

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

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

4
5 **Contact:** **Claims**

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

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

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

21
22 **Claims Confidentiality**

23 Claims staff members sign confidentiality agreements that include but are not limited to
24 the requirement that claims staff members treat all member and client information as
25 confidential. Staff adhere to all corporate and departmental policies and procedures that
26 protect the confidentiality of member, practitioner, and client information. Member,
27 practitioner, and health plan information, including information submitted to ASHA on
28 claim forms, is used solely for fulfilling duties related to their job functions and
29 authorized business purposes. Staff members follow procedural guidelines to protect the
30 confidentiality of member, practitioner, and health plan information on claim
31 submissions, the IHIS claims 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 ASHA 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, ASHA's
 5 Regulatory Compliance department obtains and coordinates all required licensures,
 6 certifications, and/or registration processes for the applicable number of individual
 7 examiners. All such licenses, certifications, and registrations are monitored by the Claims
 8 department with assistance from the Regulatory Compliance department on a monthly
 9 basis and are maintained through the standard license renewal process (typically on an
 10 annual or biennial cycle).

11
 12 **Conflict of Interest**

13 Compensation for ASHA Claims Examiners includes an incentive program based solely
 14 on productivity and quality. The incentive threshold is not determined by over or under
 15 utilization or denial of claims.

16
 17 **Inventory Management**

18 ASHA receives both paper and electronically submitted claims. All paper claims are
 19 sorted, counted, and batched. Paper claims and attached documents are scanned through
 20 digital imaging equipment to capture an electronic image for records retention. Paper
 21 claims and attached documents are imprinted with entity name, date received, batch, and
 22 page number. Paper claims are stored in a secure area within the Claims department until
 23 the claim is adjudicated, then destroyed according to corporate policy.

24
 25 Claims inventory and aging are tracked, monitored, and reported.

26
 27 **Claims Status**

28 ASHA maintains a toll free telephone line for members to call in to verify status of their
 29 claims. The claim can be tracked by member name, member identification number, date
 30 of service, practitioner tax ID, and practitioner name.

31
 32 **Record Retention**

33
 34 **Commercial**

35 Electronic images are maintained on CD ROM, stored offsite, and are retained for seven
 36 (7) years. Paper claims that were adjudicated prior to the implementation of electronic
 37 imaging are stored offsite and are maintained for a minimum of seven (7) years.

38
 39 Electronic claims are received through ASHLink, the ASHA practitioner website and
 40 ASH Clearinghouse. Each claim is electronically date-and time-stamped. Electronically
 41 submitted claims are stored in the ASHLink database for future retrieval. Back-up files

1 are produced nightly for offsite storage and are retained for a minimum of seven (7)
2 years.

3 **Medicare Advantage**

4 All Medicare Advantage claims are retained for a minimum of ten (10) years from the
5 final date of the client Medicare Advantage contract with ASHA. This retention period
6 may be extended for the period and reason specified in federal regulation 42 C.F.R. s
7 422.504(e)(4)(i)-(iii), as long as ASHA receives notice from the Medicare Advantage
8 Organization or CMS within a reasonable time before the expiration of the applicable
9 time period.

10 **Eligibility**

11 The Claims department verifies member eligibility for each claim received. ASHA
12 confirms eligibility information with the member's health plan via eligibility files,
13 telephonic inquiry, or website. ASHA will update member eligibility on a monthly basis
14 at minimum, or as frequently as submitted by the health plan.

15 **Claims Submission Timeline**

16 Claims must be received by ASHA within 180 days after the date of service. Claims can
17 be submitted via ASHLink, ASH Clearinghouse, or by mail on a CMS 1500 form. Claims
18 submitted to ASHA after 180 days will not be paid due to late submission. Submissions
19 received by ASHA outside of business hours will be considered as received the following
20 business day. Contracted practitioners are financially responsible to submit all claims in a
21 timely manner.

22 **The following exceptions apply to the 180-day submission timeline:**

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

Pended Claims

The claims payment system contains claim pend capabilities. The system has automatic and manual mechanisms for pending claims. The system automatically pends member responsibility claims. Pended claims are tracked and monitored daily. Turnaround time for a claim is not reduced by the number of days a claim is in pend status.

Member Responsibility

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

Timeliness Standards – Commercial Claims

The Claims department monitors claims turnaround time to ensure ASHA issues payment or non-payment for clean claims received via fax or mail within 30 calendar days of receipt of the claim. Clean claims received electronically are paid within 10 calendar days of receipt of the claim.

Timeliness Standards – CMS Claims

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

In the event payment determination is not made within 60-days, ASHA notifies the Medicare Advantage member of appeals and grievance rights at or before 60 days from the receipt of the claim.

Non-Clean Claim Development – Commercial Claims

Non-clean claims submitted by members, contracted practitioners, and non-contracted practitioners are developed as required under applicable accreditation standards, and state requirements. To develop claims, only the missing information that is necessary to adjudicate the claim is requested. ASHA accepts information from any reasonably reliable source that will assist in qualifying the claims as a clean claim, such as members or practitioners. Notification to request additional information is made within 30 days of receipt of the claim but in any case no longer than five (5) days from determining a claim is not a clean claim. Due to the request for additional information, a 15 day extension is allowed, making the total turn around time 45 calendar days. However, ASHA will cease counting the 45 calendar days on the day that ASHA sends the notice requesting missing information. When the requested information is received, ASHA will resume counting the 45 calendar days, and the claim is adjudicated within 15 calendar days for claims received via fax or mail, or within 10 calendar days for claims received electronically. If the requested information is medical records, the records are forwarded to a senior

1 clinical services manager for review. If requested information is not received 45 days
 2 after the initial request, a second notification letter is sent. If the requested information is
 3 not received within 90 days of the initial request, the claim will be denied accordingly.

4 **Non-Clean Claim Development – CMS Claims**

6 Non-clean claims submitted by members, affiliated practitioners, and non-affiliated
 7 practitioners are developed as required under CMS guidelines. To develop claims, only
 8 the missing information that is necessary to adjudicate the claim is requested. ASHA
 9 accepts information from any reasonably reliable source that will assist in qualifying the
 10 claim as a clean claim, such as members or practitioners. Notification to request
 11 additional information is made within 30 days of receipt of the claim but in any case no
 12 longer than five (5) days from determining a claim is not a clean claim. If the requested
 13 information is medical records, the records are forwarded to a senior clinical services
 14 manager for review. If requested information is not received within 10 days after the
 15 initial request, a second notification letter is sent. If the requested information is not
 16 received by the 55th calendar day, and no later than the 60th calendar day from the receipt
 17 of the claim, the claim will be processed according to the information available.

18 **Emergent/Urgent Services**

20 ASHA complies with applicable CMS, state, and health plan guidelines for
 21 emergent/urgent services. Medical records for claims that require determination of
 22 emergent/urgent services are forwarded to designated senior clinical services managers
 23 for review. Payment or non-payment for covered services is issued according to the
 24 clinical services management determination of the senior clinical services manager.

25 **Non-Contracted Practitioners**

27 ASHA reimburses covered services rendered to eligible members by non-
 28 contracted/unaffiliated practitioners under out-of-network benefits and/or
 29 emergent/urgent services. ASHA complies with all state and federal regulations regarding
 30 reimbursement to non-contracted practitioners. ASHA complies with contractual
 31 agreements with health plans that offer an out-of-network and out of area benefit to their
 32 members. If a dispute arises from an Out-of-Network practitioner regarding
 33 determination of reimbursement, ASH will disclose how reimbursement was calculated.

34 **Coordination of Benefits**

36 ASHA coordinates benefits for members with other insurance, including Medicare, in
 37 accordance with OPM/FEHP and industry standards. Coordination of benefits is
 38 identified at the time of claims processing.

39 **Adjustments**

41 All requests for claims adjustments are researched and made according to the findings.
 42 An adjusted claim produces a new claim number that is linked to the claim number of the

1 original claim. The claims payment system prohibits the alteration or deletion of a paid
2 claim.

3 4 **Quality Review**

5 The Claims department performs quality review and captures quality review findings in
6 the IHIS claims payment system to measure payment, coding, and financial accuracy and
7 to ensure compliance with Claims department policies and procedures and Performance
8 Standards.

9 10 **Claims Acknowledgement**

11 ASHA abides by individual state requirements for the Claim Acknowledgement statutes.

12
13 ASHA researches and monitors current and pending legislation in all states where ASHA
14 conducts business. State prescribed Claim Acknowledgement statutes are identified and
15 reported to department management.

16
17 Claim Acknowledgement statutes for individual states are maintained in the claims
18 acknowledgement letter table in the IHIS claims payment system.

19 20 **Check Process**

21 The claims check process incorporates guidelines for timeliness, security, tracking, and
22 monitoring. The initiation of a check run requires a dual log-in from one authorized user
23 in Finance and one authorized user in Claims. Claim checks are mailed within one (1)
24 day of printing. ASHA generates and mails 1099 forms to practitioners on an annual
25 basis.

26 27 **Practitioner Remittance Advice**

28 Practitioner Remittance Advice notices are generated and mailed to the practitioner of
29 services for claims received for members with a Medicare Advantage or commercial plan
30 benefit. The claims payment system assigns applicable payment/non-payment codes and
31 descriptions for all billed services. Practitioner Remittance Advice notices contain
32 payment/non-payment descriptions listed in the practitioner payment description table. In
33 the event the allowed amount of the claim is less than billed charges due to maximum fee
34 schedule, the payment/non-payment code on the Practitioner Remittance Advice includes
35 the statement that charges exceed maximum allowable fee for Out-of-Network
36 practitioners and exceeds contracted fee for In-Network practitioners.

37
38 In compliance with applicable federal and state regulations, Practitioner Remittance
39 Advice notices provide:

- 40 • Instructions for filing a grievance and appeal, including timeframes for filing; and
- 41 • CMS appeals information, including time frames for filing, as applicable.

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

3 **Member Explanation of Benefits Notices**

4 Member Explanation of Benefit (EOB) notices are generated and mailed for claims
5 received for members with a commercial group plan health care benefit that result in
6 member responsibility or is otherwise required by state law. The claims payment system
7 assigns applicable payment/non-payment codes and descriptions for all billed services.
8 Member EOB notices contain payment/non-payment descriptions listed in the member
9 payment description table.

10
11
12 In compliance with ERISA and applicable state regulations, member EOB notices
13 provide each of the following elements:

- 14 • Specific reason(s) for an adverse benefit determination;
- 15 • Specific plan provisions on which the determination is based;
- 16 • Specific description of additional information needed, if applicable, and the
17 reason such information is required;
- 18 • Instructions to appeal an adverse benefit determination with specified timelines
19 for filing an appeal;
- 20 • Notice of the right to bring to civil action by members of an ERISA regulated
21 group health care plan; and
- 22 • Notice of the right to receive, upon request and at no charge, any rule, guideline,
23 protocol, or criterion relied upon in making a benefit determination.

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

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

34 **Interest Payments**

35 **Commercial**

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

39
40
41 ASHA researches and monitors current and pending legislation in all states where ASHA
42 conducts business. State prescribed prompt payment/claim payment turnaround time

1 guidelines and applicable interest payments are identified and reported to department
2 management.

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

7 8 **Medicare Advantage**

9 ASHA abides by CMS guidelines for the calculation and payment of interest on Medicare
10 Advantage claims not meeting CMS prescribed turnaround times. ASHA monitors the
11 current CMS interest rate approved by the Secretary of the Treasury and published in the
12 Federal Register.

13
14 Current interest rates and accrual periods are maintained in an interest table in the claims
15 payment system. ASHA does not accumulate payment interest as claims are paid in full
16 at the time a payment is issued.

17 18 **Contract Approval Process**

19 Claims are accurately adjudicated based on approved payor summaries and fee schedules.
20 Newly implemented or updated payor summaries and fee schedules are verified against
21 system contract maintenance tables. All contracts undergo claims adjudication testing.

22 23 **Clinical Treatment Forms**

24 The claims payment system requires an approved Clinical Treatment Form to pay a claim
25 for services other than those provided under a Treatment Form Waiver. Covered services
26 rendered without a Clinical Treatment Form and/or outside a Treatment Form Waiver are
27 denied to the contracted practitioner as practitioner responsibility. For any covered
28 condition (ICD-9 Codes), all covered services (CPT Codes) under applicable payor
29 summary are reimbursable when verified as medically necessary or when delivered under
30 any applicable treatment form waiver.

31 32 **Indented Codes**

33 The American Medical Association (AMA) CPT code sets include “indented” codes that
34 define a series of related services that are mutually exclusive. For the range of services
35 covered by ASHA benefit plans, there are two (2) such sets of indented codes:

36 37 **Chiropractic Manipulation Services**

38 CPT Codes 98940, 98941, 98942, and 98943: Each of these codes is payable at
39 the contracted fee when billed individually. When a 98943 (extremity
40 manipulation) is billed in conjunction with a 98940-98942, it will be reimbursed
41 as part of the all inclusive per diem rate for the base spinal manipulation code.

1 Acupuncture Services
 2 CPT Codes 97810, 97811, 97813, and 97814: The 97810 and 97813 are payable
 3 at the contracted fee when billed individually. CPT 97811 or 97814 is required to
 4 be billed in conjunction with the 97810 or 97813 and will be reimbursed at the
 5 contracted per diem rate.

7 **Modifiers**

8 ASHA accepts modifiers billed with a number of procedure codes. All codes billed with
 9 modifiers will be reimbursed at the primary code's contracted rate, unless otherwise
 10 stated in the applicable fee schedule. The following is a list of acceptable modifiers with
 11 corresponding procedure codes:

12
 13 Modifier 21
 14 99205, 99215

15
 16 Modifier 25
 17 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, or 99215

18
 19 Modifier 59
 20 97140

21
 22 Modifier 26
 23 This modifier will be accepted when billed with an x-ray code and only the
 24 professional component is being billed.

25
 26 Modifier AT
 27 This modifier will only be accepted when billed with 98940, 98941, or 98942 for
 28 Medicare claims.

29
 30 Modifier TC
 31 This modifier will be accepted when billed with an x-ray code and only the
 32 technical component is being billed.

33 34 **ERISA Compliance**

35 The Claims department complies with ERISA regulatory requirements related to post-
 36 service claims.

37
 38 The Claims department issues payment or non-payment for post-service claims within 30
 39 calendar days of receipt of the claim.

40
 41 In the event additional information is required to make a payment determination, the
 42 Claims department compliance analysts prepare and mail an approved form letter that

1 provides all the following information to the practitioner before the claim is aged 30
2 calendar days:

- 3 • A specific description of the information needed to make a payment
4 determination.
- 5 • Notification that the practitioner is allowed 90 calendar days from receipt of the
6 letter to provide the specified information.
- 7 • Notification that ASHA will make a payment determination within 15 calendar
8 days of receipt of the claim of the additional information.

9
10 **Extension Notification**

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

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

18
19 **Regional Medicare Requirements – Medicare Advantage**

20 ASHA abides by the regional Medicare office interpretation of CMS rules and
21 regulations as they apply for a health plan's Medicare Advantage members within the
22 region.

23
24 **Claims Staffing Level**

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

27
28 **Claims Department Training**

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

- 31 • Daily job responsibilities and operations
- 32 • State and federal laws and regulations
- 33 • Privacy, security, and anti-fraud regulations
- 34 • URAC accreditation standard requirements

35
36 **Anti-Fraud Training and Awareness**

37 Claims department staff receives nine (9) hours of training within 180 days of
38 employment and four (4) hours each year thereafter on anti-fraud requirements. Anti-
39 Fraud Policy training includes information about ASHA's Anti-Fraud Program, Fraud
40 Special Investigation Unit (SIU), and Anti-Fraud Referral Form. Anti-Fraud Policies and
41 the Anti-Fraud Referral Form are available to Claims department staff via the Intranet.