203 CLAIMS PROCESSING

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EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 C.F.R. §§ 160, 162, and 164; 42 C.F.R. § 438.242(a)-(b); 42 C.F.R. § 447.45(d)(5)-(6); 42 § C.F.R. 447.46; 42 C.F.R. § 457.1233(d); A.R.S. § 36-2903.01; A.R.S. § 36-2903.01(G); A.R.S. § 36-2904; A.R.S. § 36-2943(D); ACOM 201; ACOM 203; ACOM 412; ACOM 434; AHCCCS Contract

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division of Developmental Disabilities (the Division).

DEFINITIONS

1. "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.
2. "Member" means the same as "client" as defined by A.R.S. § 36-551.

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. "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.
5. "Receipt Date" means the day a claim is received at the Division's specified claim mailing address or received through direct electronic submission to the Division's electronic claims processing system.

POLICY

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The Division shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. The Division shall ensure that claims processes and systems generate information in 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 Division shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:

a. The Division's subcontract;

b. The Division's Provider manual;

c. The Division's website; or

d. Other Provider platforms.

4. The Division shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date electronically received by the Division.

5. The Division shall recognize the paid date of the claim as the date on the check or other form of payment.

B. CLAIM TIMELY FILING

1. The Division shall, unless a contract specifies otherwise, adjudicate claims for each form type as follows:

a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and

b. 99% within 60 days of receipt of the Clean Claim.

2. The Division shall not pay the following claims as specified in A.R.S. § 36-2904(G):

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.

3. 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.

4. 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.

5. The Division shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes stated in item 3 of this section.

6. The Division shall process a claim for payment if the AHCCCS Director's decision reverses a decision to deny, limit, or delay authorization of services, and the disputed services were received while an appeal was pending.

a. The Provider shall have 90 days from the date of the reversed decision to submit a Clean Claim to the Division for payment.

b. The Division shall not deny claims for untimely filing if the claims are submitted within 90 days from the date of the reversed decision.

c. Additionally, the Division shall not deny claims submitted as a result of a reversed decision because a Member failed

to request continuation of services during the appeal or hearing process.

7. The Division shall adhere to the claim payment requirements in this policy for both contracted and non-contracted Providers.

C. DISCOUNTS

1. The Division shall, unless a subcontract specifies otherwise, apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the Clean Claim was received (A.R.S. § 36-2903.01(G)).
2. The Division 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 Division, in the absence of a subcontract specifying other late payment terms, shall pay interest on late payments.
2. The Division shall pay interest on late payments for hospital Clean Claims as follows:

a. The Division shall pay slow payment penalties or interest on payments made after 60 days of receipt of the Clean Claim.

b. The Division 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 (A.R.S. § 36-2903.01).

c. The Division 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 Division shall adjudicate a claim for authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS Provider, or a home and community based (HCBS) ALTCS Provider within 30 calendar days after receipt by the Division.

4. The Division shall pay interest on payments made after 30 days of receipt of the Clean Claim for licensed skilled nursing facility, assisted living ALTCS, or HCBS ALTCS 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.

5. The Division 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.
6. The Division 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.
7. The Division shall report the interest paid as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The Division shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or the 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 Division shall make claim payments via electronic funds transfer (EFT).

3. The Division shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The Division shall generate an electronic remittance advice related to the payments or denials to Providers that include at a minimum:

a. The reason(s) for denials and adjustments;

b. A detailed explanation or description of all denials; payments, 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 claims disputes and corrected claims; and

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

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

3. The Division 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 Division shall use nationally recognized methodologies to correctly pay claims including:

a. Medicaid 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 Division’s claims payment system shall assess and apply data-related edits, including:

a. Benefit package variations;

b. Timeliness standards;

c. Data accuracy;

d. Adherence to AHCCCS policy;

d. Provider qualifications,

e. Member eligibility and enrollment; and

f. Over-utilization standards.

3. The Division shall, if a claim dispute is overturned in full or in part, reprocess and pay the claim(s):

   a. In a manner consistent with the decision; and

   b. Within 15 business days of the decision.

4. The Division's 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 Division shall submit encounters in accordance with AHCCCS' standards and thresholds.

6. The Division shall adhere to the following requirements when processing claims:

a. Medicare cost sharing for Members covered by Medicare and Medicaid;

b. COB and third party liability requirements per the AHCCCS Contract and ACOM 434;

c. Claims recoupments and refunds requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS 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.

7. The Division, when cost avoiding a claim, shall apply the following payment provisions:

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

b. Claims from Providers not contracted with the Division: The Division 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 claims processing by Administrative Services Subcontractors (AdSS) Contractors.

H. CLAIMS SYSTEM AUDITS

1. The Division shall regularly audit payments to contracted and non-contracted Providers to verify that:
   a. Payments are accurate per the Provider contract terms or letter of authorization; and
   b. Emergency services Providers are paid at the current AHCCCS fee-for-service rate for non-contracted Providers.
2. The Division shall ensure audit reports are shared with the Business Operations Administrator, Business Operations Deputy Administrator, and Corporate Compliance.
3. The Division shall correct deficiencies noted in claims system audit reports and issue corrective action plans as applicable to contracted and non-contracted Providers.
4. The Division shall audit three months of claims data for both contracted and non-contracted Providers.

5. The Division shall utilize HHS-OIG RAT-STATS to generate statistically significant random samples for claims systems audit reviews.
6. The Division shall conduct the interest paid audit in January, April, July, and October.
7. The Division shall conduct the negotiated rate audit in February, May, August, and November.
8. The Division shall conduct the override audit in March, June, September, and December.
9. The Division shall regularly audit contracted Providers, both large groups and individual practitioners:
    a. At least once every five-year period;
    b. Any time a contract change is initiated; and
    c. Within six months of onboarding new Providers
10. The Division and DES-Internal Audit Administration (DES-IAA) shall adhere to the AHCCCS approved Corporate Compliance audit schedule for contracted Providers.
11. DES-IAA shall also conduct Provider audits based upon corrective action plans initiated by the Division.

12. The Division shall conduct annual audits for compliance with the Deficit Reduction Act of 2005.
13. The Division shall require contracted Providers that receive at least five million dollars in Medicaid payments annually to establish written policies for all employees.
    a. The Division shall require contracted Providers to submit the following policy documentation that includes detailed information of the following:
        i. Federal False Claims Act;
        ii. Remedies for false claims and statements;
        iii. Any state laws pertaining to civil or criminal penalties for false claims and statements;
        iv. Whistleblower protections under Federal False Claims Act and state laws; and
        v. Role of such laws in preventing and detecting fraud, waste and abuse.
    b. Organization compliance program
    c. Employee handbook, with specific discussion of:
        i. The State and federal laws referenced above;

ii. The rights of employees to be protected as whistleblowers; and

iii. The entity's policies and procedures for detecting fraud, waste, and abuse.

I. ADSS CLAIMS PROCESSING

The Division shall contract with health plans and delegate the processing of acute care claims. Refer to the AdSS Operations Manual, 203 Claims Processing policy for further details.