Current Status: *Active* **PolicyStat ID:** *6126686*

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 PROCESSING POLICY

POLICY

It is the policy of the Detroit Wayne Integrated Health Network (DWIHN) to uniformly process all claims received via EDI, Direct submitter or paper to meet at a minimum the specific product's compliance standard.

PURPOSE

The purpose of this policy is to put processes are in place to ensure HIPAA compliant claims are processed timely, accurately and comply with contract and prompt payment provisions.

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APPLICATION

This applies to providers who serve consumers who are DWIHN enrollee/members at the time of service,

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/SEI, SED,SUD, Autism
3. This policy impacts the following contracts/service lines: MI-HEALTH LINK, Medicaid, SUD, Autism, Grants, General Fund

KEYWORDS

1. **MHWIN:** Mental Health Wellness Information Network is the DWIHN main information system. MHWIN can be access via any web browser using the following URL: www.mhwin.com
2. **MI Health Link:** A new health care option for Michigan adults ages 21 or over who are enrolled in both Medicare and Medicaid and who also live in the following counties: Berry, Berrien, Branch, Calhoun, Cass, Kalamazoo, Macomb, St. Joseph, Van Buren, Wayne and any county in the Upper Peninsula.
3. **Claim Form:** An itemized statement of service rendered by health care provider (such as your doctor, clinic, or hospital) billed electronically, on the CMS 1500 or UB-04 or their successor forms.
4. **Clean Claim:** The term clean claim means a claim that has no defect, impropriety, lack of any required substantiating documentation including the substantiating documentation needed to meet the requirements for encounter data or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent

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claims under original Medicare.

5. **Prompt Payment Provisions:** The Prompt Payment rule ensures that health plans pay providers in a timely manner. Prompt Payment requires health plans to pay late interest penalties to providers after a payment due date.
6. **Integrated Care Organization (ICO**): A health insurance-based organization contractually responsible and accountable for providing integrated care to people eligible for both Medicare and Medicaid.

STANDARDS

1. **PROCESSING CLAIMS:** DWIHN staff will process claims according to contractual requirements with the ICO's and MDHHS.
   a. All claims must be paid or denied in accordance with all federal and state laws, regulations and contractual agreements.
   b. DWIHN is delegated the responsibility of oversight of claims processing, payments and appeals to ensure timely and accurate claims processing and appeal resolution.
   c. Contracted providers of service are required to submit initial clean or corrected claims in accordance with the provisions outlined in their contract with DWIHN. If the contract is silent on a time frame for submission or the provider of service is non-contracted, the provider of service has 12 months from the date of service to submit an initial clean or corrected claim.
   d. If DWIHN pays clean claims after 30 calendar days, interest must be paid at the rate used for such late payments as stated in federal regulations 42 CFR § 422.520(a)(2); Manual Ch. 11 – Section 100.2.
   e. DWIHN must pay clean claims for non-contracted providers rendering services to DWIHN Members within 30 calendar days of receipt of the claim. All other claims for non-contracted providers must be paid or denied within 60 calendar days of receipt. Calendar day time frames include all Holidays and weekends. Payment to contracted providers should be made in accordance with the provisions outlined in their contract with the DWIHN.
   f. DWIHN is expected to identify and recover overpayment's resulting from a payment error or when it has been determined that the provider of service or Member was liable for the services, in accordance with federal and state regulations.

QUALITY ASSURANCE/IMPROVEMENT

DWIHN shall review and monitor providers adherence to this policy as one element in its network management program, and as one element of the QAPIP Goals, Objectives and will include measures for both monitoring of and the continuous improvement of the programs or processes described in this policy.

COMPLIANCE WITH ALL APPLICABLE LAWS

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

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LEGAL AUTHORITY

DWIHN contractual agreement with MDHHS and ICO's. Medicare Claims processing Manual, chapter 1: section 80.

RELATED POLICIES

RELATED DEPARTMENTS

1. Claims Management
2. Compliance
3. Customer Service
4. Information Technology
5. Integrated Health Care
6. Managed Care Operations
7. Recipient Rights
8. Utilization Management

NO

INTERNAL/EXTERNAL POLICY

INTERNAL, EXTERNAL

Attachments:

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	12/2019

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Approver	Date

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Origination: 07/2018
Effective: 07/2018
Last Approved: 04/2019
Last Revised: 04/2019
Next Review: 04/2020
Owner: Deabra Hardrick-Crump: Billing/ Claims Supervisor
Policy Area: Claims Management
References:

CLAIM PROCESSING PROCEDURE

PROCEDURE PURPOSE

To provide guidelines for processing/adjudicating Electronic and Paper Claims

EXPECTED OUTCOME

DWIHN will adhere to all requirements as it relates to processing Electronic and Paper Claims according contractual agreements.

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PROCEDURE

1. **Medicaid** requirement is to pay clean claims within 45 days of receipt and unclean claims denied within 30 days of receipt.
   Medicaid Contract requirement is to pay 95% of clean claims within 30 days, ≤1% of ending inventory over 45 days old; ≤ 14% denied claims timely.
   Medicare requirement is to pay 95% of clean claims from non-contract providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of the request.
   MI Health Link Three Way Contract requirement is to pay 90% of clean claims within 30 calendar days of the request.
2. The Claims Manager shall review on daily basis the turnaround time for claims. Once a back log occurs when claims are exceeding fourteen day turn around then the Claims Management will inform the Chief Network Officer.
3. **Paper Claims**
   a. Paper Claims Submission is only available for out of network providers who do not have a direct contract with DWIHN to provide services to a DWIHN Consumer.
   b. Paper claims must be submitted on a CMS 1500 version form.
   c. Paper claims must be typewritten or computer generated.
   d. Paper claims may be returned to the provider without processing if they are illegible; incomplete, or not submitted on the correct form.
   e. DWIHN staff cannot make changes to submitted claims, they are entered as received.
   f. Paper claims are passed out daily by claims manager (oldest date first) to be entered and processed

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for adjudication.

g. Any paper claim that are lacking required information making them ineligible to be entered into the system are mailed back to the provider with a cover letter indicating the reason for return.

h. Approved claims are picked up for payment on the next check run.

i. Electronic remittance advices can be viewed in MHWIN

4. **Electronic Claims -** Claims are received daily EDI or direct submitter.

   a. Electronic Claims are received via an 837 file format or entered directly into MHWIN by the provider.

   b. Claims are adjudicated daily and submitted for supervisor approve if no errors exist.

   c. Claims are received via EDI and assigned a batch number and date.

   d. If the claim meets all pass through logic, for example: matching member name, member ID, DOB, gender, provider NPI, etc. they are assigned a batch number, batch date and uploaded into MHWIN claims system by IT staff.

   e. Providers are required to follow up on their EDI claims that do not pass the 5010 front end edits, correct them as needed and resubmit.

   f. Based on DWIHN established prepayment review criteria claims will go in a hold queue for further review by an analyst.

   g. The following 837 Companion Documents are attached to this policy and are also available on DWIHN website.
      837 5010 Professional Companion Guide
      837 5010 Professional Companion Guide for Carve Outs
      837 5010 Institutional Companion Guide
      837 5010 Institutional Guide for Carve Outs

   h. For submitting electronic claims, providers must contact the MHWIN help desk at mhwin@dwmha.com or by phone at (313)344-9099.

   i. MHWIN has a training portal (www.mhwin.com) that is identical to the production portal but allows providers to experience the program and test various modules and functionality with no worry about data loss.

   j. Providers who enter claims into MHWIN are required to check for errors prior to submission.

5. **Claim Processing**

   a. **MHWIN is designed to either pay or deny claims. The provider does not have the option to pend a claim.**

      1. The MHWIN model for DWIHN claims processing allows the provider to pre-adjudicate an entire batch or a single claims prior to submitting the claim to DWIHN. This allows the provider to identify and correct their errors before final submission of the claim(s) for payment.

      2. If claim errors exist on electronic claims and the claim adjudicator cannot resolve the error, the batch is returned to the provider with instructions on why the error occurred and or to remove the claims with error from the batch before resubmitting the batch.

      3. If errors exist on paper claims and the claims adjudicator cannot resolve the error the claim will be returned with a denial letter indicating why it could not be processed.

      4. Claims should be sent to DWIHN within 90 days from the date of service. For resubmission or

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secondary claims, DWIHN must receive the claim within 180 days from the date of service.

5. Providers can check the claim determination through MHWIN by downloading a Remittance Advice report, they also have the option to download an 835 file format.
6. A retro-eligibility claim is a claim where no eligibility was entered in the MHWIN system on the date(s) of service but, at a later date, eligibility was posted retroactively to cover the date(s) of service. Retro-eligibility fee-for-service claims are considered timely submissions if the initial claim is received by DWIHN no later than ninety (90) days from the MHWIN date of eligibility posting. Retro-eligibility claims must attain clean claim status no later than ninety (90) days from the MHWIN date of eligibility posting. Corrections to paid retro-eligibility claims must be received by DWIHN no later than 90 days from the MHWIN date of eligibility posting.
7. All claims received beyond the timely filing limit or as stipulated in the provider contract will be rejected and enrollee/members may not be billed for the services.
8. If a claim does not achieve clean claim status or is not corrected within one hundred and eighty (180) days of date of service, DWIHN is not liable to pay the claim.

6. **Claims Payment**
   a. DWIHN recommends that all payments to providers are made via electronic funds transfer. Providers should contact DWIHN's Finance Department with a request on the providers letter head, to receive electronic funds transfer.
   b. All providers will be paid according to the fee schedule. The most updated fee schedule can be found on the DWIHN website at www.dwmha.com.
   c. Contracted provider claims that do not achieve clean claim status or is not corrected within one hundred eighty (180) days of the date of service will not be paid.
   d. Slow payments are those that are paid more than thirty (30) days after the receipt of a clean claim or sixty (60) days for out of network providers of emergency and post-stabilization care. Interest shall be at the rate of 1% per month for periods following the thirtieth or sixtieth day respectively after receipt of the clean claim until the date of payment.
7. **Denied Claims**
   a. Automatic claim denial messages are generated in MHWIN when a claim does not meet the pass through logic set up in MHWIN.
   b. The provider will receive an explanation of benefits (EOB) with the denial reason.
   c. If consumers receive a service that is not covered. The claim will deny.
8. **Completed Claims**
   a. The claims adjudicator must complete a claims coversheet for each batched of claims adjudicated.
      1. Fill in the date the claims are adjudicated on, claim type (professional/facility), check date and the adjudicator's name.
      2. Return the batch to the mail room for filing.

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PROCEDURE MONITORING & STEPS

Who monitors this procedure:	Deabra Hardrick-Crump, Billing/Claims Supervisor
Department:	Claims

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Frequency of monitoring:	Annually
Reporting provided to:	Director of Management Care Operations
Comments: This procedure is associated to the CLAIMS PROCESSING POLICY	

Attachments:

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	04/2019

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