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POLICY

Southwest Michigan Behavioral Health (SWMBH) will process, adjudicate, and pay all claims in accordance with applicable state and federal requirements while adhering to business industry standards surrounding claims processing. SWMBH shall ensure that all contract providers are kept informed of claims policies and procedures; that Medicaid and Healthy Michigan Plan enrollees are protected from cost sharing obligations; that claims are properly reviewed for member eligibility; and that providers have access to fair and prompt resolution of claims-related disputes.

PURPOSE

To articulate SWMBH standards governing all aspects of claims management including adjudication, submission methods, provider communication, provider appeals and grievances, state and federal regulatory compliance, paper claim processing controls, enrollee cost sharing prohibition, denial notifications, and member plan coverage eligibility determination.

SCOPE

Finance & Operations

RESPONSIBILITIES

Claims processors; Customer Services Specialists; Provider Network Management; Program Integrity/Compliance

DEFINITIONS

Clean Claim: A claim submitted with all data elements necessary for SWMBH or the Participant CMHSP to process the claim, including: the correct date and place of service; billing for covered



services for an eligible individual; substantiation of medical necessity if required; prior authorization information if required; identification of the service using a generally accepted procedure or service coding system; and any additional documentation reasonably required by SWMBH.

MCIS / SmartCare: Managed Care Information System; the claims processing and information system used by SWMBH.

Adverse Benefit Determination (ABD): A denial or limited authorization of a requested service, including a denial based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

STANDARDS AND GUIDELINES

A. Member Plan Coverage and Eligibility Determination

1. Management Information System Capabilities

SWMBH, its Participant CMHSPs, and Providers will ensure that the Management Information System (MIS/MCIS) maintains the following capabilities:

- Monthly downloads of Medicaid eligibility information
- Individual registration and demographic information
- Provider enrollment data
- Third Party Liability (TPL) activity tracking
- Claims payment system and tracking
- Encounter data collection, maintenance, and submission in standardized ASC X12N 837 format as required by 42 CFR 438.242 *[REVISED]*
- Grievance, appeal, and disenrollment tracking *[REVISED]*
- Quality indicator reporting and HIPAA compliance *[REVISED]*

2. Eligibility Verification

SWMBH, its Participants, and Providers will determine client eligibility by reviewing the Benefit Enrollment and Maintenance (834) files, uploaded to the SWMBH system nightly, or by querying MDHHS CHAMPS through 270/271 data transfer. The following shall be checked and verified:

- Client coverage type
- Date the client's coverage begins and ends
- Third Party Coverage availability

3. SUD Block Grant Clients

SUD clients not eligible for Medicaid coverage are eligible for the SUD Block Grant. The appropriate county-specific Block Grant will be entered as the benefit plan and an Ability to Pay (ATP) determination will be completed.



B. Claims Submission Methods

1. HIPAA 837 Electronic Claims Submission

SWMBH accepts HIPAA-compliant 837 electronic claim transactions. Providers may submit electronically through the following methods:

- HIPAA 837 Clearinghouse (Availity, LLC): Primary clearinghouse. Payer keys: A3268 (SWMBH MH); A4585 (SWMBH SUD).
- Providers using their own clearinghouse should contact providersupport@swmbh.org for specification and testing information.
- SmartCare (MCIS) System: Manual direct upload. Staff must complete SWMBH-sponsored training before obtaining system credentials

2. Paper Claims

Paper claim submission is limited to providers who have received a written waiver from SWMBH. Once a provider has established a clearinghouse relationship with Availity, LLC, paper claims will no longer be accepted absent a special exception. See Section E for paper claim entry procedures.

3. Direct Data Entry

SWMBH will provide user credentials to provider billing staff to allow for direct data entry of billable claims to the SWMBH Smartcare system. Claims may be directly entered into the system on a line by line basis utilizing the professional or institutional format.

C. Provider Communication

1. Required Provider Information

Each Participant CMHSP and SWMBH must ensure contracted network providers have access to the following through the provider contract, Provider Manual, or other documentation:

- Claims filing addresses (electronic and paper)
- Telephone contact numbers for claims inquiries
- Information required for a clean claim
- Acceptable standard billing formats
- Claims filing deadlines
- Process for appealing a denied claim
- Names and addresses of delegated claims processors

2. Notice of Changes

Contracted providers must be given 30 days written prior notice of all changes affecting claims filing requirements. Failure to provide required notice of an address change excuses the contracted filing limit and payment will be allowed.

3. SWMBH Responsibility to CMHSPs



SWMBH is responsible for ensuring all Participant CMHSPs receive the same claims-related information provided to network providers.

D. Claims Adjudication

1. Adjudication Rules and Edits

The MCIS will compare the following data elements of each claim to system information at a minimum:

- CPT or HCPCS code billed versus care authorized
- Date of service versus authorization effective and termination dates
- Eligible coverage in effect for each date of service
- Other insurance information (Coordination of Benefits)
- Duplicate claim lines
- Service covered in provider agreement for date billed
- Provider current rate and units authorized
- Claimed amount against Agreement Amount if a maximum is entered
- Timely filing per individual provider contract
- Frequency limits per contract
- Secondary claims have a valid Explanation of Benefits (EOB)

2. Timely Payment of Medicaid Claims

Timely payment shall be made to all providers for clean claims. At least 90% of all clean claims shall be paid within 30 days of receipt and 99% within 90 days of receipt, except for services rendered under a subcontract in which other timeliness standards have been specified and agreed to by both parties (MDHHS Contract Section O.7).

3. Participant CMHSP Responsibility

SWMBH and/or Participant CMHSPs will perform batch adjudication on a timely basis. Clean claims that are denied or only partially approved will be set with the appropriate status. Denial notifications shall be sent to consumers and providers in accordance with Section G at the time of denial or pended status action.

4. Pended Claims

Claims may pend in the MCIS during adjudication for the following reasons:

- Member has a primary insurer who may be liable for all or part of the claimed amount
- Member has Medicaid "Pending" status in system
- Contract terms have a pending status for Rendering or Credentialed provider
- Member has no Medicaid coverage and Block Grant coverage is being determined
- Case rate claims are missing the bundle or activity codes association



Claims pended during initial adjudication will be reviewed by claims adjudication staff. The Clean Claim Date in MCIS will be corrected to reflect the date information needed to make the claim clean is provided. Claims pended 31 days post-adjudication shall be denied if the claim cannot be approved due to missing information or authorization.

5. Explanation of Benefits

SWMBH and/or Participant CMHSPs will ensure that an EOB is mailed to a minimum of 5% of Medicaid consumers served by the region annually.

E. Paper Claim Submission, Receipt & Processing Controls

1. Receipt and Date Stamping

In accordance with the MDHHS agreement, SWMBH will enter all paper claims (CMS-1500 or UB-04) into the MCIS within ten (10) calendar days of receipt. Paper claims received via mail shall be date-stamped upon receipt. The receipt date will be entered in the Claim System "Received Date" field.

2. Facility Claims (UB-04)

The following information will be entered for institutional/facility claims:

- Enrollee ID and Provider ID
- Claim Receipt Date and Clean Claim Date
- Admission Details (date of admission)
- Diagnosis Codes (principal and admitting)
- Procedure codes and line dates
- Patient Account information and Total Charge Amount

3. Professional Claims (CMS-1500)

The following information will be entered for non-institutional/professional claims:

- Enrollee ID and Provider ID
- Claim Receipt Date and Diagnosis Codes
- Patient Account and Total Claim Charge Amount
- Beginning and Ending Date of Service and Place of Service
- Procedure Code, Units, and Rendering Provider (if applicable)
- Authorization Number (if applicable)
- Other Supporting Information (e.g., EOB, Coordination of Benefits, medical records)

4. Adjudication and Payment

Once entered, the claim will adjudicate through applicable adjudication rules. Remittance advice, EOB, and payment will be issued within 30 days of the clean claim date. Denials from contracted and non-contracted providers trigger the notification procedure in Section G.

F. State and Federal Regulatory Requirements



1. Clean Claim Requirements

A claim will be considered clean when it includes documentation that:

- Lists the correct date and place of service
- Is billing for covered services for an eligible individual
- Substantiates medical necessity and appropriateness if required
- Contains prior authorization information if required for the service
- Identifies the service using a generally accepted procedure or service coding system
- Includes additional documentation reasonably required by SWMBH

2. Requesting Missing Information

When a claim is not clean:

- Claims processor must advise the provider in writing of specific missing information within 30 days of receipt.
- SWMBH shall not deny the entire claim because one or more other services listed are defective.
- A Remittance Advice indicating the denied claim and denial reason satisfies the written notice requirement. Providers with electronic MCIS access are considered notified immediately upon adjudication.
- Provider has 45 days from notice date to correct and resubmit the claim.
- SWMBH has 45 days from receipt of corrected information to finalize the claim.
- If the claim is not made clean, SWMBH has 45 days to advise the provider of its determination.

3. Interest on Late Claims Payments

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

G. Enrollee Cost Sharing Prohibition and Denial Notifications

1. Prohibition on Cost Sharing

SWMBH shall not require any co-payments, deductibles, or other cost-sharing arrangements by Medicaid or Healthy Michigan Plan enrollees unless specifically authorized by the State. Network providers and subcontractors must not seek nor accept additional supplemental payment for services authorized by SWMBH.

2. Balance Billing Prohibition

Providers are informed that payment from SWMBH constitutes payment in full for services rendered. Balance billing of a Medicaid or Healthy Michigan Plan consumer is prohibited for all providers, including out-of-network providers, regardless of claim status.

- Providers attempting to balance bill an enrollee will be referred to Provider Network Management and Program Integrity/Compliance for follow-up.
- Enrollees who present a bill for services paid out-of-pocket will be promptly reimbursed and the provider contacted.



- This prohibition applies to both in-network and out-of-network providers.

3. Denial Notification Procedure

The following procedure applies when a claim is denied for a Medicaid or Healthy Michigan consumer:

- Claims are entered into MCIS and processed through adjudication.
- Contracted providers failing to submit a clean claim will have claims denied in error with options to correct per Section F.
- Contract providers with clean claims denied receive the adverse decision through the MCIS system.
- Non-contract providers with claims denied receive a paper copy of the denial notice.
- Upon denial, claims processors submit a list of denied claims to the Customer Services Specialist.
- The Customer Services Specialist will ensure ABD notices are mailed to the consumer's address on file. Per 42 CFR 438.404(b), each notice must include: (1) the action taken; (2) the reasons for the action; (3) the specific regulation supporting the action; (4) the consumer's right to file an appeal and the procedure for doing so; (5) the consumer's right to request a State Fair Hearing; (6) the consumer's right to have benefits continue pending resolution of an appeal; and (7) the timeframe for filing an appeal.

H. Provider Appeals and Grievances

1. Provider Right to Appeal

Providers have the right to appeal adverse actions taken by SWMBH or Participant CMHSPs regarding claims denials. Consumer rights regarding appeals and grievances are governed by SWMBH Policy Manual Section 6.

2. Grounds for Appeal

Providers may appeal adverse decisions where they are being held financially responsible on non-clinical grounds, including:

- Services denied due to contract/benefit plan limitation
- Reduction, suspension, or denial of provider payment
- Denial for delayed filing
- Denial for member ineligibility
- Denial for failure to provide Third Party Liability information

3. Notice of Appeal Rights

Notification of the right to appeal will be included in each provider contract.

4. Appeal Timeframes

All provider appeals of claim payment must be submitted within 30 days of the denial date, absent extreme circumstances as determined by SWMBH. Under no circumstance will appeals be accepted



after 180 days from the original denial date. Claims denied beyond this timeframe are considered to have reached FINAL resolution.

5. Preliminary Review

Within 10 days of receipt of a provider appeal request, the claims processing department will conduct a preliminary review to determine whether additional information is required.

6. Final Resolution Timeframe

SWMBH must have an effective provider appeal process to promptly and fairly resolve provider billing disputes. SWMBH shall issue a written final determination on all provider appeals within 60 days of receipt of the appeal request. Formal written appeals to the SWMBH Chief Administrative Officer will receive a written response within 30 days.

PROCEDURES

P09.00.01 — Denial Notifications (see Section G.3 of this policy for integrated procedure)

EFFECTIVENESS CRITERIA

Claims Timeliness Reports; Clean Claims Payment Rate Monitoring (90%/30-day and 99%/90-day thresholds); Denial Notification Tracking; ABD Notice Accuracy Audits; Provider Appeal Resolution Tracking;

REFERENCES

- MDHHS PIHP Contract MA250000001325, Schedule A and Section O.7 (Claims Management System)
- BBA Section 4707 — Balanced Budget Act
- 42 CFR Part 438 — Managed Care
- 42 CFR 438.3(s) — Provider Dispute Resolution Requirements
- 42 CFR 438.230 — Subcontractor Requirements
- 42 CFR 438.242 — Health Information Systems / Encounter Data
- 42 CFR 438.404 — Adverse Benefit Determinations (including notice content requirements)
- 42 CFR 447.45 — Timely Claims Payment and Interest
- 42 CFR 424.32 — Basic Requirements for Claims
- 42 CFR 433.137 — Third Party Liability
- MCL 400.111i(4) and (5)

ATTACHMENTS

- 09.00A — Care Management Import 837 User Guide (formerly 09.03A)






09.0 Claims Management

Final Audit Report

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