

## **203 – CLAIMS PROCESSING**

EFFECTIVE DATES: 02/01/97, 04/13/12, 10/01/13, 12/01/14, 06/01/15, 07/01/16, 10/01/17, 10/01/18

REVISION DATES: 11/01/02, 06/15/05, 04/13/12, 09/19/13, 11/20/14, 12/29/14, 05/12/15, 05/11/16, 05/18/17, 09/06/18

### **I. PURPOSE**

This Policy applies to AHCCCS Complete Care, ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. This Policy stipulates requirements for the adjudication and payment of claims.

### **II. DEFINITIONS**

**ADMINISTRATIVE SERVICES  
SUBCONTRACTS/SUBCONTRACTORS**

An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

1. Claims processing, including pharmacy claims.
2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization).
3. Management Service Agreements.
4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner.
5. DDD acute care subcontractors.

A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor.

Providers are not Administrative Services Subcontractors.

**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.

**SUBCONTRACTOR**

1. A provider of health care who agrees to furnish covered services to members.
2. An individual, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or, responsibilities.
3. An individual, 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 AHCCCS agreement.

**III. POLICY**

The Contractor shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data. These processes and systems shall 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 [42 CFR 438.242(a)].

The Contractor shall have a mechanism in place 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.

**A. DATE OF RECEIPT**

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 Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse.

**B. TIMELINESS OF CLAIM SUBMISSION**

Unless a subcontract specifies otherwise, Contractors shall ensure 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.

1. The Contractor shall 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 that are 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 (A.R.S. §36-2904(G)).

2. Regardless of any subcontract with an AHCCCS Contractor, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor), the provider may file a claim for payment with the responsible Contractor. The provider shall submit a Clean Claim to the responsible Contractor no later than:
  - a. 60 days from the date of the recoupment,
  - b. 12 months from the date of service, or
  - c. 12 months from date that eligibility is posted, whichever date is later.
3. The responsible Contractor shall not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.
4. The Contractor shall process a claim for payment if the Contractor or a 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. In this circumstance, the provider shall have 90 days from the date of the reversed decision to submit a Clean Claim to the Contractor for payment. The Contractor shall not deny claims for untimely filing if the claims are submitted within 90 days from the date of the reversed decision. Additionally, a Contractor 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.
5. Claim payment requirements pertain to both contracted and non-contracted providers.

### **C. DISCOUNTS**

In the absence of a subcontract specifying otherwise, the Contractor shall apply a quick pay discount of 1% on hospital claims paid within 30 days of the date 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.

### **D. INTEREST PAYMENTS**

In the absence of a subcontract specifying other late payment terms, a Contractor is required to pay interest on late payments as specified below:

1. For hospital Clean Claims, the Contractor shall pay slow payment penalties (interest) on payments made after 60 day of receipt of the Clean Claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61<sup>st</sup> day until the date of payment (A.R.S. §36-2903.01). 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 an authorized service submitted by a licensed skilled nursing facility, assisted living ALTCS provider or a home and community based ALTCS provider

shall be adjudicated within 30 calendar days after receipt by the Contractor. The Contractor is required to pay interest on payments made after 30 days of receipt of the Clean Claim. Interest shall be 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 (A.R.S. §36-2943(D)).

3. For non-hospital Clean Claims, a Contractor is required to pay interest on payments made after 45 days of receipt of the Clean Claim. Interest shall be paid at the rate of 10% per annum (prorated daily) from the 46<sup>th</sup> day until the date of payment.
4. The Contractor 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).
5. When interest is paid, the Contractor shall report the interest as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

#### **E. ELECTRONIC PROCESSING REQUIREMENTS**

The Contractor is required to 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 eligibility verifications, claims, claims status verifications and prior authorization requests; or the receipt of electronic remittance. The Contractor shall also be able to make claim payments via electronic funds transfer and have the capability to accept electronic claim attachments.

#### **F. REMITTANCE ADVICES**

1. The Contractor shall produce a remittance advice related to the Contractor's payments and/or denials to providers and each shall include at a minimum:
  - 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, and
  - f. Providers rights for claim disputes.
2. The Contractor shall include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices shall describe this information in detail. Electronic remittance advices shall either direct providers to the link where this information is explained or include a supplemental file where this information is explained.
3. The related remittance advice shall be sent with the payment, unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT shall be sent to the provider, no later than the date of the EFT.

**G. GENERAL CLAIMS PROCESSING REQUIREMENTS**

1. The Contractor shall include nationally recognized methodologies to correctly pay claims including but not limited to:
  - a. Medicaid National Correct Coding Initiative NCCI for Professional, Ambulatory Surgery Centers (ASC) and Outpatient services,
  - b. Multiple Procedure/Surgical Reductions, and
  - c. Global Day E & M Bundling standards.
  
2. The Contractor's claims payment system shall be able to assess and/or apply data related edits including but not limited to:
  - a. Benefit Package Variations,
  - b. Timeliness Standards,
  - c. Data Accuracy,
  - d. Adherence to AHCCCS Policy,
  - e. Provider Qualifications,
  - f. Member Eligibility and Enrollment, and
  - g. Over-Utilization Standards.
  
3. If a claim dispute is overturned, in full or in part, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of decision.
  
4. The Contractor's claims payment system shall 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 Contractor shall ensure encounters are submitted in accordance with AHCCCS' standards and thresholds.
  
5. The Contractor shall adhere to the following:
  - a. Coordination of Benefits and Third Party Liability requirements per the AHCCCS Contract, ACOM Policy 201 and 434,
  - b. Claims Reprocessing requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS Claims Dashboard Reporting Guide, and
  - c. All Health Insurance, Portability and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.
  
6. When the Contractor cost avoids a claim the following payment provisions apply:
  - a. Claims from Providers **CONTRACTED** with a Contractor: Unless a subcontract with the provider specifies otherwise, the Contractor shall pay the difference between the Contractor's Contracted Rate and the Primary Insurance Paid amount, not to exceed the Contractor's Contracted rate, and
  - b. Claims from Providers **NOT CONTRACTED** with a Contractor: The Contractor 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 ADMINISTRATIVE SERVICES SUBCONTRACTORS**

1. The Contractor shall obtain prior approval from AHCCCS of all Administrative Services Subcontracts including those that call for claims processing to be performed by or under the direction of a Subcontractor. The Administrative Services Subcontract shall be submitted for prior approval and shall adhere to all requirements as specified in ACOM Policy 438.
2. Per the AHCCCS contract, “No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the Subcontractor conform to the provisions of this contract.” Accordingly, AHCCCS holds its Contractors 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 subcontract arrangements.
3. The Contractor shall forward all claims received to the Administrative Services Subcontractor responsible for claims adjudication. The Contractor shall require the Administrative Services Subcontractor to submit a monthly claims aging summary to the Contractor to ensure compliance with claims payment timeliness standards. The Contractor may consider requiring such reports to be consistent in format with the AHCCCS required reports.
4. In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor’s performance on an ongoing basis and subject it to formal review at least annually, or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion. Additionally, if at any time during the period of the Administrative Services Subcontract the Subcontractor is found to be in non-compliance, the Contractor shall notify AHCCCS and comply with ACOM Policy 438.
5. The Contractor shall monitor encounters received from the Administrative Services Subcontractor so that encounters are submitted in accordance with AHCCCS’ standards and thresholds.