BAY-ARENAC BEHAVIORAL HEALTH
POLICIES AND PROCEDURES MANUAL

Chapter: 8	**Bay-Arenac Behavioral Health Authority**		
Section: 7	**Claims**		
Topic: 1	**Claims Auditing – Adjustments, Dispute Resolutions and Appeals Processes**		
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Affiliation CEO Approval Date:			_____ ***Chief Executive Officer Signature***
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Policy:

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to implement an auditing process to ensure the accuracy of claims processing.

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to implement a dispute resolution process for its contracted provider network.

Purpose:

The policy and procedure will ensure accurate claim reimbursement to the appropriate provider.

Applicability:

☐ All BABH Staff
☒ Selected BABH Staff, as follows: Claims Staff, Financial Services Staff
☒ All Contracted Providers: ☐ Policy Only ☒ Policy and Procedure
☐ Selected Contracted Providers, as follows:
☐ Policy Only ☐ Policy and Procedure
☐ Other:

Definitions:

N/A

Procedure:

1. Errors identified after a claim has been adjudicated and paid are dealt with on a claim-by-claim basis. Errors could include: paying an incorrect amount of units claimed, paying

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an incorrect provider, two providers claiming services performed at the same time, or unsubstantiated services provided. If a network provider identifies an overpayment, that provider must:

a. Notify BABHA in writing of the reason for the overpayment and the date the overpayment was identified.
b. Return the overpayment to BABHA within 60 calendar days of the date the overpayment was identified.

2. The following steps occur if a provider has been incorrectly reimbursed.
   a. Select General Claims Search
   b. Search for claims using the available filters
   c. Select Reconsider link
   d. Enter the actual amount and units the claim should have been allowed and reimbursed
   e. Enter comments (if applicable)
   f. Select SAVE
   g. Process the adjustment
   h. If the vendor/provider does not have other claims to offset the voided claims, BABHA will request reimbursement from the vendor/provider via check.

The history of the original claim information is not destroyed and can be reviewed at any time.

3. Errors resulting in payment to the wrong vendor would result in voiding the claim. Again, this is dealt with on a claim-by-claim basis. The following steps occur if a provider has been reimbursed in error.
   a. Select General Claim Search
   b. Select Void/Reconsider to $0
   c. Enter Void Reason
   d. Process the Void/Reconsider
   e. If the vendor/provider does not have other claims to offset the voided claims, BABHA will request reimbursement from the vendor/provider via check.

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The history of the original claim information is not destroyed and can be reviewed at any time.

The claim processor would then re-key the claim under the correct provider identification number for processing.

4. Providers receiving denied claims for duplicate/overlapping services of shared consumers should reference the claim in the Electronic Health Record (EHR) (Claim Management link) for notes indicating which provider was previously paid for overlapping time(s).
   a. Both providers should work independently and seek resolution as to who provided the (direct/billable) service.
   b. If agreement is reached, the provider paid in error should submit an Adjustment and Void Request Form to the BABH Claims Dept. Once voids are processed, (see process described in 3. above) both providers may rebill for their accurate block(s) of service time.
   c. If agreement is not reached, both providers should complete a Provider Service Dispute Resolution form, attaching documentation that the service was provided, and submit to the BABH Claims Dept, who will forward to the designated BABH staff person, i.e. Contract Manager or Finance Manager. If the dispute cannot be resolved at this level, BABH internal staff will consult with the appropriate BABH Director to make a determination on which provider should receive payment.
   d. The final determination will be communicated to both providers by the appropriate BABH staff person.

The BABH Finance Department will retain records as to the resolution of disputes regarding claims.

5. Claims Appeals:

In order to process appeals in a timely manner, the following steps will be implemented.

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Step 1. The provider shall submit a written correspondence to the Finance Manager of BABH detailing the dispute. This correspondence will be stamped with an electronic date and time of arrival. The Finance Manager will make a decision within 14 days of the received correspondence.

Step 2. A written correspondence will be communicated back to the provider –
   a. upholding the original decision or
   b. over-riding the initial decision and approving the claim for payment.

Step 3. In the event that the original decision is upheld, and the provider is still in dispute of the decision, the provider shall submit a written correspondence to the Chief Financial Officer (CFO). The correspondence will be stamped with a received date. The CFO will make a decision within 14 days of the received correspondence.

Step 4. A written correspondence will be communicated back to the provider –
   a. upholding the original Finance Manager's decision or
   b. over-riding the Finance Manager's decision and approving the claim for payment.

Step 5. In the event that the claim is still in dispute, the matter will be referred to the Executive Director of BABH.

Attachments:

N/A

Related Forms:

Adjustment and Void Request Form (G:\BABH\Contracts Protected/BABHA CONTRACTS/_Network Management Folder/Claims)

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Provider Service Dispute Resolution Form (G:\BABH\Contracts Protected/BABHA CONTRACTS/_Network Management Folder/Claims)

Related Materials:

References/Legal Authority:

N/A

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SUBMISSION FORM				
AUTHOR/ REVIEWER	**APPROVING BODY/COMMITTEE/ SUPERVISOR**	**APPROVAL/REVIEW DATE**	**ACTION (Deletion, New, No Changes, Replacement or Revision)**	**REASON FOR ACTION - If replacement list policy to be replaced**
E. Lewis L. Thomas	M. Rozek	08/28/14	Revision	Chapter review – updated policy statements to reflect current practice.
E. Lesniak	M. Rozek	07/06/15	Revision	Incorporated and modified C11- S11 (Access Alliance of Michigan/Claims Processing) into C8-S7 (Bay Arenac Behavioral Health/Claims)
E. Lesniak	M. Rozek	10/31/18	No Changes	Triennial Review
E. Lesniak	M. Rozek	08/30/21	Revision	Triennial Review-added language stating overpayments need to be returned within 60 calendar days of the date the overpayment was identified