SWMBH Operating Policy 9.11

Subject: Claim Denials Due to Member Coverage	**Accountability:** Operations/Claims	**Effective Date:** 06/19/2015	Pages: 2
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** Section 7.7 **NCQA/URAC Standard** _____ **Other** • Michigan Three Way Contract; Section 2.3-Eligibility and Enrollment Responsibilities • Meridian-SWMBH Agreements; Section 2.7; Claims Payment Administration • Aetna-SWMBH 2nd Amended and Restated PIHP Contract; Payment Administration Section; 2.6.10		Last Reviewed Date: 11/16/17	Past Reviewed Dates: 6/19/15 9/7/16
LINE OF BUSINESS: ☒ Specialty Waiver (B/C) ☒ 1115 Waiver ☒ Healthy Michigan ☒ SUD Medicaid ☐ SUD Block Grant ☒ MI Health Link ☐ OTHER: ____	**APPLICATION:** ☒ SWMBH Staff and Ops ☒ Participant CMHSPs ☐ SUD Providers ☐ MH / DD providers ☐ Other:_____	Last Revised Date: 9/7/16	Past Revised Dates:
Approved : Anne Wickham Date: 11/29/17		Required Reviewer: Director of Operations	

I. Purpose

To verify patient eligibility and process claims according to patient's eligibility status.

II. Policy

In accordance with the agreement(s), Southwest Michigan Behavioral Health (SWMBH) will utilize the appropriate Management Information Services (MIS) and Benefit enrollment files to properly deny any claims associated with customers who are not eligible for benefits/coverage. Also, SWMBH will not deny covered services to eligible enrollees if the eligibility ended prior to the last daythe month, as services are eligible to be reimbursed through end of the month.

III. Standards and Guidelines

A. SWMBH will ensure that MIS and practices have the capacity to ensure that the obligations of the agreements are fulfilled. The MIS will have the following capabilities:

1. Monthly downloads of Medicaid eligible information
2. Individual registration and demographic information
3. Provider enrollments
4. Third party liability
5. Tracking and analyzing services and costs by population group, and special needs categories as specified by Michigan Department of Health and Human Services (MDHHS).

B. SWMBH will determine if the patient on claim is eligible by reviewing the Benefit Enrollment and Maintenance (834) and Payment Order Remittance advice (820) reconciliation files as the primary source for eligibility determination for Prepaid Inpatient Health Plan (PIHP) functions. The following information will be checked/verified:
   1. Patient/Enrollee coverage type
   2. Date the Enrollee's coverage begins
   3. Date the Enrollee's coverage ends (Note: Any individual enrolled in the Demonstration where coverage ended during the month will still have claims processed/paid to the end of calendar month.

C. If patient on claim is eligible for coverage, claim will adjudicate accordingly. If coverage ended on a month prior to the current month of claim, the claim will be denied.

D. Remittance Advice/Explanation of Benefits will be issued indicating final claim disposition.

IV. Definitions

A. Enrollee: an individual enrolled in an Integrated Care Organization (ICO) participating in the Demonstration, including the duration of any month in which his/her eligibility for the Demonstration ends or any Medicaid only covered eligible individual.

V. References

None

VI. Attachments

None