KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

ADMINISTRATIVE PROCEDURE 08.08

Subject: Claims Management	**Section:** Financial Management	
Applies To: ☒ KCMHSAS Staff ☒ KCMHSAS Contract Providers		**Page:** 1 of 7
Approved: (Jeff Patton, Chief Executive Officer)		
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PURPOSE

This policy and procedure outlines elements of the Kalamazoo Community Mental Health and Substance Abuse Services (KCMHSAS) claims management processes. Claims management includes processing, adjudicating and payment or denial of claims.

DEFINITIONS

Claims Adjustment Segment (CAS)
Segment of an 837 Claim that reveals payment activity of other payers.

Claims Processing
The function of claims submission, claims processing and payment for authorized services.

Claims Remittance Advice Report (RA)
The report that provides details of service activity and payment for a claims processing period.

Clean Claim
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:

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. Lists the data 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 service 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.

Covered Service
Services identified in the provider agreement (contract).

Healthcare Insurance and Portability and Accountability Act (HIPAA)
A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Additionally, it gives the Department of Health and Human Services (MDHHS) the authority to mandate the use of standards for the electronic exchange of health care data, requires the use of national identification systems for health care consumers, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable information. The transmission of information between two parties to carry out financial or administrative activities related to health care is referred to as a transaction. Transactions include data standards that are code sets and unique identifiers established for claims.

Pended Claim
A claim that must be held due to incorrect or incomplete information. This may include:
1. Authorization dates or units that do not match services.
2. Eligibility must be checked or updated.
3. Claim is absent mandated information.
4. Third party payor information has not been entered into the claim

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Primary Provider
The provider who has assumed the lead for consumer care. This position would typically fall to the support coordinator, wrap-around coordinator or the case manager. If an individual isn't receiving one of the fore-mentioned services, the clinician providing such services will be determined to be the primary provider. The Primary Provider is assigned through Access and the Person-Centered Planning process.

Receipt of a Claim
A claim will be classified as received when the claim is received in the USPS mail or on the date entered into the KCMHSAS Electronic Health Record system.

Third Party Liability (TPL)
TPL refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile

insurance and worker's compensation) or program (e.g., Medicaid, Medicare) that has liability for all or part of a recipient's covered benefit.

POLICY

I. KCMHSAS shall make timely payments to all providers for clean claims for services covered in the provider contract. This includes payment at 90% or higher of all clean claims from KCMHSAS provider network sub-contractors within 30 days of receipt, and at least 99% of all clean claims within 90 days of receipt, except services rendered under a sub-contract in which other timeliness standards have been specified and agreed to by both parties.

II. KCMHSAS shall have an effective provider appeal process to promptly and fairly resolve provider billing disputes.

STANDARDS

I. All payments for covered services will be reimbursed at the contractual rate or the rate submitted, whichever is less.

A. New providers will not be reimbursed until KCMHSAS is in receipt of a signed agreement.

B. Existing providers that have been provided with a mutually agreed upon successor agreement or amendment will be reimbursed at the rate(s) contained in the successor agreement or amendment according to the effective date(s) outlined in the documents provided. Failure to return either the successor agreement or amendment within 60 days will result in cessation of reimbursement until such time as the signed documents are received.

C. This requirement may be waived in unique situations. Waivers must be requested in writing. KCMHSAS will provide a written decision within 20 business days.

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

E. Clean claims from all other funding sources that is not paid within 45 days bears simple interest at a rate of 12% per annum.

II. Payment for claims is net of first and third-party fees, when applicable.

III. All claims must be received by KCMHSAS within 60 days of the date of service (except Borgess [365 days] and other hospitals [180 days]) in order to be considered for payment, unless otherwise noted on your specific contract. This expectation also applies to any claim needing coordination of benefits information to process. Claims that are series billed must be received within 60 days (except Borgess [365 days] and other hospitals

[180 days]) from the start day of claim line, not the end date of the claim. Claims received after this timeframe **will not** be considered for payment. Claims received within the 60-day (except Borgess [365 days] and other hospitals [180 days]) deadline and pended will be considered for payment for 365 days from the date of service. After the 365 days have passed, the service will be permanently denied and not available for correction or an appeal.

IV. All providers have the right to appeal denied/rejected claims. Denied claims can be reconsidered by initiating the Provider Grievance and Appeals procedure (see KCMHSAS policy 02.02 [Provider Grievance and Appeals (non-clinical)].

V. Claims cannot be submitted prior to date of service.

VI. Coordination of Benefits is the responsibility of the KCMHSAS provider.

VII. Explanation of Benefits will be generated and mailed to a minimum of 5% of individuals with Medicaid.

VIII. It is the responsibility of KCMHSAS and Southwest Michigan Behavioral Health PIHP to ensure their contracted network providers have access to the following information, either through their contract, Provider Manual or 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 denied claim
7. Names and addresses of delegated claims processors

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.

PROCEDURE

I. Claims processing

A. All provider claims will be filed electronically using the current KCMHSAS data layout and in accordance with HIPAA transaction standards. This requirement may be waived in unique situations. Waivers must be requested in writing to and approved by the KCMHSAS Reimbursement Manager. When this requirement is waived, the claims will be subject to a $2.00 per claim processing fee. State inpatient and certain hospitals are exempt from this requirement.

B. 837 providers can verify claims submission by using the 837 Import banner in Provider Access. This screen will tell providers the status of their import files, the total charges submitted, the number of claim lines submitted and the number of unprocessed claim lines submitted (number of claim lines submitted less the number of unprocessed claim lines submitted equals the number of claim lines accepted into the system). 837 providers are able to click into the unprocessed claims to get the error message as to why claims were not accepted. Providers then correct the errors until there are no more unprocessed claims remaining.

C. The claims runs are scheduled for every two weeks. You will find the Claims Run Schedule for the current calendar year on the KCMHSAS portal. The cutoff for claims submission for a run is typically on a Monday (see Claims Run Schedule for current Calendar year for which Monday and other days due to holidays). A claims run is finalized with the release of payment, either electronically or by check, on the Friday of the week following a claims run. For example, if the cutoff is Monday, April 10th, a claims run would occur on Wednesday, April 12th and the payment would be released to the providers on Friday, April 25th.

D. 837 providers are able to either generate a HIPAA compliant 835 file (use 835 File button) or a remittance advice (use Print RA button) through the Checks banner in Provider Access. Non 837 providers can access their remittance advice report via the Print RA button in the Checks banner of Provider Access. A remittance advice report will accompany all manual payments for those providers that have a waiver for electronic claim submission.

III. CLAIMS RECONSIDERATION

Providers (both 837 and non-837) will work their denied and pended claims (can use the To Be Worked filter or use individual Denied and Pended filters) in the Provider Access system. The provider will resolve any errors or omissions by reverting, updating the claim, marking the claim "To Re-Adjudicate" and unmarking the claim "Needs to be Worked".

IV. CONSUMER FEES

A. Determination of financial liability for each person served will be made using the KCMHSAS/Michigan Department Health and Human Services (MDHHS) policies and procedures. No individual will be refused mental health services because of an inability to pay. Individuals with Medicaid or Health Michigan will not be charged or billed by KCMHSAS or any of it's contracted provider network.

B. The primary providers are responsible for determining financial liability, the completion of the annual Ability to Pay (ATP) form and the collection of

applicable fees. Mental health related fees determined to be the responsibility of the person served would be automatically deducted from the first claims reimbursement due the provider until the monthly determined ATP is met.

C. KCMHSAS may retroactively adjust paid claims in the event a Fee Determination containing 1st party liability is completed and submitted by the provider.

D. The mental health primary provider is responsible for updating an individual's ATP annually. If this isn't done within 60 days from the ATP expiration date, KCMHSAS will assume the individual has a full ability to pay and will withhold all payments for services provided to that individual by the primary provider only. If the primary provider gets an ATP signed later than 60 days claims assessed at a full ability to pay will be re-assessed according to the new ATP.

E. Whenever an ATP is completed, a copy will be provided to the individual served.

All mental health ancillary providers are responsible for obtaining current ATP's from the primary provider.

V. COORDINATION OF BENEFITS

A. The provider must reference the ATP and comply with all TPL requirements before KCMHSAS can remit payment. Denial by the TPL due to non-compliance will result in a denial from KCMHSAS.

B. Claims paid by KCMHSAS and later determined to be covered by a TPL will be adjusted to reflect either the TPL payment or to retroactively deny and takeback a paid amount. Claims will then pend waiting for a TPL payment to be entered into the claim by the provider.

C. Mental health providers should electronically submit the Explanation of Benefit (EOB) decision from the individual's insurance regardless of decision in order to adjudicate claims where the TPL has been determined. All EOB's must be kept on file and accessible for review during an audit.

D. KCMHSAS payment liability for beneficiaries with private commercial insurance is the lesser of the beneficiary's liability (including co-insurance, co-payments, or deductibles), the provider's charge or the maximum fee screens, minus the insurance payments and contractual adjustments (a contractual adjustment is the amount established in an agreement with a TPL to accept payment for less than the charge amount).

E. Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment in full for services rendered. Neither the person receiving services nor

KCMHSAS has any financial liability in these situations.

REFERENCES

- Southwest Michigan Behavioral Health Policy
  - 9.1 (Claims Adjudication)
  - 9.3 (Electronic Claims Submission)
  - 9.4 (Provider Communication)
  - 9.6 (State Regulations)