COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEASTERN MICHIGAN /PIHP	*Policy* *Claims Payment and Appeal Policy*
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 HIPPA 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 15th. 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 15th. 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 15th 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 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 2nd 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

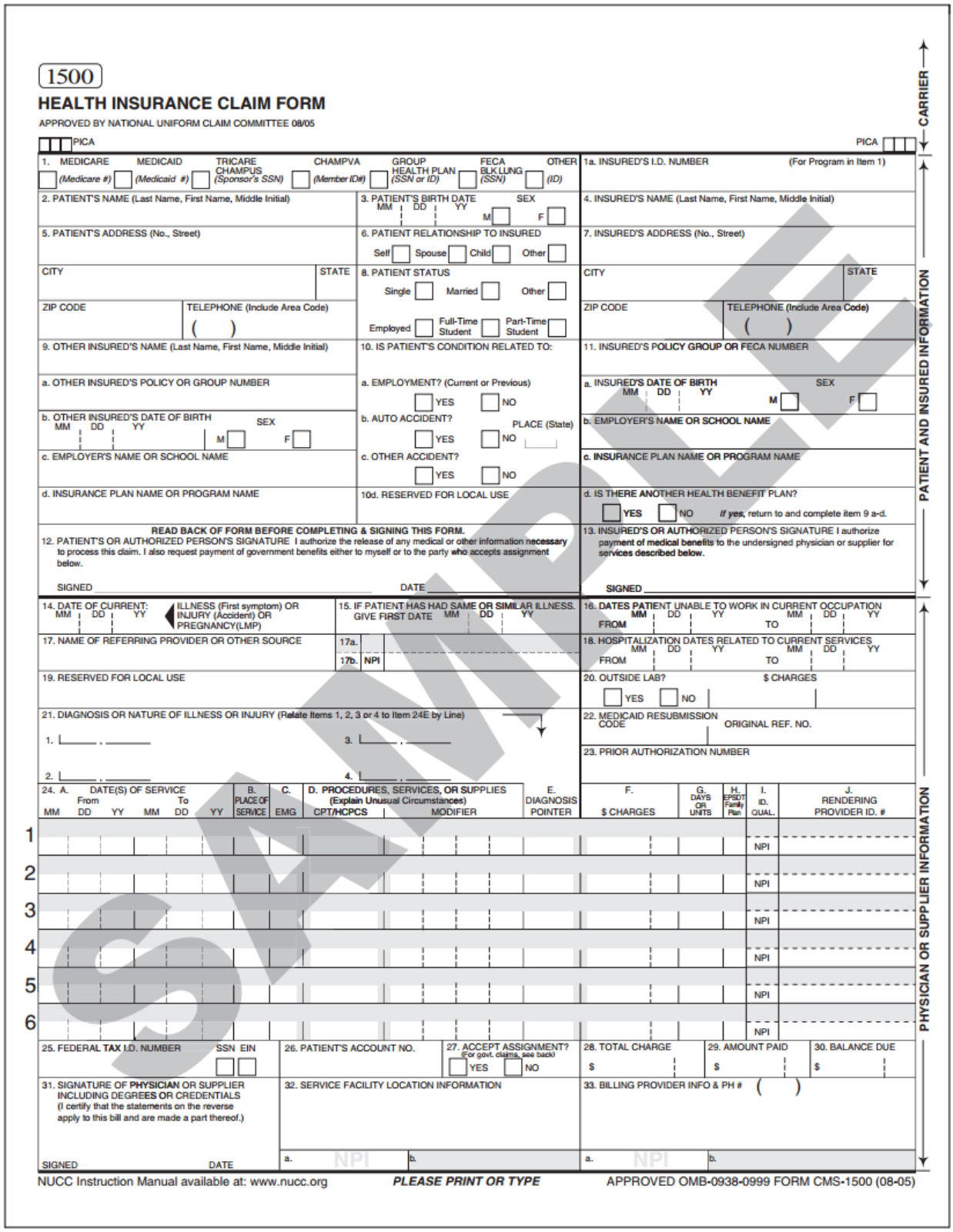
Regional service provider claims are constantly monitored through the adjudication rules and edits described in this policy. Regional service providers may be selected by CMHPSM payers for additional service verification activities related to claims that have been submitted. Additional service verification 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)

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	



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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 MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

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. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

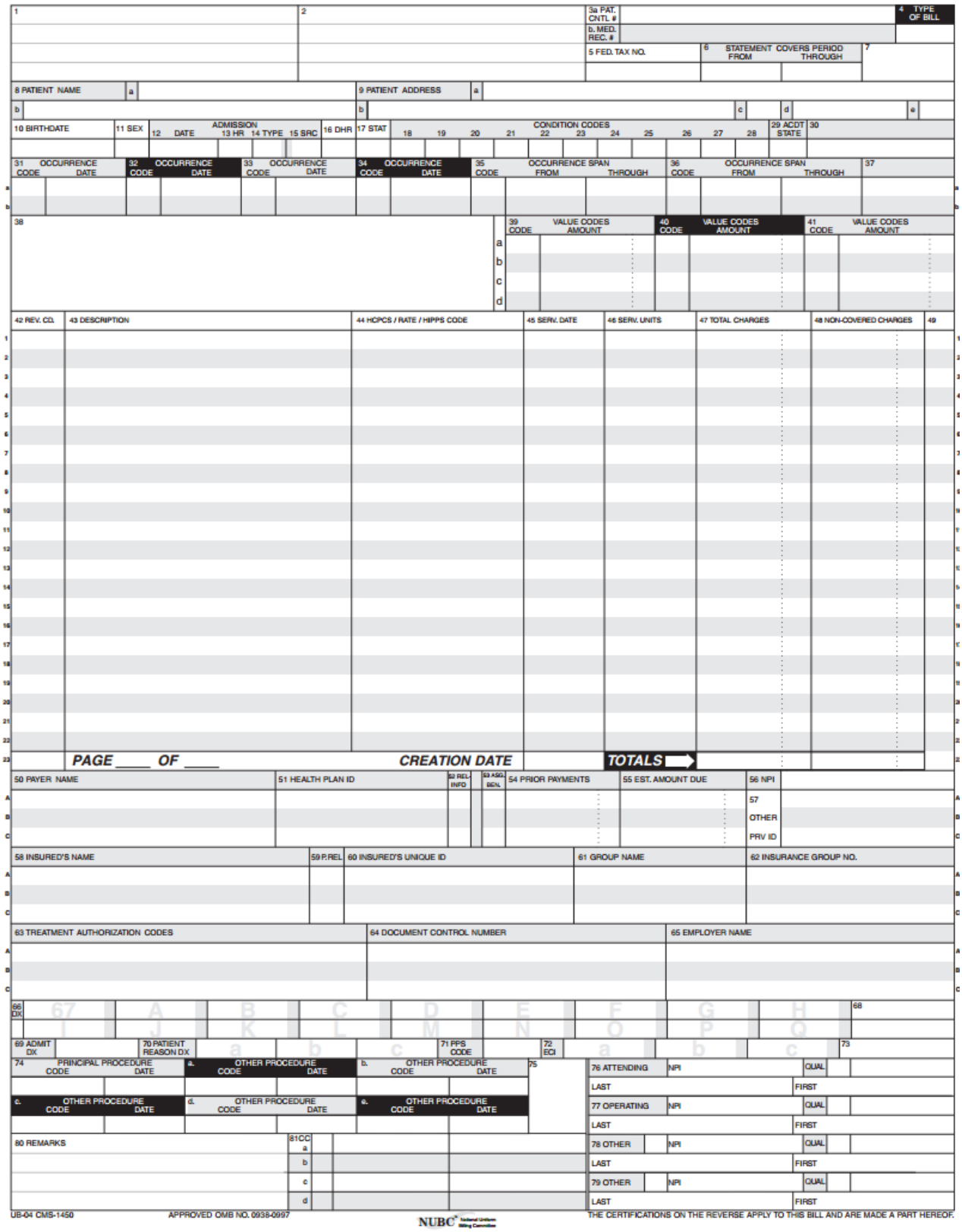
APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
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 DX
67
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81CC
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Attachment #3
Appeal Form

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

☐ Lenawee	☐ Livingston	☐ Monroe	☐ Washtenaw	☐ CMHPSM SUD

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**

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**

Determination / Outcome	**Date**