Policy: **Claims Department Policies**

Date of Implementation: **July 1, 2002**

Product: **Specialty**

The purpose of this document is to specify the policies under which the Claims department operates and the parameters under which the Claims department procedures are developed.

Written policies and procedures govern all aspects of Claims Operations. Claims procedures are managed, and revised as needed, in accordance with applicable state mandates, regulatory requirements, accreditation standards, and specific health plan delegation agreements.

This policy is in effect for those Client Summaries where American Specialty Health – Specialty (ASH) directly pays claims. For all other Client Summaries, the policies employed by ASH's health plan client as described in the applicable Client Summary will continue to govern these matters.

Claims Confidentiality

Claims staff members sign confidentiality agreements that include but are not limited to the requirement that claims staff members treat all member and client information as confidential. Staff adhere to all corporate and departmental policies and procedures that protect the confidentiality of member, practitioner, and client information. Member, practitioner, and health plan information, including information submitted to ASH on claim forms, is used solely for fulfilling duties related to their job functions and authorized business purposes. Staff members follow procedural guidelines to protect the confidentiality of member, provider, practitioner, and health plan information on claim submissions, the ASH proprietary Integrated Health Information System (IHIS) claims processing system, internal reports, and electronic files.

Claims Definitions

The Claims department applies defined terminology in its interpretation of the Claims Department Policies and Procedures Manual. Definitions are based on Centers for Medicare and Medicaid Services (CMS) guidelines, where applicable.

A clean claim is a claim that has no defect, impropriety, lack of required substantiating documentation consistent with all relevant national standards or particular circumstances requiring special treatment that prevents timely payment; and conforms to the clean claim requirements for equivalent claims under original Medicare or state requirements.

Licensure/Certification

ASH claims staff and managers are required to have licenses, certifications, and registrations in a limited number of states for those claims examiners processing claims received from claimants in those states. For states with such requirements, ASH's Regulatory and Program Compliance (RPC) department confirms the licensure requirements by state and provides this information to Claims managers. Claims managers obtain and coordinate all required licensures, certifications, and/or registration processes for the applicable number of individual examiners. All such licenses, certifications, and registrations are monitored by the Claims department with assistance as needed from the RPC department on a monthly basis and are maintained through the standard license renewal process (typically on an annual or biennial cycle).

Conflict of Interest

Compensation for ASH Claims Examiners is based on claims processing competencies developed through in-service trainings and experience in the role. This compensation program is based solely on productivity, quality, required skill acquisition and competence and is not determined by over or underutilization or denial of claims.

Inventory Management

ASH receives both paper and electronically submitted claims. Electronic claims are received through ASHLink, the ASH practitioner website and ASH Clearinghouse. Each claim is electronically date-and time-stamped. Electronically submitted claims are stored in the ASHLink database for future retrieval. All paper claims are sorted, counted, and batched. Paper claims and attached documents are scanned through digital imaging equipment to capture an electronic image for records retention. The scanned paper claims and attached documents are assigned a unique document control number (DCN), including the date scanned and other unique document identification numbers. The received date is captured by the scanning software and stored with the images. The scanned claims and documents are retained in an online, secure repository. Paper claims are stored in a secure area within Processing Services for five (5) business days, then destroyed according to corporate policy.

Claims inventory and aging are tracked, monitored, and reported.

Claims Status

ASH maintains a toll-free telephone line for members, providers and practitioners to call in to verify status of their claims. The claim can by tracked by member name, member identification number, date of service, practitioner tax ID, and practitioner name.

Record Retention

Commercial, Medicare Advantage, Medicaid and Medi-Cal

Electronic claims and electronically imaged paper claims are secured and retained for ten (10) years. Paper claims are stored in a secure area within Processing Services for five (5) business days, then destroyed according to corporate policy. Please see the *Data Retention (RC 13 – ALL)* policy for additional information.

Eligibility

The Claims department verifies member eligibility for each claim received. ASH confirms eligibility information with the member's health plan via eligibility files, telephonic inquiry, or website. ASH will update member eligibility on a monthly basis at minimum, or as frequently as submitted by the health plan.

Claims Submission Timeline

National claims (excluding California) must be received by ASH within 180 days after the date of service. California claims must be received by ASH within 365 days after the date of service. Claims can be submitted via ASHLink, ASH Clearinghouse, or by mail on a CMS 1500 form. Claims submitted to ASH after 180 days (national excluding California) and 365 days (California) will not be paid due to late submission. Submissions received by ASH outside of business hours will be considered as received the following business day. Contracted providers/practitioners are financially responsible to submit all claims in a timely manner. CMS claims for non-contracted providers/practitioners must be received by ASH within 365 days after the date of service.

The following exceptions apply to the submission timelines referenced above:

1. If a claim is denied, the provider/practitioner may re-submit within 60 days (National, excluding California) or 180 days (California) of the date of an ASH Remittance Advice.
2. If a Medical Necessity Review Form (MNR Form) is approved, providers/practitioners may submit the claim within 30 days of the return date on the MNR Response Form (MNRF).
3. If ASH is the Secondary Payor, the provider/practitioner may submit the claim, along with a copy of the Primary Payor's Explanation of Benefits (EOB), within 180 days of the date of the Primary Payor's EOB.
4. If there is third party liability and the third party denies reimbursement, the practitioner may submit the claim to ASH until 180 days of the date of the third-party denial.
5. If extraordinary circumstances exist and are demonstrated upon appeal. An extraordinary circumstance is when a health care practitioner or provider has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit transactions on a timely basis.

Pended Claims

The claims payment system contains claim pend capabilities. The system has automatic and manual mechanisms for pending claims. The system automatically pends member responsibility claims. Pended claims are tracked and monitored daily. Turnaround time for a claim is not reduced by the number of days a claim is in pend status.

Member Responsibility

The non-payment of services resulting in member financial responsibility for Commercial, non-Medicare and Medicare Advantage claims are processed according to CMS guidelines, state mandated requirements, and health plan delegation agreements, as applicable.

Timeliness Standards – Commercial, Medicaid and Medi-Cal

The Claims department monitors claims turnaround time to ensure ASH issues payment or non-payment for clean claims received via fax or mail within 30 calendar days of receipt of the claim.

Timeliness Standards – CMS Claims

The Claims department monitors CMS claims turnaround time to ensure ASH issues payment or non-payment for clean claims from unaffiliated practitioners within 30 calendar days of receipt of the claim and all other claims within 60 calendar days of receipt.

Non-Clean Claim Development – Commercial, Medicaid and Medi-Cal

Non-clean claims submitted by members, providers and practitioners are developed as required under applicable accreditation standards, and state requirements. To develop claims, missing information is requested from members or providers/practitioners. Notification to request additional information is made within 30 days of receipt of the claim but in any case, no longer than five (5) days from determining a claim is not a clean claim. Due to the request for additional information, a 15-day extension is allowed, making the total turnaround time 45 calendar days. However, ASH will cease counting the 45 calendar days on the day that ASH sends the notice requesting missing information. When the requested information is received, ASH will resume counting the 45 calendar days, and the claim is adjudicated within 15 calendar days for claims received via fax or mail, or within 10 calendar days for claims received electronically. If requested information is not received within 30 days after the initial request, a second notification letter is sent. In accordance with client or state requirements, if the requested information is not received within 45 days after the initial request, a third notification letter is sent. If the requested information is not received by the 45^{th} or 90^{th} day, the claim will be denied accordingly.

Non-Clean Claim Development – CMS Claims

Non-clean claims submitted by members, affiliated providers/practitioners, and non-affiliated practitioners are developed as required under CMS guidelines. To develop

claims, only the missing information that is necessary to adjudicate the claim is requested. ASH accepts information from any reasonably reliable source that will assist in qualifying the claim as a clean claim, such as members or practitioners. Notification to request additional information is made within 30 days of receipt of the claim but in any case, no longer than five (5) days from determining a claim is not a clean claim. If the requested information is medical records, the records are forwarded to a Manager, Clinical Quality Evaluation for review. If requested information is not received within 10 days after the initial request, a second notification letter is sent. If the requested information is not received by the 55th calendar day, and no later than the 60th calendar day from the receipt of the claim, the claim will be processed according to the information available.

Emergent/Urgent Services

ASH complies with applicable CMS, state, and health plan guidelines for emergent/urgent services. Medical records for claims that require determination of emergent/urgent services are forwarded to designated Managers, Clinical Quality Evaluation for review. Payment or non-payment for covered services is issued according to the clinical quality evaluation determination of the Manager, Clinical Quality Evaluation.

Non-Contracted Practitioners

ASH reimburses covered services rendered to eligible members by non-contracted/unaffiliated practitioners under out-of-network benefits and/or emergent/urgent services. ASH complies with all state and federal regulations regarding reimbursement to non-contracted practitioners. ASH complies with contractual agreements with health plans that offer an out-of-network and out of area benefit to their members. If a dispute arises from an out-of-network practitioner regarding determination of reimbursement, ASH will disclose how reimbursement was calculated.

Coordination of Benefits

ASH coordinates benefits for members with other insurance, including Medicare, in accordance with OPM/FEHP and industry standards. Coordination of benefits is identified at the time of claims processing.

Adjustments

All requests for claims adjustments are researched and made according to the findings. An adjusted claim produces a new claim number that is linked to the claim number of the original claim. The claims payment system prohibits the alteration or deletion of a paid claim.

Quality Review

The Claims department performs quality review and captures quality review findings in the IHIS claims payment system to measure payment, coding, and financial accuracy and to ensure compliance with Claims department policies and procedures and Performance Standards.

Claims Acknowledgement

ASH abides by individual state requirements for the Claim Acknowledgement statutes.

ASH researches and monitors current and pending legislation in all states where ASH conducts business. State prescribed Claim Acknowledgement statutes are identified and reported to department management.

Claim Acknowledgement statutes for individual states are maintained in the claims acknowledgement letter table in the IHIS claims payment system.

Check Process

The claims check process incorporates guidelines for timeliness, security, tracking, and monitoring. The initiation of a check run requires a dual log-in from one authorized user in Finance and one authorized user in Claims. Claim checks are mailed within one (1) day of printing. ASH generates and mails 1099 forms to practitioners on an annual basis.

Practitioner Remittance Advice

Practitioner Remittance Advice notices are generated and mailed to the practitioner of services for claims received for members with a Medicare Advantage, non-Medicare Medicaid, Medi-Cal or commercial plan benefit. The claims payment system assigns applicable payment/non-payment codes and descriptions for all billed services. Practitioner Remittance Advice notices contain payment/non-payment descriptions listed in the practitioner payment description table. In the event the allowed amount of the claim is less than billed charges due to maximum fee schedule, the payment/non-payment code on the Practitioner Remittance Advice includes the statement that charges exceed maximum allowable fee for out-of-network practitioners and exceeds contracted fee for in-network practitioners.

In compliance with applicable federal and state regulations, Practitioner Remittance Advice notices provide:

- Instructions for filing a grievance and appeal, including timeframes for filing;
- CMS appeals information, including time frames for filing, as applicable; and
- Medicaid appeals information, including time frames for filing, as applicable.

Practitioners are afforded a minimum of 180 days to appeal an adverse claim decision or as applicable by state law.

Member Explanation of Benefits Notices

Member Explanation of Benefit (EOB) notices are generated and mailed for claims received that result in member responsibility or is otherwise required by state law. The claims payment system assigns applicable payment/non-payment codes and descriptions for all billed services. Member EOB notices contain payment/non-payment descriptions listed in the member payment description table.

In compliance with ERISA and applicable state regulations, member EOB notices provide each of the following elements:

- A clear and concise explanation in easily understandable language of the specific reason(s) for an adverse benefit determination;
- Specific plan provisions on which the determination is based;
- Specific description of additional information needed, if applicable, and the reason such information is required;
- Instructions to appeal an adverse benefit determination with specified timelines for filing an appeal;
- Notice of the right to bring to civil action by members of an ERISA regulated group health care plan; and
- Notice of the right to receive, upon request and at no charge, any rule, guideline, protocol, or criterion relied upon in making a benefit determination.

Any member claim denial notice, including but not limited to EOBs, subject to the Affordable Care Act also provide each of the following:

- Information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist members with the appeals and external review processes;
- Information regarding the availability of diagnosis and treatment codes and their meanings; and
- Information regarding the availability of language assistance.

Additionally, ASH notifies Medicare Advantage members of services not paid (denied) as member responsibility within 30 calendar days of the receipt of the claim. The notification to the Medicare Advantage member for services not paid (denied) as member responsibility contains applicable appeals and grievance information as prescribed by CMS, state regulatory guidelines, or health plan, including a minimum of 180 days to request the appeal.

ASH has a process to provide, upon request by a claimant or potential claimant, specific payment rules and policies.

Interest Payments

Non-Medicare (Commercial, Medicaid, Medi-Cal)

ASH abides by individual state requirements for the calculation and payment of interest on commercial and Medicaid claims not meeting state prescribed turnaround times.

ASH researches and monitors current and pending legislation in all states where ASH conducts business. State prescribed prompt payment/claim payment turnaround time guidelines and applicable interest payments are identified and reported to department management.

Current interest rates and accrual periods for individual states are maintained in an interest table in the claims payment system. ASH does not accumulate payment interest as claims are paid in full at the time a payment is issued.

Medicare Advantage

ASH abides by CMS guidelines for the calculation and payment of interest on Medicare Advantage claims not meeting CMS prescribed turnaround times. ASH monitors the current CMS interest rate approved by the Secretary of the Treasury and published in the Federal Register.

Current interest rates and accrual periods are maintained in an interest table in the claims payment system. ASH does not accumulate payment interest as claims are paid in full at the time a payment is issued.

Contract Approval Process

Claims are accurately adjudicated based on approved client summaries and fee schedules. Newly implemented or updated client summaries and fee schedules are verified against system contract maintenance tables. All contracts undergo claims adjudication testing.

Medical Necessity Review Form (MNR Form)

The claims payment system requires an approved MNR Form to pay a claim for services other than those available within the contracted provider/practitioner's applicable Clinical Performance System tier level. Covered services rendered without an MNR Form and/or outside a contracted provider/practitioner's Clinical Performance System tier level are denied to the contracted provider/practitioner as practitioner responsibility. For any covered condition (diagnosis codes), all covered services (CPT Codes) under the applicable client summary are reimbursable when verified as medically necessary or when delivered under any applicable Clinical Performance System tier level.

Modifiers

For all claims ASH accepts modifiers billed with a number of procedure codes. If more than one modifier is billed, only the first modifier will be imported into the claims processing system for adjudication. ASH applies applicable CMS National Correct Coding Initiative (CCI) edits to all claims. Some codes, when used in combination, require the use of modifiers in order to be reimbursable. All codes billed with modifiers will be reimbursed at the primary code's contracted rate, unless otherwise stated in the applicable fee schedule.

ERISA Compliance

The Claims department complies with ERISA regulatory requirements related to post-service claims.

The Claims department issues payment or non-payment for post-service claims within 30 calendar days of receipt of the claim.

In the event additional information is required to make a payment determination, the Claims department compliance analysts prepare and mail an approved form letter that provides all the following information to the provider/practitioner before the claim is aged 15 calendar days:

- A specific description of the information needed to make a payment determination.
- Notification that the provider/practitioner is allowed 45 calendar days from receipt of the letter to provide the specified information.
- Notification that ASH will make a payment determination within 15 calendar days of receipt of the claim of the additional information.

Extension Notification

The Claims department may extend the time limit for making a commercial claim payment determination from 30 days of receipt of the claim to 45 days with the following conditions:

- An extension is necessary due to matters beyond the control of ASH;
- The member and practitioner are notified of the extension by letter before the claim is aged 30 days; and
- The reason for a delay is captured in the IHIS claims payment system.

Regional Medicare Requirements – Medicare Advantage

ASH abides by the regional Medicare office interpretation of CMS rules and regulations as they apply for a health plan's Medicare Advantage members within the region.

Claims Staffing Level

The Claims department monitors staffing levels and maintains an appropriate number of staff to meet claims processing turnaround times.

Claims Department Training

The Claims department performs and documents departmentally specific training and education on topics including, but not limited to, the following:

- Daily job responsibilities and operations
- State and federal laws and regulations
- Privacy, security, and anti-fraud regulations
- Accreditation standard requirements

Anti-Fraud Training and Awareness

Claims department staff receives corporate anti-fraud requirement training, annually, as conducted by Human Resources. Anti-Fraud Policy training includes information about ASH's Anti-Fraud Program, SIU Committee, and Anti-Fraud Referral Form. Anti-Fraud Policies and the Anti-Fraud Referral Form are available to staff via the Intranet.

NON-DISCRIMINATION

ASH does not discriminate against a member, provider, or practitioner for any reason and does not support any discriminating against members for any reason, including but not limited to age, sex, gender, gender identification (e.g., transgender), gender dysphoria, marital status, religion, ethnic background, national origin, ancestry, race, color, sexual orientation, patient type (e.g., Medicaid), mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, source of payment, geographic location within the service area or based on political affiliation. ASH renders credentialing, clinical performance, and medical necessity decisions in the same manner, in accordance with the same standards, and within the same time availability to all members, providers, practitioners, and applicants.