Chapter 11: Claims Processing

General Information

All claims submitted to Health Choice Insurance Co. (Health Choice) are extensively edited by the Health Choice claims processing system. The process begins with a check of the quality and completeness of the data entered on the claim.

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).

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

After editing for completeness and correctness of the data submitted, 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 member 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
- The claim is reviewed by Health Choice medical staff before payment, if required
- The service is allowed for the member's age and gender
- The services were part considered included or mutually exclusive of another service performed
- The services billed exceeded maximum units
- The services were considered as part of a Global days

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 or does not exceed service limitations. The claims system audits for duplications, checking the member, provider, date of service, and procedure/diagnosis are the same on a paid claim as the claim being reviewed.

Editing Process

The claims system attempts to apply all edits during a single processing cycle. This enables 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.

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.

If one or more edit(s) fail during the editing process, there are two possible outcomes:

- Pended Claim - claim may stop processing and "is pended" for internal review when the error detected concerns data or procedures that may be resolved by Health Choice staff.
- When a claim requires Medical Review, for example, it will be pended internally until Medical Review screens the services being billed. Internally pended claims are generally handled without input from the provider. The exception is when medical documentation is requested for a claim under review.
- Denied claim - If the data required for adjudication is complete but the service does not meet Health Choice policy requirements, the claim will deny without payment. For example, if a provider was not registered or if a recipient was not eligible on the date of service, the claim will deny without payment.

Health Choice's intention is to process all clean claims in a timely manner, within 30 days. A claim is considered "clean" on the date the following conditions are met:

- All required information has been received by Health Choice.
- The claim meets all Health Choice submission requirements.
- The claim is legible enough to permit electronic image scanning or manual input.
- Any errors in the data provided have been corrected.
- All medical documentation required for medical review has been provided.

A Claim Reference Number (CRN*)* is assigned to all claims on initial submission to 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 Insurance Co.

When submitting documentation 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 initial CRN when resubmitting, adjusting, or voiding a claim. In the event of a duplicate of an existing claim, the resubmission is subject to denial.

Pricing of Claims

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment. Claims are priced using methodologies which are based on the contractual status of the providers from whom claims are received.

The system determines if a specific rate has been prior authorized.

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

Recoupment

Under certain circumstances, Health Choice may find it necessary to *recoup* or take back money previously paid to a provider. Overpayments and erroneous payments are identified

through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

Upon completion of the recoupment, Health Choice will send a remittance advice explaining the action, date of the action, recipient, date of service, and appeal rights.

If payment is recouped for a reason other than third party recovery, the provider will be afforded additional time to provide justification for re-payment.

It is against federal law for a provider to keep funds that he/she is not entitled to.