Section: Claims	Policy Name: **State & Federal Regulations**	Policy Number: **09.06**
Owner: **Chief Administrative Officer**	Reviewed By: **Anne Wickham**	Total Pages: **3**
Required By: ☐ **BBA** ☒ **MDHHS** ☐ **NCQA** ☒ **Other (please specify):** **Michigan Insurance Code, SSA 1902(a)(37)(A)**	Final Approval By: Anne Wickham Anne Wickham (Jul 21, 2022 14:27 EDT)	Date Approved: Jul 21, 2022
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **1/1/2014**

Policy: As a contract agency of the State of Michigan, Southwest Michigan Behavioral Health (SWMBH) is responsible and required to adhere to state and federal regulations regarding the processing of claims for payments of services to customers.

Purpose: As a contract agency of the State of Michigan, SWMBH is responsible and required to adhere to state and federal regulations regarding the processing of claims for payments of services to customers.

Scope: Operations

Responsibilities: Claims processors

Definitions: None

Standards and Guidelines:

A. Clean Claims

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 date 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.

B. Requesting Missing Information
1. Claim processor must advise the provider what information is needed to complete the claim. The notice must be in writing and must be issued within 30 days of receipt of the claim.
2. The health plan shall not deny the entire claim because 1 or more other services listed on the claim are defective.
3. The requirement of 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 reason. Providers who have electronic access to the SWMBH claims system will be considered notified of claims dispositions immediately upon adjudication of the claim.
4. If the claim is denied, the provider has 45 days from the date notice is received to correct the defects and ensure the information is received by the health plan.
5. If the claim is made clean, the health plan will have 45 days from the receipt of the additional information to finalize the claim.
6. If the claim is not made clean, the health plan will have 45 days to advise the provider of the adverse determination.

C. Interest Due for Late Claims Payments
1. Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute.
2. A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.

Procedures: None

Effectiveness Criteria: None

References: None

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	3/16/2020	Throughout Policy	New template	A. Wickham
1	7/14/2022	Remove MHL references	Throughout	A. Wickham

09.06 State & Federal Regulations

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