SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

NUMBER: DA1022

NAME: CLAIMS PROCESSING AND PAYMENT PROCEDURE

INITIAL APPROVAL DATE:	03/20/2002	APPROVED BY: Administrative Comm.
(LAST) REVISION DATE:	08/24/2023	APPROVED BY: CFO
(LAST) REVIEW DATE:	10/17/2024	REVIEWED BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. **PURPOSE**

To establish a procedure for the uniform and timely processing and payment of claims.

II. **APPLICATION**

Populations: **NONE**
Programs: **Direct - NONE**
Contracted - ALL

III. **POLICY**

IV. **DEFINITIONS**

A. **Clean Claims** – A claim for behavioral health services that is completed in the format specified by the contract and that can be processed without obtaining additional information from the provider of service or a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

B. **Contract Management Department** – The assigned staff and/or provider responsible to conduct and coordinate the overall contract management process.

C. **Provider** – The individual, organization or entity providing services under the terms established by a contractual agreement with Sanilac CMH.

V. **STANDARDS**

A. All contracts for behavioral health services will set specific requirements for the timely submission of required documentation and billing of services (i.e. documentation is due according to Attachment B of the service contract, invoices due within 5 business days of month ending).

B. Upon receipt of the claim in OASIS, the Sanilac CMHA Billing Specialist will adjudicate the claim, verify that the appropriate documentation is available, and the dates and times are accurate with the service information entered into OASIS or submitted on a paper claim. If it is not, the claim may be returned to the provider for correction(s). Once through the adjudication process, the claim is finalized in OASIS. The claim information is scanned into a shared billing folder and a Purchase Requisition is submitted to the Finance Department for payment to the rendering provider.

C. Within 5 business days of receipt, invoices that are regarded as clean claims will be initialed by the staff member and sent to the Finance Department.

D. Within 5 business days of receipt, the Finance Department will review the claim for completeness and accuracy, and initial to authorize payment. At a minimum, checks are cut mid-month and at the end of the month. Clean claims will be paid in the next payment cycle.

E. Ninety percent of all clean claims will be processed and paid within 30 days of receipt, and ninety-nine percent within 90 days of receipt.

F. The Contract Management Department will monitor the submission and payment of contract provider claims in accordance with the Contract Management Policy and Procedures.

G. The Finance Department will monitor the timeliness of claims payment from receipt to payment.

VI. HOSPITAL CLAIMS

A. The Hospital will submit a UB-04 CMS 1450 or complete claim data entry into OASIS by the provider to Sanilac CMH within 60 days of discharge date for patients who have Medicaid or Healthy Michigan Plan eligibility at the date of admission and coordination of benefits is not applicable.

B. Sanilac CMH will not pay any claim if the "initial claim" is received by Sanilac CMH more than one year after the date of discharge. All claims for a given fiscal year must be received by Sanilac CMH by 10/31 following the end of the fiscal year; otherwise, payment will be denied. The Hospital will adhere to the billing limitations stated in the "General Information for Providers" chapter of the Medicaid Provider Manual.

C. Hospital bills will be routinely submitted within 60 days of the date of discharge for any payment consideration.

D. Sanilac CMH is the payer of last resort. The Hospital is required to take full advantage of the highest benefit coverage provided by the patient's third-party insurances and to comply with the requirements in the "Coordination of Benefits" chapter of the Medicaid Provider Manual. This includes, but is not limited to the following:

1. All services must be provided by staff persons who meet the credential requirements of the patient's third-party insurance.
2. The Hospital must obtain prior authorization from the patient's third-party insurance when required by the payer
3. The Hospital must forward evidence of accessing the third-party funds. The EOB (Explanation of Benefits) must be included when the hospital sends its claims to Sanilac CMH. A UB-04 CMS-1450 (or claim data entry into OASIS by the provider) with the other insurance's Explanation of Benefits/denial attached is required to be submitted to Sanilac CMH within 60 days of receipt of the Other Insurance's payment.
4. Sanilac CMH shall not be responsible for any costs of services which could have been covered by benefits for which the patient was eligible for through third-party payers. If the Hospital bills Sanilac CMH for services that should be covered by a third-party payer, Sanilac CMH will reach out to the provider to ensure that they are aware of the coverage and that they have relevant coordination of benefit information.

5. For services provided to all patients, the Hospital's maximum reimbursement shall not exceed the lesser of the third-party payer's maximum allowed amount or the Hospital's contract rate.
6. The Hospital will not charge the public system a higher rate for a service rendered to an individual than the lowest charge that would be made to others for the same or similar service to the general public or a similar segment of the population within the service area.

E. With regard to a hospital admission for an indigent patient (No Insurance Coverage or Ability to Pay), the Hospital agrees to:
    1. Assist the patient with completing a Medicaid application within 30 days of the date of admission. Hospital will comply with the Medicaid Application Filing Requirements. If patient is non-compliant, the Hospital will not be held responsible for the application. For any "Application for Health Coverage & Help Paying Cost" submitted to DHHS after the month of discharge, a Retroactive Medicaid application must also be completed online for the month of admission.
    2. Hospital will not bill the indigent patient. Sanilac CMH will follow-up with the patient after DHHS determination has been made regarding Medicaid eligibility if needed for payment of services.
    3. If a DHHS determination has not been made and received by the Hospital, an "initial claim" must be submitted to Sanilac CMH by the filing deadline to ensure payment to the hospital and to comply with the Medicaid guidelines should DHHS determine the patient to be Medicaid eligible retroactively. Such an "initial claim" will be submitted for activity purposes only, and will not be considered for payment until the claim is received with the determined DHS form 1150 (Application Eligibility Notice) attached, along with documentation that the Hospital completed the Admission/Enrollment and Discharge/Disenrollment information in CHAMPS in a timely manner. The "initial claim" will be denied until the claim is received with the above-mentioned documentation.

F. The Hospital shall provide Sanilac CMH's Access Unit with patient discharge information prior to submitting a claim to Sanilac CMH.
    1. Once a claim is received and keyed into OASIS, if it indicates the discharge information is missing, Sanilac CMH will deny payment at that time, will notify the Hospital within 3 business days by phone of the missing discharge information and send a denial Explanation of Benefits to the Hospital.
    2. Claims denied for missing discharge information will not be reprocessed for payment until the Hospital has given the discharge information to Sanilac CMH's Access Unit.
    3. Hospitals should notify Sanilac CMH's hospital claims processor after the discharge information has been provided to the Access Unit so that the claim can be reprocessed.
        a. The date Sanilac CMH receives the discharge information shall be considered the initial date the claim was received by Sanilac CMH for purposes of deducting a prompt-pay discount, if applicable to the contract.
        b. If Sanilac CMH fails to notify the Hospital of the missing discharge information by phone, within three business days of receiving and keying in the initial claim, the initial claim date will be considered the initial date the claim was received by Sanilac CMH for purposes of deducting a prompt-pay discount, regardless of the missing discharge information.

G. Sanilac CMH will pay the Hospital within 45 days of receipt of clean claims.

H. The Hospital will not be reimbursed for any services that Sanilac CMH has not authorized. Authorization of a service is not a guarantee of payment. Services are authorized based on information provided to Sanilac CMH by the individual or the Hospital. If information is received subsequent to service authorization that is material in nature and which could have resulted in services originally being denied, service authorization may be voided.

I. Liability for Payment: Hospital may not bill individuals for the difference between the Hospital's charge and Sanilac CMH's payment for services. Hospital shall not seek nor accept additional supplemental payment for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if Sanilac CMH provided the services directly.

J. Sanilac CMH shall not be responsible for any costs of services which could reasonably be covered by benefits for which the individual was eligible or could be billable to third-party payer. The Hospital shall seek out all third-party reimbursement. Sanilac CMH is the payer of last resort.

VII. ATTACHMENTS

VIII. REFERENCES

Contract Management Policies and Procedures