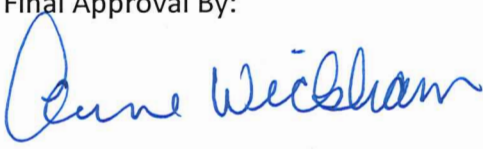




Section: Claims	Policy Name: MHL – State & Federal Regulations	Policy Number: 09.06
Owner: Chief Administrative Officer	Reviewed By: Anne Wickham	Total Pages: 3
Required By: <input type="checkbox"/> BBA <input type="checkbox"/> MDHHS <input type="checkbox"/> NCQA <input checked="" type="checkbox"/> Other (please specify): <u>See References Section</u>	Final Approval By: 	Date Approved: <u>11/4/19</u>
Application: <input checked="" type="checkbox"/> SWMBH Staff/Ops <input type="checkbox"/> Participant CMHSPs <input type="checkbox"/> SUD Providers <input type="checkbox"/> MH/IDD Providers <input type="checkbox"/> Other (please specify): <hr/>	Line of Business: <input checked="" type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify): <input checked="" type="checkbox"/> Healthy Michigan _____ <input checked="" type="checkbox"/> SUD Block Grant <input checked="" type="checkbox"/> SUD Medicaid <input checked="" type="checkbox"/> MI Health Link	Effective Date: 11/4/2019

Policy: It is the policy of Southwest Michigan Behavioral Health (SWMBH) to adhere to all Federal and State regulations regarding claims processing including but not limited to those referenced below.

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.
4. If the claim is denied, a letter must be sent with the returned claim. The provider has 45 days from the date the 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 MI Health Link claim that is not paid within 30 days shall bear simple interest at a rate of 12% per annum.
3. Clean claims from all other funding sources that is not paid within 45 days shall bear simple interest at a rate of 12 % per annum.

Procedures: None

Effectiveness Criteria: None

References:

- A. Michigan Insurance Code, SSA 1902(a)(37)(A)

Attachments: None

