Origination:	*12/2019*
Effective:	*12/2019*
Last Approved:	*12/2019*
Last Revised:	*12/2019*
Next Review:	*12/2020*
Owner:	*Deabra Hardrick-Crump: Billing/ Claims Supervisor*
Policy Area:	*Claims Management*
References:	

CLAIMS RECONSIDERATION POLICY

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to document a process for handling claim adjustments that meet the requirements specified in the contract with MDHHS and ICO's.

PURPOSE

The purpose of this policy is to identify a process that will adhere to all requirements as it relates to claim adjustments for the MI Health Link, Medicaid, SUD and Autism programs.

APPLICATION

DWIHN will adhere to all requirements as it relates to claims payment adjustments, overpayment's, and/or underpayments

1. The following groups are required to implement and adhere to this policy: DWIHN Board, DWIHN Staff, Contractual Staff, Access Center, Network Providers, Crisis services vendor, Credentialing Verification Organization (CVO)
2. This policy serves the following populations: Adults, Children, I/DD, SMI, SED,SUD, Autism
3. This policy impacts the following **contracts/service lines**: MI-HEALTH LINK, Medicaid.SUD, Autism, Grants, General Fund

KEYWORDS

1. **Reconsideration:** The process of considering/reviewing something again.
2. **Adjustment:** Any manipulation of a payment made to a provider.
3. **Overpayment:** Any claim paid more than established rate identified in the DWIHN rate summary sheet.
4. **Underpayment:** Any claim paid less than the established rate identified in the DWIHN rate summary sheet.

STANDARDS

DWIHN staff, contractors and subcontractors will:

1. DWIHN must establish and maintain a process to address the receipt, handling and disposition of a

reconsideration in accordance with applicable federal and state laws and contractual agreements.

2. Reconsideration of denied claims and must be submitted to DWIHN within 60 calendar days of the denial notice.
3. If a favorable or partially favorable determination is made, the payment must be issued at the time of determination.
4. If the determination is to uphold the original denial, DWIHN must immediately notify the provider of the decision to uphold.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor contractors adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals and Objectives.

The quality improvement programs of subcontractors, and direct contractors must include measures for both the monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN staff, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. **Medicaid Provider Manual** - http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
2. **MI Health Link Three Way Contract** - https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIContract01012018.pdf and as amended https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MIContractAmendment.pdf
3. **CMS Provider Manual** - https://wayback.archive-it.org/2744/20111201152311/http://www.cms.gov/Manuals/IOM/list.asp

RELATED POLICIES

RELATED DEPARTMENTS

1. Claims Management
2. Compliance
3. Information Technology
4. Legal
5. Managed Care Operations

6. Management & Budget
7. Quality Improvement
8. Recipient Rights

YES

INTERNAL/EXTERNAL POLICY

EXTERNAL

Attachments:

Corrected Claims Reconsideration.xlsx

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	12/2019

Approver	Date

Origination:	*11/2019*
Effective:	*11/2019*
Last Approved:	*11/2019*
Last Revised:	*11/2019*
Next Review:	*10/2020*
Owner:	*Deabra Hardrick-Crump: Billing/ Claims Supervisor*
Policy Area:	*Claims Management*
References:	

CLAIMS RECONSIDERATION PROCEDURE

PROCEDURE PURPOSE

To provide guidelines for a process for handling claim adjustments that meet the requirements specified in the contract with Michigan Department of Health and Human Services (MDHHS) and Integrated Care Organizations (ICO's).

EXPECTED OUTCOME

A process flow for all claim adjustments for the MI Health Link, Medicaid, Substance Use Disorder (SUD) and Autism programs.

PROCEDURE

1. When an overpayment or underpayment is suspected by the provider, the provider must notify Detroit Wayne Integrated Health Network (DWIHN) claims department of the suspected overpayment or underpayment . The attached corrected claims reconsideration form must be completed for the reconsideration to occur.
2. Once the reconsideration form is received by DWIHN the reconsideration will be processed in Mental Health Wellness Information Network (MHWIN).
3. DWIHN will adjust any overpayment's or underpayments.
4. The claims department will notify providers when an overpayment or underpayment is discovered by DWIHN.
5. Overpayment and underpayment adjustments for providers are deducted from the provider’s next check run and reported back to providers on their Explanation of Benefits (EOB) EOB/835.
6. DWIHN may impose sanctions and corrective actions for incurring overpayment(s). If a provider does not correct and return an overpayment to DWIHN as required within 40 days after the overpayment is identified, DWIHN will impose sanction(s) for each incorrect claim and take other action, up to and including provider subcontract termination. Federal law states that “any overpayment retained by a person after the deadline for reporting and returning the overpayment” [60 days after identification] is regarded as a false claim and subject to penalties and enforcement under the False Claim Act (31 U.S.C. 3729 et seq). DWIHN will notify appropriate state/federal authorities about the provider’s False Claim Act obligation.
7. Refund Checks for over-payments will be returned to the provider at the claims supervisor's discretion. A

reconsideration form will be sent to the provider for completion, this will allow DWIHN the ability to recoup overpayment's in MHWIN.

PROCEDURE MONITORING & STEPS

Who monitors this procedure:	Deabra Hardrick-Crump, Claims Management
Department:	Claims
Frequency of monitoring:	Annually
Reporting provided to:	Director of Managed Care Operations (MCO)

Comments:

1. MCO will ensure all reporting sanctions and corrective actions are reported as one element of the Risk Management Assessment.
2. This Procedure is associated with the Claims Reconsideration Policy.

Attachments:

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	11/2019

Approver	Date

CLAIMS RECONSIDERATION FORM

(A) Member ID	(B) Provider Name	(C) DOS	(D) Service Code Billed	(E) Modifier	(F) Time of Service	(G) Original Batch #	(H) Original Claim #	(I) Reason for Reconciliation

Column A - MH-WIN member identification number of the consumer
Column B - Service provider name
Column C - Date of service billed
Column D - CPT code billed
Column E - Modifier billed, if any
Column F - Time of service billed, if required
Column G - Batch number of original paid claim
Column H - Claim number of original paid claim
Column I - Indicate the reason you are requesting the reconciliation. Be specific (e.g., **billed incorrect date** or **used incorrect rate; rate should be $xx.xx**, etc.)