MSHN
Mid-State Health Network

POLICIES AND PROCEDURE MANUAL

Chapter:	**Financial Management**		
Title:	**Finance – Claims Procedure**		
Policy: ☐ **Procedure:** ☒ **Page:** 1 of 3	**Review Cycle:** Biennial **Author:** MSHN CFO	**Adopted Date: 11.18.2014** **Review Date:** 05.09.2023	**Related Policies:** Financial Management

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Purpose

The purpose of this procedure is to describe the methodology by which MSHN's Claims Staff and Community Mental Health Services Programs (CMHSP) will process claims within the Mid-State Health Network (MSHN) Region.

Procedure

A. MSHN and CMHSPs will pay approved clean claims within 30 days of receipt of claim.

B. MSHN and CMHSPs will assume liability for claims for services that meet the following criteria:
   1. The service is delivered under a contract between MSHN or the CMHSP and a service provider.
   2. The service provider has billed and received reimbursement and/or an Explanation of Benefit (EOB) from other liable third parties prior to billing MSHN or the CMHSP AND
   3. The provider has received an authorization for the provision of service. This can be received in the form of a pre-authorization or retro-authorization, based upon the individual provider contract and/or as follows:
      a. The service has been pre-authorized by another Prepaid Inpatient Health Plan (PIHP) or CMHSP on an emergency basis to a consumer who is a resident of the MSHN service area, OR
      b. The service is provided on an emergency basis by an approved member of MSHN or the CMHSP provider panel, and it can be determined that, but for the urgency of the need, the service would have been pre-authorized by MSHN or the CMHSP.

C. MSHN or the CMHSP will pay pending claims within 30 days of receipt of all required documentation.

D. Denied claims may be appealed in writing to the MSHN's Chief Financial Officer or the CMHSP Chief Financial Officer or individual identified within the provider contract. Written appeal must be received within 20 days after the provider receives the denial of payment. If the service provider is not satisfied with the action obtained from the original appeal, the provider may, within 30 days of receipt of the action, appeal to MSHN's Chief Executive Officer (CEO) or the CMHSP Executive Director (ED). The MSHN CEO or CMHSP Executive Director will send a written response to the provider.

E. MSHN Provider Discrepancies – On occasion MSHN has two providers seeking payment for the same person with overlapping date and time services. The resolution are as follows:

   a. Provider 1 receives payment for a claim. Provider 2's claim is flagged as a duplicate and returned to the provider as a denial. Provider 2 contacts claims to dispute the denial.
      i. MSHN's Claims processor logs the relevant service information into Claims_UM (Utilization Management) spreadsheet and forwards to UM department for review.

ii. UM Team conducts a review of provider documentation such as progress note, sign-in sheet, or other written verification.
iii. Once UM completes their review, an outcome is noted in the Claims_UM log.
    1. If the UM Team review supports Provider 2's claim, Provider 1's claim will be voided and Provider 2's claim will be adjudicated.
    2. If the review does not support Provider 2's claim, MSHN's Claims Processor will send an email response noting no further action will be taken.
    3. In some cases, UM may be unable to determine an outcome. In these cases, the associated information will be sent to MSHN's Compliance Officer for review and resolution.

b. In all cases, Provider 2's claim must be submitted within 90 days of the date of service. MSHN may make an exception to the 90-day rule if Provider 2 is able to show proof of third-party billing delays.
c. The Claims_UM log will be forwarded to the Compliance Officer at least quarterly to identify potential fraud trends or other compliance concerns.

Applies to

☒ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☒ MSHN CMHSP Participants: ☐ Policy Only ☒ Policy and Procedure
☐ Other: Sub-contract Providers

Definitions

Clean Claim: A claim submitted for payment that is completed in the format specified by the CMHSP and that can be processed without obtaining additional information from the provider of service or a third-party payer. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
Pending Claim: A claim that requires additional information from the provider of service or from a third-party payer before it can be approved for payment. Pending claims are not considered to be clean claims.
Provider: One that provides mental health and/or substance use disorder specialty supports and services under contract with CMHSP.
Liable Third Party: Refers to any health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded plan or commercial carrier, automobile insurance and workers compensation) or program (e.g., Medicare) that has liability for all or part of a recipient's covered benefit.

Other Related Materials:

N/A

References/Legal Authority:

Section 1902(a)(25) of the Social Security Act
42 CFR 433 Subpart D
Michigan Mental Health Code Section 226a
Public Health Code
Michigan Medicaid Provider Manual

Michigan Department of Health and Human Services Contract for 1115 Behavioral Health Demonstration Waiver Program, the Health Michigan Plan and relevant approved Waivers (Children's Waiver Program (CWP), Habilitation Supports Waiver (HSW), Serious Emotional Disturbance (SED))

Change Log:

Date of Change	Description of Change	Responsible Party
11.18.2014	New Procedure	Chief Financial Officer
03.20.17	Procedure Update	Chief Financial Officer
03.2018	Annual Review	Chief Financial Officer
03.2019	Procedure Update	Chief Financial Officer
01.2020	Procedure Update	Chief Financial Officer
05.2021	Procedure Update	Chief Financial Officer
01.2023	Procedure Update	Chief Financial Officer