

# GREATER COLUMBIA BEHAVIORAL HEALTH

## Policies and Procedures

Category: Fiscal Management  
Approved On: 11/07/05  
Approved By: The Board of Directors  
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**No.: FM821.00**

**Title: Plan to Pay Community Hospitals for Title XIX Services Directly  
(Without using DSHS as an Intermediary)**

### **I. Goal:**

Have an efficient and secure system in place to pay community hospitals directly without using DSHS as an intermediary by September 1, 2006.

### **II. Evaluation of Requirements: January 6, 2006 – February 3, 2006**

Upon being awarded the Mental Health contract Greater Columbia Behavioral Health will perform an evaluation of the systems and requirements of community hospitals to process claims. This evaluation will be performed either directly or by contract. Once this evaluation is complete an appropriate claims system will be evaluated.

### **III. Evaluation of Claims Systems: February 6, 2006 – April 28, 2006**

Upon determining the requirements unique to the community hospitals in the service area, Greater Columbia Behavioral Health will perform an evaluation of claims systems. This evaluation will be performed either directly or by contract. The claims system will be required to meet the unique requirements of community hospitals and the GCBH as well as the following common requirements.

#### **A. MIS Security and Information Integration:**

The RSN computer systems with other systems will have a secured FTP site available for both incoming and outgoing transfers which will link the systems computer systems with others. The format used for the exchange of encounter and claims data will be HIPAA Standard ASI 871 record format. In situations where data transmission processes are unavailable, the system will have a secured website which allows for real-time viewing of claims status, etc.

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Data Elements required from GCBH and the community hospitals will include Benefit accumulators, Certificate of Coverage, Plan additions and deletions, and Plan changes. In addition to Lifetime or calendar maximums. Benefit accumulation data elements would include Inpatient days, Outpatient encounters, RTC, Partial days if accumulation is different than outpatient encounters.

**B. Data Elements Captured by the System and Reporting:**

The system will capture demographic information such as name, date of birth, gender and social security number for the subscriber. Additional data elements will need to be easily captured and managed at the GCBH request.

The types of statistical reports needing to be generated to monitor care and cost include inpatient admissions and bed days per 1000 members, hospital discharge follow-ups, readmissions, outpatient encounters per 1000 members. In addition to ad hoc analysis when needed.

**C. Web Technology and the Internet:**

The use of secure websites and FTP sites setup to facilitate the exchange of files between the system and GCBH and providers / community partners will be critical. All of our Web and Internet processes will be HIPAA-compliant.

Web based viewing capabilities for claim status will need to be updated by the system on a real-time basis.

The system will be required to be fully compliant with HIPAA regulations regarding security and patient confidentiality of electronic information.

**D. Claims Processing Procedures:**

All claims need to be scanned into claims workflow system within one business day of receipt. Images of claims will be keyed into the system and the claims automatically adjudicated nightly through batch processing on the claims payment system. Claims that can throughput based upon the information submitted, the presence of an authorization and an automated plan design, need to be auto adjudicated and batched for payment processing. Pended claims will be assigned to a claims analyst, whose workflow is automated and monitored through supervisory look-downs. All pended claims will be

reviewed using the stored image, not a paper claim, all stored images will be electronically date stamped and monitored for appropriate and timely dispensation. Claims submitted that do not include all required claims field, or for services not receiving appropriate authorization will be denied and an EOP generated indicating the reason for denial and the process by which the claim can be resubmitted with appropriate documentation.

E. Claims Performance Standards for Timeliness and Accuracy:

The turnaround goal for both contracted and non-contracted providers is 30 days for clean claims. Turnaround goals will be adjusted as needed based upon regulatory requirements for either the line of business, federal or state requirements. The standard will be 95% of all claims resolved within 30 calendar days and 100% within 60 days. Standards for financial and procedural accuracy will be 97% and 95% respectively.

All claims with a payable amount in excess of \$1000 will be pended to the Internal Claims Quality Control (ICQC) Unit for audit. All components of the claims will be audited for accuracy and either released or returned to the claims unit for correction prior to payment. In addition, the ICQC audit team will randomly review daily audit trails of claims under \$1000. A random audit program should be implemented where a percentage of each claims analyst's claims with a payable amount under \$1000 are chosen for audit. The results of these audits will be available to GCBH through the system reporting features.

F. Questionable Billing Practices:

The authorization for services will be specific to the member, provider, service date range, and procedure code. If the claim data does not match the criteria built into the system it will be reviewed by an analyst to determine if the claim is legitimate and what is needed to resolve the mismatch. Rules for approval, denial or review will be customized based on requirements.

G. Reconciliation of Duplicate or Suspect Duplicate Claims:

Duplicate claim criteria needs to be built into the system. Claims that match a portion of the criteria will pend for analyst review with a message of a possible duplicate. Claims that definitely meet the criteria are automatically denied as such.

H. Record Retention:

Claim and correspondence images will be stored in the system and burned to CD after 3 to 6 months where they will be available for viewing permanently. Images will be available immediately upon request.

**IV. Implementation of Claims Systems:** May 1, 2006 – July 31, 2006

Upon determining the best claims system, Greater Columbia Behavioral Health will implement and test the claims system. This implementation will be performed by both in-house and contracted staff. The testing will be inclusive of community hospitals, GCBH and if appropriate, the out-side claims provider.

**V. Go live with system:** September 1, 2006

Community Hospitals are paid for Title XIX Services Directly by GCBH.

**VI. Scheduled Review of this Policy:**

The revision of the GCBH policies and procedures manual is on a two year cycle. The GCBH policy review and approval process is a three month process. This policy is scheduled to be reviewed every second year:

- A. by GCBH staff by August of odd years,
- B. by the Regional Advisory Board (RAB) by September of odd years,
- C. by the GCBH Board of Directors by October of odd years, and
- D. outside of the schedule if required.