Subject: **Finance**	Procedure: **MCCMH MCO Policy 7-010 Exhibit D: Overlapping Service Codes**	
Last Updated: **08/30/2024**	Owner: **Chief Financial Officer**	Pages: **2**

I. PURPOSE:

To define and describe the operational guidelines for providers to use when they are denied payment for services due to overlapping service edits.

II. DEFINITIONS:

Clean Claim
A claim that has no defect, impropriety, or lack of any required substantiating documentation including a lack of the substantiation documentation needed to meet the requirements for encounter data or a particular circumstance requiring special treatment that prevents timely payment. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

III. PROCEDURE:

A. MCCMH ensures the integrity of the claims payment system by establishing claims payment edits that identify overlapping services.

B. MCCMH's PCE Claims Payment System provides timely information to providers regarding overlapping service codes.

C. Before submitting batches of claims to MCCMH, providers must adjudicate their batches to determine what errors have been identified.

    1. Language related to overlapping services will contain the necessary information for providers to determine how they can resolve the error. For example, error number LA09 will read, "Duplicate and/or overlapping service already claimed on this date. See claim number (claim it is conflicting with) from provider (provider ID/provider name)."

    2. Such information will allow the provider to contact the other provider in question and resolve the overlapping issue.

D. It is recommended that claims with overlapping denials be separated into a different batch and clean claims submitted. This will ensure that the entire batch is not held up while duplicate issues are being resolved.

E. Providers must resolve and submit clean claims within 60 calendar days of the date of service, following the regular claims submission guidelines.

F. If a provider is unable to resolve the overlap, they will send their batch for processing as normal.

G. Overlapping services will be processed as denials upon receipt. Claim appeals are available through the claims appeal module.

H. If the two providers believe that the overlapping services should be allowed due to the nature of the services or medical necessity, a claim appeal should be created by the provider whose service was denied.

1. Documentation must be available for review in FOCUS or attached to the appeal.

2. Appeals will be processed within 5 business days.

3. For further information on submitting a claim appeal, refer to the guides under "Help" in the FOCUS system.

I. If the overlap is approved for payment, MCCMH staff will pay the denied claim or instruct the provider on proper claim submission within claim appeal comments. The submitter will receive email notification for each appeal update.

J. If the overlap is denied for payment, the provider determined by MCCMH to be in compliance with all local, state, and federal coding and billing regulations will be paid. The provider determined by MCCMH to be out of compliance will have their claim reconsidered by MCCMH. The provider may submit a claim correction if there was a time error.

IV. REFERENCES:

None.

V. RELATED POLICIES:

MCCMH MCO Policy 7-010, "Claims Process"

Annual Review Attestation / Revision History:

Revision #:	Revision/Review Date:	Revision Summary:	Reviewer/Reviser:
1	06/14/2022	Revision of Protocol	MCCMH Finance Division
2	08/30/2024	Revision of Protocol	MCCMH Finance Division