Subject: **Finance**	Procedure: **MCCMH MCO Policy 7-010 Exhibit A: Claim Information**	
Last Updated: **08/30/2024**	Owner: **Chief Financial Officer**	Pages: **6**

I. PURPOSE:

To define and describe the operational guidelines for handling claim information.

II. DEFINITIONS:

None.

III. PROCEDURE:

A. Adjudication Report

1. All providers are required to run and review the adjudication report in FOCUS prior to submitting claims.

2. This report will show any overlapping services, the rates paid, and denied services.

3. Healthcare providers that have access to the FOCUS system may view claims at any time.

B. Authorized Units

1. At the time of adjudication, Units Available are transferred to Units Claimed.

2. Units are transferred to Paid to Date when they become approved for payment.

C. Batches

1. Upon entering claims into the FOCUS system, a batch is created. The batch is created with a system assigned number.

   a. Providers continue to add claims to a batch.

   b. Providers can start a new batch using the batch drop down and selecting new batch.

   c. Claims can be moved from one batch to another batch or to a new batch after they are saved.

2. Upon batch completion, but prior to MCCMH submission, providers are required to adjudicate and review claims to target claim errors.

    a. Once a batch is sent to MCCMH by a provider, the provider no longer has access to the batch unless a claims staff returns it.

    b. Batch return requests should be sent to claims@mccmh.net.

    c. A provider can view their batch status at any time.

    d. Providers can see whether their batch status has been accepted or rejected when it is sent to MCCMH for processing.

    e. Providers can use the buttons in the claim batch screen to select denied claims, partial paid claims, paid zero claims. These selection options allow providers to filter to just the claims with issues.

D. Batch Status

1. Claim Data Entry

    Claims are being entered into a batch by the provider. MCCMH has not received the batch for review.

2. Not Adjudicated

    The batch has been sent to MCCMH; claims staff has not reviewed the batch.

3. Adjudicated - Ready

    a. A batch is adjudicated and has been reviewed by claims staff. The batch is returned to the provider for errors or questions.

    b. A batch is returned in its entirety, as the claims staff were unable to separate a claim from a batch.

4. Adjudicated – Pending Approval

    Review is complete and the batch is forwarded to an accountant for processing. The batch may be sent back to the provider.

5. Approved for Payment

    a. The batch has been approved by accounting staff.

    b. During this step, a batch cannot be returned to a provider. If a provider finds an error, a Claim Appeal is completed.

    c. All clean claims are paid within 30 calendar days of receipt.

6. Paid/Sent to GL- No Payment posted

The batch is complete. The payment is in process, but payment has not been loaded into FOCUS yet.

7. Paid/Sent to GL – Payment posted

    a. All payment information is now available in FOCUS.

    b. Providers can view each claim and/or batch for date of completion and check number.

    c. Once a provider receives a check or EFT, it is the provider's responsibility to view and/or print the EOP.

E. Claims

1. Claim Staff Processing – Log into FOCUS

    a. Claims are visible in *Adjudicated – Ready* status (Refer to Section III.D.3 of this procedure) and sorted into date order; oldest claims appearing first.

    b. Claims staff manually manage the claims inventory.

    c. Claims are held in inventory for no more than 20 calendar days.

    d. Clean claim batches are adjudicated within 48 hours of the submission date. To adjudicate a batch, the claims staff must elect the batch by placing a check box in the appropriate box followed by clicking the hyperlink to adjudicate. Once batches have been adjudicated, they move to *Adjudicated – Pending Approval* status (Refer to Section III.D.4 of this procedure).

    e. Misdirected claims are addressed by the billing diagnosis and are not accepted into the system.

2. Claim Status

    Claims staff must report the status of any claim a provider is inquiring about in a timely manner. In the instance where a provider is inquiring about the authorization itself, the provider is directed to MCO Staff.

3. Claims Review

    a. Accountants review the claims adjudication report prior to preparing and authorizing check requests.

    b. Accountants run monthly reports to review verifying standard payment accuracy and high-dollar amount claims thresholds.

    c. The FOCUS system and adjudication process control the claim payment amounts.

    d. Any questionable claims issues identified by claims staff or finance staff are referred to the MCCMH Corporate Compliance Division for investigation.

F. Comment Field

The comment field is used to address any pertinent information by providers and claims staff.

G. Edits

1. Batches must be adjudicated by providers prior to forwarding them to MCCMH, to avoid prolonged payment on a claim or a batch return. Edits may include, but are not limited to:

   a. No Open Admission

   b. Units Exhausted

   c. No Authorization Found (837 Format)

   d. Duplicates

   e. Conflicting Services

   f. Discharge Summaries – Hospitals Only

2. An edit may arise at the time of adjudication, warranting a removal of the individual claim from the batch. Providers can delete this claim or move the claim to a new batch. Once an edit is corrected, providers can submit the claim for processing.

3. The following describes the most common edits encountered, in addition to how they should be addressed:

   a. No Open Admission

      MCO has not received completed documentation from the provider to open the person's served record. The MCO staff must be contacted to update the system. If a provider fails to do so, claims staff will forward an email for review.

   b. Units Exhausted

      Units are exhausted when there are no longer any available units to claim against an authorization. Providers need to monitor their utilization and work with the assigned case manager to ensure the authorizations are requested timely.

   c. No Authorization Found

      There must be a valid authorization to process a claim. Any services that require authorization must have an authorization before claims can be saved and submitted.

   d. Duplicates/Overlapping

The FOCUS system allows for service overlaps in accordance with what is allowable for same time reporting on the MDHHS encounter code chart. Any services not specifically allowed per the code chart with have a duplicate edit when a provider claims a service code during a specific time period in which another provider has already claimed a service. Codes which are not allowed to be claimed will be denied. It is the provider's responsibility to properly submit a claim. If a duplicate edit occurs, the provider must resolve the issue in accordance with the Overlapping Service Code Protocol (MCCMH Policy 7-010, Exhibit D).

e. Conflicting Services

Conflicting Services occur when two or more authorization service codes overlap with another provider during the same time frame or when service codes overlap with the same provider that are not allowed within the system.

i. A conflicting service edit can occur because of a data entry error. If it is not the result of a data error, the provider must submit supporting documentation with the claim.

ii. In some instances, a conflicting service error can occur when two different codes of service are allowed on the same date. Claims staff must verify this prior to payment and require the provider to provide supporting documentation to the appropriateness of the claim.

f. Discharge Summaries – Hospitals Only

Claims will be denied if the necessary paperwork has not been submitted to MCO by the provider. Once paperwork is received by MCO, the discharge date will be entered into the system.

H. Fiscal Year

1. The fiscal year is a twelve-month period which begins on October 1st of each year.

2. All providers must adhere to the timely filing standard of 60 calendar days. Please refer to MCO Policy 7-010 for further information.

I. General Information

1. Claims can be entered into the FOCUS system in either Direct Data Entry format or 837 Electronic File format.

2. Direct Data Entry consists of HCFA 1500 or UB04 claim forms. Providers enter claims for professional services on the HCFA 1500 or 837P if electronic and claims for institutional services on the UB04.

J. Hospitals

1. All hospitals utilize the UB04 claim form for institutional events, which consist

of inpatient stays or partial days. These may include authorized ECT treatments. Inpatient stays are billable when the person served is in the hospital from midnight to midnight.

2. With authorization, the first day of admission is payable; discharge date (the last day a person is in a hospital) is not.

3. Partial days may consist of any day except weekends. The first and last day for partial days are payable with authorization.

K. Non-Contracted Provider

Refer to MCCMH Policy 7-010 and corresponding exhibit documents.

L. Overrides

Claims staff can override events within a claim where appropriate. In the event claims staff override a particular event prior to realizing a batch needs to be returned to the provider, the batch must be adjudicated prior to returning for overrides to hold. Said overrides may include, but are not limited to:

1. Partial Day Services

These services can be provided along with residential and/or inpatient.

2. Rate

A person served may have a higher per diem rate than set in place by the fee schedule. This is indicated in the person's authorization.

3. Known FOCUS Issues with an Edit

A known issue sometimes arises which will require the intervention of claims staff to override an edit and pay a claim.

IV. REFERENCES:

None.

V. RELATED POLICIES:

MCCMH MCO Policy 7-010, "Claims Process"

VI. EXHIBITS:

None.

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	8/30/2024	Creation of Procedure.	Deputy Chief Financial Officer