# CHAPTER 11:

# Claims Processing

Reviewed/Revised: 9/24, 1/24, 5/25, 12/25. 3/26

## 11.0 GENERAL INFORMATION

All claims/encounters submitted to ACA StandardHealth with Health Choice 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, 2023" it must be recorded as 12/10/2023 (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/.

For specific payment policies, billing requirements, and reimbursement guidance applicable to claims processing, providers should refer to Exhibit 11.1.

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 ACA StandardHealth with Health Choice 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 are 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 ACA StandardHealth with 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 a claim fails an edit or an audit, an error record is created for that claim. All failed 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: *Understanding the Remittance Advice*), for more information.

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

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 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.

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: *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. ACA StandardHealth with Health Choice's pricing methodologies include, but are not limited to the following:

- DRG Pricing Formulas (See chapter: *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

ACA StandardHealth with Health Choice 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-covered procedure code based on the billed place of service (POS) code.

## 11.3 INTEREST PAYMENTS

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

**Interest:**
Interest terms follow state statutes; ARS 44-1201 and ARS 20-3102. Which state interest, all Form Types, should be applied at 10% per annum (Days of interest owed * 0.000273973 * Payment owed) for any clean claims not paid within 30 days of receipt. Interest calculation begins on day 31 from the date of clean claim receipt.