CHAPTER 11:

Claims Processing

Reviewed/Revised: 10/01/18, 10/02/19, 1/1/20, 9/1/20, 1/1/21, 5/1/21

11.0 GENERAL INFORMATION

All claims/encounters submitted to Health Choice Arizona are reviewed for completeness and accuracy. The process begins with a systematic check of the quality and completeness of the data entered on the claim.

All required fields must be included on all claim submissions or the claim will be rejected.

If required fields are not completed or if any fields are completed incorrectly, an error code will be identified for the claim. For example, if the date is "December 10, 2016" it must be recorded as 12/10/2016 (MM/DD/YYYY format). If Prior Authorization (PA) is required the PA number must be reported with all numbers including leading zeros (i.e. 0000123456).

The system also confirms that a provider ID, recipient ID, date(s) of service, place of service code (CMS 1500), diagnosis code(s), procedure/revenue/NDC code(s) and billed charges are present on the claim. These data elements, as applicable, are required on all claims.

When submitted a claim with multiple pages (a multi-page claim) **all lines must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in).

Refer to the ASCX12 HIPAA Guidelines for information on correct formatting for electronically submitted claims. A copy of the HIPAA Guidelines can be obtained From the Washington Publishing Company at http://www.wpc-edi.com/.

The final step in the review of the claim is an audit process to assure that reimbursement for the service has not been previously paid and does not exceed service limitations. The claims system audits for duplications, checking for whether information on a previously approved claim/encounter matches information on the claim/encounter being reviewed.

11.1 EDITING PROCESS

The claims system attempts to apply all edits during a single processing cycle. This enables Health Choice Arizona to report all errors to the provider and avoid claims failing new edits after the provider has corrected and resubmitted the claim.
However, if certain data is missing, incorrect, or invalid, completion of the entire processing cycle may not be possible.

The system edits to ensure that data fields are valid and logical. The most important of these edits assure that:

- The provider ID number is shown on the claim
- The provider has the authority to provide this service
- The recipient is on file, eligible, and entitled to the service
- The service was covered by Health Choice on the date it was delivered
- Diagnosis and procedure codes were valid for the date of service
- Prior authorization is obtained if required and full PA number is reported (leading zeros)
- The claim is reviewed by Health Choice medical staff before payment, if required
- The service is allowed for the recipient's age and gender
- The services were part considered included or mutually exclusive of another service performed
- The services billed don't exceed maximum units
- The services were not considered as part of Global days

When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits.

However, if a crucial edit is encountered (such as a **required** field being found blank) the editing process for the rest of the claim will be **stopped**. The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit. This includes, but is not limited to, missing, incorrect or invalid data.

> Note: If there are other fields that are blank, filled out incorrectly, or invalid appearing *after* the field that failed the initial editing process, these will not be caught by the system until *after* the provider makes the initial field correction and sends the **replacement** claim back in for review.

Once the edit has been corrected and resubmitted by the provider the editing process may continue and may encounter other critical edits. This may cause the claim to deny and be reported on the remit.

Edits related to the claim denial are displayed on the Remittance Advice with an action code. A description of the action code is listed on the last page of the Remittance Advice, (see Chapter 13: *Understanding the Remittance Advice*), for more information.

A Claim Reference Number (CRN*)* is assigned to all claims on initial submission to Health Choice Arizona. The first five characters of the CRN represent the Julian date the claim was initially received by Health Choice Arizona. The remaining numbers make up the claim document number assigned by Health Choice Arizona.

When submitting documentation (e.g., Medicare EOB) subsequent to submission of a claim, the CRN of the initial submission of the claim should be provided to enable Health Choice Arizona to link the documentation to the claim.

Providers also must provide the CRN when resubmitting, correcting or voiding (when applicable) a claim. If a claim/encounter is resubmitted without the CRN, the claim/encounter will be treated as a first-time submission.

Behavioral Health claims billed with a primary behavioral health diagnosis (claims identified with both numeric and alpha characters i.e. 12345E67890) require the most recently processed claim number in the claim series (e.g.A1, A2, etc.), be used for claim resubmissions/replacements/reversals (when applicable), not simply the first claim processed. Please refer to your most recent EOB for the most recently processed claim number.

Once a claim is priced, applicable discounts, penalties, primary insurance payments, etc. are applied to the allowed amount to arrive at a final reimbursement amount.

Reference Chapter 1: *Introduction to Health Choice Arizona*, for additional information on Provider Reimbursement.

Reference Chapter 14: *Medicare and Other Insurance Liability*, for additional information on the lesser-of methodology utilized when other payers are involved.

11.2 PRICING OF CLAIMS

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment. Health Choice Arizona's pricing methodologies include, but are not limited to the following:

- DRG Pricing Formulas (See Chapter 19: *Hospital Services*)
- Ratios, such as inpatient and outpatient cost-to-charge ratios
- Out-Patient Fee Schedule (OPFS) Logic
- Percentage of the billed charge
- Set amounts, or capped fees, such as the unit price for ambulance mileage
- Negotiated rates
- Medicare coinsurance and deductible, minus any other third party payments, for Medicare-covered services for members with Medicare.
- The system determines if a specific rate has been prior authorized.

Health Choice Arizona has adopted a facility/non-facility rate differential similar to the Medicare format. The facility/non-facility rate structure assigns a reimbursement rate for a given Health Choice Arizona-covered procedure code based on the billed place of service (POS) code.

11.3 QUICK PAY DISCOUNT / INTEREST PAYMENTS

Health Choice Arizona ensures the application of Quick Pay Discount/Interest when appropriate, in accordance with the methodology outlined in the AHCCCS Contractor Operations Manual, Policy 203 which can be located at: https://azahcccs.gov/

The following procedures apply to claim payments to contracted providers with fee-for-service and single case agreements.

Slow Pay Penalties:

- For hospital Clean Claims, Health Choice shall pay slow payment penalties (interest) on payments made after 60 day of receipt of the Clean Claim.

- Health Choice 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).

In the event a claim is reprocessed as a result of an overturned claim dispute or State Fair Hearing, the claims shall be reprocessed within 15 days from the date of the decision, and interest shall be paid back to the date the clean claim was received.

Quick Pay Discount:

Health Choice 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.