VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

Title: Claims – VBCMH MCIS - ViewPoint | **Number:** III.18
Originated: 04/25/06 | **Approved By:** Executive Team
Revised: 07/13/10, 10/23/15, 06/14/17, 05/29/19, 5/17/22, 9/20/22

DIRECTIVE:
Van Buren Community Mental Health (VBCMH), as a Participant of Southwest Michigan Behavioral Health (SWMBH), will utilize VBCMH's Managed Care Information system (MCIS) for the processing of all contractual mental health claims. Southwest Michigan Behavioral Health is an administrator of Medicaid behavioral health benefits acting as the Michigan Department of Health and Human Services (MDHHS) 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 VBCMH.

Inpatient Facility and Crisis Residential services are authorized by SWMBH. The VBCMH utilization manager or designee will monitor weekly the CM Authorizations banner in SWMBH's SmartCare system for any authorizations of inpatient services that have dates/units that need to be modified on the initial authorization in the ViewPoint system and will make such modifications so that authorizations in both systems match.

PROCEDURES:

I. COMMUNICATION TO CONTRACT PROVIDERS:

It is the responsibility of VBCMH 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 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:

All claims shall be filed using the current Van Buren data layout in accordance with HIPAA transaction standards or via the VBCMH MCIS 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 VBCMH by utilizing the file upload process through the VBCMH MCIS software system. The 837 Companion

guide can be located within the "Help" section of Viewpoint and made a part of this policy by reference. Providers are required to successfully submit test claims batches before access to the production system will be granted.

VBCMH MCIS System
Chrome is the preferred browser for use of Viewpoint but there is no required web browser for use. The following claim fields are required:

- Consumer name
- Dates of service
- Time of service (if procedure code requires)
- Procedure code and modifiers
- Diagnosis
- Total Charges
- Place of Service
- Units
- Rendering Provider
- Any third-party payments (COB)

Paper Claims
Only providers who are afforded a waiver by VBCMH will be allowed to submit claims via paper format. Unless otherwise waived by VBCMH all paper claims must be submitted on an original UB04, CMS1500 or VBCMH 3806 claim form. There will be no deviation from this requirement unless the provider meets the waiver provision to do so.

Address to File and Contacts
All paper claims for VBCMH should be sent to:

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

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

For inpatient providers, it is the "Through" date indicated on the claim.
For all other providers, it is the date the service was 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
- 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 within 120 days of the Medicare resolution.

Adjudication Schedule
All claims are adjudicated within the VBCMH MCIS software system at a minimum of weekly.

III. CLAIMS CONTROLS:

All claims, regardless of billing format or claim type, must be processed within 90 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 the VBCMH MCIS software system due to missing information must be tracked manually to ensure processing time frames are consistent with the law.

Payment will be made to all providers for at least 90% of all clean claims within 30 days of receipt of a clean claim and at least 99% of all clean claims will be paid within 90 days.

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.

Claim Numbers
- The VBCMH MCIS software 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.

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 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 enough 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.

V. PAPER CLAIMS ENTRY:

All claims for which VBCMH has an actual or purported accountability shall be entered into VBCMH's MCIS software system. Claims for services not authorized are not able to be entered. Providers will receive a denial letter. These claims are tracked in an excel data sheet. 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 VBCMH. Claims submitted longer than 365 days from the date of service shall be entered into the VBCMH MCIS software system, or tracked in excel when unable to be entered, 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 the VBCMH MCIS software system 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.

Staff with UM authorization access shall not have access to enter claims.

<u>Medicaid Eligibility</u>
Medicaid Eligibility will be verified initially upon intake. PCE updates Medicaid automatically each month from the State 834, and provides a warning at the top of the client record when coverages end.

Clerical staff members do financials yearly and verify other coverages (Medicare, Medicare Advantage plans, Private insurance). If any time during the year a claim is rejected an e-mail is sent for coverage to be verified/updated.

The VBCMH MCIS software system 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 the VBCMH MCIS software system to match name, address, date of birth and social security number.
- If a match is not found, search CHAMPS or 270/271 transfer or like source to establish Medicaid eligibility.

<u>Covered Services</u>
The VBCMH MCIS software system does not allow entry of claims for non-covered services and services without contracts. There must be an active authorization for a customer for a provider to enter a claim in the system. Any claim submitted without a prior authorization will be automatically denied and returned to the provider with a denial letter. Claims that are denied using this process are logged and tracked. Copies of the denial letters are maintained.

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 VBCMH Provider Network staff at 269-655-3304.
- Specific information regarding covered services and supplemental Medicaid Bulletins can be found at http://www.michigan.gov/mdhhs/. VBCMH staff shall review covered services with *all new employees* and review changes/additions with existing staff quarterly when new the Medicaid Provider Manual is published.
- Services denied due as they are a non-covered service will have a denial letter sent to the provider within 30 days of denial by VBCMH staff.

<u>Authorization of Services</u>

Claims that have service authorizations must be keyed into the VBCMH MCIS software system. If there is no authorization present the claims are tracked in an excel spreadsheet and the provider is sent a letter of rejection.

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 upon service inception, 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 Insurances policies section of Administrative tab in the VBCMH MCIS system. Once entered, it is verified annually. If claims are rejected then a note is entered in the record to re-verify coverage with the customer.

- 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 on a spreadsheet 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. Authorizations must be entered into the system in order for payment of the secondary insurance. The Finance department sends the secondary authorization requests to Quality staff who enters the authorization. Once completed the finance team is notified of authorization entry completion.

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 VBCMH MCIS software system for claims to process.
T

All staff can look up eligibility for capitated coverages within the VBCMH MCIS software system via the 271 CHAMPS data upload completed within the system. All Capitated data is managed by system, additional coverages are collected and entered as part of the eligibility determination and annual financial review process completed by Access Technicians and primary staff depending on the department's procedures. Demographic information can be updated at any time in the client's record as staff are informed of changes. All staff can access and see entered insurance and third-party information in the insurance tab of the client's chart and changes are submitted via the insurance change form to staff who are responsible for maintaining the process.

VI. CLAIMS ADJUDICATION:

Adjudication

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

- Compares the date of service to authorization effective and termination dates
- Searches for duplicate claim lines and/or overlapping service activity logs
- 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 provider has an active fee schedule for the dates of service
- Compares to and from dates to units billed
- Validates the service does not exceed the frequency allowed if such is specified in the fee schedule
- Validates if start/stop times are present when required by the CPT and Revenue Code Crosswalk
- Validates that dates of service are after October 1, 2021
- Validates the service was submitted within the time frame specified in the provider record
- Validates that the units billed does not exceed the maximum allowed per day
- Validates units billed vs. elapsed time reported if CPT code is setup to require time
- Validates elapsed time is within the proper parameters (i.e., 90832 is 16-37 minutes)
- Validates the number of units claimed are available on the authorization
- Validates if consumer has 3rd party insurance covering the billed service that COB data has been provided on the claim line

- Validates that professional services list a rendering provider/NPI

Batch Adjudication Schedule
VBCMH claims adjudication staff will perform batch adjudication of claims a minimum of once weekly.

VBCMH Responsibility
- Ensure claims for secondary processing are received by VBCMH and EOB's have been requested from the primary carrier if necessary.

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

VBCMH claims staff are responsible for working any denials (full or partial) that indicate:
*No fee schedule exists for the service under this provider on the date of service
*No open admission was found for the date of service
*Duplicate and/or conflicting service previously claimed on this date of service
*Consumer hospitalization discharge date is missing on authorization.

Re-Adjudication of Claims
Occasionally a claim that has been adjudicated in the VBCMH MCIS software system 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.

SWMBH can provide consultative assistance, when needed, to resolve complex claims issues or refer them to the SWMBH Chief Administrative Officer

VBCMH will ensure that an EOB is mailed to a minimum of 5% of the Medicaid consumers served by the VBCMH annually.

VBCMH Explanation of Benefits Procedure (EOB)

VBCMH will ensure that an EOB is mailed annually following the process below:
1. The AP Claim Detail Report which is found under the Reports and Downloads banner will be generated using the date range of 10/1 – 9/30 of the previous year. The report must be run prior to 9/30 to ensure mailing by 10/1.
2. The report will be filtered by funding sources
3. A sample size equaling a minimum 10% of the resulting list will be chosen to be issued EOBs
    a. This is an over sample to ensure that only active customers receive EOBs and to account for returned mail due to address changes.
4. EOBs will be sent only to active customers
5. The Case numbers will be entered in the History of the Consumer EOB/Summary of Service Reports module, which will produce the EOBs to be sent to the customers.
6. If needed, this process can be completed on a quarterly basis.

VII. ACUTE 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 needs to send a claim/ letter requesting payment along with the primary payor EOB to:

    Van Buren Community Mental Health Authority
    Attn: Billing

P.O. Box 249
Paw Paw, MI 49079-0249

2. 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 a denial letter should be sent to the provider.

3. Medicaid must pay the copay, coinsurance and/or deductible amount up to the contracted amount. The primary payer determines medical necessity by virtue of having already paid the claim.

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

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

6. If no financial obligation by Medicaid is found in the request, VBCMH will forward a letter of denial to the provider and maintain documentation of such.

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 VBCMH at the following address within one year of date of service or 120 days post Medicare payment received whichever is earlier:

   Van Buren Community Mental Health Authority
   Attn: Billing
   P.O. Box 249
   Paw Paw, MI 49079-0249

2. The Van Buren CMH will determine if a financial obligation of Medicaid benefits is warranted. The MDHHS guidelines on the payment of Medicaid secondary coverage to Medicare primary coverage will be used to make this determination. Van Buren CM will ensure that the MCIS software system is updated to reflect current Medicare coverage benefits.

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

4. If no financial obligation by Medicaid is found in the request, VBCMH will forward a letter of denial to the provider and maintain documentation of such.

5. Upon issuance of authorization for payment of Medicaid funds, the UM department will forward an authorization to the provider 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 SWMBH 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 SWMBH 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 VBCMH 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 the VBCMH MCIS software system 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 the VBCMH MCIS software system.

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

In accordance with State and Federal regulations for the recovery of overpayment to providers, claims not recovered within 60 days will be referred to the Compliance office that then may require the involvement of the Michigan Office of the Medicaid Inspector General (OIG) as appropriate.

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 the VBCMH MCIS software system 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.

7. Ensure that encounters associated with the refund request have been reverted prior to the expiration of the 60-day timeframe, regardless of when the refund has been received.

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. If the check is to be refunded the VBCMH Viewpoint software system must be updated reversing the encounters to maintain the integrity of encounter reporting and documenting the reason for the reversal. The financial software system Dynamics must also be updated to reflect this activity. 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.

Security of "live" (Negotiable) Checks

VBCMH will follow established procedures for opening, logging, posting and depositing checks. These procedures should include securing checks in a lock box or safe until they are ready for deposit. Returned checks related to claims processing may require time to research, update Viewpoint 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, inboxes or work files.

VBCMH 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 ViewPoint and Business Central to ensure future checks are not returned.

Reasons for Refunds

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

VBCMH issued 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 their patient (paid wrong provider)
- ⦿ an overpayment has previously been identified and refund requested

Updating the ViewPoint software system

1. VBCMH 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.

2. All other VBCMH issued checks returned by the provider must be researched.
   a. If the check was issued to the wrong provider, the returned check must be VOIDED, and the claim reprocessed to the correct provider
   b. 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 reconsidered to $0
   c. If the check is a pay back for a disputed amount a note must be added to the claim advising the rationale for the takeback.
   d. Both the Dynamics check/ payment system and Viewpoint will be updated to reflect any changes regarding returned checks – ensuring that these systems match is essential.

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 claim's notes. If the check has been voided, re-process the claim.

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 fully utilized 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 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 (OIG) is mandated to protect the integrity of U.S. 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 HHS, 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 in which 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 identity 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 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 re-designated 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.

Van Buren CMH staff will:

- Ensure that claims presented for reimbursement are appropriately billed. Do not make assumptions and enter missing data.
- Enter 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 Health and Human Services (MDHHS) 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: levans@vbcmh.com
- Direct Telephone: 269-655-3304
- In Person or Mail Delivery to the following address:
  Compliance Officer
  Van Buren Community Mental Health
  801 Hazen Street, Suite C, PO Box 249, Paw Paw, MI 49079

XII. SYSTEM SECURITY:

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, individuals whose job function requires the entering or updating of service authorizations may not be granted security to enter or adjudication claims.

Periodic password changes are required. Providers are required to request access for new users an provide information when a staff member no longer requires access to Viewpoint. If a provider neglects to inform VBCMH of a staff termination, within 30 days of no access the account will be locked, and access denied.

Requesting System Security

1. Employees needing security to access the VBCMH MCIS software 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 Provider Network. 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 the VBCMH MCIS software system or needing to change their access should contact the VBCMH Provider Network staff person identified as responsible for this set-up. This identified individual will assist with the changes in access.
3. If the request is a change to existing security, VBCMH 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.
4. If the request represents a new system user, VBCMH Provider Support will check for conflict-of-interest concerns and ensure that the user is added and document the addition.

5. Documentation of all the VBCMH's MCIS software system users' ID's, employee job functions, and assigned security are maintained within the VBCMH MCIS software system and accessible only by those with System Administrator security clearance.

Confidentiality of System Information
All the VBCMH MCIS software system 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 VBCMH MCIS software system 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 when prompted.
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 VBCMH Provider Supports 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 VBCMH Provider Support staff to terminate VBCMH MCIS software system 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 VBCMH MCIS software system 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 VBCMH policy, violating confidentiality of system access, passwords, patient privacy or ethics is considered a disciplinary offense and could result in revocation of your VBCMH MCIS software system 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 GRIEVANCE AND APPEALS PROCEDURE:

Providers have the right to appeal adverse actions taken by VBCMH regarding claims denials."

Provider Claims Grievance and Appeals Procedure

1. Providers may Appeal adverse decisions where they are being held financially responsible for charges based on the following non-clinical issues:
    - Services denied due to contract/benefit plan limitation
    - Reduction, suspension, or denial to provider payment
    - Denied for delayed filing
    - Denied for member ineligibility
2. Notification of Right to Appeal will be included in each provider contract.
3. All provider appeals of claims payment should be made within 30 days of denial and will not be accepted after 180 days post denial date. Any claims denied beyond this time frame are considered to have reached a FINAL resolution. The appeal will be directed to the VBCMH Finance Supervisor.
4. Within 10 days after a provider appeal request, a preliminary review of the claim and appeal details to determine if additional information from provider is required will be done by the claims processing department. If additional information is requested the provider will be notified in writing of the request.
5. The provider must submit all documents, written statements, and other documentation that supports the appeal within 10 days from receipt of the request to the VBCMH Finance Supervisor. The provider should also include a copy of the denial notice/remittance advice and the dollar amount of the claim for each disputed claim.
6. The VBCMH Finance Supervisor and/or claims processors will review all information submitted and determine if the original denial should be overturned in their opinion. If the original denial is

    upheld by the VBCMH Finance Supervisor and/or claims processor they will submit all appeals and documentation to the VBCMH CFO for review and determination.
7. Final determination of claims status will be made within 30 days of receipt of all requested information. The final determination will be made in writing and explain the facts upon which the determination is made. The decision of the CFO is considered final for General Fund determinations. The decision of VBCMH is considered final for determinations for funds received through the PIHP.
8. Claims submitted beyond 365 days post service date will not be considered for payment of appeal.
9. Providers within the SWMBH region may, as a final step, appeal any Medicaid claims dispute decisions to the SWMBH Chief administrative Officer.

Attachments:

A. Appeal / Dispute form

B. Van Buren CMH (VBCMH) COMPANION GUIDE FOR THE 837 PROFESSIONAL CLAIM Version 5010A1