203 CLAIMS PROCESSING

REVISION DATE: 11/8/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2903.01(G); 36-2904.G; 42 § C.F.R. 438.242(a); 45 §§ C.F.R. 160.101 et seq., 162.100 et seq. and 164.102 et seq.; AHCCCS Contract; Section F3 Contractor Chart of Deliverables

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Administrative Services Subcontract" means a contract that delegates any of the requirements of the Division's contract with AHCCCS.
2. "Clean Claim" means 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.
3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and

Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.

4. "Member" means the same as "client" as defined by A.R.S. § 36-551.
5. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
6. "Receipt Date" means the day a claim is received at the AdSS's specified claim mailing address or received through direct electronic submission to the AdSS's electronic claims processing system or received by the AdSS's designated clearinghouse.
7. "Subcontractor" means one of the following:
    a. A Provider of health care who agrees to furnish covered services to Members; or
    b. A person, agency or organization with which the AdSS has contracted or delegated some of its management/administrative functions or responsibilities; or

c. 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.

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The AdSS shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. These AdSS shall ensure that claims processes and systems generate information pertaining to the following areas:
   a. Service utilization;
   b. Claim disputes;
   c. Member grievances and appeals; and
   d. Disenrollment for reasons other than loss of Medicaid eligibility.

3. The AdSS shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:
    a. The AdSS subcontract;
    b. The AdSS Provider manual;
    c. The AdSS website; or
    d. Other Provider platforms.
4. The AdSS shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date the claim is electronically received by the AdSS.

B. CLAIM TIMELY FILING, PAYMENT, AND REPORTING REQUIREMENTS

1. The AdSS shall adjudicate claims for each form type as follows, unless a subcontract specifies otherwise:
    a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and
    b. 99% of all Clean Claims within 60 days of receipt of the Clean Claim.

2. The AdSS shall ensure 95% of Clean Claims reach paid status on a Provider's first billing submission.
3. The AdSS shall ensure less than 20% of a Provider's second submission of claims are denied.
4. The AdSS shall submit a report to the Division with the following Clean Claim payment or claim payment denial information monthly:
    a. Percentage of Clean Claims that reach paid status on a Provider's first billing submission.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the paid status percentage of Clean Claims falls below the contract performance minimum of 95%.
    b. Percentage of claims that are denied, calculated by dividing the total number of claims denied in the month by the total number of claims processed in the month.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the total

percentage of denied claims reported is above 20%; or

ii. The AdSS shall highlight the appropriate field in the report and provide an explanation if there is a 15% increase of denied claims from the previous reporting month.

5. The AdSS shall refer to Attachment B of the DDD Claims Dashboard Reporting Guide for additional reporting guidelines.
6. The AdSS shall not pay claims
   a. Initially submitted more than six months after the 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 the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.
7. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization

(MCO), when one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

8. If the Provider submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:
   a. 60 days from the date of the recoupment;
   b. 12 months from the date of service; or
   c. 12 months from the date that eligibility is posted; whichever date is later.
9. The AdSS shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes listed in item 7 of this section.
10. The AdSS shall adhere to claim payment requirements that pertain to both contracted and non-contracted Providers.

C. DISCOUNTS

1. The AdSS shall apply a quick pay discount of 1% on acute hospital inpatient, outpatient, and freestanding emergency

department claims paid within 30 days of the date on which the Clean Claim was received.

2. The AdSS shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS

1. The AdSS shall pay interest on late payments and report the interest as directed in the Division Encounter Manual and the DDD Claims Dashboard Reporting Guide.
2. The AdSS shall pay slow payment penalties or interest on payments made after 60 days of receipt of the hospital Clean Claim as follows:
    a. The AdSS shall pay interest at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.
    b. The AdSS shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding

emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The AdSS shall pay interest on payments made after 30 days of receipt of a Clean Claim for authorized services submitted by a licensed skilled nursing facility as follows:
   a. At the rate of 1% per month; and
   b. Prorated on a daily basis from the date the Clean Claim is received until the date of payment.
4. The AdSS shall, for non-hospital Clean Claims, pay interest on payments made after 45 days of receipt of the Clean Claim as follows:
   a. At the rate of 10% per annum; and
   b. Prorated daily from the 46th day until the date of payment.
5. The AdSS shall 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.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The AdSS shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or their assigned representative interested in and capable of electronic submission of:
    a. Eligibility verifications;
    b. Claims;
    c. Claims status verifications; and
    d. Prior authorization requests; or
    e. The receipt of electronic remittance.
2. The AdSS shall make claim payments via electronic funds transfer (EFT).
3. The AdSS shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The AdSS shall generate an electronic remittance advice advice related to the payments or denials to Providers that includes at a minimum:
    a. The reasons for denials and adjustments;

b. A detailed explanation or description of all denials and adjustments;

c. The amount billed;

d. The amount paid;

e. Application of coordination of benefits (COB) and copays;

f. Providers rights for claim disputes;

g. Detailed instructions and timeframes for the submission of claim disputes and corrected claims; and

h. A link or supplemental file where claims dispute or corrected claims submission information is explained.

2. The AdSS shall send the electronic remittance advice with the payment, unless the payment is made by EFT.

3. The AdSS shall send any remittance advice related to an EFT to the Provider no later than the date of the EFT.

G. GENERAL CLAIMS PROCESSING REQUIREMENTS

1. The AdSS shall use nationally recognized methodologies to correctly pay claims, including:

a. National Correct Coding Initiative for professional, ambulatory surgery centers, and outpatient services;
b. Multiple procedure or surgical reductions; and
c. Global day evaluation and management bundling standards.

2. The AdSS shall ensure that the claims payment system assess and apply data-related edits including:
   a. Benefit package variations,
   b. Timeliness standards,
   c. Data accuracy,
   d. Adherence to Division and AHCCCS policy,
   e. Provider qualifications,
   f. Member eligibility and enrollment, and
   g. Overutilization standards.
3. The AdSS shall, if a claim dispute is overturned in full or in part, reprocesse and pay the claim(s):
   a. In a manner consistent with the decision; and
   b. Within 15 business days of the decision.

4. The AdSS claims payment system shall not require a recoupment of a previously paid amount when:
    a. The Provider's claim is adjusted for data correction, excluding payment to a wrong Provider; or
    b. An additional payment is made.
5. The AdSS shall submit encounters in accordance with Division and AHCCCS standards and thresholds.
6. The AdSS shall adhere to the following requirements when processing claims:
    a. COB and third party liability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual;
    b. Claims processing requirements per contract and the DDD Claims Dashboard Reporting Guide;
    c. Claims recoupments and refunds requirements per contract, Division Operations Policy 412, and the DDD Claims Dashboard Reporting Guide; and

d. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 C.F.R. §§ Parts 160, 162, and 164.

5. The AdSS, when cost avoiding a claim, shall apply the following payment provisions:

a. Claims from Providers contracted with the AdSS: The AdSS shall pay the difference between the AdSS contracted rate and the primary insurance paid amount, not to exceed the AdSS contracted rate.

b. Claims from Providers not contracted with the AdSS: The AdSS shall 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.

H. CLAIMS PROCESSING BY THE AdSS

1. The AdSS shall request prior approval from the Division for obtaining subcontracts for claims processing to be performed by or under the direction of a subcontractor.

2. The AdSS shall remain 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.
3. The AdSS shall forward all claims received to the subcontractor responsible for claims adjudication.
4. The AdSS shall require the subcontractor that processes claims to submit a monthly claims aging summary to the AdSS to monitor compliance with claims payment timeliness standards.
5. The AdSS shall monitor the payment processing subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.
6. The AdSS shall, upon completing the formal performance review of the payment processing subcontractor:
    a. Communicate any performance deficiencies resulting from the review to the subcontractor;
    b. Establish a corrective action plan that addresses the deficiencies; and

c. Provide the results of the performance review and the correction plan to the Division upon completion.

7. The AdSS shall monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.