SWMBH Operating Policy 9.6

Subject: State and Federal Regulations	**Accountability:** Operations	**Effective Date:** 01/01/2014	Pages: 2
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** _____ **NCQA/URAC Standard** _____ **Other** Michigan Insurance Code, SSA 1902(a)(37)(A)		Last Reviewed Date: 11/16/17	Past Reviewed Dates: 6/18/15 6/1/16
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: 6/1/16	Past Revised Dates: 6/18/15
Approved : Anne Wickham Date: 11/29/17		Required Reviewer: Director of Operations Chief Compliance Officer	

I. Purpose

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.

II. Policy

It is the policy of SWMBH to adhere to all Federal and State regulations regarding claims processing including but not limited to those referenced below.

III. 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.

IV. Definitions

None

V. References

None

VI. Attachments

None