Subject: Claims Adjudication		**Accountability:** Operations/Claims	**Effective Date:** 01/01/2014	Pages: 2
REQUIRED BY: **BBA Section** ________ **PIHP Contract Section** Section 7.8.2 **NCQA/URAC Standard** ________ **Other** ________			Last Reviewed Date: 11/16/17	Past Reviewed Dates: 6/11/15 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: 6/11/15	Past Revised Dates:
Approved : [signature] Date: 11/29/17			Required Reviewer: Director of Operations	

I. Purpose

To articulate Southwest Michigan Behavioral Health (SWMBH) standards regarding Claims Adjudication.

II. Policy

SWMBH and/or its Participant Community Mental Health Service Providers (CMHSP) will adjudicate all claims based on the following standards while adhering to business industry standards surrounding claims processing.

III. Standards

A. <u>Adjudication rules and edits:</u>

The Managed Care Information System (MCIS) will compare the following data elements of the claim to system information or logic at minimum:

1. Compares the Current Procedural Terminology (CPT) code billed to the care authorized
2. Compares the date of service to authorization effective and termination dates
3. Validates eligible coverage was in effect for each date of service
4. Searches for other insurance information
5. Searches for duplicate claim lines.
6. Validates that the service was covered in the provider agreement for the date of service billed
7. Validates the provider's current rate and the number of units authorized
8. Validates the claimed amount against the Agreement Amount field if a maximum agreement amount for a provider agreement is entered.
9. Validates the service was submitted within the time frame allowed per individual provider contract.
10. Validates the service does not exceed the frequency allowed if such is specified in the contract
11. Ensures claims for secondary processing have a valid Explanation of Benefits.

B. Timely Payment of Medicaid Claims

Payment shall be made to all providers within 30 days of receipt of a clean claim within 30 days and at least 99% of all clean claims shall be paid within 90 days.

C. Participant CMHSP Responsibility

1. SWMBH and/or Participant CMHSPs will perform batch adjudication on a timely basis.
2. Claims that are denied or only partially approved will be set with this status. Ensure that denial and pend notification are sent to external providers in accordance with policy within 30 days of denial or pended status. Only those providers who have received a waiver to submit paper claims will receive paper letters. All other providers can find their denials or partial approvals within the MCIS system at any time.

D. Pended Claims

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

1. Member has a primary insurer who may be liable for all or part of claimed amount.
2. Member has Medicaid "Pending" status in system
3. Contract terms have a pending status for Rendering or Credentialed provider status.
4. Member has no Medicaid coverage and GF coverage is being determined.

Claims that pend during initial adjudication will be reviewed by claims adjudication staff. The "Clean Claim Date" in the MCIS will be corrected to reflect the date on which the information needed to make the claim "clean" is provided. Claims with a pending status 31 days post adjudication shall be denied as a matter of course if the claim cannot be approved due to missing information or authorization.

E. Explanation of Benefits

SWMBH and/or participant CMHSPs will ensure that an Explanation of Benefits is mailed to a minimum of 5% of the Medicaid Consumers served by the region annually.

IV. Definitions

None

V. References

None

VI. Attachments

None