

## 203 CLAIMS PROCESSING

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2903.01.G, 36-2904.G; 42 CFR 438.242(a), 45 CFR 160.101 et seq., 162.100 et seq., and 164.102 et seq., Section F3 Contractor Chart of Deliverables

DELIVERABLES: Claims Dashboard

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It stipulates requirements for the adjudication and payment of claims. See Section F3, Contractor Chart of Deliverables.

### **Definitions**

- A. Administrative Services Subcontracts - An Administrative Services Subcontract is a contract that delegates any of the requirements of the Division's contract with AHCCCS, including, but not limited to:
  - 1. Claims processing, including pharmacy claims
  - 2. Credentialing, including those for only primary source verification
  - 3. Management Service Agreements
  - 4. Service Level Agreements with any Division
  - 5. Subsidiary of a corporate parent owner claims process.
- B. Clean Claim – A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
- C. Subcontractor –
  - 1. A provider of health care who agrees to furnish covered services to members
  - 2. A person, agency or organization with which the Administrative Services Subcontractor (AdSS) has contracted or delegated some of its management/administrative functions or responsibilities
  - 3. A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Division agreement.

### **Claims Processes and Systems**

The AdSS must develop and maintain claims processes and systems that ensure the correct collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in information on areas including, but not limited to, service utilization, claim disputes, and appeals.

The AdSS must have a mechanism to inform providers of the place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

### **Receipt Date**

The receipt date of the claim is the date of the date stamp on the claim or the date on which the claim is electronically received. The receipt date is the day on which the claim is received at the AdSS specified claim mailing address, received through direct electronic submission, or received by the AdSS designated clearinghouse.

### **Claim Submission Timeliness**

A. Unless a contract specifies otherwise, the AdSS ensures that, for each form type, 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim. The AdSS must track and report the following monthly:

1. Percentage of clean claims that reach PAID status on a provider's first billing submission

The AdSS will ensure that 95% of all clean claims reach PAID status on the provider's first billing submission. *The AdSS will highlight field and provide an explanation if this falls below contract performance minimum.*

2. Percentage of claims that are DENIED

- i. *The AdSS will highlight field and provide an explanation if the total percentage reported is above 20% OR*
- ii. *The AdSS will highlight field and provide an explanation if there is a 15% increase from the previous reporting month.*

*For example, if the previous month's percent claims denied was 10%, the AdSS must provide an explanation if the current month's percent is 11.5% or greater.*

Percentage of claims denied:

$$\frac{\text{Total number of claims denied in the month}}{\text{Total number of claims processed in the month}}$$

- B. In addition, 95% of clean claims will be paid on first submission and less than 20% of second submission claims will be denied.
- C. The AdSS must refer to ATTACHMENT B of the DDD Claims Dashboard Reporting Guide for additional information on reporting guidelines.

The AdSS must not pay:

- A. Claims initially submitted more than six months after date of service for which

payment is claimed or after the date that eligibility is posted, whichever date is later;  
or

- B. Claims submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

When any payor recoups a claim because the claim is the payment responsibility of another payor (responsible payor), the provider may file a claim for payment with the responsible payor. The provider must submit a clean claim to the responsible payor no later than the latest of the following dates:

- A. 60 days from the date of the recoupment
- B. 12 months from the date of service
- C. 12 months from date that eligibility is posted.

The payor must not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

### **Discounts**

The AdSS must apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the clean claim was received.

### **Interest Payments**

The AdSS must pay interest on late payments and report the interest as required.

For hospital, clean claims, the AdSS must pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest must be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.

For authorized services submitted by a licensed skilled nursing facility, the AdSS must pay interest on payments made after 30 days of receipt of the clean claim. Interest is paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment.

For non-hospital clean claims the AdSS must pay interest on payments made after 45 days of receipt of the clean claim. Interest is paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

The AdSS must pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

### **Electronic Processing and Remittance Advices**

- A. The AdSS must accept and generate required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission. Accepted electronic submissions include eligibility verifications, claims, claims status verifications, and prior authorization requests.
- B. The AdSS must make claim payments via electronic funds transfer (EFT) and accept electronic claim attachments.
- C. The AdSS must generate an electronic remittance that includes:
  - 1. The reason(s) for denials and adjustments
  - 2. A detailed explanation/description of all denials and adjustments
  - 3. The amount billed
  - 4. The amount paid
  - 5. Application of Coordination of Benefits (COB) and copays
  - 6. Providers rights for claim disputes
  - 7. Instructions and timeframes for the submission of claim disputes and corrected claims.
- D. The AdSS must send electronic remittance advice with the payment, unless the payment is made by EFT. The AdSS must either direct providers to the link where this information is explained or include a supplemental file where this information is explained. Any remittance advice related to an EFT is sent no later than the date of the EFT.

### **General Claims Processing**

The AdSS must follow all general claims processing requirements as described below.

- A. The AdSS must use nationally recognized methodologies to correctly pay claims; these methodologies include but are not limited to:
  - 1. National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgery Centers, and Outpatient Services
  - 2. Multiple Procedure/Surgical Reductions
  - 3. Global Day E & M Bundling Standards.
- B. The AdSS claims payment system must assess and apply data-related edits including but not limited to:
  - 1. Benefit Package Variations

2. Timeliness Standards
  3. Data Accuracy
  4. Adherence to Division and AHCCCS policy
  5. Provider Qualifications
  6. Member Eligibility and Enrollment
  7. Overutilization Standards.
- C. If a claim dispute is overturned, in full or in part, the AdSS reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.
- D. The AdSS claims payment system must not require a recoupment of a previously paid amount when the provider's claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made. The AdSS must ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.
- E. The AdSS must adhere to the following:
1. COB and Third Party Liability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual
  2. Claims processing requirements per contract and the Claims Dashboard Reporting Guide
  3. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.
- F. When the AdSS contractor cost avoids a claim, the following payment provisions apply:
1. Claims from providers CONTRACTED with the AdSS: Unless a subcontract with the provider specifies otherwise, the AdSS must pay the difference between the AdSS Contracted Rate and the Primary Insurance Paid amount, not to exceed the AdSS Contracted Rate.
  2. Claims from providers NOT CONTRACTED with the AdSS: The AdSS must pay the difference between the AHCCCS Capped-Fee-For-Service rate and the Primary Insurance Paid amount, not to exceed the AHCCCS Capped-Fee-For-Service.

### **Claims Processing By AdSS Contractors**

- A. The AdSS must obtain prior approval from the Division for subcontracts regarding claims processing to be performed by or under the direction of a subcontractor.
- B. The AdSS remains responsible for the complete, accurate, and timely payment of

all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of administrative service arrangements.

- C. The AdSS must forward all claims received to the subcontractor responsible for claims adjudicating.
- D. The AdSS must require the subcontractor to submit a monthly claims aging summary to the AdSS to ensure compliance with claims payment timeliness standards.
- E. The AdSS must monitor the subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.
  - 1. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan.
  - 2. The results of the performance review and the correction plan must be communicated to the Division upon completion.
- F. The AdSS must monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.