

**I. FINANCIAL ELIGIBILITY**

- A. A person eligible for Board services is defined as an individual who receives, or is eligible to receive a CMHSP subsidy, or who is eligible for Medicaid services under the Medicaid Provider Manual in the Mental Health and Substance Abuse Section, or who is enrolled in the MI Child program. Access referral and authorization procedures are found in Section B.
- B. The CMHSP will determine the financial eligibility of the consumer for CMHSP services, based on the individual's insurance and ability to pay. In some situations, the CMHSP will not have all the necessary financial information at the point of an intake/authorization. The PROVIDER will provide evidence of efforts to establish consumer eligibility and will assist the consumer with completing an application for Medicaid coverage.
- C. CMHSP may deny payment for any inpatient or partial hospitalization days of care when there is not **documentation** of the PROVIDER's efforts to establish a consumer's eligibility and/or application for Medicaid coverage. CMHSP may **not** deny payment when the PROVIDER has provided evidence that: (1) an individual's primary coverage other than Medicaid is found to be invalid; **and** (2) there is no ability to pay; **and** (3) admission meets Medicaid Medical Necessity and the Affiliation's Service Selection Guidelines.
- D. The Medicaid application and information relating to benefits shall be forwarded to the individuals listed below:

**Allegan County Community Mental Health**

Sarah Clark  
P.O. Drawer 130  
Allegan, MI 49010  
269-673-6617

**Community Mental Health of Ottawa County**

For Medicaid applications:

Lisa Vasche  
12265 James Street  
Holland, MI 49424  
(616) 494-5425

For Facility Admission Notice:

Chris Madden  
12265 James Street  
Holland, MI 49424  
(616) 494-5450

**HealthWest**

MaryBeth Tiffany  
376 E. Apple Avenue  
Muskegon, MI 49442  
231-724-3633

**West Michigan Community Mental Health**

Sharon Dostal,  
Reimbursement Department  
920 Diana Street  
Ludington, MI 49431  
231-845-6294

**Kent Community Mental Health Authority d/b/a network180**

Senior Claims Examiner  
Claims Unit  
Kent Community Mental Health Authority d/b/a network180  
3310 Eagle Park NE, Suite 100  
Grand Rapids, MI 49525  
616-336-3909

- E. If a consumer has more than one insurance policy, the consumer will be asked to verify which insurance is primary, secondary, etc. If the consumer is unable to verify his/her insurance, a call will be placed to the insurance company(ies) to ensure proper billing.
- F. If a consumer has Medicaid along with another insurance, Medicaid is always secondary to the other insurance. Verification of benefits is obtained by calling MediFAX/MPHI.

**II. BILLING AND PAYMENT CONDITIONS**

- A. All claims should be sent to the following addresses:

**Allegan County Community Mental Health**

Sarah Clark  
P.O. Drawer 130  
Allegan, MI 49010  
269-673-6617

**Community Mental Health of Ottawa County**

Ruth Negelkirk  
12265 James Street  
Holland, MI 49424616-393-5673

**HealthWest**

Brandy Carlson  
Claims Department  
376 E. Apple Avenue  
Muskegon, MI 49442  
231-724-1174

**West Michigan Community Mental Health**

Jane Shelton  
Claims Processing Department  
920 Diana Street  
Ludington, MI 49431  
231-845-6294

**Kent Community Mental Health Authority d/b/a network180**

Senior Claims Examiner  
Claims Unit  
3310 Eagle Park NE, Suite 100  
Grand Rapids, MI 49525  
616-336-3909

- B. The payment is considered to be an all-inclusive rate as described in Section A of the Inpatient Provider Manual. Services not prior authorized will not be reimbursed. The rate will be effective based on the first day of the episode and not the service date. Inpatient stays of less than one (1) day will be paid at the per diem rate, and the code required for the claim is **762-Extended Observation Day**.
- C. Valid claims shall be electronically submitted for CMHSP authorized consumers on HIPAA-compliant transactions (837 submissions) within 180 days from the end of the month in which the consumer was discharged. Business to business testing of transactions may be necessary. A clean claim will contain the required consumer data and the ability to pay and reimbursement information. The codes required for the claims are **100-Inpatient** and **912-Partial Hospitalization**. Appropriate documentation of service delivery must also exist in the medical record. *PROVIDERS that are exchanging personal health information with Kent Community Mental Health Authority d/b/a Network 180 will be required to have a Trading Partner Agreement in place.*
- D. For individuals with Medicaid and/or other insurance, a claim is filed to the primary insurance according to the procedure of the PROVIDER. Once a payment is received from primary insurance, a contractual allowance (if any) is taken. A claim is then sent to

the secondary insurer, with a copy of the primary explanation of benefits as appropriate. If a rejection is received from the primary insurance, a determination is made based on the reason for denial. Only the amount listed as copay or deductible will be sent to the secondary insurer. There will be 90 days allowed for the submission of claims after Medicaid or indigent status is no longer pending third party approval.

- E. "Clean" Claims for authorized services provided by the CMHSP Boards of Allegan, Kent, Muskegon, Ottawa, , and West Michigan Community Mental Health will be processed and paid within 30 days of receipt of complete and accurate claims.
- F. Payment from the CMHSP is considered payment in full and will not exceed the contracted per diem. The PROVIDER agrees not to bill, charge, collect a deposit from, seek compensation from, seek reimbursement from, surcharge, or have any recourse against a consumer or persons acting on behalf of a consumer, except to the extent the applicable Health Plan specifies a co-payment, coinsurance, consumer fee based on the ability to pay and deductibles.
- G. Questions regarding payments and claims status should be directed to the contact person listed for each CMHSP.
- H. The PROVIDER will at least annually audit their claims to ensure billing integrity. A Plan of Correction will be required and additional audits will be performed if there are significant findings. The audits and Plans of Correction will be available to CMHSP staff upon request. The PROVIDER is required to prepare a claim adjustment for any claim determined to have been inappropriately billed during the PROVIDER audit.

**III. AUTHORIZATION AND PAYMENT PROCEDURES:  
Inpatient And Partial Hospitalization Services**

Benefit Structure	Authorization	Payment
<p>Medicare/Medicaid</p> <p>Medicare Deductible and co-insurance amounts covered by Medicaid.</p>	<p>Pre-authorizations are not required, but <b>notification is required within 15 days of discharge.</b></p>	<p>Payment is to be made based on Michigan Medicaid Provider Manual rules in effect at the time of the admission.</p>
<p>Medicare/Medicaid</p> <p>Medicare days expired during the inpatient stay.</p>	<p>No pre-authorization, but <b>notification is required within 15 days of discharge.</b> Billing office notifies CMHSP when Medicare days have expired. If medical necessity criteria is met, authorization back to the Medicare expiration will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.</p>	<p>CMHSP will pay the balance of contracted per diem not covered by insurance up to the contracted amount.</p>
<p>Commercial Insurance/Medicaid:</p> <p>Commercial Insurance pays percentage of per diem.</p>	<p>No pre-authorization. Provider must request retrospective review after determination that CMHSP has a financial obligation.*</p>	<p>CMHSP will pay the balance of the Third Party Liability (TPL) deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate.</p>
<p>Commercial Insurance/Medicaid:</p> <p>Commercial Insurance pays for specified number of days, or dollar amount, and Medicaid pays the remainder.</p>	<p>No pre-authorization, but notification is requested. Billing office notifies CMHSP when Commercial insurance is non-existent or commercial insurance days have expired. If medical necessity criteria is met, authorization back to the expiration of the commercial insurance will be completed and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.</p>	<p>CMHSP will pay the balance of contracted per diem not covered by the TPL that meets criteria or the full per diem if the insurance is non-existent.</p>

Benefit Structure	Authorization	Payment
Commercial Insurance with Medicaid or Medicaid eligibility received retroactively.	Retrospective review * following Medicaid eligibility and notification to CMHSP.	CMHSP will pay the balance of the TPL deductible and co-insurance, if the TPL allowed amount (Provider payment plus contract adjustment) is less than the total contracted per diem rate.
Medicare Insurance Only.	No pre-authorization or retrospective authorizations necessary.	No CMHSP payment.
Commercial Insurance Only:  Days expired during the inpatient stay.	No authorization or CSR process.	CMHSP funds will not be authorized. CMHSP does not supplement insurances.
Commercial Insurance Only:  Policy terminated prior to admission <b>or</b> policy does not have a provision for inpatient mental health benefit <b>AND</b> no ability to pay.  (This does not include people who have used up their inpatient days on their policy.)	PROVIDER Billing office notifies CMHSP. PROVIDER staff completes an ability to pay with the consumer. If medical necessity is met, authorization back to the date of admission will be completed, and CSR process will be in place, or a retrospective review will be completed if notification occurs post-discharge.	CMHSP funds will be authorized for approved days of care per review.

**\* Retrospective reviews will be completed by CMHSP within 30 days of receipt of documentation.**

NOTE: CMHSP may deny payment for any inpatient or partial hospitalization days of care when there is no documentation of the PROVIDER's efforts to establish a consumer's eligibility and/or application for Medicaid coverage. CMHSP may not deny payment when the PROVIDER has provided evidence that: (1) an individual's primary coverage other than Medicaid is found to be invalid; (2) there is no ability to pay; and (3) admission meets Medicaid Medical Necessity and the Affiliation's Service Selection Guidelines.

**IV. CMHSP'S PROCESS FOR RESPONDING TO A CMHSP-DENIED CLAIM**

- A. Any claims to be resubmitted must be resubmitted within **120 days** of the date of the Denied Claims Report for CMHSP process. If a PROVIDER error was made in billing, the PROVIDER will make the necessary correction(s) and resubmit the claim. If after checking for errors the PROVIDER believes that the claim was rejected due to an error in the CMHSP claims processing system, the PROVIDER will submit the reason for the appeal in writing to CMHSP, along with any copies of backup evidence. The PROVIDER should send this information to CMHSP to the attention of the following individual:

**ALLEGAN**

Michell Truax  
Allegan County Community Mental Health  
P.O. Drawer 130  
Allegan, MI 49010

**HEALTHWEST**

Brandy Carlson, Mental Health Comptroller  
HealthWest  
376 E. Apple Avenue  
Muskegon, MI 49442

**OTTAWA**

Mental Health Financial Manager  
CMH of Ottawa County  
12265 James Street  
Holland, MI 49424

**NETWORK180**

Claims Appeal Department  
Attn: Theresa Jennings, Financial Supervisor  
Kent Community Health Authority d/b/a network180  
3310 Eagle Park NE, Suite 100  
Grand Rapids, MI 49525

**WEST  
MICHIGAN**

Jane Shelton  
Claims Processing Department  
West Michigan Community Mental Health  
920 Diana Street  
Ludington, MI 49431

- B. CMHSP may deny payment based on denial of admission, denial of continued stay, and retrospective review. In these cases, the initial request for CMHSP authorization for payment of an admission, additional days during a continued stay review, or a retrospective review (defined as the process of approving payment for inpatient care after the individual has been discharged) may be denied by the CMHSP Board's Gatekeeping staff, e.g., master's level clinician. In cases of denial, the CMHSP staff must clearly identify in writing the utilization management criteria used for making the

decision and the alternative service offered. If CMHSP denies payment based on any one of these reasons, the facility may submit a Request for Claims Reconsideration Form C060P. (See form at the end of this section.) CMHSP then sends a decision to the inpatient facility.

C. Within **seven (7) business** days of the CMHSP or PIHP decision to deny a claim, the inpatient facility may then file an appeal of that decision through the process detailed below.

1. Facility will complete the Request for Claims Reconsideration Form (C060P). (See form at the end of this section.)

a. Complete all fields and fax the completed form to Inpatient Appeals.

**Allegan County CMH: 269-673-2738**

**HealthWest: 231-724-4545**

**CMH of Ottawa County: 616-393-5653**

**Kent CMH Authority d/b/a Network 180: 616-336-8830**

**West Michigan CMH: 231-845-7095**

b. For clinically-based appeals, clearly identify the symptoms and functioning documentation for Medical Necessity and Clinical Appropriateness to support the service being requested as defined by the service eligibility criteria for inpatient/partial hospitalization care. (Part III)

c. The facility may request an expedited review for denied urgent care, e.g., admissions denials or denied continued stay days, by checking the section on the bottom of the form. An expedited review is defined as a request to change a denial for urgent care in which the typical time frame for reviews seriously jeopardizes the life or health or ability of the consumer to regain maximum function. It must be supported by information cited in Part III.

2. CMHSP will document the review of the request for reconsideration by completing the Reconsideration Decision Form (C010P). (See form at the end of this section.)

a. A CMHSP Master's level staff person not involved in the prior adverse decision is appointed to review the appeal. They have the authority to approve services for which there are explicit criteria, however, in the case of clinical issues, they do not have the authority to deny.

b. For appeals of clinical issues, e.g., admissions denials or denied continued stay days, a same specialty practitioner must do the review (a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal), for example, a child psychiatrist reviewing a child case appeal.

- c. The reviewing psychiatrist will review the request and may contact the requesting facility psychiatrist. The reviewing psychiatrist will document his/her findings in the Summary of Peer Contact section of the form (Part IV), and fax the form to the inpatient facility.
- d. Within **thirty (30) days** of receipt of the facility request, a decision on an appeal for a retrospective review will be completed by CMHSP.
- e. Within **forty-eight (48) hours** of receipt of the facility request, a decision on an expedited request for continued stay days will be completed by CMHSP.
- f. Within **three (3) business days, excluding Sundays and legal holidays**, a denial of admissions that is not a retrospective review will be completed by CMHSP.