**THE SOCIAL WELFARE ACT (EXCERPT)**
**Act 280 of 1939**

## 400.111i Timely claims processing and payment procedure; external review; report; definitions.

Sec. 111i. (1) The commissioner of office of financial and insurance services shall establish a timely claims processing and payment procedure to be used by health professionals and facilities in billing for, and qualified health plans in processing and paying claims for, medicaid services rendered. The commissioner shall consult with the department of community health, health professionals and facilities, and qualified health plans in establishing this timely payment procedure.

(2) The timely claims processing and payment procedure established by the commissioner under subsection (1) shall provide for all of the following:

(a) That a "clean claim", for the purposes of this section, means a claim that does at a minimum all of the following:

(*i*) Identifies the health professional or health facility that provided treatment or service, including a matching identifying number.

(*ii*) Identifies the patient and plan.

(*iii*) Lists the date and place of service.

(*iv*) Is for covered services.

(*v*) Is certified pursuant to section 111b(17) and has the identifying information required under section 111b(21).

(*vi*) If necessary, substantiates the medical necessity and appropriateness of the care or service provided.

(*vii*) If prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate.

(*viii*) Includes additional documentation based upon services rendered as reasonably required by the payer.

(b) A universal system of coding to be used on all medicaid claims submitted to qualified health plans.

(c) That a claim must be transmitted electronically or as otherwise specified by the commissioner and a qualified health plan must be able to receive a claim transmitted electronically.

(d) That a health professional and facility must bill a qualified health plan within 1 year after the date of service or date of discharge from the health facility.

(e) That after a health professional or facility has submitted a claim to a qualified health plan, the health professional or facility shall not resubmit the same claim to the qualified health plan unless the time frame in subdivision (f) has passed or as provided in subdivision (h).

(f) Except as otherwise provided in this subdivision, that a clean claim must be paid within 45 days after receipt of the claim by the qualified health plan. For a pharmaceutical clean claim, the clean claim must be paid within the industry standard time frame for paying the claim as of the effective date of this subdivision or within 45 days after receipt of the claim by the qualified health plan, whichever is sooner. A clean claim that is not paid within this time frame shall bear simple interest at a rate of 12% per annum.

(g) That a qualified health plan must state in writing to the health professional or facility any defect in the claim within 30 days after receipt of the claim.

(h) That a health professional and a health facility have 30 days after receipt of a notice that a claim or a portion of a claim is defective within which to correct the defect. The qualified health plan shall pay the claim within 30 days after the defect is corrected.

(i) That a qualified health plan must notify the health professional or facility and the commissioner of the defect if a claim or a portion of a claim is returned from a health professional or facility under subdivision (h) and remains defective for the original reason or a new reason.

(j) An external review procedure for adverse determinations of payment as provided in subsections (4) and (5). The costs for the external review procedure shall be assessed as determined by the commissioner.

(k) Penalties to be applied to health professionals, health facilities, and qualified health plans for failing to adhere to the timely claims processing and payment procedure established under this section.

(*l*) A system for notifying the licensing entity for health maintenance organizations, qualified health plans, and other health care insurers if a penalty is incurred under subdivision (k).

(3) If a qualified health plan determines that 1 or more covered services listed on a claim are payable, the qualified health plan shall pay for those services and shall not deny the entire claim because 1 or more other covered services listed on the claim are defective or because 1 or more other services listed on the claim are not covered services.

(4) The commissioner shall establish an external review procedure as provided in this subsection and subsection (5). A health professional or facility may request an external review by the commissioner of a

qualified health plan's adverse determination if the health professional or facility makes the request not later than 30 days after receipt of a notice under subsection (2)(i). Within 10 days after a request for an external review, the commissioner shall complete a preliminary review to determine whether the external review may proceed or request more information from the health professional, facility, or the qualified health plan. The health professional, facility, or the qualified health plan shall supply the commissioner with the requested information not later than 10 business days after receipt of the request for information from the commissioner. Not later than 5 business days after receipt of any information requested by the commissioner, the commissioner shall complete a preliminary review to determine whether the external review may proceed. If the commissioner determines the external review may not proceed, the commissioner shall notify in writing the health professional or facility of the specific reasons for the determination and may permit the health professional or facility to reapply for a preliminary review by the commissioner. If the commissioner determines the external review may proceed, the commissioner shall notify in writing the health professional or facility and the qualified health plan and shall require the qualified health plan to provide not later than 7 business days after the notice any information used by the qualified health plan in making the adverse determination. Failure by a health professional or facility or qualified health plan to provide the commissioner with requested information permits the commissioner to terminate a review and issue a decision reversing or affirming an adverse determination.

(5) If the commissioner determines that an external review may proceed, the commissioner shall immediately assign an independent review organization to conduct the external review. Only an independent review organization meeting qualifications established by the commissioner shall be assigned to conduct an external review. The independent review organization may request the health professional or facility and the qualified health plan to provide information and shall review all pertinent information submitted by the health professional or facility and the qualified health plan along with the terms of coverage under the medicaid plan. The independent review organization shall make a written recommendation that includes the rationale and supporting documentation and any recommendation for an assessment of interest to the commissioner not later than 30 days after being assigned as the review organization. The commissioner shall notify in writing the health professional or facility and the qualified health plan of his or her decision reversing or affirming the qualified health plan's adverse determination and shall include the principal reasons for the decision not later than 15 days after receipt of the assigned independent review organization's recommendation. If an adverse determination is reversed, the qualified health plan shall immediately pay the claim and any interest assessed by the commissioner.

(6) Beginning not later than October 1, 2000 and continuing thereafter, the department of community health shall not enter into or renew a contract with a qualified health plan unless the qualified health plan agrees to follow the timely claims processing and payment procedure established under this section and requires health professionals and facilities under contract with the qualified health plan to follow the timely claims processing and payment procedure established under this section. The department of community health shall not enter into or renew a contract with a qualified health plan unless the commissioner determines that the qualified health plan satisfies all of the following:

(a) Is a health maintenance organization licensed or issued a certificate of authority in this state.

(b) Uses standardized claims as outlined in the provider contract and accepts claims submitted electronically in a generally accepted format.

(c) Demonstrates the ability to provide all required or covered medicaid services including covered specialty care to the estimated number of enrollees on a regional basis.

(d) Meets the criteria for delivering the comprehensive package of services under the department of community health's comprehensive health plan.

(7) The commissioner shall report to the senate and house of representatives appropriations subcommittees on community health by October 1, 2001 on the timely claims processing and payment procedure established under this section.

(8) It is not a fraudulent act for a health professional or facility to submit a claim under this section that includes 1 or more rendered services that are determined not covered services.

(9) As used in this section:

(a) "Medicaid" means the program of medical assistance established under section 105.

(b) "Qualified health plan" means, at a minimum, an organization that meets the criteria for delivering the comprehensive package of services under the department of community health's comprehensive health plan.

**History:** Add. 2000, Act 187, Imd. Eff. June 20, 2000.

**Popular name:** Act 280