

1 **Policy:** **Claims Department Policies**

2
3 **Date of Implementation:** **July 1, 2002**

4
5 **Product:** **Specialty**

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7
8 The purpose of this document is to specify the policies under which the Claims department
9 operates and the parameters under which the Claims department procedures are developed.

10
11 Written policies and procedures govern all aspects of Claims Operations. Claims
12 procedures are managed, and revised as needed, in accordance with applicable state
13 mandates, regulatory requirements, accreditation standards, and specific health plan
14 delegation agreements.

15
16 This policy is in effect for those Client Summaries where American Specialty Health –
17 Specialty (ASH) directly pays claims. For all other Client Summaries, the policies
18 employed by ASH’s health plan client as described in the applicable Client Summary will
19 continue to govern these matters.

20
21 **Claims Confidentiality**

22 Claims staff members sign confidentiality agreements that include but are not limited to
23 the requirement that claims staff members treat all member and client information as
24 confidential. Staff adhere to all corporate and departmental policies and procedures that
25 protect the confidentiality of member, practitioner, and client information. Member,
26 practitioner, and health plan information, including information submitted to ASH on claim
27 forms, is used solely for fulfilling duties related to their job functions and authorized
28 business purposes. Staff members follow procedural guidelines to protect the
29 confidentiality of member, provider, practitioner, and health plan information on claim
30 submissions, the ASH proprietary Integrated Health Information System (IHIS) claims
31 processing system, internal reports, and electronic files.

32
33 **Claims Definitions**

34 The Claims department applies defined terminology in its interpretation of the Claims
35 Department Policies and Procedures Manual. Definitions are based on Centers for
36 Medicare and Medicaid Services (CMS) guidelines, where applicable.

37
38 A clean claim is a claim that has no defect, impropriety, lack of required substantiating
39 documentation consistent with all relevant national standards or particular circumstances
40 requiring special treatment that prevents timely payment; and conforms to the clean claim
41 requirements for equivalent claims under original Medicare or state requirements.

1 **Licensure/Certification**

2 ASH claims staff and managers are required to have licenses, certifications, and
 3 registrations in a limited number of states for those claims examiners processing claims
 4 received from claimants in those states. For states with such requirements, ASH's
 5 Regulatory and Program Compliance (RPC) department confirms the licensure
 6 requirements by state and provides this information to Claims managers. Claims managers
 7 obtain and coordinate all required licensures, certifications, and/or registration processes
 8 for the applicable number of individual examiners. All such licenses, certifications, and
 9 registrations are monitored by the Claims department with assistance as needed from the
 10 RPC department on a monthly basis and are maintained through the standard license
 11 renewal process (typically on an annual or biennial cycle).

12
 13 **Conflict of Interest**

14 Compensation for ASH Claims Examiners is based on claims processing competencies
 15 developed through in-service trainings and experience in the role. This compensation
 16 program is based solely on productivity, quality, required skill acquisition and competence
 17 and is not determined by over or underutilization or denial of claims.

18
 19 **Inventory Management**

20 ASH receives both paper and electronically submitted claims. Electronic claims are
 21 received through ASHLink, the ASH practitioner website and ASH Clearinghouse. Each
 22 claim is electronically date-and time-stamped. Electronically submitted claims are stored
 23 in the ASHLink database for future retrieval. All paper claims are sorted, counted, and
 24 batched. Paper claims and attached documents are scanned through digital imaging
 25 equipment to capture an electronic image for records retention. The scanned paper claims
 26 and attached documents are assigned a unique document control number (DCN), including
 27 the date scanned and other unique document identification numbers. The received date is
 28 captured by the scanning software and stored with the images. The scanned claims and
 29 documents are retained in an online, secure repository. Paper claims are stored in a secure
 30 area within Processing Services for five (5) business days, then destroyed according to
 31 corporate policy.

32
 33 Claims inventory and aging are tracked, monitored, and reported.

34
 35 **Claims Status**

36 ASH maintains a toll-free telephone line for members, providers and practitioners to call
 37 in to verify status of their claims. The claim can be tracked by member name, member
 38 identification number, date of service, practitioner tax ID, and practitioner name.

39
 40 **Record Retention**

41 **Commercial, Medicare Advantage, Medicaid and Medi-Cal**

42 Electronic claims and electronically imaged paper claims are secured and retained for ten
 43 (10) years. Paper claims are stored in a secure area within Processing Services for five (5)

1 business days, then destroyed according to corporate policy. Please see the *Data Retention*
 2 (*RC 13 – ALL*) policy for additional information.

3 4 **Eligibility**

5 The Claims department verifies member eligibility for each claim received. ASH confirms
 6 eligibility information with the member’s health plan via eligibility files, telephonic
 7 inquiry, or website. ASH will update member eligibility on a monthly basis at minimum,
 8 or as frequently as submitted by the health plan.

9 10 **Claims Submission Timeline**

11 National claims (excluding California) must be received by ASH within 180 days after the
 12 date of service. California claims must be received by ASH within 365 days after the date
 13 of service. Claims can be submitted via ASHLink, ASH Clearinghouse, or by mail on a
 14 CMS 1500 form. Claims submitted to ASH after 180 days (national excluding California)
 15 and 365 days (California) will not be paid due to late submission. Submissions received by
 16 ASH outside of business hours will be considered as received the following business day.
 17 Contracted providers/practitioners are financially responsible to submit all claims in a
 18 timely manner. CMS claims for non-contracted providers/practitioners must be received
 19 by ASH within 365 days after the date of service.

20 21 **The following exceptions apply to the submission timelines referenced above:**

- 22 1. If a claim is denied, the provider/practitioner may re-submit within 60 days
 23 (National, excluding California) or 180 days (California) of the date of an ASH
 24 Remittance Advice.
- 25 2. If a Medical Necessity Review Form (MNR Form) is approved,
 26 providers/practitioners may submit the claim within 30 days of the return date on
 27 the MNR Response Form (MNRF).
- 28 3. If ASH is the Secondary Payor, the provider/practitioner may submit the claim,
 29 along with a copy of the Primary Payor’s Explanation of Benefits (EOB), within
 30 180 days of the date of the Primary Payor’s EOB.
- 31 4. If there is third party liability and the third party denies reimbursement, the
 32 practitioner may submit the claim to ASH until 180 days of the date of the third-
 33 party denial.
- 34 5. If extraordinary circumstances exist and are demonstrated upon appeal. An
 35 extraordinary circumstance is when a health care practitioner or provider has
 36 determined and can substantiate that it has experienced a significant disruption to
 37 normal operations that materially affects the ability to conduct business in a normal
 38 manner and to submit transactions on a timely basis.

39 40 **Pended Claims**

41 The claims payment system contains claim pend capabilities. The system has automatic
 42 and manual mechanisms for pending claims. The system automatically pends member

1 responsibility claims. Pended claims are tracked and monitored daily. Turnaround time for
2 a claim is not reduced by the number of days a claim is in pend status.

3 4 **Member Responsibility**

5 The non-payment of services resulting in member financial responsibility for Commercial,
6 non-Medicare and Medicare Advantage claims are processed according to CMS
7 guidelines, state mandated requirements, and health plan delegation agreements, as
8 applicable.

9 10 **Timeliness Standards – Commercial, Medicaid and Medi-Cal**

11 The Claims department monitors claims turnaround time to ensure ASH issues payment or
12 non-payment for clean claims received via fax or mail within 30 calendar days of receipt
13 of the claim.

14 15 **Timeliness Standards – CMS Claims**

16 The Claims department monitors CMS claims turnaround time to ensure ASH issues
17 payment or non-payment for clean claims from unaffiliated practitioners within 30 calendar
18 days of receipt of the claim and all other claims within 60 calendar days of receipt.

19 20 **Non-Clean Claim Development – Commercial, Medicaid and Medi-Cal**

21 Non-clean claims submitted by members, providers and practitioners are developed as
22 required under applicable accreditation standards, and state requirements. To develop
23 claims, missing information is requested from members or providers/practitioners.
24 Notification to request additional information is made within 30 days of receipt of the claim
25 but in any case, no longer than five (5) days from determining a claim is not a clean claim.
26 Due to the request for additional information, a 15-day extension is allowed, making the
27 total turnaround time 45 calendar days. However, ASH will cease counting the 45 calendar
28 days on the day that ASH sends the notice requesting missing information. When the
29 requested information is received, ASH will resume counting the 45 calendar days, and the
30 claim is adjudicated within 15 calendar days for claims received via fax or mail, or within
31 10 calendar days for claims received electronically. If requested information is not received
32 within 30 days after the initial request, a second notification letter is sent. In accordance
33 with client or state requirements, if the requested information is not received within 45
34 days after the initial request, a third notification letter is sent. If the requested information
35 is not received by the 45th day or other client-specified timeframe, the claim will be denied
36 accordingly.

37 38 **Non-Clean Claim Development – CMS Claims**

39 Non-clean claims submitted by members, affiliated providers/practitioners, and non-
40 affiliated practitioners are developed as required under CMS guidelines. To develop
41 claims, only the missing information that is necessary to adjudicate the claim is requested.
42 ASH accepts information from any reasonably reliable source that will assist in qualifying
43 the claim as a clean claim, such as members or practitioners. Notification to request

1 additional information is made within 30 days of receipt of the claim but in any case, no
2 longer than five (5) days from determining a claim is not a clean claim. If the requested
3 information is medical records, the records are forwarded to a Manager, Clinical Quality
4 Evaluation for review. If requested information is not received within 10 days after the
5 initial request, a second notification letter is sent. If requested information is not received
6 within 30 days after the initial request, a third notification letter is sent. If the requested
7 information is not received by the 55th calendar day, and no later than the 60th calendar day
8 from the receipt of the claim, the claim will be processed according to the information
9 available.

10 **Emergent/Urgent Services**

11 ASH complies with applicable CMS, state, and health plan guidelines for emergent/urgent
12 services. Medical records for claims that require determination of emergent/urgent services
13 are forwarded to designated Managers, Clinical Quality Evaluation for review. Payment or
14 non-payment for covered services is issued according to the clinical quality evaluation
15 determination of the Manager, Clinical Quality Evaluation.

16 **Non-Contracted Practitioners**

17 ASH reimburses covered services rendered to eligible members by non-
18 contracted/unaffiliated practitioners under out-of-network benefits and/or emergent/urgent
19 services. ASH complies with all state and federal regulations regarding reimbursement to
20 non-contracted practitioners. ASH complies with contractual agreements with health plans
21 that offer an out-of-network and out of area benefit to their members. If a dispute arises
22 from an out-of-network practitioner regarding determination of reimbursement, ASH will
23 disclose how reimbursement was calculated.

24 **Coordination of Benefits**

25 ASH coordinates benefits for members with other insurance, including Medicare, in
26 accordance with OPM/FEHP and industry standards. Coordination of benefits is identified
27 at the time of claims processing.

28 **Adjustments**

29 All requests for claims adjustments are researched and made according to the findings. An
30 adjusted claim produces a new claim number that is linked to the claim number of the
31 original claim. The claims payment system prohibits the alteration or deletion of a paid
32 claim.

33 **Quality Review**

34 The Claims department performs quality review and captures quality review findings in
35 the IHIS claims payment system to measure payment, coding, and financial accuracy and
36 to ensure compliance with Claims department policies and procedures and Performance
37 Standards.

1 **Claims Acknowledgement**

2 ASH abides by individual state requirements for the Claim Acknowledgement statutes.

3
4 ASH researches and monitors current and pending legislation in all states where ASH
5 conducts business. State prescribed Claim Acknowledgement statutes are identified and
6 reported to department management.

7
8 Claim Acknowledgement statutes for individual states are maintained in the claims
9 acknowledgement letter table in the IHIS claims payment system.

10
11 **Check Process**

12 The claims check process incorporates guidelines for timeliness, security, tracking, and
13 monitoring. The initiation of a check run requires log-in from one authorized user in
14 Finance. Claim checks are mailed within one (1) business day of printing. ASH generates
15 and mails 1099 forms to practitioners on an annual basis.

16
17 **Practitioner Remittance Advice**

18 Practitioner Remittance Advice notices are generated and mailed to the practitioner of
19 services for claims received for members with a Medicare Advantage, non-Medicare
20 Medicaid, Medi-Cal or commercial plan benefit. The claims payment system assigns
21 applicable payment/non-payment codes and descriptions for all billed services. Practitioner
22 Remittance Advice notices contain payment/non-payment descriptions listed in the
23 practitioner payment description table. In the event the allowed amount of the claim is less
24 than billed charges due to maximum fee schedule, the payment/non-payment code on the
25 Practitioner Remittance Advice includes the statement that charges exceed maximum
26 allowable fee for out-of-network practitioners and exceeds contracted fee for in-network
27 practitioners.

28
29 In compliance with applicable federal and state regulations, Practitioner Remittance
30 Advice notices provide:

- 31 • Instructions for filing a grievance and appeal, including timeframes for filing;
- 32 • CMS appeals information, including time frames for filing, as applicable; and
- 33 • Medicaid appeals information, including time frames for filing, as applicable.

34
35 Practitioners are afforded a minimum of 180 days to appeal an adverse claim decision or
36 as applicable by state law.

37
38 **Member Explanation of Benefits Notices**

39 Member Explanation of Benefit (EOB) notices are generated and mailed for claims
40 received that result in member responsibility or is otherwise required by state law. The
41 claims payment system assigns applicable payment/non-payment codes and descriptions
42 for all billed services. Member EOB notices contain payment/non-payment descriptions
43 listed in the member payment description table.

1 In compliance with ERISA and applicable state regulations, member EOB notices provide
2 each of the following elements:

- 3 • A clear and concise explanation in easily understandable language of the specific
4 reason(s) for an adverse benefit determination;
- 5 • Specific plan provisions on which the determination is based;
- 6 • Specific description of additional information needed, if applicable, and the reason
7 such information is required;
- 8 • Instructions to appeal an adverse benefit determination with specified timelines for
9 filing an appeal;
- 10 • Notice of the right to bring to civil action by members of an ERISA regulated group
11 health care plan; and
- 12 • Notice of the right to receive, upon request and at no charge, any rule, guideline,
13 protocol, or criterion relied upon in making a benefit determination.

14
15 Any member claim denial notice, including but not limited to EOBs, subject to the
16 Affordable Care Act also provide each of the following:

- 17 • Information regarding the availability of, and contact information for, any
18 applicable office of health insurance consumer assistance or ombudsman to assist
19 members with the appeals and external review processes;
- 20 • Information regarding the availability of diagnosis and treatment codes and their
21 meanings; and
- 22 • Information regarding the availability of language assistance.

23
24 Additionally, ASH notifies Medicare Advantage members of services not paid (denied) as
25 member responsibility within 30 calendar days of the receipt of the claim. The notification
26 to the Medicare Advantage member for services not paid (denied) as member responsibility
27 contains applicable appeals and grievance information as prescribed by CMS, state
28 regulatory guidelines, or health plan, including a minimum of 180 days to request the
29 appeal.

30
31 ASH has a process to provide, upon request by a claimant or potential claimant, specific
32 payment rules and policies.

33 34 **Interest Payments**

35 **Non-Medicare (Commercial, Medicaid, Medi-Cal)**

36 ASH abides by individual state requirements for the calculation and payment of interest on
37 commercial and Medicaid claims not meeting state prescribed turnaround times.

38
39 ASH researches and monitors current and pending legislation in all states where ASH
40 conducts business. State prescribed prompt payment/claim payment turnaround time
41 guidelines and applicable interest payments are identified and reported to department
42 management.

1 Current interest rates and accrual periods for individual states are maintained in an interest
2 table in the claims payment system. ASH does not accumulate payment interest as claims
3 are paid in full at the time a payment is issued.

4 **Medicare Advantage**

5 ASH abides by CMS guidelines for the calculation and payment of interest on Medicare
6 Advantage claims not meeting CMS prescribed turnaround times. ASH monitors the
7 current CMS interest rate approved by the Secretary of the Treasury and published in the
8 Federal Register.
9

10
11 Current interest rates and accrual periods are maintained in an interest table in the claims
12 payment system. ASH does not accumulate payment interest as claims are paid in full at
13 the time a payment is issued.

14 **Contract Approval Process**

15 Claims are accurately adjudicated based on approved client summaries and fee schedules.
16 Newly implemented or updated client summaries and fee schedules are verified against
17 system contract maintenance tables. All contracts undergo claims adjudication testing.
18

19 **Medical Necessity Review Form (MNR Form)**

20 The claims payment system requires an approved MNR Form to pay a claim for services
21 other than those available within the contracted provider/practitioner's applicable Clinical
22 Performance System tier level. Covered services rendered without an MNR Form and/or
23 outside a contracted provider/practitioner's Clinical Performance System tier level are
24 denied to the contracted provider/practitioner as practitioner responsibility. For any
25 covered condition (diagnosis codes), all covered services (CPT Codes) under the applicable
26 client summary are reimbursable when verified as medically necessary or when delivered
27 under any applicable Clinical Performance System tier level.
28

29 **Modifiers**

30 For all claims ASH accepts modifiers billed with a number of procedure codes. If more
31 than one modifier is billed, only the first modifier will be imported into the claims
32 processing system for adjudication. ASH applies applicable CMS National Correct Coding
33 Initiative (CCI) edits to all claims. Some codes, when used in combination, require the use
34 of modifiers in order to be reimbursable. All codes billed with modifiers will be reimbursed
35 at the primary code's contracted rate, unless otherwise stated in the applicable fee schedule.
36

37 **ERISA Compliance**

38 The Claims department complies with ERISA regulatory requirements related to post-
39 service claims.
40

41
42 The Claims department issues payment or non-payment for post-service claims within 30
43 calendar days of receipt of the claim.

1 In the event additional information is required to make a payment determination, the
 2 Claims department compliance analysts prepare and mail an approved form letter that
 3 provides all the following information to the provider/practitioner before the claim is aged
 4 15 calendar days:

- 5 • A specific description of the information needed to make a payment determination.
- 6 • Notification that the provider/practitioner is allowed 45 calendar days from receipt
 7 of the letter to provide the specified information.
- 8 • Notification that ASH will make a payment determination within 15 calendar days
 9 of receipt of the claim of the additional information.

10 **Extension Notification**

11 The Claims department may extend the time limit for making a commercial claim payment
 12 determination from 30 days of receipt of the claim to 45 days with the following conditions:

- 13 • An extension is necessary due to matters beyond the control of ASH;
- 14 • The member and practitioner are notified of the extension by letter before the claim
 15 is aged 30 days; and
- 16 • The reason for the delay is captured in the IHIS claims payment system.

17 **Regional Medicare Requirements – Medicare Advantage**

18 ASH abides by the regional Medicare office interpretation of CMS rules and regulations
 19 as they apply for a health plan’s Medicare Advantage members within the region.

20 **Claims Staffing Level**

21 The Claims department monitors staffing levels and maintains an appropriate number of
 22 staff to meet claims processing turnaround times.

23 **Claims Department Training**

24 The Claims department performs and documents departmentally specific training and
 25 education on topics including, but not limited to, the following:

- 26 • Daily job responsibilities and operations
- 27 • State and federal laws and regulations
- 28 • Privacy, security, and anti-fraud regulations
- 29 • Accreditation standard requirements

30 **Anti-Fraud Training and Awareness**

31 Claims department staff receives corporate anti-fraud requirement training, annually, as
 32 conducted by Human Resources. Anti-Fraud Policy training includes information about
 33 ASH’s Anti-Fraud Program, SIU Committee, and Anti-Fraud Referral Form. Anti-Fraud
 34 Policies and the Anti-Fraud Referral Form are available to staff via the Intranet.

35 **NON-DISCRIMINATION**

36 ASH does not discriminate against a member, provider, or practitioner for any reason and
 37 does not support any discriminating against members for any reason, including but not
 38

1 limited to age, sex, gender, gender identification (e.g., transgender), gender dysphoria,
2 marital status, religion, ethnic background, national origin, ancestry, race, color, sexual
3 orientation, patient type (e.g., Medicaid), mental or physical disability, health status, claims
4 experience, medical history, genetic information, evidence of insurability, source of
5 payment, geographic location within the service area or based on political affiliation. ASH
6 renders credentialing, clinical performance, and medical necessity decisions in the same
7 manner, in accordance with the same standards, and within the same time availability to all
8 members, providers, practitioners, and applicants.