VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

Title: Claims – Venture MCIS
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DIRECTIVE:
Van Buren Community Mental Health (VBCMH), as an affiliate of Venture Behavior Health (Venture), will utilize Venture's Managed Care Information system (MCIS) for the processing of all contractual mental health claims. Venture Behavior Health is an administrator of Medicaid behavioral health benefits acting as the Michigan Department of Community Health's regional administrator for the Medicaid benefit plan. The claims process currently consists of claims entry, service authorization and check issuance performed by Van Buren Community Mental Health. Claims adjudication is administered by Venture Behavioral Health. Inpatient Facility and Crisis Residential services are authorized by Venture Behavioral Health. Venture claims submission and processing are summarized in this procedure and detailed in Venture Behavior Health's Claim's Policies and Procedures 1.1 through 1.17.

I. COMMUNICATION TO CONTRACT PROVIDERS:

It is the responsibility of Van Buren Community Mental Health to ensure that their contracted network providers have access to the following information, either through their contract, Provider Manual or other documentation including electronic media.

- Address to file claims (both electronic and paper)
- Telephone contact numbers
- Information that must be contained in a claim in order for it to be considered "clean"
- Acceptable standard billing formats
- Dates by which claims must be filed to be considered for payment
- Process for appealing a denied claim
- 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 12-month claims filing limit will be excused and payment allowed when required notice of address change is not provided.

II. FILING CLAIMS:

VBCMH shall follow the policy of Venture Behavioral Health effective September 1, 2010, that all claims shall be filed using the current Venture Behavioral Health data layout in accordance with HIPAA transaction standards or via the Provider Access software system unless provider is granted a waiver to submit claims via paper method.

Acceptable Standard Billing Formats

HIPAA 837 File Format
Providers who wish to utilize this format may do so by submitting claims directly to the Venture Behavioral Health contracted claims clearinghouse, currently Netwerkes.com, or by utilizing the file upload process through the Provider Access software. Providers will be required to successfully submit test claims batches before access to the production system will be granted.

Provider Access System
Provider's staff utilizing this system must have attended a Venture Behavioral Health sponsored training before obtaining user names and passwords to the system. The Provider Access system requires the use of Internet Explorer 6.0 or higher and the following claim fields are required:

- Consumer name
- Dates of service
- Procedure code and modifiers
- Diagnosis
- Total Charges
- Place of Service
- Units
- Rendering Provider
- Any third party payments

Paper Claims
Only providers who are afforded a waiver by Venture Behavioral Health as outlined in the Waiver of Electronic Submission Policy (see Paragraph XIV of this procedure, or Venture Claims Procedure 1.17) will be allowed to submit claims via paper format. Unless otherwise waived by Venture Behavioral Health all paper claims must be submitted on an original UB04, CMS1500 or VBCMH 3806 claim form. There will no deviation from this requirement unless the provider meets the waiver provision to do so.

Address to File and Contacts
All paper claims for Van Buren Community Mental Health should be sent to:

Van Buren Community Mental Health
ATTENTION: Claims Processing
P.O. Box 249
Paw Paw, MI 49079-0249

EXCEPTION: Facilities submitting claims for *secondary payment of inpatient hospitalization* should mail their claim, EOB from the primary carrier and medical records to:

Venture Behavioral Health
100 Country Pine Lane
Battle Creek, Michigan 49015
CONTACT: Shirley Poole
Phone: 1-800-897-3035

Time Frame to File
Regardless of submission methodology, claims must be initially received and acknowledged by Venture Behavioral Health within twelve months from the date of service or the timeframe within their individual contract if less.

For inpatient providers, it is the "Through" date indicated on the claim
For all other providers, it is the date the service was actually rendered or delivered

There will be no appeal for submission of claims for dates after one year except for those noted in the Exceptions paragraph.

Some claims may require additional documentation to support prior filing and receipt. For example:
- Claim replacements
- Claims previously billed under a different provider ID number
- Claims previously billed under a different beneficiary ID number
- Claims previously billed using a different date of services

Exceptions to the 12-month filing limit will be considered under the following circumstances:

- Administrative error by Venture Behavioral Health
- Medicaid beneficiary eligibility was established retroactively
- Judicial Action/Mandate: A court or departmental administrative law judge ordering payment of the claim
- Medicare processing was delayed. The claim was submitted to Medicare within 90 days of the date of service and submitted to VBH within 120 days of the Medicare resolution.

Adjudication Schedule

Mental health claims are adjudicated within the system on a daily basis.

III. CLAIMS CONTROLS:

All claims, regardless of billing format or claim type, must be processed within 45 days of receipt date when all necessary information is received to consider it "clean". Claims lacking necessary information must be tracked and the provider notified of needed information within 30 days. Claims not entered into Streamline due to missing information must be tracked manually to ensure processing time frames are consistent with the law.

Paper Claims Submission:

Sorting, Batching and Date Stamping

- Claims are considered "received" on the date delivered to the claims processing office.
- Claims mail must be date stamped on the face of the claim with the date received or if the envelope is date stamped, the envelope must be attached to the claim.
- Claims should be entered into the claims system in the order received.
- Un-entered claims should be kept in a secure location filed by date in order of receipt.
- Claims that are not yet entered into the system should be kept in a separate folder/filing cabinet to ensure that claims are not misplaced, lost or not entered.

Received Date vs. Entry Date

- The Streamline system will prompt you to enter the claim "Received Date".
- Do not use the date the claim is entered into Streamline unless the claim is being entered on the same day received.
- The "Received Date" in Streamline should always match the date stamp on the claim or claim envelope.

Claim Numbers

- The Streamline system will generate a unique identifying "number" for each entered claim line. The numbers are assigned by the system, and are sequentially numbered.
- The claim line number will appear on the provider remittance advice to track claim activity and is used to retrieve the original document for post payment audits and respond to claims inquiries.

Clean Claim Date

- The Streamline system will automatically populate the "Clean Claim" field with the information in the "Received Date" field. Not all claims are filed with the necessary information to be processed as a clean claim.
- The "Clean Claim Date" must be manually updated to reflect the date additional information is received to meet the criteria of a clean claim.

Clean Claim Date - Electronically Entered Claim

- The Streamline system will automatically populate the "Clean Claim" field with the information in the "Received Date" field. Not all claims are filed with the necessary information to be processed as a clean claim.
- The VBCMH claims processor must manually update the date if when additional information is received to meet the criteria of a clean claim.

Confidentiality of Claim Documents

- Claim documents must not be left on desk surfaces and in open areas accessible by patients, visitors or staff members not involved in the processing of the claim.
- Claim documents should be kept secured when not being worked.
- The Health Insurance Portability and Accountability Act (HIPAA) require that all personal health information be protected and kept confidential. The contents of medical claims cannot be shared with individuals not involved in the delivery of services or directly involved in the processing of the claim without authorization from the member or legal guardian.

Retention and Retrieval of Claims

- Original claim documents are filed by provider in date received order.
- Claims documents needed for post payment review or for check validation must be copied. The original document should not be sent to Accounts Payable, Utilization Management, Compliance, or other requestors.
- Claims are kept in active files for one year.
- Original claim documents must be kept for seven years in accordance with industry standards for retention.

IV. STATE REGULATIONS:

Regulatory Reference

Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006

Clean Claims

Clean claims are defined by Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 (14) as claims that do all of the following:

- Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
- Sufficiently identifies the patient and health plan subscriber.
- Lists the date and place of service.
- Is billing for covered services for an eligible individual.
- If necessary, substantiates the medical necessity and appropriateness of the service provided.
- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
- Identifies the service rendered using a generally accepted system of procedure or service coding.
- Includes additional documentation based upon services rendered as reasonably required by the health plan.

Requesting Missing Information

- VBCMH will advise the provider what information is needed to complete the claim. The notice must be in writing and must be issued within 30 days of receipt of the claim.
- The health plan shall not deny the entire claim because 1 or more other services listed on the claim are defective.
- The requirement of written notice can be met with a Remittance Advice that is sent to the provider with the payment of other claimed amounts that indicates the denied claim and the denial reason.
- If the claim is not denied, a letter must be sent with the returned claim (see Appendix C).
- The provider has 45 days from the date the notice is received to correct the defects and ensure the information is received by the health plan.
- If the claim is made clean, the health plan will have 45 days from the receipt of the additional information to finalize the claim.
- If the claim is not made clean, the health plan will have 45 days to advise the provider of the adverse determination.

Interest Due for Late Claims Payments

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

- A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum.
- The interest shall be paid *in addition to* and *at the time of payment* of the claim.
- A civil fine can be imposed of not more than $1,000 per violation for failing to pay claims timely. The aggregate fine for multiple violations will not exceed $10,000.
- Assessment of a civil fine does not preclude a health professional or facility from seeking court action.

V. PAPER CLAIMS ENTRY:

All claims for which VBCMH has an actual or purported accountability shall be entered into Venture's Managed Care Information System (MCIS) (Care Management). Providers (contracted, non-CMHSP Providers) shall submit claims to the VBCMH in the prescribed format defined in the Provider Agreement that is consistent with federal and state laws or regulations. Any other claim submission format must be approved by Venture. Claims submitted longer than 365 days from the date of service shall be entered into Care Management but denied as a matter of policy, supported by state law. Exceptions to the 12 month filing limit are described under "Filing Claims" section (see Paragraph II).

All claims submitted, shall be date-stamped upon arrival to the VBCMH claims processing office and shall be entered into Care Management within **10** days following procedures outlined under "Claims Controls" section (see Paragraph III).

Staff responsible for entering claims data will enter all data as it appears on the claim form. If incomplete or erroneous data is provided, the claim will be denied or returned to the provider and a corrected claim requested. The exception to this requirement is the verification of eligibility, as some claims could be filed with various member identifications.

Affiliate staff with UM authorization access shall not have access to enter claims. All claims will be adjudicated in the central Venture office.

Medicaid Eligibility

The Care Management eligibility system uses the unique member ID that is created by Medicaid. You may receive a claim that is billed with a social security number, commercial health plan ID number or find that the Medicaid number is incorrect.

- These claims must be researched in Care Management to match name, address, date of birth and social security number.
- If a match is not found, search CHAMPS or Medifax or like source to establish Medicaid eligibility.
- If a match is not found in CHAMPS or Medifax the consumer should be entered into Care Management so that the claim may be entered. The claim will deny based upon no eligibility found.
- In some instances, eligibility is found in CHAMPS or Medifax, but it has not been created in Care Management. VBCMH staff may create a "Pending" eligibility status in Care Management. This will allow authorizations to be entered and claims to pend for review.

Covered Services

The Care Management system will allow entry of claims for which non-covered services or services without contracts. When benefit changes are made and approved by CMS (Center for Medicare and Medicaid Services), they are updated in the Care Management system by Venture staff. Benefit changes are loaded into the system with the appropriate effective/termination date to ensure claims payment accuracy.

- If you are unable to enter a claim or authorization for a service which you believe to be a covered service, contact Venture Operations Department at 800-897-3035.
- Specific information regarding covered services and supplemental Medicaid Bulletins can be found at

- http://www.michigan.gov/mdch/. VBCMH staff shall review covered services with *all new employees* and review changes/additions with existing staff no less than annually.
- Services denied due to being a non-covered service will have a denial letter sent to the provider within 30 days of denial.

Authorization of Services

All claims must be keyed into the Care Management system. If the authorization is not present or does not fully match the services billed, the Care Management system will pend or deny the claim*. Do not delay entry of the claim or hold the claim in order to resolve authorization issues.* All claims must be entered within 10 days of receipt by the VBCMH claims processing office.

- If a claim is denied for no authorization and the provider can support that the authorization does exist, the claim can be reprocessed. However, Utilization Management must first enter the authorization into the system.
- If a provider renders services which exceed those authorized, they may request an authorization be issued and re-file the claim.

Other Insurance

VBCMH staff shall verify with their patients prior to services being rendered if other commercial insurance exists; if the patient is eligible for Medicare or if their condition is work related or related to an accident. This information must be entered in the COB section of the Membership Module in Care Management. Once entered, it is good to verify that the information is up to date at least every 6 months.

- Claims received for secondary consideration must be submitted with an Explanation of Benefits from the primary carrier. Claims received without the EOB should be entered into Care Management and denied with a letter requesting the EOB.
- Claims received for secondary consideration with an Explanation of Benefits attached, should pay the contracted amount less the payment made by the primary carrier. If payment from the primary carrier exceeds the contracted amount, no additional payment is due and denial letter should be sent to provider.

Valid Provider

Providers must be loaded in the Care Management system as *participating* with a Contract or *non-participating* with a Letter of Agreement and payment terms in order for authorizations to be entered and claims to pay. Claims submitted by providers who have terminated their contract, will only be considered if authorizations are issued and dates of service are during time frames when the contract was in effect.

- Since authorizations are required prior to services being rendered, you should not receive claim billings from non-contracted providers. These services would be denied at the point of authorization or a Letter of Agreement created.
- If claims are received, the claims should be entered into the Care Management system where they will be denied and a denial letter should be sent to the provider.

Valid Codes

The Care Management system is updated annually or as needed with valid billable codes.
All codes must be entered as billed on the claim document. Codes should **NEVER** be corrected or changed without a corrected UB04, CMS1500, or VBCMH 3806 from the provider of service.

- If claims are received with invalid or obsolete codes the claim may still be entered into the Care Management system. The claim will be denied for having a non-billable code and a denial letter should be sent to the provider indicating the code billed was invalid or obsolete within 30 days of denial.

Claims for General Fund Members

It is the responsibility of VBCMH to establish eligibility for coverage under the General Fund. Once eligibility is established, claims are processed using the same policies and procedures as Medicaid business. Authorizations must be entered in Care Management in order for claims to process.

VI. CLAIMS ADJUDICATION:

Adjudication

The system will compare the following data elements of the claim to system information or logic:

- Compares the CPT code billed to the care authorized.
- Compares the date of service to authorization effective and termination dates.
- The claim date plus the billing terms from the provider's contract must be earlier than the received date of the claim.
- Validates insurance coverage was in effect for each date of service.
- Searches for other insurance information.
- Validates that the service was covered in the provider agreement for the date of service billed.
- Validates the provider's current rate and the number of units authorized.
- Validates the claimed amount against the Agreement Amount field if a maximum agreement amount for a provider agreement is entered.
- Validates the service was submitted within the time frame specified in the contract.
- Validates the service does not exceed the frequency allowed if such is specified in the contract.

Batch Adjudication Schedule

Venture claims adjudication staff will perform batch adjudication of claims a minimum of once daily or once weekly for Substance Abuse claims entered.

VBCMH Affiliate Responsibility

- Ensure claims for secondary processing are received by Venture Behavioral Health and EOB's have been requested from the primary carrier if necessary.
- VBCMH claims staff are responsible for all "To Be Worked" claims within the system that are denied or partially approved with the following reasons:
    - Member is not eligible for any plan
    - No rate can be found
    - No contract exists
    - Invalid diagnosis code
- Claims that are denied or only partially approved will be set with this status. Staff are required to view each claim and either rework the claim or remove the status so that claim status is changed to "To be Paid".
- Ensure that denial and pend letters are sent to external providers in accordance with policy within 30 days of denial or pended status. Only those providers who have received a waiver to submit paper claims will receive paper letters. All other providers can find their denials or partial approvals within the Provider Access system at any time.

Provider Responsibility

Ensure claims that are being submitted for secondary processing have a valid EOB and that EOB is submitted.

Provider claims staff are responsible for all "To Be Worked" claims within the system that are denied or partially approved with the following reasons:

- No authorization exists for dates of service
- Units authorized exceeds requested amount
- No rate can be found for date of service
- No contract exists for date of service
- Claim received after the billable period
- Frequency exceeds contract rules

Pended Claims

Claims may "pend" in Care Management during the adjudication process for the following reasons:

- Member has a primary insurer who may be liable for all or part of claimed amount.
- Member has Medicaid "Pending" status in Care Management.
- Member has no Medicaid coverage and GF coverage is being determined.

Claims that pend during initial adjudication will be reviewed by Venture claims adjudication staff. Review of pended claims must be completed within 7 days to ensure providers are notified timely if additional information is needed for adjudication. Providers must be notified within 30 days from receipt date of the claim. The "Clean Claim Date" in Care Management will be corrected to reflect the date on which the information needed to make the claim "clean" is provided.

Pended Claims will be worked using the following guidelines:

- Coordination of Benefits—Claims pended for Coordination of Benefits will be approved if:
  - The service is a non-covered benefit by the primary insurer, or
  - The claim is being billed to the General Fund, or
  - An EOB for the claim in question has been received, and
  - Inpatient claims have been reviewed and financial liability determined.

  If claims are received without an Explanation of Benefits from the primary carrier and review of the claim determines coverage is secondary, the claim will be denied. Before denying the claim, Venture will contact VBCMH to determine if the EOB has been received in their office.
- Pending Status Medicaid—Claims pended for Pending Status Medicaid will be approved once Medicaid eligibility is verified for the dates of service in question either by CHAMPS upload into Care Management or through web-Denis or Medifax or like source establishes such.
- GF Coverage Determination – All claims that are pended to determine GF eligibility of the consumer are will have a final adjudication status completed within 30 days of the date upon which the claim is deemed "clean", as determined by VBCMH claims processors and Venture Operations.

Pended claims will be approved only if proper authorization for the treatment and dates of service exist in Care Management and all other required claim elements have been satisfied.

Re-Adjudication of Claims

Occasionally a claim that has been adjudicated in Care Management will require re-handling. VBCMH claims staff should:

- Work with the provider to resolve the payment discrepancy
- Ensure all needed information and authorizations have been provided
- Submit the claim for re-adjudication.

Venture will provide consultative assistance, when needed, to resolve complex claims issues or refer them to the Venture Operations Manager.

VII. ACCUTE CARE CLAIMS – MEDICAID SECONDARY TO COMMERCIAL:

1. Within one year of date of service or 120 days post primary payment received, whichever is earlier, the facility sends a letter requesting coverage, the primary payor EOB, and the medical chart to the following address:

   Attn: UM Supervisor
   Venture Behavioral Health
   100 Country Pine Lane
   Battle Creek, MI 49015

2. Determination of medical necessity is facilitated by utilization management for the stay. If determined to be partially or fully medically necessary an authorization for the use of the benefit is forwarded to the facility with a copy to the VBCMH claims department along with the letter and EOB from the provider.

3. If any part of the requested authorization is denied because the patient did not meet the medical necessity criteria, a letter of denial with reasons and the rights to appeal is forwarded to the facility with a copy to the VBCMH claims department along with the request letter and EOB

from provider. Instructions to the facility regarding next steps in the process of appeal should be included.

4. UM Department will ensure that MCIS is updated to reflect current primary payor coverage in the COB system. Additionally, the utilization management department will forward a copy of the EOB for archiving and use against any future claims.

5. Facilities will continue to file claims for payment with the VBCMH claims department.

VIII. ACUTE CARE CLAIMS – MEDICAID SECONDARY TO MEDICARE:

1. The facility sends a letter or copy of CMS1500, or UB04 along with the Medicare EOB to Venture at the following address within one year of date of service or 120 days post Medicare payment received whichever is earlier:

   Attn: Operations Manager
   Venture Behavioral Health
   100 Country Pine Lane
   Battle Creek, MI 49015

2. The Venture Operations Department will determine if a financial obligation of Medicaid benefits is warranted. The MDCH guidelines on the payment of Medicaid secondary coverage to Medicare primary coverage will be used to make this determination. Operations Department will ensure that the MCIS system is updated to reflect current Medicare coverage benefits.

3. If financial obligation by Medicaid is determined by the Operations Department the request will be forwarded with notification (approval) memo to the Venture UM Department for authorization for payment to be made. This authorization will serve only as authorization for financial reimbursement in the claims system.

4. If no financial obligation by Medicaid is found in the request, the Operations Department will forward a letter of denial to the facility as well as to the VBCMH claims department.

5. Upon issuance of authorization for payment of Medicaid funds, the UM department will forward an authorization to the facility as well as to the VBCMH claims department.

IX. OVERPAID CLAIMS:

VBCMH establishes the following procedures for the identification, notification and collection of overpaid claims. These facility-specific procedures are consistent with the Venture Claims Procedures. Checks refunded or returned which are related to over paid claims are addressed in Paragraph X of this procedure. Issues related to notification and recovery of overpayments which are unable to be resolved locally, should be referred to Venture Behavioral Health for investigation and resolution.

Reasons for Overpayments

There are numerous reasons why claim payments can be overpaid. The most common are:

- Claim was overpaid due to processing error, such as entering the wrong number of units.
- Claim was paid twice. Duplicate payment was not identified by the system.
- Provider received payment from another carrier. Medicare is primary.
- Member is not his patient. The incorrect provider was selected in processing the claim.
- There may be an error in the provider fee schedule/contract or misunderstanding regarding payment terms. A change in payment terms may have occurred which has not been updated.
- There may be an error in the member's benefit load allowing claims to pay that should not.
- Human error.

Notification/Review Process

NOTE: Claims overpayments that are generated due to system related problems, benefit load problems or provider fee schedule/contract problems should be documented with examples and communicated to Venture Behavioral Health during the recovery process.

VBCMH will designate an individual or department to coordinate the review and recovery of overpaid claims. This area/individual will:

1. Review the claim for all needed elements, such as claim number, member ID, date of service. If information is needed, it may be requested from the provider or from the individual who identified the overpayment.

2. Review the claim for processing accuracy.
   If the claim is determined to have been processed correctly, send notification back to the individual who identified the overpayment with an explanation as to why the claim is processed correctly.

3. Correct the claim in Care Management and determine if the overpayment can be recovered through offset.

Offsetting Future Claims Payments

Collection of overpayments through offset is the preferred method of recovery. However, offsetting cannot be used when there will be no future claims submitted by the overpaid provider or under the provider ID which generated the overpayment. This may occur when providers terminate their participating status or change their billing arrangements.

If the overpayment can be collected through offset, correct the claim in Care Management and notify Venture Behavioral that the claim should be reverted and denied.

VBCMH will be responsible to ensure proper communication to the provider. If the provider EOB generated from Care Management will not fully explain the reason for offset, the provider must be contacted. Record should be kept to support how this notification occurred.

Refund Checks

If the overpayment cannot be collected through offset, VBCMH must notify the provider of the amount overpaid and reason. *Manual refunds will not be requested for amounts under $25.00.*

1. Notify the provider in writing. Phone calls can be made to discuss the overpayment and collection follow-up but are not used as the primary notification.

2. Allow 30 days for the refund to be received.

3. Place a note on the claim in Care Management to alert others that the request has been initiated.

4. When payment is received, refer to procedures outlined in “Returned Checks” (Paragraph X of this procedure) for handling of the check.

5. If payment is not received in 30 days, generate a “Second Request” in writing.

6. If payment is not received in 60 days, place a phone call to establish a date for refund or resolve any disputes.

If provider refuses to refund monies due to VBCMH further action may be taken including contract termination, civil suit and/or reporting of provider to the Michigan Office of the Medicaid Inspector General.

X. RETURNED CHECKS:

VBCMH has established and documented procedures for securing, posting and depositing checks received through the postal system. Checks refunded or returned which are related to claims payments must be researched and the Care Management system updated to maintain the integrity of financial reporting. All check research should be resolved within 7 days. Care must be taken to observe check issue dates to prevent the check from becoming "stale dated" making it non-negotiable. Issues related to refunded or returned checks which are unable to be resolved by VBCMH, should be referred to Venture Behavioral Health for investigation and resolution.

Security of "Live" (Negotiable) Checks

Follow established procedures for opening, logging, posting and depositing checks. Returned checks related to claims processing may require time to research, update Care Management and possibly correct the claims payment. In these cases, the original check should be deposited and/or secured in the safe. A *copy of the check* and any attached documentation should be used to complete the claims research. "Live" checks should not be left on desk surfaces, in-boxes or work files.

Care Management checks returned by the postal system for insufficient postage or address correction can be corrected and re-mailed. Incorrect addresses need to be updated in Care Management to ensure future checks are not returned.

Reasons for Refunds

The provider or postal system may return claims payments. In some cases the Care Management generated check is returned and in other situations, the provider may deposit the Care Management check and refund a portion or all of the payment through a check generated from their office or facility's Accounts Payable System.

- Care Management checks may be returned due to:
  - Insufficient postage
  - Bad address
  - No forwarding address
  - Document damage during the postal handling
  - Provider has determined no payment was due

- Provider issued checks may be received because:
  - Claim was overpaid due to processing error
  - Duplicate payment was issued
  - Provider received payment from another carrier
  - Member is not his patient (paid wrong provider)
  - An overpayment has previously been identified and refund requested.

Updating Care Management

- Care Management issued checks that have been returned by the postal system and have been re-mailed should have a note entered in the claims system advising the date re-mailed and listing the corrected address, if appropriate.

- All other Care Management issued checks returned by the provider must be researched.
  - If the check was issued to the wrong provider, the returned check must be VOIDED and the claim reprocessed to the correct provider.
  - If the check is a duplicate payment, the returned check must be VOIDED and a note added to the claim advising payment was a duplicate and the claim reverted and denied.

- If the provider is returning the check because it is underpaid, the check can be VOIDED and the claim corrected in the system to create an accurate payment.

If claims research determines the payment is correctly due to the provider, telephone the provider to discuss your findings. If the check has not been voided, re-mail the payment and note actions taken in the claims notes. If the check has been voided, re-process the claim.

- All provider issued checks must be researched.
  - Deposit or secure these checks and perform research from check copies.
  - If research determines that the initial payment was correct and no refund is due, telephone the provider and resolve. If the check has not been deposited, the check can be voided and returned to the provider.
  - If research determines that the claim was overpaid and the refund is appropriate, the claims associated with the refund check should be denied in the Care Management system and the Refund process should be utilized to credit the proper claim lines within the system.

XI. FRAUD AND ABUSE:

All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post and pre-payment review of claims should be performed to ensure services are appropriate, necessary and comply with Medicaid policy. In addition, claims review should also verify that services were billed appropriately and that third party resources were utilized to the fullest extent available.

The Michigan Department of Attorney General uses the following State laws for investigating Medicaid provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 et.seq.)
  An individual, whether a provider, an employee, or an accomplice, convicted of submitting false claims is subject to a fine of up to $50,000 and a prison sentence of four to ten years for each count, as well as full restitution to the Medicaid Program for of all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

  Some examples are:
  - Billing for services not rendered.
  - Billing without reporting payments received from other sources such as Medicare.
  - Billing for a brand name drug when a generic substitute was dispensed.
  - Misrepresenting the patient's diagnosis in order to bill for unnecessary tests and procedures.
  - Billing a date of service other than the actual date services were rendered.
  - Accepting "kickbacks" as cash payments or gifts in exchange for favorable treatment.
  - Fraudulent Cost Reports.

- Social Welfare Act (MCLA 400.111d)

- Public Health Code (MCLA 333.16226)

The Office of Inspector General is mandated to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide

network of audits, investigations, inspections and other mission-related functions performed by OIG components. There are six offices within the U. S. Department of Health and Human Services (HHS), Office of the Inspector General (OIG). The Office of Investigations (OI) is responsible for conducting and coordinating investigative activities related to fraud, waste and abuse in more than 300 HHS programs.

The United States Department of Justice is the chief law enforcement agency of the Federal Government. Examples of criminal activity they would represent the Federal Government are:

- False statements on claims
- Concealment of material facts or events affecting eligibility
- Misuse of benefits by a representative payee
- Buying or selling Social Security cards or SSA information
- SSN misuse involving people with links to terrorist groups or activities
- Crimes involving SSA employees

Other violations include:

- Conflict of interest
- Fraud or misuse of grant or contracting funds
- Significant mismanagement and waste of funds
- Standards of conduct violations

Allegations of identify theft will be referred by the OIG to the Federal Trade Commission.

The following federal laws are primarily used:

- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act)
  - Violations of Section 1128A include but are not limited to:
    - Billing for claims for medical items or services, which were not provided.
    - Billing codes for services that result in a higher reimbursement than what was actually rendered.
    - Services rendered by an individual who was not a licensed physician
    - Coverage not in effect on the date of service
    - Billing for services that were not medically necessary
    - Hospitals who knowingly make payment to a physician as an inducement to reduce or limit services
    - Physicians who accept such payments
- Social Security Act (Section 1909) which was redesignated 1128B
  - Violators under this section:
    - Convicted of a felony can be fined not more than $25,000 or imprisoned for not more than five years, or both.
    - Convicted of a misdemeanor can be fined not more than $10,000 or imprisoned for not more than one year, or both.

All employees of VBCMH, Venture Behavioral Health, their delegates, or individuals under contractual arrangements will comply with all State and Federal Laws by:

- Ensuring that claims presented for reimbursement are appropriately billed. Do not make assumptions and enter missing data.
- Entering claims for adjudication without alteration. All claims should be entered as billed. Providers may submit corrected claims if needed.
- Never accept gifts in exchange for special treatment.
- Report suspected fraud immediately.

In addition, every effort will be made to identify third party payment resources. Use diligence in reviewing these claims for secondary payment and re-verify other insurance no less than annually.

The Program Investigation Section of the Michigan Department of Community Health (MDCH) is responsible for investigating all suspected Medicaid Provider fraud and/or abuse.

If you suspect claims fraud, report it to the VBCMH Compliance Officer through one of the following mechanisms:

- Telephone Hotline: 1-800-292-5419
- Electronic Mail: mfarrington@vbcmh.com
- Direct Telephone: 1-269-655-3323
- In Person or Mail Delivery to the following address:
  Compliance Officer
  Van Buren Community Mental Health
  801Hazen Street, Suite C
  Paw Paw, MI 49079

XII. SYSTEM SECURITY:

VBCMH and Venture staff will avoid Conflict of Interest between their claims entry, claims payment and authorization functions through the MCIS security access protocols and management practices. For VBCMH, the boundary between their Provider and MCO roles shall be established in principle and in practice.

Periodic, regular and ad hoc MCIS audit trail reports for each user shall be performed by the Venture database administrator and analyzed by Venture management. MCIS audit trail reports for VBCMH staff will be available to the VBCMH CEO's.

Any person may request that the Venture COO initiate an audit report within MCIS. If, in the Venture COO's judgment, an actual or perceived structural or MCIS access Conflict of Interest exists, a formal written request will be made to the VBCMH CEO to remedy the conflict and initiate removal of MCIS access.

Requesting System Security

1. Employees needing security to access the Streamline Care Management system or needing to change their access should contact their supervisor to make this request. Once approved, the employee or his/her supervisor will forward the request via e-mail to the local Technology Manager. The request should include the user's name, department, the change/addition needed and business purpose for the request.
2. Providers needing access to the system via Provider Access portal or needing to change their access should contact the VBCMH staff person as specified during Provider Access training or in their Provider Manual. This identified individual will contact the local Technology Manager or Venture Operations Manager.
3. Requests for access or change of access will be forwarded to the Venture Operations Manager for approval.
4. If the request is a change to existing security, the Venture Operations Manager will review the business need and department to ensure separation of duties is maintained. If no Conflict of Interest exists, the request will be approved and the changes will be implemented.
5. If the request represents a new system user, the Venture Operations Manager will check for conflict of interest concerns and notify appropriate technology staff to add the User ID and document the addition.
6. Documentation of all Streamline Care Management users ID's, employee job functions, and assigned security are maintained within the MCIS and accessible only by those with System Administrator security clearance.

Confidentiality of System Information

All Streamline Care Management users are required to comply with HIPAA security and privacy regulations. Access (including viewing, browsing, etc.) is restricted to only such data that is required to complete business processes. Employees are prohibited from casual viewing of patient information for reasons other than the completion of business transactions. Patient information cannot be discussed with or released to anyone other than the patient, their legal guardian or those authorized by the patient.

Confidentiality of System Access and Passwords

1. Each employee granted a Streamline Care Management User ID, accesses the system with a unique password. The initial password is assigned by an Administrator with instructions to change the password on initial login.
2. Thereafter, passwords should be changed quarterly.
3. If you suspect that someone has gained access to your password:
   a. Report the incident immediately to your supervisor and the Security Officer
   b. Change your password immediately.
4. If you forget your password, contact Venture Technology Staff for assistance. You will be asked to validate your identity and the password can be reset. The user will change the temporary password on login.
5. Supervisors should notify the Venture Technology staff to terminate Streamline PCM access for employees who terminate employment or whose job functions change to no longer require system access.
6. Employees are responsible for all transactions made in the MCIS with their User ID.
   a. Never allow others to access the system while you are logged in.
   b. Never disclose your password.
   c. Do not login when others could observe the password you enter
   d. Do not allow others visual access to the patient information available to you through your security
   e. You must have a password-protected screensaver that is activated after a maximum of 10 minutes inactivity
   f. Logoff the system at the end of the day and when leaving your desk for extended periods

In accordance with Venture policy, violating confidentiality of system access, passwords, patient privacy or ethics is considered a disciplinary offense and could result in revocation of your Streamline Care Management User ID.

Levels of Security

Security levels are assigned to limit access to information and systems necessary only to perform specific job functions. The use of security levels also ensures appropriate separation of job functions to prevent a Conflict of Interest. For example, employees whose job function requires the entering or updating of service authorizations may not be granted security to enter or adjudicate claims.

Conflict of Interest

A Conflict of Interest related to system security may expose the organization to potential misuse. Potential Conflicts of Interest include but are not limited to the following security combinations:

1. Enter/adjudicate claims and enter authorizations
2. Enter/adjudicate claims and enter contract information

XIII. CLAIMS APPEALS AND DISPUTES:

Providers have the right to appeal adverse actions taken by VBCMH or Venture Behavioral Health. Generally the reconsideration process can be either an “appeal” or a “claim dispute.”

Provider Claims Appeals

Providers may Appeal adverse decisions where they are being held financially responsible for charges on the basis of the following issues:

- Denied service authorizations
- Pre-authorization of procedures, hospitalizations or medications are denied
- Hospital length of stay denied or reduced
- Medical necessity denial
- Services denied due to contract/benefit plan limitation

Provider Claims Disputes

Providers may request that claims denied for administrative reasons be reconsidered. Some examples of these claims denials are:

1) Claim denied for member not eligible
2) Claim denied for no authorization
3) Claims denied for missing information
4) Claim denied for delayed filing
5) Claim underpaid due to billing/processing error
6) Disagreement regarding payment methodology

Venture will respond to all calls or written inquiries from providers questioning claim denials or methodology for payment calculation. Resolution of these inquiries should include:

- Documentation of the issue.
- Research to determine if re-processing is warranted due to error or additional information.
- Identification and correction of eligibility and system issues.
- Submission of requests to have claims corrected (where appropriate).
- Involving provider relations, as needed, to resolve contractual issues and provide education.
- Ensuring provider is advised of the outcome of the dispute.
- Advising the provider of his right to further levels of appeal.
- All appeals or disputes regarding denied claims must be filed within 120 days post denial.

XIV. WAIVER OF ELECTRONIC SUBMISSION:

Venture Behavioral Health will consider waivers to the Venture requirement of electronic submission of claims on an individual provider basis.

Automatic Exceptions

The following provider types shall be afforded an automatic waiver without necessity of applying:

- Out of Network Providers
- Providers who submit 18 or fewer claims with no more than 31 claim lines per claim per fiscal year.
- State hospital facilities
- Providers who are new to the regional list of Venture Behavioral Health providers will be granted an automatic 90 day waiver.

Applying for Waiver

Providers who wish to be considered for a waiver to submit paper claims must submit that request in writing to the Venture Behavioral Health Operations Manager in one of the following manners:

Mail:
Venture Behavioral Health
Attn: Operations Manager
100 Country Pine Ln.
Battle Creek, MI 49015

Fax:
(269) 979-9728
Attn: Operations Manager

Email:
amw@summitpointe.org

The following information must be included in any application for a waiver:

- Provider Name
- Contact Person
- Phone Number
- Name of CMHSP contract is with
- Barriers to utilizing electronic methods
- Amount of time waiver is needed

Waiver Decision

The Venture Behavioral Health Operations Manager will take one or more of the following actions within 15 business days of receipt of waiver application:

- Approve the waiver in it's entirety
- Approve the waiver for a shorter period of time than requested
- Work in conjunction with VBCMH to determine if any accommodation can be afforded the provider.
- Deny the waiver

Appeal of Decision

At the request of any provider, the VBCMH Provider Network Manager or at the prerogative of the Venture Operations Manager any provider request for waiver may be submitted to the Venture CEO Committee for final determination. The Venture CEO Committee will receive only the information needed to render a decision which will not include any identifying information such as name or contracted affiliate. All waiver determinations of the Venture CEO Committee are final.