

Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual	
Policy Name: Claims Reimbursement- “Clean Claims”	Claims
Date: 8-99 Last Reviewed by QI Committee: 7-06, 7-07, 7-08, 7-09, 7-10, 7-11 Last Revised by QI Committee: 7-05, 7- 08, 7-09	Page: 1 of 2 Policy Number: CL-1

Purpose: To pay completed (clean) paper claims within 30 working days of receipt by Beacon Comprehensive Behavioral Health Management (Beacon CBHM).

Policy:

1.0 Definitions

- 1.1 “Clean Claim” meets the following conditions:
 - 1.1.1 Is sent on a CMS 1500 claim form, or an accepted electronic equivalent (National Standard Format Version 2.0).
 - 1.1.2 The information requested by Beacon CBHM (i.e. authorized CPT code, ICD-9 code, rendering provider’s tax ID number is present and legible on the CMS 1500 or an accepted electronic equivalent) and the plan is 100% complete with no missing or illegible information.
 - 1.1.3 The claim is sent by a Beacon CBHM and appropriate Payer contracted provider or provider group. The provider must be in “good” and “active” status in both panels or have signed a Single Case Agreement (SCA) with Beacon CBHM.
- 1.2 “Rejected Claim” meets the following conditions:
 - 1.2.1 Does not meet one of the above conditions of a “clean claim”.

2.0 Process

- 2.1 Claim is received from an appropriately contracted Beacon CBHM provider and stamped with the date received.
- 2.2 Claims Examiner adjudicates claim against authorization and co-pay schedule.
- 2.3 Claims deemed not “clean” will be returned to the provider within 30 days of receipt with a denial code documented on the (EOB) Explanation of Benefits as to why the claim could not be processed for payment. A detailed form letter is sent to providers for more complex denial issues.
- 2.4 Clean claims received Monday through Friday of each week are adjudicated within five business days following date of receipt.
- 2.5 Each Wednesday an EOB summary of the providers and the amount to be paid for each claim batched Monday through Friday of the prior week is forwarded to the Accounts Payable (A/P) processor to process for payment.
 - 2.5.1 After the A/P processor has processed the batch, a Distribution Breakdown Register is generated. The totals from this report are compared to the totals from the EOB Summary Report. If the totals don’t match, the

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A/P processor would research the discrepancy. A series of other financial reports (e.g., check register, checkbook posting, computer posting journal and a funding report) are generated, batched together and filed.

- 2.5.2 The checks are then printed and given to the Vice-President of Financial Operations for final approval and signature.
- 2.5.3 After checks have been signed, they are matched to the appropriate EOB (explanation of benefits) and mailed to the appropriate provider.
- 2.6 The timeframe from final adjudication of claim until issuance of check is approximately two weeks.