BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: External Institutional Claims Payment & Appeal Process	SECTION: 07-80-02 Page 1 of 7
APPLICATIONS: Accounting Department, Reimbursement Office, Internal MCO, External Institutional Providers EFFECTIVE DATE: March 14, 2019 APPROVED BY: Chief Executive Officer REVISED: 4/19, 2/2020, 2/2022, 2/2023, 2/2024, 6/2025, 8/2026	REQUIRED BY: MDHHS Contract SWMBH Contract SWMBH Procedure 9.05, 9.06 and 9.07 MCL 500.2006

PURPOSE:

To ensure a timely claims reimbursement process for authorized health care services. Institutional external claims must be received/submitted within the contractual time limit specified by each provider's contract from the Date of Service to be considered for payment. All Institutional 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 Institutional external claims and shall adhere to state and federal 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 all 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. 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 information sufficient 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 must use the UB-04.

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 for its electronic health and billing system.

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

PROCEDURE(S):

1. General Requirements: The services that constitute the claim have been authorized.
2. The services have been provided and properly documented 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. All documentation must be received by the PIHP and BMHA.
7. Ensure claims for secondary processing have COB information entered from an Explanation of Benefits (EOB) i EOBs must be sent via fax, secure email or first-class mail to BMHA.
8. The claim has been received by BMHA within the filing limit identified within the Provider's contract.
9. 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.
10. 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 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.

   **NOTICE: For security and audit compliance, access to the EHR (IRIS) will only be granted to individually assigned email addresses; requests using share, group, or mailing list addresses will be denied without exception.

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 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 hospitals in 3 different locations. If you are billing for John Doe who was inpatient at hospital 2, you will select hospital 2's address location.
      - Enter consumer name or case number and select "search for consumer"
      - Select Enter UB-04 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. You will need to enter the diagnosis, and it must be a mental health diagnosis based on the prescreen authorization. Non-mental health diagnosis will be denied.
      - 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 to reference a claim correction or an audit finding correction

   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 submitted 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 or adjudication date if a COB is claimed.
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. (Hospitals and Crisis Residential providers are permitted to file paper claims).

2.All paper claims must be submitted on an original UB-04 claim form or other approved format.

3 The following claim fields are required on a UB-04:

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

4. Paper claims should be submitted to:

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

5. 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.

D. *Claims Processing*

1. A Remittance Advice will be sent with all checks if the provider submits paper claims.

2. Each external claim submitted for payment is considered to be 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.

3. BMHA's Claims Specialist will hold the paper claim(s) and send out a denial letter or pend the claim for additional information until the claim(s) are considered "clean".

   a. 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".
   b. 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".

4. 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 the Accounting Department 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, Chief Financial Officer and Accounting will work together to pay all clean claims within 30 days.

5. 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.

6. Providers or Internal MCO staff may notify SWMBH UM, clinicians or supervisors regarding any missing authorizations or authorization corrections.

E. ***Missing / Additional Information***

Requesting Missing and/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.
6. If the claim is not made clean BMHA will have 45 days to advise the contracted and non-contracted Provider of the determination.

III. ***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 to provider payment.
3. Denied for consumer ineligibility.
4. Denied for failure to provide third party liability information.
5. Denied for delayed filing.

B. Notification of the Right to Appeal will be included in each provider's contract.

C. 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 time frame are considered to have reached a FINAL resolution.

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

E. 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.

F. 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**: Externalprovider@RiverwoodCenter.org
      Subject Line: Appeal

   4. Appeals may NOT be submitted via IRIS messaging

G. 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, phone number

H. 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.

I. 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.

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

IV. 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 Claim Appeal Request Form 07-80-01 & 07-80-02

Reviewer: Director of Provider Network and Chief Financial Officer
Reviewed: 4/19, 2/2020, 5/2021, 2/2022, 2/2023, 2/2024, 6/2025