Chapter: 8	**Bay-Arenac Behavioral Health Authority**		
Section: 7	**Claims**		
Topic: 2	**Claims Submission and Reimbursement –**		
Page: 1 of 4	**Supersedes:** **Pol: 6-19-03** **Proc: 6-3-09, 8-25-08, 6-19-03**	**Approval Date:** **Pol: 8-20-15** **Proc: 7-6-15**	*Board Chairperson Signature* *Chief Executive Officer Signature*
Policy applies to: 11-10-1, 11-10-2, 11-10-3, 11-10-4, 11-10-5, 11-10-6, 11-10-7, 11-10-8, 11-10-9, 11-10-10, 11-11-1, 11-11-2, 11-11-3, 11-11-4, 11-11-5, 11-11-6, 11-11-7, 11-11-8, 11-11-9, 11-11-10, 11-11-11, 11-11-12, 12-3-1			
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Policy

It is the policy of Bay-Arenac Behavioral Health Authority (BABHA) to receive, process and adjudicate claims from its contracted provider network that meets or exceeds behavioral health industry and regulatory standards for the public mental health care system.

Purpose

This policy and procedure establishes that professional and institutional services by providers will be billed to BABHA using standard CMS 1500 billing forms, Electronic 837P files, National Uniform Billing Committee (NUBC) UB-04 claim forms, Electronic 837I files, or Direct Data Entry (DDE) into the BABHA Electronic Health Record (EHR).

Applicability

☐ All BABHA Staff
☒ Selected BABHA 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

Standard

BABHA will process 90% or higher of CMS 1500 and UB-04 claims submissions within 30 days of receipt.

Definitions

N/A

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Procedure

1. Claims may be submitted electronically or on paper. Claims may be prepared on a typewriter or computer. Handwritten forms must be legible. It will be up to the discretion of BABHA to determine legibility.

2. Instructions for completing the CMS-1500 claim form are available on the NUCC website or through your CMS-1500 vendor.

3. Instructions for completing the UB-04 claim forms

   - Dates must be eight digits in the formal MMDDCCYY (i.e., 01012002). Be sure the dates are within the appropriate boxes on the form.
   - Use only black ink.
   - Handwritten claims must be legible.
   - Only service line data can be on a claim line.
   - Separate the claim form from the carbon.
   - Keep the file copy for your records.

Forms that do not meet the above requirements cannot be processed and will be returned to the provider unprocessed.

Claim attachments are required to be directly behind the claim it supports and must be identified with the customer's name and identification number. Attachments will be 8 ½" X 11" on white paper.

4. Reporting Provider NPI
   BABHA requires that NPI numbers be reported in any applicable provider loop or field (e.g., attending, billing, referring and rendering) on the claim. Both the NPI and the provider's Taxpayer Identification Number (TIN) or Employer Identification Number (EIN) must be reported at the billing provider loop for all electronic claims.

An Individual NPI is the number associated with an individual healthcare professional (e.g. MD, DO).

A Group NPI is the number required for organizations who provide healthcare services and receive payment. The Group NPI must be reported in the billing provider loop or field. For professional claims the Individual NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter Group NPI as the rendering provider.

5. After claims are entered into the EHR system an adjudicated report is generated. An audit of this report is manually performed to sample the edits performed by the system. Examples include, but are not limited to:
    - Determine consumer eligibility
    - Determine if procedure code is in the provider's contract
    - Determine if reimbursement amount is correct
    - Appropriateness of number of units billed in relation to procedure performed
    - Spot check denials for duplicates to ensure system is properly denying
    - Keypunch errors

6. Once it has been determined that all items on the adjudicated report are ready for the payment process, the claims are approved for payment.

7. The final step is typically completed one time per week and that is to Select Approved Batches for Payment Requests. This step transfers the claims to Accounts Payable.

Attachments

N/A

Related Forms

CMS 1500 (CMS.gov)

UB-04 (CMS.gov)
5010A1 Professional Claims Companion Guide (CMS.gov)

Related Materials

N/A

References/Legal Authority

1. Medical Services Administration Bulletin 02-08; HCFA 1500/837P Provider Manual Chapter IV, Billing and Reimbursement, Effective 4-1-02.
2. MCL Section 400.111i, Act 280 of 1939, revised through PA 5 of 2003

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
K. Bauer	C. Pinter	08/25/08		
K. Bauer	K. Bauer	06/03/09		
E. Lesniak	M. Rozek	07/06/15	Revision	Operational Change. Chapter review; updated Policy statement to reflect current practice. Incorporated and Modified C11-S11 (Access Alliance of Michigan/Claims Processing) into C08-S07 (Bay-Arenac Behavioral Health/Claims)
E. Lesniak	M. Rozek	10/31/18	Revision	Triennial Review-Minor change to Policy Statement-added word "receive"
E. Lesniak	M. Rozek	08/30/21	No Changes	Triennial Review