

<b>COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN /PIHP</b>	<i>Policy Claims Payment and Appeal Policy</i>
Department: Regional Finance Author:	Local Policy Number (if used)
Regional Operations Committee Approval Date 3/25/2019	Implementation Date 4/22/2019

**I. PURPOSE**

To establish the standards by which behavioral health (Mental Health and Substance Use Disorder) service claims, submitted by service providers, are reviewed for accuracy, conformance to authorizations, and paid within the requirements stated in the current contract between the State of Michigan-Department of Health and Human (MDHHS) and the CMHPSM or the regional CMHSPs.

**II. REVISION HISTORY**

DATE	REV. NO.	MODIFICATION
10/01/2018	1	Language revisions

**III. APPLICATION**

This policy shall apply to the CMHPSM as the PIHP, the CMHSPs within the CMHPSM region (herein after referred to as CMHPSM payers) and all service providers submitting service claims.

**IV. POLICY**

It is the policy of the CMHPSM that service claims submitted directly to the CMHPSM, or to one of its regional CMHSPs will be appropriately adjudicated and processed according to this policy, MDHHS rules and all applicable federal regulations. Service providers serving CMHPSM consumers will follow this policy related to claims payment.

**V. DEFINITIONS**

- Adjudication- claims payment process that involves paying clean claims or denying claims after comparing claim information to payer coverage requirements and system edits.
- Claim- formal request for payment related to mental health or substance use disorder service delivery based upon service rates.
- Clean Claim- a claim that does not contain a defect related to adjudication rules or other CMHPSM claim requirements.
- Denied Claim – a claim that did not meet the CMHPSM adjudication rules and/or claim requirements.

- CMHPSM Payers - The CMHPSM itself as the PIHP, or one of the CMHSP entities within the CMHPSM region that pay service claims to their contracted service providers.
- HIPAA - Health Insurance Portability and Accountability Act, law designed to protect patients' health and treatment information.
- Service Provider – Any entity authorized to provide specialty services on behalf of the CMHPSM payers (PIHP or CMHSP).
- Electronic Health Record (EHR) - a digital version of a patient centered health record.

## VI. STANDARDS

### A. Claims Payment Process

The CMHPSM payers (CMHPSM and its partner CMHSPs) will adjudicate all claims and pay valid clean claims based on the following standards.

#### 1. Service provider Claim Submission

Claims will be submitted by direct entry into the CMHPSM web-based electronic health record (EHR). Service providers may also submit claims electronically through a CMHPSM approved format, such as an 837 file transfer. Service providers submitting paper claims must use a HIPAA compliant HCFA 1500, CMS 1450 (UB04) or a CMHPSM approved format. Service providers must submit claims within the following prescribed timeframes:

- a. 60 calendar days of providing a service
- b. 60 calendar days from date of discharge for all inpatient hospital stays
- c. 90 calendar days of providing service where the CMHPSM payer is a secondary payer.

#### 2. Adjudication

The CMHPSM payer staff will perform adjudication activities on service claims, included but not limited to: system edits, manual edits, claim documentation reviews, primary insurance validation, and/or Medicaid Service Verification sample audits. Service providers may be required to submit additional information to CMHPSM payers upon request including service documentation, copies of primary insurance EOB's, etc.

#### 3. Clean Claims

All clean claims submitted electronically to the CMHPSM payer will be paid within 30 calendar days of the submission date by the CMHPSM payer. Claims not submitted electronically will be processed within 90 calendar days of receipt.

#### 4. Pended Claims

Claims may be pended for multiple reasons during the claims adjudication process. These claims may be denied or returned to the service provider for correction. Batches that have been returned to service providers must be corrected and resubmitted within 30 calendar days of the date it was returned to the service provider. CMHPSM payers will assist service providers upon request.

#### 5. Denied Claims

A denied claim may be rebilled. A corrected clean claim must be entered and resubmitted for payment within 30 calendar days of the original denial or the EOB/Remittance advice date the original claim

appeared. If a rebilled claim is denied for a second time, service provider must follow appeal process for final determination.

**6. Reconsidered Claims**

Previously paid claims may need to be reconsidered by the CMHPSM payer for multiple reasons. The reconsideration process may result in an increase or decrease in the payment to the service provider which would be reconciled in a future payment to the service provider.

**7. Claim Data Layout**

Service providers follow the current data claim layout, data fields requirements, etc. as prescribed by the CMHPSM to ensure claims meet all CMHPSM, MDHHS, and/or federal field requirements.

**8. HIPAA**

Service providers must follow all HIPAA regulations when submitting claims.

**9. Other Claim Information**

Service provider must maintain documentation supporting claims in a format that provides evidence that service was provided as billed. CMHPSM payer may review supporting documentation in its determination of appropriateness of claims.

**10. Fiscal Year End Claims Submission**

Service provider must submit all claims for the previous fiscal year (October-September) no later than October 15<sup>th</sup>. Batches received with different fiscal year claims will be denied and no additional Fiscal Year end submission time will be allotted. Due to the end of the year reporting requirements set by MDHHS, the CMHPSM payer may shorten submission days for Pending, Denied and Appealed claims after October 15<sup>th</sup>. Failure to follow the Fiscal year End Claims Submission process may result in payment denial. Exceptions to the process must be approved by the CMHPSM payer.

If October 15<sup>th</sup> falls on a Saturday, Sunday or federally recognized holiday, the due date will be the next business date.

**B. Service Provider Appeals**

**1. Service Provider Right to Appeal**

Service providers may appeal CMHPSM payer decisions related to service claim payment denials. The CMHPSM payer and service provider should first communicate so each party understands the reason for denial. If communication between the parties does not resolve the situation, service providers shall follow the Service Provider Appeal Process as outlined in this standard.

**2. Service Provider Appeal Process**

Service providers will utilize the CMHPSM appeal form which can be found on the CMHPSM website [www.cmhpsm.org](http://www.cmhpsm.org) or through your local CMHPSM payer contact.

- a. Service provider submits appeal form, with all relevant documentation attached, to the CMHPSM Payer that denied the claim, within 30 calendar days of the most recent denial or the EOB/Remittance advice date the original claim appeared.
- b. The CMHPSM payer designee reviews the appeal form and attached documentation to make a determination within 15 business days of receiving the appeal.
- c. CMHPSM payer will provide the appeal determination to the service provider. Services approved in the appeal must be re-entered in EHR and submitted to CMHPSM payer by the

- service provider within 15 business days of receiving the appeal determination.
- d. If the service provider disagrees with the determination, they have the right to file a second appeal within 15 business days of receiving the appeal determination.
  - e. Service provider submits a written appeal and includes any additional information to the CMHPSM payer's Executive Director or their designee.
  - f. CMHPSM payer's Executive Director or their designee makes determination on 2<sup>nd</sup> appeal and returns final determination to the service provider within 15 business days of receiving the appeal. Services approved in the appeal must be re-entered in the EHR and submitted to CMHPSM payer within 15 business days of receipt of final determination.

**C. Provider Compliance with Medicaid Service Verification Activities**

Regional service provider claims are constantly monitored through the adjudication rules and edits described in this policy. Regional service providers may be selected by CMHPSM payers for additional service verification activities related to claims that have been submitted. Additional service verification activities include but are not limited to random or targeted service claim reviews.

**VII. EXHIBITS**

- A. Attachment #1: HCFA 1500 Form Example
- B. Attachment #2: CMS1450 (UB04) Form Example
- C. Attachment #3: Appeal Form (Form found at [www.cmhpsm.org](http://www.cmhpsm.org))

**VIII. REFERENCES**

Reference:	Check if applies:	Standard Numbers:
42 CFR Parts 400 et al. (Balanced Budget Act)	X	
45 CFR Parts 160 & 164 (HIPAA)	X	
42 CFR Part 2 (Substance Abuse)	X	
Michigan Mental Health Code Act 258 of 1974	X	
The Joint Commission - Behavioral Health Standards	X	
Michigan Department of Community Health (MDHHS) Medicaid Contract	X	
Current Michigan Medicaid Provider Manual	X	
Current Michigan Provider Qualifications Chart	X	
Current PIHP/CMHSP Encounter Reporting Costing Per Code and Code Chart	X	

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div>														
<b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>														
<input type="checkbox"/> PICA										PICA <input type="checkbox"/>				
1. MEDICARE <input type="checkbox"/> <small>(Medicare #)</small>	MEDICAID <input type="checkbox"/> <small>(Medicaid #)</small>	TRICARE <input type="checkbox"/> <small>CHAMPUS (Sponsor's SSN)</small>	CHAMPVA <input type="checkbox"/> <small>(Member ID#)</small>	GROUP <input type="checkbox"/> <small>HEALTH PLAN (SSN or ID)</small>	FECA <input type="checkbox"/> <small>BLK LUNG (SSN)</small>	OTHER <input type="checkbox"/> <small>(ID)</small>	1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		7. INSURED'S ADDRESS (No., Street)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )						9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE		11. INSURED'S POLICY GROUP OR FECA NUMBER  a. INSURED'S DATE OF BIRTH MM   DD   YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> <small>If yes, return to and complete item 9 a-d.</small>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.														
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____								
14. DATE OF CURRENT: MM   DD   YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM   DD   YY.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM   DD   YY TO MM   DD   YY			17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM   DD   YY TO MM   DD   YY 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		
19. RESERVED FOR LOCAL USE  21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER								
24. A. DATE(S) OF SERVICE From MM   DD   YY To MM   DD   YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. SPICIT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #			
1	2	3	4	5	6	NPI	NPI	NPI	NPI	NPI				
25. FEDERAL TAX I.D. NUMBER	SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____			33. BILLING PROVIDER INFO & PH # ( ) a. NPI _____ b. _____					

Attachment #2 CMS1450 (UB04) Form Example

1		2		3a PAT. CNTRL. #		4 TYPE OF BILL					
				b. MED. REC. #							
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH					
8 PATIENT NAME		9 PATIENT ADDRESS									
a		a									
b		b		c		d					
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION 13 HR 14 TYPE 15 SRC	16 DHR	17 STAT	CONDITION CODES 22 23 24 25 26 27 28			29 ACOT STATE	30	
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE CODE	36 OCCURRENCE DATE	OCCURRENCE SPAN FROM THROUGH		37 OCCURRENCE CODE	OCCURRENCE SPAN FROM THROUGH		
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT					
a		a		a		a					
b		b		b		b					
c		c		c		c					
d		d		d		d					
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49			
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PAGE ____ OF ____		CREATION DATE		TOTALS							
50 PRIOR NAME		51 HEALTH PLAN ID		52 P. REL.	53 INSUR. ID	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI			
								57 OTHER PRV ID			
58 INSURED'S NAME		59 P. REL.	60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.				
63 TREATMENT AUTHORIZATION CODES				64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME				
66	67	A	B	C	D	E	F	G	H	68	
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73	
74 PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE	75	76 ATTENDING NPI		QUAL			
						LAST		FIRST			
77 OPERATING NPI	QUAL				78 OTHER NPI		QUAL				
					LAST		FIRST				
79 OTHER NPI	QUAL				80 REMARKS		QUAL				
					b		FIRST				
					c		QUAL				
					d		LAST				



## Regional Service Provider Claim Payment Appeal Form

Providers must use this form to appeal service claims denied by Lenawee, Livingston, Monroe, Washtenaw or CMHPSM SUD payers.

Provider Name:	Appeal Date:
Contact Person:	Contact Email:
Contact Phone:	Contact Fax:

**CMHPSM Payer**

<input type="checkbox"/> Lenawee	<input type="checkbox"/> Livingston	<input type="checkbox"/> Monroe	<input type="checkbox"/> Washtenaw	<input type="checkbox"/> CMHPSM SUD
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**EHR Claim ID Number(s)**

**EHR Batch Number(s)**

**Denial Date and Reason for Denial**

**Basis of Appeal**

**Resolution Requested**

**Service Provider Authorized Signature**

**Date**

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Completed appeal form, including supporting documentation, should be faxed or e-mailed directly to the appropriate CMHPSM Payer department (i.e. Appeal of Lenawee CMH denial of payment sent to Lenawee CMH, appeal of CMHPSM-SUD sent to CMHPSM, etc.)

**Received by CMHPSM Payer**

**Date**

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**Determination / Outcome**

**Date**

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