contract from the Date of Service or adjudication date if a COB claim.

3. IRIS requires the following steps in submitting the electronic claim(s) form:
   a. Go to Claims Management Menu

   b. Select (1) Claims Entry
      - Select your Provider location. If you have more than one site, you will bill according to each location e.g.) Provider A has AFC homes 1, 2 and 3. If you are billing for John Doe who lives in home 2, you will select home 2's address.
      - Enter consumer name or case number and select "search for consumer"
      - Select "Enter HCFA-1500" on the authorization for the claim to be billed.
      - Claim Batch will permit you to either enter a "new batch" or continue with a "batch" previously entered in the system but not yet submitted for BMHA review. The existing batch may include claims for other consumers. Batch numbers are automatically assigned by IRIS when data is entered and saved.
      - Consumer's name, date of birth, sex, address, and diagnosis will prefill.
      - BMHA Authorized service procedure code(s) and any required modifiers will prefill in the electronic form for use

   c. Provider must enter the following:
      - Date(s) of Service – this may be entered as a single day or as a range of days
      - Procedure Code and modifiers (if relevant)
      - Place of Service (POS) codes (a list of codes is available by selecting the "?" on the screen)
      - Start and Stop time of service will be required for certain codes that are time based
      - Charges or per unit rate for services rendered by provider
      - Number of units used
      - Coordination of Benefits (if applicable)
      - Rendering provider name and NPI number (if applicable)
      - Provider name and address will prefill on the form
      - Comments may be made by the provider on the bottom of the form.

d. Once completed, save your work

e. Select (2) Claims Batch List
- When the claims list comes up there are several choices 1) view 2) adjudicate 3) submit claims or 4) view batch information.
- Provider must "adjudicate the claims" prior to submitting to BMHA. This action will create a report which will show the number of claims, payment information and any errors that should be corrected prior to submission to BMHA.
- After the adjudication report is reviewed and errors are fixed by the provider, the provider may select "Submit Claims for Adjudication." This will send the batch to BMHA for review and start the claims process.

4. IRIS contains a HELP button at the top of the home page containing reference materials for provider use.

B. HIPAA 837 File Format

1. Providers who wish to utilize this format may do so by first coordinating with BMHA (Director of Provider Network) and PCE to ensure the format is compatible with IRIS and BMHA requirements.

2. Providers must provide, upon request, a copy of the fully executed Business Associate Agreement the Provider has with their software vendor.

3. Once formatting has been approved and a test file has been successfully completed the Provider may directly submit claims to BMHA via HIPAA 837 upload in IRIS.

4. All claims must be submitted within the contractual filing limit set forth in the provider's contract from the Date of Service (regardless of testing stage).

5. Once a file is submitted, an adjudication report must be run, and any corrections should be made prior to being submitted to BMHA for Adjudication and payment.

C. Paper Claims

1. Only providers who are afforded a waiver by BMHA as outlined in the Waiver of Electronic Submission Procedure (07-11-06) will be allowed to submit claims via paper format.

2. All paper claims must be submitted on an original HCFA 1500 claim form or other approved format.

3. There will no deviation from this requirement unless the Provider obtains written permission from SWMBH.

4. The following claim fields are required on a HCFA 1500:

a) Consumer Name, Date of Birth, and Address
b) Medicaid ID number
c) Diagnosis
d) Dates of service
e) Place of Service
f) Procedure code and modifiers
g) Total Units/Days
h) Total Charges
i) Rendering Provider and NPI number
j) Insurer
k) Any third-party COB information (if applicable)
l) Provider name and NPI number

5. Documentation of start and stop times must be included on the paper claim form or on an additional sheet for procedure codes requiring it.

6. Paper claims should be submitted to:

Berrien Mental Health Authority
Attention: External Claims
P.O. Box 547
Benton Harbor, MI 49023

7. Should BMHA's address change, BMHA will provide 30 days written notice to all providers. Providers should give BMHA at least 30 days written notice of all address or business information changes. Failure to provide such notice could result in delayed or no claims payment.

III. Claims Processing

A. All claims will be processed through IRIS and providers will have access to track claims and view payment history if providers submit electronic claims. If providers submit paper claims, a remittance advice will be sent with all checks.

B. Each external claim submitted for payment is a "clean claim" when it meets the clean claim criteria listed above. The claims payment system will be utilized to confirm that claims are reimbursed within 30 days of receipt of a clean claim.

C. BMHA's Claims Specialist will adjudicate the claim(s) received electronically and will either approve the claim(s) based on the adjudication report or will return the claim(s) to the provider for additional information or to be corrected.

1. BMHA's Claims Specialist will adjudicate the electronic claim(s) received and will either approve the claim(s) as submitted (a "clean claim") or pend the claim(s) for additional information/correction until the claim is considered to be a "clean claim".

2. BMHA's Claims Specialist will adjudicate the paper claim(s) received and will either approve the claim(s) as submitted (a "clean claim"), deny the claim and send a denial letter, or pend the claim for additional information until the claim(s) are considered to be a "clean claim".

D. Once the claim(s) are adjudicated and approved by the Claims Specialist, they will be forwarded to the Chief Financial Officer for review and approval. After they are approved, the claims will be submitted to Accounting for payment. If a claim is rejected by the Chief Financial Officer, it will be returned to the Claims Specialist for review, if needed. The Claims Specialist, the Chief Financial Officer and Accounting will work together to pay all clean claims within 30 days.

E. Providers who have claims within a batch that are not paid or are partially paid will receive notification within 30 days via the detailed Remittance Advice for each batch. If a check is not issued, they will receive a denial letter explaining the reason for denial. Claims Specialist will notify the Customer Services Representative per the Denial Notification procedure 07-07-01.

F. Providers, using the adjudication report, and the Claims Specialist, will work all denied claims to determine action needed pursuant to the following guidelines:

1. Authorized Units Exhausted – Provider issue. The Case Manager who is responsible for requesting authorization should be contacted if needed.
2. Unable to enter procedure code – BMHA or Provider issue. The Case Manager, who is responsible for requesting authorizations should be contacted to discuss this issue.
3. No contract exists – BMHA or Provider issue.
4. Claim received outside the contractual filing limit will not be considered for payment – Provider issue or BMHA issue.
5. Duplicate or Conflicting Claims – BMHA will work with Providers to resolve the issue.
6. Frequency exceeds contract rules – Provider issue.
7. Required credential modifier must be specified – Provider issue.
8. Contract rate is less than the claim amount – Provider issue or BMHA.
9. The rate associated with the authorization is $0.00 / $1.00 – BMHA issue.
10. Third-party COB –Provider issue.
11. Units billed does not match the time range specified – Provider issue.

G. Providers or Internal MCO staff may notify clinicians or supervisors regarding any missing authorizations or authorization corrections that need to be made.

H. Providers are encouraged to fix their claims issues and resubmit corrected claims to BMHA for adjudication within their contractual filing limit.

IV. Missing/Additional Information

A. Requesting Missing or Additional Information
   1. The Claims Specialist must advise the Provider what information is needed to complete the claim (i.e. – "make it clean"). The Notice must be in writing and must be issued within 30 days of receipt of the claim.

   2. BMHA shall not deny the entire claim because 1 or more other services listed on the claim are unable to be adjudicated.
   3. The requirement of a 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 reasons or a Remittance Advice that is accessible in IRIS – BMHA's claims payment system.

   4. If the claim is denied due to missing information, a letter must be sent with the returned paper claim. The Provider has 45 days from the date the notice is received to correct the defects and ensure the information is received by BMHA.

   5. If the claim is made clean, BMHA will have 45 days from the receipt of the additional information to finalize the claim. If the claim is not made clean, BMHA will have 45 days to advise the contracted and non-contracted Provider of the determination.

V. Overlapping / Duplication Error

A. IRIS will give an error "Duplicate and/or conflicting service previously claimed on this date of service." after the initial adjudication report is run. When this error comes up, Provider must check to be sure there are no data entry errors that need to be corrected. If there are errors, correct them and rerun the adjudication report. If this error still appears there are several steps that need to be followed to get this claim processed:

1. Provider's Responsibility:
   a. The adjudication report will list what is causing the error. EG.) "See claim # 00001" or "See SAL #00001". The Provider should verify that the error claim number is not one of their own claims. A SAL is an internal BMHA service that BMHA and provider will need to work together to resolve.
   b. If the error is with a SAL or a claim number that the provider cannot find as one of theirs, the errored claim line must be moved to a separate batch. Failure to move disputed claims will result in delays of all claims in the batch. The Provider submitting the error to BMHA, must verify the information they submitted is accurate according to their records. If there is more than one claim line with this error, they can all be put in the separate batch to be submitted to BMHA. If clinical documentation for the claim has not been submitted to BMHA already, it should be done at this time. Failure to submit clinical documentation will result in delays of all claims in the batch.

2. BMHA's Responsibility:
   a. BMHA staff will review relevant documentation from any claim lines or SALs involved to determine, based on MDHHS rules to make a determination on if the claim, or any part of it, is able to be paid.
   b. BMHA staff will contact any other Provider(s) whose claim(s) will be affected, to allow them time to verify their claim.

c. BMHA will notify all Providers involved of their determination and of any recoupments that will need to be made to ensure MDHHS rules are being followed.

3. Process timeline:
   a. Claim is submitted to BMHA, within their timely filing deadline
   b. BMHA has up to 30 days to contact any other Providers involved
   c. Providers contacted by BMHA must respond to claim verification inquiry within 45 days with any additional documentation requested.

4. BMHA will make a determination within 60 days of the original claim submission as long as all documentation has been received timely.

5. BMHA may need to consult MDHHS or SWMBH for guidance and/or clarification. This could delay the processing of the overlapping claim(s).

VI. Appeals

A. Providers may Appeal adverse decisions where they are being held financially responsible for charges based on the following issues:

   1. Services denied due to contract/benefit plan limitation
   2. Reduction, suspension, or denial provider payment
   3. Denied for failure to provide third party liability information
   4. Denied for member ineligibility
   5. Denied for delayed filing

B. Provider Claims Disputes - Providers may request that claims denied for administrative reasons be reconsidered. Some examples of these claims' denials are:
   1. Claim denied for member not eligible
   2. Claim denied for no contract
   3. Claim denied for no authorization
   4. Claim denied for missing information
   5. Claim denied for delayed filing
   6. Claim underpaid due to billing/processing error
   7. Disagreement regarding payment methodology

C. Notification of the right to appeal will be included in each Provider's contract.

D. All Provider appeals of claim payment should be made within 30 days of denial and will not be accepted after 180 days post denial date. Any claims denied beyond this timeframe are considered to have reached a final resolution.

E. If the claim could not be entered due to no authorizations, the Provider appeal of claim payment should be made 30 days within post service date. An appeal will not be accepted after 180 days post service date. Any claim beyond this timeframe is considered to have reached a FINAL resolution.

F. BMHA will respond to all written inquiries from providers questioning claim denials or methodology for payment calculation. Resolution of these inquiries should include:

1. Documentation of the issue in IRIS Notes.
2. Research to determine if re-processing is warranted due to error or additional information.
3. Identification and correction of eligibility and system issues.
4. Submission of requests to have claims corrected (where appropriate).
5. Involving provider relations, as needed, to resolve contractual issues and provide education.
6. Ensuring provider is advised of the outcome of the dispute.

G. Appeals must be sent to one of the following addresses:
1. By mail: Berrien Mental Health Authority, Attn: Claims Specialist/Appeal, PO Box 547, Benton Harbor, MI 49023
2. By Fax: (269) 934-3388 Attn: Claims Specialist/Appeal
3. By Email: Externalclaims@RiverwoodCenter.org
4. Subject Line: Appeal
5. Appeals may NOT be submitted via IRIS messaging

H. Appeals must include the following:
1. BMHA Dispute/Appeal Form
2. All documentation and correspondence that relates to the appeal/dispute
3. Contact information of Provider – name, address and phone number

I. The Director of Provider Network will review the information submitted and consult with other teams and/or clinical supervisors to assist with determination if needed. Within 10 days after a provider appeal request, a preliminary review of the claim and appeal details to determine if additional information from provider is required will be done by the Internal MCO Department. If additional information is required, the provider will be notified in writing of the request. Submission by the provider must be within 10 days of the request for more information.

J. The Director of Provider Network will notify the Provider of the decision, in writing, within thirty (30) days of the receipt of the Provider's Appeal and all requested information. A copy of the determination letter will be placed in the Provider's file. All decisions are FINAL.

K. Claims submitted beyond three hundred and sixty-five (365) days post service date will not be considered for payment or appeal.

VII. Interest Due for Late Claims Payment

Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.

FORMS: BMHA Appeal Request Form (07-80-01 & 07-80-02)

Reviewer: Director of Provider Network & Chief Financial Officer

Reviewed: 8/07, 6/08, 9/09, 10/09, 7/10, 10/12, 7/13, 7/14, 7/15, 4/16, 9/16, 12/16, 2/17, 6/17, 3/18, 3/19, 4/19, 2/2020, 5/2021, 2/2022, 2/2023, 2/2024, 6/2025, 2/2026