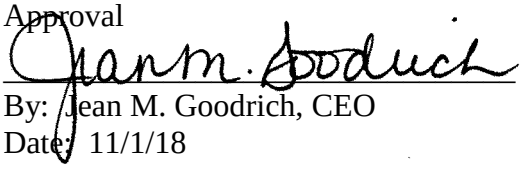
Chapter 4: Fiscal Policies & Procedures	Effective Date: 11/1/18
Section 4.1: External Claims	Replaces Policies Dated: 9/11/17, 12/15/16, 1/19/15, 2/14/13
Policy 4.1.1: Definition of Clean Claim	Board Policy Reference: No. 03-005, 03-007 (Oversight)
Approval  By: Jean M. Goodrich, CEO Date: 11/1/18	Responsibility: Finance Director

PURPOSE:
Summit Pointe is responsible and required to adhere to State and Federal regulations regarding the processing of claims for payments of services to customers.

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:

Clean claims are defined by Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006 (14) as claims that do all of the following:

- Identifies the health professional or health facility that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
- Sufficiently identifies the patient and health plan subscriber.
- Lists the date and place of service.
- Is billing for covered services for an eligible individual.
- If necessary, substantiates the medical necessity and appropriateness of the service provided.
- If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.
- Identifies the service rendered using a generally accepted system of procedure or service coding.
- Includes additional documentation based upon services rendered as reasonably required by the health plan.

Requesting Missing Information –

- Summit Pointe must advise the external provider what information is needed to complete the claim. The notice must be in writing and must be issued within thirty (30) days of receipt of the claim.
- The health plan shall not deny the entire claim because one (1) or more other services listed on the claim are defective.
- The requirement of written notice can me met with a Remittance Advice that is sent to the external provider with the payment of other claimed amounts that indicates the denied claim and its denial reason.
- If the claim is denied, a letter must be sent with the returned claim.
- The external provider has forty-five (45) days from the date the notice is received to correct the defects and ensure the information is received by the health plan.
- If the claim is made clean, the health plan will have forty-five (45) days from the receipt of the additional information to finalize the claim.
- If the claim is not made clean, the health plan will have forty-five (45 days) to advise the external provider of the adverse determination.

Interest Due for Late Claims Payments –

- Failure to pay claims timely is an unfair trade practice unless the claim is reasonably in dispute.
- A clean claim that is not paid within forty-five (45) days shall bear simple interest at a rate of 12% per annum.
- The interest shall be paid in addition to and at the time of payment of the claim.

REFERENCES:

Michigan Insurance Code, Chapter 500, Act 218 of 1956, Section 500.2006

ATTACHMENTS:

None