Chapter 4: Fiscal Policies & Procedures	Effective Date: 11/1/18
Section 4.1: External Claims	Replaces Policies Dated: 9/11/17, 12/8/16, 1/19/15, 2/14/13
Policy 4.1.4: Claim Adjudication	Board Policy Reference: No. 03-005, 03-007 (Oversight)
Approval  By: Jean M. Goodrich, CEO Date: 11/1/18	Responsibility: Finance Director

PURPOSE:
To articulate Summit Pointe's standards regarding Claim Adjudication.

POLICY:
It is the policy of Summit Pointe to establish and maintain procedures for the timely submission and processing of claims for external contractors within its provider network that meet regulatory standards and encompass an avenue for claims appeal and dispute resolution.

DEFINITIONS:
External Provider: Contracted provider of authorized services for Summit Pointe customers.

PROCEDURES / REQUIREMENTS:

Summit Pointe will adjudicate all claims based on the following standards while adhering to business industry standards surrounding claims processing.

A. Adjudication Rules and Edits:

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

- Compares the CPT code billed to the care authorized and contracted provider.
- Compares the date of service to authorization effective and termination dates.
- Validates insurance coverage was in effect for each date of service.
- Searches for other insurance information.
- Searches for duplicate claim lines.
- Validates that the service was covered in the provider contract for the date of service billed.
- Validates the provider's current rate and the number of units authorized.
- Validates the claimed amount against the contracted amount. If a charge is more than the contract, the contract amount will be paid and the rest denied.
- Validates the service was submitted within the time frame allowed per individual provider contract.

- Validates the service does not exceed the frequency allowed if such is specified in the contract.
- Ensures claims for secondary processing have a valid Explanation of Benefits.

B. Timeliness:

- Claims must be initially received and acknowledged by Summit Pointe within twelve (12) months from the date of service or the time frame within their individual contract if less. For inpatient providers, date of service is based on the discharge date indicated on the claim.
- Exceptions to the 12-month filing limit will be considered under the following circumstances:
  - Administrative error by SWMBH or Summit Pointe.
  - Medicaid beneficiary eligibility was established retroactively.
  - Judicial Action/Mandate: A court or administrative law judge ordering payment of the claim.
- Payment shall be made to all providers within 30 days of receipt of a clean claim.

C. Denied Claims:

- Claims that have been adjudicated and denied in the claims processing system will require Summit Pointe claims staff to work with all necessary internal staff members to resolve payment discrepancies, ensure all needed information and authorizations have been provided, and submit the claim for re-adjudication.

D. Explanation of Benefits

Summit Pointe will mail an Explanation of Benefits to a minimum of 5% of the Medicaid Consumers served annually.

E. External Provider Responsibility

It is the external provider's responsibility to ensure that claims are entered accurately for services rendered. If the external provider's services can be reimbursed partially, or in full, by other health insurance coverage plans, the provider must seek reimbursement through those plans prior to seeking secondary reimbursement by Medicaid. Submission of claims for secondary Medicaid processing must be accompanied by a valid EOB.

REFERENCES:

MDHHS PIHP Contractual Requirements – Section 6.6

ATTACHMENTS:

None