203 CLAIMS PROCESSING

REVISION: 10/01/2019
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REFERENCES: A.R.S. §36-2903.01. G

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

Definitions

A. Receipt Date - The receipt date of the claim is the date stamp on the claim, or the date electronically received. The receipt date is the day the claim is received at the Division's specified claim mailing address, received through direct electronic submission to the Division, or received by the Division's designated Clearinghouse.

B. Clean Claim - A clean claim is 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.

C. Claim Submission Timeliness - Unless a contract specifies otherwise, the Division ensures that, for each form type (Dental/Professional/Institutional), 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.

General Claims Processing Information

The Division develops and maintains claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in the provision of information on areas including, but not limited to, service utilization, claim disputes, member grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

The Division ensures there is a mechanism, such as the Division website or other provider platforms, to inform providers of the appropriate 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.

The Division follows all general claims processing requirements as described below.

A. The Division uses nationally recognized methodologies to correctly pay claims; these methodologies include but not limited to:

   1. Medicaid 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 Division's claims payment system assesses and/or applies data-related edits, including but not limited to:

   1. Benefit Package Variations

2. Timeliness Standards

3. Data Accuracy

4. Adherence to Arizona Health Care Cost Containment System (AHCCCS) Policy

5. Provider Qualifications

6. Member Eligibility and Enrollment

7. Over-Utilization Standards

C. If a claim dispute is overturned, in full or in part, the Division reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.

D. The Division's claims payment system does 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 Division ensures encounters are submitted in accordance with AHCCCS' standards and thresholds.

E. The Division adheres to the following:

1. Coordination of Benefits and Third Party Liability requirements per the AHCCCS Contract, ACOM Policies 201 and 434,

2. Claims Reprocessing requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS 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 Division cost avoids a claim, the following payment provisions apply:

1. Claims from Providers **contracted** with the Division: The Division pays the difference between the Contracted Rate and the Primary Insurance Paid amount, not to exceed the Division's Contracted rate.

2. Claims from Providers **not contracted** with the Division: The Division will 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.

The Division Responsibilities

A. Discounts

The Division applies 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). Quick pay discounts are applied to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a UB-04 claim form.

B. Interest Payments

The Division pays interest on late payments and reports the interest as required.

1. For hospital clean claims, the Division pays slow payment penalties (interest) on payments made after 60 days of receipt of the clean claim. Interest is 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. Slow pay penalties (interest) are applied to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a UB-04 claim form.

2. A claim for authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS provider, or a home and community based ALTCS provider shall be adjudicated within 30 calendar days after receipt by the Division. The Division pays 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.

3. For non-hospital clean claims, the Division pays 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.

4. The Division pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

C. Electronic Processing and Remittance Advices

The Division accepts and generates required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission.

1. Accepted electronic submissions include eligibility verifications, claims, claims status verifications, and prior authorization requests.

2. The Division makes claim payments via electronic funds transfer and accepts electronic claim attachments.

3. The Division generates an electronic remittance that includes:

   a. The reason(s) for denials and adjustments

   b. A detailed explanation/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

   Note: The Division includes instructions and timeframes for the submission of claim disputes and corrected claims on its remittance advice.

4. The Division sends the remittance advice with the payment, unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT is sent no later than the date of the EFT.

Claim Timely Filing

Per *ARS 36-2904, Section G*, the Division will 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.

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.

AdSS Claims Processing

The Division contracts with health plans and delegates the processing of medical claims. Refer to the *AdSS Operations Manual, 203 Claims Processing policy* for further details.