INTEGRATED SERVICES OF KALAMAZOO

ADMINISTRATIVE PROCEDURE 08.08_01

Subject: Claims Management	**Section:** Financial Management
Applies To: ☒ ISK Staff ☒ ISK Contract Providers ☐ ISK CCBHC Services ☐ ISK CCBHC DCO Contract Providers	**Page:** 1 of 7
Revised: 05/24/2023	**Supersedes:** 05/03/2021

PURPOSE

This policy and procedure outlines elements of the Integrated Services of Kalamazoo (ISK) claims management processes. Claims management includes processing, adjudicating and payment or denial of claims.

DEFINITIONS

Claims Adjustment Segment (CAS)
Segment of an 837 Claim that reveals payment activity of other payers.

Claims Processing
The function of claims submission claims processing and payment for authorized services.

Claims Remittance Advice Report (RA) and Explanation of Benefits (EOB)
The reports that provide details of service activity and payment for a claims processing period.

Clean Claim
Clean claims are defined by Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 (14) as claims that do all 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, place of service, and start and stop time of the 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.
9. Can be processed without obtaining additional information from the provider of service or a third party.

Covered Service
Services identified in the provider agreement (contract).

Denied Claim
Claims that have been submitted to ISK's electronic health record or received through USPS mail to be considered for payment that are paid at a lower amount than the billed amount, or no payment has been issued.

Healthcare Insurance and Portability and Accountability Act (HIPAA)
A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Additionally, it gives the Department of Health and Human Services (MDHHS) the authority to mandate the use of standards for the electronic exchange of health care data, requires the use of national identification systems for health care consumers, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable information. The transmission of information between two parties to carry out financial or administrative activities related to health care is referred to as a transaction. Transactions include data standards that are code sets and unique identifiers established for claims.

Primary Provider
The provider who has assumed the lead for consumer care. This position would typically fall to the wrap-around coordinator or the case manager. If an individual isn't receiving one of the fore-mentioned services, the clinician providing such services will be determined to be the primary provider. The Primary Provider is assigned through Same Day Access and the Person-Centered Planning process.

Receipt of a Claim
A claim will be classified as received when the claim is received in the USPS mail or on the date entered with the batch submitted marked complete into the ISK Electronic Health Record system.

Third Party Liability (TPL)
Any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured or self-funded plan or commercial carrier, automobile insurance and worker's compensation) or program (i.e., Medicaid, Medicare) that has liability for all or part of a recipient's covered benefit.

STANDARDS

I. All payments for covered services will be reimbursed at the contractual rate or the rate submitted, whichever is less.

A. New providers will not be reimbursed until ISK is in receipt of a signed agreement.

B. Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute.

C. Clean claims from all other funding sources that are not paid within 45 days bears simple interest at a rate of 12% per annum.

II. Payment for claims is net of first and third-party fees, when applicable.

III. All Claims must be received by ISK within 60 days of the date of service to be considered for payment, unless otherwise noted in your specific contract. This expectation also applies to any claim needing coordination of benefits information to process. Claims received after this timeframe **will not** be considered for payment. Claims received within the 60-day (or contract specific timeframe) deadline and are not approved paid at zero may be reconsidered for payment for 365 days from the date of service if a new claim is entered into the electronic health record (EHR). After the 365 days have passed, the service will be permanently denied and not available for correction or an appeal.

IV. Professional claims that are series billed (CMS 1500 form) must be received within 60 days from the start day of claim line, not the end date of the claim. Institutional claims (UB 04 form) must be received within 60 days (or contract specific timeframe) from the date of discharge.

V. Submission of claims from ISK Provider Network can include direct data entry into the electronic health record, or an electronic submission of an 837.

VI. All providers have the right to appeal denied claims. Denied claims can be reconsidered by initiating the Provider Grievance and Appeals procedure (see ISK policy 02.02 [Provider Grievance and Appeals (non-clinical)].

VII. Claims cannot be submitted prior to date of service.

VIII. Coordination of Benefits is the responsibility of the ISK provider, unless the ISK provider is a Designated Coordinating Organization (DCO) If the provider is a DCO, Coordination of Benefits is the responsibility of ISK.

IX. Explanation of Benefits will be generated and mailed to a minimum of 5% of individuals with Medicaid.

X. It is the responsibility of ISK and Southwest Michigan Behavioral Health PIHP to ensure their contracted network providers have access to the following information, either through

their contract, Provider Manual or other documentation including electronic media.

1. Address to file claims (both electronic and paper).
2. Telephone contact numbers.
3. Information that must be contained in a claim in order for it to be considered "clean".
4. Acceptable standard billing formats.
5. Dates by which claims must be filed to be considered for payment.
6. Process for appealing denied claim.
7. Names and addresses of delegated claims processors.

Contracted providers must be given 30 days written prior notice to all changes. Failure to give required notice of address change could result in delayed or lost claim filings. The contracted claims filing limit will be excused and payment allowed when required notice of address change is not provided.

PROCEDURE

I. CLAIMS PROCESSING

A. All provider claims must be filed electronically using the current ISK data layout and in accordance with HIPAA transaction standards for 837 file upload or by direct data entry into EHR. Hospitals with secondary inpatient claims will submit a CMS 1500 or UB 04 claim with primary EOB either through USPS mail or by secure/encrypted email to ISKinpatient@iskzoo.org. If ISK staff determine ISK has a contractual liability for the claim an authorization will be entered into EHR. Communication will be sent to the hospital that an authorization is now available in EHR for the hospital billing staff to enter the claim into EHR. Hospitals are exempt from this requirement. Hospitals are permitted to submit claims using at CMS 1500 form sent through USPS mail. These claims will be entered into EHR by ISK staff. Communication regarding unaccepted claims (i.e., no authorization, ISK is not the county of financial responsibility) will be sent via USPS mail or by secure email and include information about the dispute resolution process. Letters will be logged and retained by ISK staff.

837 providers can upload claims by using the "Upload EDI 837 Claims Files" in the Electronic Health Record (EHR) This step will also give the status of the 837 file: "File Accepted – No Errors", "File Accepted – Errors Exist", or "File Rejected". If an 837 file has errors, providers are able to "Download 837 Error Report" from this screen. To make corrections, Providers will need to correct the errors in their originating system and then recreate the 837 file and upload to the EHR again. The claims will now appear in a new batch within the menu item "Step (2) – Review and Send Batch of Entered Claims to CMH for Payment" After finalizing the 837 upload, the status of the submission can be viewed by accessing "View Uploaded 837 Files". This screen will tell providers the status of their import files, the number of claim lines submitted and the number of unprocessed claim lines submitted (number of claim lines submitted less the number of unprocessed

claim lines submitted equals the number of claim lines accepted into the system). 837 providers are also able to download the 837 Error report to view the details of the errors, Providers can contact the ISK Financial Analyst assigned to their agency regarding claims not accepted into the system.

B. The claims runs are scheduled for every two weeks. You will find the Claims Run Schedule for the current calendar year on the ISK portal. The cutoff for claims submission for a run is on a Tuesday (see current Calendar Year Claims Run Schedule for which Tuesday). A claims run is finalized with the release of payment, either electronically or by check, on the Friday of the week following a "claims run". For example, if the cutoff is Tuesday, May 12th, a claims run would occur on Wednesday, May 3rd and the payment would be released to the providers on Friday, May 12th.

C. 837 providers can generate a HIPAA compliant 835 file, the electronic transaction that provides claim payment information and documents the EFT (electronic funds transfer). The 835 files can be retrieved by selecting "Claim Submission (AP)", then "Step (3) – View Checks and Print EOB") Each batch submitted will have a "Download 835" selection for 837 files submitted. A non-electronic remittance advice is available as well in "Step (3) – View Checks and Print EOB" as well. To access this feature, use "Print EOB", a PDF EOB will be created. "Print Remittance Advice" or "Print Remittance (Short)" will create a RA pdf file. "Remittance Advice Report" will show payment information on screen only, no pdf.

D. Non 837 providers EOBs should be retrieved through the EHR, this is available in "Step (3) – View Checks and Print EOB". To access this feature, use "Print EOB", a PDF EOB will be created. "Print Remittance Advice" or "Print Remittance (Short)" will create a RA pdf file. "Remittance Advice Report" will show payment information on screen only, no pdf.

II. CLAIMS RECONSIDERATION

Providers (both 837 and non-837) should review their batches in the ISK Electronic Health Record after provider adjudication and again after ISK adjudication. If the Provider has submitted a claims batch to ISK but the batch is not paid, the provider can request ISK to return the batch to the provider so that the provider can make corrections.
If the batch is in paid status, the provider can contact ISK to reconsider the claim(s).

III. CONSUMER FEES

A. Determination of financial liability for each person served will be made using the ISK/Michigan Department Health and Human Services (MDHHS) policies and procedures. No individual will be refused mental health services because of an inability to pay. Individuals with Medicaid or Healthy Michigan will not be charged or billed by ISK or any of its contracted provider network.

B. The primary providers are responsible for determining financial liability, the completion of the annual Ability to Pay (ATP) form and the collection of applicable fees. Mental health related fees determined to be the responsibility of the person served would be automatically deducted from the first claims reimbursement due the provider until the monthly determined ATP is met.

C. ISK may retroactively adjust paid claims in the event a Fee Determination containing 1st party liability is completed and submitted by the provider.

D. The mental health primary provider is responsible for updating an individual's ATP annually. If this isn't done within 60 days from the ATP expiration date, ISK will assume the individual has a full ability to pay and will withhold all payments for services provided to that individual by the primary provider only. If the primary provider gets an ATP signed later than 60 days claims assessed at a full ability to pay will be re-assessed according to the new ATP.

E. Whenever an ATP is completed, a copy will be provided to the individual served.

All mental health ancillary providers are responsible for obtaining current ATPs from the primary provider.

IV. COORDINATION OF BENEFITS

A. The provider must reference the ATP and comply with all TPL requirements before ISK can remit payment. Denial by the TPL due to non-compliance will result in a non-paid claim by ISK.

B. Claims paid by ISK and later determined to be covered by a TPL will retroactively be reconsidered, the claim payment reduced to zero, and take-back any paid amounts. Once the TPL is processed, claims will need to be resubmitted with the TPL in the EHR for the claim to be reprocessed for payment**.**

C. ISK Provider Network should keep all EOBs on file and accessible for review during an audit.

D. ISK payment liability for beneficiaries with private commercial insurance is the lesser of the beneficiary's liability (including co-insurance, co-payments, or deductibles), the provider's charge or the maximum fee screens, minus the insurance payments and contractual adjustments (a contractual adjustment is the amount established in an agreement with a TPL to accept payment for less than the charge amount).

E. Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment

in full for services rendered. Neither the person receiving services nor ISK has any financial liability in these situations.

REFERENCES

- Southwest Michigan Behavioral Health Policy (and/or same named/theme policies if SWMBH alters the numbering system of their policy manual)
  - 9.1 (Claims Adjudication)
  - 9.3 (Electronic Claims Submission)
  - 9.4 (Provider Communication)
  - 9.6 (State and Federal Regulations)